In order to understand where this style of accommodation and care has come from we need to take account of the development of sheltered housing in the UK. The model that we now recognise as conventional sheltered housing began to emerge shortly after the Second World War. Growth during the 1950s was relatively slow, with perhaps 28,000 people living in sheltered housing by 1960. Most of the accommodation, in flats and self-contained bungalows, came from local authorities.

The first priority of post-war housing policy had been the clearance of damaged or unfit housing and the building of family accommodation. By 1960 the lack of balance in existing programmes was beginning to be recognised and greater emphasis was placed on providing accommodation for older people. Official government policy began to encourage housing departments to build "accommodation mid-way between self-contained dwelling and hostels providing care." (Ministry of Housing and local government design bulletin (1958).) The design guidance – accommodation for a warden, alarm system and a communal sitting room – reflected this ‘hybrid’ concept.

This guidance set the tone for the next thirty years. Fletcher identifies two fundamental elements in this. First, it suggested a model of housing which combines self-contained accommodation with communal facilities. Second, it advocated a particular model of community care which ensured that people move along a continuum of built provision as their need for care increases. The first of these two assumptions remains influential in the design of most schemes, including those intended to be Very Sheltered. The second element is challenged by some champions of the development of Very Sheltered housing, including Fletcher himself in his 1991 policy report. By adding additional facilities and services to the conventional model of sheltered housing it is argued that people can receive rising levels of support whilst remaining in place, obviating the need for them to change their housing context as they move along a continuum of care.

Further guidance in the joint circular from the Ministry of Housing and Local Government and Ministry of Health in 1961 introduced the idea of a ‘balanced population’ of tenants. The idea is based on the assumption that fit people in a scheme help those who are frailer and that the total support needs of all the tenants should not exceed the capacity of the warden service. This notion has been consistently challenged, most notably by Butler. He contended that it introduced a fundamental contradiction into the concept of sheltered housing. If this was indeed to be seen as a form of provision that gave something additional to those who needed it sheltered housing could only be allocated to those with an appropriate
level of need. Allocation solely to those with high levels of need would make the warden’s role untenable in the models of sheltered housing operating in the early 1980s. If to achieve balance those with lower levels of need were introduced into a scheme this must be an inappropriate use of public funds. This line of argument will appear again when we come to consider the characteristics of those allocated to Very Sheltered Housing.

Arguing from a quite different premise: that the demand was so great among those with high levels of need only an irresponsible provider could allocate available places to those whose need was less pressing, Fletcher advocated an end to the notion of a "balanced community". In more recent work on sheltered housing in general and the role of the warden in particular this abandonment of the concept of balanced community is taken as read. Thus Hasler and Page can take a more consistently dependent tenant population as the starting point for defining a new role for the warden that is not as a "hands-on" carer but as a professional partner in the allocation, assessment and care delivery system.

Two cornerstones of the vocabulary of sheltered housing were provided by the Ministry of Housing and Local Government circular 82/69 that set the pattern for the continuing rapid growth in provision in the 1970s. This circular introduced the distinction between Category 1 schemes for more active elderly people and Category 2 schemes for the less active. This distinction still influences current designs and language. Category 1 schemes were seen as grouped self-contained housing designed especially for older people. Category 2 schemes included communal facilities, warden accommodation and office, an alarm system, a guest room, laundry facilities and a common room. It is this style of provision that we have referred to as "conventional sheltered housing".

As tenant populations grew older, and the age for first admission to sheltered housing increased, providers began to recognise that the needs of their tenants could not be met within a conventional sheltered housing scheme with a traditional warden service. Whilst a traditional warden service and peer support among tenants could cope over a long period with one or two frail tenants in a scheme, or a slightly larger number for short periods, a situation in which a significant proportion of tenants needed care services posed difficulties. Care often seemed to come into the scheme in an uncoordinated, almost haphazard way and the warden was left to cover the care gaps. From the early 1980s some providers began to develop schemes in which more coherent arrangements for care were negotiated with social service authorities and some additional facilities were introduced into schemes. Some experimented with the provision of meals, most looked to provide facilities for assisted bathing, treatment rooms and other specialised facilities. These were know by a variety of titles including the ludicrous jargon of "category two and a half", placing them somewhere between conventional, category two, sheltered housing and residential care or Part Three homes. These schemes, some new build and others by the conversion of existing sheltered schemes, provided the first examples of Very Sheltered Housing.

**Early "Very Sheltered" developments**

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

The variety of emerging provision was illustrated by Tinker in her research for the Department of the Environment in 1989. She found that Very Sheltered Housing varied considerably in design, particularly in terms of the type of accommodation provided with a flat, bedsitter or bedroom provided for individual tenants. Some schemes were registered with the local authority under the Registered Homes Act 1984 as residential care homes, thus providing full meals and personal ‘hands-on’ care. Others offered meals but more a more ‘home help’ style of care. Some schemes provided all the care staff themselves whereas others used staff employed by the local authority who bought the care into the scheme.

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

The experience of "hard to let" conventional sheltered housing

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

Preliminary analysis by Miscallef was confirmed by Tinker and others in their study of difficult to let sheltered housing. Among the strategies identified by which providers of sheltered housing might tackle this problem was bringing care services into the scheme and allocating flats to frailer old people. In its "Appraisal Guide for Sheltered Housing" the National Housing Federation suggests that improving services may form part of a strategy to improve letting, citing the examples of providing a meals service or a bathing service. More thoroughgoing, it suggests, would be the up-grading of the scheme through such measures as ramping access, providing hand and grab rails, fitting appropriate door handles and taps. More substantial modifications might include installing showers.

This approach has its dangers, especially when the primary focus is on changes to physical environment, or even additional services, without a thorough appraisal of the purpose of the scheme and the needs of those it is being targeted to serve. As Fletcher rightly points out: "The concentration on features rather than purpose can mask a relative lack of clarity about who sheltered housing is for and whose need it is
trying to meet."

This is a view endorsed by the Audit Commission who refer to the current pattern of sheltered housing as "entirely historic and not related to any identifiable levels of need or demand." Analysis of experience in forty-seven local authorities led the Audit Commission to the conclusion that: "None of the field work authorities conveyed a clear vision of the future role of sheltered housing. There is little evidence of joint working with social services and local Registered Social Landlords to include sheltered housing in a wider strategic approach to services for older people. Working in isolation from the social services assessment process, housing authorities are less able to identify the needs of older residents across all tenures and develop and allocate sheltered housing accordingly."

Nevertheless, sheltered housing in general, and an enhanced form such as Very Sheltered Housing in particular began to establish itself as a desirable element in future patterns of provision for the accommodation and care of frail older people. In good practice guidance issued in 1997 the Department of Health gives examples of sheltered housing where a housing department wished to improve use of sheltered stock and a social services department wished to develop an alternative to residential care provision. This resulted in the refurbishment of a sheltered block which was upgraded to provide accommodation for frail elderly people. The resident warden was reported to liaise with care workers provided by the social services department.

Specialist Registered Social Landlords, such as Hanover and Housing 21, have promoted particular approaches to Very Sheltered Housing and supported their advocacy with a range of publications. These have set out design criteria for buildings, management and care systems, and research on the experience of the various stakeholders in the development of new schemes.

Reinventing sheltered housing or replacing residential care?

From a different standpoint Martin Shreeve, formerly Director of Social Services for Woverhampton MBC and past chair of the ADSS Older Persons’ Committee, has advocated the wholesale re-provision of residential care through the development of purpose-built Very Sheltered Housing schemes. Wolverhampton have now worked through their four year programme to achieve that re-provision and change the use of a small number of residential care premises to provide resource centres for community based support, rehabilitation beds, respite care and other specialist uses.

Support for the strategy of replacing residential care home provision with Very Sheltered Housing comes also from the Royal Commission on Long Term Care. Their support for Very Sheltered Housing draws on the perception that it is both more cost effective and provides a better quality outcome for service users. The research material provided to support the Commission’s findings and recommendations reflects the variety of past and current provision and makes no serious attempt to discriminate between them.

For some the advocacy of Very Sheltered Housing is grounded in the desire to establish a new and more
appropriate culture out of which accommodation and a context for the delivery of care may be provided. Jef Smith, former General Manager of Counsel and Care, writes in his Foreword to Joanna Bartholomeou’s report on the experience of people living in Hanover Housing’s extraCare:

"Forms of residential provision for older people based on health and social welfare models – residential care and nursing homes, long stay units, almost all facilities offering grouped care – cannot avoid referring back to the hospital and the workhouse in the way they operate. Both these institutions, however benignly they were managed, defined people as essentially problematic; their inmates were – in the case of hospitals still are – reluctant guests on someone else’s territory." Smith in Bartholomeou

This clearly makes a claim for Very Sheltered Housing that it should not simply sit somewhere between conventional sheltered housing and residential care but that it should replace the latter as a more appropriate style of provision. That leads us toward some exploration of what Very Sheltered Housing is for: is it simply adding to the range of available options, filling a gap in the continuum or does it offer an alternative, the consequence of which will be the redundancy of a substantial part of what is currently provided as residential care? The answer given to this question will be influential in deciding what definition ought to be provided for Very Sheltered Housing, the characteristics of the tenant population and the cost-effectiveness of this arrangement over the alternatives.

Different agendas lead to different models

This account of the emergence of new models that draw on sheltered housing illustrates that its advocates come from different starting places. There are conflicting agendas from the various stakeholders, whether declared or not. Very Sheltered Housing is put forward as a means of addressing all these agendas but this may be in part because the various stakeholders mean different things by the term.

Within social service departments, and among commentators such as Smith and Shreeve, the primary objective is to establish a context in which a number of key values may be expressed. These are seen to be frustrated by the experience of residential care or by the realities of care gaps for those remaining in general housing. These values help define a new model for life in old age that is characterised by encouraging the maintenance of independence, facilitating lifelong learning, providing security, offering empowerment and encouraging participation. For some the Very Sheltered model answers two questions: how to move on from the restrictions of residential care and finally making sense of sheltered housing.

Others within social services, or even in some cases the same people but working within a different area of their responsibilities, are focused on the cost-effectiveness of this solution. Does Very Sheltered Housing offer good value for money when compared with the provision of accommodation and care for older people in their own homes, in conventional sheltered housing or in residential care? The answer to that question relies entirely on a definition of the client group for whom the provision is intended. If
Very Sheltered Housing is populated by older people whose aggregate care needs do not meet the level of provision built into the arrangement then it is difficult to justify on cost grounds. Schemes that grow out of a desire to protect or enhance the future viability of a conventional sheltered housing scheme may struggle to demonstrate that they represent value for money. Re-provision that accommodates and cares for those formerly in residential care, or those who would otherwise have been allocated to residential care, will find it easier to achieve the aggregate levels of need that will justify the levels of care capacity associated with Very Sheltered Housing.

The application of Best Value principles to Very Sheltered Housing attempts, to some extent, to balance these two approaches, looking at both simple financial tests of value but also at the quality of the provision and the extent to which it reflects user-aspirations and contributions.

A third approach is that of housing providers seeking to follow the encouragement given in policy and in the literature to maintain the viability of their existing stock by changing its function to Very Sheltered Housing. This may be intended both to enable a higher proportion of an ageing tenant population to remain in their current accommodation, and the potential of letting to a more dependent group within the community. The dilemma here is that it is often the oldest and least suitable stock that is suffering difficulties with letting and is therefore identified for conversion. There is a temptation to minimise the amount of work needed to modify the physical arrangement of schemes whilst "badging" them with the same label as a purpose-built Very Sheltered scheme. An example would be a conventional sheltered scheme operating for more than six years as Very Sheltered whilst still having no lift and no programme to adapt bathrooms within flats to make them accessible by converting baths to showers.

To suggest that different stakeholders are pursuing different agendas is not to impugn their motives, nor to suggest that the outcomes they achieve are not worthwhile. Different agendas may be met by widely differing outcomes. For example relatively minor improvements in a conventional sheltered housing scheme may greatly improve its lettability and in the short-term allow some tenants to avoid a move to an institutional setting. Such a limited programme of changes will not meet the more ambitious agenda of those who wish to create an enabling environment within which older people may not only enjoy independence but also find some enrichment of their quality of life and opportunities for personal growth. The use of an undifferentiated terminology to describe the outcomes sufficient to meet such differing agendas leads to confusion and mutual frustration.

The alternative models of Very Sheltered or Extracare housing

Very Sheltered Housing is generally defined by a combination of facilities and services. To varying degrees all the alternative models offered by the principal providers meet these requirements.

In his examination of nine Very Sheltered schemes in Peterborough and Cambridgeshire Baker identifies nine "defining characteristics":

- Self contained accommodation
• Equipment for care
• Care staff, probably including 24 hour cover
• Catering
• Communal facilities
• Social and religious worship
• Provision of an appropriate level of care for tenants
• Help with domestic tasks and shopping
• Some wider activities and services

The difficulty with this list is that all the elements, except perhaps equipment for care and care staff, especially if providing 24 hour cover, are available to tenants of conventional sheltered housing either through their housing provider or by access to community support services from the social services. Trotter and Phillips offer a rather more detailed list:

• Self-contained flats with full kitchen and bathroom facilities to mobility and, usually, wheelchair standards
• Staff facilities including office and sleep over
• Barrier free spaces which are accessible, aid mobility and are fully equipped, with lifts to all floors or as many floors as possible.
• A range of service areas for hairdressing, laundry and chiropody, etc.
• Communal areas including day rooms, catering and dining facilities, which offer the possibility of communal meals or café services
• Guest facilities
• Good links to the local area
• Staff on site responsible for the building, management and the co-ordination of care and support services
• Privacy for residents combined with services to the local area.

The Housing Corporation Scheme Development Standards (1998) identify carer facilities: staff room, toilets, changing room and sleep over room as essential features. Hanover would add the provision of a shop within the scheme, generally open part-time and often provided by a local supermarket, as a key element and emphasise the importance of providing a suitable store and charging area for pavement scooters. Anchor Housing would suggest that adequate laundry facilities within the flat obviates the need for a separate laundry and doubts the need for a shop. Extracare would place great emphasis upon the provision of social, educational and recreational facilities, relating these also to the use of the scheme by older people drawn from the surrounding community.

Differentiation is largely through the definition of roles, particularly that of the scheme manager, and arrangements for the delivery and management of services. The model promoted by Extracare Charitable Trust and Anchor Trust is one in which roles are integrated: one person supporting the tenant
with a range of needs: personal care, cleaning and domestic tasks, social animation, and so on. This is believed to more replicate the "natural life" model in which an informal carer would provide seamless support and stimulation covering personal, domestic and social spheres.

These two providers also prefer to integrate the management of services, believing there are cost savings to be made that cannot be achieved through other arrangements. Thus the Manager for the scheme will provide housing management and care management functions. This also implies a level of involvement in the assessment of need, development and supervision of care plans that we shall refer to again below.

Hanover promotes a model in which they provide and manage the premises and housing services while contracting out to separate agencies care provision, cleaning and catering. They believe this allows for the application of appropriate expertise, flexibility in achieving value for money and protects the role of the Court Manager as advocate for the tenants in relation to the providers of other services.

In all these arrangements the role of the senior member of staff on site is a crucial one. Whether the formal arrangements recognise it or not they all exercise some degree of influence in the delivery of care to the tenants. Emerging practice allows for the involvement of the manager, with appropriate training, in the initial assessment of suitability for allocation of a tenancy and the development of an initial care plan. The Manager would then co-ordinate the various sources of information about emerging patterns of need and adjust the care plan accordingly, subject to audit by the Care Manager representing the interests of the commissioners. The needs of the individual must be met within a budget for the overall activity of the scheme. In such an arrangement the Manager provides a single point of accountability to funder/commissioner and to the tenant. Whilst it may be argued that such an arrangement carries with it an incentive to exaggerate levels of need to maintain income some emerging experience suggests that when skilfully managed the flexibility of such an arrangement allows for cost effective outcomes of high quality.

**Telling Very Sheltered apart from Sheltered housing**

At the lower end of the range it is important to establish what distinguishes Very Sheltered Housing from conventional Category Two sheltered housing. This is complicated by the changing role of warden and increasing complexity of services required for an ageing tenant population. It may be helpful to introduce a third category of "Enhanced Sheltered Housing". This refers to a scheme in which the warden’s role has been developed in line with the principles set out by Page and others, a dedicated care team may be attached to the scheme and some additional specialised facilities may have been provided. However it may be distinguished from Very Sheltered Housing in that the building has not been subject to rigorous appraisal and re-modelling to eliminate the limitations of its initial design. Both the culture and facilities of the scheme may fall short of what is required to promote Life Long Learning, peer support and the enrichment of old age, all of which are characteristics of Very Sheltered Housing at its best. Whilst the arrangements for care may have been improved to decrease waste and increase flexibility they may lack completely flexible twenty-four hour by three hundred and sixty-five day a year cover.
At the upper end of the range it is equally important to establish whether it is possible to distinguish Very Sheltered Housing from a high-quality residential care home. Some would argue that a concentration of very frail older people in a scheme, whatever its physical environment and espoused philosophy, will create the culture and ambience of a residential care home. They argue that successful Very Sheltered Housing needs a balanced community that includes people with levels of care need that would not attract services in other circumstances. We have already noted that the original notion of a "balanced community" in sheltered housing was abandoned by some almost a decade ago. Again there is a danger of confusion of terminology for what is proposed here is a balance struck at a higher mean level of dependency. Even so the notion that some within Very Sheltered Housing should not currently be in need of its services and facilities has implications for financial viability and Best Value.

Size is also an issue here. Some providers argue that to achieve viability in the provision of care staff on a twenty-four hour three hundred and sixty-five days a year basis aggregate requirement for care within the scheme will need to exceed three hundred hours per week, including night-time cover. For a small scheme, or one in which only a small number of units are designated as Very Sheltered housing, this may imply an improbable average level of need. In a scheme of twenty units for example, if seventy hours of night time cover per week are excluded, the implication is that the average tenant will require more than one and a half hours of care each day.

**Attempting definitions**

Given the variety of models offered by providers, and the circumstances that may attach to local opportunities, a single definition is probably neither achievable nor helpful. We offer a range of features that should be included, some of which we would regard as essential and others desirable or open to a variety of responses. This will take account of the following principal areas:

**The basis of occupation**

This is fundamental and a major distinction between Very Sheltered Housing and residential Care. All those occupying a Very Sheltered Housing scheme do so on the basis of a tenancy with the rights the status of tenant confers. There are no benefits to the older person occupying the accommodation in other arrangements, such as the granting of a "licence to occupy". Whilst the provider may prefer an arrangement that allows greater discretion in relation to occupants who pose problems, perhaps through deterioration in physical or mental health, there are no advantages to the older person. Occupation on the basis of a tenancy, within the framework of the 1996 Housing Act, should be regarded as an essential element in defining Very Sheltered housing.

**Assessment and allocation**

In its report on the role of housing in community care the Audit Commission recognised the difficulties that may arise when assessment and allocation practice is not properly integrated: "The tension between the demands of stock management and the needs of frail older people is perhaps inevitable. Rather than
using sheltered housing as a key community care resource, some councils apply straightforward letting criteria – if there are empty places in sheltered units they will be let to waiting older people, irrespective of their degree of frailty. "Placing fit, active older people in sheltered housing can be an expensive option." If this is true of conventional sheltered housing it is all the more apparent in relation to Enhanced Sheltered Housing or Very Sheltered Housing.

As far back as 1991 Fletcher and Gillie were calling for an integrated approach to assessment and allocation. "In the future, the ability of any sheltered housing provider to manage a more dependent group of tenants will be reliant on the ability of the health authority and social services department to deliver adequate care services into a scheme. This raises the question as to whether these agencies, particularly the social services department as the lead agency for community care, as well as the local authority housing department, should be given some involvement in the nomination, assessment and perhaps also tenant-selection process."

The Department of Health offered similar guidance in 1997: "Planning principles include partnership between local agencies who have responsibility for services and participation by users of community care services and their carers." Developing mechanisms that allow the delivery of a co-ordinated package of housing, health and social care services to address individual’s needs were seen to be a high priority.

The Audit Commission drew attention to the risk that failure to properly connect assessment and allocation procedures between housing and social service authorities might lead to an inappropriately high level of service: "One danger of poor assessment is that people may receive more services than they need." This phenomenon is often referred to as "upward substitution".

Best practice indicates that assessment and allocation should be through an integrated process that gives weight to both housing need and care requirements. The two assessment disciplines should be carried out in a parallel and balanced way so that they each contribute to an appropriate outcome. The modification of the housing assessment and allocation process by simply giving greater weight to "medical factors" does not represent best practice. Whilst it may be an appropriate way of allocating Enhanced Sheltered housing it is not appropriate for the allocation of Very Sheltered housing. the need for care cannot be one in a range of subordinate needs taken into account as indicators of housing need.

The concept of "medical factors" is outmoded and perpetuates the medicalisation of responses to ageing that has led to dependency models rather than enabling models for service provision. Whilst the opinion of the General Practitioner may be helpful assessment by a Care Manager, Occupational Therapist, of Community Nurse will have equal or greater significance in achieving an appropriate allocation.

Best practice suggests that an allocation panel, comprising housing and social service representatives, together with the providers (when this is not the housing authority) and the scheme manager, should have both housing and care assessments before them in making allocations. Allocation should not be made on the basis of housing need, even with strong medical support, where the care assessment does
not indicate that the applicants need falls within the range provided within the scheme.

Where possible the scheme manager should receive training that will allow them to monitor changing levels of need and adjust service delivery accordingly. This may be subject to review with the representative of the care commissioners and care providers on a regular basis and also subject to the normal review and audit procedures of the care commissioners. If review and adjustment is to be carried out by a Care Manager on behalf of the social service department then, ideally, one person should be responsible for all tenants once they are settled in the scheme.

The purpose of the integrated assessment and allocation arrangements is that people who will derive benefit from the particular services and facilities of a Very Sheltered Housing scheme should have priority in allocation. Whilst those making allocations will wish to avoid an over concentration of tenants at the upper end of the scheme’s dependency range they will wish to ensure that the aggregate needs of the tenants meet or exceed the minimum viable care capacity provided.

The use of a standard instrument for measuring the need for services on consideration for allocation of a flat and in subsequent monitoring. The instrument developed by Wolverhampton MBC is attached as Annex One and is recommended for use in Gloucestershire.

**Care arrangements**

The patterns of work in conventional sheltered housing that laid the foundations for Very Sheltered Housing were largely a response to wasteful arrangements for providing care to sheltered housing tenants. Different agencies and individual carers attending to the needs of different tenants in an uncoordinated way led to calls for a small teams of care staff to be dedicated to particular schemes and to liaise closely with the scheme Warden. The commitment of a dedicated staff team to provide services within the scheme is a fundamental requirement for Very Sheltered Housing. Best practice indicates that such a team will be responsive to the needs and wishes of individual tenants, seeking not to provide a level of care that either encourages dependency through over provision nor leaves the tenants feeling unsupported. Such an approach needs constant fine tuning to the needs and circumstances of the tenant. Such flexibility needs a high level of training, and of management support close to the point of service delivery. The provision of care within a Very Sheltered Housing Scheme will be on a twenty-four hour, 365 day a year basis. If the tenants of the scheme do not require such cover then either the scheme is not Very Sheltered Housing or tenants have been inappropriately allocated to it.

**Management arrangements**

We made reference above to the divergent approached adopted by major providers in defining the role of the scheme manager. Some providers argue strongly that maximum cost benefit and service quality can only be achieved when one person on-site is responsible for all areas of service: housing management, catering, care provision, etc. Those advancing this model would generally argue for support to be provided to tenants by a single member of staff delivering an integrated pattern of services:
personal care, domestic assistance, social animation. Some would also argue for the integration of management responsibilities above the level of the local scheme.

Other providers promote a model in which functions are differentiated at each level. The scheme manager has housing management functions and no formal responsibility for the delivery of care. Other aspects of service, such as catering and cleaning will be contracted out and the manager may have responsibility for ensuring contract compliance. Service delivery will be entrusted to a range of agencies who will each provide structures for management and support. The difficulties that can arise when the distinction between the roles is not clearly understood are identified in Greenwood and Smith’s study for Hanover. The study found a range of practice among Hanover scheme managers, most of whom could not avoid some involvement in care issues, if only to pass on information to the care provider’s staff.

The arrangements being put into place for the commissioning of contracts for the delivery of social services funded care services in Gloucestershire imply that housing facilities and care services will normally be delivered by different agencies. The preferred option would be for the scheme manager employed by the housing provider to have a direct and acknowledged role in assessment and allocation processes, in the continuing evaluation of care needs and the consequent adjustment in care plans, and in the work programmes of care staff.

The scheme manager will have training needs arising from the multi-agency and inter-disciplinary nature of the role. All staff working within the scheme and those who manage them will also have training needs in relation to their own roles and the understanding of the roles of those with whom they work.

**Philosophy into practice**

The values and philosophy of the providers are a crucial element in the creation of genuine Very Sheltered Housing. The adoption of an integrated approach to meeting the needs of tenants in a holistic way will lead to flexibility in the roles of those who work directly with tenants. This should allow them to integrate practical assistance with emotional support and social animation.

Providers should be expected to demonstrate a commitment to enabling, to resisting over provision leading to dependency, and a commitment to the personal development of tenants. This will need to be shown in their values and philosophy but also in the practical facilities they offer, the roles defined for staff and the expectations the organisation has of them and the outcomes they are willing to be measured by.

**The physical environment**

Very Sheltered Housing has too often been defined first by reference to the additional facilities it provides and this has often ignored the need for the whole building to support independence. This can only be achieved through high standards of accessibility both in common parts and in individual flats.
The design principles for achieving this are well documented. Adequate standards of space and accessibility may sometimes be difficult to achieve in the re-modelling of existing schemes. The achievement of accessibility in common parts is only part of the answer and a scheme that is to be regarded as genuine Very Sheltered Housing needs to comprise individual dwellings that also meet contemporary standards for space and lay-out. Guidance on such re-modelling is well set out in Trotter and Phillips.

Current opinions about the provision of specialist facilities vary. Whilst some would see the provision of facilities for assisted bathing, treatment rooms, laundry rooms and so on as essential others would wish to cope with as many of these needs as possible by enhancing the facilities within individual flats. There is common ground in relation to the provision of dining facilities, office and staff accommodation.

In overall design there is widespread acceptance of Trotter’s design principle of progressive privacy. All new-build schemes and, wherever practicable, remodelled schemes should seek to demonstrate it. This is especially important where some of the facilities, those for dining and social and recreational activities, are to be shared with people from the surrounding community.

The importance attached to facilities for recreational, social and educational activities varies but such facilities, and a clear approach to their use, should be a requirement for all Very Sheltered schemes. Pottery and craft facilities, access to computers and internet connection, are examples of what is currently provided and express a commitment to life-long learning.

The ultimate test of all these design features is whether the provider can demonstrate a clear understanding of why they have provided them and the ways in which they will ensure their effective use. Providing them because they are on the checklist in the design guidance should not be enough.

**Funding**

One of the advantages claimed for Very Sheltered Housing over residential care is that the tenant is left with a higher level of disposable income. Funding arrangements should be equitable to the tenant without any loading of costs to the disadvantage of self-financing tenants. Thus a scheme that is viable only with very high levels of rent or with a raft of additional charges will not be equitable for those tenants who are not eligible for Benefit.

The scheme must also represent value for money for those funding the services when compared to alternative provision for the same person. The key to this equation is appropriate allocation and flexible response to changing care needs. Some providers argue that a degree of financial imbalance is inevitable in the early years of a scheme, especially where an existing tenant population is retained in a scheme re-designated as Very Sheltered Housing. They also argue that to achieve all the objectives set out here, costs for a given individual will exceed those that might apply if they were still in general housing or even in residential care. Their argument is for a view that takes in the whole tenant population over an extended timescale. Whilst this has an element of special pleading it is reasonable to recognise this as
the reality for perhaps the first three or four years of a re-designated scheme (at average replacement rates this will allow for a third or more of flats to be re-allocated to those with care needs appropriate to the facilities of the scheme) or within eighteen months to two years of a new scheme.

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