Comparative evaluation of models of housing with care for later life

Karen Croucher, Leslie Hicks, Mark Bevan and Diana Sanderson

This research studies seven different housing with care schemes for older people in England.

A growing number of housing schemes for older people combine independent living with relatively high levels of care. However, there are questions about what, if any, model works best for older people. This report examines how different models of housing with care address the needs of older people.

The longitudinal study compares seven different housing with care schemes, including 'village' style and smaller schemes operated by a range of provider organisations in different locations. The authors consider:

- what makes schemes distinctive
- services and resources, and
- how different needs for housing, care and support are balanced.

This report will be of interest to those commissioning and developing housing schemes for older people, including policy makers, service planners and commissioners.

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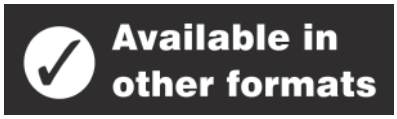

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1 Introduction

Reflecting concerns about how the housing, care and support needs of the growing number of older people will be met, there has been much interest on the part of policy makers, service commissioners and practitioners in the role of housing schemes for older people that combine independent living with relatively high levels of care. There is no single blueprint for housing with care schemes. Provider organisations across the statutory, not-for-profit and private sectors have undertaken various new developments or remodelled existing schemes, often taking quite different approaches to type of tenure, care services and provision of amenities and facilities. However, certain common aims are shared. Schemes are intended to:

- promote independence
- reduce social isolation
- provide an alternative to residential or institutional models of care
- provide residents with a home for life
- improve the quality of life for residents.

An in-depth literature review undertaken at an early stage in the project (Croucher *et al.*, 2006) indicated that the evidence base for housing with care is relatively limited. Evaluations have usually focused on single schemes (e.g. Croucher *et al.*, 2003; Bernard *et al.*, 2004) or on the provision of one provider organisation (e.g. Valleley *et al.*, 2006).

Aims and study methods

Here we present the findings of a longitudinal, comparative study of seven different housing with care schemes for later life. The three main aims of the study were to:

- identify and describe a number of different models of housing with care for older people
- examine these models in terms of funding, the types of care and support provided, the characteristics of the residents, engagement with the wider community, and issues around choice and control

- assess the impact of different models of housing with care on individuals with different needs at different points in their lives.

The study was undertaken in two phases over a two-year period, 2004–06. The project specification indicated that participating schemes should be managed by a range of different provider organisations, located in different parts of the UK and designed to appeal to independent older people, but also able to meet care and support needs as they arise. Participating schemes were identified through website searching and direct contact with provider organisations. Where provider organisations indicated their interest, scheme managers were invited to a seminar to discuss the detail of the project and the input that would be needed from the schemes themselves. Following the seminar, only one scheme declined to participate further. We were unable to recruit a private sector scheme, despite approaching a number of different private sector companies.

The seven participating schemes were located in urban, suburban and rural settings in different parts of England. They were operated by a range of different provider organisations with different funding arrangements. To protect the anonymity of the research participants, we use fictitious names for the schemes throughout the report.

The seven schemes are:

- Beech Tree Village
- Pine Grove Village
- Hawthorne House
- Delphinium House
- Willowbank
- Moorlands Court
- Sycamore Court.

The two largest schemes were Beech Tree Village and Pine Grove Village. Beech Tree Village was operated by a charitable trust. Located in a 240-acre estate, it consisted of almost 300 cottages, a new separate development of 49 extra care flats for people who needed additional support, and a large residential and nursing home facility. Pine Grove Village was a more recent development on the edge of

a provincial city, with 152 bungalows and a central complex that accommodated various community facilities including a care home for those residents who could no longer live independently. Hawthorne House was also operated by a charitable trust. The scheme was split over two sites: one site with almost 80 flats in a courtyard development in a provincial city centre, and the second a new development of 54 flats outside the city centre. Delphinium House and Willowbank were both operated by housing associations. Delphinium House was a new purposely developed building containing almost 40 flats, with a small courtyard garden, dining room/ cafeteria and other shared facilities for residents located on the edge of a village. Willowbank, converted from a former seaside hotel, housed almost 40 flats and had other communal facilities with accommodation for local primary care health services on the lower floors. Moorlands Court was a new development in a provincial town centre, consisting of 39 flats and a 15-bed respite/residential care unit, operated in partnership between a housing association and local social services. Finally Sycamore Court, operated by a not-for-profit limited company with a number of similar schemes across the north of England, provided 53 flats on a leasehold basis and was located in a residential area of a large city.

Further details of the schemes and the services provided are presented in Table 4 in Chapter 4 below.

First phase

In the first phase of the fieldwork, we sought a basic common data set from each of the participating schemes including:

- profile of the resident populations
- services provided on site
- numbers of staff
- amenities
- funding sources
- entry criteria
- type of accommodation

- charges to residents
- management and cost data.

All residents in each of the participating schemes were invited to take part in an interview or focus group with members of the research team. For the most part, residents responded enthusiastically to the invitation. A total of 156 residents took part (interview participants: *n* = 106; focus group participants: *n* = 50). Of the participants, 114 were female (70 per cent) and 42 were male (30 per cent). The ages of the participants ranged from 55 to 96. Table 1 shows the numbers of participants by age group (where age was disclosed).

Table 1 Numbers of residents participating in Phase 1 by age and gender

	55–70	71–80	81–90	90+	Total
Female	12 (13%)	38 (42%)	35 (39%)	4 (5%)	89 (100%)
Male	8 (21%)	13 (35%)	13 (35%)	3 (9%)	37 (100%)
Total	20 (16%)	51 (41%)	48 (38%)	7 (5%)	126*

* Age of 30 participants not disclosed (female: *n* = 25; male: *n* = 5).

Topics covered in the groups and interviews with residents included reasons for moving to the schemes, attitudes towards the design and physical environment, experience of living in a community, care and support services, and affordability.

We also interviewed key informants in each scheme, including scheme managers, managers of different service elements, staff involved directly with residents (care staff, catering staff support workers and maintenance staff) and, in the case of one charitable trust, a number of the trustees. A total of 64 interviews with key informants were conducted. At interview we discussed roles and responsibilities, organisational models, levels of staffing, methods of evaluation and review, and relationships with other organisations (e.g. primary health care providers).

Second phase

The purpose of the less extensive second stage of the project was to identify any changes in residents' circumstances and services within the previous year. We only contacted residents who had participated in the first stage, and in the case of Beech Tree Village and Hawthorne House, two of the largest schemes, we only contacted those residents in the new elements of the schemes. A total of 34 residents were interviewed or took part in focus groups in the second stage of the project (Table 2).

Table 2 Numbers of residents participating in Phase 2 by age and gender

	55–70	71–80	81–90	90+	Total
Female	3 (11%)	13 (46%)	11 (39%)	1 (4%)	28 (100%)
Male	2 (33%)	2 (33%)	2 (33%)	0	6 (100%)
Total	5 (15%)	15 (44%)	13 (38%)	1 (3%)	34 (100%)

Similarly, we limited interviews with key informants at the second stage, focusing on care managers, changes in care and support services, and updating baseline information. A total of 13 interviews were conducted. Some of these participants were new members of staff who had taken up post during the interval between the first and second stage.

Topic guides are presented in the Appendices.

Structure of the report

In the following chapters we present the findings of the evaluation. In Chapter 2 we present the views of the residents who participated in the project, highlighting their motivations for moving and their attitudes towards age-segregated environments. In Chapter 3 we address the factors that appeared to have shaped the schemes and made them distinctive. Chapter 4 considers the care and support services in the different schemes and Chapter 5 addresses how different levels of needs for services were balanced. Finally in Chapter 6 we draw together the main lessons for practitioners, commissioners and service providers with regard to future developments of housing with care for later life.

Note that throughout the report for the sake of clarity we refer to people living in the schemes as ‘residents’, although people were referred to in a number of different ways – owners, tenants, residents, villagers, depending on where they lived.

2 ‘A different way of life’

In this chapter we report residents’ experiences of living in housing with care settings. More than 150 older people living in the seven different schemes participated in the project, a much larger number than anticipated. Below we address a number of themes, including:

- motivation for moving to housing with care settings
- expectations and experiences of living in the schemes
- attitudes towards individual dwellings and the physical environment
- resident consultation processes
- links with the wider community.

Motivations for moving

Across the schemes there was a range of motivations for moving that can be broadly categorised as ‘non-care’ and ‘care related’. It is not, however, easy to generalise and most people had moved for a complex combination of reasons. Moves were sometimes prompted by a particular event, for example a bereavement or illness, which then prompted concerns about future housing and care needs, or the need to be nearer family or to find a more suitable property.

Non-care motivations included:

- planning for the future
- being attracted by a particular development
- moving to be nearer family
- feeling alone and vulnerable following bereavement
- housing need and/or inappropriate, insecure accommodation
- concerns about poor community safety.

> We were seriously thinking about downsizing and we were thinking about, well if we're going to downsize sometime, isn't it better to downsize now than wait till we're doddery before we downsize, while we're still sort of capable of downsizing, still capable of fitting in somewhere else.
> (Interview with resident couple, Pine Grove Village)

> I was pleased to come in because of that nagging thought of what if I came a cropper, that was always there, and I was getting tired of looking after myself. And let's see – I was 84, and I realised that the time was coming when it would be good to find somewhere else, and here it was.
> (Interview with resident, Moorlands Court)

> I had a beautiful house right in the middle of *[city]*, literally four minutes from everything in a quiet backwater, big garden, and I loved that and then over the years the whole community broke down because of student accommodation, which is a big problem in many university cities, and that was quite distressing because what had been a good community became … I knew I couldn't live there forever because I couldn't see myself in my seventies surrounded by this occupation, and I'd looked in *[city]* for bungalows over the years and never found one … I knew I had to move from *[city].*
> (Interview with resident, Pine Grove Village)

> I was mugged twice living there *[previous flat]*, and I went up there because I thought I would be safe, but I wasn't. It's where I got mugged, and an arm broken, and my nose and my jaws, first time, second time, it's my leg, I'm not the same as I was before.
> (Interview with resident, Delphinium House)

> We liked where we were, we didn't necessarily like who was living around us.
> (Interview with resident couple, Delphinium House)

> I would still love to be there *[previous home]*, but it was second floor, and no lift, and the steps were getting harder and harder knee-wise and I've got a pacemaker, so you know, I had to look ahead, but I'm not really ready for this, I dared not turn it down, and I'm very pleased I didn't.
> (Interview with resident, Hawthorne House)

Many residents had been in housing need prior to moving to the schemes. Sometimes people had been virtually homeless, in very insecure or inappropriate accommodation, had lost their accommodation tied to their jobs, experienced

financial crisis due to divorce or bankruptcy or were living in neighbourhoods where they no longer felt safe. Much of the housing and care literature tends to focus on care needs, and pays less attention to the housing needs of older people. There is also a significant literature that reports older people's desire to 'stay put', and indeed current policy is determinedly focused on maintaining people in their own homes. For many of our participants, staying put was simply not an option.

Those people who had moved for care-related reasons had often been directed to particular schemes by social services or housing providers. Although health problems were often the primary driver for moving, many individuals also had non-care-related reasons for moving as well.

For some of the very old and frail among our participants, housing with care was seen to be a much better option than residential care which would have been their only alternative. Indeed a small number of our participants had previously lived in residential care, and many others had seen friends and relatives in residential care settings and were generally unimpressed by what they had seen or experienced first hand, particularly the quality of the accommodation and what was perceived to be the institutional nature of these settings, as well as the cost. Many remarked that in comparison with residential care in particular, housing with care generally provided better value for money. One participant from Moorlands Court had experience of both residential care and intensive domiciliary care in an independent bungalow. Neither option compared favourably with his current situation where he felt he received the care and assistance he needed, but could also have a more active social life.

> *[Living in the bungalow]* lacked all the good things of this place, I didn't see anybody, I closed my little bungalow door, and then I was entombed in this place for the rest of the day. But I've had excellent service here, no problems, apart from the petty ones.
> (Interview with resident, Moorlands Court)

Others had lived in sheltered accommodation, and often had gradually seen the levels of support decrease as on-site wardens were replaced with mobile wardens. Others had investigated the possibilities of housing association or council properties, and in some cases, although the properties they had been offered had been more spacious, they were often considered unsuitable because they were in a poor state of repair or in a poor area. Security was a primary concern for both fit and frail, as illustrated by the comments from a resident who had previously lived in sheltered housing:

> I suppose I came for the 24 hour care, that appealed to me. I'm very fit at the moment, and that's when I thought …. our warden, as she was then, became a scheme manager with less and less care, more interested – it wasn't her fault, she had to be in charge of the building – if you had a leak or anything like that, she wasn't even living on the premises, she didn't even live in *[city]* she came from *[village at some distance]* and I think I could see the writing on the wall, that in a few years we wouldn't even have a warden or a scheme manager as such.
> (Interview with resident, Hawthorne House)

When the selection criteria of the different schemes are considered, it is clear that none of the schemes could meet all the needs or preferences of the various people we met across the different settings. Those schemes that would only accept people with clearly defined care needs were unable to accommodate those people who were seeking to make plans for the future, or were primarily seeking somewhere to live. Other schemes required residents to be independent at least at the point of entry, thus the very frail would be unlikely to be accepted. Others required residents to have certain levels of income. Residents acknowledged that schemes were selective, but were relatively undisturbed by this, as illustrated by these comments from an interview with a married couple:

> *Wife:* And it's nice being amongst a community of like-souls in a way, and a very caring community.
>
> *Husband:* I think – I know that 'selection process' is not a PC word – but I think the *[charity's]* selection process they have is quite clever, cos there's an extraordinary mix of people here, quite a lot of ex-nursing staff, there's a lovely lady who's an ex-publican, and there's *[name]* who was a doctor in *[city]*.
>
> *Wife:* That's one of the pluses, in talking to people, it's fascinating.
>
> *Interviewer:* Is it a good social mix?
>
> *Husband:* I would think so, I think they're *[charity]* very astute and very clever.
>
> (Interview with resident couple, Hawthorne House)

Many expressed how they felt very 'lucky' or 'grateful' to be where they were, and were content to know that their neighbours were people like themselves.

The attractions of particular schemes

People's decisions to apply to the particular schemes where they lived were generated by a number of different, usually quite personal, circumstances and preferences. Affordability was a key concern. Location was another important consideration. For some, remaining in a particular place was crucial to retain family and other social networks, although a number of respondents had moved long distances to be nearer to their families as they got older. Many people also stressed the importance of location in terms of access to everyday services and facilities – local shops, banks, health care services, and especially transport services.

The accommodation and setting were also important. In the schemes where residents purchased their accommodation, the quality and size of the accommodation were key factors in deciding to apply, although other considerations such as location were also important. It was noted both at Hawthorne House and Beech Tree Village that many prospective residents were put off by the limited size of the accommodation they had been offered; however, people were prepared to accept smaller accommodation if there were other things that they valued – feeling safe, access to care, having a garden, being in a cottage instead of a flat, being able to have a dog, certain facilities on site, location, and so forth. Clearly individuals made trade-offs between different elements of schemes, depending on their own personal priorities.

> I came – I saw it advertised – and I was in a bit of a desperate situation myself at the time. I had the dog and the main reason I came to even look was because they accepted dogs and I thought as soon as I saw it – I didn't mind that it was small because I spent most of my life living in a bedsit, although it would be lovely to have a bedroom – so it's so wonderful because you can have a little garden, and I've got an allotment, and they do lovely things like line dancing and bowls. I'm tremendously happy.
> (Interview with resident, Beech Tree Village)

Many people we met had willingly given up home ownership to rent properties. Most were glad to be free of the responsibility and expense of home maintenance and repair, and also to have the opportunity to release the equity in their former homes. Others had been unable to afford to purchase a suitable property in the area of their choice (particularly people moving to be near relatives in more expensive parts of the country).

Expectations and experience

In many cases people did not really know what to expect prior to moving to their new homes. Transitions could be difficult, and people did take time to adjust to what many people described as 'a different way of life'. Nearly everyone we met spoke about 'coming in here', and their previous lives 'outside', so people clearly saw their schemes as boundaried in some way, and distinct from the rest of the world.

Independence and security

Across all the schemes residents spoke about the combination of independence and security that the schemes offered them, in line with the findings of other research related to housing with care for later life (Croucher *et al.*, 2006). The idea of independence was closely linked with privacy, having your own accommodation (however small) where you could carry on your life as you chose, with the option of engaging with the community as and when you chose. Being part of a community was also important to some people.

> It's total independence if you want it, you are your own person in your own house, and you do not get any interference and no pressure. If you want to join everything you can join, and if you don't want to you can just be laid back and relax.
> (Interview with resident, Beech Tree Village)

> I like it because you're independent and yet you're not alone.
> (Interview with resident, Beech Tree Village)

> I think I was fairly open-minded because I'd never lived anywhere like this. I just felt that as I was getting older it would be nice to feel that you belong somewhere because when you're on your own, although I have a family they have their families and their responsibilities, and when you've been on your own it is nice to feel you belong somewhere, so you belong to a community, which is a nice feeling in that respect.
> (Interview with resident, Hawthorne House)

> I'm very happily settled, everybody's got their own ideas when they come and having come from your own property whether you've come from sheltered housing or not, it's a different way of living. But the beauty of it is here you have your own independence and if you don't wish to join in

> you needn't but I feel like there's quite a lot that like to join in and make it a community, so I'm really very happy here.
> (Interview with resident, Hawthorne House)

Alongside this was the security of knowing that help was at hand should it be needed. Residents placed great value on on-site 24-hour staff cover, particularly those who lived alone. As one of the focus group participants who suffered from asthma explained:

> I had been thinking for some while I ought to do something, I was ill quite a lot. It gets very frightening when you're on your own, especially because it's breathing – I wouldn't mind if my arm was bad – but in the middle of the night when you can't breathe if you ring the agency doctor and you can't speak to them to tell them what you want, and I had quite a few attacks like that.
> (Focus group with residents, Hawthorne House)

Security, however, was not just about knowing care staff were at hand. For some it was about being in a safe environment where the outside world was kept at bay. People spoke about 'sanctuary' and 'being away from all that madness out there':

> I thought this would be alright. I suppose in a sort of way it was sanctuary. You see I'd had my husband all my life, up till then I'd never been on my own.
> (Interview with resident, Sycamore Court)

These notions of sanctuary and withdrawal appeared to reflect a range of concerns: about being alone and therefore more vulnerable; about lack of confidence in services on the 'outside', not just care services but other services as well, particularly those to do with home maintenance and repairs; about security of tenure and having a roof over your head; as well as concerns, often based on unpleasant personal experiences, about crime and personal security.

> It's the vulnerability, I think that's one thing we underestimate when you get older, is vulnerability.
> (Interview with resident, Pine Grove Village)

> I needn't lock my door if I don't want to, so I think everybody feels safe … and one of the best things is having a workman on site. And if you need anything done, they're here, and that in a sense is really good for older people. They can't cope on their own. And if you need something and you

haven't got any family, to think you can just ring up and say can someone come and help me, that is security.
(Interview with resident, Beech Tree Village)

I know what it is to be without a home, so I was more than grateful for this … so I was thrilled to bits, and still am.
(Interview with resident, Hawthorne House)

We lived in a flat right on the riverside and we had endless trouble with children and we just couldn't relax half the time. Any time I heard the children I'd be thinking what was going to happen next. We did have problems. So you can just imagine what it was like for us to move in here. It's like *[fellow resident]* just said, we feel safe, secure. But another reason why we came here was because that house was owned by *[landlord]* and they decided to sell it. We rented that flat so obviously we were a little bit concerned about what was going to happen to us.
(Focus group with residents, Hawthorne House)

Being part of a community

Across the different schemes there was a variety of views regarding what made a community and whether a community had developed or was developing. Obviously the schemes that had been longer established, notably Beech Tree Village and Hawthorne House, where residents had lived for many years, were seen to have a more distinct and shared collective identity; however, even in the more recently opened schemes, most residents felt communities were developing, albeit a little slowly.

We explored what people felt were the key elements of 'community'. Ideas of community were linked very strongly with mutual help and support, the willingness of neighbours to 'keep an eye out' for each other and help people through times of crisis or illness, to be friendly and kind, and at the same time respect the privacy of other people. On reflection it seems that people's homes were their most private space, and usually only those considered 'friends' were invited to share these spaces. Community appeared to be located outside the domestic setting: at mealtimes, in informal encounters when going to the shop or walking the dog, when outside gardening, or at more formal social events. The schemes with more outdoor space, gardens and shared rooms or spaces where people could meet either formally or informally appear to offer more opportunities for community formation.

Staff and organisational attitudes were also clearly linked to a sense of community or belonging. A stable staff group across all elements of provision – care, catering, maintenance – where residents had the opportunity to get to know individuals by name or exchange a few words when they saw them about their duties enhanced people's sense of community. In some schemes a member of staff called briefly on each resident every day, and this daily contact enhanced residents' sense of belonging or being cared about.

From the residents' perspectives, one of the most important aspects of living in housing with care was the independence, and the lack of pressure to take part in social activities if you didn't want to. From our discussions and interviews it was clear that privacy was very highly valued; nevertheless people also valued the company and opportunities for a social life that housing with care could offer. This is not to say that people were not lonely, and many people said they were lonely, particularly those who had lost their partners and after many years of living as a couple found themselves living alone.

> I am as happy as I can be, there is the problem of loneliness, undoubtedly there is the problem of loneliness. The evenings are very long.
> (Interview with resident, Sycamore Court)

People also felt very strongly that it was very much the individual's choice as to whether to take part and get involved in social activities. This is a strong theme that emerged from all the interviews and group discussions. There were those who preferred not to join in and others who were clearly very active in different groups and societies. Those who were less sociable were seen to be exercising their right to choose and they did not appear to be considered 'outsiders' by the more sociable residents.

> The people that are friendly come out, and you meet all the people that are open and like company, and the people that don't want to bother you never see, so it suits everybody.
> (Interview with resident, Sycamore Court)

It seemed that social isolation was a particular difficulty for frail residents; again this is very much in line with the findings of other research (Croucher *et al.*, 2006; Evans and Means, 2007). It is difficult to generalise, as some of the very old people we met found company or going out very tiring and onerous, and said they were content with a fairly quiet life. However, others did not and would have welcomed more opportunities to go out, or do things that they found interesting or engaging. Residents often remarked on those who 'never come out' of their flats, and expressed concerns about their isolation.

> What they do in their flats all day, I don't know … how they can spend the day, more or less isolated, that's a mystery to me.
> (Interview with resident, Sycamore Court)

There is a tension between leaving residents to organise social activities and facilitating activities for frailer, older residents who simply do not have the energy to organise activities, or need assistance with going out or participating, for example someone to push a wheelchair.

Despite feeling that community within schemes was important, many people were adamant that it was important to maintain a life 'outside' the scheme, with existing friends or family networks, voluntary work and religious groups.

> I think that if you move into a place like this, some people have come from quite a distance, I think it's much better if you can still keep links with your other life as well and not cut yourself off completely. It's a nice community here, it's a bit like a village, I know every single person, and I could tell you which flats most of them live in … It's pleasant, and I like to have people around me. *[Husband]* is not quite such a mixer as I am, but he hasn't given up his allotment, and he still works for *[charity]*, and we're still not too far from the children. On the whole it works OK.
> (Interview with resident, Sycamore Court)

Clearly the location of the schemes could make it more or less difficult to maintain social networks. Many residents in the more isolated of our schemes spoke about feeling 'marooned' or 'cut off', particularly those who did not have a car.

There were some negative aspects of community life. Gossip and rumour were mentioned, and residents noted the particular importance of keeping financial affairs private. Where some residents were in receipt of means-tested benefits and others were not, this could generate considerable friction between residents. People were reluctant to discuss private finance, but many questioned the wisdom of saving for later life when you would in effect be penalised for your efforts, and those who had 'spent up and squandered' would be supported by the state. These views are not unusual (see, for example, Croucher and Rhodes, 2006).

> One thing about it that people hate: what people don't know they make up. They want to know everything. You can't do a thing, you can't have a heart attack or anything like that in peace.
> (Interview with resident, Beech Tree Village)

The various entry criteria for the different schemes introduced an element of homogeneity into the communities. People often had very similar incomes, or came from the same location. From the residents' perspective homogeneity was a desirable feature of the schemes. As noted above, differences in income, or rather differences in receipt of benefits, could cause friction, although where people had similar incomes, or were all paying the same for services (as in Hawthorne House or Pine Grove Village), this did not appear to be such a significant issue. Whether the schemes served a particular locality or drew residents from further away appeared to play a part in community development. It was clear that when residents came from the same locality (Hawthorne House, Moorlands Court, Willowbank, Delphinium House) many people already knew each other, indeed often people applied to a particular place because they already had friends or family there. In these schemes, most people often had well-developed local social networks and continued with voluntary activities, attending the same churches and other interest groups. Where people had come from further away (usually to live nearer families) they were more dependent on fellow residents for social contacts.

Living in an age-segregated setting

Age-segregated housing is criticised on the grounds that it is unnatural and inherently ageist to separate older people from other age groups. Our participants were not on the whole troubled by living in an age-segregated environment. Indeed many were relieved to be in an environment that focused on and respected the needs and preferences of older people. There also appeared to be 'solidarity in ageing'. People appreciated having others around them who understood old age because they too were getting older. This shared understanding appeared to promote a strong ethos of mutual help and support among residents. Of particular interest were the experiences of the residents of Beech Tree Village where many people had more than 20 years of experience of living in an age-segregated environment.

> You don't feel old here, because there are so many people who are ten even 20 years older than you who are still very active and taking a great part, and so you realise – at least I realised – oh boy, I might have another 20 years yet, if I was outside I'd be the 'old lady' ready to go at any minute.
> (Focus group with resident, Beech Tree Village)

Participant 1: I did sort of wonder, you know 'old people', but there's also a lot of young people that work and live here, so it's quite a mixture.

Participant 2: We cover four decades from 60 to 100, so you get variants.

Participant 3: You get variants of old people, usually the youngest people in mind are 100 years old.

Participant 4: They are, it's surprising.

Participant 2: And also it's good because you can help the older people, you know, we help each other.

(Focus group with residents, Beech Tree Village)

There's a lot of difference to the type of people who are coming in at the moment at 60 – I came in at 64, I'm 72 now – and me. They're agile and young and that, but seriously there's a lot of difference in attitudes. It's a different decade, we were children of the war, and the people who are coming in now weren't, so therefore they're further along the line so they've got different attitudes and experiences and I think that's good … so there's enough leeway there not to feel old.
(Interview with resident, Beech Tree Village)

And another nice thing is that if you go out, doesn't matter where you go always people will talk to you, they'll say hello, morning, they'll talk to you. I lived in *[town]* for 20 years and I couldn't walk down the road and talk to people, there's too many people. So although there's a lot of people here they all wave and say hello because they're all in the same position as you are.
(Interview with resident, Beech Tree Village)

An important point to make is that ages of residents in the participating schemes ranged over three and sometimes four decades. In some cases residents did note that such a wide age range could result in splits along age boundaries, although as illustrated below, where a resident (aged 77) describes a birthday party, it was not necessarily age, but rather disability or infirmity that could come between people.

> Half the room were drinking heavily, and were young, well you know, my sort of outlook, and the party didn't break up till half past 12, which was hard on the staff – I came up at half past nine, and believe me I'd had enough *[to drink]*, and the rest were like a geriatric day room, chairs sitting round the room. And the older ones are the nicer people, people you can talk to.
> (Interview with resident, Hawthorne House)

Attitudes towards disability and illness did vary across the schemes. In Delphinium House and Willowbank, both new schemes, non-disabled residents were sometimes surprised that people with very high care needs or mental health problems were living in the same scheme. The non-disabled people thought the disabled people should be somewhere with more care. Conversely, the disabled people thought the non-disabled people did not need to be 'in a place like this'. People with cognitive impairment were often dismissed as potential friends or companions – 'you can't have a conversation with half of them' – or were a source of anxiety and disruption.

In Moorlands Court, however, where a number of people had moved in from residential or nursing home care, the integration between the fit and frail seemed to work very well – people who were sometimes very seriously disabled often spoke about the care and kindness of their neighbours. For these people there was no doubt that the quality of their lives had improved, because of more social and intellectual stimulation. Residents in this scheme all came from a relatively small geographical area and many people knew each other prior to moving to the scheme, which had generated much local interest through its development stage. In Beech Tree Village people who became too ill or disabled to live in their own flats or bungalows could move into a different part of the scheme, either a new purpose-built block with additional care facilities, or to the on-site nursing home. The residents who had moved on – particularly those in the nursing home – were perceived as different and not necessarily part of the community. The non-disabled residents tended to engage with these residents in particular ways – quite often providing 'voluntary' services, for example a team of volunteers provided a manicure and hand massage service for frail and infirm residents; arranging flowers for dining rooms; or organising coffee mornings or games sessions.

Living in feminised environments

In all the schemes the majority of residents (and care staff) were women. Residents themselves rarely suggested that this made a noticeable difference to the community,

and it was certainly not something they had thought about before they had moved. When asked, some men did say they were reluctant to join certain groups or activities if they were the only man there, and some missed other male company.

Participant 1 (male): I go *[on outings]* and I'm the only gent there sometimes, and I'm sorry I went. It's a ladies' day and it's ladies' chat.

Participant 2 (female): A lot of men don't join in things.

Participant 3 (female): Even in the keep fit you never get a gentleman come to the keep fit.

Participant 1: I would come to it, if it were more balanced, the same with the swimming.

(Focus group with residents, Beech Tree Village)

Male members of staff – most usually maintenance, gardening or catering staff – were greatly welcomed as they provided opportunities to chat about 'male' topics. From the women's perspective, being in the majority was not a difficulty, except for some activities, dancing groups for example, where there were never enough male partners.

> I mean, we've all been married, we've all had children, we've all had husbands, and it's something we're quite content to be without.
> (Focus group with residents, Beech Tree Village)

At Beech Tree Village, there was a regular 'men's breakfast' where all the men from the different elements of the scheme got together. We did not find other examples of anything similar. Reflecting on the kind of social groups and activities that were available across the different schemes, some were clearly intended to appeal to men and women alike (for example, games sessions and film shows). Some schemes had also subscribed to satellite TV sport stations. The larger schemes appeared to offer some advantages to men, simply because within a larger group of residents, although men were still in the minority, there was a greater number of men, and a wider range of facilities that could include traditional 'male' activities, for example allotments, gardens or a bowling club.

On the theme of gender and sexuality, only one participant disclosed that he was gay to the research team. He had been cautious about coming out to other

residents in his scheme; however, he felt that those residents he had taken into his confidence had been very accepting. We know very little generally about the housing preferences of older gay people and this is an area worthy of further research.

Individual homes and physical environment

Depending on when schemes were developed, the individual accommodation, site layout and facilities were not always designed in line with contemporary standards (space, access for disabled people, energy efficiency). The two leasehold schemes provided the most spacious individual accommodation. Some of the accommodation in the schemes (both old and very new) was very small. Very often the residents' main complaint was how their daily lives and activities, and sense of personal identity, were highly constrained by a general lack of living space, although others had adjusted to smaller spaces. Below a resident explains her feelings on first being shown a flat in her scheme:

> They took us into one the flats that was for a disabled person, and for me it was a culture shock. There were about ten of us, crowded into this small room, cos they vary in size the flats, and I saw this little flat, it was furnished, and I thought my god where do I put my vacuum cleaner, where do I put my furniture, that was such a … I was numb, absolutely numb. I couldn't get away quick enough, I really couldn't. I made some excuse, and said I had to leave. I was really upset.
> (Interview with resident, Hawthorne House)

In some cases, it was not possible for residents to continue with the same lifestyle and patterns of activity that were enjoyed prior to moving. It was difficult to entertain visitors and continue patterns of family-orientated activities (e.g. cooking Sunday lunch) as there simply was not enough room to cook a meal for a number of people, or have a dining-room table and/or sufficient chairs for more than two people to sit down. Similarly lack of storage space was a big concern, as it was hard to maintain hobbies and interests, to keep clothes tidy, or to store household appliances, tools, books or craft/study materials. Many people we met also spoke with regret about the possessions they had been forced to dispose of, or replace with smaller items, often at considerable expense.

Most noticeable in many of the more recently built schemes (with the exception of the leasehold schemes) was the proportion of space in individual dwellings given over to wheelchair access, particularly in bathrooms, which were quite often the largest

room in the dwelling. While residents acknowledged the value of dwelling spaces that could take account of their possible future needs for a wheelchair, their main concern was lack of space generally. There is a simple message here – greater emphasis needs to be placed on space for living.

On a related theme, within individual dwellings, often little attention appeared to have been given to designing for other types of impairment, particularly sensory impairments, or to simple details such as the location of meters for ease of reading, window locks and catches that were easy to use, the height and accessibility of kitchen cupboards, colour contrasting of switches and fixtures, and so forth. When people spoke about their accommodation, generally it was these small details that caused the greatest irritation and inconvenience.

Given that many of the schemes were newly built, it was perhaps surprising that few schemes appeared to make significant use of new technologies. All the dwellings (with the exception of the older cottages in Beech Tree Village) had alarm call systems. Most had secure entry systems to the schemes and sometimes systems to restrict access within the schemes. While these on the whole worked well, there were some issues about staffing for reception areas. In the new element of Hawthorne House, a new telephone system had been installed that allowed residents to ring each other on an internal network and also receive voicemail. Although it was not a complicated system, some residents were confused, and staff noted that it was relatively simple for residents to access other people's voicemail. A centralised heating system had also been installed which had not been particularly successful and had proved difficult and complicated to repair. Residents had also been provided with new white goods, including a combined microwave oven and grill with digital controls. Many (although not all) residents had been unable to master the controls, and this made it difficult for them to cook and prepare meals, and was a source of intense frustration and annoyance. At second visit, the charitable trust had removed the cookers and replaced them with more standard appliances much to everyone's relief.

Lifts were often 'pinch points'. There were sometimes not enough lifts, or they were too small to accommodate mobility buggies or people on stretchers.

Outdoor space was also important, and easy access to outdoor space was greatly welcomed. Where schemes were flats, balconies were valued. Gardens (individual and communal) were a source of enormous pleasure and a point of interest. They provided space for leisure, for being outside without having to 'go out', and a space for informal meetings. Individual gardens, however small, were spaces where people could be creative and express their individuality.

In those schemes that were flats, parking spaces could be limited. At Moorlands Court, where local community health staff had a base, parking could be difficult for residents, especially finding a space near to the building for those who had mobility problems.

Having a voice

Across the different schemes there were various mechanisms for consulting with residents, ranging from relatively formal processes of committees with elected representatives, which then met regularly with management organisations, to more informal means, such as a regular open meeting or coffee morning with managers where residents could raise concerns and staff could tell residents about future events. From our discussions, what appeared to matter most to residents was not so much the consultations or having elected representatives, but being able to go directly to someone if they needed to report a repair, or ask questions about different services, or raise any concerns they had. In those schemes that were self-contained and not part of a wider organisation, residents noted that 'you've got it all here from top to the bottom', and appreciated the ease of access they had to various managers when they were located on the premises.

Although most people thought on the whole that the committees and residents groups did a good job, they also recognised that it was onerous for those who were in key positions, and it was often difficult to find people to fill these roles, particularly when the majority of residents were relatively infirm. Many people were clear that they did not want to be directly involved themselves as it would take up too much of their time and energy.

> We're working harder than we did when we were living in our own house, because we only had to make decisions for ourselves then, but now we're having to make decisions that affect the whole court.
> (Interview with residents committee member, Sycamore Court)

> Whenever I'm in the dining room, 'Can I just have a word?' – sometimes I wish I didn't live on the premises.
> (Interview with residents committee member, Moorlands Court)

Residents' views varied across the schemes regarding the extent to which they were consulted on key decisions. Where committees were in place, some residents felt that they were consulted and that the committees provided an effective way of

linking residents with management; however, others did not. There were also those who questioned how far residents could and should be involved in the running of different schemes where the best interests of current and future residents had to be considered and when difficult decisions had to be made.

> I am very wary of this *[residents' involvement]* because one doesn't quite know where it's going to lead and these are certainly not questions I personally want to ask nor responsibilities I would like to get involved in quite frankly.
> (Interview with resident, Pine Grove Village)

Some of the schemes had regular newsletters. Some were a collaborative effort between staff and residents, and others resident- or staff-led. These were highly useful sources of information about what was happening in the schemes, such as social events, meetings or outings, as well as providing opportunities to announce changes in staffing and general reinforcement of information, for example around fire safety, regular residents' meetings and so forth. In some cases they were a forum for debate and discussion about topics that were contentious, or general reflections on life in the different communities. They appeared to be one of the most effective ways of keeping people informed about a range of issues and counteracting rumours, and also provided a record or history of life in the different schemes.

Links with the wider community

We found little evidence that people disengaged with the wider community. Many people were conscious of the need to keep in contact with the outside world. Age-segregated living offered them the opportunity to engage with the wider community on their own terms, from a position of security. Residents of all ages were engaged in a wide range of voluntary, community and social activities outside the schemes. However, those who were frail or disabled were less likely to be active outside their schemes, simply because they found going out quite difficult, even in schemes that were conveniently located in town centres or on accessible transport routes. Schemes serving local communities appeared to offer some advantage, because people could simply maintain their existing social networks without too many difficulties.

The wider community was not always something that people wanted, or felt comfortable with, and these feelings were usually related to the need for security and sanctuary. Thus although people spoke about the importance of maintaining outside

interests, these interests were usually quite personal, and people preferred to engage with the community on their own terms, rather than be forced into interaction.

> People are changing, not changing but things are different. Families are out all the time, there's no family life to the same extent, so you could be lonely, and then you get howling dogs and crying babies and you think, oh dear. It's nice here. I'm not one for thinking it's better to be in the community. You sometimes don't want the community if you know what I mean.
> (Interview with resident, Hawthorne House)

The relationship between different schemes and the wider communities in which they were located was related to the socio-demographic profile of the residents, for example whether they were drawn from the locality or came from further afield, the location of the schemes and the local profile of the managing organisation.

In those schemes in relatively rural locations, some residents expressed feelings of isolation, even when the scheme itself had a variety of services and facilities. The city centre locations were appreciated by residents because of the ready access to services and facilities. However, this access sometimes had to be balanced against noise, anti-social behaviour and crime.

> When I hear drunks outside in the early hours of the morning, if it wakes me up I can turn over and go back to sleep thinking well, I'm in here, I'm in bed, there's a hefty door on the front. When we first came here, every time, whenever we heard a woman screaming in the street, we'd rush over to the window.
> (Interview with resident, Hawthorne House)

Rarely did residents feel their security within the scheme was compromised by central locations, although in one scheme – Delphinium House – residents were sometimes reluctant to go out alone because the locality had significant levels of street crime, and plans to open the scheme café to the wider community had been curtailed on security grounds.

There were a number of ways that links and interactions between individual residents in the schemes and the wider community were structured in formal ways by staff. For residents with limited personal mobility, a valued service (available only in some schemes) was help with access to local shops and services, either through provision of a minibus service to local supermarkets or by staff escorting residents to the shops. Another approach was to bring services into schemes, in addition to health

practitioners such as chiropodists or physiotherapists. Willowbank had facilitated regular visits by a clothing retailer and was working on introducing internet shopping.

At an organisational level, one scheme, Moorlands Court, was determined to keep a high profile in the local community and actively recruited local volunteers to work in the scheme (see below).

Sharing facilities with the wider community

In Beech Tree Village, Delphinium House, Moorlands Court and Willowbank people from outside the schemes were able to make use of some of the communal facilities. In these schemes, providers viewed the communal facilities as a resource for the wider community, and in some cases the use of facilities was a way of raising additional income to help sustain the viability of facilities.

In Willowbank, the communal facilities were intended to be a shared resource for other tenants of the housing association who lived adjacent to the scheme, and were a way of developing the social scene within the community in which Willowbank was situated.

Delphinium House had employed a Community Link Worker to establish links with the wider community. Their remit was to engage frail elderly people in the local community in activities on site and encourage them to use the lounge, library, salon and café, as well as to find out about clubs and activities outside Delphinium House that residents could join.

Residents across the schemes tended to hold strong views about the extent to which other people could use communal facilities. There was a great sense of ownership amongst respondents over the facilities in the scheme where they lived, especially as residents often contributed financially to communal services as part of their overall charge. There was also a view that the sense of security and safety which schemes provided was compromised by allowing people to make use of buildings and facilities.

Participant 1: They've put out a notice up to say that they'll do wedding receptions, thinking of people from outside and bringing them in. Well we don't want the outsiders coming in because they're taking over everything that we paid for.

Participant 2: This is our home you know …

> *Participant 1:* You don't invite all and sundry into your home, do you?
>
> (Focus group with residents, Delphinium House)

There was also an issue about the extent to which residents were inconvenienced by sharing facilities with others. This view was evident in two schemes (Moorlands Court and Delphinium House) where catering facilities were shared with other people. At Moorlands Court, the restaurant was shared with a day centre located in the scheme, and there were two sittings for lunch. Moorlands Court residents were asked to wait until the second sitting, the timing of which had been pushed back on a number of occasions, such that residents were being asked to wait for longer and longer before they could be served. In addition the room occupied by the day centre was not open for use by residents when the day centre was closed. The room had the best views over the garden, and some residents resented that access to the facility was restricted.

At Beech Tree Village the swimming pool was open to the wider community, and the village hall and gardens hired out for wedding receptions and other functions. However, residents had often made a conscious decision to move into a space that offered to meet the specific needs of older people, and these aspirations were felt to be compromised by ready access for the wider community.

> Say today it's school holiday. That road up there it's full of cars – that's kids using the swimming pool. And we've had several complaints about it, all these cars coming in and the kids running round the Green. And people – like not only me – the lady up the end there she's 90 odd, she needs to have a sleep in the afternoon and the kids running round hollering and hooting. And there's people who sort of bring their children up here for a swim. They pay such a lot of money every year to use it. Yet it's our swimming pool, yet we can only use it a couple of hours every day. It's unbelievable – they ain't got no feeling of old people.
> (Interview with resident, Beech Tree Village)

At Pine Grove Village, residents had been consulted over whether or not to make restaurant facilities open to people from the wider community. The result of the consultation had been a resounding 'no'. The level of interaction with the surrounding community could be a contentious topic. As one resident commented:

> There have been and still are some residents who would like almost, they may not put it in these words, but I'm convinced of this, they would like to put a fence around this place. Very inward looking. I don't necessarily

> mean a metaphorical fence, I think one or two would like to see a literal fence … We're very pleased to see people from *[village]* coming in, but there have been some residents who *[feel]* 'this is ours', I think because we pay for it, and are digging deeply into our pockets. And at times it erupts.
> (Interview with resident couple, Pine Grove Village)

However, this tension was not universal across all the schemes. At Willowbank, there had been a history of strong social interaction between the tenants who had lived in sheltered accommodation that had previously been on the site now occupied by the new scheme and the community. This sheltered accommodation had been demolished and the extra care facility developed in its place. A number of residents noted that the level of social interaction with the wider community had subsequently fallen, although the provider was working hard to re-establish these links. This example highlighted the difficulty of managing change and also of mitigating the impact on residents of wider alterations to public funding regimes. In this instance, the introduction of Supporting People charges for housing-related support and rent restructuring had removed the flexibility to charge tenants in the wider community for communal facilities located in Willowbank.

Delphinium House is a high-rise development where progressive privacy was designed into the scheme, with facilities accessible to members of the wider community on lower floors, but access to upper floors, where residents had their homes, restricted. To some extent, the housing association had attempted to manage the initial expectations of residents by explaining to tenants before they moved in that the scheme was intended to be a shared resource for the wider community. Nevertheless, tensions were still apparent in relation to some residents' concerns about public access into the scheme.

Changes over time

The views of residents did not appear to change much in the time between first- and second-phase fieldwork. At the second meetings or interviews in the newer schemes, residents were clearly more settled, often the snagging details with flats or buildings had been resolved, and social networks and groups were developing. Schemes were becoming 'home' to people. Residents gave accounts of events – celebrations, special parties or outings – that had created shared experiences and memories. It was also clear that some people's own lives had changed – some had experienced illness or bereavement – and they often reflected on how these painful or difficult experiences had been mitigated by living in the schemes.

Following reductions to some funding schemes, there had been some changes to services. For example, in Delphinium House the support element of services had been reduced. It was sometimes difficult to convey to residents and staff why things had changed. Changes, particularly changes in fees and charges, could have an unsettling effect on residents and staff.

Key messages

In line with the findings of other research, residents from a range of backgrounds in the participating schemes valued the combination of independence and security offered by housing with care. Some of the debate around housing with care focuses on the perceived disadvantages of age-segregated housing. This study demonstrates that, from residents' perspectives, age-segregated living is seen to offer a number of advantages to living 'in the community', notably a sense of security and – for some – sanctuary, and opportunities to engage with the wider community on their own terms.

Those involved in this study reported a wide range of motivations for moving, and decisions were often driven by a complex mix of different concerns and needs, including needs for accessible, affordable and secure housing, as well as access to care and support both now and in the future. Staying put was simply not an option for many people. For those with care and support needs, housing with care offered a more attractive option than other alternatives available to them.

Being part of a community appeared to offer some advantages. There is evidence of 'solidarity in ageing' and mutual support, particularly in those schemes where residents had lived over many years. Residents welcomed the opportunities for informal and formal social activities. There were mixed attitudes towards disability in the different settings and, in line with other evidence, the very frail, housebound or cognitively impaired appear more likely to be on the edge of social groups and networks. This would suggest that staff and organisations need to be more proactive in assisting these particular groups with social activities. Similarly men are almost inevitably in the minority. More thinking is required in terms of activities and spaces that accommodate the preferences of male residents.

Space standards within the home were a particular concern of residents in some schemes. The main message here is that more space is needed for 'living', not just for 'functioning'.

Only a very small minority of people across all the schemes felt that they did not have some say in how the schemes were managed and organised. Of particular interest, and perhaps contrary to current thinking, is the general unwillingness of many residents to become involved in committees or formal mechanisms for resident consultation. Overall it seems that what the majority of people wanted was good, clear information, particularly around any changes to services or major disruptions such as refurbishment plans, and also the opportunity to put their views across to the management organisations or care staff. Perhaps where people wanted more control or input was in their home environments (for example, choice about white goods if these were provided, or control over centralised heating systems).

Sharing facilities with the wider community was evidently a controversial issue for many residents, who expressed concerns about security and inconvenience. Nevertheless, this view was not universal, and others welcomed the opportunities for social contact that greater links with the wider community brought.

3 What makes schemes distinctive

This comparative evaluation was designed to identify differences and similarities between the participating schemes and to identify any particular factors that influenced the schemes generally and/or particular elements of the schemes, and the experiences and levels of satisfaction of residents. Schemes were chosen because ostensibly they were all providing a similar combination of housing with care. All schemes had 24-hour (usually sleeping) staff cover, and residents had their own 'home' within the scheme. Nevertheless no scheme was quite like another. Four key factors appear to make schemes distinctive. These are:

- reliance (or not) on public subsidy
- 'selection' or 'entry' criteria adopted by managing organisations
- size of the schemes
- location and design of the schemes.

Reliance on public subsidy

The organisations that operated the participating schemes were distinctive, as shown in Table 3.

Schemes developed as partnerships between housing associations and local social services were more likely to be responding to local needs and existing service provision, and to draw on previous organisational experience of similar developments. Schemes that were not partnership projects were able to exercise more autonomy in comparison with those schemes that were partnerships between housing associations and social services. To a greater or lesser extent, depending on their financial status, they were able to deliver and/or develop services and new elements of provision within their own schemes, often drawing on their own financial resources. Practice could therefore have the potential to be more innovative, although there could also be a danger of working in isolation.

Table 3 Characteristics of organisations operating the schemes

	MC	SC	PGV	DH	W	HH	BTV
Status of parent organisation:							
Charitable trust	✓		✓			✓	✓
Not-for-profit company		✓					
Housing association				✓	✓		
Numbers of similar schemes:							
One-off scheme						✓	✓
Single scheme but more planned			✓	✓	✓		
One of several/many similar schemes	✓	✓					
Other housing-related developments:							
Extra care housing for older people only	✓	✓				✓	✓
Housing provision for people of all ages			✓	✓	✓		
Source of development capital:							
Parent organisation – 'gifted'						✓	✓
Parent organisation – 'commercial basis'			✓				
Partner organisation(s)		✓		✓	✓		
Fundraising/donations	✓						
Geographical coverage of organisation:							
Local (e.g. specific town/ city/county)					✓	✓	✓
Regional		✓	✓	✓			
National	✓						
Location of scheme:							
Within or on edge of a city		✓	✓			✓	
Within or on edge of a town/ village	✓			✓	✓		
Self-contained rural setting							✓
Status of clients:							
Owner-occupiers/ leaseholders only		✓	✓				
Tenants only				✓	✓	✓	✓
Mixed tenure	✓						
Main sources of funding for clients:							
Self-funding			✓				
Self-funding (often including state benefits)	✓	✓		✓	✓		✓
Services subsidised by organisation						✓	
Other facilities within scheme:							
Generic housing for older people				✓			✓
Extra care housing	✓	✓	✓	✓	✓	✓	✓
Plus NHS/social services facilities	✓			✓	✓		
Plus respite and/or long-term care	✓		✓			✓	✓

MC: Moorlands Court; SC: Sycamore Court; PCV: Pine Grove Village; DH: Delphinium House; W: Willowbank; HH: Hawthorne House; BTV: Beech Tree Village.

Organisational attitudes also impacted on service delivery, ways of consulting with residents and attitudes towards engaging with the wider community. For example, partnership schemes were more likely to be developed as a social hub or resource centre for the local community. Moorlands Court provided a service hub for the wider community, with a social services day centre and an NHS chiropody service in the central complex. This scheme also provided the office base for a variety of services (e.g. social services home care team). These features, together with the volunteer programme consisting of over 80 volunteers drawn from the local community, meant that there was a steady flow of non-residents into the scheme with an inevitable impact on residents, particularly on their feelings about what constituted 'our home'. This situation was similar to one in another smaller scheme, Delphinium House, where part of the organisational brief in relation to Supporting People funding included involving the wider community in scheme activities.

As noted above, locating services for the wider community within schemes is not always what residents want and, on the basis of current evidence, does not appear to promote significant community integration.

Across all the schemes, regardless of the type of organisation, residents were on the whole satisfied, although some did have complaints or concerns. Different schemes were also at different stages in their development and new services were still bedding down. Nevertheless it is clear that from the perspective of the majority of residents, housing with care works well regardless of provider status. With regard to residents' levels of satisfaction, the reputation of the organisation, or previous knowledge or experience of a particular landlord, often influenced residents' decisions to move, although decisions to move were also mediated by a range of other factors.

Entry criteria

All the schemes had entry criteria. Age, the capacity to live independently, needs for care, and income were the key variables. In addition, three schemes only accepted people who lived in a defined geographical area. Five schemes required residents to be above a certain age (the lowest being 55), although three schemes also accepted younger people with disabilities and related care needs. Three schemes required applicants to be in good health or relatively good health when they moved to the scheme and pass a medical or have a doctor's report to verify their health status. Conversely other schemes required residents to have defined care needs. In these cases applicants were jointly assessed by housing and social services staff to

ensure their suitability for the schemes and that care needs were sufficient to justify a placement, but not beyond the capacity of care services within the schemes. In line with the conditions of their charitable status, two schemes asked residents to declare their financial assets. Residents with assets over certain levels were not able to join the schemes. For the two schemes where residents purchased the lease on their properties, residents clearly needed to have a certain amount of capital to move in; indeed one scheme required applicants to have a 'financial check' before they were accepted.

In addition application procedures could be fairly lengthy depending on the demand for the scheme, the assessment process and how waiting lists operated. Very few of these schemes could routinely provide accommodation in a crisis, although as vacancies arose where there was a waiting list, people in the greatest need were usually given priority.

Two of the charitable trusts operated a closed assessment process where the final decision on applications rested with the trustees of the charity. Applicants were interviewed extensively as part of the application process. Although it was difficult to get explicit comment about how decisions were made, it was clear that those who appeared to be 'problematic', usually because of poor mental health or alcohol problems, were unlikely to be accepted. One organisation was open about the dilemmas it faced in balancing the needs of its frail and elderly residents against those of individuals who were clearly in need of assistance and support, but were likely to be fairly disruptive to the existing community.

> One's got to be aware that this is a community and we find it very difficult to try and balance up the need to keep the community peaceful – I suppose is the word – or harmonious and somebody who has obvious needs and really needs looking after. And this must be an ongoing dilemma everywhere.
> (Interview with staff member, Hawthorne House)

The entry criteria predetermined the social, economic and physical composition of each community of residents with consequences for the homogeneity of the schemes. The population of each scheme was – in effect – fairly carefully controlled by each of the managing organisations at the point of entry. It is clear that, although older people could choose to apply to any of the schemes, they could not 'choose' to live there.

Circumstances where a move to alternative accommodation would be required were less clearly defined. Where schemes had care homes, clearly there were

opportunities to offer more intensive care within these settings; however, the presence of a care home did not necessarily guarantee former residents a place. For example, the cost of a place in the on-site care home in one charitable trust scheme was above the level that local social services would pay, thus residents could find themselves placed elsewhere if they required financial assistance from local social services. In other schemes, decisions regarding whether residents required more intensive or specialised care were made on an individual basis. Some staff questioned whether explicit exit criteria were required.

Size of the schemes

The largest of our schemes were village-style schemes – Pine Grove Village and Beech Tree Village. Pine Grove Village provided 152 bungalows with a 42-bed care home on a 12-acre site on the edge of a provincial city. Beech Tree Village has 278 cottages, a block of 49 self-contained apartments for people who need support to maintain their independence, and an on-site nursing and residential home with almost 100 places that had formerly been the hospital for the scheme when it was first built. The scheme was set in a 240-acre estate. Hawthorne House was the next largest scheme, although this was spread across three sites, one a courtyard complex of approximately 80 flats in a provincial city centre, the second a smaller, new development of 54 flats out of the city centre, and a 13-bed nursing home in the city centre. The remaining schemes contained between 40 and 60 flats, all on single sites and in single buildings.

It may be anticipated that certain economies of scale apply to larger schemes and therefore greater opportunities exist to offer more services from within schemes themselves. Although this may be the case with non-care-related facilities and amenities, the range of care services on offer within schemes did not appear to be a function of size itself. For example, a small scheme – Moorlands Court – offered both residential and respite care. Interior facilities such as a laundry, guest facilities and alarm calls were similar across the schemes, with a range of leisure provision most often located centrally within the scheme, or in an easily accessible prominent position.

Features which did vary in relation to the size of schemes were the availability of amenities and external facilities. While such features might be considered unessential, they were attractive elements and greatly appreciated by the residents. For example, the biggest scheme, Beech Tree Village, had two chapels, a small swimming pool, a (resident-managed) guest house and accommodation for staff

and their families. Additionally, the scheme had a club house, a post office and extensive open formal gardens and open space. These all offered opportunities for meeting neighbours and catching up on local developments, and generated a shared sense of belonging. Staff accommodation was also provided on site. The scheme resembled village life as it is more widely understood; it was occupied by a mixture of generations, those who were economically active and those who were not.

The two largest schemes had more activities on site, led either by the organisation itself or by residents. This was in part because of a larger resident group, but also in part because of the additional facilities and amenities in the scheme (for example, it is possible to organise a keep-fit group, yoga class or art group if there is space where these activities can take place). Such groups and activities in turn led to greater opportunities to establish relatively self-contained communities. The two largest schemes were less centrally located, thus the need for more amenities on site was potentially greater.

For those schemes located in town centres there may have been less pressure to provide on-site entertainment and catering. Residents could and did use local services – for example, local pubs and cafés for lunch. However, there was no apparent consistency in approach to these kinds of provision in respect of size or location. For example, Moorlands Court (a smaller, centrally located scheme) provided regular meals, an array of entertainment opportunities and the use of a minibus, as did Pine Grove Village.

Linking to current interests in the social well-being of older people, there appeared to be significant social advantages for residents who lived in the larger communities. People were more likely to find others with shared interests simply because there were more people. Similarly, frictions or difficulties between particular individuals or groups could be diluted in a wider group of people. All the schemes were highly feminised environments in terms of both residents and staff. In larger schemes there were greater numbers of men, although they were still in the minority, and thus more opportunities for male company and interest groups. Exercise and education classes, outings and 'special events' became more viable because of greater numbers of potential participants. In the larger schemes there was a much more diverse range of usually resident-led activity and interest groups. Our observations suggest that in the larger schemes residents expressed a greater sense of collective identity, and a sense of belonging to something that increased motivation to contribute to the community in some way. There was also a greater sense of 'solidarity in ageing' (see Chapter 2). It may, however, be unwise to see this as attributable to the size of the scheme as there may have been other factors at work, for example the nature and reputation of the managing organisation or the profile of the residents themselves.

It is important to note that all the larger schemes required residents to be relatively fit and well at the point of entry. Moreover the findings of the study of Berryhill Village (Bernard *et al.*, 2004) show that larger communities could promote cliques of residents, leaving some feeling excluded and marginalised.

Location and design

The location and design features of the schemes were also extremely important influences on how the schemes operated and on residents' daily lives. Location was of crucial importance to residents, and ease of access to facilities outside the scheme determined how facilities within schemes were used or needed. The location of schemes was determined by the resources and sites available at the time the schemes were developed.

Residents' views towards the design of their homes have been covered in some detail in Chapter 2 above. Perhaps the most important points to briefly reiterate here are those related to space for living, and to ensuring that design takes account of a range of impairments and disabilities.

Key messages

No scheme was quite like another. Four factors appeared to shape the schemes – reliance on public subsidy, the entry criteria adopted, the size of the schemes, and their location and design. Those schemes that were not dependent on statutory sector funding had the potential to be more innovative; however, partnership schemes were more likely to be responding to local needs and existing service provision, and could draw on previous organisational experience of developing similar schemes.

Partnership schemes were also more likely to be the hub or centre for resources for the wider community. However (see Chapter 2 above), shared resources could inconvenience residents and impinge on their sense of home and ownership of their schemes, and did not appear to greatly enhance community integration.

At the heart of current policy is the issue of choice and extending choices for older people. While housing with care schemes such as those participating in this evaluation do indeed extend the range of options for some older people, residents could not choose to live in any of these schemes. They had to meet various eligibility

criteria at the point of entry. Similarly it is not clear under what circumstances residents would have to move to different types of facilities and how much choice they might have in such circumstances.

The size of schemes does not appear to influence the range of care services that can be offered; however, it does influence the variety and range of facilities and amenities available to residents. In addition, larger schemes appear to offer some social advantages to residents.

4 Services and resources

This chapter describes and examines the nature of services which were accessible to those living in the schemes. The chapter draws extensively on information provided by managers, staff and residents within each participating organisation. As may be anticipated, on-site services and the nature and frequency of care provided varied across the sample in relation to the aims of and funding sources for each scheme. Levels of care, support and other services provided within each scheme at the time of the fieldwork are broadly summarised in Table 4. Note that the service charges in this table are indicative, and although accurate when the data were collected may not reflect exactly current charges and rents.

Selection criteria and their impact on services and resources

As noted above, a requirement for those wishing to move to some schemes was that they had specific care needs, and, at the other extreme, some schemes required potential residents to be relatively fit and active on application. However, although selection criteria varied, the services provided within schemes were strikingly similar.

Initial selection: assessment and service planning

All schemes viewed selection and therefore accurate initial assessments of residents' needs as essential to overall service provision and to the long-term stability and viability of the scheme. The social, physical and economic composition of each community of residents was determined at an early stage in line with the purpose and function of the scheme.

Assessments of different aspects of a person's needs and resources were made in different ways. At Moorlands Court, Delphinium House and Willowbank the levels of needs that could be accommodated, subsequent care plans and agreement to funding might involve several agencies, which together determined individual access to services. Pine Grove Village assessed both health status and financial capacity to afford to become resident. Assessments for the general rented accommodation at Hawthorne House and Beech Tree Village were tied to fairly low levels of physical need and financial status. At Sycamore Court, clear indications were given as to the type of needs that could be accommodated within the schemes in promotional material and at visits by prospective buyers.

Table 4 Levels of care, support and other services

	Accommodation	Care and support provided/charges	Other services and facilities
Moorlands Court	Single complex (refurbished Victorian building with new-build additions) 31 one-bedroom flats 8 two-bedroom flats Respite care and residential unit: 15 beds Lifts to all floors All properties for rent Located in centre of small town Close to local amenities and public transport	Care and support core hours 7 a.m. to 10 p.m. daily to residents in flats Residents have individual care plans and packages Care and support provided by in-house teams All residents visited daily 24-hour emergency communication system linked to Respite Care Unit (with waking carers for overnight support) Support from team of approximately 80 volunteers Single flat £841 monthly (including: rent £374; support £209; non-support services £58; catering £208) Double flat £1,144 monthly (including: rent £410; support £222; non-support services £94; catering £416) Individual care packages charged separately	Meals: lunch and tea provided as part of package in centrally located restaurant with on-site catering Conservatory/lounge and courtyard garden Coffee bar (volunteer-led) Hairdressing NHS chiropody Assisted bathing provided by NHS Office base for: social services home care team; volunteer community project; Talking Newspaper offices; WEA and U3A; NHS Community Mental Health Team Social services day care centre (30 places five days per week)
Sycamore Court	Single complex purpose built 47 two-bedroom flats 6 one-bedroom flats All properties leasehold Located in residential area of a large city Close to local amenities and public transport	1.5 hours assistance per week from the housekeeping assistants Extra help available from housekeeping assistants paid for by owners at cost. Note residents may also opt to purchase care from other providers 24-hour emergency communication system with on-site sleeping staff cover Leases sold at current market rate Annual service charge £4,200	Meals: lunch and tea provided as requested, with on-site catering Residents' lounge Communal garden Handyman and gardening service Double guest room with en suite shower room Laundry room Wheelchair store with facility to recharge batteries

(Continued)

Table 4 Levels of care, support and other services (Continued)

	Accommodation	Care and support provided/charges	Other services and facilities
Pine Grove Village	21-acre site with central complex 152 one- and two-bedroom bungalows, each with a garden plot and parking space Care centre for respite and longer-term residential/nursing care; 42 beds including 11 elderly mentally infirm beds All properties leasehold Located on the outskirts of a small city Close to limited local amenities and public transport	Bungalows: up to 21 hours per week based on assessed needs 24-hour emergency communication system in bungalows 24-hour waking night cover in care centre Leases sold at current market rate Annual community charge (covering all care, support and other services): couple £8,999; single person £5,081 Note range of options available for payment	Self-service café and coffee shop (use optional); on-site catering Licensed restaurant with waiter service Assisted dining room Health activity centre with spa pool Community shop (managed by residents) Hairdressing salon Guest room Maintenance and gardening Communal facilities: arts/crafts room, music room; library; computer room with internet access; minibus 24-hour CCTV monitoring of site Daycare nursery is attached to the care centre
Delphinium House	Single complex (refurbished hotel) 35 one-bedroom flats 5 two-bedroom flats Lifts to all floors All properties for rent Located in a small coastal town, 200 metres from the sea front Close to local amenities and public transport	Care and support core hours: 7.30 a.m. to 10.30 p.m. Flexible or specialist care is available outside the core hours for specific service users if requested by social services Care and support provided by in-house team 24-hour communication system with sleeping night cover All residents visited daily Total monthly charge: £954 (including rent, support charge and service charge) Individual care packages charged separately	Café 3 communal lounges Laundry Library Roof garden Treatment room Guest room 2 assisted bathrooms Hair salon Computer room Resource room Ground floor and first floor: 2 GP surgeries; pharmacy; chiropody clinic and community nurses

(Continued)

Table 4 Levels of care, support and other services (Continued)

	Accommodation	Care and support provided/charges	Other services and facilities
Willowbank	Single complex 32 one-bedroom flats 3 two-bedroom flats 3 two-bedroom bungalows Lift to flats All properties to rent Village location, two miles from a small town, adjacent to a sheltered housing development. Limited local facilities and transport	Care and support core hour: 8.30 a.m. to 5.00 p.m. Each resident has their own care plan and care is provided by the LA Care provided by dedicated social services team Support provided by housing association Telephone alarm service is provided linked to individual dwellings with at least one carer on site throughout day and night External volunteers assist some residents with shopping Rent and service charges (including rent, catering and support) per week: one-bed flat 1 person £166; one-bed flat 2 people £212; two-bed flat 1 person £210; two-bed flat 2 people £220; bungalow 1 person £172; bungalow 2 people £211 Individual care packages charged separately	Bistro Courtyard sensory garden 2 communal lounges Twin guest room for visitors Laundry Assisted bathing Part-time nurse-led clinic, where physiotherapy and chiropody are also delivered
Hawthorne House	(1) 80 one-bedroom flats in city centre courtyard complex of Grade I/II listed buildings (2) 54 one-bedroom flats in new purpose-built development outside city centre (3) Nursing home: 11 permanent beds, 2 respite beds in city centre location All properties to rent Public transport and amenities easily accessible to both elements of scheme	Care staff on duty 24 hours Residents have individual care plans and packages All residents visited daily Care and support services provided by in-house team Emergency call system in each flat Rent and service charges Weekly payment of £55 in city centre and £84 in new development covering rent, support services and heating Any additional support from social services home care charged separately	In both complexes: laundry, chapel, communal lounge/dining room with wide-screen TV, video and Sky facility, communal gardens, guest room In new scheme: lounge and conservatory, roof gardens, hairdressing facility, hydro bath Main offices located in city centre complex

(Continued)

Table 4 Levels of care, support and other services (Continued)

	Accommodation	Care and support provided/charges	Other services and facilities
Beech Tree Village	(1) 278 cottages (2) 49 extra care flats in new, purpose-built block (3) Residential home: 44 nursing home beds, 46 residential home places (4) Private nursing home All properties to rent Extensive 240-acre parkland estate, 2.5 miles from a small town and local amenities Local bus service runs to the site	Limited support services to cottage residents (including info/advice on benefits/pensions and Supporting Independence worker, transport around site) Community alarms to cottages if requested via local social services. Home care to cottages provided by LA Extra care flats staffed 24 hours (sleeping night cover). Each resident has individual care plan and care package Care services provided in-house to both extra care and residential homes Some use of resident volunteers Cottages: rents for cottages ranged from £292 to £564 per month Monthly amenity charge for cottages £63 Extra care: rent £95 per week; service charges £42 (including electricity and hot water); support £30. Lunch £3.50 per day Individual care packages charged separately	Bowling green and putting green Village stores and post office (operated by trust) 2 churches Therapy swimming pool Clubhouse (bar, restaurant and conservatory) Resident-run charity shop Resident-run library Launderette Village hall Guest house Meals provided to extra care flats Main organisational offices on site Staff accommodation on site Extensive communal gardens and grounds (including fishing ponds, woodland, allotments) GP surgery on site 2 afternoons per week (emergency appointments only). Falls Prevention Programme (with PCT)

Balancing needs and resources was a constant requirement and presented challenges to managers of services, particularly in those schemes which were in their early stages of development.

> When people were originally assessed, they're assessed on a balance of so many low, so many medium, so many high and what happened when they moved in, everybody shot up to high … and we've only got very few on low needs now. So I wouldn't be taking any more high needs for instance, I'd be taking medium needs because the needs are increasing all the time so I've got to be very careful to keep the balance because of the staffing levels that I've got and the hours that I've got.
> (Interview with service manager, Moorlands Court)

In this scheme needs were linked to establishment hours. These were influenced considerably by the nature of the contract held with the local social services department.

In those schemes which had longer histories and less pressure to meet external funding source requirements (Hawthorne House and Beech Tree Village), the same dilemma in terms of needs was present. However, this seemed likely to be recognised overtly and guarded against at the point of entry: residents had to have low-level needs when moving to live there. At Pine Grove Village, at a relative midpoint in its developmental history, early decisions about a mix of needs at initial assessment had been revised in order to give priority to fit and healthy residents.

Responding to changes in need

Keeping pace with changes in levels of needs was an important part of routine management practice. Some schemes (Delphinium House, Hawthorne House, Willowbank) provided daily (optional) pop-in services to all residents. Moorlands Court offered daily check-up phone calls to tenants. Pine Grove Village and Beech Tree Village relied on direct approaches from residents themselves, as well as informal observations from staff and other residents. Pine Grove Village also offered pop-in visits, but only for those assessed as needing this service rather than on a routine basis.

Reviews

Where particular needs were identified at the point of entry, these were routinely reviewed in all schemes. For some funding sources these were a requirement. Reviews involved extensive formal work, and the implications for management of resources were immediate, as illustrated by this scheme manager:

> Any review that takes place we would always have the tenant there, any family members that wished to be present, the key worker and the assigned social worker and in some situations I will attend those meetings as well.
> (Interview with service manager, Delphinium House)

The extent to which others were seen to be involved in reviewing residents' needs differed considerably. Some schemes had formal structures which included members of staff from various levels of the organisation; others supplemented more formal structures with picking up information and views from staff on an ad hoc basis in order to be in touch with changes in residents' capabilities.

Support services

Drawing distinctions between care and support within the schemes in this study was a challenge. In terms of service delivery in some schemes, 'care' and 'support' were funded differently, and for this reason what was 'care' and what was 'support' needed to be differentiated. Thus a worker funded by Supporting People would not be found carrying out personal care tasks, and a care-funded worker would not be doing domestic work or taking people shopping. In practice, however, in some schemes the same staff were delivering both care and support through a joint contract, which could result in a fairly complex working environment.

> The way we sort of structure is that we have specific times of day when care is taking place, and specific times of day when support is taking place, although that's not to say that some care doesn't happen during support hours, for whatever reason.
> (Interview with service manager, Delphinium House)

Achieving clarity with staff in carrying out their roles was important in some schemes in order to avoid overstepping the boundaries between where care ends and support begins, for example staff in a support role might ask, 'Why can't I just

do the hoovering for that person?', instead of working to enable residents to do it for themselves. Achieving clarity with residents was not always a simple task, and in some instances residents complained about the apparent withdrawal and deterioration of services. In one scheme, payment for support was reorganised on the basis of paying for what was received as distinct from being built into an overall charge. This had prompted misunderstandings among residents about what they would be asked to pay for:

> When that first came out in April there was a bit of a hoo-ha about it. People were up in arms saying we'll be charged if we press our pendant, so it was quite difficult to get across that that wasn't the case and situations like that were already accounted for as part of the support charge. *[It's]* settling down now, but it's been a slow couple of months to get everybody happy with it.
> (Interview with service manager, Willowbank)

Bureaucratic divisions in relation to funding streams were difficult to communicate *within* schemes, both to residents and staff, and any changes to services could appear to de-prioritise individual needs and have an unsettling effect on residents.

In schemes which were not accountable to differing funding sources for provision of staff (Sycamore Court, Pine Grove Village, Hawthorne House), such bureaucratic boundaries were elided although delineation was not altogether avoided.

Sources of care and support services within schemes

All schemes provided forms of care and support services from within their own resources with the exception of the 'village' (as opposed to the extra care) element of Beech Tree Village where a Supporting Independence worker assisted residents with links to other agencies providing care and support. Care services and the community alarm services for the residents in the cottages in the village were sourced from the local council. Residents were directly responsible for organising this themselves. In this respect there was potential for high levels of care and support being received without awareness from the scheme itself, and conversely for needs to remain unmet.

Those schemes which provided care and support in-house consistently noted that a degree of flexibility could be extended to service users in respect of responding to need and developing the nature of provision.

> People are in some respects getting a better service here than they would for instance if they were in the community receiving a domiciliary care package at home. They are very time-bound there. You couldn't ring up on a Tuesday and say 'Well actually I don't want my call at eight o'clock tomorrow, I'd like it at nine', because that has a major impact on every other person that's using that service. Because staff are based in the project we can be a bit more flexible around that, so we do have days where tenants say 'Well actually I'd quite like a lay in later today, is it OK if I have my care delivered later?' and we can do that within reason. (Interview with service manager, Delphinium House)

In situations which required an increase in externally funded care or support there were degrees of freedom around this for a limited period; however, more formal arrangements had to be made were the situation to continue. Providing differing forms of service from within a single organisation and on a single site offered the strongest potential for flexibility and responsiveness in relation to need.

Utilising appropriate initial selection criteria has to be matched with an understanding of how to ensure that residents' changing needs can continue to be met by services. Schemes approached residents' changing needs by initially increasing care and support within residents' own homes. Later stages might involve a move to other forms of care and support within the schemes where possible, or a move to a different care environment. All schemes aimed to assist individuals for as long as possible.

Out-of-hours care

With the exception of the village element of Beech Tree Village, all the participating schemes had 24-hour staff cover although this was often sleeping staff cover through the night. Carers were relatively limited in what they could do if they were called by a resident during the night, and usually there was only one member of staff on duty. Generally their role was to reassure and call emergency services if these were required. Indeed there was an expectation that calls for assistance in the night should be relatively rare, and waking night cover was only provided within the care home element of schemes. There needed to be a critical mass of residents who needed regular assistance in the night to justify the provision of waking night cover, or more than one carer on duty. It was also clear from discussion with staff that there were concerns as to how much assistance could or would be provided by community nurses out of hours to residents in their own homes.

Residential and respite care services

Three schemes in the study (Moorlands Court, Pine Grove Village, Beech Tree Village) had some form of provision on site for residential or respite care. A further scheme (Hawthorne House) had its own small care home with nursing facilities. In Pine Grove Village these services were located within the central complex of the site. At Moorlands Court they were located on an upper floor. Provision at Beech Tree Village was situated on one of the entrance roads of the site, separate from the majority of accommodation. Residential provision in Hawthorne House was adjacent to although separate from the general accommodation. Largely because of location, it was possible for residents of the wider schemes to bypass those living in the residential or respite care provision except in Pine Grove Village.

Residential and respite care provision were intended to allow easy transition from one form of accommodation to another and, in some situations, to enable movement back and forth from residents' flats or bungalows, for example during a period of convalescence. A varying proportion of residents in these parts of the schemes had come directly into the care home and had not previously been resident in the scheme. As with other aspects of provision in the schemes, these specialist facilities changed over time, evolving in response to such things as demand, changes in the residents and changes in funding opportunities. Residential care provision in Moorlands Court had started life as a respite unit, but had then altered its purpose and function in line with demand and was in the process of 'getting the balance right' between the two aspects of provision.

Those responsible for the organisation and management of these specialist units saw them as integral to the fundamental organisational aim, namely that of providing flexibly for changes in levels of need without the upheaval of selecting and moving to new accommodation. There appeared to be little overlap between the different elements of provision within schemes, for example there were usually separate teams of staff and clearly delineated operational boundaries.

Moving on

A corollary of having the capacity to respond to changes in need is developing a shared understanding of when needs can no longer be met. Those schemes that had on-site residential care facilities appeared to come closest to being able to offer a home for life.

None of the schemes appeared to have specific criteria which stated the circumstances under which a move either to the care home element or to alternative accommodation would be sought. Only one scheme (Delphinium House) had formally developed 'move-on' procedures available to the research team, setting out the responsibilities of the organisation in assisting residents with finding suitable alternative accommodation rather than defining the circumstances when residents would be required to move. Most staff we met across the different schemes felt that as residents' needs changed, the possibility or not of meeting those needs would be discussed on an individual basis, thus fixed 'move-on' criteria were not required.

> Somebody who's been in a long time who is very, very close to all staff, it's very difficult to say the words 'mum needs to move' or 'dad needs to move', but it's a team decision. If I think somebody maybe needs a little bit more care than residential I would ask the team first, 'Do you think we should keep this lady? Can we cope with this lady? Have we got the staffing to cope with this lady? Is it fair on the other clients that we've got?' It's discussed as a team.
> (Interview with service manager, Moorlands Court)

The most commonly agreed challenge for those working within schemes in the study was their capacity to care for those residents who developed dementia-type illnesses. All schemes were reluctant to initially select residents who suffered with dementia, although there was a general will to provide for those residents who developed dementia-type illnesses while they lived in the scheme. Pine Grove Village had invested considerable resources in dementia services, developing staff skills through training and working with residents to raise dementia awareness. This had proven beneficial for staff and residents.

> So they've *[staff in residential care unit]* all had some kind of dementia training, mental health training and it's funny cos I mean they were frightened of it *[dementia]* to start with and very few wanted to do it but, you know, quite a few have warmed to it and feel a lot easier because they actually feel more confident in how they handle it, you know, and supported in it.
> (Interview with service manager, Pine Grove Village)

The agreed points of strain for all service sectors within schemes were around behaviour which became challenging in some manner. Wandering behaviours were a particular concern, as were what staff perceived as the misuse of alarm cords, particularly during the night when there was sleeping night cover.

> *[We]* can cope with a certain level of dementia/confusion – gently remind people where they are, but *[we]* cannot cope with challenging behaviours, doesn't work for the rest of the residents, particularly when people are wandering into other people's rooms.
> (Interview with service manager, Beech Tree Village)

Recently Valleley *et al.* (2006) have published a detailed study of the role of extra care housing in supporting people with dementia. Although the care and support of people with dementia was not a central focus of our study, our findings echo those of Valleley *et al.*, particularly regarding how best the needs of residents with challenging behaviours can be met in schemes where the promotion of independence is a central ethos.

Service integration and staffing arrangements

The benefits of bringing together general care and support services for people living in their own homes and residential units within one setting were clearly seen at the level of management. Different forms of liaison and communication took place between those responsible for general care and support and those responsible for the more specialist units, potentially facilitating the planning and prioritisation of scheme residents' needs.

> *[Support in residents' homes]* comes from *[care manager]* and her carers unless they feel that the person isn't coping and they're not able to manage them out there and then she will pop along and say well so-and-so's a little bit, you know, I just think perhaps they ought to be coming into *[residential home]*, so I'll go over or *[accommodation manager]* will go over and just have a chat and, you know, assess the situation. What we try and do is to keep them in *[their homes]* with the carer for as long as possible.
> (Interview with service manager, Pine Grove Village)

The proximity of managers who were responsible for different service elements was seen as extremely beneficial. Such co-location presented informal opportunities to exchange information and details about service progression and residents' needs.

> I can go to day care and get some residents into day care, I can go to *[manager]* on respite and say 'Can you help me out with this?' and she will do, if she's got availability of course. So yes, we work together quite closely.
> (Interview with service manager, Moorlands Court)

In schemes where service managers came together formally as a functional group (Moorlands Court, Delphinium House), the 'team' nature of provision overall allowed each manager to develop an understanding of different elements of the service and their respective strengths and difficulties.

While boundaries for responsibility and practice were clearly understood by those at management level, the boundaries between different aspects of the schemes were often more difficult for front-line staff and residents to grasp. For example, where specialist units employed waking night staff it was not always easy for residents to accept that they were unable to call on these staff rather than someone who was 'sleeping over' for support if needed (Moorlands Court, Pine Grove Village, Hawthorne House, Beech Tree Village). Similarly, and particularly at times when staff were working outside office hours, some staff would see their logical reference points to be those who had expertise in specific areas and who were located nearby, as shown in this discussion with a group of care staff:

Home carer 1: And we're out there *[working in the scheme]*, if we've got a medical problem, you know, we can't call in the nurse in here *[residential unit]* cos she's not allowed out, we're out there on our own aren't we?

Home carer 2: Yeah.

Home carer 1: So what I always do is …

Home carer 2: We have to make the decision whether to call the doctor or call an ambulance.

Researcher: So it's quite a responsibility?

Home carer 2: Oh yeah.

Home carer 1: And it's quite frightening sometimes, not at the time when you're getting on with it but afterwards you're …

Home carer 2: You've been in quite a few situations like that *[name].*

Home carer 1: I have but all I've done is I've rung 999 to get professional help.

Home carer 3: We can't call on anyone from here *[residential unit].*

(Focus group with care staff, Pine Grove Village)

At the level of front-line practice, this kind of division was often regarded as unhelpful and not in line with the perceived overall 'integrated' aim of the scheme.

Particularly for those working on the front line, opportunities to incorporate practice insights into decision-making processes were seen as part of the purpose of the organisation. Where these opportunities apparently were not available or were not being utilised, staff could quickly become dispirited.

Across the schemes the presence of integrated services provided a sense of security for both residents and managers of services. Residents knew their likely options if their needs changed, and managers could work together to prioritise residents with fluctuating needs.

> We had a lady who fell and broke her leg, so she came and had her hip done and came just for convalescence really. A couple of my permanent clients *[on respite/residential]* are from the *[general accommodation]* who are more needy, so yes, which I like because it's very much integrated … I think it's nice because people who need more care know the staff, I mean even though I work upstairs I still go downstairs in the restaurant and I meet the clients from the flats and I think the fact that they're still in *[this scheme]* is not an upheaval for them, because they're still in *[this scheme]*, they're still seeing regular faces, they've not been moved completely out of the building somewhere.
> (Interview with service manager, Moorlands Court)

Catering, housekeeping and general maintenance services

The provision of non-care services was an integral part of the daily life of the schemes, contributing to the personal, social and domestic well-being of residents, and to their sense of security and community.

With the exception of Hawthorne House and the village element of Beech Tree Village, all schemes provided on-site catering. In some schemes residents were expected to take their meals in the dining room as part of their tenancy, which was not always welcomed by residents. Nevertheless, having access to a decent cooked meal every day was of high importance to most people, particularly those for whom cooking and shopping were onerous. Moreover, mealtimes gave structure to the day and provided opportunities for social contact with other residents and with staff. In addition to the regular meals service, most schemes could cater for functions

– birthdays, Christmas parties and other special occasions. Such events were of significant importance in creating shared experiences and memories, and a sense of belonging and community. The quality of food was always a discussion point with residents.

Catering, housekeeping and maintenance staff all played a key part in contributing to the identity of the schemes and enhancing residents' well-being.

> Perhaps if I notice in the laundry that tenants who are supposed to do their own washing but they're not well or they're not coping, and I go back and report it.
> (Interview with member of housekeeping team, Delphinium House)

Volunteers

Only Moorlands Court made extensive use of volunteers from outside the scheme. A part-time co-ordinator managed and supervised more than 80 volunteers who carried out tasks that were essential to the functioning of the scheme, for example staffing the reception area at the secure entrance to the scheme and providing administrative support to managers and shopping, visiting and befriending services to residents. An active volunteer element brought the benefits of integrating the local community within the scheme. Other schemes offered less structured volunteering opportunities: for example, a team of residents in Beech Tree Village volunteered in the extra care and residential provision on site, and Willowbank had a number of volunteers from external organisations coming into the scheme. At the later stages of the project, Delphinium House was developing plans to incorporate organised volunteers into the scheme, driven primarily by a member of staff funded by Supporting People monies.

Cost of care and support to residents

Residents of those schemes where properties were rented paid a weekly or monthly rent and/or a service charge. These charges differed, sometimes significantly, across the schemes both in their amount and the services covered. Usually care needs were assessed and these services charged on an individual basis. Where residents were leaseholders, once the lease had been purchased, monthly or annual service charges were made. Pine Grove Village had a unique, insurance-type funding arrangement for care services.

The first point to make is that (with the exception of Hawthorne House, a charitable trust, which was in the enviable position of being able to subsidise its services to residents) all these schemes were costly places to live. For rented schemes, rent, service and support charges for a single flat were usually around £800 to £900 per month (in 2006), and more for double flats. Individual care packages were charged separately and residents were usually encouraged to claim Attendance Allowance when this was appropriate. For the same period, average fees for residential care in the private and voluntary sectors amounted to approximately £1,600 per month (PSSRU, 2006) – though this obviously included payment for care received. The two leasehold schemes made annual service charges to residents of more than £4,000 per person and, at the time of the data collection, the market price of a lease for a two-bedroom property in both schemes was approaching £200,000. Many residents were fairly vague about how much they were paying for services and service charges.

The two leasehold schemes were obviously of restricted affordability. Many although not all of the residents in the remaining schemes received some state assistance. Attendance Allowance in its current form is not means tested but other benefits are. Thus some people who did not qualify for means-tested support could find the schemes expensive places to live, and affordability was a concern for some of those we met. As noted in Chapter 2, most residents felt that in comparison with other alternatives such as residential care, housing with care generally did offer value for money. In some instances, however, although residents had assessed needs for particular kinds of care, they were reluctant to purchase the care as it did not appear to them to be value for money. There may be a danger that residents might choose to buy less care than they need, which may in turn compromise the financial viability of schemes where staffing levels are based on the assessed needs of residents.

Key messages

On-site services and the nature of the services provided varied across the different schemes, and this appeared to be related to aims and funding sources for different schemes. Balancing needs and resources was a constant and challenging task for managers.

Those schemes where care and support services were provided in-house appeared to be able to respond more flexibly to changes in need.

Distinctions between ‘care’ and ‘support’ appeared to be somewhat artificial, and often were a consequence of different funding mechanisms rather than a response to different patterns of need. Such distinctions were also difficult to communicate to front-line staff and residents.

Every scheme was committed to supporting people in their own homes as far as was possible and none of the schemes had defined ‘move-on’ criteria. On-site residential and respite care provision allowed changes in need to be met without the upheaval of moving to new accommodation. There were significant benefits at the level of management of having a residential care unit and more general services within one scheme, as this allowed planning for residents’ future needs. However, boundaries between different elements of the schemes could be difficult for front-line care staff and residents to comprehend (for example, home carers not being able to call on nursing staff in the residential unit for assistance).

In line with the findings of other research, the needs of people with dementia-type illnesses, particularly those with challenging or wandering behaviours, could not easily be accommodated within the schemes evaluated here.

All staff, whatever their tasks and roles, contributed to the well-being and comfort of the residents. The use of volunteers, drawn from both residents within schemes and people outside, provided opportunities to enhance services and integrate schemes with the wider community.

The service charges in all the schemes were considerable and many of those residents who were self-funding were concerned about the affordability of services.

5 Meeting and balancing needs

One of the main objectives of this study was to develop a greater understanding of how different models of housing with care met the different needs of individuals at different points in their lives. Here we consider different types of needs and how well they were met in different schemes.

Housing need

Much of the discourse around housing with care has focused on care needs and care services, no doubt reflecting the interest in the use of housing with care as an alternative to residential care provision. This study shows, however, that the housing needs of older people should not be underestimated. Many of the residents, particularly in those schemes where there was an expectation of being in good health at the point of entry, were primarily seeking a secure, accessible and affordable place to live in later life. Financial difficulties, divorce, the breakdown of informal living arrangements with friends or relatives, the loss of accommodation linked to employment once people retired, and insecurity of tenure are all examples of reasons why people were seeking housing (see Chapter 2 above). In addition, some participants' former homes had become disabling environments as they grew older (for example, a lack of facilities within the property that could not easily be remedied such as flats without lifts, inaccessible locations or anti-social behaviour in the neighbourhood).

Support needs

Although many residents who participated in this study were very happy with the services they were receiving, there were still apparent 'service' gaps that were often filled by volunteers from outside the schemes, fellow residents, or residents' families. These gaps were often related to 'support' as distinct from 'care' needs (although, as noted above, the distinction between support and care can be artificial). In some cases, this 'informal' input was integral to the functioning of the schemes and the well-being of individual residents, and indeed contributed to a sense of community. It was clear, however, that some residents, particularly the older and frailer residents and especially those with no family support readily available, or those living in schemes where there was not an active volunteer base, could be relatively isolated

and lonely and some might struggle to meet some of the schemes' expectations of independence.

Working with voluntary sector agencies, local volunteers and resident volunteers appeared to be one way of drawing in more support services (for example, assisting people with shopping, lifts to church or hospital appointments and, crucially, going out to social events or functions). Encouraging volunteers from the wider community also helped promote the profile of the scheme locally.

Care needs

A key question for providers is whether housing with care can provide a realistic alternative to care in a residential home. Housing with care was offering an alternative to many of the residents we met. Many would have been living in residential homes had they not been living in housing with care, often not because they needed excessive amounts of care, but simply because they were frail or in poor health, or needed an environment that was accessible and safe, with the knowledge that help was at hand should it be needed. Others we met had previously lived in residential care and found housing with care a preferable alternative. This is not to say, however, that all needs could be met within a housing with care setting. Some clearly could not.

Although 24-hour staff cover was usually available, carers were relatively limited in what they could do if they were called by a resident outside the core hours of care provision. When residents did call frequently on out-of-hours care, this could prove to be the catalyst for considering other care options.

Evidence indicates that there is a general lack of knowledge about how best to provide end-of-life care in housing with care settings (Croucher, 2006; Croucher *et al.*, 2006). This study indicates that some schemes could and did provide end-of-life care, but most usually within the on-site residential care facilities. In all instances, as in local community situations, external support (such as Macmillan nurses) would be drawn upon to assist residents as needed. Over the course of this study all schemes reported small numbers of deaths among their residents. In some cases, residents had been able to die in their own homes; however, in others, hospice, nursing home or hospital care had been required. The capacity of schemes without on-site residential care to provide care to residents with chronic health problems and increasing needs who are approaching the end of their lives is perhaps questionable, although in practice this should be possible if the right resources are put into place.

Again there is a tension between the promotion of independence and the needs of those with chronic, life-limiting conditions.

Caring for people with mental health problems

Across the schemes, care services appear to be geared towards supporting people with physical disabilities and illnesses, and less attention generally appeared to be directed towards the needs of people with mental health problems, including people with dementia-type illnesses. In two of the schemes, however, younger people with long-standing functional mental health problems were being successfully supported by scheme staff. The safe environment worked very well for these individuals who would have had difficulties with independent living in the community. Their presence appeared to be tolerated rather than welcomed by other residents.

Although most of the schemes could support people who were becoming confused or forgetful, only Pine Grove Village could provide care for people with more challenging and difficult behaviours and this was within the care home element of the scheme. This study and other evidence (Croucher *et al.*, 2006; Valleley *et al.*, 2006) suggest that housing with care cannot at present easily support people with dementia-type illnesses or challenging behaviours. Some staff we met questioned whether 'independence' was a realistic objective for people with dementia.

Health care

In those schemes where a GP surgery or nurse clinic was held regularly on site, there were clear benefits to residents and staff. Residents were reassured by knowing the facility was there and that they did not have to face a journey to a surgery, and the staff had the opportunity to discuss concerns with nurses or GPs when they were visiting. As others have highlighted, housing with care offers advantages to district nursing services in particular as it facilitates the efficient targeting of services and preventative initiatives (Valleley *et al.*, 2006).

In terms of nursing services – for example, district nursing and more specialist nursing such as Macmillan nurses – there were many examples of close working between care staff and nursing staff. It was evident, however, that health care professionals are not always clear about the purpose and ethos of housing with care. There were examples of health care providers assuming that greater levels of care were being provided to residents than was the case. Similarly there were instances

when additional support from health care providers (for example, out-of-hours visits by district nurses) enabled residents to remain in the housing with care scheme, and conversely the absence of this support promoted a move to a different setting. There needs to be awareness building of the purpose and function of housing with care among a range of health care providers.

Key messages

The 'housing' element of housing with care is not secondary, nor should housing need be a secondary consideration in allocation of places. The quality of accommodation and its capacity to provide comfortable, manageable space for living were key factors in generating satisfaction within schemes, particularly with regard to feelings of independence.

There appears to be an inherent tension between the promotion of 'independence' and the needs of some very frail older people. Moreover, the levels of funding available from Supporting People grants do not appear to be adequate to cover a wide range of support needs, particularly around social activities and engagement. If housing with care schemes are to focus on promoting independent living, there needs to be a realistic assessment of the type of support services that need to be in place (and provision of appropriate resources) to sustain these concepts.

Resources for housing with care must include appropriate support from community health and specialist health care services. There needs to be greater clarity on the part of health providers about exactly what housing with care can provide and similarly the types of services, particularly community health services, that will be required. We are thinking here particularly of community nursing services and general practitioner services – including out-of-hours cover.

6 Lessons for practitioners, commissioners and policy makers

In this final chapter we consider the main lessons that can be drawn from this evaluation to inform the development of housing with care schemes in the future. First, we consider whether there is a single or dominant model that appears to work best. We then consider how well housing with care serves different types of needs, and the main lessons for the physical design and location of schemes. Finally we consider what this study has added to the existing evidence base.

Is there a dominant model?

A question this evaluation has tried to address is whether there is a dominant or single model of housing with care that works best. It became clear through the course of the evaluation that it was difficult to make judgements about comparative effectiveness. The size of schemes, their location and design, eligibility criteria, provider organisations and the partnerships that were in place made each scheme quite distinctive (see Chapter 3). Reflecting on this study (and the evidence from previously conducted studies), we would argue that currently there is no single dominant model that works best, although those schemes participating in this study with an on-site or linked residential care facility came closest to providing a 'home for life'. Similarly larger schemes appeared to offer some advantages to residents with regard to social networks, activities and additional amenities and resources that might not be viable in smaller schemes.

From the perspective of residents, no single model appeared to be more greatly favoured or to generate lesser or greater levels of satisfaction. The majority of those residents who participated in this study felt that housing with care works well for the most part. It is the combination of security and independence that is so attractive. Where residents did have complaints these were usually related to their individual accommodation (see below).

Selection criteria

Although all the participating schemes have extended the range of options for older people, all the schemes operated some sort of entry criteria, thus choices for older people still appear to be relatively constrained.

The resident profile in each of the participating schemes was quite distinctive, and this was due in no small part to the application of various eligibility criteria which allowed communities of people with similar life experiences and backgrounds to develop. This may be contrary to current notions of inclusion – one of the concepts at the heart of housing with care (see Riseborough and Fletcher, 2003) – nevertheless from the perspective of residents who were living in the schemes an element of selection was not unwelcome. From the perspective of managing organisations, eligibility criteria were essential to ensure that the needs of residents who came into the schemes would not overburden the care resources available within the schemes, and in some instances ensure that the new residents would not disturb the equilibrium of the existing community (see Chapter 3 above).

There was an absence of explicit 'move-on' criteria in the schemes. It was clear that some needs could not always be met (see below); in some cases this required a move to a different element of the scheme, or to a completely different care setting. When asked, many staff questioned the need for explicit move-on criteria, as they felt that needs should be assessed on an individual basis, and were eager to ensure that, where possible, residents could remain in the schemes. We would, however, welcome more explicit mechanisms for decision making at the point where residents' needs can no longer be met (see also Oldman, 2000), and at least a commitment from managing organisations that they will assist residents to find suitable, alternative accommodation. Our concerns here are particularly for those people who do not have close family or others who can advocate on their behalf, and who may find themselves having to seek alternative accommodation at a point when they are most vulnerable or ill. We did not explore the sensitive topic of next or final moves with residents, nor did we talk to former residents who had moved on to other care settings. This is perhaps a limitation of this project.

Legally landlords can evict tenants with assured tenancies, but they are required to make alternative living arrangements. We are not clear what the position might be where an individual is a leaseholder or holds some other type of tenure agreement. We note too that the introduction of the Mental Incapacity Act may have implications for managing organisations, particularly if residents can no longer live in a scheme as a result of cognitive impairment.

Housing need

As noted in Chapter 5 above, much of the attention directed towards housing with care has focused on care needs and care services; however, the housing needs of older people should not be underestimated. The main message here is that the housing element of housing with care is not secondary, nor should housing need be a secondary consideration in the allocation of places. As noted in Chapter 2, the quality of the accommodation and its capacity to provide a comfortable, manageable space for living were key factors in generating satisfaction with schemes, particularly with regard to promoting independence. Many of the participants had moved from properties that had over time become 'too big' for them, with the associated concerns about maintenance and upkeep of the properties and gardens as well as concerns about affordability (for example, council tax, heating, cost of repairs etc.). If older people are offered attractive housing choices, it seems likely that this could facilitate the release of much needed family homes, both in the social and private rented sector, and onto the open market.

This study demonstrates that some older homeowners are willing to give up homeownership. They may want increased flexibility or reduced responsibilities for the property or they may want to release some of their personal property-related equity. Others may not be able to afford to continue as homeowners into later life. This suggests that there will need to be a wide range of flexible packages for leasing and/or renting properties within this sector of the market in the future to make it attractive to older people from a variety of housing backgrounds. The tenure choice of older people, particularly given the increasing numbers of older people who are homeowners, is a topic that is worthy of further investigation.

Support needs

As noted in Chapter 5, in a number of schemes there were apparent 'service gaps' often related to support as distinct from care, and some of the oldest and frailest residents, particularly those without the support of close family, may struggle to meet providers' expectations of independence. Indeed, there appears to be an inherent tension between the promotion of independence and the needs of some very frail older people. Moreover, the levels of funding available from Supporting People grants do not always appear to be adequate to cover a wide range of support needs, particularly around social activities and engagement. If housing with care schemes are to focus on promoting independent living, there needs to be a realistic assessment of the type of support services that need to be in place (and provision of

appropriate resources) to sustain these concepts and indeed a wider discussion of what provider organisations *and* older people understand as 'independence'.

Working with voluntary sector agencies and local volunteers is a way of enhancing support services, and is to be welcomed for the opportunities it creates for promoting schemes in the wider community.

Care needs

One of the biggest challenges for providers is to keep pace with the changing needs of residents. Effective assessment at the point of entry and regular review are an essential part of management. In-house co-ordination of provision appeared to provide the greatest flexibility in response to changing needs (see Chapter 4 above).

While many care needs could be met, there are areas of practice which could usefully be further explored, particularly if housing with care is to provide a realistic alternative to more institutional type models of care. These include:

- care and support of those with long-standing mental health problems
- care and support of people with dementia-type illnesses
- out-of-hours/night-time care
- end-of-life care.

Perhaps a key point here is that housing with care is not a panacea for all older people's housing, care and support needs. This study and other evidence suggest that housing with care cannot easily support people with dementia-type illnesses or challenging behaviours. The need for alternative provision must be addressed.

Similarly, more careful consideration is required of how well housing with care can meet the needs of those with chronic, life-limiting health conditions who are approaching the end of their life. Guidelines for end-of-life care in care homes have recently been published by the NHS End of Life Care Programme (2006) and the National Council for Palliative Care. Current policy places a determined focus on ensuring dignity at the end of life and developing best practice in end-of-life care for older people with a range of chronic conditions across a range of settings (Department of Health, 2003, 2005, 2006; End of Life Care Programme, 2006; Seymour *et al.*, 2005). Again this is an area of practice that could be further explored.

Health care agencies should be closely involved in the development of the housing with care schemes. There needs to be greater clarity on the part of health providers about exactly what housing with care can provide and similarly the types of services, particularly community health services, that will be required. We are thinking here particularly of community nursing services and general practitioner services – including out-of-hours cover. Where possible, the option should be explored of having some general practitioner or nurse practitioner sessions provided within the scheme. Where such services are in place, they appear to work well from the perspective of residents and staff.

Physical design

Space for living

The design of individual dwellings and overall scheme layout are as crucial to the maintenance of independence and quality of life of residents as the provision of care and support services. As highlighted in earlier chapters, there are a number of messages around the design of individual dwellings and schemes. Space standards within individual dwellings need to be as generous as possible. There needs to be space for living – entertaining, hobbies and pastimes, room for treasured possessions and storage for household appliances, tools and so forth. Currently the focus of design appears to be on wheelchair access; however, other types of disability, for example sensory and cognitive impairments, appear generally to be less well understood or addressed in design terms. Individual dwellings also need to be designed with thought given to future adaptation or installation of aids and equipment, and with thought towards how well the spaces within individual dwellings will allow carers to assist residents.

Careful thought also needs to be given to smaller design details. For many of our residents, it was these that caused them frustration and annoyance – fiddly window catches and locks, cupboards that were difficult to access, location of electrical sockets, heating controls and so forth.

Individual versus communal spaces

One way of mitigating the limitations imposed by the size of the accommodation was for schemes to provide a range of communal facilities on site, for example by

providing communal laundry facilities rather than space for a washing machine in each home. It was clear that there were trade-offs to be made by residents in terms of choosing to move into some housing with care schemes and being able to continue performing daily living tasks within their own home. For some residents there was no option in this regard, and they required an environment where tasks such as washing could be done by others. However, for those residents who could undertake these kinds of tasks, there was an issue about how far this kind of choice should be built into the design of their homes.

Within schemes, spaces where people can meet and also encounter each other informally are important. As noted earlier, garden spaces, patios and balconies are greatly valued by residents.

Designing for the future

A balance was also required in relation to meeting the current needs of older people while enabling schemes to meet future requirements and aspirations. An important aspect of the provision of accommodation was the amount of technology that the majority of current residents were comfortable using. The over-riding messages seemed to be: keep the technology simple and robust.

Links with the outside community

The issue of sharing facilities with the wider community was evidently a controversial one for many residents, who expressed concerns about security, inconvenience and a sense of intrusion into their ‘home.’ Others, however, welcomed the opportunities for social contact that greater links with the wider community brought.

Using community facilities to generate income is problematic and not something that was always appreciated or welcomed by residents. A key issue here for providers is to manage the expectations of residents with regard to the role and purpose of the schemes, both before residents move in and on an ongoing basis, to minimise the risk of tension and anxieties.

Costs and affordability

This study was not designed to explore the cost-effectiveness of different models of housing with care or to compare it to residential or nursing home care. However, there are key points that can be made regarding costs and affordability.

The charges made to residents are not inconsiderable. In some schemes many residents were reliant on state benefits, and there may be some danger that if levels of benefits change, schemes may not be affordable to those who are self-funding. For those who were self-funding, housing with care could be expensive, and there was some evidence that some residents chose not to purchase some elements of care within schemes because they thought it was expensive. If schemes are developed and staffed on the assumption of given levels of need within the resident group, the viability of schemes may be threatened if residents choose not to 'purchase' services. For the most part residents felt that housing with care provided better value for money than other options, because of the advantages of independence and greater privacy.

In those schemes where some residents might be self-funding and others in receipt of means-tested benefits, frictions between those receiving benefits and those not were consistently reported. Residents need independent, confidential and accurate advice regarding benefit entitlement and financial management.

New schemes may need to make convincing cases locally that housing with care offers value for money in order to attract capital and revenue investment. It may be argued that housing with care plays a preventative role by supporting older people's independence, as well as preventing hospital admissions, facilitating early discharge from hospital and delaying/preventing admission to long-term care. The wider range of benefits to residents, including the impacts on national objectives such as independence, well-being and choice, should also be considered.

Building on the evidence

In their review of research evidence presented to the Royal Commission on Long Term Care, Tinker *et al.* (1999) concluded that very sheltered housing was one of a range of options for older people, but not a panacea. They made a number of key points regarding very sheltered housing:

- Although there were high levels of satisfaction among residents, there were a minority who would have preferred to return to their own homes.
- The ability of schemes to provide an alternative to institutions was questionable as there was evidence of a lack of care services.
- Very sheltered housing was more expensive in terms of resource costs to the public purse than staying at home.
- Many people had been directed towards very sheltered housing rather than making a positive choice of this type of provision.
- Haphazard allocation procedures resulted in a lack of clarity regarding the kinds of needs that very sheltered housing was intended to address.
- There was a lack of clarity around the purpose of very sheltered housing.

Our study and its companion literature review allow further development of some of Tinker's conclusions. This study has found high levels of satisfaction among residents across a range of housing care schemes; however, there were people who were concerned about some aspects of the schemes, most usually around the detail of design, or charging policies for services. Very few expressed concerns about the concept of housing with care, and most felt confident that they had made a good decision when moving to these settings. The combination of security and independence allowed them to be 'at home', but not 'in a home'.

Very few participants in this study had been directed towards housing with care. Indeed, the eligibity criteria of different schemes meant residents were chosen. Allocation procedures were not haphazard, although they did vary considerably from scheme to scheme. Providers are clear about the types of needs that their individual schemes can address. While schemes such as those participating in this study do allow greater choices for some older people, there is no single or dominant model. Overall it would seem that housing with care still remains a highly variable form of provision. The importance of linking the evidence from this and other studies, and facilitating the rapid dissemination of findings and promoting learning networks, cannot be overemphasised.

Tinker's conclusion that it was questionable whether very sheltered housing could be used as an alternative for residential care is supported by the evidence review. This study demonstrates that some schemes can and do provide an alternative to residential care; however, there are tensions around the capacity of housing with

care to accommodate individuals who have high-level care needs and still remain true to the concept of promoting 'independence' in later life. Providers are also concerned that housing with care should not become 'like a care home'. Decisions as to whether a particular resident can be cared for in a particular setting are made on an individual basis, and can depend very much on the capacity not just of the housing with care scheme, but on other local services (for example, community nursing), to provide a package of services. Housing with care schemes cannot exist in isolation, but need to be embedded in wider national and local strategies for older people's services.

Above we have noted a number of areas where further research could usefully be undertaken, for example around the provision of end-of-life care and the tenure choices of older people. We would also note that there are some gaps in the evidence base that this study has not addressed. For example, it would be helpful to know more about the role of housing with care in addressing the future housing and care needs of older people from black and minority ethnic communities. Similarly it was our observation that a significant proportion of care staff were from a variety of different ethnic groups. This could present particular challenges to residents, staff, and managing organisations. For example, staff whose first language was not English needed opportunities to improve their language skills, there could be differences in attitudes towards death and dying, and indeed differences in attitudes towards ageing and older people. Given the growing numbers of care workers from abroad, it would be useful to explore this particular issue further.

A final point to be made is that the agendas on older people's housing and services are changing. There appears to be a greater awareness of the need to consider and plan for the demographic changes of the next two decades. Much work has been done recently to suggest and develop different mechanisms for paying for care needs in the future. Affordable housing is also a key policy concern. Schemes such as those evaluated here offer lessons for policy makers and planners, and evaluations such as this may help us address some of the crucial current and emerging policy questions.

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Appendix 1: Residents' topic guide

Explanation and consent

Restate the role and objectives of the research: 'The University of York is comparing eight different kinds of retirement housing/community for older people across the UK to better understand which types of retirement housing older people prefer and the reasons they like to live there. The research is being funded by the Joseph Rowntree Foundation.'

Establish that respondent(s) understand the reasons for the interview and what their role within the interview is.

Restate that the duration of the interview will be between 45 and 60 minutes, though this in part depends on how much someone says. Explain that the respondent(s) can withdraw their consent for the interview at any time during the interview and that they are not expected to answer any question they would rather not answer.

Explain that the respondent's (or respondents') answers are confidential, but that they may be quoted in an anonymised form: 'We may report or quote what you say, but not in any way that could be used to identify you or allow someone to guess who you are.' Seek consent for use of recording equipment.

Do they have any questions?

There will be another chance to ask questions about the research at the end of the interview.

A About the interviewee(s)

A1 Age

A2 Gender

A3 Ethnicity

A4 Who do you live with?

A5 Do you have any pets?

B Moving to live here

B1 How long have you lived here?

B2 Which people or events would you say influenced your decision to move here?
- health worries, yourselves/partner
- managing last home
- managing gardening
- felt isolated, wanted company
- worried about losing independence
- wanted to be nearer family, children or grandchildren
- did not want to pressure family into looking after you
- pressure from children
- pressure from professionals
- other reasons? What were they?

B3 Were there things about this retirement community or scheme that appealed to you?
- affordability and/or value for money
- location (why?)
- the immediate environment/ambience/'feel'
- design and layout of site (accessibility, attractiveness, practicality)
- the design of your home (accessibility, attractiveness, practicality)
- amenities and facilities on site (what in particular?)
- the presence of 'like-minded' people
- a way of avoiding isolation or loneliness
- care and support services on offer (any services in particular?)
- 'home for life' service
- presence of nursing/registered care on site
- presence of dementia services on site
- sense of security and safety from having help nearby
- safety and security from crime
- other (what?)

B4 Were there things about here (this scheme) that made you hesitate about moving in?
- negative feelings about any of the previous list
- how did you feel about living in a more communal setting?
- how did you feel about living in housing that is just for older people?
- did you feel segregated?

C Being a resident

C1 What is it like living here?
- best aspects
- worst/bad aspects
- or just your likes and dislikes …

Physical environment

C2 Could you tell me what you think about the design of your home?
- best aspects
- worst/bad aspects
- layout
- space
- privacy
- comfort (particularly temperature control)
- security
- noise
- positioning/accessibility of key features such as bathing facilities
- storage.

C3 Could you tell me what you think about the design and the layout of the site/community/scheme generally?
- worst/bad aspects of design and layout of the site?
- do you feel secure here? Too much/not enough security?

C4 Is it easy to move around the scheme/site?

C5 Is it easy to go to other places from the scheme/site?
- public transport links
- taxis (cost and availability)
- do they have a car? What difference does that make?

Activities

C6 Are you involved in any activities in this community/scheme?
- work through list of scheme-specific activities
- seek views on those activities in which respondent(s) participate
- if do not participate in activities, why?

C7 Do you think your social life and leisure activities have improved since moving to this scheme/community? Why?

Representation and control

C8 Do you have anything to do with the residents association/committee?
- what sort of role? elected? attend meetings?
- what do you think about the association/committee?

C9 Does the business/charity/almshouse/RSL listen to tenants (residents or customers) enough?

C10 What are the rules and regulations like when you live here?
- particular rules that are good or bad?
- rules on pets.

Community

C11 To what extent would you describe this scheme/here as a 'community'? Is there a 'community spirit'?

C12 How much time do you spend outside the scheme? Day to day? Holidays (and do you take protracted holidays)?

C13 Would you say that this scheme/community suits certain types of people more than others?

C14 What is it like living with other older people on a shared site/in a shared building?

Social support

C15 Day to day, would you say you had enough company?

C16 Do friends, family or neighbours pop in and see you?

C17 Are the staff or volunteers here friendly? Are any of them your friends?

Amenities

C18 What do you think about the range of amenities on offer?
- work through list of amenities specific to that scheme/community
- is there anything lacking in terms of amenities? (what?)
- underused or rarely used amenities? (why?)

C19 What amenities do you use the most and use the least? Why is that?

C20 Do you think you make the best use of the amenities that are available to you here? Why is that?

Management

C21 What do you think about the management of this scheme/community?

C22 If you have something you wish to complain about, or comment about, or if there is something you would like to see changed in some way, who do you approach?

C23 What do you think about the staff here?
- attitude of staff towards residents
- attitudes of residents towards staff.

D Care and support

D1 What sorts of help can you get here?

- someone to take you to the shops
- someone to go shopping for you
- someone to help you manage bills or money
- someone to help around the house (cleaning, odd jobs etc.)
- someone to help with the garden
- someone to pop in and see how you are
- an alarm system to call help if you need it
- someone to help with things like getting up or washing yourself
- meals cooked in, or delivered to, your home
- registered care home/extra care facilities (where present)
- help for people with dementia.

D2 Have you had any of the sorts of help we have been talking about? Which ones? What sorts of help does that involve?

D3 On the whole have you been satisfied, or dissatisfied with any care services you have received?

D4 Do you receive care from outside agencies such as the district nursing service or other NHS services, social services or charities?

D5 What about your family (if present)? Do they 'check up' on you?

D6 Do your family, neighbours or friends ever pop round to check on you?

D7 What about you popping in to see how neighbours or friends are, do you do that?

D8 Are there any new services you would like to see here?

E Affordability and value for money

E1 If there are differing fee structures or payment plans in the scheme, establish which one they are on (*where applicable, i.e. resident(s) or tenant(s) are making direct payments of one form or another – may not apply to at least some almshouse residents*).

E2 How affordable is it here?

E3 Was the level of any fees/rent that you have to pay something that influenced your decision to move here?

E4 Has the affordability changed over time? For example, have rents or fees risen more than was expected?

E5 Is it good value for money? How does it compare with any alternatives you are aware of, or which you may have considered (referring back to decision to move)?

F Income

Preface this section by stating that they do not have to answer this question if they do not want to.

F1 Does living here make a difference to your living costs?

G Lessons for the future

G1 In your experience what are the most important lessons that can be learned from here that might be applied to other schemes/communities?

G2 How did your expectations of the scheme/community prior to moving here compare with your experience of living here?

H Overall

H1 Overall, how happy would you say you are with life here?

H2 Was it a good decision to move?

H3 Any regrets or problems about living or moving here that we have not talked about?

H4 Any good things about moving or living here that we have not talked about?

H5 Anything else you would like to say or feel we should have talked about?

Ending the interview

Thank you very much for taking the time and trouble to talk to me/us. This kind of research is very dependent on people like yourselves agreeing to participate in the work.

We will send copies of the reports we produce from this work to all the schemes/ communities that have participated in the work.

Do you have any final questions that you would like to ask me/us about the research?

Appendix 2: Interview with key informants – generic guide

A Own role and responsibilities

I'd like to start by knowing a bit about you and your own role within [this organisation] and something of your professional background and experience.

A1 Can we start by you telling me how you came into post?
- when this was, and what the post was then
- what you did previously, and other jobs/background details
- extent to/point at which involved in development of organisation (impact of history)
- clarity of role when came into post.

A2 Can you tell me what your current job entails?
- description, key responsibilities
- reporting to whom – key relationships; manager in relation to: deputy (?); staff and team residents as individuals and as a group
- networks across the boundary of the organisation (peer orgs, company itself)
- clarity in role, determined by whom
- degrees of freedom/autonomy around role: own supervision and what purpose this serves
- extent of responsibility for decision making (what kinds, how achieved)
- main areas of difficulty/challenge
- main areas which work well.

B The development of the organisation and its model of support and care

B1 Can you tell me a bit about your own involvement with the development of the scheme?
- the scheme in overall terms
- aims and vision
- how differs from peer organisations.

B2 And what about now, how would you describe the main objectives of the scheme?
- are there different objectives for different groups of stakeholders? Do these differences cause conflict?

B3 Do you feel that these objectives are being met?
- short-term/long-term objectives, how performance is being measured.

B4 What do you feel are the most positive features of the organisation here?
- why are these features positive? What difference do they make?

B5 Are there any features of the organisation that you feel inhibit good performance?
- in what ways are these features inhibitive? How could they be improved?

B6 Are there any external factors that cause difficulties for the organisation of the scheme?
- statutory service providers, local labour market, relationship with wider community.

B7 How do you think these difficulties might be resolved?

B8 What do you think about the overall approach (ethos) which this scheme has? (*Probe for engagement with overall philosophy.*)

C Administration of the organisation itself

C1 Can you describe to me the kinds of administration systems you use?
- monitoring systems and record keeping
- quality assurance
- evaluation and review
- financial procedures (effective/efficient management of the business)
- safe working practices (moving and handling, fire safety, first aid, maintenance, security … ?? full list or what??)
- relationship of your area of responsibility to the overall organisation.

D Staffing

D1 What is your experience of recruiting and retaining staff?
- good points, difficulties?
- any particular staff groups, local labour market, reasons why there might be any problems?

D2 How would you describe the morale of your own staff here?
- and staff here in general?
- reasons for these being so; negative and positive aspects of working here?

D3 How would you describe your own involvement with staff?
- collaborative stance, hands-on, walk the floor, through others
- feels to be in touch with what's taking place
- preferred approach
- staff autonomy in day-to-day practice.

D4 How would you describe the relationship between the residents/tenants/service users and the staff here?
- conflicts between residents' expectations and staff responsibilities/roles.

E Working with residents/tenants/service users

E1 How do you keep informed of residents' views about living here?
- through the regular residents committee and other residents groups, formal complaints procedures, informal contacts with residents and staff.

E2 How satisfied do you think that residents are generally with services here?
- what are the main areas of satisfaction/dissatisfaction? Are there particular groups of residents who seem more/less happy than others with the scheme?

E3 And can you describe to me the sense of community which exists here?
- are there apparent splits between different groups of residents, or other possible sources of division?

E4 What more might be done to develop this scheme as a community?

F Evaluation and review

F1 What arrangements are in place generally for monitoring what takes place?
- means of feedback from different groups: residents, staff, relatives, wider community
- inspection arrangements, which bodies?

G Relationships with other organisations/services

G1 What role do you play in relationship to other organisations?
- level of inter-agency working: health, housing, voluntary sector
- what this entails for this manager.

H Likely areas for change in the future

H1 Any plans for development of your service, of the scheme in general?

I Overview and closing

I1 I'd like to close by asking some general questions about the scheme.
- how would you describe what it's like to work here?
- would you recommend it to others?
- how would you describe what it's like to live here (*prompt for adequacy of provision*)?
- would you like to live here yourself? If so/not – reasons for this
- would you choose this as a place to live for your friends or relatives? If so/not – reasons for this
- what do you like least about your job?
- what do you like most about it?

I2 Is there anything you would like to add that we haven't discussed?

THANK YOU FOR YOUR HELP

Describe next steps for the research, where appropriate.