PSSRU

Evaluation of the Extra Care Housing Funding Initiative: Initial Report

Robin Darton, Theresia Bäumker, Lisa Callaghan, Jacquetta Holder, Ann Netten and Ann-Marie Towers

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PERSONAL SOCIAL SERVICES RESEARCH UNIT

University of Kent
University of Kent
Cornwallis Building
Canterbury
Kent CT2 7NF

Tel: 01227 823963/823862
PSSRU@kent.ac.uk

London School of Economics
London School of Economics
LSE Health & Social Care
Cowdray House
Houghton Street
London WC2A 2AE
Tel: 0171 955 6238
PSSRU@lse.ac.uk

University of Manchester
University of Manchester
First Floor
Dover Street Building
Oxford Road
Manchester M13 9PL
Tel: 0161 275 5250
PSSRU@man.ac.uk

www.PSSRU.ac.uk

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Summary

Section 1

- The Extra Care Housing Fund was announced by the Department of Health in 2003 to develop innovative housing with care options for older people and stimulate effective local partnerships between health, social services, and housing agencies and providers. The Fund provided £87 million to help create up to 1,500 places between 2004–2006, and further funds have been made available in subsequent years. The successful bids for the funds include both new build and remodelled schemes, and some of the new build schemes involve the upgrading/remodelling of existing buildings as part of the development.

- Extra care housing is a development of sheltered housing that aims to meet the housing, care and support needs of older people, while helping them to maintain their independence in their own private accommodation. An earlier term for extra care housing was very sheltered housing. A number of studies of sheltered housing, very sheltered housing and extra care schemes have been undertaken, but these have often concentrated on individual developments, and the larger-scale comparative studies that have been conducted are mainly rather dated. A few recent studies have compared several schemes but, at the time the Fund was announced, there was a dearth of large-scale studies, and very little information about cost-effectiveness.

- The objective of the PSSRU study is to evaluate 19 new build schemes for older people funded between 2004–06, and is the first evaluation of specialised housing supported by the Department of Health. The evaluation aims to examine the development of the schemes from their implementation, and to follow the residents' experiences and health over time. A particular feature of the evaluation is to compare costs and outcomes with those for residents moving into care homes.

- The evaluation also provides an opportunity to collect research evidence about the process and impact of new approaches to providing accommodation and care for older people, and funding has been obtained for three complementary studies: a study of the development of social activity and community involvement in extra care; an in-depth study of one of the schemes to investigate and compare costs to all stakeholders before and after residents move into extra care: and a joint project with

colleagues from the University of Sheffield to develop a tool to identify design and environmental features of buildings that promote the well-being of users. Funding has also been agreed to extend the collection of data to a second scheme in one of the local authority areas included in the evaluation.

- This report presents information collected from eight schemes that have opened to date, seven in 2006 and one in 2007, in the following local authority areas: Bradford, Brighton & Hove, East Riding, Enfield, Havering, Northamptonshire, Peterborough and West Sussex (Horsham DC).

Section 2

- The eight schemes that were open and for which data were available at the time of writing are described in terms of their geographical location, the type and size of the accommodation, their organisation and management, the tenure options available to residents, and the services and facilities provided.

- Seven of the schemes are in urban areas and seven were built on brownfield sites.

- They all provide apartment style accommodation, with the village in Northamptonshire providing bungalows as well as flats.

- The most common form of tenure across the schemes was social rent, or a combination of social rent and shared ownership. The tenure mix within the schemes typically contained more units for social rent than units for purchase.

- The average size of the non-village extra care housing schemes was 45, ranging from 38 to 64.

- Six schemes offered mainly one-bedroom accommodation, while in two schemes, including the village, the majority of units had two bedrooms.

- The schemes aimed to support older people with dementia and most offered day care services. A small amount of intermediate care was offered in some of the schemes and some included outreach services for the community.

Section 3

- There were high levels of response in four of the eight schemes. Refusal rates do not appear to be closely related to levels of dependency, except in Havering, where the refusals appear to have been among those with higher levels of cognitive impairment.

- The people who moved into extra care required much less support than those who moved into care homes. They were younger, on average, and were more likely to be male and less likely to be widowed or living alone. The majority (85 per cent) had been living in their own home or sheltered housing, whereas nearly two-thirds of the people admitted to care homes had been in hospital, a care home or had been receiving intermediate care.

- Similarly, those who moved into extra care were substantially less physically and cognitively impaired than those who moved into care homes. Just under 30 per cent of those who moved into extra care had moderate or more severe levels of dependence, compared with two-thirds of those moving into a care home providing personal care and over 85 per cent of those moving into a care home providing nursing care.

- For cognitive impairment, 4 per cent who moved into extra care were severely impaired, compared with 39 per cent of those moving into a care home providing personal care and 54 per cent of those moving into a care home providing nursing care.

- Although there may be some underestimation of the levels of cognitive impairment among residents moving into one of the schemes, it would appear that most prefer to admit residents with fewer problems of cognitive functioning so that they can become familiar with their new accommodation before the development of more severe cognitive impairment. The low level of severe cognitive impairment among the new residents is consistent with this.

Section 4

- The majority of residents made both the decision to move, and where to move to. Although nearly all visited the scheme beforehand, less than a quarter evaluated alternative options.

- Residents with care needs indicated that the most important reasons for moving out of their previous home were own physical health, lack of services, coping with daily tasks, and difficulty in getting around their homes. For residents without care needs, garden maintenance and fear of crime were of more importance than these.

- The most important factors which attracted residents to the extra care schemes were tenancy rights/'having your own front door', an accessible bathroom and living arrangements, the size of bungalows, the security offered by scheme, and the care support available on site.

- Factors associated with particular features of extra care housing (pull factors) were much more important in motivating a move than dissatisfaction with previous living conditions (push factors). Even though health concerns were reported, residents perceived themselves, and in fact were, relatively healthy.

- The move to extra care seems to be a planned move primarily in anticipation of future needs, but also to meet existing, albeit in most cases relatively low, current need.

- Just over half of residents expected an improved social life, whereas one-third did not expect any change; indeed, social/communal facilities were not the most important attractions to residents.

- Nearly all residents expected to live in the extra care schemes for as long as they wanted to; a third of those with care needs reported that they had no intention of moving on.

Section 5

- This section describes the initial findings of the social well-being project funded by the Joseph Rowntree Foundation.

- All schemes with data to date have, to some degree, adopted a user-led approach to social activity provision.

- Most schemes had a number of regular (weekly or fortnightly) activities alongside less regular one-off events. Activities can serve a social purpose, and contribute to a sense of community at the scheme.

- Shops and restaurants are emerging as being important to the development of the social life at the schemes. The reverse also applies: the absence of such facilities is seen to undermine the opportunities for socialisation.

- Links with the local community take time to develop. The local context of the scheme may be important in determining the extent of community development that develops.

- Residents' health and mobility can be a barrier to getting involved in organising and running their scheme's social life, as well as to participation in social activities and events. The nature of the care routine can also be a barrier to participation.

- Having an active and involved residents' committee, interested residents, helpful staff, and a well-designed scheme were cited as factors helpful in developing a scheme's social life.

- There were indications of neighbourliness and 'community spirit'. Factors which may influence the social climate of a scheme include the previous existence of a sheltered housing scheme on site, having a mix of tenures, having a mix of health and dependency levels, and the role and personality of the scheme manager.

Section 6

- This section presents some preliminary conclusions and outlines the next steps of the evaluation.

Section 1: Introduction

Background

A central principle underlying government policy, under both the present and the previous administrations, has been to help people maintain their independence in their own homes for as long as possible. In particular, there has been a long-standing policy to reduce admissions to care homes. However, the ageing of the population is placing increasing pressure on all forms of accommodation for older people. Increasingly, housing has been seen as an essential component in the development of effective community care services, but housing and social services have tended to develop separately (Audit Commission, 1998; Oldman, 2000). The present government identified a need for partnership between health, housing and social services for the development of successful community care services in its 1998 White Paper (Cm 4169, 1998). This has been reinforced in subsequent policy documents (Office of the Deputy Prime Minister, 2006; Department for Communities and Local Government, 2008). In particular, government policy emphasises the personalisation of services, placing individuals at the centre of the process of bringing housing, health and social care together, with the aim of giving people greater choice and control over the services they receive (Department for Communities and Local Government, 2008).

The 1998 White Paper identified several factors that adversely affected the promotion of independence, including the trend towards concentrating resources on the most dependent people and the imposition of restrictions on the size of domiciliary packages leading to greater numbers of admissions to care homes. In order to help people achieve and maintain their independence, the White Paper emphasised the importance of developing better preventative services and improving rehabilitation services, and enabling people to remain in their own homes for as long as possible. The National Service Framework (Department of Health, 2001) was designed to ensure that health and social care services supported independence, by setting overall standards of care wherever the person was living, together with standards for conditions associated particularly with old age, including stroke, falls and mental health problems. Equally, the suitability of a person's housing is central to the successful improvement of standards (Office of the Deputy Prime Minister, 2003).

The government's overall strategy for ageing emphasises the promotion of active ageing, with older people participating in society (Cm 6466i, 2005). However, although good quality housing has been identified as central to maintaining independence and

well-being, little attention has been given to the needs of older people in building ordinary housing (Cm 6466i, 2005). Furthermore, many older people still live in unsatisfactory or unsuitable housing, despite improvements in housing quality. A number of initiatives have been developed to enable people to remain in their own homes for as long as possible. These include the requirement that new housing is built to Lifetime Homes Standards, increases in the Disabled Facilities Grant Programme for funding adaptations to existing homes, and additional support for telecare, ranging from personal and other alarm systems to sophisticated environmental monitoring systems (Department for Communities and Local Government, 2008).

Financial incentives and arrangements have an important role to play in supporting the independence of older people and helping them to remain in their own homes. The Royal Commission on Long Term Care recommended changing the balance from residential care towards home-based forms of care using financial mechanisms (Cm 4192-I, 1999), and the Wanless Social Care Review (Wanless, 2006) examined possible funding mechanisms for packages of services designed to deliver different types of social care outcomes. Supporting People (Department of Social Security, 1998) was introduced in 2003 to co-ordinate different sources of funding to provide housing-related services for vulnerable people, with the aim of providing a stable environment to enable independent living. The programme provides support of varying duration to a wide range of people, including longer-term help for older people, mainly in sheltered and extra care housing. The types of support provided by Supporting People to older people include support with daily living skills; practical housing-related support such as finding a handyman or gardener; advice and help in claiming benefits or obtaining community care or health services; the provision of community alarm services and telecare; establishing or maintaining social support; and emotional support and counselling (Cm 6466i, 2005).

The government has introduced new methods of financial support, with the aim of promoting independence and personalisation, to give people greater choice and control over the services they use. Direct payments to individuals, to enable them to arrange their own care, were introduced in 1997, and extended to older people in 2000. However, the take-up of direct payments was slower than had been hoped (Cm 6499, 2005). In addition to seeking ways of extending direct payments, the government is testing the development of individual budgets, which would be held by the local authority on behalf of the person using services or their carer (Cm 6499, 2005; Cm 6737, 2006). Direct payments cover social care budgets, but individual budgets will bring a range of separate funds together, including those from the Supporting People

programme (Cm 6737, 2006). The government has decided that personal budgets will be implemented for adults eligible for publicly-funded social care, and may be taken in the form of a direct payment or by the local authority continuing to pay for their preferred care package, or by a combination of both of these (Department of Health, 2008). Decisions on the implementation and the form of individual budgets will be subject to the results of the evaluation of the pilot schemes (Department for Communities and Local Government, 2008).

For older people seeking housing with care and support, the Department of Health announced funding in 2003 to support the development of extra care housing to increase the range of options available (Department of Health, 2003d). Extra care housing is a development of sheltered housing that aims to meet the housing, care and support needs of older people, while helping them to maintain their independence in their own private accommodation. Extra care housing offers a variety of housing tenures, and can enable people to safeguard their financial assets by purchasing or part-purchasing their accommodation.

The majority of extra care housing has been developed for older people, often with a qualifying age of 55 years rather than 65 years, but some developments for other client groups, such as people with learning disabilities, are also being considered. Although the qualifying age for entry may be below 65 years, the majority of entrants are older than this. Extra care housing offers support and care to residents for 24 hours a day, and has been viewed as a possible alternative to moving into a care home (Cm 6499, 2005). Indeed, some have advocated the complete re-provision of residential care by developing extra care housing. However, there is a range of models for supporting people with substantial care needs, such as those suffering from dementia. Research by Vallelly et al. (2006) found that extra care housing was a popular option for older people suffering from dementia and their families, and was able to provide a good quality of life for such residents. However, some residents, for example those who developed severe behavioural problems, did move to other settings, mainly to nursing care. Different models of provision and the roles of extra care housing and care homes are discussed in The Extra Care Housing Toolkit produced by the Housing Learning and Improvement Network (Care Services Improvement Partnership, 2006). Extra care housing also provides a location for services for the local community, as well as more specialist intermediate care and outreach services to support rehabilitation following hospital treatment.

Although extra care housing is seen as providing a possible alternative to a care home, the level of provision of extra care is much lower. In 2007, there were about 37,600 extra care dwellings in England (Elderly Accommodation Counsel, 2007), compared with about 270,000 personal care places and 449,000 personal and nursing care places in care homes in the United Kingdom (Laing & Buisson, 2007). However, although the volume of extra care is much smaller, there has been a significant growth in extra care provision, from around 21,000 dwellings in 2003 (Department of Health, 2003a) to the 2007 figure of 37,600. In addition, extra care dwellings may be occupied by more than one person, typically a married couple, and so the comparison with the figures for care home underestimates the relative level of extra care provision to some extent.

'Extra care housing' has become the preferred term for housing integrated with care, but other terms that have been used include 'care plus', 'assisted living', 'category 2.5 housing' and 'very sheltered housing' (Laing & Buisson, 2006). A number of studies of sheltered housing and extra care schemes have been undertaken, but these have often concentrated on individual developments. Three large-scale studies were undertaken to provide systematic comparisons of sheltered and very sheltered schemes (Butler et al., 1983; Tinker, 1989; McCafferty, 1994), but these are now rather dated. Recently, Croucher and colleagues have published a comparative study of seven schemes (Croucher et al., 2007), and Evans and Vallelly have undertaken studies including a number of schemes managed by one housing provider (Vallelly et al., 2006; Evans and Vallelly, 2007). However, at the time, there was a dearth of large-scale studies of this type of provision and very little information about cost-effectiveness (Croucher et al., 2006).

The Extra Care Housing Fund was announced by the Department of Health in 2003 to develop innovative housing with care options for older people and stimulate effective local partnerships between health, social services and housing agencies and providers (Department of Health, 2003b). The Fund, originally part of the Department of Health's Access and Systems Capacity Grant programme, provided £87 million for local authority social services departments and housing associations to help create up to 1,500 places between 2004–2006 (£29m for 2004-05 and £58m for 2005-06) (Department of Health, 2003d). In addition, a further £60 million for 2006–2008 (£20m for 2006-07 and £40m for 2007-08) was announced in 2005 (Department of Health, 2005; Health and Social Care Change Agent Team, 2005), and a further £80m is being invested to support the continued development of extra care housing by 2010 (Department for Communities and Local Government, 2008). In total, around 400 bids were submitted for the funds in the first four years, and 61 were successful. Of these, three successful bids in 2005-06

were jointly funded with the Housing Corporation. The successful schemes include both new build and remodelled schemes, although some of the new build schemes also involve the upgrading/remodelling of existing buildings as part of the development.

Aims and Associated Studies

As noted above, previous studies of specialised housing schemes are rather dated, or relatively small-scale, and this is the first evaluation of specialised housing supported by the Department of Health. The objective of the PSSRU study is to evaluate new build schemes for older people funded in the first two rounds on behalf of the Department of Health. The evaluation aims to examine the development of the schemes from their implementation, and to follow the residents' experiences and health over time. A particular feature of the evaluation is to compare explicitly costs and outcomes with those for residents moving into care homes. The PSSRU has undertaken a number of studies of care homes and their residents (Bebbington et al., 2001; Darton et al., 2006; Netten et al., 2001, 2002). The aim is to collect information on the characteristics of the residents of extra care schemes to enable comparisons to be made with the residents of care homes.

More broadly, the evaluation provides an opportunity to collect research evidence about the process and impact of new approaches to providing accommodation and care for older people. In addition to the work funded by the Department of Health, the PSSRU has been awarded funding for three further studies that will complement the main evaluation. These include two projects supported by the Joseph Rowntree Foundation (JRF): a study of the development of social activity and community involvement in extra care, the early results of which are presented in this report; and an in-depth study of one of the schemes to investigate and compare costs to all stakeholders before and after residents move into extra care. The third study is a joint project with colleagues from the University of Sheffield funded by the Engineering and Physical Sciences Research Council (EPSRC). This study will develop a tool devised by the Sheffield researchers for assessing whether care homes meet the needs of their users (Parker et al., 2004), for use in sheltered and extra care housing. Funding has also been agreed to collect comparable information about a second scheme in the same local authority area as one of the schemes included in the evaluation.

Method

The evaluation is being conducted during the PSSRU's current five-year funding period, from 2006–2010, to allow the tracking of the outcomes for the older people who move into the schemes. The schemes included in the evaluation were expected to open over a period of 18 months, from April 2006 to October 2007, as shown in table 1.1. However, a number of the schemes have experienced delays; some have completely re-designed the building, in some cases for a new site. In consultation with the Department of Health, it has been agreed to restrict the main evaluation from the 22 originally planned to the 19 schemes that were due to open by Summer 2008, according to information available in Summer 2007. This will allow sufficient time to undertake the longitudinal follow-up of residents over a period of 18 months from moving in, and to complete the analyses and prepare a final report for the Department in 2010. The schemes that have had to be excluded from the main evaluation have been offered the opportunity to participate by collecting comparable information, as far as timing allows.

In order to develop close relationships with the schemes, local interviewers have been recruited to liaise with each scheme, and to assist in data collection, including helping residents to complete questionnaires when required. The local interviewers all receive training by the PSSRU and have full CRB checks. The initial stages of the evaluation have received ethical approval from the appropriate Research Ethics Committee at the University of Kent.

Two main sets of information are being collected about individual entrants to the schemes included in the evaluation. First, information on the demographic characteristics and care needs of residents is being collected, drawing on the information collected in the assessment process, using a questionnaire designed to correspond to one used in a recent study of admissions of older people to care homes (Darton et al., 2006) and a number of similar previous studies. The questionnaire has been developed in consultation with representatives of the schemes to ensure that the information required is relevant and available to the staff involved in the application process. Similar information is being collected about residents six months and 18 months after moving in, to identify their current level of physical and mental functioning and their use of care services. The completion of each questionnaire is subject to the consent of the resident or their representative.

Second, new residents are being asked to complete a questionnaire about their expectations of extra care and their experiences of moving into the scheme, assisted,

where necessary, by the local interviewer. This questionnaire is being followed up by the study of social activity funded by the Joseph Rowntree Foundation. Six months after each scheme has opened, four residents and two members of staff are being interviewed in each scheme to identify the degree to which facilities are used, how much residents participate in activities, the extent of community involvement in the scheme, and residents' involvement in the wider community. This is being followed at 12 months after opening by a survey of all residents, and an interview with a subsample, to identify individual views, levels of well-being and levels of participation, and to assess the social climate of the scheme.

In addition to the collection of information about individual entrants, information will be collected from the local authorities concerned and the housing associations managing the schemes about the development and operation of the schemes. In particular, information will be collected about the financial arrangements of the schemes. This information will be collected at the scheme level and will not relate to individual residents. As noted above, a central purpose of the evaluation is to compare costs and outcomes, in terms of changes in dependency and survival, with those for residents moving into care homes. The evaluation will compare the overall costs of extra care and care homes, adjusting for resident characteristics such as dependency, at the level of the scheme or home. However, it will not be able to compare the cost-effectiveness of the different types of provision in terms of well-being, since comparable measures of outcome for the two forms of provision are not available.

The Schemes

The 19 schemes covered by the main evaluation include three care villages, each with approximately 250 units of accommodation, and 16 smaller developments, with between 35 and 75 units. The schemes have been developed to support residents with a range of levels of disability, as well as to provide facilities for members of the community living outside the scheme. The schemes offer a mixture of housing tenures, including rented accommodation and leasehold and shared ownership arrangements. However, the care villages provide relatively more accommodation for sale, and three of the six smaller schemes that opened in 2006 only provide accommodation for rent.

A number of the schemes provide intermediate care, designed to help people make the transition from hospital care back to their own homes. These individuals are not being included in the evaluation, which is restricted to the long-term residents of the schemes.

In addition, some residents enter schemes without requiring a care assessment. In care villages, the majority of new residents do not require care services, and so the information required for comparisons with care home residents is not available, although information from residents about their expectations and experiences is being collected. These residents are more likely to have been owner-occupiers and to have purchased their accommodation.

This Report

The purpose of this report is to present information collected from the first group of schemes to have opened, and for which data were available. As noted above, a number of the schemes included in the evaluation have experienced delays. By the middle of 2007, 10 schemes had opened, seven in 2006 and three in 2007, as shown in table 1.1. Data were available for the preparation of this report from the seven schemes that opened in 2006 and from one of the three schemes that opened in the first half of 2007: Brighton & Hove, East Riding, Enfield, Havering, Northamptonshire, Peterborough and West Sussex (Horsham DC) in 2006, and Bradford in 2007.

This report presents information about the characteristics of the residents at assessment and their expectations of extra care and their experiences of moving into the scheme for the eight schemes. Table 1.2 presents details of the total number of residents identified, the number of refusals for each questionnaire, the number of losses due to deaths or moves away, and the number of completed questionnaires. The losses due to death or moving away could have occurred after the data were collected, and so the columns are not mutually exclusive. Some residents enter schemes without requiring a care assessment, and only information about their expectations and experiences is being collected for these residents. In particular, the care village in Northamptonshire provides 270 units of accommodation, but 90 residents are expected to receive packages of care services. Seventy-five residents in Northamptonshire were receiving services for the purposes of completing the assessment questionnaire for this report, and information was available for 37 of these individuals.

Table 1.1: New build schemes (funded 2004–06): opening dates, sizes and tenure

	Opening date[2]	*Rented units (social or market rent)*	*Buy or shared owner-ship units*	*Inter-mediate/ respite care units*	*Total number of units*
2004–05 (Round 1)					
Brighton & Hove	07/06	33	0	5	38
East Riding	04/06	24	6	9	39
Enfield	11/06	48	0	0	48
Havering	08/06	50	5	9	64
Liverpool[1]	09/08	47	0	2	49
Milton Keynes	06/07	100	158	0	258
Northamptonshire	08/06	125	145	0	270
Peterborough	07/06	34	0	6	40
Staffordshire[1]	12/08	–	–	–	42
Stoke-on-Trent	04/08	42	25	8	75
West Sussex (Horsham DC)	07/06	29	10	1	40
2005–06 (Round 2)					
Blackburn with Darwen	11/07	39	8	1	48
Bradford	04/07	32	14	0	46
Cheshire[1]	09/09	41	83	0	124
Darlington	10/07	36	0	6	42
Derbyshire	06/08	16	23	4	43
Ealing	10/07	35	0	0	35
Hartlepool	06/08	97	145	0	242
North Yorkshire	12/07	38	0	1	39
Rotherham	04/07	22	13	0	35
Wakefield	09/07	41	4	0	45
West Sussex (Crawley BC)	11/08	39	0	0	39

Notes:

1. Liverpool, Staffordshire and Cheshire schemes have been excluded from the main evaluation due to delays in completion. Information on tenure for Staffordshire scheme is not available since the scheme was modified following the successful bid.
2. For the 19 schemes included in the main evaluation, the opening date is the date when the first residents moved in or are expected to move in. For the three schemes excluded from the main evaluation, the opening date is the planned date of completion, as reported in Summer 2007.

Table 1.2: Summary of response to the assessment and resident questionnaires (8 schemes)

	Total no. ident-ified	*Refusals*		*Losses*		*No. of responses*			
		Ass-ess-ment	*Resid-ent*	*Died*	*Move away*	*Ass. & resid.*	*Ass. only*	*Resid. only*	*Total with data*
Bradford	51	10	11	2	0	35	2	1	38
Brighton & Hove	36	0	0	0	0	35	1	0	36
East Riding	36	14	23	0	0	13	9	0	22
Enfield	52	0	0	2	0	42	10	0	52
Havering	31	13	13	0	0	18	0	0	18
Northamptonshire	244	18	17	13	13	34	3	160	197
Peterborough	41	1	1	6	4	40	0	0	40
W Sussex (Horsham)	50	3	3	4	1	39	4	0	43
Total number	541	59	68	26	18	256	29	161	446

The structure of this report is as follows: section 2 describes the characteristics of the schemes; section 3 describes the characteristics of the residents prior to moving in, at assessment; section 4 describes the residents' expectations of extra care and their experiences of moving into the scheme; section 5 describes the information collected in the initial interviews for the JRF-funded study of social activity; and section 6 presents some preliminary conclusions and outlines the next steps of the evaluation. The key points arising in the report are presented in the summary.

Section 2: Scheme Characteristics

Introduction

This section of the report describes the characteristics of the extra care housing schemes. It is divided into six main sections. Sources of information, primarily the bid documentation, are identified before the schemes are described in terms of their geographical location, the type and size of the accommodation, their organisation and management, the tenure options available to residents, and the services and facilities provided. It focuses on the seven schemes that opened in 2006 and one that opened in the first half of 2007, and for which initial data collection activities have been completed. Of these eight schemes, seven were awarded funding in the first round (2004-05), and one in the second round (2005-06).

Sources of Information

The Department of Health required applications for funding to be submitted by local authorities responsible for social services in a standardised format on a Bidding Form spreadsheet included in the bidding pack, and those prepared by the successful schemes were made available to the researchers. As well as the Bidding Forms and application documents, bids typically included supporting letters and building plans. Additional appendices included by some of the successful submissions included feasibility studies, allocation and nomination arrangements and policies, and copies of local and regional strategies.

Application Guidance issued in August 2003 for the 2004-05 funding round (Department of Health, 2003c) outlined bidding criteria and provided detailed guidance on the type of information that bids should include. The Extra Care Housing Fund application requirements and bidding criteria changed over time, but the information provided was relatively standardised and could be compared easily. That said, the level of detail about particular policies and plans differed across the bids, for example in relation to eligibility criteria for prospective residents, planned allocation and nomination arrangements, intended dependency profiles and/or tenant participation. Clearly, this variability was likely to have resulted from the different stages in planning and development achieved by the partnerships in advance of funding approval.

Inevitably, not all the plans specified in the bids materialised and changes have been made, including some major redesigns, as noted in section 1. To help monitor such changes, confirm details of schemes that had opened and identify the local authority perspective, a survey was conducted in the Summer/Autumn of 2007 with the extra care housing leads at Councils with Social Services Responsibilities (CSSRs) about the extra care housing schemes participating in the PSSRU evaluation. The survey aims were to identify:

- Progress and any major changes to schemes since the bids were successful.
- Implementation issues, including challenges or barriers, and helpful or supportive factors.
- Any lessons learnt or examples of good practice that it would be useful to share.

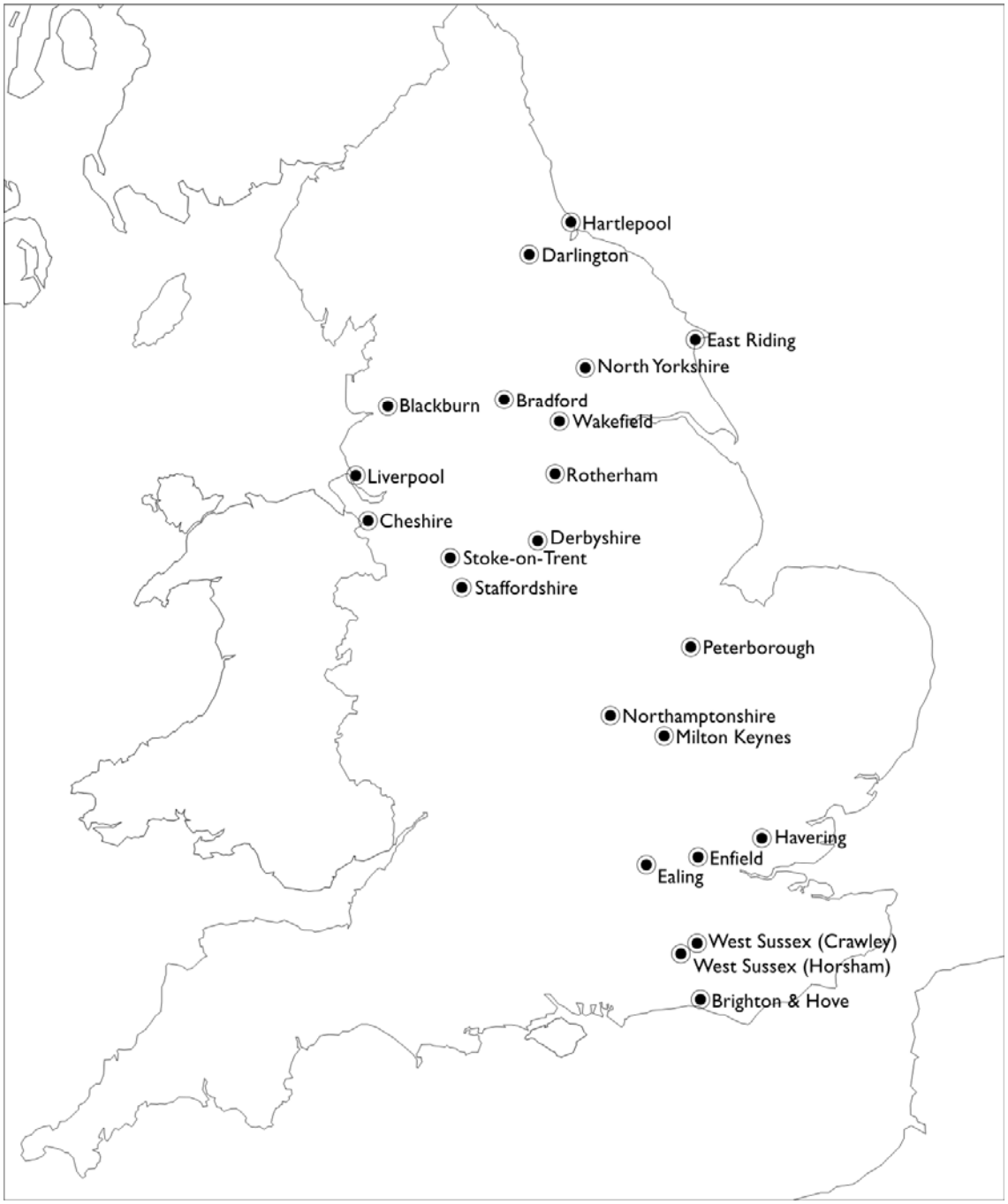
The survey included the 22 schemes originally planned to be included in the evaluation. Eighteen of the survey questionnaires were returned and the responses include information about seven of the eight schemes focused on in this report. The information presented here reflects that provided in the bids, updated to reflect the results of this survey, where available, and the ongoing fieldwork for the evaluation.

More generally, the national network, the Housing LIN, is a resource that provides information about housing, care and support for older people, including information about the Department of Health's Extra Care Housing Grant programme, and market information on the supply of extra care housing.

Location

Figure 2.1 shows the geographical distribution of the 22 schemes originally selected for the evaluation. Table 2.1 shows the location profile of the first eight schemes for which data were available, in terms of the type of local authority, the government office region, the rural or urban nature of the area, and whether they were built on brownfield sites.

Figure 2.1: New build schemes (funded 2004–06) selected for the evaluation



Note: Cheshire, Liverpool and Staffordshire schemes have been excluded from the main evaluation due to delays in completion (see section 1).

Each type of local authority is represented within the wider sample of schemes in the evaluation, with the exception of Inner London. The eight schemes described here are located within five regions: two in each of the South East, Yorkshire and The Humber and London, one in the East Midlands, and one in the East of England. The majority of the schemes (seven) were built on brownfield sites.

The majority of the schemes are in urban areas; seven are in urban settlements with populations greater than 10,000, with 'less sparse' population densities[1]. One scheme is in a small town and fringe area within a rural domain, again with a less sparse population density. It is worth noting that large extra care housing villages are likely to change the size and character of the locations in which they are built.

[1] The Rural and Urban Area Classification 2004 was developed by the Office for National Statistics, the Department for Environment, Food and Rural Affairs, the Department for Communities and Local Government, The Countryside Agency and the National Assembly for Wales. It is based on a physical settlement approach and builds on the 2001 Census. It is commonly used in neighbourhood and small area statistics. It produces a code that indicates the 'Morphology' and 'Sparsity' for Super Output Areas, which are described as urban or rural depending on whether the majority of the population falls inside a settlement of population 10,000 or more. 'Rural' areas are then further subdivided through the identification of rural towns, villages and isolated dwellings. Population sparsity is calculated for each hectare grid square according to the number of households in surrounding hectare squares up to a distance of 30 km.

Table 2.1: Location profile of extra care housing schemes

	Number of schemes
Local authority	
County council	2
Metropolitan district	1
Outer London borough	2
Unitary authority	3
Government Office Region	
East Midlands	1
East of England	1
London	2
North East	0
North West	0
South East	2
South West	0
West Midlands	0
Yorkshire and The Humber	2
Rurality	
Urban (> 10,000 – Less Sparse)	7
Town and Fringe (Less Sparse)	1
Village, Hamlet & Isolated Dwellings (Less Sparse)	0
Urban (> 10,000 – Sparse)	0
Town and Fringe (Sparse)	0
Village, Hamlet and Isolated Dwellings (Sparse)	0
Brownfield sites	7
Total number of schemes	8

Accommodation Type and Size

The build types and styles are described in table 2.2. All of the eight schemes were completely new build developments, although some of the other schemes in the evaluation include a re-modelled component. One scheme was a village, which provided mainly flats and a small number of bungalows. The village was the only scheme to provide a mixture of building styles: the other seven schemes just provided apartment-style accommodation.

Table 2.2: Prevalence of build types and styles for schemes

	Number of schemes	*Total units*
Build type		
New build	8	585
Build style		
Apartments	7	315
Villages (apartments and bungalows)	1	270

Table 2.3 below indicates the size of each scheme and the proportion of units with different numbers of bedrooms. The average size of the schemes (excluding the village) was 45 units. All offered both one and two bedroom units. None offered three bedroom units.

Table 2.3: Number of bedrooms and units of accommodation, by scheme

Scheme	*Percent 1-bedroom units*	*Percent 2-bedroom units*	*Number of units*
Bradford	43	57	46
Brighton & Hove	84	16	38
East Riding[1]	87	13	39
Enfield	75	25	48
Havering	88	12	64
Northamptonshire[2]	33	67	270
Peterborough	90	10	40
West Sussex (Horsham DC)	87	13	40
Total number of units	337	245	585

Notes:
1. Number of units by number of bedrooms was not specified in the survey. This information is based on that available in the bid.
2. Information for this scheme is based on the bid information.

Organisation and Management

Alongside the local authorities and registered social landlords, the bids specified a range of organisations as partners:

- Private developers
- Contractors
- Health care providers/Primary Care Trusts
- Care providers
- Supporting people
- Cost consultants
- Architects
- Regeneration agency and site vendors

Most bids identified three partners, although a few identified four. The extent to which care and support arrangements were in place at the bidding stage varied. The 2007 survey of extra care housing leads within local authorities asked a number of questions

about care and support, including whether there was a single care provider, whether residents could change care provider, whether the care organisation was separate from the organisation managing the scheme, and the sector of provision. A single care provider was more common than multiple providers (and was the case for six of the seven schemes included in the survey). In most cases, the social services contacts indicated that residents could change care provider, if they wished. However, one person stated that residents could not, and another stated that they were unsure. It is unclear how easy it would be for an individual resident to opt out of using the domiciliary care team dedicated to providing care to a scheme. The schemes included a range of care providers in terms of sector of ownership, including social services (three schemes), not-for-profit organisations (two schemes) and private, for-profit organisations (two schemes). In the majority of cases, the care provider organisations were separate from the organisation managing the scheme, but in one case the care provider was linked to the organisation managing the scheme.

Tenure

Table 2.4 shows the tenure options available across the schemes. Social rent, or a combination of social rent and shared ownership were the most common forms of tenure available in the extra care housing schemes. Seven of the eight schemes offered one or two forms of tenure (setting aside the issue of intermediate or respite care provision): three schemes offered accommodation for social rent only, and four offered mixed tenure in terms of social rent and shared ownership. The village offered a mix of four types of tenure: social rent, shared ownership, open market sale, and market rent. None of the schemes offered the combinations of social rent and open market sale, or social rent and market rent.

Table 2.4: Tenure profile of schemes

	Number of schemes
Type of tenure	
Social rent	3
Social rent and shared ownership	4
Social rent, shared ownership, market rent and open market sale	1
Total number of schemes	8

Table 2.5 shows the proportion of units provided by type of tenure for each scheme. Within the five schemes that provided mixed tenure, the most common form of tenure in every case was social rent, accounting for between 45 per cent and 87 per cent of the accommodation. Typically, less than a quarter of units were allocated to shared ownership, where this was available, except for the village where the proportion rose to nearly one-third. In one case, a slightly higher proportion of units was available for open market sale than for shared ownership. Only the village indicated, in its bid documentation, plans to provide accommodation for market rent, and this was in a very small quantity (three bungalows).

Table 2.5: Types of tenure, by scheme

Scheme	*Percent social rent*	*Percent shared owner-ship*	*Percent open market sale*	*Percent market rent*	*Percent inter-mediate/ respite care*	*Number of units*
Bradford	70	13	17	0	0	46
Brighton & Hove	87	0	0	0	13	38
East Riding	62	15	0	0	23	39
Enfield	100	0	0	0	0	48
Havering[1]	78	8	0	0	14	64
Northamptonshire[2]	45	31	22	1	0	270
Peterborough	85	0	0	0	15	40
West Sussex (Horsham DC)	73	25	0	0	2	40

Notes:
1. Information on intermediate care for this scheme is based on the bid information since the survey response was unclear about the provision of units for intermediate care.
2. Information for this scheme is based on the bid information.

In some instances, the proportion of shared ownership units provided or planned for was relatively low, when compared with the proportion of owner-occupiers in the local community. For example, one area highlighted that 88 per cent of the local population were owner-occupiers, but only allocated 10 out of the 40 flats for shared ownership.

Within schemes, units can vary considerably. In addition to tenure and the number of bedrooms, planned units varied in terms of size/floor area and the assistive technology to be made available. Differences between units were sometimes associated with tenure. In the village, for example, one-bedroom units were planned in greater numbers for social rent than for open market sale (35 compared with seven).

Services and Facilities

Table 2.6 indicates the extent of the provision of accommodation for specific client groups and the number of schemes intending to provide services for the local community.

Client Groups Supported

All eight schemes planned to provide for people with dementia, but none specified in their plans that they intended to designate specific accommodation or units for this group. One scheme planned to be a centre of dementia excellence for the local area. Some bids described the way in which good practice design features would be used throughout the scheme to support the needs of people with dementia, such as orientation prompts and security systems.

Six of the eight schemes intended to provide housing and care for older people from Black and Minority Ethnic (BME) communities. Of these, four designated the number of units they expected to provide to people from BME communities. These comprised a minority of the total number of units: 24 units across four schemes, providing a total of 165 units. None of the schemes planned explicitly to provide for older people with learning disabilities.

Services Provided

Seven of the eight schemes planned to offer day care services or facilities for the local community, and the other indicated that day care was under consideration. Of these schemes, four planned to provide services via a day care centre, and a fifth intended communal facilities to operate as a day care centre.

Table 2.6: Profile of intended services and client groups

	Number of schemes
People with dementia	8
Intermediate care	5
Respite care	2
People from BME communities	6
Day care	7
Outreach	5

Five schemes planned to provide intermediate care. Of these, two also referred to providing respite care. It appears that that the terms 'intermediate care' and 'respite care' in the bids can be treated as interchangeable. This might be due to the way in which some units were designated for a short-term use in general, whether that was for specialist intermediate care or for respite care. One scheme planned to provide a Rehabilitation Training Centre.

Five of the bids referred to offering outreach services to the community. Definitions of outreach services tended to refer simply to services provided by schemes that the wider community would be able to use. For example, restaurant and lounge facilities were identified as potential resources that could be operated as community day centre resources.

Facilities

Table 2.7 shows the facilities planned for the schemes, drawn from the bids. The extra care housing facilities most commonly identified in the plans were restaurants, sitting rooms, hairdressers and assisted bathing, which were to be provided by all eight schemes. Other facilities available in the village include a 'village hall', a craft room and a greenhouse. Another scheme identified the provision of community transport. Additional facilities identified after schemes opened include a cinema.

The use of facilities could change once schemes opened. Facilities identified by the scheme managers as being in place six months after opening are described in section 5.

Table 2.7: Facilities planned in bids

	Number of schemes
Restaurant	8
Sitting room/lounges	8
Café	5
Library	3
Meeting room/space	4
IT area	3
Gym or exercise facilities	5
Hairdresser on site	8
Shop	4
Laundry facilities for resident use	2
Laundry facilities – unclear if for resident or staff use	6
Guest accommodation available	5
Medical/consulting room	5
Assisted bathing	8
Buggy store	6

Changes to Schemes

Various changes have occurred to the schemes since they were planned for the bidding phase. Types of change include changes to the overall number of units provided, the tenure options available, the proportion of one and two-bedroom units provided within schemes, and the balance between intermediate care and respite care provision. The nature of the changes include: decreases to the number of one-bedroom units and increases to the number of two-bedroom units (and vice versa); increases in the total number of units (two schemes); and a reduction in the number of intermediate care units (two schemes). One scheme changed from a two-phase development to a single-phase development.

Overview

Seven of the eight new build extra care housing schemes described in this report were built on brownfield sites, and the majority are located in urban areas. They all provided apartment-style accommodation, with the village providing bungalows as well as flats. Six of the schemes offered more one-bedroom flats than two-bedroom flats, and two schemes provided more two bedroom units. The most common form of tenure available across the schemes was social rent, or a combination of social rent and shared ownership. The tenure mix within the schemes typically contained more units for social renting than units for purchase. In terms of the number of units of accommodation, the average size of the non-village extra care housing schemes was relatively small, and was comparable to the size of newly-registered care homes (Laing & Buisson, 2007). The schemes aimed to support older people with dementia and most offered day care services. A small amount of intermediate care is offered in some of the schemes, and some include outreach services for the community.

Section 3: The Characteristics of Residents Moving into Extra Care

Introduction

The purpose of this section is to present information about the characteristics of the residents at assessment for the schemes that have opened to date. These include the seven schemes that opened in 2006 and one of the three schemes that opened in the first half of 2007. As explained in section 1, two main sets of information are being collected about individual entrants to the schemes included in the evaluation. First, information covering residents' demographic characteristics and care needs is being collected, drawing on the information collected in the assessment process. Second, information is being collected from residents about their expectations of extra care and their experiences of moving into the scheme. Some residents enter schemes without requiring a care assessment, and only information about their expectations and experiences is being collected for these residents, as described in section 4. The care village in Northamptonshire provides 270 units of accommodation, but 90 residents were expected to receive packages of care services.

This section provides information about 285 residents who moved into the eight schemes, and compares their characteristics with a sample of 820 residents admitted to care homes in early 2005 (Darton et al., 2006). The 285 residents include the majority or all of the eligible individuals in four of the eight schemes (Brighton & Hove, Enfield, Peterborough and West Sussex (Horsham DC)), over 70 per cent in Bradford, around 60 per cent in East Riding and Havering, and around 40 per cent of the expected number in the care village in Northamptonshire.

The information on the demographic characteristics and care needs of residents was collected using a questionnaire designed to correspond to one used in a recent study of admissions of older people to care homes (Darton et al., 2006) and a number of similar previous studies. The completion of the questionnaire was subject to the consent of the resident or their representative. This section includes comparisons of the characteristics of the residents who moved into the schemes with the individuals included in the survey of admissions to care homes.

Description of the Residents

Demographic Characteristics

Table 3.1 presents information about the demographic characteristics of the residents. The ages of the residents ranged from 45 to 97 years, with a mean of 78 years. Approximately 15 per cent of residents were aged under 65, and 13 per cent were aged 90 or over. Male residents accounted for 35 per cent of the residents, and there were very similar numbers of males and females in each marital status category, apart from widows, who accounted for 36 per cent of residents. Only 13 of the residents were recorded as being of non-white ethnic origin.

Housing Circumstances

Table 3.2 presents information about the previous housing circumstances of the residents. The majority of residents had previously been living in a private household (61 per cent), 25 per cent had previously been living in sheltered housing or supported housing, and 8 per cent had previously been living in a care home. Among those who had been living in a private household, the majority had been living in a house (41 per cent) or a flat/maisonette (39 per cent), while 18 per cent had been living in a bungalow. The majority of these residents had been living in rented accommodation (53 per cent), or rent-free (7 per cent), but 38 per cent had been owner-occupiers. As may be expected from the information on marital status shown in table 3.1, the majority of residents had been living alone, particularly those who had been living in sheltered housing. However, approximately 14 per cent of those who had been living in a private household had been living with their children or other family members.

Table 3.1: Demographic characteristics of residents

	No.	*%*
Age		
Minimum	45	–
Mean	78	–
Maximum	97	–
Age group		
45 to 49	2	0.7
50 to 54	2	0.7
55 to 59	17	6.0
60 to 64	22	7.7
65 to 69	25	8.8
70 to 74	26	9.2
75 to 79	53	18.7
80 to 84	42	14.8
85 to 89	57	20.1
90 and over	38	13.4
Missing	1	–
Sex		
Male	100	35.1
Female	185	64.9
Marital status		
Single	38	14.3
Married/living as married	79	29.7
Divorced/separated	35	13.2
Widowed	114	42.9
Missing	19	–
Sex and marital status		
Single males	18	6.8
Single females	20	7.5
Married/living as married males	38	14.3
Married/living as married females	41	15.4
Divorced/separated males	17	6.4
Divorced/separated females	18	6.8
Widowed males	17	6.4
Widowed females	97	36.5
Missing	19	–
Ethnic origin		
White	271	95.4
Mixed race	1	0.4
Asian/Asian British	4	1.4
Black/Black British	8	2.8
Missing	1	–
Total number of individuals	285	100.0

Table 3.2: Housing circumstances before moving into extra care

	No.	*%*
Previous accommodation		
Private household	173	60.7
Sheltered/supported housing	70	24.6
Care home	22	7.7
Hospital	10	3.5
Intermediate care	4	1.4
Other	6	2.1
Private household: type		
House	71	41.0
Bungalow	32	18.5
Flat/maisonette	68	39.3
Bedsit/rooms	2	1.2
Private household: tenure		
Owner occupied/mortgaged	65	37.6
Rented from LA/HA	79	45.7
Privately rented	13	7.5
Rent-free	12	6.9
Not known/missing	4	2.3
Private household: composition		
Lived alone	90	52.0
Lived with spouse	52	30.1
Lived with spouse and children	8	4.6
Lived with children	10	5.8
Lived with other family	6	3.5
Other/missing	7	4.0
Sheltered housing: composition		
Lived alone	56	80.0
Lived with spouse	12	17.1
Other/missing	2	2.9
Total number of individuals	285	100.0

Informal and Formal Care

Tables 3.3 and 3.4 present information on the receipt of informal care and formal care services before moving into extra care, and table 3.5 presents information on the planned services to be provided for the resident after moving into extra care. Nearly 60 per cent of residents were recorded as either having received informal care from a person in the same household (18 per cent) or at least weekly from someone outside the household (40 per cent), while 35 per cent did not receive informal care.

Table 3.3: Receipt of informal care before moving into extra care

	No.	*%*
Receipt of informal care		
Lived with informal carer	50	18.4
Contact every day/nearly	42	15.4
Contact 2–3 times a week	38	14.0
Contact once a week	28	10.3
Contact less than once a week	14	5.1
Contact frequency not known	6	2.2
No informal care	94	34.6
Missing	13	–
Total number of individuals	285	100.0

Home care was received by 43 per cent of residents before moving into extra care. However, only 11 per cent received more than 10 hours of home care per week, corresponding approximately to the definition of intensive home care (The Information Centre, Adult Social Care Statistics, 2007), and very few (6 per cent) received more than 14 hours per week, or two hours per day. Few residents were recorded as having received other care services before moving into extra care. Around 20 per cent had attended a day centre and a similar proportion had received meals on wheels, while just under 15 per cent had received visits from a nurse or health visitor.

A higher proportion of residents was expected to receive home care after their move to extra care, compared with the proportion who received home care before moving. Overall, 66 per cent were expected to receive home care in extra care, and nearly 12 per cent were due to receive more than 14 hours per week. Meals are an important service provided in extra care, and nearly 60 per cent were recorded as being due to receive meals, in the majority of cases nearly every day or daily. Although 39 per cent were recorded as not being due to receive meals, this may reflect the particular type of meal service being provided, rather than indicating that these residents will not receive any meals. For example, in a 'pay as you go' service residents are free to purchase each meal available, and so would not be recorded as being due to receive meals. As may be expected, a similar proportion of residents were due to receive frequent visits from a nurse or health visitor after moving in as before. Fewer were reported to receive less frequent visits after moving in than before, but there were more cases where the information on nurse visits after moving in was missing.

Table 3.4: Receipt of formal care before moving into extra care

	No.	*%*
Receipt of home care in last month		
No	140	51.9
>0–7 hours per week	44	16.3
>7–14 hours per week	31	11.5
>14–21 hours per week	11	4.1
>21 hours per week	4	1.5
Frequency not known	26	9.6
Receipt not known	14	5.2
Missing	15	–
Visits to day centre in last month		
None	190	73.9
4–5 times a week	7	2.7
2–3 times a week	18	7.0
Once a week	20	7.8
Frequency not known	10	3.9
Receipt not known	12	4.7
Missing	28	–
Receipt of meals on wheels in last month		
None	190	75.4
More than once a day	5	2.0
Every day/nearly	22	8.7
2–5 times a week	8	3.2
Frequency not known	12	4.8
Receipt not known	15	6.0
Missing	33	–
Visits from nurse in last month		
None	174	69.0
Every day	5	2.0
At least once a week	15	6.0
1–3 times a month	12	4.8
Frequency not known	7	2.8
Receipt not known	39	15.5
Missing	33	–
Visits from NHS therapist in last month		
None	199	78.0
Received	14	5.9
Receipt not known	42	16.5
Missing	30	–
Receipt of direct payments in last month		
No	209	83.6
Received	3	1.3
Receipt not known	38	15.2
Missing	35	–
Receipt of intermediate care in last month		
No	222	88.8
Received	6	2.4
Receipt not known	22	8.8
Missing	35	–
Total number of individuals	285	100.0

Table 3.5: Formal care to be provided after moving into extra care

	No.	*%*
Home care		
No	88	32.7
>0–7 hours per week	53	19.7
>7–14 hours per week	42	15.6
>14–21 hours per week	18	6.7
>21 hours per week	14	5.2
Frequency not known	51	19.0
Receipt not known	3	1.1
Missing	16	–
Meals		
None	99	39.1
More than once a day	24	9.5
Every day/nearly	106	41.9
2–5 times a week	7	2.8
Frequency not known	13	5.1
Receipt not known	4	1.6
Missing	32	–
Visits from nurse		
None	204	85.0
Every day	5	2.1
At least once a week	15	6.3
1–3 times a month	2	0.8
Frequency not known	4	1.7
Receipt not known	10	4.2
Missing	45	–
Visits from NHS therapist		
None	195	79.3
Received	8	3.3
Receipt not known	43	17.5
Missing	39	–
Receipt of direct payments		
No	237	96.0
Received	1	0.4
Receipt not known	9	3.6
Missing	38	–
Total number of individuals	285	100.0

Financial Circumstances

Table 3.6 presents information on the financial circumstances of residents prior to moving into extra care. There was a relatively high proportion of cases for which the information was recorded as not known or the question was left blank. Among those residents for whom the information was recorded as known, 92 per cent were recorded as receiving a State Retirement Pension and 38 per cent were recorded as receiving a private pension. Approximately 55 per cent were recorded as receiving Pension Credit or Attendance Allowance, and approximately 65 per cent were recorded as receiving Housing Benefit or Council Tax Benefit.

Table 3.6: Financial circumstances of residents before moving into extra care

	No.	*%*
Receipt of State Retirement Pension		
Yes	198	73.6
No	18	6.7
Don't know	53	19.7
Missing	16	–
Receipt of Private Pension		
Yes	70	27.0
No	116	44.8
Don't know	73	28.2
Missing	26	–
Receipt of Pension Credit		
Yes	105	39.6
No	83	31.3
Don't know	77	29.1
Missing	20	–
Receipt of Housing Benefit		
Yes	129	48.5
No	70	26.3
Don't know	67	25.2
Missing	19	–
Receipt of Council Tax Benefit		
Yes	128	48.7
No	65	24.7
Don't know	70	26.6
Missing	22	–
Receipt of Attendance Allowance		
Yes	103	39.3
No	88	33.6
Don't know	71	27.1
Missing	23	–
Receipt of Disability Living Allowance		
Yes	56	21.6
No	135	52.1
Don't know	68	26.3
Missing	26	–
Receipt of other income		
Yes	32	13.2
No	130	53.7
Don't know	80	33.1
Missing	43	–
Total number of individuals	285	100.0

Physical and Cognitive Functioning

Table 3.7 presents information on the physical and cognitive functioning of residents, including the ability to undertake activities of daily living (ADLs), relating to personal care, and instrumental activities of daily living (IADLs), relating to domestic tasks, and two summary measures of physical and cognitive functioning. For the proportions of residents unable to perform ADLs and IADLs without help, the percentages were based on the net number of individuals, excluding missing cases, in the same way as for the information tabulated in the form of the complete distribution. Physical functioning was measured by the Barthel Index of Activities of Daily Living (Mahoney and Barthel, 1965), with scores ranging from zero (maximum disability) to 20 (minimum disability). Cognitive functioning was measured by the Minimum Data Set Cognitive Performance Scale (MDS CPS) (Morris et al., 1994), with scores ranging from zero (minimum) to 7 (maximum). The scores on the Barthel Index have been grouped into five categories (0-4, 5-8, 9-12, 13-16, 17-20), following Granger et al. (1979), but with an additional subdivision of the group of higher scores.

Over half of the residents were unable to go out of doors, use stairs or steps or bath or wash all over without assistance, and about one-third required assistance with dressing. However, fewer than 20 per cent required assistance with the other self-care tasks, and only five individuals required assistance with feeding themselves. Over 50 per cent required assistance with no more than two tasks, and 30 per cent were able to undertake all tasks without assistance. The majority of residents required assistance with domestic tasks, such as housework, shopping and personal laundry, and over 50 per cent required help to prepare hot meals. Just under 40 per cent required assistance to make snacks and hot drinks, but only 13 per cent required assistance with using the telephone, both activities being important in extra care, where residents' apartments have kitchen facilities and telecare systems may require residents to use sophisticated technology.

The Barthel Index summarises residents' abilities to undertake activities of daily living. Just under 30 per cent of residents were classified as having moderate or more severe levels of dependence using the index (scores of 0–12). Similarly, only a small proportion of residents were identified as suffering from cognitive impairment. Only 19 per cent were identified as having some cognitive impairment and only 4 per cent were severely impaired.

Table 3.7: Physical and cognitive functioning of residents

	No.	*%*
ADLs: unable to do without help		
Go out of doors	161	57.5
Bath/shower/wash all over	155	55.8
Get up/down stairs or steps	149	53.4
Dress/undress	99	35.9
Get in/out of bed (or chair)	50	17.8
Get around indoors (except steps)	47	17.0
Wash face and hands	38	13.5
Use WC	35	12.5
Feed self	5	1.8
IADLs: unable to do without help		
Do housework	204	73.1
Do household shopping	198	71.7
Do personal laundry	187	67.0
Do paperwork/pay bills/write letters	162	60.0
Prepare hot meals	149	53.2
Make snacks and hot drinks	108	38.6
Use telephone	34	13.0
Number of 9 ADL tasks assisted with		
None	76	29.6
1	28	10.9
2	34	13.2
3	30	11.7
4	37	14.4
5–9	52	20.2
Missing	28	–
Barthel Index of ADL (grouped)		
Very low dependence (Score 17–20)	112	42.9
Low dependence (Score 13–16)	74	28.4
Moderate dependence (Score 9–12)	38	14.6
Severe dependence (Score 5–8)	30	11.5
Total dependence (Score 0–4)	7	2.7
Missing	24	–
MDS Cognitive Performance Scale		
Intact (0)	171	63.8
Borderline intact (1)	46	17.2
Mild impairment (2)	21	7.8
Moderate impairment (3)	19	7.1
Moderately severe impairment (4)	5	1.9
Severe impairment (5)	6	2.2
Very severe impairment (6)	0	0.0
Missing	17	–
Total number of individuals	285	100.0

Comparisons Between Residents of Extra Care and Care Homes

As noted above, a specific aim of the evaluation is to collect comparable information on the characteristics of the residents of the extra care schemes to that collected about the residents of care homes, to enable comparisons to be made between individuals in the two types of accommodation. Table 3.8 presents comparisons of the people who moved into extra care housing and those who were admitted to care homes from a survey conducted in 2005 (Darton et al., 2006). The 2005 survey focused on individuals who were being assessed for local authority financial support, but it did include owner-occupiers as well as people who were in rented accommodation.

As may be expected from the preceding discussion, the people who moved into extra care required much less support than those who moved into care homes. The people who moved into extra care were younger, on average, and were more likely to be male and less likely to be widowed or living alone. The majority (85 per cent) had been living in their own home or sheltered housing, whereas nearly two-thirds of the people admitted to care homes had been in hospital, a care home or had been receiving intermediate care.

Overall, the people who moved into extra care were substantially less physically and cognitively impaired than those who moved into care homes. Just under 30 per cent of residents who moved into extra care were classified as having moderate or more severe levels of dependence using the Barthel index (scores of 0–12), compared with two-thirds of those moving into a care home providing personal care and over 85 per cent of those moving into a care home providing nursing care. For cognitive impairment, 4 per cent who moved into extra care were severely impaired, compared with 39 per cent of those moving into a care home providing personal care and 54 per cent of those moving into a care home providing nursing care.

Table 3.8: Comparison of new residents in extra care and care homes

	Extra care	*Care homes with personal care*	*Care homes with nursing care*
Age			
Minimum	45	65	65
Mean	78	85	84
Maximum	97	102	103
Age group (%)			
Under 65	15.1	–	–
65 to 69	8.8	1.8	4.4
70 to 74	9.2	5.9	8.5
75 to 79	18.7	12.6	14.0
80 to 84	14.8	24.5	18.8
85 to 89	20.1	25.5	26.6
90 and over	13.4	29.8	27.7
Sex (%)			
Male	35.1	26.8	30.8
Female	64.9	73.2	69.2
Marital status (%)			
Single	14.3	9.3	12.5
Married/living as married	29.7	17.2	23.0
Divorced/separated	13.2	5.1	1.6
Widowed	42.9	68.4	63.0
Previous accommodation (%)			
Private household	60.7	27.2	17.2
Sheltered/supported housing	24.6	10.0	3.1
Care home	7.7	11.6	17.6
Hospital	3.5	38.3	53.8
Intermediate care	1.4	7.3	4.2
Other	2.1	5.6	4.2
Previous household size (%)			
Lived alone	60.1	77.0	69.3
Lived with others	39.9	23.0	30.7
Barthel Index of ADL			
Mean	14.8	10.4	5.4
Barthel Index of ADL (grouped) (%)			
Very low dependence (Score 17–20)	42.9	10.3	3.1
Low dependence (Score 13–16)	28.4	23.3	9.2
Moderate dependence (Score 9–12)	14.6	31.9	9.2
Severe dependence (Score 5–8)	11.5	21.1	25.0
Total dependence (Score 0–4)	2.7	13.5	53.5
MDS CPS (grouped) (%)			
Intact (Score 0)	63.8	14.9	15.1
Mild impairment (Score 1–3)	32.1	45.7	30.7
Severe impairment (Score 4–6)	4.1	39.4	54.2
Total number of individuals	285	494	271

The schemes have been developed to support residents with a range of levels of disability, and to provide an alternative to residential care for at least some individuals. Typically, the schemes are aiming for a balance of residents with high, medium and low care needs, and the figure of 30 per cent for residents with Barthel scores in the range 0-12 indicates that this is being achieved. Some of the schemes are aiming specifically to support residents with dementia, including one that opened in 2006, as is shown in table 3.9, but most prefer to admit residents with fewer problems of cognitive functioning so that they can become familiar with their new accommodation before the development of more severe cognitive impairment. The low level of severe cognitive impairment among the new residents is consistent with this. However, it should be noted that the information presented here is based on the residents who have moved into the first few schemes, and the position may change once all the schemes have opened and become established. Table 3.9 indicates that the schemes that had relatively low response rates (East Riding, Havering and Northamptonshire) did not have lower proportions of residents with higher levels of dependency, with the possible exception of Havering, where the refusals appear to have been among those with higher levels of cognitive impairment.

Table 3.9: Comparison of residents, by scheme

Scheme	*Number of indiv-iduals*	*Mean age*	*Percent female*	*Mean Barthel score*	*Percent cog. intact*	*Percent severely impaired*
Bradford	37	77.7	73.0	15.8	53.4	14.3
Brighton & Hove	36	74.2	72.2	12.6	72.2	2.8
East Riding	22	73.6	50.0	16.0	68.4	0.0
Enfield	52	75.5	57.7	15.9	60.0	2.0
Havering	18	78.6	66.7	16.4	75.0	0.0
Northamptonshire	37	77.1	75.7	12.5	70.0	3.3
Peterborough	40	80.0	62.5	13.8	61.5	5.1
West Sussex (Horsham DC)	43	83.1	60.5	15.9	60.5	2.3
All schemes	285	77.7	64.9	14.8	63.8	4.1

Section 4: Residents' Views and Reasons for Moving into Extra Care

Introduction

This section examines which factors motivated residents to move into the schemes, their experience of the move and their expectations of extra care. Soon after admission, two sets of information are being collected from new entrants to the schemes. The first set of information concerns their assessment data, results from which have been outlined in section 3. For the second set of information, residents are approached and asked to complete a questionnaire with, if necessary, the assistance of the local interviewer. The questionnaire aims to obtain information about their decision to move to extra care housing, by whom it was initiated and what the underlying motivations were, and their expectations of extra care.

The findings reported in this section include information from 417 residents who moved into seven schemes that opened in 2006 and one that opened in the first half of 2007. No assessment data were collected for 161 residents, all but one of whom lived in the care village in Northamptonshire (see table 1.2). The residents in the care village without assessment data have been assumed not to have care needs. This section will sometimes describe results separately for these two sub-groups of residents: those with and those without care needs. Multivariate analysis was used to examine the dataset, specifically to determine whether demographic information predicted which reasons residents identified as important. For example, a study by Kupke (2001) in Australia demonstrated that motivations for moving vary depending on marital status and gender.

The Decision to Move

The majority of residents (67 per cent) reported that their move to the scheme was decided upon by themselves entirely, whilst 17 per cent felt confident that they were partly involved in the process. For approximately a third, family and/or friends played an influential role in the decision. Only in 10 per cent and 15 per cent of the cases, respectively, did a General Practitioner or other professional put forward the idea of a move. This suggests that, predominantly, the move was not triggered by acute health problems but was one of voluntary choice. Seventy-one per cent of residents reported that they actively chose the specific scheme themselves. Significant associations were found between the resident making the decision to move and (i) choosing the scheme

themselves (correlation coefficient (r) = 0.370, $p < 0.001$), and (ii) identifying the reputation of the scheme as an important reason for moving ($r = 0.288$, $p < 0.001$).

Overall, 87 per cent of residents visited the scheme before moving in, and 74 per cent of their families did likewise. However, only 20 per cent visited a similar scheme and 10 per cent visited a care home prior to their move. One might have expected more residents to have evaluated alternative options as part of their planning process for such an important decision. Where accommodation was available for purchase or part-purchase, residents seem to have considered a move in response to the marketing employed. It might be, therefore, that residents had the specific scheme in mind when they considered a move to extra care housing. Other factors, such as geographic location, influence of family and/or friends, or the importance of specific selection criteria, may have played a crucial role (Kichen and Roche, 1990). It seems that residents positively chose to live in extra care housing. They were not forced into an involuntary move, and they were not a passive audience unable to make a well informed choice.

The Experience of Moving

Whilst moving is a potentially stressful event for people of all ages, older adults are especially vulnerable, given that they have often been accustomed to living in their homes for many years. Overall, two-thirds of residents experienced the move as quite or very stressful. Interestingly, 39 per cent of residents with care needs, compared to only 16 per cent without care needs, said that they did not find the move at all stressful. Again, 61 per cent of residents with care needs, compared to only 38 per cent of those with no care needs, reported that the move had no negative effect on their physical health. Understandably, residents were more prone to experience physical health declines after a stressful move ($r = 0.545$, $p < 0.001$). Nonetheless, it is surprising that those without care needs were more likely to suffer health effects. A possible explanation is that the residents without care needs all lived in the same care village, comprising 270 units, and the process of moving-in could have been more intense than for smaller schemes, which ranged in size from only 38 to 64 units. Furthermore, 57 per cent of residents moved to the care village from a different area; a study by Heisler et al. (2004) suggests that moving to a retirement community from a distance may be an unidentified risk factor for adverse health consequences.

Overall, nearly all residents (90 per cent) described their move as well organised. Fifty-one per cent and 33 per cent, respectively, said members of staff were very and quite helpful, while 66 per cent of residents did not feel at all alone during the move. Generally, residents felt in control of the move (88 per cent), which may reflect the fact that taking the initiative or being jointly involved in the decision making process led to a feeling of control.

Reasons for Moving Out of Their Previous Home

The push-pull theory of migration (Lee, 1966) provides a useful framework for examining reasons motivating a move: push factors represent the negative aspects of a person's previous/current living conditions that influence the consideration of a housing change. Residents were asked to score several factors in terms of whether they were very, quite, or not at all important in their decision to move. The mean score was used to rank the factors in terms of the most influential: table 4.1 presents this information separately for residents with and without care needs.

Among those with care needs, the most relevant reasons for moving out of their previous homes were, as may be expected, related to health. The majority identified their own physical health as a very important reason (55 per cent), while 24 per cent stated that it was quite important. Approximately 60 per cent reported as very or quite important the lack of services available and problems in coping with daily tasks. Housing-related factors, such as difficulty in getting around the house and managing the home, were identified as very important by 27 per cent of residents and as quite important by another one-quarter. Interestingly, among those without care needs, 24 per cent also identified own physical health as a very important reason, while 34 per cent stated that it was quite important. However, more than two-thirds of the residents without care needs reported that all other health-related factors were of no importance in their decision to move to extra care. Instead, approximately 60 per cent identified as very or quite important garden/household maintenance and fear of crime.

Table 4.1: Push factors for moving to extra care

	Percent reporting as very important	
	With care needs	*With no care needs*
Health issues		
Own health	54.7	23.8
Coping with daily tasks	34.0	3.8
Lack of services	34.4	8.1
Difficulty getting around house	33.2	5.6
Spouse health (not applicable for 55%)	17.2	16.3
Housing issues		
Home too much to manage	27.3	15.0
Need adaptations to get around	27.7	3.8
Garden maintenance	30.1	33.1
Too far from shops	13.7	11.3
Home too large	15.6	11.9
Home in disrepair	5.5	1.9
Care home closed	8.2	0.0
Cost of living	2.7	1.9
Social issues		
Isolated from community	17.2	7.5
Fear of crime	14.1	30.6
No wish to live alone	16.0	19.4
No friends/family nearby	10.9	10.6

Health Concerns

Relative to other push factors, health concerns were a primary factor for moving, both for those with care needs (55 per cent) and those without (24 per cent). On average, however, residents with care needs rated their self-perceived health status (measured on a scale of 1 = very good to 5 = very bad) between fair and good, with only 18 per cent and 3 per cent reporting bad and very bad health, respectively. The importance attached to physical health as a reason for moving could be attributed to the fact that residents

were considering the future implications of deteriorating health. There was no significant association between importance of physical health as a reason for moving and self-perceived health. Among those without care needs, coping with daily tasks and difficulty in getting around the house were only important for 4 per cent and 6 per cent, respectively. A study of a retirement village (Kingston et al., 2001) similarly found that, although many people had moved to the village citing poor health, they rated their own health as significantly better than a matched sample of older people drawn from the locality where many of the retirement community's residents had formerly lived.

Sixty per cent of residents with care needs had experienced some lack of services and support in their previous home. There was an association between reporting lack of services and reporting health concerns as relevant reasons for moving ($r = 0.356$, $p < 0.001$). Given the preceding findings, a move attributed to health concerns may reflect a move to obtain guaranteed access to care services for current and, more importantly, future needs. Residents who were unmarried were more likely to cite lack of services as a factor influencing their decision to move: they may wish not to become a burden on informal care-givers in the event that their health declines further. Choosing to move to a purpose-designed setting, where any current and future needs will be met by guaranteed access to care, is a means of ensuring independence in the future (Croucher et al., 2006).

Housing Issues

Residents with care needs focused most on how the physical characteristics of housing exacerbated declining health. Thirty-three per cent reported that a mobility problem in their previous home was a very important reason to move, whereas 28 per cent identified needing adaptations to get around as a strong incentive to move. Information from the follow-up stages of this evaluation will show whether living in a more accessible, purpose-designed environment helps maintain, or even improve, residents' independence. Research has shown that people are able to do more for themselves and, in some cases, return to activities that they had previously given up because of the difficulties presented in their former accommodation (Croucher et al., 2006).

Among residents without care needs, more than half (60 per cent) identified the freedom from the burden of garden/household maintenance as a very or quite strong incentive to move. Married respondents who reported worse health were more likely to cite this as an important push factor, possibly concerned about the burden falling on their spouse. The release from household upkeep and maintenance can be viewed as a current need, a

future need, or both (Krout et al., 2002). Among those without care needs, fear of crime was also a more frequently-cited reason to relocate, reported by 60 per cent, compared with only 18 per cent of those with care needs. This finding is surprising, but may be explained in part by a locational effect. The residents without care needs all lived in the care village in Northamptonshire, and nearly half indicated that they lived in the same area beforehand.

Reasons for Choosing Extra Care Housing

Table 4.2 presents information on those features of the extra care schemes which attracted residents the most, described as pull factors in Lee's (1966) push-pull model. The most important attractions for the majority of residents, with little difference between those with and without care, were tenancy rights/'having your own front door' (80 per cent), type of tenure (60 per cent), accessible bathrooms and living arrangements (72 per cent), size of units (67 per cent), security offered by the scheme (71 per cent) and flexible on-site care and support (71 per cent). It is this combination of features that makes extra care housing distinctive from other types of provision for older people. The fact that residents value this indicates that appropriate decisions were made: they maximised the fit between their needs and the characteristics of the environment (Lawton, 1986). The attractions of extra care were substantially more important reasons to move to extra care than difficulties encountered in residents' previous homes.

Accommodation Features

Among both those with and without care needs the most important pull factor, citied by 76 per cent and 85 per cent respectively, were tenancy rights and 'having your own front door'. Having your own front door reflects the fact that the flats in extra care schemes are self-contained. Tenancy rights indicate that the accommodation is not inexplicably bound up with the care received, and gives the security needed for a resident to consider their accommodation to be their own home (Laing & Buisson, 2006). Multivariate analysis showed that younger movers were more likely to mention tenancy rights as a key factor in their decision to move. Self-contained accommodation facilitates privacy as well as autonomy in terms of performing tasks and activities, possessions and company (Croucher et al., 2006). Seventy-two per cent of residents noted the importance of accessible living arrangements and bathrooms in their decision to move. The importance attributed to these accommodation features reflects a desire for independence by residents.

Table 4.2: Pull factors for moving to extra care

	Percent reporting as very important	
	With care needs	*With no care needs*
Tenancy rights/own front door	76.2	85.0
Accessible bathroom	77.0	65.6
Care support on site	75.4	62.5
Size of flats/bungalows	70.7	60.6
Security offered by scheme	71.1	70.0
Communal/dining facilities	59.8	56.3
Type of tenure available	55.1	69.4
Social and leisure facilities	42.6	56.9
Location to the local community	42.6	31.1
Proximity to family/friends	42.6	36.3
Cost of living at the scheme	23.0	28.8
Reputation of the scheme	20.7	49.4
Alternative was a care home	16.0	16.9

For 69 per cent of residents without care needs, thus those living in the care village, the type of tenure available was also an important attraction. The care village consists of 270 units, of which 45 per cent are for social rent, 31 per cent are for shared ownership and 22 per cent are for open market sale (see table 2.5). The interest in, and demand for, a variety of tenures which enable residents to safeguard their financial assets by purchasing or part-purchasing their accommodation has important implications for planners and the future development of extra care.

Care and Support On Site

The availability of and reassurance offered by 24-hour on-site care was, as may be expected, a very important factor for 75 per cent of residents with care needs. For those with no care needs, 63 per cent rated it as very important, whilst approximately 30 per cent said it was only somewhat important. The accommodation characteristics of extra care, in the preceding discussion, seemed to have more importance in the decision-making process of those without care needs.

Care and support on site was mentioned more frequently as a consideration for moving by female respondents who were married than by those who were unmarried. This may reflect both a wish not to become a burden on their spouses in the event of declining health, and a wish to be assured that their spouses will have care and support in the event that they themselves pass away (Krout et al., 2002). Such findings were previously reported by Cohen et al. (1988), as well as by Sheehan and Karasik (1995). Approximately one-third of residents in the sample were married (see section 3), and since they are likely to represent a growing proportion of those living in extra care housing, this should be taken into consideration in terms of the mix of two-bedroom units and types of tenures offered by schemes.

For the majority of residents (70 per cent), irrespective of whether they had care needs, the least frequently-identified reason for choosing extra care was the fact that a care home was the only alternative. The move was thus rarely an involuntary one following an acute health problem, which is the case for the majority of admissions to care homes, where the older person has very little input in the decision-making process and may not really understand what is on offer before they move (Stilwell and Kerslake, 2004; O'May, 2007).

Seventy per cent of residents moved into the scheme because of the security offered. In light of the fact that about half of all residents (49 per cent) did not consider fear of crime to be an important reason to move away from their previous homes, 'security' can be broadly interpreted. A sense of security may be derived from the knowledge that 24-hour on-site care is available if and when it should be needed. Security can also relate to an accessible environment which makes people less fearful of falling or injuring themselves (Croucher et al., 2006).

Social Facilities

The availability of social, leisure and dining facilities was of high importance for just over half of residents, relatively less of an attraction than the accommodation characteristics and care service provision discussed above. Communal areas are seen as strategic in that they allow greater opportunities for social contact, which is one of the principal aims of extra care housing. Several explanations could account for this finding. Communal facilities are a feature shared with residential care settings, but residents might not be aware that the facilities available in extra care housing extend beyond those available in sheltered housing or care homes, and therefore do not consider such facilities as a basis for choosing extra care housing. Secondly, 16 per cent

of residents with care needs did not regard social facilities as at all important in their decision to move, compared to only 3 per cent of those without care needs. Health and mobility impairments may come into play, creating a reluctance to engage in an active social life, which is in line with findings of other research (Croucher et al., 2007; Evans and Vallelly, 2007). Interestingly, among those without care needs, female residents were more likely to say that they moved because of the social facilities.

Expectations

Social Life

Just over half of the residents (60 per cent) expected their social life to be improved and, as a result, that they would be less isolated and would socialise more. There were associations between this expectation and reporting that social facilities ($r = 0.320$, $p < 0.001$) and security ($r = 0.231$, $p < 0.001$) were very important attractions of extra care housing, as just discussed. There was also an association between this expectation and citing isolation from the community as a reason for moving out of their previous accommodation ($r = 0.289$, $p < 0.001$). Younger respondents with care needs were more inclined to cite isolation from the community as an important factor for relocation. Also, residents who were younger and married were more concerned about living alone in the future. Sheehan and Karasik (1995) similarly found that younger people on a continuing care retirement community (CCRC) waiting list were more likely than older people to identify increased social opportunities as a reason for relocating.

Notably, a third of respondents, irrespective of care receipt, did not expect their social life to change after their move to extra care. Previous studies have shown that, from residents' perspectives, one facet of independence is the choice of whether or not to participate in social activities; i.e., the lack of pressure to be involved is very highly valued (Croucher et al., 2007). This concurs with the findings that, relative to other pull factors, the availability of social facilities was not one of the strongest attractions of extra care housing; not all residents seek the same level of social interaction.

Contact with Family/Friends

A quarter of the residents expected to see their family and friends more frequently. However, overall, 65 cent of residents did not expect to see a change in the frequency with which they saw family and/or friends. Several explanations could account for this

finding. The proximity of the scheme to family and/or friends was a very important (40 per cent) or a quite important consideration (30 per cent) for residents in moving to the specific scheme. Approximately 45 per cent of residents previously lived in the same area; Golant (1992) notes that maintaining the same contact to family and friends is the primary reason for such local moves (see also Gober and Zonn, 1983). Secondly, as noted previously, approximately 80 per cent were most attracted to extra care by the fact that the accommodation is self-contained with its 'own front door'. This enables family relationships to continue as usual and family members can still offer support and assistance.

Length of Stay and Moving On

As may be expected, there were high expectations about the anticipated length of stay in extra care housing. Overall, 91 per cent of residents reported that they expected to live in the scheme for as long as they wished. A term frequently used in the context of extra care housing is 'ageing in place' – residents should be able to remain in extra care housing well beyond the point where they would have had to leave dispersed home care and been admitted to a care home or hospital. This is a function of the accessible design of the structure and of the level of support that can be given by a care team based within the scheme (Laing & Buisson, 2006). For those respondents with care needs, 30 per cent indicated that they had no intention of moving on. For those with no care needs, 88 per cent saw the need to move into a care home as a very unlikely future possibility, but did not rule it out.

Summary

This section of the report explores a relatively new type of residential transition: the move to extra care housing. However, it should be noted that the information presented here is based on residents who have moved into new build schemes, seven schemes that opened in 2006 and one that opened in the first half of 2007.

Factors motivating a move were categorised in terms of Lee's (1966) push-pull model of migration. The findings presented showed that push factors served to make individuals aware of their needs. Aspects of their previous living conditions which motivated individuals to begin thinking of a move the most were: a decline in their own physical health, exacerbated by lack of support services; inappropriate homes; and difficulty in household/garden maintenance. According to Engel et al. (1995), need

recognition is the first stage of decision making. However, it seems that, overall, these push factors were not so important as to amount to a decision to move. In fact, those who moved into extra care were substantially less physically and cognitively impaired than older people who move into care homes (see section 3), and who often move involuntarily (Stilwell and Kerslake, 2004; O'May, 2007). Such an involuntary type of move is described by the third stage of Litwak and Longino's (1987) model of old-age migration. Indeed, the fact that the on-site care provision was an important motivation for even healthy residents to move to extra care suggests that they were consciously avoiding an unplanned, involuntary move. The motivational and decisional locus thereby remained with them: the great majority of residents made both the decision to move, and where to move to. In making these decisions, findings showed that certain features of extra care housing were much more important reasons to move than dissatisfaction with previous living conditions. In particular, the emphasis was placed on accommodation aspects such as tenancy rights, accessibility and size of units, and also on the availability of on-site care and support. Moving into extra care housing therefore seems to be in response to pull factors and in anticipation of push factors; i.e. future needs.

These findings suggest that, in terms of Litwak and Longino's (1987) model, the older people studied here might fall both within the first and second stages, but not the third stage. The first stage describes a planned move towards amenities and friendship networks; however, only half of the respondents considered social facilities an important attraction, and one-third did not expect their social life to change. The second stage describes a move to adapt to moderate disability levels, when the older person is no longer able to live independently in their home and wishes to increase the proximity to kin. Indeed, the emphasis given to housing aspects as a reason to move indicates that respondents had a need for appropriate housing. The physical characteristics of inappropriate housing exacerbate declining health and undermine independence unnecessarily.

The reasons for moving to extra care housing are multidimensional, involving a desire to meet existing, but in most cases relatively low, needs for appropriate housing and for care services, and also a desire to ensure that future needs will be met, with a minimal burden to one's spouse and/or family. It seems that residents positively choose extra care themselves in order to increase, or maintain, their independence, and also to be 'care ready'; that is, to reduce the likelihood of having to move very late in life. Nearly all residents expected to live in the extra care schemes for as long as they wanted to;

one-third of those with care needs reported that they had no intention of moving on at all.

Section 5: Social Well-Being in Extra Care Housing: Emerging Themes

Background

An important consequence of moving into a care setting is that older people's levels of activity and social well-being are particularly reliant on that community; as people become older (and frailer), their lives become gradually more affected, and even defined, by their immediate physical and social environments (Godfrey et al., 2004).

For individuals moving into an extra care housing scheme, social well-being is likely to be affected by characteristics of the scheme, such as the approach taken to social activity, the design of the scheme and facilities available, and the nature of the care routine. These different features are expected to influence an individual's well-being through their effect on the social climate of the scheme, the type, rate and quality of social activities, and on various social aspects, such as perceived social support and the development of friendships. For example, research across various types of housing for older people has indicated that the way in which such developments are designed can influence opportunities for social interaction (Zaff and Devlin, 1998; Percival, 2000; Sugihara and Evans, 2000; Evans and Vallelly, 2007). Additionally, friendship development within long-term care settings has been found to be related to the nature of the care routine (McKee et al., 1999), while the development of good friendships can affect individual activity levels, which in turn impacts upon well-being and life satisfaction (Warr et al., 2004).

Although the community within a scheme is important, making or maintaining links with the wider community is also likely to be important for social well-being. Residents of a scheme can be linked to the local community in a variety of ways. For example, through maintaining links with friends and family in the community, by using the local amenities, or via people coming into the scheme, either to provide a service (e.g. entertainment) or to use the facilities (Brooks et al., 2003). Research conducted in housing with care settings has indicated that maintaining such links is important to older people (Croucher et al., 2003; Bernard et al., 2004).

Alongside the literature, much current policy relating to older people and their living arrangements is focused on quality, choice, control and independence, with well-being being a central theme. Policy initiatives with particular relevance for social well-being include *Opportunity Age* (Cm 6466i, 2005), the government's strategy for ageing, with its emphasis on the promotion of active ageing within the wider community and

enabling older people to remain full and active participants in society. Similarly, the report *A New Ambition for Old Age* (Department of Health, 2006) sets out the plan for the second phase of the government's 10-year National Service Framework for Older People, with the focus on three themes: dignity in care, joined-up care and healthy ageing. Regarding the latter, the report states that the government 'will provide extra support for socially excluded groups, including those with mobility problems, sensory or cognitive impairments, who are socially isolated, living in poverty or with specific needs arising from race or culture, so that these groups also have the opportunity to enjoy active ageing' (Department of Health, 2006, p. 15).

The initial report from the UK Inquiry into Mental Health and Well-Being in Later Life (Lee, 2006) drew together evidence from a range of sources, including older people and their carers, to discover what helps to promote good mental health and well-being in later life. Five areas of crucial importance to well-being were identified: lack of discrimination, participating in meaningful activity, supportive relationships, good physical health, and income. In the final report from the Inquiry (Lee, 2007), the focus was on prevention in the area of mental health, with social isolation cited as a common risk factor; additionally, older people again mentioned participation and relationships as important to their well-being.

Well-being is also the focus of the final report from the Social Exclusion Unit, *A Sure Start to Later Life* (Office of the Deputy Prime Minister, 2006). This policy initiative aimed to use the Sure Start approach to children's services to reduce social exclusion for older people, through the provision of a 'single accessible gateway' to a wide range of services across a variety of areas, including housing, transport, social care, social activities and health, with early intervention being key. The report emphasises a number of issues relevant to the current project. The importance of ensuring that older people are treated with dignity and respect when accessing health and care services is emphasised, reflecting the wider policy emphasis on dignity. Reference is made to the fact that central to the well-being of older people is the ability to continue to have opportunities for meaningful relationships, leisure, learning and volunteering, and so address social isolation. The home is recognised as crucial in maintaining independence and quality of life, as is the availability of flexible, accessible local transport.

The Project

The schemes being investigated as part of the overall evaluation put forward a variety of proposals for addressing social activity and community participation. A companion project to the main evaluation, funded by the Joseph Rowntree Foundation (JRF), is focusing on the first year after each scheme opens, and aims to identify:

- How the variety of approaches to developing social activities and community involvement are implemented in practice.
- Residents' expectations and experiences of these approaches.
- The relative effectiveness of different approaches in terms of friendship formation and activity participation by individual residents.
- The variation in social climate and incentives to participate twelve months after opening.

There are two stages of data collection. Six months after opening, four residents and two members of staff are interviewed in each scheme, in order to discover how the social life is developing in each scheme. Twelve months after opening, a survey of all residents and interviews with a subsample of up to 250 residents will identify individual views on the social life at each scheme, levels of participation, well-being, and the social climate of the scheme.

This section reports on preliminary work on this project, describing initial findings for six of the schemes that opened in 2006. The section describes the early development of social life across the schemes, and highlight some emerging themes; more in-depth discussion and analysis will take place in later reports. It should be emphasised that the findings presented here are from the initial, exploratory stage of the work, and from only a small sample of schemes. These schemes are among the first funded by the Department of Health and, at the time of data collection, had only been open for six months. Inevitably, social activities and relationships need time to develop. A more detailed version of this section (Callaghan et al., 2008) and a separate literature review (Callaghan, 2008) have been prepared for the JRF.

Across the six schemes, interviews were conducted with 33 residents and 11 members of staff. Of the residents, 20 were female, and six of the interviews were carried out with married couples. In each scheme, interviews were held with the manager and another member of staff who was involved in some way in the social life of the scheme. These staff members included an additional manager, a community participation officer,

two senior care workers, and an activities coordinator. Of the staff members, eight were female.

Emerging Themes

Approach to Social Activity

In the bids to the Department of Health there were a variety of approaches to social activity and it had been planned that, in the early stages of the project, schemes would be classified in terms of the approach to social activity that they had adopted. It seemed from the bids that some would be user-led, some would be fitness-led, some would emphasise the links with the local community, and some would take no particular approach. To date, however, these differences do not seem clear cut, and so schemes have not been classified in this way.

All of the scheme managers that were spoken to cited resident involvement as key to their approach to social activity, and most used the term 'user-led'. Scheme managers seemed to take on a facilitative role. The following quotes from managers of three of the schemes illustrate these points:

> 'We're trying to more and more encourage resident-led entertainment and activities.'
> (Scheme manager 07)

> 'We would like the residents to organise and manage their own social life. That's the main aim; it promotes their independence, and they get what they want.'
> (Scheme manager 04)

> 'Even though organising social activities is part of my role, the whole idea is for them to be involved. That's what it's all about, it is their scheme, whatever they want goes – with the help and support of the staff here.'
> (Scheme manager 05)

One noticeable difference, however, is the approach taken by the village-style scheme. Although the scheme takes a user-led approach to activities, the scheme manager also mentioned 'active ageing' as a guiding principle:

> ‘What we’re trying to achieve is that everybody has the opportunity of reaching their goals, but also having an active older life, because it’s demonstrated that if they maintain an active older life individuals maintain a better quality of life for longer.’
> (Scheme manager 07)

In practice, the user-led approach is played out differently across the schemes. Three of the six schemes had some form of residents’ committee, whose roles seem to range from organising and running activities themselves, to being consulted on ideas presented by staff:

> ‘The residents’ association, because they are active and interested, is organising and running certain activities – bingo, coffee morning once a fortnight, the games afternoon. By and large, I leave that up to them.’
> (Scheme manager 01)

> ‘I don’t put anything on without consultation with them. We have a fortnightly meeting with the residents’ committee, and ideas that I have are put to them, and then it’s arranged.’
> (Scheme manager 05)

The extent of involvement of the scheme managers in residents’ social life varied between schemes. In one scheme, the two managers describe themselves as taking a ‘hands-off’ approach, as required by their employer, the Registered Social Landlord:

> ‘We facilitate and help people if they need advice on starting up any social activities but we don’t have as much input as scheme managers might have done in the past. … We don’t get involved in many of the social activities at all but we did help them start up a social committee.’
> (Scheme manager 02)

> ‘Our philosophy is to leave it tenant led. In the old days, with wardens, part of their role was to do the social life, but with all the other demands and work now, you cannot do that. So, the management position: you manage the building, and let them get on with it, and just give them help and advice.’
> (Scheme manager 03)

In fact, it was felt by one of the managers that this was not the best approach to social activities, and that they should be able to get more involved in the social life if residents were not able to run the social life themselves, which may be the case as residents become frailer:

> '… we should have a say … because they need a social life don't they, they need to have something. If they're not able to do it, I think it should be down to us.'
> (Scheme manager 02)

In other schemes, the manager appeared to take a more active role in residents' social lives, for example by providing some events themselves (one manager was a qualified keep-fit instructor, and planned to run a class), or by using existing contacts from previous posts (for example as warden in a sheltered housing complex) to put on events and activities. The first quote below from one scheme manager suggests that, at a wider organisational level, managers are expected to play a larger role; the latter quote reflects this from the point of view of a resident in that scheme:

> 'Each individual scheme is left to the scheme manager to decide how they want to do the social life, and to ask the residents what they want.'
> (Scheme manager 05)

> Interviewer: 'How did the activities here start? Was it the residents or staff who decided what to do?'
> 'Theoretically I suppose, it's us, but in fact [scheme manager] knows so many people, she knows the ropes, and she's the one in actual fact who the thing revolves round. It's not the carers, they have nothing to do with it, and the residents generally speaking don't – there is a committee, about five of us on it and [scheme manager] sits on that as well.'
> (Resident 16, male)

Of the three schemes without a residents' committee, one hoped, in time, to resurrect an old 'residents' user group' which was set up for tenants of the sheltered housing previously on the site. Another did set up a residents' committee soon after opening, but this was unsuccessful:

> 'What we are encouraged to do is to get them to start a tenants' association. … But it's not worked here. We did start it, it lasted about three weeks. It was just

too much for the people. This is too big a building, and we've got people of varying needs, and it was worrying them.'
(Scheme manager 06)

There was some suggestion that the third scheme without a specific residents' committee did not have one out of principle; according to one resident, the Registered Social Landlord felt that it might encourage a 'them and us' attitude to develop between residents and staff. This did not appear to have an effect on the scheme's user-led approach to activities, however, as there seemed to be significant resident involvement. It is also worth noting that this scheme did hold regular meetings at which residents were given the opportunity to air their views.

Other ways in which schemes have ensured residents' involvement in their scheme's social life include asking them at coffee mornings or other social gatherings what they would like to do, asking them to indicate their preferences on a form, discussing social activities with them as part of their support plan, and in one scheme holding an 'activities forum':

'Residents are asked about social life when a support plan is done with them. One of the questions is "is there anything you would like to see happening here that isn't", and "would you like to be a part of running [activities]"'.
(Scheme manager 05)

'Yesterday for example, we had an activities forum on what new things they'd like to see or what other elements they'd like to see being brought into the [the scheme], or outside of [the scheme] as well'.
(Scheme manager 07)

These other methods are important, as not all residents will join residents' committees. Often, it is the less frail residents who are on the committee:

'Younger residents … are keen to get involved in residents' association. It gives them something to plan and develop.'
(Scheme manager 01)

> ‘Because of the banking that’s involved, and the more physical side of things, it has to be people who are more mobile and able bodied. There is a committee, but the three main people obviously are very able.’
> (Scheme manager 02)

Alongside their general approach to social activity, there is also evidence that scheme managers recognise the importance of not having too full a social calendar, and also that some residents will prefer not to socialise:

> ‘Also, it is important to have some time when there aren’t activities running and people don’t feel pressured to do something. I’m not concerned if there’s not something happening all the time.’
> (Scheme manager 01)

> ‘Some people are quite happy to live independently and be left on their own. I sometimes think there’s a bit … of a nanny state – “you need to get them involved”. Why? If they don’t want to get involved they don’t have to. It’s up to them, and it should be.’
> (Scheme manager 06)

Activities, Groups and Events in Place at Six Months

The range and extent of activities that the six schemes had in place or planned at six months is shown in table 5.1. The most common activities were bingo, coffee mornings or afternoon teas, exercise classes, and religious services or groups. Across the schemes, other activities included gardening, arts and crafts, knitting circles, musical groups, IT classes, and games.

There were mixed opinions of the activities in place, as demonstrated in the following quotes:

> ‘We go to bingo, we love bingo. We like going down to tea and biscuits with all of them – that’s Tuesday. They have a singer, one of the residents sings. Thursday they have a general get together with music. It’s good.’
> (Resident 21, female)

> ‘I mean, sing-alongs and all that – it’s quite nice, it gets everybody together – but they don’t update the things. I mean, all the music we knew is 50s and 60s.’
> (Resident 23, female)

However, even when activities were not to a resident’s taste, there was recognition that they could still serve a social purpose, as indicated in these quotes from residents of two schemes:

> ‘We have the usual things, like bingo; I never thought it would be popular, but it is. … It makes money for the residents’ association, as well as giving people something to do for a couple of hours’.
> (Resident 02, male)

> ‘They had a singer once … terrible. I go for the sake of the community, whether I really enjoy it or not. People singing is not … I wouldn’t pay to hear them. But it’s community down there, we’ve all got to try and help it.’
> (Resident 16, male)

> ‘The other entertainers tend to be singers – not exactly my cup of tea, but I go down to it. Giving the committee some support.’
> (Resident 19, male)

Furthermore, there were some examples of residents attending activities that they were unable to fully take part in simply so that they could enjoy the social interaction. This was particularly evident in one scheme, where residents attended armchair aerobics for the enjoyment of the music and the company.

On the other hand, there was also a feeling amongst residents that if you did not enjoy a particular social activity that was going on, or would just prefer to be alone, you had that choice, as these quotes from residents in two of the schemes illustrate:

> ‘You can do what you like, you can stay in your flat, or you can go down in the lounge and talk to the others. Sometimes you feel you want to be quiet, and be on your own. I’m not unsociable, but I do like to be on your own sometimes.’
> (Resident 18, female)

> '… I would have thought it's the best answer to everything – you've got privacy but you've got activities that are there.'
> (Resident 14, female)

In terms of occasional activities and events, all schemes either had or planned to have seasonal events and other one-off entertainments (see table 5.1). Two of the schemes had already attempted an outing, while the other four planned to do this in future. Outings were often mentioned as being something that residents would like to see developed.

Alongside such one-off events, most schemes had a number of regular (weekly or fortnightly activities) as illustrated in this example:

> 'There are activities going on four days a week now. Monday is bingo, they love bingo. Tuesday is Karaoke; they all come down and have a cup of tea. Thursday is just a get-together with music, Friday is bingo again – bingo is very popular. So I think, considering we're quite new, that's not bad.'
> (Scheme manager 06).

One scheme, however, had a slightly different approach in that there were not many regular activities, but instead a variety of one-off events. The manager felt that this was a particularly positive aspect of the social life at the scheme:

> Interviewer: 'Has anything been particularly helpful in setting up activities?'
> 'The variety … not having the same thing going on.'
> (Scheme manager 05)

This manager also recognised that you do not necessarily need an organised programme of activities to encourage social interaction:

> 'You don't need to necessarily organise something, sometimes you can just sit as a group … what I did one afternoon was sit with the residents – there was a group of them, 20-25 – and over a cup of tea we went round and everyone said what their job had been when they were younger, so that people learnt a little bit about each other. You can build up from something like that.'
> (Scheme manager 05)

> ‘As well as the organised afternoon teas, sometimes the chef bakes them a batch of scones, or leaves a cake out, which she will tell me about, so then I will say at lunchtime “if you want to come down at half four there will be homemade scones and a cup of tea”’.
> (Scheme manager 05)

Although schemes did appear to have a range of activities available, there were a number of residents across the schemes who felt that there was not enough going on. However, there was also recognition that six months was ‘early days’, and that it can take time for activities to be set up and a social life to get started, as can be seen in the quotes below:

> ‘They’re waiting to get a social club together; I’m one of many on the committee. Apparently we’re waiting for clearance to get [funds]. I imagine once that’s settled, they’ll be able to do more.’
> (Resident 08, female)

> ‘It takes time – I understand from another manager in another scheme that it took them nearly a year to get everything running. It’s sensible, we don’t want to do things that fail, we want to do things that work.’
> (Resident 14, female)

Facilities Available at Six Months

The range of facilities schemes had available at six months is shown in table 5.2. An important question for this project is whether particular facilities serve as meeting places for residents and help to foster social interaction and friendship development. Certain facilities are emerging as being important in this respect. Shops can provide an opportunity to meet other residents, as the following quote from one staff member illustrates:

> ‘The shop has been a catalyst to getting people integrating well together.’
> (Staff member 02)

In this particular scheme, residents organised and ran the shop themselves, and one female resident involved in this seemed to particularly value the social interaction centred on the shop, as seen in the quote below:

> ‘Oddly, I think the shop has become a social activity. Not only is it nice for people to be able to buy for themselves, but often people come down and chat.’
> (Resident 14, female)

There is also some indication that restaurants can aid friendship development, particularly when all residents eat a midday meal together (generally paid for as part of their rent/service charge):

> Interviewer: ‘Are people starting to develop friendships?’
> ‘Yes definitely. I think a lot of it is down to the dining room at lunchtime, because they have to come down and eat their meal together, that’s where they form their friendships – they’re getting out and meeting people which is a really good thing, otherwise a lot would be in their flats all day and wouldn’t meet people. Lunchtime is a really good positive part of the day.’
> (Scheme manager 04)

> ‘They tend to meet up more at lunch time. Some of them will hang around chatting.’
> (Scheme manager 02)

Residents seemed to value mealtimes, as illustrated below. Indeed, for some residents, as indicated by scheme manager 04 above, lunchtime is their main opportunity to meet people:

> ‘It’s fun really, the meal is at 12.30 but we all start coming at 12 which I think indicates that we like the social activity, and those who have time stay for a cup of tea. It’s the social event of the day really. It’s one of the best things – for all of us, cooking a main meal is beyond us; you do get one really good main meal.’
> (Resident 14, female)

> ‘I just mix with the people I have lunch with, and we might sit there and talk for a while.’
> (Resident 09, female)

In one scheme where the restaurant was temporarily shut at six months due to financial reasons, the loss to the scheme’s social life was noticed by both residents and staff. The manager of the scheme commented that:

> ‘The restaurant was a really good social area. … It was a big blow when it shut. They did miss it, the ones who had lunch.’
> (Scheme manager 06)

Similarly, in one scheme where there was a large restaurant that was not open in the evenings, one resident felt that the impact on social life at the scheme was significant:

> ‘I find that it’s difficult to get friends to come here; there’s no restaurant open in the evenings so I can’t invite them over. … I think it’s sad because a restaurant in the evening could be the hub, you wouldn’t have to make too many events happen, they would happen normally, people would mix and join each other.’
> (Resident 28, female)

In general, at this early stage communal lounges in the schemes did not seem to serve as meeting places for residents, except for when there was a particular activity going on:

> ‘… but the lounge, I sometimes go down and get a book when the library come, but there's nobody ever in the lounge in the afternoon’.
> (Resident 09, female)

> ‘I don’t think an awful lot of people use the lounges. The lounge on this floor is beautiful. I’ve been in there and whiled away an hour or so occasionally. But it isn’t really used a lot, apart from functions and things like that … but I’m very pleased it’s there. The one downstairs is used a lot more, that’s where any activity takes place.’
> (Resident 06, male)

On the other hand, in one of the schemes it was felt by both residents and staff that the lounge was in frequent use:

> ‘… There’s always somebody in the lounge. Some days there are only two or three, but that’s only at certain times, others times there's quite a lot, nearly always a lot.’
> (Resident 17, female)

> ‘People tend to come downstairs and sit in the lounge area because, I suppose, that’s where the tea facilities are.’
> (Scheme manager 05)

However, it seems that this was only by a particular group of female residents, and not all residents in the scheme, as the following comment suggests:

> ‘In theory they can [meet up in the lounge], but the point is only a few go regularly, only perhaps seven or eight women go and sit there, either go to sleep, or wait for tea time. … It’s not a general thing to get everybody down there, some people never go down – you can’t stop it, that’s the way people are.’
> (Resident 16, male)

Several possible reasons were put forward as to why lounges were not generally used as meeting places. The following quotes indicate some of these reasons, and also indicate that residents seem to meet up in other ways and at other locations in the schemes:

> ‘I think eventually they might start using the lounges more, but it’s new.’
> (Scheme manager 06)

> ‘People say they’re disappointed it [the lounge] is not being used, but I think you have to look at from a different angle and understand that people are happy in their own homes. … There are some residents who are really sociable and go knocking on people’s doors, and having coffee and stuff. I think they’re more likely to visit each other than meet here. They do sometimes. I think we need to have more social things actually going on in here to get this room used more.’
> (Scheme manager 04)

> ‘We meet for social reasons at about 5 o clock down in the hallway. I know it sounds daft when we’ve got lovely lounges, but we meet there and we talk about anything. … I started it off, by going down to read my book, then others joined me. I think there are about eight of us now … and yet it doesn’t take off in the lounge. I think what they like is seeing people coming in and out, passing through, saying hello; they wouldn’t see that in the lounge.’
> (Resident 01, female)

> ‘I do notice that on this floor there's an entrance out to the garden, and I notice that there’s a big area there with some armchairs there, and when I’ve been up to the laundry I’ve seen people, about four or five couples, just sitting there having a chat. Perhaps they use that instead of the lounge.’
> (Resident 23, female)

Links with the Local Community

Across the schemes, there were varying degrees of community interaction. One of the schemes already seemed to have achieved to some degree its aim (stated by the scheme manager) to become a community resource, with a restaurant open to the community, and activities and social evenings to which local residents and residents of other nearby extra care or sheltered housing were invited. The benefits of this interaction are described by the scheme manager below:

> 'It's a two-way thing. The ground floor is a public space, a resource for the community. … The benefits of that are many-fold. Not least, if you've got people that are loathe to connect and are becoming withdrawn, it makes it that bit easier; it's a stepping stone.'
> (Scheme manager 01)

Another scheme also strongly emphasised the community element, with plans for a doctor's surgery and a café open to the community which will house part of the collection from the local library (which was to be temporarily closed down). It was hoped that these facilities would encourage people to come in, and interaction to happen between local residents and residents at the scheme:

> 'As more and more people start to use the building, on the lower ground floor, the community area, contact will happen naturally, especially through things like the library.'
> (Staff member 02)

> 'A lot of them [the residents] were quite isolated before, so it's good for them to have the interaction with people other than those they live with.'
> (Scheme manager 04)

Other schemes were keen to build up their links with the local community, but recognised that this can take time, especially as residents need time to settle in themselves:

> 'We're hoping to get people more involved [from the local community], but at the moment we haven't. … I don't think the place has really been open long enough to get things like that going.'
> (Resident 19, male)

> ‘Initially, I think it was thought that it was going to be more of a community resource, and I think it will be. For example, the assisted bathrooms are not used very much by our residents because the individual bathrooms are lovely. Our director would quite like it to go out into the community; people could come in via Age Concern or the day centre to use the bathrooms. The kitchen as well; people could come in. Apparently there’s a 90-year-old lady who lives round the corner, it’s been put to her that she could come in and have her hot meal here Monday to Friday, or even all week. She hasn’t done so – that’s her choice – but it would be a good idea.’
> (Scheme manager 02)

One scheme seemed to take a more cautious approach to community involvement for a number of reasons, including the nature of the locality, and the difficulty of monitoring who would come in, and when:

> ‘I’m not sure whether people coming in from the community is a good idea. There was a lot of talk about the internet café being open to the community. … Do we really want young kids from round here walking in and out of the building? No. Nobody thought it through, we don’t want that. It’s fine if people want to come and do things here and the tenants can join in, but I would be very careful of who, and what groups would use it.’
> (Scheme manager 06)

This highlights how important the setting and context of the scheme is to its relationship with the people in the community it is situated in. For example, if a scheme is located in an area where there are other extra care or sheltered housing schemes (as in the first example given in this section), it is more probable that people from outside the scheme will come in, as activities are more likely to be of interest to them. Similarly, if the scheme can provide a service to the surrounding area, local residents will have a reason to come in, and making links may feel more natural:

> ‘We’re going to have a doctor’s, and that will make a big difference, we’ll be having the estate coming in. And the café … I think the idea of just coming in unless there’s a reason or an invitation to come in, may not be very easy to accept.’
> (Resident 14, female)

In general, residents commented positively about people coming into the schemes, giving reasons such as the added opportunity for social interaction, and the financial benefit to the scheme:

> ‘They were aware from the start that the ground floor is a public arena. Also, room rental comes directly off residents’ service charge. Most of them like the idea that it’s a public domain – they know they have their privacy upstairs; you can’t get up there without a fob. It took them a while to get used to it, one or two felt like they’d moved into a home, but I tell them: once you go upstairs you lock your door in the same way as on a street – if you want to talk to your neighbours you can, but you don’t have to, it’s totally up to you.’
> (Scheme manager 01)

> ‘I don’t think it [the scheme] could stand on its own two feet really, if people didn’t come in from other complexes.’
> (Resident 04, male)

> ‘None of us want to be old people shoved out of the way. I think the idea of meeting with the community as often as possible without them feeling we’re a nuisance … I think this [the scheme] is so much in the centre of [local area] that if we can offer facilities for them and they can come and help us, it must be good.’
> (Resident 14, female)

On the other hand, some slightly negative attitudes have emerged towards day centres in the two schemes where these were in place at six months:

> ‘I have had one or two comments in the past, like ‘it’s our lounge’. But actually, people don’t use the lounge so why can’t they [the day centre]. They are not intrusive.’
> (Scheme manager 02)

> ‘Unfortunately there is a bit of a ‘them and us’ which is a shame really. Maybe when the restaurant opens again, the day centre should stop all sitting together. Not have their tables.’
> (Scheme manager 06)

As well as bringing the community into the scheme, both residents and staff recognised the importance of being able to access their local community, and maintain any links they may previously have had; as one resident put it:

> 'The attitude of the management I think is quite right – that you have a life outside [the scheme].'
> (Resident 31, male)

Similarly, another resident mentioned the value of being able to go out:

> 'I go out myself in my buggy, go into [local town], do my own shopping, browse round the bookshops and such – so there's that relief.'
> (Resident 16, male)

Residents across the schemes went out into the community for a number of reasons including visiting the doctor's surgery and other such appointments, going shopping, attending day centres, going to church, and also visiting family or friends (although it seemed to be more the case that family and friends came into the schemes). Some residents had their own cars, while others used local taxi and bus services. For other residents, however, the location of their scheme or the lack of accessible transport meant that getting out was more difficult, as indicated in the following comments from residents in two schemes:

> 'Some can get on the bus, there's one up the road, but I can't. I can't even get up to the shops. I find it a bit isolated.'(Resident 12, female)

> We had a meeting two or three weeks ago … they're trying to negotiate for one of the buses to stop outside. For a bus, you have to walk over there, or up to the shops, which is quite a way. So that would be a boon if we could get a bus, it would be ideal.'
> (Resident 23, female)

Difficulties in Establishing a Social Life

Although the schemes have largely been successful in setting up activities and beginning to develop a social life, certain obstacles have been encountered during this process.

The most frequently-mentioned issue by both residents and staff was the health and mobility of residents. It has already been noted that in one scheme the residents' committee was unsuccessful; this was felt to be due in part to the varying health needs of the residents. It was recognised by both residents and staff in the schemes that for a significant number of extra care residents, getting involved in setting up or running activities would be difficult. It was seen as important to have a mix of 'fit' and 'frail' residents, as illustrated in the comments below:

> 'It's tenant-led. The problem we have with extra care is that the residents are frail, and it's [hard] getting people that are able to do that. We're lucky here because we have some residents from [sheltered housing scheme previously on site], who are in better health. If it wasn't for them there wouldn't be a social life.'
> (Scheme manager 03)

> 'I think there's not enough mixture of a few able-bodied (I'm calling myself able bodied, I'm not really!). … There are so many in wheelchairs, there isn't enough [of a] mix with people who want to go out and do things. We asked for volunteers for the shop and only six of us do it.'
> (Resident 12, female)

Furthermore, the fact that many residents receive care can restrict the type of activity that it is possible to put on, as well as the time of day that activities can take place, a point illustrated in the quote below:

> 'The residents' association tried a coffee morning but it didn't work; in the morning a lot of them are having care and so that's the carers' busiest time. So you can't release the care staff to go and bring them down, because when they do an activity, it takes at least half and hour to go round and get everyone.'
> (Scheme manager 06)

Other problems encountered by individual scheme managers included a lack of interest on the residents' part in helping to organise or run activities (although it may be that this is linked to health and mobility problems), and an unwillingness of residents to pay for activities, which in turn restricted the type of activities that can be put on. Also, one scheme manager felt that the fact that there were three different agencies working in her particular scheme (one providing care, one management and housing-related support,

and one day centre services) hindered the development of a community feeling in that scheme.

Problems had also been encountered by some scheme managers in forging links with the local community; it seemed that people in the community could sometimes perceive the scheme in the wrong way:

> 'Although there's been publicity, lots of people don't know it's here and refer to it as a care home. Lots of articles refer to it as a care home … goes against idea of the place as a community resource.'
> (Scheme manager 01)

> '… there is a perception, because this was [an institution] … I haven't experienced it myself, but feedback I get from residents is that there are some who don't realise its changed. And that it's an old peoples' home, which it's not.'
> (Scheme manager 07)

Factors Aiding the Development of Social Life

There were a number of factors that appeared to have contributed to the successful features of the development of schemes' social lives during the first six months. In particular, residents themselves were seen by staff in two of the schemes to have been a big help; specific factors mentioned included having an active and involved residents' committee, having interested residents, and having residents who could bring existing skills and expertise into the scheme. Some of these points are illustrated in the following quotes:

> Interviewer: 'Has anything been particularly helpful in setting up activities?' 'Residents … they'll tell me what they like and don't like. When I first came, I stood near the notice board, and there was a feeling among certain residents that activities were more Benidorm than Barbados. More Blackpool. So we've been able to turn that around.'
> (Scheme manager 07)

> 'One of the residents is a puppeteer, so he ran an afternoon of that. He makes his puppets upstairs in the craft room. He wanted to give a talk, he did a talk about puppets in Victorian times. We've got other residents who've now said they

could give a talk on photography, things have snowballed – it's really coming from them now.'
(Scheme manager 05)

'Some residents run activities; they may have initiated them and run them themselves. If I look at the orchestra, music appreciation group, some of the well-being activities, like hand waxing, are run by [resident] volunteers. Sometimes staff run them, or we have people from outside to run them if we need that expertise. But actually, within a [scheme] like ours, we have a vast pool of expertise.'
(Scheme manager 07)

Another helpful factor mentioned by one scheme manager was the staff. When asked whether anything had been particularly helpful in setting up activities and a social life at the scheme, this manager replied:

'Having all the staff on board and helping. Especially at the beginning, the carers did beyond what they were supposed to do in helping people down and stuff. And once the community development worker started, that made things easier, it was another pair of hands.'
(Scheme manager 04)

Other features mentioned included having a set lunchtime for all residents (discussed above), and facilitative design. One scheme manager commented of their particular scheme that it was:

'… designed in a way as to be very adaptable in the way that we use the space.'
(Scheme manager 01).

In terms of making links with the local community and encouraging local residents to become involved in the life of the schemes, it seems that links managers have made in previous positions can prove useful:

'… from my previous jobs, understanding and working with other health professionals and social workers has established those links already which I can bring in here. Also, the care staff being involved with different people around [in the community] … we can all work together.'
(Scheme manager 04)

> ‘When I worked for the charity, we were based at the community resource centre in [local town]. I get on well with the manager there – I make her aware of what’s going on here and she publicises things for me. She’s trying to encourage groups that she has to come and base themselves here, which would be good as it would mean instant activities and instant barrow-loads of people.’
> (Scheme manager 01).

Barriers to Participation in Social Life

Even once a scheme’s social life has begun to develop successfully, barriers can still exist for some residents and prevent them from taking part. Interviews to date have indicated a number of potential barriers, but also highlighted some ways in which these have been overcome.

A significant barrier for some residents is their health and mobility problems, which do appear to restrict their social lives, as illustrated in the quotes below from residents and staff. A particular problem seems to be getting people to and from activities and events:

> ‘One of the problems to a degree is probably the infirmity of some of the people here – there’s a limit to what they can participate in.’
> (Resident 06, male)

> ‘Not being able to see, I have to rely on others to help. Prevents me taking part.’
> (Resident 21, female)

> ‘Most of the problems at the beginning and still now to a certain degree is getting people from their flats to the activities. While I and [another staff member] are here to help, the days that we’re not here it doesn’t happen, a lot of people don’t have anyone to come and collect them. That’s the main problem – getting people to the social activities.’
> (Scheme manager 04)

> ‘The biggest problem is [needing] the carers to get you to anything.’
> (Resident 12, female)

Closely linked to health and mobility, is the care that residents receive. The first two quotes below, from managers of one of the schemes, describe the difficulties that can

arise and hinder participation. The third quote, from a resident in a different scheme, succinctly summarises the problem:

> ‘It’s difficult because a lot of residents are reliant on somebody bringing them downstairs, so if it’s not in their care package, we have to rely on the carers. They would probably be ticked off if they were doing over and above what was in the care packages, but you don’t want to penalise somebody because they can’t get out of their room. … Staff here can’t take the responsibility for pushing people around all the time, especially if there are other people that need their care sorted as well.’
> (Scheme manager 02)

> ‘… It would be nice to have a system where the carers have flexibility to take people downstairs for impromptu reasons, but they are tied to times. So it would be nice to have the flexibility of a nursing home [in terms of staff deployment] but with the independence of extra care, it would be fantastic. I hate saying to people that their carers can’t do something because it isn’t paid for, it’s so sad.’
> (Scheme manager 03)

> ‘There are only about twelve at the coffee morning. Again, you have to get your carers to push you down and take you back. Everything comes down to if it’s on your care plan, it’s a bit hard.’
> (Resident 12, female)

Two schemes in particular mentioned the fact that, due to the timing of care visits, it could be difficult to have activities and events in the evenings:

> ‘In the evenings, apart from the bingo and the Christian things, there’s not much. A lot of the people have their care calls in the early evening – there’s not really an evening social [life]. I don’t think there will ever be the scope [for that], unless the level of care changes.’
> (Scheme manager 04)

> ‘The carers are doing all the tea-time calls and the evening stuff, so to do any sort of activity in the evening is going to be exceedingly difficult, because then it puts the care routine out.’
> (Scheme manager 06)

However, as the following quotes suggest, the type of problems mentioned above can sometimes be overcome:

> ‘We schedule some of the activities for 11am and 2pm, specifically to make them accessible for those on care.’
> (Scheme manager 07)

> ‘We did start with a coffee morning every week, but that has proved not good, because some of the residents who have a lot of care are not able to get down here early. And by the time you’ve got something organised, it’s nearly lunch time. I asked them, and they all preferred to have an afternoon tea. So now, once a fortnight, we have an afternoon tea.’
> (Scheme manager 05)

A different type of barrier stems from the nature of the activities themselves; some activities and events are simply not of interest to a number of residents. This is of course down to personal taste, but can be linked to fact that schemes often have residents covering a wide range of ages, as mentioned in the final quote below:

> ‘I know they’ve got a bingo going, but I don’t go. And they’ve got somebody to do exercises, but I’m not into it.’
> (Resident 09, female)

> ‘Thursday they have a film – it’s Musicals but I like a Whodunit.’
> (Resident 12, female)

> ‘I did organise a magic show last month, but hardly anyone came. So maybe I got it wrong – I asked them if that’s what they wanted, but then nobody came.’
> (Scheme manager 04)

> ‘The youngest resident here I think is 61, and the oldest is 97. So you’ve got a big age gap … the people in their 90s will like the old Vera Lynn songs, while the ones in their 60s might not. So I think it’s difficult to get somebody in who everybody will like.’
> (Staff member 03)

It could be argued that it is here that bigger schemes benefit from their size; due to the larger numbers of both staff and residents, they are able to have a larger number and variety of activities, as indicated in the following quote:

> ‘I don’t think you could bring anything else in, I think they’ve covered everything.’
> (Resident 32, female)

However, too much choice was also suggested as a problem, and it seemed that activities were still not as well attended as they could be:

> ‘We can’t join in all the activities we’d like to, because we’re busy doing other things. But, having said that, we did have a meeting about two weeks ago about activities, raising the question of why don’t people go to the activities. And one of the points I put forward was, there are too many.’
> (Resident 31, male)

Another potential barrier is being single or widowed. As illustrated vividly in the following quote, it can be difficult to go to an activity or event if you do not have a partner to go with. The end of the quote also points towards the wider implications for social well-being that being widowed can have:

> ‘… but you remember at school, if they’re in cliques in the hall and you go by yourself, it’s not nice to think “do they want me?” and you don’t know who to sit with, until somebody says “come here”. … You don’t want to push in if you’re not wanted. If you’ve got a husband, there’s no problem, because you’ve got him to talk to – and also I miss that, when you come home you’ve got nobody to discuss it with, what you’ve done.’
> (Resident 29, female)

Finally, there was some indication that financial constraints could prevent people from taking part in activities. A manager from one of the schemes spoke of the difficulty in getting residents to pay for activities, while a resident from a different scheme commented:

> ‘They try and put lots of little activities on, like a singer comes, some music and things like that – and they say “£5 a head” and people won’t go. But when there’s no charge, the place is packed.’
> (Resident 27, male)

Developing Social Climate

The first few months after opening are likely to be important to the type of social climate that develops. In turn, the social climate will have an impact upon residents’ social well-being. Interviews to date have raised some interesting themes. For example, it seems that a sense of community is developing in the schemes, with residents and staff mentioning growing neighbourliness:

> ‘I look out for people here, they’re all older, a couple of them can’t get out. If you don’t see someone for a couple of days we’ll go and knock on the door, or ask [scheme manager] to go in. We all look after each other … it’s the best way to be really isn’t it?’
> (Resident 03, female)

> ‘In time, it will be a really good community. People do look out for one another – they ask “where’s so and so, I haven’t seen him for a couple of days.”’
> (Resident 08, female)

> ‘At the beginning, there was a lot of work between myself, carers and residents in getting people here [for the coffee morning], as there are a lot of people that need help mobilising. Now we’ve fallen into more of a pattern, some residents call on other residents.’
> (Scheme manager 04)

> ‘… they [the residents] are very supportive of the staff team, and their neighbours. Somebody will give a lift to somebody if they need it, or will give a lot of support if there’s been a bereavement, or whatever it is, if somebody’s not been well.’
> (Scheme manager 07)

However, many people seemed to indicate that they felt it was somewhat early in the scheme’s development for a tangible ‘social climate’ to have emerged. The following

responses to the question, ‘Would you describe the scheme as a community?’ illustrate this:

> ‘I think it’s becoming one – you can’t make a community very quickly. We’ve lost to death four people, and new people are always coming. I think we befriend each other as much as we can.’
> (Resident 14, female)

> ‘Not at the moment. I think, give it another three to six months and it’ll be a lot better. Unfortunately in the past six months we’ve had two deaths … one’s moved right away, back to where he came from. But I think there is a community spirit growing up … with the birthday parties and things like that.’
> (Resident 19, male)

Another question that was used to explore the developing social climate was ‘Are there any cliques here?’ In general, it was felt that this was not the case, and that where cliques were developing these were not harmful, and were simply ‘like-minded people’ forming friendships and groups, as suggested in the following quote:

> ‘Yes, but nothing too harmful. There are people who have had more worldly, wider travelled experiences than others, they tend to congregate together, and others who may be more local based, who tend to stick together, particularly those who’ve lived in [local area]. … In coffee mornings, you can change the seating in different ways, and no one tries to bag their favourite seat which is very unusual, they’re very amenable to moving around.’
> (Staff member 02)

However, there was some indication of groups forming around various factors such as living in the same facility previously. In answer to the query about cliques in the scheme, one scheme manager said:

> ‘We did notice this. You’ve got to bear in mind that we closed a scheme down – so those people that moved across from that scheme knew each other, so they naturally gravitated towards each other. … As they’ve got used to each other, used to people from other schemes and from their homes, people are much better. But when something is new and strange, and you don’t know how it will turn out, people will naturally gravitate to people that they know.’
> (Scheme manager 02)

Many of the schemes have a mix of tenures available, with residents being able to rent, buy or part-buy their apartments. Early indications suggest that, in terms of social climate, the mix of residents with different tenures is something that may need to be carefully managed. For example, speaking about residents who had their flats on a shared-ownership basis, one manager commented that:

> ‘They tend to keep themselves to themselves. I don’t think we’ve helped that pattern because we’ve put them all together. There are two rental flats amongst them which upset them.’
> (Scheme manager 03)

Similarly, the manager of another scheme described the particular challenges of integrating those residents who own their apartments with those who rent. A resident from the same scheme also seemed to feel this divide, albeit not in terms of tenure:

> ‘There have been some challenges, and some of that has come about where we’ve set up Friends groups very early on who have been, in the main, purchasers. … And therefore, in the main, they are part of the choir and any other groups that got going before it went live. And I think something we need to think about going forward is to involve those that are likely to rent. Or, once they are allocated, incorporate them into those Friends groups before it goes live. Otherwise, you have a bit of a them and an us.’
> (Scheme manager 07)

> ‘If you’re in the choir, they know each other and get a sense of what's on. But if you’re not in the choir, you’re a bit out of it.’
> (Resident 29, female)

There were also some signs that the mix of dependency levels, a feature of extra care housing, although having a number of benefits (in terms of the sustainability of a scheme’s social life, for example), can also present some challenges and, as the third of the quotes below suggests, have an impact on the social climate of a scheme:

> '… I also think that the authorities, or whoever it is that's responsible for posting people in here, I don't think they looked closely enough at the ability of the person. From my personal view, there's only about two or three people here that I would want to have a conversation with; I'm sorry it's got to be like that, that's the way I feel.'
> (Resident 16, male)

> 'The only problem among us is [resident with dementia], because she upsets everybody. But nobody seems to think anything should be done about it, everybody just takes it as everyday. But people worry about it.'
> (Resident 17, female)

> 'I think you need a few more fit people here. It leans more towards being a home than an actual retirement village. The mixture is not quite right yet. I think a lot more people are quite ill or frail here than they are fit. I don't think the mixture is quite right, I know they did try to get a certain scale. … People seem to need a lot more help here than is forthcoming.'
> (Resident 28, female)

Another tentative finding is that the nature of the care at the schemes can have an important effect on the social atmosphere. This seemed to be implicit in the interviews, and is shown to some degree in the way that care routines can affect participation, as discussed above. One resident described the issue well in the following two quotes:

> 'I think the enthusiasm has been lost here somewhere along the way. And I think it mainly stems from two basic things – the restaurant, which could be a great bringer-together of people, and the care.'

> 'I haven't dealt with the social things here very well. I think it's because the basic things aren't right, and you have not got the enthusiasm for the rest.'
> (Resident 28, female)

One final factor which is emerging as being as being of potential importance to the social climate of the schemes is the scheme manager, as suggested in the following two quotes:

> 'A few weeks ago we had a designer coming in to show their fashions, and we helped people to try things on. He came back in, and said that it had been a

pleasure to be there, and that it was such a nice atmosphere; you feel at ease straight away, and that it was down to us, the scheme managers. It's how the scheme managers come across – and we are quite relaxed.'
(Scheme manager 02)

'… [Scheme manager] is smashing; she's of great value to this place. Without her … I don't suppose it would be too bad, but she's a definite plus. She looks at everybody as if they're the most important person in the world. So she makes the atmosphere I suppose really.'
(Resident 16, male)

Summary

When considering the findings presented here, it is important to remember that these are findings from the early exploratory stage of the work, and that only six of the schemes are covered. A different picture may emerge once six-month data are incorporated from all the schemes. Similarly, these initial findings may appear different in the light of supplementary data from the 12-month survey and follow-up interview. These data will be analysed alongside those from the wider evaluation, including baseline and follow-up information on residents' health and dependency, and residents' views on their reasons for and experiences of moving to extra care housing.

All six schemes in this initial sample seem to be adopting a user-led approach to residents' social life in some form. Of course, the overall picture may change as more schemes are visited, but it may be that rather than classifying schemes in terms of their different approaches, they could be described in terms of the degree to which the user-led approach has been adopted.

Schemes had a variety of social activities in place at six months. Most schemes had a number of regular (weekly or fortnightly) activities, alongside less regular one-off events such as musical entertainment and bazaars. Although there were mixed opinions of the activities in place, these early findings suggest that activities can serve a social purpose and help to contribute to a sense of community at the scheme.

Certain facilities are emerging as being important to the development of the social life at the schemes. Shops can provide an opportunity to get to know other residents, and there is also some indication that restaurants can aid friendship development, particularly

among residents who eat a midday meal together. The reverse also applies: the absence of such facilities is seen to undermine the opportunities for socialisation.

Two of the schemes in particular saw themselves as community resources, and most other schemes were aiming towards this; it was felt that both residents and the local community could benefit from the interaction. It seems that the local context of a scheme may be important in determining the extent of community involvement that develops, although, as already mentioned, it is very early days.

The initial interviews have also highlighted some particular barriers and facilitators in establishing and participating in the social life at the schemes. Health and mobility problems were the most frequently-mentioned barriers to residents organising and running a scheme's social life, and the care routine can also restrict the type and timing of activities. Similarly, health and mobility, along with the nature of the care routine, also seems to be a particular barrier to participation for some residents. On the other hand, having an active and involved residents' committee, interested residents, helpful staff, and a well-designed scheme were cited as factors helpful in developing the social life of a scheme.

In terms of the developing social climate at the six schemes, there were positive examples of neighbourliness and signs of 'community spirit', although it was recognised that such things do take time to develop. There were also indications of various factors that could have an influence on the social climate, both at six months and in the future, including the previous existence of a sheltered housing scheme on the site, having a mix of tenures, having a mix of health and dependency levels, and the role and personality of the scheme manager.

Given the preliminary nature of these findings, no definite conclusions can be drawn, nor recommendations made for future extra care developments. However, the emerging themes discussed in this chapter indicate that valuable information about social well-being in extra care housing will be gained as part of this project. It is worth noting that our findings echo many of those from other recent JRF-funded work on social well-being (Evans and Vallelly, 2007). Once the project is complete, it can build on this and other work, and will be useful in informing those involved in the commissioning and designing of future extra care schemes about how different approaches to social life and activity work in practice, and what is most effective in the early stages of scheme development in facilitating social participation, activity and well-being.

Table 5.1: Overview of activities, groups and events in place at six months, as reported by residents and staff

	Scheme 1	*Scheme 2*	*Scheme 3*	*Scheme 4*	*Scheme 5*	*Scheme 6*
Regular activities						
Residents' Association/Committee	✓	✓	Planned	✓	Not successful	
Coffee morning	✓	✓	✓	Not successful	Not successful	
Afternoon tea				✓		
Bingo	✓	✓	✓	Planned	✓	✓
Games (e.g. cards, dominos, scrabble)	✓	Planned	Not successful	Planned		✓
Games (e.g. bowls, table tennis, snooker)						✓
Exercise classes (e.g. Tai Chi, armchair aerobics)	Planned	✓		✓		✓
Talks/discussions	Planned			✓		✓
Film groups			✓			
Religious services/groups			✓	✓	Planned	✓
Gardening	✓		Planned		✓	✓
Karaoke					✓	
Quizzes/brain teaser sessions				Planned	✓	✓
Knitting circle					✓	✓
Poetry and creative writing						✓
Language lessons						✓
Swimming						✓
Arts and Crafts (e.g. painting, woodwork, flower arranging)	Planned			✓		✓
Dancing (e.g. line dancing)						✓
Sing-alongs				✓	✓	
Musical groups (e.g. choir, orchestra)						✓
IT group/classes		✓		✓		✓
Occasional activities						
Socials/entertainment (e.g. singers, magic shows)	✓	Planned	✓	✓	Planned	✓
Dances (e.g. tea dance)	✓					✓
Seasonal events (e.g. religious festivals)	✓	✓	✓	✓	✓	✓
Sales (clothes, books)		✓	✓	✓		
Bazaars/fairs		✓		Planned		
Trips/outings	Planned	Planned	Planned	✓	Planned	✓

Note: Scheme numbers *do not* correspond with staff identification numbers in text.

Table 5.2: Facilities available at six months, as reported by staff

	Scheme 1	*Scheme 2*	*Scheme 3*	*Scheme 4*	*Scheme 5*	*Scheme 6*
Communal lounge (public)	✓	✓	✓	✓	✓	✓
Communal lounge (residents only)	✓			✓	✓	✓
Restaurant/dining room	✓	✓	✓	✓	✓1	✓
Café			✓			✓ (café/bar)
Shop	✓		✓	✓		✓
Hair salon	✓	✓	✓	✓	✓	✓
Beauty/therapy salon			✓	✓2	✓	✓
Gym/fitness room				✓3		✓
Library			✓	✓	✓	✓
Library service		✓				Planned
Computer/IT room		✓		✓		✓
Craft/hobbies room				✓		✓
'Village hall'						✓
Cinema			✓			
Garden	✓	✓		✓	✓	✓
Quiet room		✓4				
Doctor's surgery			✓			
Laundry	✓	✓	✓	✓	✓	✓
Faith room			✓			✓
Day Centre		✓			✓	
Cash point						✓

Notes:
1. Not operational at 6 months; closed down as not financially viable. Re-opened April 2007.
2. Originally fitness room: see note 3.
3. Fitness room not used; equipment would not fit in. Instead, will be used as health and beauty room.
4. Quiet room not used, so is now used as surgery for community matron.

Section 6: Conclusion

The results presented in this report are based on information collected in the early stages of the evaluation from the first eight schemes, and are intended to provide an overall picture of the schemes included. Future reports will be based on information collected in a larger number of schemes, which will provide the opportunity to subdivide the data collected according to the type of scheme. In addition, the evaluation involves the collection of follow-up information about residents, which will enable the identification of changes over time. The results reported for the study of social well-being are based on six schemes, and are based on the initial, exploratory stage of the study. Later reports will include information from a larger number of schemes and from larger samples of residents in the later stage of the study. Inevitably, new communities and relationships take time to develop, and subsequent reports may present a different picture.

However, the information presented in this report does represent a significant addition to the quantity of information available about extra care schemes and their residents, and further reports will add to this. As noted above, other studies have often concentrated on individual developments. Although there have been a few recent studies that have compared several schemes, the present study involves the collection of equivalent information from 19 schemes, some of which is directly comparable with information from surveys of individuals moving into a care home.

This report focuses on initial findings about the characteristics of the residents, their expectations and reasons for moving to extra care, and the development of social activities within the schemes. To summarise, the main initial findings are as follows:

- People who moved into extra care were substantially less physically and cognitively impaired, and required much less support, than those who moved into care homes. The lower levels of cognitive impairment would suggest that the extra care schemes generally preferred new residents to be able to become familiar with their new accommodation before the development of more severe impairment.

- The features of extra care housing were much more important factors in motivating the move into extra care than dissatisfaction with previous living conditions, while the availability of on-site care provided those without immediate care needs to anticipate future changes and avoid further moves at a later stage in their lives.

- The design and facilities, together with resident and staff involvement were identified as important factors in the development of the social life of a scheme. Within the schemes a variety of activities had been established during the first six months, and shops and restaurants were important venues for residents to meet each other. However, the health and mobility of the residents and restrictions imposed by care routines could be barriers to becoming involved in activities. Links with the local community were taking time to develop, and were dependent on the nature of the local community.

As noted above, future reports will expand the information presented in this report to include information from a larger number of schemes included in the evaluation. In addition, the collection of follow-up information about residents will enable the identification of changes over time, and compare these with those of residents moving into care homes. Information is also being collected about the development and operation of the schemes, in particular financial information, and future reports will compare the overall costs of extra care and care homes, adjusting for resident characteristics such as dependency. Separate reports will also be produced for the projects on social well-being and the costs of extra care supported by the Joseph Rowntree Foundation, and the joint project with colleagues from the University of Sheffield supported by the Engineering and Physical Sciences Research Council on the design of extra care schemes.

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