

Evaluation of the Extra Care Housing Funding Initiative: Summary of Initial Findings

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RESEARCH
SUMMARY

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BACKGROUND

A central principle underlying government policy is 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. 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. The Extra Care Housing Funding Initiative (ECHFI) represented the first investment by the Department of Health in capital funding for housing and aims to develop such innovative housing with care options for older people and stimulate effective local partnerships between health, social services and housing agencies and providers. The Fund committed £147 million towards such developments between 2004 and 2008.

While there have been a number of small-scale evaluations, there is a lack of large-scale research evidence about the benefits and costs of housing and care schemes. The study reported here represents the first major study of housing and care funded by the Department of Health.

AIMS

The principal aim of the study is to evaluate the development of new-build schemes for older people funded in the first two rounds of the ECHFI. The evaluation is following these early schemes from their implementation, including tracking residents' experiences and health over time. A particular feature of the study is to compare costs and outcomes with those for residents moving into care homes. The aim is to collect information on the characteristics of residents of extra care schemes in a way that allows comparisons to be made with the results of previous studies PSSRU has undertaken of care homes and their residents.

More broadly, the evaluation provides an opportunity to collect 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, 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 (see below); 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. A further study on evaluating design of such schemes has also been commissioned by the Engineering and Physical Sciences Research Council (EPSRC) and is being led by researchers from Sheffield University.

METHOD

Originally, it had been planned to collect information about all 22 new-build schemes funded in the first two rounds of the ECHFI (2004–2006), but delays in the opening of some schemes and the requirements of the research timetable mean that it will only be possible to include 19 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.

Two main sets of information are being collected about new residents:

- The demographic characteristics and care needs of residents, drawing on information collected in the assessment process
- Residents are being asked to complete a questionnaire about their expectations of extra care and their experiences of moving into the scheme

Six months after they have moved in, residents are being asked about their current care needs, receipt of services and well-being. At the same time, a

number of residents and staff are being interviewed to identify how social activities and links with the community are developing. A year after the opening of the scheme all residents are being sent a questionnaire about the social life, and some residents are being invited to provide more in-depth information about the social impact of living in these schemes. The collection of information about care needs, service receipt and well-being is being repeated 18 months after people have moved in.

RESULTS

Here we summarise the main findings of the initial report (Darton et al., 2008), which drew on data that was available for eight schemes that had opened in 2006 and early 2007: Bradford, Brighton and Hove, East Riding, Enfield, Havering, Northamptonshire, Peterborough and West Sussex (Horsham DC).

The schemes

The majority of the eight schemes are in urban areas. One scheme is a village, which provides mainly flats and a small number of bungalows. The other schemes all provide apartment-style accommodation. The average size of the schemes (excluding the village) is 45 units, while the village provides 270 units of accommodation. All of the schemes provide one- and two-bedroom accommodation but, apart from in the village and one of the smaller schemes, the majority of units have one bedroom. Three of the smaller schemes provide accommodation for social rent, and the remaining four provide accommodation for a combination of social rent and shared ownership, while the village provides accommodation for social and market rent, shared ownership and open market sale.

The residents

By Autumn 2007, 541 people had moved into the eight schemes and, of

these, 446 (82 per cent) chose to take part in the evaluation. Of those taking part, 285 (64 per cent) had a care need; those without a care need mainly lived in the village. Similar information was available about 494 people with care needs who had moved into care homes providing personal care following a local authority assessment in 2005 (Darton et al., 2006).

The ages of the 285 residents ranged from 45 to 97 years, with a mean of 78 years. Approximately 15 per cent were aged under 65, and 13 per cent were aged 90 or over. Just over a third (35 per cent) were men and just under a third (30 per cent) were married. There were very similar numbers of men and women in each marital status category, apart from widows, who accounted for 36 per cent of all residents. Only 13 of the residents were recorded as being of non-white ethnic origin.

Compared with those who moved into care homes, people who moved into extra care were younger, more likely to be male, and less likely to be widowed or living alone (see table 1). Prior to moving in, the majority (85 per cent) had been living in their own home or sheltered housing, whereas nearly two-thirds of the people moving into care homes had been in hospital, a care home or had been receiving intermediate care. Nearly two-fifths (38 per cent) of those who had lived in private households had been owner-occupiers, although primarily they were moving into social rented accommodation.

Those who moved into extra care had much less physical and mental impairment and required much less support 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. A very small proportion (4 per cent) who moved into extra care were severely mentally impaired, compared with 39 per cent of those moving into a care home providing personal care.

Prior to moving in, nearly 60 per cent of residents were recorded as either having received informal care from a person in the same household (22 per cent) or at least weekly from someone outside the household (36 per cent). In terms of formal services, 43 per cent of residents had received home care, but very few (6 per cent) received more than 14 hours per week, or two hours per day. More residents were expected

Table 1. Comparison of people moving into extra care and care homes (personal care)

	Extra care	Care homes
Mean age [Range]	78 [45–97]	85 [65–102]
Female (%)	65	73
Non-white (%)	5	1
Single/divorced/separated (%)	27	14
Married (%)	30	17
Widowed (%)	43	68
Living alone (%)	60	77

to receive home care after their move to extra care. Overall, 66 per cent were expected to receive home care, and nearly 12 per cent were due to receive more than 14 hours per week.

Reasons for moving and expectations

In addition to those residents who had been assessed, a number of people with no care needs moved into the schemes. With only one exception, these residents moved into the village. The questionnaire asking about people's expectations and experiences was given to all residents and returned by 417 residents (77 per cent of the 541 people living in the schemes).

The majority of residents made decisions about moving themselves, both whether to move (67 per cent) and where to move to (71 per cent). Although nearly all (87 per cent) visited the scheme beforehand, less than a quarter considered other options.

People move because of both 'push' factors associated with their current accommodation and 'pull' factors that attract them to where they move.

Residents with care needs indicated that the most important reasons for moving out of their previous home (push factors) were their own physical health, a lack of services, coping with daily tasks, and difficulty in getting around their homes (see figure 1). For residents without care needs, garden maintenance and fear of crime were more important. Those things which attracted residents to the schemes (pull factors) were having their own front door and tenancy rights, an accessible bathroom and living arrangements, the size of the accommodation, the security offered by the scheme, and care support on site (see figure 2).

Comparison of figures 1 and 2 suggests that pull factors associated with extra

care housing were much more important in motivating a move than push factors.

Overall, two-thirds of residents experienced the move as quite or very stressful. Interestingly, people without care needs reported more stress: 16 per cent without care needs said that they did not find the move at all stressful, compared with 39 per cent of residents with care needs. This may have been due in part to the support of staff and relatives. Overall, nearly all residents (90 per cent) described their move as well organised. Fifty-one and 33 per cent, respectively, said members of staff were very and quite helpful.

In terms of expectations, nearly all residents (91 per cent) expected to live in the extra care schemes for as long as they wanted to. Just under a third of those with care needs (30 per cent) reported 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.

Overall, 65 per cent of residents did not expect to see a change in the frequency with which they saw family and/or friends. This may be related to the fact that in 45 per cent of cases people were moving locally.

Social well-being

Information about social activities six months after opening was available for six schemes. All of these schemes had, to some degree, adopted a resident-led approach, although how this actually operated in practice varied between the schemes.

Most schemes had a number of regular (weekly or fortnightly) activities, alongside less regular one-off events. Shops and restaurants are emerging as being important to the development of the

Figure 1. Push – reasons to move

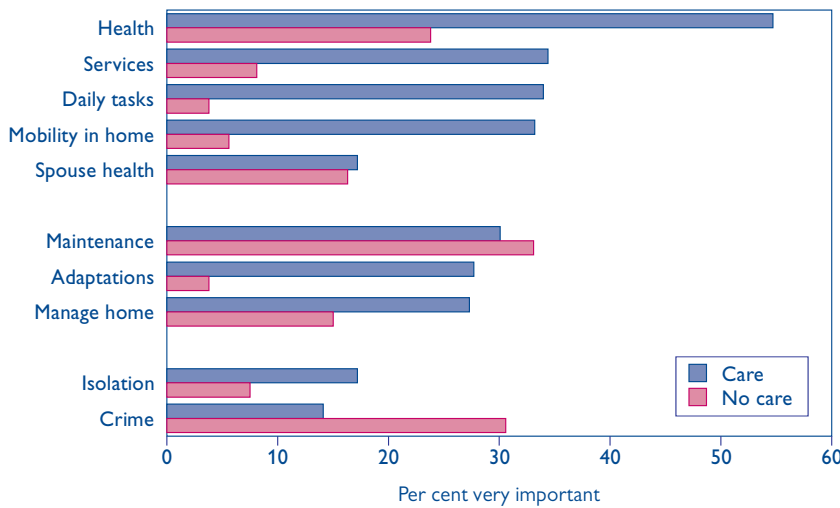
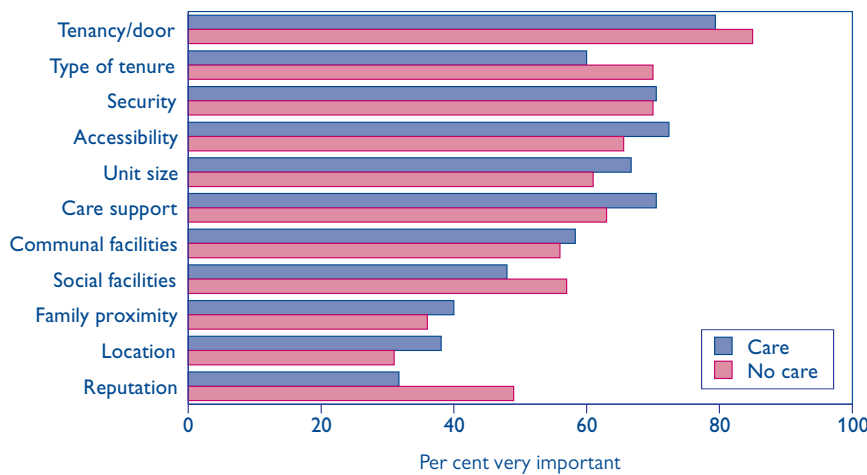


Figure 2. Pull – attractions of extra care



social life of schemes. For example, one member of staff commented that:

‘The shop has been a catalyst to getting people integrating well together.’

The reverse also applied: the absence of these facilities was seen as undermining opportunities for socialisation. Links with the local community were taking time to develop and were dependent on the local context, particularly transport.

The balance between being able to socialise and having your own front door was highly valued. For example, one resident said:

‘...I would have thought it’s the best answer to everything – you’ve got privacy but you’ve got activities that are there.’

Residents’ health and mobility can be a barrier to getting involved in organising and running their scheme’s social

life, as well as a barrier to participation in social activities and events. The nature of the care routine can also be a barrier. For example, one scheme manager said:

‘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.’

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’ developing. Factors which may affect the social climate, the ‘feel’ of a place in terms of

friendliness, and levels of conflict include the previous existence of a sheltered housing scheme onsite, having a mix of tenures, having a mix of health and dependency levels, and the role and personality of the scheme manager.

CONCLUSIONS AND NEXT STEPS

These are very early results so we need to be careful about generalising from the results, especially since information is only available about one care village at this stage. Information is currently being collected from a further five schemes, including another village, and future reports and summaries will provide a broader picture. Inevitably, social activities and relationships need time to develop, and future reports should reflect this. Nevertheless, the information collected so far provides a unique snapshot of eight new schemes and their residents. In the light of the move to use extra care as an alternative to care homes the study provides us with an opportunity to compare people moving into early innovative schemes funded under the ECHFI with those moving into a care home. It would appear that most schemes prefer to admit residents with lower levels of physical and mental impairment than is common in care homes. This reflects both policies of prevention and supporting independence as mixed communities can provide mutual support. For those with mental impairment, moving to a new environment before they become more severely impaired means that people can become familiar with their new surroundings while they are still able to do so.

The move to extra care seems to be a positive choice by people themselves, planned primarily in anticipation of future needs rather than as the result of a crisis, as is so often the case for care homes. It is encouraging to see the pull factors of the schemes themselves featuring so highly in their accounts of the reasons for moving and their expectations.

We might expect the biggest impact of the move on people’s social lives to be associated with the facilities and activities provided on site. While social factors were not the predominant draw to extra care housing, they were cited as important by about half of residents. This raises the question to what extent people’s social well-being improves on moving into these schemes.

Early results of the evaluation of social well-being suggest that the activities provided and facilities such as shops and restaurants serve a social purpose, and contribute to a sense of community. However, where people have care needs the organisation of care can act as a barrier to participation, suggesting that the approach to commissioning and providing care needs to be sufficiently flexible to allow full exploitation of the opportunities for wider aspects of well-being in these schemes.

Many questions remain to be addressed. In particular it is important to have a good understanding of the full cost implications of this approach and how it sits in the overall balance of care. Future papers will report on this and how people's needs change over time.

REFERENCES

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The research team

Ann Netten, Robin Darton, Theresia Bäumker, Lisa Callaghan and Jacquetta Holder. The project secretary is Lesley Cox (01227 823963; e-mail L.A.Cox@kent.ac.uk).

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Cornwallis Building, University of Kent, Canterbury, Kent, CT2 7NF
London School of Economics and Political Science, Houghton Street, London, WC2A 2AE
University of Manchester, Dover Street Building, Oxford Road, Manchester, M13 9PL

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