

Social well-being in extra care housing

Simon Evans and Sarah Vellely

This study looks at ways of promoting and facilitating the social well-being of 'frail' people living in extra care housing.

The well-being of older people is an important issue for policy across health, housing and social care, and local authorities are increasingly considering extra care as a way of replacing older models of residential care provision and addressing low demand for traditional forms of sheltered housing.

The researchers interviewed residents and managers from six extra care housing schemes in England to explore their experiences in terms of social well-being.

They conclude that the social well-being of tenants should be a major consideration in the planning, designing and management of extra care housing and they identify a range of factors that need to be taken into account.



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Executive summary

This document reports on a research project carried out by researchers from the Faculty of Health and Social Care, University of the West of England, Bristol, and Housing 21. The research was funded by the Joseph Rowntree Foundation and was carried out between April 2006 and March 2007. A literature review was carried out as part of this work and has been written up as a separate document. The publication of this research report is timely, coming as it does when well-being has become an increasingly important issue which frames policy across health, housing and social care.

Extra care housing

Extra care is becoming established as a popular model of specialist housing with care provision for older people. Developing extra care is a key plank of government policy in terms of its aims to promote choice, independence and well-being for older people. There are many different models of extra care in existence. Indeed, the flexibility of this form of provision is one of its key strengths, but, conversely, this very flexibility makes extra care hard to define. Put simply, extra care offers housing with full legal rights associated with being a tenant, or homeowner, in combination with 24 hour on-site care that can be delivered flexibly according to a person's changing needs. At a conceptual level, extra care is primarily housing, meaning that it should not look or feel in any way institutional. People who live in extra care developments are in their own homes. Extra care housing can be for rent, outright sale or part ownership, and some developments are mixed tenure. Extra care housing is designed to wheelchair accessible standards, and some schemes have flats which are specifically designed and adapted for wheelchair users to live in. Local authorities are increasingly looking to extra care as a strategic response to replacing older models of residential care provision, and to address issues of low demand in older traditional forms of sheltered housing. Extra care is increasingly seen as having the potential to form a base for community health services, outreach services and intermediate and rehabilitative care.

Aims and methods

The overall aim of this study was to explore the social well-being of 'frail' people living in extra care housing. Data were collected through 36 in-depth interviews with extra care residents and managers from six extra care housing schemes in England.

In selecting tenants as potential research participants, managers were asked to aim for diversity in terms of three criteria: extent of physical frailty; age; and the 'localness' of tenants. Transcriptions and written-up notes were loaded into Qualrus®, a qualitative data analysis software package, and analysed for thematic content. In addition, the Affect Balance scale was used as a self-reported measure of well-being.

Research findings

Interviews with tenants and scheme managers identified a range of factors that played a part in promoting social well-being for people living in extra care housing. The following emerged as particularly important themes.

- *Friendship and social interaction:* For many tenants, the friendships and acquaintances that they developed within the scheme were the basis of their social lives. Opportunities for social interaction focused on a range of organised social activities. For others, the ability to maintain social networks in the wider community was equally important.
- *The role of family carers:* Family members played a large part in the lives of many tenants in terms of the practical and emotional support they offered. Many of the tenants interviewed during this study had family living locally but, even for some tenants whose family lived further away, they were an important source of social contact.
- *Engaging with the wider community:* Tenants who took part in the study engaged with a range of amenities in the local community, and local community members accessed resources within the court. There was a real sense that being part of community activities that took place away from the court made life more interesting, stimulating, exciting and engaging.
- *The role of facilities:* The extra care housing schemes that took part in this project had a range of on-site facilities available. These included shops, restaurants, communal areas, hairdressers, beauty salons, gardens, day centres and guest rooms. For many tenants, such facilities served as important venues for social interaction and were at the core of their social lives.
- *Design, location and layout:* A common design feature of the schemes in this study was an indoor 'street', a central route through the scheme around which a range of facilities are arranged. If sensitively designed, this can provide a safe, dry and level environment that maximises accessibility and increases the

opportunity for tenants to meet each other for both formal and informal social activities. The positioning of schemes in rural locations presents particular challenges in terms of enabling tenants to engage with the local community.

- *Staffing issues and the culture of care:* To a large extent, the overall approach within any scheme towards tenant welfare and well-being is determined by the policies of provider organisations and the experience and attitude of scheme managers and other staff. A person-centred approach to care provision supports social well-being through key-worker systems, along with a flexible approach to spending time with tenants.

Use of the Bradburn Affect Balance Scale during this project was problematic, and insufficient data were collected to allow meaningful analysis. This highlights the difficulties of measuring well-being with a short, questionnaire-based tool.

Conclusions

This research explored the social lives of people living in extra care housing and identified a range of factors that can impact on their social well-being.

Most participants reported a high level of satisfaction with their social well-being and overall quality of life. Having their own home and the independence that it provided seemed to be an important part of this, as was the overall extra care housing environment, the friends they made within it and the contact that they had with the wider community. A minority of participants were less integrated socially and reported feeling isolated and lonely at times. This was most common among specific groups of tenants, including people with physical frailties or impaired mobility, people with cognitive impairment and single men.

Implications for practice

- The social well-being of tenants is an important factor that needs to be taken into account fully in the planning, design and management of extra care housing.
- It is important to provide and facilitate activities that are adequately funded and cater for a range of interests and abilities. Good practice could be standardised through the specification of activity requirements in contracts with local authorities.

- The opportunity to develop and maintain a social life that is independent of the housing scheme is crucial. This means facilitating tenants to engage with the wider community through, for example, accessible design and affordable transport.
- There is a need for an evidence base of good practice for supporting social well-being. The involvement of designers, local planners, service providers and other interested parties at an early stage of development is crucial to achieving schemes that are integrated with the local community.
- Restaurants and shops are important as venues for social interaction and should be considered in the core specifications when commissioning a scheme.
- Some tenants are at particular risk of social exclusion, including people who have recently moved in, people who do not receive regular contact from family or friends and people who have impaired mobility. Tenants likely to come into these categories should be identified and offered appropriate additional support.
- A person-centred approach to care provision can contribute towards social well-being. This should be based on comprehensive personal profiles developed in collaboration with tenants, their relatives and referrers.
- Key-worker systems can maximise the benefits of interaction with staff, particularly for tenants at the greatest risk of social exclusion. Staff need appropriate training and support to enable them to promote social well-being.
- Diversity is a key feature of extra care housing in terms of age, care needs, health status, cognitive functioning and aspirations. Social well-being depends on a range of stakeholders understanding and tolerating this diversity, including tenants, family carers and professionals across housing, health and social care. Clear information and good communication are key to achieving this.
- It is important that care and support services are provided and maintained outside core hours of work. In addition to ensuring that sufficient paid staff are available at these times, a number of creative solutions have been indicated in this study, such as engaging volunteers and local people with a connection to the scheme to provide activities.
- The findings of this report suggest the need for information on supporting social well-being to be included in profiles of extra care housing and other long-term care options.

- Extra care housing is well-placed to deliver the strategic objectives outlined in *Opportunity Age* (Department for Work and Pensions (DWP), 2005) of promoting well-being and the health of older people in the communities it serves. More research is needed to explore the impact that extra care has within the wider community.

Dedication

The researchers would like to dedicate this report to the memory of Pam Dudley, who sadly died before this research was completed. Pam was the manager of Oak House, one of the case study schemes in this study. We have worked with Pam over several years, and her knowledge and insight have informed the development and direction of our research. She contributed to this study on social well-being and our previous study on extra care housing for people with dementia. Pam's knowledge, expertise and commitment to promoting the well-being of older people was greatly valued and helped enormously in the production of both reports. Pam worked tirelessly to ensure that frail older people, particularly those with dementia, were included within the social life of the schemes she managed. She will be greatly missed by all her colleagues, and particularly the residents at Oak House.

1 Introduction

This research project aimed to explore how supported housing settings can promote and facilitate social well-being. The focus of the research was on frail older people in extra care housing. Although there is evidence that social support is closely linked to health and well-being in later life (Antonucci *et al.*, 1996), there has been very little research into the dimensions of well-being for frail older people in supported housing settings. A key aim of the project was to take up the themes identified in previous literature and explore them in the extra care housing context.

Definitions are problematic in the area of quality of life and well-being. Quality of life measures abound, each with a different focus in terms of what constitutes quality of life. Common approaches adopted are needs-based, satisfaction-based and psychosocial models. A key issue is that different people may value different aspects of their life to different extents, and therefore quality of life means different things to different people and at different times in the life course. There is now a growing consensus that any meaningful measure must take firmly into account what is important to the people to whom it is being applied (Bowling, 1997; Owen, 2006). An example of this approach is found in the Joseph Rowntree Foundation (JRF)-funded workbook (Riseborough and Jones, 2005), which uses a range of 'domains' based on research with older people to assess quality of life in specialist housing and residential care. There are also questions about the extent to which such measures take into account physical and cognitive capacity (Boldy *et al.*, 2006). Some writers make a useful distinction between general quality of life and health-related quality of life. The World Health Organization Quality of Life Group produced the following broad and comprehensive definition which is now widely used:

an individual's perception of their position in life in the context of the culture and value systems in which they live and in relation to their goals, expectations, and standards and concerns. It is a broad-ranging concept affected in a complex way by the person's physical health, psychological state, level of independence, social relationships, and their relationships to salient features of their environment.
(World Health Organization, 1993)

The term 'well-being' is widely used in the research literature, often interchangeably with 'quality of life' and 'life satisfaction', but often without any attempt at a definition. Where definitions are discussed, they tend to focus on four aspects of lifestyle: physical, emotional, social and financial. Social well-being, the subject of this review, can be seen as a sub-set of general well-being and is slightly easier to define. At a basic level, it is that aspect of overall well-being that relates to social interaction

and engagement. However, much of the relevant literature includes social well-being as part of a wider concept of well-being, sometimes explicitly but more often by implication. Our research study has adopted the approach of much well-being literature by focusing on a broad range of factors, including social relations, social interaction, relationships, friendship networks and social support.

Similarly, the word 'frailty' is widely used in relation to older people throughout the literature, but again there is a lack of consensus about its meaning and use. Often, the term is used with minimal consideration of its precise meaning but, when definitions are included, they are predominantly medical/biological in nature. These identify a range of chronic conditions that lead to body-wide deterioration and a decline in physical activity (Hamerman, 1999). This can lead to an assumption that to be old is inevitably to be frail and that the older you are the more frail you become. However, some writers assert that the state of frailty is largely separable from the ageing process (Bortz, 2002). In health prevention work, a range of lifestyle factors are presented as increasing the likelihood of frailty, including smoking, depression and obesity (Woods *et al.*, 2005). The current research is based on a social model, whereby the concept of frailty moves beyond purely physical conditions and is an outcome of the relationship between the individual and his or her environment. In this model, formal and informal support networks mediate the experience of frailty for the individual.

2 Background: the policy context for social well-being

Since the 2005 general election there has been a renewed emphasis on older people's issues, largely in response to the fact that an increasing proportion of the electorate is aged 50 or over. Partnership, choice and control are also at the heart of the policy agenda, along with a rights-based approach to challenging discrimination, particularly through human rights legislation and the increasing emphasis on evidence-based policy and outcomes.

Well-being is clearly an important issue for public policy, as fundamentally it is at the heart of what older people want from public services. The first report of the UK inquiry into Mental Health and Well-being in Later Life (Lee, 2006) started by asking older people about their aspirations, and their views are clear. They want freedom from discrimination, participation in meaningful activities, good relationships, good physical health and an adequate income. Consultations from other inquiries and research studies reach similar conclusions. The JRF Task Group on Money and Care for Older People (JRF, 2004) stressed the importance of looking at older people's issues from a 'whole person' perspective rather than in terms of fragmented services. It identified a range of principles important to older people, including 'being valued for their lives and experiences' and 'having the choices and control to feel independent'.

Challenging discrimination

Part of the impetus for a renewed focus on well-being comes from the human rights agenda. Help the Aged has spearheaded a campaign to challenge age discrimination by promoting the effective implementation of the Human Rights Act. The scale and impact of age discrimination has been hugely underestimated across society.

Help the Aged (Harding, 2006) makes the point that many issues associated with ageing have been couched in terms of social policy problems, using the language of benign paternalism at best, or at worst using a discourse which frames older people as being a 'burden' and a drain on the resources of the rest of society. Crucially, generations of older people have, to some extent, internalised this definition of themselves. It is this 'structural inequality', Tessa Harding, then the Senior Policy Adviser at Help the Aged argued, that has manifested itself in low expectations and self-confidence among older people.

Harding goes on to counter age discrimination with a 'rights-based' approach. The 'social model of ageing' demands that barriers are removed that prevent older people from participating fully in society on equal terms. More fundamentally, treating older people in an unequal or discriminatory way is a breach of their human rights. The Commission for Equality and Human Rights, set up in early 2007, is due to address age equality as part of its remit.

The Human Rights Act came into force in October 2000. It asserts the equal dignity and worth of each person, regardless of age, ethnicity, gender, status or other characteristics.

The Human Rights Act is of critical importance to older people, but currently its potential to promote their well-being and protect them has not been maximised. In terms of the well-being agenda, the Act requires service providers to go beyond practical help and to meet the social, psychological and emotional needs of older people. Thus, the argument continues, the rights-based approach can be used to challenge historic models of service provision to older people that are paternalistic.

The recently published '*New Ambition for Old Age*' report (Department of Health, 2006a) sets out a five year plan for recognising the human rights of older people and treating them with dignity and respect. This was supported by the launch in November 2006 of the Government's 'Dignity in Care' initiative, which aims to ensure that all older people are treated with dignity when using health and social care services.

Continuing the theme of combating discrimination and ensuring that people are able to live in communities where they can participate equally, the Disability Discrimination Act 2005 has been extended so that, by December 2007, all social housing providers need to fulfil the Disability Equality Duty (DED). As part of the DED, Disability Equality Schemes that record the disability equality work being undertaken in all the housing associations' organisational functions (from asset management to employment) must be produced and published by December 2007 as a regulatory requirement from the Housing Corporation.

From December 2006, housing associations have been required by law to make 'reasonable adjustments' to ensure that disabled people are not treated less favourably for a disability-related reason. A 'reasonable adjustment' is anything from a physical adaptation to a contractual change or a change to operational policies and procedures. This has implications for well-being in that, clearly, activities or facilities provided in housing schemes must be inclusive.

***Opportunity Age* and a raft of new initiatives to promote well-being**

Older people are becoming more actively engaged politically, and have more say on issues that affect them. The Better Government for Older People agenda has had a tangible impact on policy directions. Since the 2005 general election, there has been a renewed political focus on older people, not least because, by the time of the next election, a majority of the electorate will be aged over 50. *Opportunity Age* (DWP, 2005) is the first 'joined-up' national strategy on ageing and has a cross-cutting agenda to address the inclusion of older people. Crucially, *Opportunity Age* emphasises active ageing in communities and choice and independence in services. *Opportunity Age* was the impetus behind the development of a range of new indicators designed to assess the independence and well-being of older people, monitored against the outcomes and effects of government and local strategies for older people.

The 2006 Local Government and Public Involvement in Health Bill increased the powers of local authorities in relation to their duty to promote the well-being of local residents. It also presents more opportunities for older people to engage directly in local decision making and service delivery. The Local Government White Paper *Strong and Prosperous Communities* (Department for Communities and Local Government, 2006) stresses the importance of neighbourhood involvement in local decision making and has paved the way for a raft of initiatives such as Local Strategic Partnerships (LSP), Local Area Agreements (LAA) and the Sustainable Communities agenda (Office of the Deputy Prime Minister (ODPM), 2005). Local Strategic Partnerships aim to coordinate agencies across public, private and voluntary sectors at local level.

Local Area Agreements are three year partnerships between central and local government and local service providers. One of their current priorities is to promote healthier communities for older people. There is an expectation that LAAs will give focus to the well-being agenda and that well-being itself will be a key indicator for measuring the performance of local councils. Local Area Agreements aim to join up services and agencies locally, using pooled budgets so that a holistic approach to promoting and sustaining well-being for individuals in local communities can be delivered. Behind this is the public sector reform strategy, which seeks to break down the barriers between central and local government and between public, private and voluntary sectors.

Health and social care

In social care, the ways in which services are commissioned and provided are being overhauled. The Government White Paper *Our Health, Our Care, Our Say* (Department of Health, 2006b) emphasised a new direction for health and social care, delivering services 'closer to home'. This is seen as a resource shift from acute services to primary care in the community. Choice and control are at the heart of the new 'personalisation of services' agenda, which links to self-directed support (including direct payments and individual budgets). The thinking behind this is that individual budgets put the individual in the role of the commissioner and therefore in control of the services they receive.

The personalisation agenda is highlighted in a new commissioning framework for services, which marks a step-change in the way care and support services for older people are commissioned. The new consultation document *Commissioning Framework for Health and Well-being* (Department of Health, 2007) sets out a productive vision for the future of health and social care services, as well as providing a framework for this to take place. Rather than addressing illness or acute interventions, services will be commissioned to promote and prolong well-being. Thus the emphasis has shifted to prevention. Older people in particular should benefit from the new commissioning agenda, including potential improvements in access to crucial low-level services that prevent further, more serious ill-health.

This consultation sets out the framework that the Department of Health plans to establish for the future development of commissioning between health and social care. It aims to help commissioners by demonstrating how personalised services, the promotion of health and well-being, the proactive prevention of ill-health and partnership working can be achieved. Through eight key steps:

- 1 Putting people at the centre of commissioning
- 2 Understanding the needs of populations and individuals
- 3 Sharing and using information more effectively
- 4 Assuring high quality providers for all services
- 5 Recognising the interdependence between work, health and well-being
- 6 Developing incentives for commissioning for health and well-being

- 7 Making it happen – local accountability
- 8 Making it happen – capability and leadership.

Social inclusion and well-being

The Sure Start to Later Life (ODPM, 2006) policy is another key initiative focused on well-being for all older people. Predicated on the Sure Start method developed for children's services, this programme aims to prevent the social exclusion of older people through a cross-cutting programme of early interventions. In relation to health and social care, the report states that all older people should have access to a fair and transparent health and care service where they can be treated with dignity and respect. It is the intention to build more capacity into services, to make them more responsive to the needs of individuals, more accessible to communities and to boost preventative approaches. It is clear that issues of social isolation and loneliness cannot be solved at national government level alone.

Opportunities for leisure, learning and volunteering have been shown to be vitally important for older people in terms of enhancing their well-being, and Sure Start makes explicit reference to this. A 'decent' home is also viewed as crucial to the well-being of older people. For those older people who wish to remain in their homes, the report identifies a need for the provision of high quality adaptation services at a local level and the development of a national housing strategy for an ageing society. Older people have clearly stated that they value flexible, individualised transport services which can allow them to retain their independence within their local community. This is especially true of rural areas, where transport provision can be inadequate.

The Link-Age Plus project aims to use the Sure Start principles of service delivery to deliver locally owned, responsive, non-stigmatised and economically effective services that support dignity and well-being for individuals. This initiative is currently being piloted in eight localities, using multidisciplinary teams to develop and deliver integrated services covering welfare benefits, health, personal care and housing check-ups for all older people in the area.

The publication of this research report is therefore very timely, coming as it does when well-being has become an increasingly important issue that frames policy across health, housing and social care.

About extra care housing

Extra care, the model of 'housing with care' that has been the focus of this study, is becoming established as a popular model of provision for older people (Darton and Muncer, 2005). Developing extra care is a key plank of government policy in terms of its aims to promote choice, independence and well-being for older people. In addition to development funding from the Housing Corporation, the government has invested £147 million between 2004 and 2008 in the Extra Care Housing Fund, which is administered by the Department of Health. Its purpose is to fund and develop innovative new schemes or remodel existing sheltered housing or residential care schemes to deliver specific health outcomes. Funded schemes are required to contribute to the range of solutions aimed at preventing unnecessary admissions into hospital or residential care, and/or to assist in reducing delayed transfers of care from hospitals. Successful schemes from this investment programme also need to show how they deliver an inclusive approach for adults with long-term conditions, including learning difficulties, physical disabilities, dementia and mental health.

Alongside the funding programme, which aims to deliver 1,500 extra care housing places between 2006 and 2008, the Department of Health has commissioned the Personal Social Services Research Unit (PSSRU) to undertake an evaluation of all the funded schemes. The PSSRU has also been funded by the JRF to explore how successful the new Department of Health funded extra care schemes are in terms of delivering well-being. The PSSRU study on social well-being is complementary to this current report in that the findings documented here will be linked with the broader PSSRU well-being work, which is due to conclude in 2009.

There are many different models of extra care in existence. Indeed, the flexibility of this form of provision is one of its key strengths. Conversely, this very flexibility makes extra care hard to define. Put simply, extra care offers housing with full legal rights associated with being a tenant or homeowner in combination with 24-hour on-site care that can be delivered flexibly according to a person's changing needs. At a conceptual level extra care is primarily housing, meaning that it should not look or feel in any way institutional. People who live in extra care developments are in their own homes. Extra care is primarily about 'quality of life' not just 'quality of care' (Riseborough and Fletcher, 2004).

Extra care housing can be for rent, outright sale or part ownership, and some developments are mixed tenure. Extra care housing is designed to wheelchair accessible standards and some schemes have flats which are specifically designed and adapted for wheelchair users to live in. Local authorities are increasingly looking to extra care as a strategic response to replacing older models of residential care

provision and to address issues of low demand in older traditional forms of sheltered housing. Extra care is also seen as having the potential to form a base for community health services, outreach services, and for intermediate and rehabilitative care.

Extra care housing is proving an increasingly popular choice for older people who may need some level of on-site care and support and/or specially designed housing to help them to remain independent for as long as possible. Referrals to extra care housing are generally made by social services, though health and housing professionals also have a role in the allocations process. A holistic approach is taken when assessing need for extra care, looking at personal and family circumstances, current housing and support needs. In practice, many people move into extra care settings because of a crisis situation, such as a health emergency, accident, sudden illness or death of a partner, which significantly affects their ability to remain living independently in their homes.

For some people, extra care can be a viable and preferable alternative to residential care. In most of Housing 21's extra care schemes for rent, people move in because of an assessed care need; they and/or their partner requires care at least once a day. One of the main benefits of extra care housing is that it enables couples where one partner is highly dependent to remain living together. In cases where a couple has moved into an extra care scheme on the basis of the high care needs of one of the partners, if that person dies the surviving partner is able to remain in the extra care scheme if that is their choice, regardless of their care needs at the time.

Though the flexibility of care provision is considered one of the main strengths of extra care housing so that, as someone's care needs change, a responsive service can be reconfigured around those new demands, there are limitations. Pressure on resources, coupled with the fact that for many people, as they age in place, they need more care, means that, over time, more people in some extra care schemes are in the 'high dependency' category. This, along with increasing funding pressures, stretches the resources for care and support provision.

There is growing evidence that the ability of extra care housing to continue to provide a good quality of life for residents is predicated on having skilled and committed managers and staff who are able to respond to the challenges associated with balancing a range of competing elements. These key challenges include balancing risk with autonomy, achieving continuity of care while managing increasing staffing and resource pressures, and maintaining the independence of residents while minimising the possibility of their becoming socially isolated (Vallelly *et al.*, 2006). This research specifically addresses the challenge of how to maximise the potential of extra care housing in minimising social isolation. It was commissioned in

recognition of the fact that there is a gap in the existing knowledge base on how best to promote social well-being in extra care housing.

Kite marking

Given that the government aims to promote a dynamic and sustainable extra care market, there are a number of government funded research and evaluation projects under way with the goal of improving the evidence base for the effectiveness of extra care housing. The Housing Corporation has recently funded a project entitled 'Raising the Stakes', which aims to develop a practical knowledge resource for commissioners and providers of extra care housing. It also has the goal of raising awareness of extra care housing among older people, their relatives and advocates and the wider public. One specific output of the project is intended to be a 'kite marking' system of accreditation to improve and streamline information provision on extra care for potential customers.

The Elderly Accommodation Counsel (EAC), who are lead partners in the 'Raising the Stakes' project, describe the idea for a kite mark as something that will give confidence to consumers by:

- establishing a common language for describing all forms of housing with care for older people;
- requiring providers to be clear about their overall objectives and signed up to a process of measuring outcomes for customers against these;
- while at the same time supporting a dynamic and innovative market. (EAC, 2006)

The kite marking system is intended to be industry owned and independently managed though, at the time of writing, it is unclear what organisation would administer it, how it would be quality controlled and whether service standards will also be developed and monitored as part of the process. Some housing providers have expressed a view that the kite mark could evolve into a separate tier of regulation which may be counterproductive in terms of promoting a dynamic marketplace.

3 The research literature: an overview

This project included a full review of the literature on social well-being and older people, which has been written up as a separate document. Here, we present a summary of the main themes from that review and, in the discussion part of this report, we refer to our findings in relation to some of the themes from the previous literature.

Although there is considerable ambiguity around the use of the terms ‘well-being’ and ‘quality of life’ in the literature, there is far more consensus as to what are the main factors that promote them. For example, a UK survey of people aged 65 or over found that the most important factors in quality of life included maintaining social activities and having good social relationships, help and support (Gabriel and Bowling, 2004). Similarly, a Swedish study asked older people which of eight categories were most important to their quality of life. The most frequent response was ‘social relations’, followed by health, activities, functional ability, well-being, personal beliefs and attitudes, living in their own home and personal finances. In addition, they were asked to choose from a ‘show card’ three items that they regarded as important to quality of life. The authors concluded that social relations, functional ability and activities influenced the quality of life of older people as much as health status (Wilhelmson *et al.*, 2005).

A recent Age Concern report, *Promoting Mental Health and Wellbeing in Later Life* (Lee, 2006) identifies five key areas that influence mental health and well-being in later life: discrimination, participation in meaningful activity, physical health, poverty and relationships.

In addition, social isolation (absence of meaningful relationships and lack of social contacts) is identified as a strong risk factor for poor mental health, which is experienced by a million older people in the UK. This work also emphasises the importance of intergenerational contact and identifies the need to encourage and support older people to take advantage of opportunities for meaningful activity, social interaction and physical activity. In a study of older Americans in the general population, Larson (1978) found well-being to be most strongly related to health, followed by socioeconomic factors and degree of social interaction.

Marital status and aspects of people’s living situations were shown to be important for well-being, while age, sex, race and employment showed no consistent independent relationship. Exclusion is often identified as a barrier to social well-being. *A Sure Start to Later Life* (Social Exclusion Unit, 2006) suggests a range of factors that can contribute towards exclusion for older people, including the

difficulties of escaping from mid-life exclusion, the impact of key life events such as bereavement, the impact of age discrimination on aspirations and the environment. A recent study, carried out in Sweden and based on data from the European Study of Ageing Well (Borg and Blomqvist, 2006), concluded that life satisfaction in older people with reduced self-care capacity is determined by an interaction between social, physical, mental and financial factors.

There is increasing support for a preventative approach to promoting well-being. Godfrey *et al.* (2004) suggest the need to focus on opportunities for personal development and growth, adjustment to the experience of loss, engagement in social life, involvement in activities, intimacy/companionship, stimulation, social and practical support. Wistow *et al.* (2003) argue that well-being is an important component of successful ageing and call for a greater focus on promoting older people's quality of life and their engagement in the community.

The nature of the literature as revealed by a scoping search led to the need to broaden the search to include wider definitions of well-being/quality of life and a range of long-term care settings. Within these parameters, the following six key themes were identified: social interaction; gender, marital status and parenthood; the environment; purpose, religion and spirituality; exercise and activity; and the philosophy of care.

There is widespread consensus concerning the importance of social networks and social interaction to quality of life and psychological and social well-being (Antonucci *et al.*, 1996). The impact of social interaction comes through its role in meeting older people's needs for intimacy, comfort, support, companionship and fun. By contributing to a sense of purpose and attachment, social interaction can also ameliorate the negative impact of past events and experiences. The logical conclusion of this literature is that interventions which minimise social isolation can help increase social well-being.

There is mixed evidence regarding levels of social interaction in residential care settings compared with that for older people generally. Overall, it seems that people in such settings who are physically frail and/or cognitively impaired have lower levels of social interaction than other residents. The literature examines different types of social interaction in housing with care settings and concludes that there are more non-intimate relationships than intimate ones. However, it is the intimate relationships which are most important in terms of sense of well-being and, crucially, many of these are with family and friends from outside their housing setting. The importance of connections and networks in the wider community outside housing with care settings is a recurring theme in the literature (e.g. Owen, 2006). It is also important to

note that, while housing with care settings may be conducive in terms of friendship for some, they can be more challenging for less socially adept residents, including people with cognitive impairment and mental health problems (Croucher *et al.*, 2006).

Organised activities provide the main opportunity for social interaction in housing with care settings, particularly for long-term care residents in poorer health who may have problems getting out. Some specific activities have been shown to have an impact in certain settings. For example, regular reminiscence groups can increase self-esteem in nursing homes and access to the Internet can increase social interaction (Chao *et al.*, 2006). A range of specific interventions have been implemented to target social isolation, but there is little evidence of what works. Not surprisingly, group activities appear to be more effective than those that operate on a one to one basis. Another key finding is that some residents seek solitude rather than social interaction; the important thing is to have the opportunity and choice to interact or not (McKee *et al.*, 1999; Vallely *et al.*, 2006).

There is contradictory evidence from the literature regarding the association between gender and well-being in older age. This can be partly explained by the different nature of male and female social networks and the reluctance of older men to take part in organised social events. Some studies have suggested that significant negative life events such as widowhood have a more damaging effect on men's psychological and social well-being than on that of women (Carmel and Bernstein, 2003).

For the population as a whole, married men and women report greater levels of happiness and lower levels of stress than the unmarried, and this trend appears to be particularly strong for older people. The role of partners in providing social and psychological support seems to be important in terms of well-being.

There is little research evidence regarding parenthood and well-being for older people, and what does exist is inconclusive. This may be largely due to the seemingly complex relationship between gender, marital status and parenthood factors. There is considerable evidence that family carers provide extremely high levels of support to many people in a range of housing with care settings (Potts, 1997). It would seem logical therefore that those without such support might have lower levels of well-being, but this review found no studies that looked specifically at this issue.

There is a broad literature which acknowledges the importance of the built environment, particularly for people in long-term care settings who may rely on it to compensate for physical and cognitive impairments. Some studies have linked the design of housing with care settings to quality of life, and a range of factors have

been identified as important, including choice and control, a sense of community, normalness, comfort and personalisation (e.g. Parker *et al.*, 2004). It has also been suggested that stringent implementation of health and safety regulations in such environments can have a negative affect on the well-being of tenants, particularly those with physical and cognitive impairments. For example, the fear of injury can discourage staff from allowing free access to outdoor spaces.

Facilities play an important role in providing venues and opportunities for social interaction and the development of friendships. The provision of communal eating areas is of particular importance, although some writers have suggested that they can also have a negative impact by contributing towards the feeling of an institutional environment. Access to gardens and other outdoor spaces is increasingly seen as important in the literature (Chalfont, 2005). The benefits of these include opportunities for exercise, provision of a different social environment, sensory stimulation, access to plants and wildlife and the therapeutic effects of gardening.

There is a wide range of research literature that identifies the potential benefits of promoting purpose, religion and spirituality for older people, particularly in long-term care settings. These include greater life satisfaction, higher levels of optimism, a greater sense of self-worth and lower levels of death anxiety. One study found that spirituality was a significant predictor of psychological well-being and moderated the negative effects of frailty (Fry, 2000). Personal meaning, religiosity and spirituality contributed more significantly to well-being than did demographic variables or other traditional measures such as social resources, physical health or negative life events, particularly for institutionalised elders. However, another study found that purpose in life rather than extrinsic or intrinsic religious orientation was positively related to community-dwelling elders' subjective well-being (Ardelt, 2003). Purpose in life also has a strong association with social integration, psychological well-being and low levels of depressive symptoms. However, there is some evidence that a feeling of purpose in life may be reduced in older age owing to increasing losses such as widowhood and retirement (Pinquart, 2002).

The link between physical exercise and well-being/quality of life is unclear. Any positive effects appear to be fairly modest but may be greatest for those who are physically frail. There is, however, some evidence that moderate physical activity such as walking can prevent cognitive impairment and dementia (Jorm, 1994). Also, physical activity interventions focusing on balance and resistance training can improve physical functions and prevent falls and disabilities in daily living. Reduced ability to perform everyday tasks has, in turn, been associated with lower life satisfaction, particularly among those aged 85 and over. Crucially, it appears to be

the effect of poor health in terms of limiting the opportunities for physical activity that often leads to lowered well-being.

The importance of a range of organised activities in long-term care settings has been widely recognised by government and many health organisations. The Health Survey for England (Department of Health, 2002) has shown that women in care homes take part in more organised activities than men do, and younger residents take part in more activities than those aged 80 or over. Overall activity level is positively associated with well-being and life satisfaction for people between the ages of 50 and 74. Activities engaged in for social reasons are more closely linked to well-being than other types of organised activity. As with physical exercise, there is some evidence that the impact of social activities may be greatest for people with physical frailties. There is some evidence for the benefits of specific activities. For example, singing can improve social and emotional well-being (Hillman, 2002); activities involving humour have been found to reduce anxiety and depression (Houston, 1998); gardening has therapeutic benefits and increases social contact (Heliker *et al.*, 2000); and volunteering has a positive impact on self-esteem (Morrow-Howell *et al.*, 2003).

There are considerable differences between housing with care schemes in the number and range of activities available and a dearth of occupational provision for people with dementia in specialist care units. Most of the latter spend the majority of their time unoccupied, and there is little meaningful interaction between staff and this client group (Armstrong-Esther *et al.*, 1994).

The overall philosophy of care in an organisation and within specific housing with care settings can have a great impact on the social environment and therefore on levels of well-being. Activities in many long-term care settings tend to focus on the provision of personal care and the meeting of minimal universal needs. This can lead to a lack of stimulation for residents and low levels of staff–patient interaction. Attitudes to health and safety and risk can also be barriers to social interaction. Some authors have suggested that relationship-centred care offers significant advantages in terms of quality of life for older people (Nolan *et al.*, 2004). Opportunities for service users to be involved in decisions about care delivery and service development on an ongoing basis are increasingly seen as central to a sense of well-being. However, older people in a range of residential settings appear to have relatively low levels of participation in such decision making.

Overall, the literature identifies some key factors in promoting social well-being for older people. Although the literature relates to a wide range of environments, it is likely that much of the best practice highlighted is relevant to extra care and

other housing with care settings. The literature also reveals the complex nature of the interaction between a range of factors in promoting well-being. For example, access to good food through an on-site restaurant or dining room can be important to nutrition, which has been shown to be associated with high levels of well-being. Finally, a need has been identified for more research that focuses specifically on the area of social well-being for older people in extra care housing and other similar settings.

4 Research design and methods

The overall aim of this study was to explore the social well-being of 'frail' people living in extra care housing. Data were collected through in-depth interviews with extra care residents and managers from six extra care housing schemes in England.

Research governance was provided by the University of the West of England, Bristol, in its role as research sponsor. This included ethical review by the Research Ethics Committee at the University of the West of England, Bristol. The research was supported by a project advisory group, which met three times during the course of the project.

Data collection methods were based on those that had been successfully used by the researchers in previous studies in extra care housing settings. Data were collected from six extra care housing schemes in England. All Housing 21's extra care schemes have a number of facilities and a range of activities to promote social well-being. The schemes selected for this study were those which had particularly innovative good practice examples of measures to promote social well-being. This reflects the project's focus on exploring and disseminating good practice. Schemes were also chosen to reflect diversity in terms of location. Those selected were in Dorset, Suffolk, Liverpool, London and two in Gateshead. Four schemes were in suburban areas, one was on the edge of a village, and one was on the outskirts of a small town. The researchers paid an initial visit to each of these six schemes in order to introduce themselves and the project to the managers and to collect some background information on the schemes. This initial face to face contact was important in terms of engaging the managers with the project and asking for their help with the recruitment process.

The initial contact with tenants was made by scheme managers. This avoided the need for the research team to access contact details and meant that the project was introduced to tenants by someone they already knew, thus minimising stress and intrusion. In selecting tenants as potential research participants, managers were asked to aim for diversity in terms of three criteria: extent of physical frailty; age; and the 'localness' of tenants. They were also asked to include both men and women in the sample. This wish list was impossible to meet completely, given the small sample size, but overall managers did a good job in recruiting a diverse sample.

As a result of the process outlined above, 30 tenants were recruited to take part in the study. Two different methods were used for arranging research interviews. In one scheme, the tenants provided their contact details and were contacted directly by the research team to arrange a convenient date and time. In the other schemes, the

managers took on the role of liaising with the research team and the tenants and set up a schedule for the interviews. This difference in process was a result of the preferences of each manager. Managers were very flexible about arrangements for their own interviews and were all interviewed on the same day as the tenants in their scheme. This ability to carry out all the interviews in each scheme in a single day was essential to a project that combined a small budget with multiple research sites in different parts of the country.

Informed consent was obtained from participants at the time of interview. Written consent was obtained from the majority of tenants who took part in the study, but a few were unable to sign owing to their health status, and their consent was audio taped. Six interviews were carried out in the presence of a relative or spouse who was in the flat at the time that they took place. In some cases, this meant that they inevitably encouraged or prompted interviewees on occasions, but the researchers did not feel that their presence inhibited the participants' contributions. Participants were asked where they would like the interview to take place, and most chose their own flats. A small number opted to use communal areas of the housing scheme. Interviews were semi-structured and followed a broad interview schedule based on themes from the literature and previous work carried out by the researchers. Most of the interviews were audio taped for later transcription. However, a small number of interviews were noted instead, either because participants were not happy to be audio taped or because the interview setting was not conducive to this method. For example, one interview took place in a large and busy communal lounge where background noise would have made the tape impossible to transcribe. Documents containing transcriptions and written up notes were loaded into Qualrus®, a qualitative data analysis software package, and analysed for thematic content.

The Affect Balance scale was used as a self-reported measure of well-being (Bradburn, 1969). It was chosen because of its short and easy format (ten questions with Yes or No answers) and because it can be completed by participants alone or with the help of the researcher if required. An Affect Balance Scale score was computed by subtracting Negative Affect Scale scores from Positive Affect Scale scores and adding a constant of 5 to avoid negative scores.

Participant profiles

The researchers did not have access to any personal information about tenants who took part in the study apart from that provided by them during the course of their research interview. The profiles of participants are therefore not comprehensive, but the following information does provide a general picture of those who took part.

- Thirty extra care tenants and six managers were interviewed as part of the study.
- Twenty of the tenants were female, and ten were male.
- Six were living with their spouses, while the remainder lived on their own.
- All but four of the tenants who participated in the study had previously lived locally, and two of those had moved into the area to be closer to family carers.
- Most had moved from their previous accommodation because of changes in their health status or personal care needs, or those of their spouse.
- For many participants these changes had led to reduced mobility, and most used some kind of walking aid.

In addition to the interview information available about those who participated in the study, the following supplementary information profiles the wider population of Housing 21 residents. This is based on internal survey work and management information held by Housing 21 and an annual survey tracking the changing care needs and dependency levels of its total resident population. The most recent findings available are from October 2005. At the same time, Housing 21 conducted its national tenant survey, with questionnaires completed by residents or their advocates. This generated 294 responses from extra care residents (a response rate of 53 per cent), living in 11 housing schemes, 414 households or 73 per cent of Housing 21 dwelling stock nationally.

Seventy-eight per cent of people who live in Housing 21's extra care housing schemes are single and by far the majority (70 per cent) are female. Sixty per cent of residents have 'high' or 'medium' dependency levels, or at least seven hours of personal care per week (one hour per day or more). Half of all residents also receive informal support from friends and family. Additionally, 73 per cent receive domestic ('home help') services. Nearly all residents have meals provided, the majority via the on-site restaurant where this facility is provided. Overall, 83 per cent of Housing 21's extra care resident population have a social services assessed care service.

In terms of 'frailty', a high proportion of the extra care population have long-term illnesses and/or impaired mobility, and two-thirds use mobility aids at least some of the time. Twenty-seven per cent of all residents use a wheelchair to get around their scheme, while 56.8 per cent use wheelchairs to travel further distances beyond the scheme. Sixty-seven per cent of respondents to the tenant survey stated that they had a long-standing illness or health condition which affected their activities

of daily living. Over a quarter (27 per cent) were diagnosed or suspected as having dementia. Up to 35 per cent of residents have various mental health conditions. Visual impairment was reported in 11.4 per cent of residents and 23 per cent used hearing aids, though 39 per cent of respondents to the tenant survey stated that they had impaired hearing.

The extra care schemes

Table 1 summarises the features of the six extra care schemes that took part in the study. A more detailed description of each is included in Appendix A of this report.

All six schemes were new build and of a modern design. (see figure 1)

Figure 1 – Oak House front view



Table 1 Summary profile of the six case study schemes

	Scheme A: Oak House, Suffolk	Scheme B: Cedar Court, Lewisham	Scheme C: Fountain Court, Gateshead	Scheme D: Winton Court, Gateshead	Scheme E: Brookside House, Liverpool	Scheme F: Foyle Bank, Dorset
<i>General information</i>						
Type of location	Rural	Suburban	Urban	Suburban	Urban	Rural
Year opened	2004	2001	2004	2003	2004	2005
Accommodation details	38 flats: 8 × two bedroom, 30 × one bedroom. Specialist unit for people with dementia included	40 flats: 38 × one bedroom, 2 × two bedroom	40 flats: all one-bedroom flats designed for occupation by one or two people	40 flats: all one bedroom	40 flats: 20 × one bedroom and 20 × two bedroom	37 flats for rent, 11 bungalows available on shared ownership basis
Wider area accessibility	Small village accessible via footpath from scheme	Local shops, bus stop and station 10–15 minutes away, uphill	Local bus routes (bus stop nearby). Town centre two miles away	Bus stop to town centre in front of scheme	Bus stop – 500 m. Three miles from city centre	Bus stop ½ km from scheme linking island to mainland
<i>Care and support requirements (for referrals)</i>						
Minimum care hours per week	4 hours	10 hours	10 hours	10 hours	4 hours	4 hours
Minimum age	60 or 55 if registered disabled	60 or 55 if registered disabled	60 or 55 if registered disabled	60 or 55 if registered disabled	60 or 55 if registered disabled	60 or 55 if registered disabled
<i>On-site care and support services</i>						
Contractual arrangements for care	360 hours per week	Block contract of 400 hours per week	Block care contract of 400 hours per week	440 hours per week	Block care contract of 400 hours plus per week	Housing 21 has won the contract for care services and will provide from May 2007. Currently care agencies deliver

Continued

Table 1 Summary profile of the six case study schemes – Continued

	Scheme A: Oak House, Suffolk	Scheme B: Cedar Court, Lewisham	Scheme C: Fountain Court, Gateshead	Scheme D: Winton Court, Gateshead	Scheme E: Brookside House, Liverpool	Scheme F: Foyle Bank, Dorset
Staffing arrangements	Court manager (CM) has mental health nursing background. Post part funded by social services. Senior support workers	CM responsible for housing and care. Senior support workers oversee care assistants	CM responsible for housing and care. Senior support workers oversee care assistants	CM employed by Housing 21. Care staff work within teams led by senior support workers. Training officer (on-site) coordinates staff training	Senior care workers oversee care assistants. Care coordinator manages on-site and community contract	CM is responsible for housing and care
<i>Activities and communal amenities</i>						
Communal amenities	Restaurant, residents' lounge, hair salon, three assisted bathing facilities (one Jacuzzi), five 'pod' lounges, day centre, room, laundry, guest room, private garden	Shop, restaurant, residents' lounge, hair salon, private garden, laundry, guest room, day centre, consulting room	Shop, restaurant, residents' lounge, hair salon, private garden, laundry, guest room, health care suite, community centre	Shop, restaurant, residents' lounge, activities room, community centre, hair salon, private garden, laundry, guest room	Shop, restaurant, residents' lounge, hair salon, gym, health care suite, IT resource room, community centre, garden, sun terrace, laundry, guest room treatment room	Dining room, residents' lounge, hair salon, private garden and residents', courtyard laundry, guest room, treatment room
Activities	Activities coordinator part funded by Supporting People monies. Music evenings, games and quiz afternoons, coffee mornings. 'Friends of Oak House' fund-raising group raise monies for facilities and events	Amenities open to wider community. Day centre. Coffee mornings, quiz, bingo and exercise classes. Links to local community organisations who provide community transport and range of off-site activities	Luncheon club (open to wider community). Cinema nights. Bingo. Quiz evenings. Shop and restaurant open daily and used regularly by many local people. Greengrocer's stall weekly	Men's club fortnightly – open to local residents. Lunch club, games and quiz afternoons, bingo, singalongs, arts and craft sessions. Restaurant and shop open to wider community	Residents Community Association arranges various activities. Facilities open to wider local community	Local baker visits once a week and sets up stall selling freshly baked produce. Tenants committee raises funds for, and provides activities. Mobile library visits regularly. Film shows

Continued

Table 1 Summary profile of the six case study schemes – Continued

	Scheme A: Oak House, Suffolk	Scheme B: Cedar Court, Lewisham	Scheme C: Fountain Court, Gateshead	Scheme D: Winton Court, Gateshead	Scheme E: Brookside House, Liverpool	Scheme F: Foyle Bank, Dorset
Health care links	Good links between scheme staff and local health services. All tenants have their own GP. Regular visits from district nurses, occupational therapists, etc.	Each tenant registered with local GP who visits as appropriate. District nurses visit once or twice a day. Contract with local chiropodist who visits regularly	CM calls district nurses, occupational therapists, physiotherapists as necessary. Each tenant is registered with own local GP. Contract with local chiropodist who visits regularly	All tenants registered with local GP. District nurses visit on referral. Regular visits from local chiropodist.	All tenants registered with local health centre. District nurses visit three times a week. Chiropodist and optician visit regularly	Local GP allocated to court and visits weekly. District nurses visit once or twice a day. Access to psycho geriatrician. Several tenants registered with CPN. Local chiropodist visits regularly.

Limitations of the research

This study recruited a small sample of participants from a single setting: extra care housing. To that extent it was an exploratory study, with the limits to generalisability that this approach implies. However, the findings support many of the themes found in previous research, and we believe that many of the key messages are relevant to a wide range of housing and care settings. All six of the schemes that served as case study sites for this project were run by the same provider, Housing 21, and are therefore likely to share the same ethos and similar systems.

For both ethical and practical reasons, recruitment was coordinated by housing scheme managers. This gave them considerable influence over who took part in the project. For example, only one tenant interviewed had significant cognitive impairment, although the sample was diverse in many ways, including age, care needs, localness and levels of frailty. It is important to bear in mind that there was no intention to recruit a representative sample, and the focus of the study was, in any case, on good practice.

It should be noted that interviews in one scheme were conducted by a member of the research team who is employed by the host organisation. This made sense in terms of resource allocation, as the study is a small-scale one, and the case study site was close to the interviewer's main work place. Issues and concerns about possible bias were discussed openly with the project funders and the advisory group. Given that 'the interviewer is him- or herself the research instrument' (Kvale, 2006), there were a number of subjective issues which, it is acknowledged, may have had some impact on the research findings. There are likely to be differences in style between interviewers, irrespective of their gender. Clearly, the fact that interviews in one case study site were conducted by a female interviewer, as opposed to the others which were all conducted by a male interviewer, may have had some impact on the prompts used and the themes covered. For example, interviews conducted by the female interviewer with female respondents may have covered some topics in more depth than were evident in other interviews. The transcripts suggest, for example, a greater emphasis on activities such as the social aspects of shopping as a cultural pursuit rather than as a purely functional activity.

Though the interviewer is employed by the host organisation, she does not work in an operational capacity or at the case study site, so the participants were not known to her in any respect prior to the interviews taking place. This was felt to minimise the possibility of bias, and consistency of approach was maintained as far as possible.

It should be noted that the research fieldwork was carried out during autumn/winter 2006 and spring 2007. This has a potential impact on the findings in at least two ways. First, the fact that Christmas fell in the middle of the research period may have influenced the number of activities that took place within the housing schemes. One respondent did mention this and suggested that there was less to do at other times of the year. Secondly, it seems likely that tenants made less use of the scheme gardens at this time of the year than they might do during the summer.

5 Research findings

In this section we present the findings from interviews with tenants and scheme managers. We look at self-reported levels of satisfaction with quality of life before going on to examine a range of factors that appear to contribute towards social well-being in this setting. Finally, we present an analysis of the Bradburn Affect Balance Scale results.

Quality of life and social well-being

Tenants who participated in the research reported high levels of overall satisfaction with their quality of life and their social lives. For example, the tenant quoted below had initially been reluctant to move into an extra care housing scheme but was very glad that he had done so.

I've never been so happy in all me life and I am so at ease here. The accommodation's excellent, the neighbours are excellent, the area, I mean I've got beautiful trees as you can see.

(Male tenant 040)

A wide range of factors appeared to contribute towards this overall feeling of well-being. A female tenant who was 97 years old when interviewed for the research told us that extra care housing offered her greater independence compared with her previous accommodation, which was very important to her. Overall, she felt that her quality of life was very good.

When I'm gone I hope the next person will be as happy here as I am. I couldn't wish for anything better. I am happy and safe here.

(Female tenant 004)

One of the features of extra care housing is the fact that people live there with full tenancy rights, including that of 'private enjoyment' of their own flats. For some this also seemed to be an important factor in a feeling that it was their home, as vividly demonstrated in the following quote:

Well it's cosy and it's mine. I feel as though its mine. I'd rather be here than anywhere else ... it's my domain I can run around in the nude if I want to. Yes, I like it here.

(Female tenant 103)

Other factors mentioned as contributing to a good quality of life were the design of the extra care environment and the opportunities for friendship that it provided.

Not all respondents were so happy with extra care housing, and some told us that they did not feel as if they fitted in. This is demonstrated by the next quote from a tenant who lived with her husband:

It's very nice but you feel out of place. It was a change of environment for us to what we were used to.
(Female tenant 102)

A small minority of participants reported being bored or isolated, and this was often linked to impaired mobility, a theme that we come on to later in this report. First, we explore some of the factors that appear to be important in social well-being for tenants.

Factors in social well-being

Interviews with tenants and scheme managers identified a range of factors that seemed to play a part in promoting social well-being for people living in extra care housing. In this part of the report, we examine the following factors which emerged strongly from the data analysis:

- friendship and social interaction
- the role of family carers
- engaging with the wider community
- the role of facilities
- design, location and layout
- staffing systems and the culture of care.

Friendship and social interaction

The majority of tenants expressed satisfaction with their social lives in extra care housing, and several compared it positively with the situation in their previous accommodation, as in the following quote:

We get all sorts of invitations here. There is always something going on which when you are stuck in your own home ... you know if you can't get out what do you do, you can't do anything can you?

(Female tenant 022)

When discussing their social lives and social well-being, tenants frequently mentioned friends within the extra care scheme as being of great importance. For many tenants, the friendships and acquaintances that they developed within the scheme were the basis of their social lives. As in any community, different levels of friendship exist in extra care housing along a continuum from casual acquaintance to intimate friend. However, it can be argued that all types of friendship are important to social well-being.

We are all very friendly, we all speak to one another. Yes I would say we are, even if we don't have a lot to say or a lot in common, it's only politeness to say hello in my view.

(Female tenant 050)

Other tenants were more reserved about their relations with other tenants, as described by the following quote from a female tenant living with her husband:

The social life is not too bad. Yes, we have very good neighbours, very good neighbours. We don't put ourselves forward, we don't impose ourselves on people, we never have done.

(Female tenant 102)

Managers recognised the importance of tenants having the choice to socialise or not. One manager emphasised the benefits of tenants 'from different backgrounds' getting on together, but added that some 'clashes of personality' are inevitable (Scheme Manager 032).

The existence of opportunities for social interaction seemed to be vital to the development of friendships. It is possible to distinguish two types of interaction from the interview transcripts: within the extra care scheme and beyond the scheme.

Social interaction within extra care schemes

There were great variations in the extent to which respondents interacted with other tenants. For some, spending time with other tenants was a regular daily activity, as described by one scheme manager:

You get clusters of tenants that'll sit upstairs near the dining room. Some of the ladies just sit and have a chat in the afternoon.
(Scheme Manager 024)

As the above quote suggests, this appeared to be largely a female activity. Some tenants had much less social contact with others living in the scheme. The woman quoted below lived with her husband, and they spent most of their time together in their flat. They had little interaction with other tenants.

The only time I see them ever is when I've been out there in the summer and they've been on their balcony, so I've waved out to them. And we did go down there once, didn't we? We went to the restaurant once and I met the people at the end.
(Female tenant 106)

The main opportunities for social interaction as described by tenants were provided through activities arranged within the scheme, both social and occupational. The importance of social activities was recognised by tenants. One spoke with enthusiasm about the many parties in the scheme, and how they made her 'feel good' (Female tenant 003). The study found a wide range of activities on offer across the six housing schemes, including tea mornings, arts and crafts, bingo, card games, dominoes, fitness classes, entertainers (including magicians, an opera singer and belly dancers), parties for birthdays and other occasions, and quizzes. A variety of external trips were also organised for tenants, including visits to restaurants, garden centres, concerts and a firework display, boat trips and regular visits to a swimming pool. These were highly valued by tenants, as the following quote suggests. The language used by this tenant is interesting in the way that she describes a trip to church as an 'out'. This highlights the importance placed on spending time away from the scheme.

I did arrange with <name> to take me to church on Christmas Day. But now I am lucky you see, I have got Dial a Ride and they take me to church on a Sunday. I am on that permanently and also, lets face it, it's an 'out' isn't it?
(Female tenant 104)

Some schemes were much busier than others in terms of the number of organised activities available to tenants. To some extent this seemed to depend on the importance placed on them by the scheme manager. For example, one manager was very aware of the role of social activities and described the social 'programme' in the following terms:

On a regular basis there's coffee morning on a Tuesday, which is always very, very active, as you can see today! They have raffles and then we have meetings once a month as well, on a Tuesday. There's games afternoons, there's bingo twice a week. The social committee organises trips probably every one to two months and there's also just sort of informal gatherings, where tenants will come down and sit in the foyer, or sit outside and mingle.

(Scheme Manager 005)

This portrayal was echoed by tenants of the same scheme, who described their social lives as 'Never a dull moment!' (Female tenant 006) and 'I've never had so many parties in all my life you know, it really is lovely' (Female tenant 104). A minority felt that there were not enough activities to keep them occupied, particularly at certain times of year.

The Christmas just gone, we had a couple of parties like carol singers and stuff like that, but there's not a lot you can do actually.

(Male tenant 040)

The biggest difference between schemes, however, was not in the number of activities but in the range of activity types. All six schemes organised regular social activities but some were more imaginative in the range of activities on offer, particularly in terms of occupation and exercise. Examples found during the study included music and dance workshops, exercise classes, arts and craft sessions, a men's group and hydrotherapy. (see figure 2)

Where these sorts of activity existed they appeared to be greatly valued by tenants, as the following quote suggests:

It keeps us on the move, we don't do anything other than the sitting down, but it is arm exercises and spreading your hands and all this sort of business, keeping your joints on the move mainly which is quite enjoyable.

(Female tenant 022)

Some tenants did not enjoy the specific activities available although, in the following quote about bingo sessions, this was outweighed by the fact that it did at least provide an opportunity to socialise:

Oh, I hate it (bingo), but I do go to all the bingo ones because you're mixing in, aren't you? Otherwise you're stuck in a room.

(Female tenant 022)

Figure 2 – Social activities within extra care schemes: T'ai Chi class



Several tenants found it difficult to take part in some of the activities on offer. In the next quote a female tenant describes, with some frustration, the difficulty she experienced during a craft session:

A lady came to make baskets and found I couldn't because I had my hands done. I had that metacarpal cut last year and the year before and, although I don't have any pain, I get this numbness and holding things I find it, you know I don't think I could weave the thing.
(Female tenant 104)

This suggests a need to take into account a range of ability levels when planning activities so that all tenants have the opportunity to take part. The study did find good examples of inclusive activities, as described in the following quote from a tenant who used a walking frame to get around.

I like music and as I say I like dancing, I get hold of the back of the chair and I dance around it, looking silly but not caring, I don't care a blow what they think of me, I am dancing with a chair!
(Female tenant 050)

The importance of encouraging tenants to take part in social activities was acknowledged by managers, and some schemes had an agreement that, when any party is arranged in the scheme, all tenants have to be invited. This inclusive approach was appreciated by tenants, one of whom said:

That's another nice thing, if it's your birthday your loved ones arrange a party for you here. We go downstairs into the lounge, our lounge, and it's very nice and everybody is welcome.

(Female tenant 104)

Social interaction may be more difficult for people when they first move into a scheme. The overall social environment is important in this situation, and the study found a general willingness to embrace new friendships, as indicated by the following quote:

There are some new people coming and we do make them welcome. We chat to them you know and we say, 'oh, are you coming down to the keep fit, are you coming down to the sing song', and have a chat with them because some of them found it very hard to settle in.

(Female tenant 104)

Men, couples and social interaction

The literature suggests that men are somewhat reluctant to take part in organised activities, and this was certainly borne out by our research. A number of men interviewed felt that the activities on offer did not cater for their interests and, as a result, they spent a great deal of time alone in their flats. In Scheme D this issue had been recognised, and a men's group was established. This was initially led by an occupational therapist from the local authority, and it attracted not only male tenants, but also men from the local community. As well as just sitting and chatting, funds had been raised to purchase a pool table and electronic dart board, both of which were very popular. (see figure 3)

Tenants who attended the weekly group talked very enthusiastically about it, and it seemed to provide a strong sense of belonging. One tenant who had been a miner and a semi-professional footballer commented on the feeling of 'comradeship' that those activities had provided and that he now missed. He felt that nothing could replace that, but as the following quote suggests, the men's group was the next best thing.

It's lovely that. We just sit and talk, we have questions, I really enjoy that. Some people come from outside. In fact one fellow has come since it began.

(Male tenant 016)

Figure 3 – Playing pool as part of the men’s group



Extra care housing plays an important role in supporting couples, particularly where only one partner has personal care needs. For one couple, the move into extra care had brought them back together after a long period apart, due to her stay in a nursing home. For them extra care housing appeared to play a major part in maximising their social well-being by enabling them to live together and support each other. However, the dynamics of the relationship between couples in this setting are complex and require further study. For example, does the fact that men are less likely to take part in social activities inhibit their partners from joining in?

How activities are organised

The study found that the way in which activities were organised could have an impact on the extent to which tenants took part in them. Two different models for arranging activities were found: in four schemes they were organised by staff, while in the other two schemes they were organised by tenants. Under the ‘staff-organised’ model, the role of organising activities was carried out either by care staff in their spare time or by a part time paid Activities Coordinator, funded by the local authority or the housing provider.

Tenants were aware of the work done by staff who organised activities, particularly where this was a paid role. However, the tenant-organised system appeared to have a number of advantages. First, there was some evidence that tenants were more willing to engage with a programme of activities that were organised by other tenants. In one scheme there had been an initial reluctance to take part in activities arranged by staff, and it was only when tenants took over this role that things really got going. Another advantage of this system, which may be related to the increased participation in activities, is that tenants had a much greater say in what activities took place, and so the events were more popular. In addition, taking on the role of organising activities led to feelings of satisfaction and sense of purpose among those tenants on the organising 'committee'. Finally, under this system, the tenants were able to put on events that raised significant amounts of money, which was ploughed back into further activities. This was greatly appreciated by other tenants, as the following quote demonstrates:

I think the committee that we've got is very good, because last week we all went to a restaurant, 30 of us, and had a nice lunch, and they paid for it all.
(Female tenant 007)

This is particularly valuable in the context of the difficulty that schemes often experience in raising sufficient funds to pay for a range of activities. The tenant-led system was also appreciated by managers for its ability to attract tenants who might not otherwise take part, as indicated in the following quote:

We've got a good social committee that organises social events, rallies people round. Again, peers do tend to sort of uplift other tenants and make them more sociable so it gets them out of the depression, gets them out of their flats.
(Scheme Manager 005)

Social activities, both formal and informal, are an important opportunity for social interaction and can therefore be important to the social well-being of tenants. However, several tenants told us that they preferred to spend most of their time on their own in their flats, often watching TV or listening to the radio. One tenant enjoyed having the opportunity to take part in social activities, but it was equally important for her to have the choice not to take part.

The best part of this is you can go downstairs and have a chat with them and be with them, but if you want to shut your door then you do. You shut your door and you don't want to see no one, you don't want anybody chatting to you.
(Female tenant 104)

Another important aspect of how activities are organised is funding. As we have seen, some schemes had specific funding to employ a part time activities coordinator as part of their contract with the local authority. Others rely on the goodwill of staff and other volunteers in organising activities in their spare time, while others have handed over this responsibility to tenants. Whatever model is chosen, it is important that sufficient funds are available to support the provision of a range of activities in order to promote social well-being.

Supporting diversity

The study found some evidence of a lack of tolerance by some tenants of those who they perceived as being different from them in various ways. Extra care housing tenants span a large range of ages, from 55 to over 100, and one tenant felt that this was not appropriate.

There are lots of people in here who shouldn't be, they're too old.
Incontinence, it comes to us, don't get me wrong. There's people in here old enough to be my mother and father, I'm not exaggerating.
(Male tenant 040)

One key aim of this form of housing is to support independence for people across a range of needs, but the following quote from the same tenant suggests a misunderstanding of the purpose and nature of extra care housing.

I thought this was the place where you look after yourself independently.
Obviously I'm limited because I've got one leg. I do everything myself in this house.
(Male tenant 040)

A similar reason was given by another tenant for her view that extra care might not be suitable for people with reduced cognitive function or dementia:

To have a flat like this where you've got a perfectly good kitchen which is well fitted out and things, I mean they can't cook for themselves. They can't even look after themselves so what a waste it is, when there must be an awful lot of people who would be glad to be in here and look after themselves.
(Female tenant 022)

This tenant said that it was difficult to have a conversation with tenants with memory problems, but she also described how she frequently knocked on their doors to remind them to come to social activities taking place in the scheme. This suggests that the way tenants view others whom they perceive as different does not necessarily influence their actual behaviour towards them. However, it does raise the possibility that understanding and tolerance can have an impact on the opportunities for social interaction in long-term care settings.

Findings from previous research suggest that a large minority of extra care tenants have significant memory problems, although the incidence is often under-reported by managers and staff (Vallelly *et al.*, 2006). In the current study we did find some evidence of low-level interventions to facilitate social interaction for people with memory loss. For example, care staff wrote messages on yellow stickers as a reminder for one tenant to attend activities and social events in the scheme. The messages, written large in black marker pen, were attached to her sideboard and not only reminded her to go, but also prompted her carers to remind her.

Social lives beyond the housing scheme

As we have seen, social interaction within housing schemes is central to the social lives of the majority of tenants. However, external friendships are also important to many. Several tenants told us that they continued to have regular contact with external friends. For many, this took the form of meeting up to go out to shops, restaurants and other local facilities. For example, one tenant felt that moving into extra care kept her in touch with her local friends:

I've got friends that call for me and we go shopping together. I'm not forgotten.

(Female tenant 006)

For another tenant, maintaining contact with external friends was not easy, and this could lead her to feel lonely, as the following quote suggests:

I get lonely, yes, but I have made friends and I am still in touch with my old friends but I don't see them nowhere near as much.

(Female tenant 050)

The potential difficulty of maintaining a social life beyond the scheme was recognised by some managers, as the quote below indicates. This quote also identifies impaired mobility as an important challenge to social well-being, and we return to this theme later in these findings.

I would say it is very difficult, I really would. I think it's geographical rather than anything else because at <scheme name> itself we have limitations on bus services. Even though we have the <name> train station very near by, it's still 5 to 10 minute walk, even longer for somebody that has disabilities.

(Scheme Manager 105)

The role of family carers

Family members played a large part in the lives of tenants. Many of the tenants interviewed during this study had family living locally, but even for some tenants whose family lived further away, they were an important source of social contact. Family carers played an important role in the lives of most tenants, not least in terms of the practical and emotional support they offered. Practical support included hair cutting, cooking, decorating, home maintenance, shopping and providing transport to attend a range of events, facilities and appointments. Family members who visited most often were daughters, sons, daughters- and sons-in law and grandchildren, with occasional mention of brothers and sisters. The following extract illustrates the extent of some families' involvement:

My daughter has got my car and she does a tremendous amount for us. If I had to go somewhere she would take me, and the same goes for my wife, you see?

(Male tenant 114)

For some tenants, leaving the scheme was only possible when relatives came to take them out. Several tenants needed help with mobility, either to feel confident in walking or with managing their wheelchairs. Relatives also provided a range of activities, including taking tenants out for lunch, shopping, visiting local attractions and beauty spots and providing company at home. As the following extract illustrates, although the physical demands on carers of managing such outings were sometimes challenging, the joy the visits brought to tenants could not be overstated:

I am very lucky in the fact that I have got a marvellous daughter who comes to visit every day ... (She) takes me out once a week. I go to <name of nearby town>. It is lovely, but the thing is, she is finding it difficult having to push me around in the wheelchair.

(Female tenant 007)

There was a real sense that visits by relatives made tenants feel cared about, supported and special. In families that demonstrated care, affection and support, tenants clearly articulated a sense of belonging that supported their independence and well-being. Tenants enjoyed not only family visits, but also being able to talk about family members, highlighting their achievements with pride and pleasure. It appeared that how close local relatives lived to the court determined to a large extent the frequency with which they visited; however, more important than the frequency of visits was the reassurance tenants gained from living in close proximity to their family, particularly at times of difficulty. At the same time, some tenants expressed the view that their relatives worried less about them now that they were living within the court, as they knew they were being cared for and checked on regularly. Overall, it appeared that tenants who had no close relatives or whose families lived too far away or were too busy to visit felt this was a loss and were more isolated.

Encouraging family involvement

From the perspective of care managers, family support could be a key element in tenants' successful integration into the housing scheme. Although structured care was provided through formal care packages, families offered a different type of support that could prevent tenants becoming isolated and help maintain their independence. One manager illustrated how, with good communication and flexible provision, it had been possible to support one tenant who, when diagnosed with cancer, needed her daughter to stay in the guest room at the court. This enabled her to visit the hospital regularly, keep in close contact and communicate effectively with court staff about her mother's discharge. Several tenants mentioned the guest room facility as helpful in keeping contact with family, particularly those who visited from long distances. However, the key to family involvement appeared to be clear communication by the court staff with relatives in terms of what was being provided for tenants in their care, and ongoing encouragement to stay involved.

Engaging with the wider community

Another factor that can influence the level of external contact is the development of links between the scheme and local community. Tenants who took part in the study were asked to reflect on their relationship with the wider community. Responses focused on the ways in which older people engaged with activities within the local community and how local community members accessed resources within the court. Several tenants talked about how church services offered them an opportunity to get to know members of the local community. Some visited local churches, while others

attended religious meetings within the court. Another tenant described her love of Sunday visits to the homes of Help the Aged Volunteers for tea:

I am taken to somebody's house for tea, they take people in my position an elderly person that doesn't get out, and the drivers are all voluntary. We go to someone's house; we have been to <town>, we have been to <another town>, we have been to <another town>, we have been to <another town>. In the summer they have got beautiful houses, we sit out in the garden and you know strawberries and cream and all that.
(Female tenant 104)

This tenant expressed not only her enjoyment and the sense of well-being such activities invoked, but also how community visits prevented isolation and the feeling of being 'trapped' within the court associated with her lack of mobility. One tenant attended a local gymnasium twice a week, although, while this could be accessed through the local train service, his impaired mobility meant he had to rely on the community bus.

During interviews, tenants did not generally focus on their ongoing relationships with people within the local community. However, there was a real sense that being part of community activities that took place away from the scheme made life more interesting, stimulating, exciting and engaging. Male tenants, in particular, commented about enjoying watching changes taking place within the local community, while several female tenants felt their spirits were lifted by contact with children from local schools, who regularly came in to sing or perform for them. There was a real sense that for many tenants getting 'out and about' was something they would continue to do for as long as they possibly could. For those with less mobility who found it difficult to access local facilities, a range of businesses visited with takeaway foods, pastries, eggs, vegetables, clothes, cosmetics and groceries, all of which engaged tenants in a sense of participation with their local area. Community professionals working locally played an active role in the schemes, undertaking health promotion and community safety activities for staff and group members.

She also brings them people to talk about like benefits information, also community safety, you know different aspects of community living and life. We also have doctors coming on a regular basis, we have district nurses with liaison, the Chemist comes in on a weekly basis to deliver medication. We have district nurses coming to do catheter bags and medication, eye drops and training about enabling the staff to learn how to maintain the well-being of their individual clients.
(Scheme Manager 105)

The ability to engage with community activities was linked to a range of factors, including the availability and accessibility of transport, the quality of pavement access for electric scooters and the support of care staff. Those residents who were not able to access the community because of lack of mobility or ill-health suggested that this affected their general sense of well-being, largely because they felt restricted and missed doing activities they had enjoyed in the past. Several tenants talked about using their scooters as a way of getting out and about, allowing them access to local pubs and amenities. They also identified how poorly maintained footpaths and anxiety about crossing local roads could act as barriers to visiting local amenities.

The role of facilities

The extra care housing schemes that took part in this project had a range of on-site facilities available. These included shops, restaurants, communal areas, hairdressers, beauty salons, gardens, day centres and guest rooms. Many of these facilities were situated on indoor 'streets', providing an accessible and safe environment in which tenants can access a range of services. For many tenants, such facilities were at the core of their social lives, and some facilities seemed more important than others in this respect. One scheme manager described how the on-site hair salon fulfilled a social role:

Thursday mornings are just absolutely buzz here, with the hairdressing activity and people who perhaps don't see each other quite so often meet up there. Sometimes they will have a cup of coffee or something afterwards.

(Scheme Manager 024)

Most of the schemes had a shop at which tenants could buy basic goods, including toiletries, household goods, basic food products and newspapers. In addition, tenants could order just about anything they needed, and it would be available within a day or two. In the schemes that had on-site shops, they provided a major focal point and meeting place for tenants. Schemes A and F had no shop, because it had not been included in the original design, and there was evidence that tenants missed the opportunity for social contact that it could provide. One tenant told us:

No there isn't a shop, that is one of the drawbacks really. We all say we wish there was a shop if only to walk around and maybe meet people in the shop and get to know local people.

(Female tenant 022)

There was some evidence that the absence of a shop, and the resultant reduction in opportunities for social interaction, could be compensated for by encouraging retailers to bring goods to the scheme. For example, some schemes arranged for regular visits by stalls selling vegetables, cosmetics, clothing and a range of other products.

Restaurants were another facility that provided a focal point for social interaction, although in some schemes they were quite small and had to accommodate tenants in several 'sittings'. Scheme A did not have a restaurant for the first year after opening, and tenants had to eat meals in their own flats. When the restaurant did eventually open, the manager was surprised at how many tenants wanted to eat together, including some with dementia. This led to a recognition of the importance of the restaurant as a venue for social interaction. Scheme F had a restaurant when it opened, which was operated on contract by a local business. However this had proved uneconomical and had to close down after about nine months. Tenants now had ready-cooked meals delivered to the scheme, which they heated up in their own kitchens and ate in their flats. This led to comments about missing the social interaction that communal mealtimes provided as well as criticism of the quality of the food.

All six extra care schemes had communal gardens that could be used by tenants and, for some, this facility provided another important social venue, particularly during the summer. (see figure 4)

Figure 4 – Communal garden used by tenants



The nature of these gardens varied considerably between schemes in terms of the range of features and the extent to which they were used by tenants. Many tenants told us that they had been keen gardeners in their previous accommodation, and some talked with great enthusiasm about the gardens, as in the following quote from a tenant of Scheme B.

There is a little summerhouse down there but I think the foxes live in there, I am sure they do. But we hear the birds and oh it's so lovely. In the summer we sit out there, in fact quite well into the year we sit out there with your coat on.

(Female tenant 104)

In other schemes the gardens were not so well used, although they were still valued by tenants as a nice view. It was not always possible to determine the reasons for this, and it may depend on the particular interests of tenants, but in Scheme F poor access was an obvious cause. This particular scheme had a garden running down the length of one side of the scheme and a courtyard garden in the middle of the buildings. The former had been deemed unsafe to use because the whole site was on a slope and the concrete paths became very slippery in certain conditions. The courtyard garden had been nicely planted using money raised by the tenants, but access was by a short flight of steps, and this meant that several tenants could not use it. Requests had been made to install a ramp but, at the time of the research, the issue of how to fund this had not been resolved. Several tenants told us that this situation was very unsatisfactory. As one remarked, 'We spent all that money on the pots and the plants and nobody can get out there!' (Female tenant 008).

All the schemes had a range of communal areas and these were the focus of social interaction and therefore central to the social life of many tenants. These areas are usually large rooms containing a range of comfortable seating, often arranged into clusters so that tenants can sit in small groups. Most have a television, and some include a sliding partition so that the room can be used for more than one purpose at any one time. The function of these areas was extensive and included acting as a communal 'lounge', a venue for social activities and somewhere for tenants to meet with family members and external visitors.

Some schemes had more than one communal lounge, often on different floors of the building. These included smaller 'pod' lounges, which are situated near to tenants' flats and take the form of separate rooms or areas adjoining corridors. They usually contain a few armchairs and/or sofas, and some of those that are in a separate room have other features including tables, a music player and a range of reading materials. These smaller lounges were important in creating a feeling of ownership and

belonging, as suggested by a female tenant who said 'Yes, this is our special one ... we come in here for our meals, it is really nice' (Female tenant 023).

Some facilities were not so successful as social venues. The most obvious of these was a well-equipped spa room that had been an innovative feature of Schemes A and C when they first opened. Unfortunately, these had never been used for health and safety reasons and, in one scheme, this room served as a storage area. However, enterprising tenants in another scheme had recognised the potential of the space and used it as a weekly venue for showing films.

On-site facilities can also promote social interaction and well-being by attracting people from the local community into extra care schemes. Restaurants and shops appeared to be particularly successful in this respect, and schemes with both these facilities gave the impression of being the most integrated with the local community. In some schemes, these facilities could only be maintained as commercially viable through the custom of local residents. Some scheme managers told us how they encouraged residents and groups from the local community to use the facilities. Their strategy included offering the use of meeting rooms, setting up lunch clubs, holding local events such as healthy living days and inviting local people to scheme events such as Christmas parties, religious services and fetes.

Design, location and layout

One of the unique features of extra care housing compared with other long-term care settings is its design. Although a wide range of models fall under the umbrella concept of extra care housing, one increasingly common design feature is the use of indoor 'streets' around which schemes are arranged. These streets form a central route through the scheme and are often the site for a shop, the restaurant and a range of other facilities. Access to corridors containing tenants' flats is via a security-controlled doorway which leads off the street. This arrangement, sometimes called 'progressive privacy', (see figure 5) means that people from the local community can come into the scheme to use a range of facilities but cannot access individual flats without the consent of tenants. This promotes feelings of safety among tenants and encourages a sense of community by, for example, allowing tenants to leave their front doors open during the day.

The indoor street style of design has a number of advantages. (see figure 6) By providing a safe, dry and level environment, it maximises accessibility and increases the opportunity for tenants to move around the scheme and meet each other for both formal and informal social activities. There are additional potential benefits in terms

Figure 5 – Ground floor layout



Figure 6 – Indoor Street



of getting the exercise that walking provides and accessing on-site facilities, thereby supporting independence. Accessible design is crucial in long-term care settings and particularly for tenants with impaired mobility, as discussed by one scheme manager:

It's a purpose-built building, so we've got lifts, we've got the wide corridors and we've got the motorised scooters, which we encourage.
(Scheme Manager 005)

However, this style of design needs to be sensitively implemented in order to aid orientation, particularly for tenants with cognitive impairment. Some tenants and relatives of Scheme E felt that the indoor street was too long and repetitive, making it potentially confusing.

Most schemes have a guest room, which is useful for those relatives or friends who want to visit tenants and live a long way away. In order to encourage visitors, it is important that these rooms are well designed. In most of the schemes studied they were light, airy and comfortable, but one had no external windows and seemed far less inviting. The role of gardens as a venue for social interaction has been mentioned earlier in this report. Here again, in order to promote their use, they

need to be well designed, and this means giving consideration to landscaping and planting. One tenant felt that the range of plants left something to be desired.

Oh yes I think everybody enjoys having the garden area. The only fault at the moment is that there are not a lot of flowers. It is nearly all laurel bushes and that kind of thing, evergreen but nothing much to see.
(Female tenant 022)

The layout of a scheme can have a considerable impact on the overall social environment by encouraging interaction. For example, some feel more welcoming than others to tenants' family and friends and people from the local community. This is partly achieved by having an open plan entrance area with comfortable seating and a visible reception area where staff can easily be approached. One manager recognised the importance of 'first impressions' to someone visiting the scheme:

It can give the impression that people are coming in and that people are enjoying it and people are around, or it can give the impression of 'well where is everybody'. I think for people that are coming into a space for the first time then that's very important.
(Scheme Manager 105)

The design of individual flats can also have an impact on social well-being by providing a comfortable and pleasing environment for visits from other tenants, family members and external friends. Many tenants told us that they appreciated the design of their flats, particularly in terms of their size. Having a good view was also important to tenants, as described in the next quote. While not directly related to social well-being, it is evident that this design feature is an important element of quality of life for this tenant.

Oh it's lovely and I have got such a lovely view. You see the trees blooming and the sunsets and the morning sun is beautiful, oh yes. And it's so big, I mean these flats are big but they have got to be because of wheelchairs.
(Female tenant 104)

Of the six schemes in this study, five were in an urban setting, while Scheme A was on the edge of a small village. Of the five urban schemes, Scheme F was in a relatively isolated setting on the edge of a small town, while the other four were in busy suburbs of large cities. Our findings suggest that several aspects of location can have an impact on social well-being. The main impact of location in terms of social well-being seems to be on access to the local community and the opportunities it

provides for social interaction. For example, schemes in a rural area are less likely than those in an urban setting to be within easy reach of shops, banks and other community-based facilities, particularly for tenants who are physically frail. One scheme manager described the problems that a rural location could cause for some tenants:

Yes I think it causes them more problems because there isn't a good public transport system out here especially, and also the fact that there's no local shop that's a big downside. We've sort of found alternatives but none of them are ideal really and unless people have got supportive families that can come and take them out it's not easy.
(Scheme Manager 024)

It can also be more difficult for people living in rural schemes to maintain contact with external friends, unless they live very locally. Equally, it is less likely that people from the local community will visit a scheme to use facilities such as the shop and restaurant if it is difficult to access, and this can also reduce opportunities for social interaction. However, it is important to recognise that there are some potential advantages to being in a rural setting. Scheme F was situated on an 'island', which was connected to the mainland by a narrow spit of land. This meant that most of the people living in the scheme had previously lived in the nearby small town, and many had previously known each other. As one tenant put it,

Well it's mostly <name of island> people so where it's a small island you get to, you know ... and I've got to know quite a lot of the people.
(Female tenant 007)

Although the setting of this scheme made it more difficult for tenants to access some of their social networks and facilities in the wider community, it had inherited from the 'island' a feeling of close community as a result of its relatively remote and isolated location.

Other aspects of where a scheme is located can apply to both urban and rural schemes. For example, good access to footpaths, bus routes, post boxes and pedestrian crossing can all encourage tenants to get out and interact with the local community. The nature of the immediate site on which an extra care scheme is built is also important, particularly for physically frail tenants. Five of the schemes in this study were built on fairly level sites, which provided good access to the garden and the wider community. However, Scheme F sat on a sloping piece of ground, and this did appear to impact on the opportunities for tenants to go outside. The communal garden was virtually 'out of bounds' for all tenants because the sloping paths could

be slippery, particularly in wet weather. In the following quote, the scheme manager acknowledges the restrictions that the site could cause for tenants.

It's not very good because physically we're in a very hilly situation and we haven't got buses that come directly to our door. We have got the disabled bus, the mobility bus that will take people into town once a week in wheelchairs and motorised scooters, so that can be organised if they're signed up for that service.

(Scheme Manager 005)

This quote also raises the issue of accessible design and its role in social interaction and well-being for tenants. One tenant was full of praise for the design of her extra care accommodation, which she compared with her previous home.

They had these big security doors which you went out but I was on the 6th floor. I could go through the door but where could I go with a Zimmer? I couldn't get on a bus or do anything so it was no good going out there. I couldn't just go outside and stand on the forecourt doing nothing and then sometimes of an evening I used to feel a bit sad.

(Female tenant 104)

In comparison, she could now move around the scheme with relative ease to meet up with other tenants and access a range of on-site services. However, it is also important that tenants have access to the walking aids that they need. One tenant found walking painful and could only just move around her own flat. She felt that an electric wheelchair would improve her life considerably, but had been advised by local assessors that she did not qualify for one. She felt that she was being denied access to parts of her own home, as described by the following quote.

When I have to go outside I'm so shattered and I can't get round the garden. They said that because I could manage to get around me house they didn't think it was necessary. But I thought well that's all wrong, this whole building is my house, there's a shop downstairs. It's painful getting down there and I've never heard any more about it.

(Female tenant 041)

This situation is very much an exception; the majority of tenants enjoy access to all parts of the building and have the opportunity to take a full part in the social life of the scheme. However, supporting tenants to maintain an independent social life away from the scheme is more of a challenge. Enabling access to wider social networks and other community links is the key element in achieving this. Several tenants with

impaired mobility found it difficult to get out of the housing scheme, as the following quote describes.

I can't, not with this (indicates wheelchair). It's far too hard for me to go out with this. When I first came I had a chair at home and I kept hitting the door, but here I can just go straight through.

(Male tenant 016)

This quote highlights the benefits of accessible design within the scheme in terms of wheelchair access. Another wheelchair user did regularly go out on his electric scooter and gained a lot of pleasure from his trips to the local park.

I go up there on me scooter in the summer time. In the bandstand there's usually a band. There's always lots of stuff going on, on a Sunday.

(Male tenant 040)

This tenant had considered going further into the city but was wary of doing so because some of the pavements did not have dropped kerbs. Accessible design needs to extend beyond the immediate scheme and also be implemented in the local community. Scheme B, which was also in an urban setting, did have good local pavements, and many tenants used scooters to access local friends and shops, but going any further was more difficult. There was a train station 300 yards away, but it could only be accessed by a flight of steps. There were several bus services that served the local area, but the nearest stop was a ten minute walk away. This can act as a major barrier to tenants who are physically frail and highlights the need for better integration of extra care housing with local services and amenities. The manager of one scheme had applied for a post box to be moved so that it was easier for tenants to access, but the process had proved to be very long and bureaucratic. This may seem a relatively minor issue, but small details like this can have a significant impact on the opportunity for tenants to go beyond the scheme and engage with the local community.

Staffing issues and the culture of care

It is evident that the culture of care that operates within an extra care housing scheme is a major factor in tenants' overall quality of life and well-being. The findings of this study demonstrate that this culture can also have an impact on social well-being. To a large extent, the overall approach within any scheme towards tenant welfare and well-being is determined by the policies of provider organisations and the experience and attitude of scheme managers and other staff. Recent research

literature argues for a person-centred approach to care provision, largely on the grounds that this is the only way to identify and address the needs of older people, including the maximisation of their quality of life, well-being and independence. This approach is promoted by Housing 21, the service provider for all six schemes in this study, as reflected in their mission statement: 'To promote independence and choice for older people through quality housing, care and support'. This was reflected in the attitude and enthusiasm of the scheme managers who were interviewed in the project.

For some tenants, care staff are their biggest source of social contact, and this is most likely to be the case for those who have little or no regular contact with family and friends. At a general level, the system of care working in operation may be important. Some schemes operated a key-worker system whereby one or two care staff regularly supported each tenant, while other schemes have a more generic approach. It could be argued that the key-worker system offers more opportunity for social interaction through the development of a stronger relationship between tenants and staff. There is certainly evidence that tenants appreciated contact with care staff, as the following quote indicates.

They are great the girls, always cheerful you know and they always ask how you are, but I think sometimes they must feel tired. But they don't moan, they have got a big cheerful smile.
(Female tenant 104)

The opportunity for staff to interact with tenants on a social basis can also be limited by the task-orientated nature of the contract with the local council to provide care and support. This means that, in theory, tenants should be charged for time that staff spend sitting and chatting with them. One tenant described how this system operates, saying 'sometimes they haven't got time and you have to sign their book, but usually they have at least 5 or 10 minutes talk with you' (Female tenant 050). In practice, a more flexible approach is often taken and staff frequently give up some of their own time. One scheme also had a number of ex-staff who volunteered to come in and help out for specific events and trips in this way. Another scheme had an established group of 'Friends' who provided a range of support, including arranging trips and raising funds. Overall there appeared to be scope for further work in developing links with external 'supporters' for the benefit of tenants.

A task-centred approach also impacts on the ability to support tenants in accessing activities and facilities both within the scheme and beyond it in the local community. This may be particularly true for those who had little or no contact with friends or family carers. There is little or no capacity to offer additional support to help a tenant

get out, unless a tenant pays extra for this service. The limitations that this can place on social interaction are illustrated by the following quote from a tenant who was unable to walk more than a few steps unaided but did not qualify for an electric wheelchair.

I pay for everything and I'd have to start paying for all of that. But apart from that, even if I was I would still try to help myself get around and that's the only way I could really manage without any effort, an automatic chair.
(Female tenant 041)

However, variations in staffing levels and systems may have an impact on the extent to which this is a barrier to social interaction. One scheme manager was clear that there was sufficient flexibility in their staffing system to overcome this issue for most tenants.

I'm not conscious of it being a real problem here because we're generally pretty aware of the people that need assistance down to anything and the regular events. I think we do have the time generally, unless there was something exceptional going on.
(Scheme Manager 024)

Restrictions on the availability of staff to help tenants on external trips may be less of a problem in schemes that have a funded activities coordinator who can accompany them.

Another feature of care provision in the extra care setting is that, while some care is available 24 hours a day, the staffing is at a lower level in the evenings and at night time. In one scheme, a single member of staff was on duty after 5 p.m. and at weekends, which limited the opportunity for tenants with impaired mobility to get around the court and attend social activities, as described by the tenant below.

But the only problem we find here is that all the staff have gone by five o'clock so we're virtually then back in your own flat for the evening. You feel like a lot of children shut in for the night, especially the people in wheelchairs, because there's no staff to bring them out. The wheelchair people can't participate because we are not allowed to ... I mean, my husband could push someone in a wheelchair out of their flat but we're not allowed, of course, because of health and safety.
(Female tenant 106)

This is not Housing 21's policy, but it is a widely held perception in this particular setting and is an example of how a minor misconception or miscommunication can significantly undermine the potential for social well-being of disabled people. It is a particularly pertinent issue, given that the Disability Discrimination Act states that housing providers must make 'reasonable adjustments' to ensure that disabled people are not treated less favourably owing to their disability. Since this project has been carried out, steps have been taken locally by staff to review procedures and address this issue.

In order to supplement the qualitative data collected, this study also planned to use the Bradburn Affect Balance Scale (Bradburn *et al.*, 1965) as a measure of participants' well-being. However, the researchers experienced difficulties using it in this setting, and the limited amount of data collected did not allow substantial analysis. A detailed description of the problems encountered and the data collected is in Appendix B.

6 Discussion and conclusions

This research has explored the social lives of people living in extra care housing and has identified a range of factors that can affect their social well-being. Most tenants who were interviewed as part of the study felt that they had a good social life and reported a high level of satisfaction with their quality of life. Having their own home and the independence that it provided seemed to be an important part of this, as was the overall extra care housing environment, the friends they made within it and the contact that they had with the wider community. A minority of participants were less integrated socially and reported feeling isolated and lonely at times. This was most common among specific groups of tenants, including people with physical frailties or impaired mobility, people with cognitive impairment and single men. This finding is consistent with previous work highlighting that, while housing with care settings may be conducive to friendship and community formation for some, for others they could be alienating. This led to evidence of marginalisation of groups of residents who are frail or cognitively impaired (Percival, 2001; Croucher *et al.*, 2006).

For most tenants, the friendships and acquaintances that they develop within the scheme provide the focus of their social lives. This supports findings from previous research, which have identified the role of social networks in promoting quality of life and well-being in other long-term care settings (Phillipson, 1997; Gilbert and Hirdes, 2000; Godfrey *et al.*, 2004). Our findings also confirm previous research literature that reports a reluctance among male tenants to take part in organised social activities (Department of Health, 2002). The fact that women live longer than men has led to the phenomenon of ‘the male minority’ in extra care housing and other similar settings. This study has found men to be at greater risk of social isolation and has identified the need to provide activities that match their interests and preferences. A men’s group had been established in one of the schemes that took part in the study and was a good example of what can be achieved in this respect. Three of the male participants in this study lived with their spouses, and they all spent much of their time in their flats together.

This study has also found that, as in other care settings, developing and maintaining friendships within extra care schemes is largely dependent on having opportunities for social interaction through a range of activities, both organised and informal. All the schemes in the study had some organised activities on offer, but some were much livelier than others. The reasons for differences in levels of social activity are similar to those identified by Valletly *et al.* (2006) and included staffing and funding arrangements. In addition, however, this study found two contrasting models for organising activities: staff led and tenant led. The latter seemed to offer some potential advantages, including providing a sense of purpose for the organisers,

engaging with more tenants, and raising money to fund further events and purchase equipment. However, the success of this model would appear to depend on the willingness and the ability of a sufficient number of tenants to take on the role of 'organisers'. Also, scheme staff need to be aware of the fact that changes in the health status of tenant-organisers can affect their ability to take on this role. This therefore seems to be an issue that needs to be considered and decided on a case-by-case basis, depending on the situation in each scheme.

Schemes also differed in the extent to which they provided activities that were creative and inclusive, or activities offering an element of rehabilitation. Access to these activities is important, given increasing evidence demonstrating their significance in improving well-being and maintaining levels of activity in older people (Houston, 1998; Atchley, 1998; Heliker *et al.*, 2000; Hillman, 2002; Warr *et al.*, 2004; Hays and Minichiello, 2005). Findings from this study suggest that more attention needs to be paid to how such activities can be provided more widely and inclusively, while also recognising the need for imaginative solutions to fund-raising. Extra care housing provides a home for a wide range of older people, and there was some indication of a lack of understanding and tolerance of this diversity within the housing communities. Addressing this issue is crucial owing to the importance of a diverse and 'balanced' community in supporting social well-being. In this context, diversity can include age, culture, care needs, living arrangements, mobility and aspirations. In terms of balance, it is also important to take into account changes over time in terms of health needs and levels of dependency in long-term care settings. A lack of understanding and tolerance about the aim of extra care housing to support diversity can lead to some tenants becoming excluded and socially isolated. It is therefore important to consider the role of marketing and other forms of information in clarifying exactly what extra care is and who it is aimed at. These issues are currently being addressed by the extra care housing kite marking group, discussed previously in this report.

Extra care housing schemes typically provide a range of facilities, including shops, restaurants, computer rooms, beauty salons, hairdressers, gyms and gardens. This study confirms the importance of such facilities in terms of maximising independence for tenants as well as acting as venues for social interaction. Shops and restaurants are particularly important in this respect and also attract people from the local community into the scheme. Those that do have a shop or a restaurant seem to have more of a 'buzz' about them. *Opportunity Age* stresses the importance of active ageing in communities, and there is clearly potential for the best extra care schemes to act as a community 'hub' for health and care services, as well as a broader range of amenities and activities that aim to promote well-being. This study, though small scale and qualitative, has given examples of cases where this is working well. The

strategic role of extra care housing as a resource to promote social well-being and active ageing should be a key feature of local older people's strategies and be clearly linked to Local Area Agreements.

However, there are economic barriers to the provision of shops and restaurants. Many small, local businesses of this type find it hard to stay economically viable in the long term. This study has shown that the lack of an on-site restaurant can have a detrimental effect on the social well-being of tenants. Given the demonstrable benefits to the well-being of tenants and the wider community and the long-term sustainability of extra care housing, providers and commissioners should consider innovative approaches to the provision of shops and restaurants, even if this means subsidising them. The new commissioning consultation *Commissioning Framework for Health and Wellbeing* (Department of Health, 2007) emphasises the value of services which promote and prolong well-being. Thus, long-term sustainable solutions should be sought using this framework as a basis. For example, commissioners could think about developing incentives for local businesses who provide services within extra care schemes.

Communal lounges are the focal point of social interaction for many tenants and can serve as a venue for a wide range of activities. Some schemes also have smaller lounges around the scheme that can create a sense of local 'neighbourhood' for those who live near them. This point has direct relevance to the 'personalisation agenda'. The new commissioning framework emphasises the importance of putting people at the heart of the commissioning process and designing facilities and services around their needs. Designers of extra care housing should be mindful of the need to provide spaces within schemes so that residents can use them creatively and personalise them actively.

For many tenants, then, their main social interaction takes place within the extra care scheme. However, for others the opportunity for an independent social life beyond the housing scheme is equally important. This includes contact with a range of friends, organisations and family members. Family carers are a major source of social contact for most tenants, and virtually the only source for some. In addition, they provide a range of practical and emotional support, including helping tenants to access the local community and the facilities it provides. Croucher *et al.*'s (2006) review concluded that more intimate and confiding relationships were most important in terms of maintaining a sense of well-being and were generally with family and friends from outside their housing setting. It is therefore important that scheme managers build on existing good practice with tenants' families while encouraging and supporting relatives in their role through good communication and arrangements that facilitate their involvement.

A common feature of the schemes in this study was the indoor 'street' around which the facilities and accommodation are arranged. This provides a safe, dry and level environment which encourages tenants to get around the scheme and interact with others. While not a complete alternative to getting out into the wider community, it does offer some advantages as a living environment for people who are physically frail and those with cognitive impairments. While extra care housing is a flexible model that is provided through a great variety of designs, it is important to ensure that design features that support social well-being continue to be implemented.

This study builds on previous work by the authors that highlighted the importance of the extra care environment in supporting independence (Vallelly *et al.*, 2006; Evans *et al.*, 2007). It also highlights how the layout and design of a scheme can have an impact on social well-being by incorporating features that welcome friends and relatives into the scheme and by providing a suitable environment in which tenants can entertain their guests. Location has also emerged as important, and those schemes that are rural can face additional challenges in terms of enabling tenants to access their social networks in the wider local community. In particular, this study highlights the challenges to community participation posed by restricted access to community transport, poorly designed and located street furniture and lack of available support staff to facilitate outings. In addition, independence for those with impaired mobility is significantly influenced by the nature of the site on which a scheme sits.

Landscapes that are not level can reduce access to scheme gardens and present problems for tenants who want to access local facilities on foot or by wheelchair. Again, these difficulties need to be addressed with reference to the new commissioning framework. Commissioning extra care housing for well-being means that commissioners, providers and partners need to think carefully about the wider location of schemes. The Sure Start to Later Life (ODPM, 2006) initiative points out that a decent home is vital to the well-being of older people. This definition should be applied not just to the physical design and repair of the home, but also to its accessibility to wider community amenities and transport facilities.

Social well-being is also influenced by the culture of care within a scheme. Several authors have identified the value of person-centred care that recognises the importance of an inclusive approach to interaction and does not limit independence by over-cautious risk management strategies (Armstrong-Esther *et al.*, 1994; Nolan *et al.*, 2004; Evans and Means, 2006). The value of this 'personalised service' approach has been recognised recently by the Minister for Social Exclusion, along with the challenges to achieving it (*The Guardian*, 2007). Our study emphasises the role of care staff as a major source of social interaction for some tenants, particularly

those who have little contact with relatives, which makes the system of care delivery vital. Contracts for care provision are usually focused on practical care and support tasks, making it hard for staff to spend time 'just sitting and chatting' with tenants. The availability of staff resources can also affect the opportunity for some tenants to get around within the court. One tenant who used a wheelchair often had to eat lunch in her flat because no appropriately trained staff were available to take her down to the restaurant. At the time of writing, the impact of the Disability Discrimination Act on extra care housing is difficult to assess, but it is clear that the requirement for housing providers to make 'reasonable adjustments' so that disabled people are treated equally will mean that situations such as this are not only unacceptable, but also against the law and regulatory requirements. Activities and services in extra care housing must be inclusive and, as of December 2007, social housing providers will need to undertake extensive reviews of policies and procedures to fulfil their Disability Equality Duty. The findings of this study also suggest that key-working systems can offer greater opportunities for tenants to develop stronger relationships with the staff who support them.

One key aim of this project has been to focus on the experiences of 'frail' tenants and identify factors that affect their social well-being in particular. The difficulties of defining the broad concept of 'frailty' have been discussed in the literature review that forms part of this project, but we can identify some specific challenges for promoting social well-being for people with physical and mental frailties in extra care housing. A large proportion of people living in extra care housing are physically frail and, for many of the tenants in our study, this included some level of impaired mobility. As a result, many tenants used some form of walking aid, including Zimmer frames, wheelchairs and electric scooters. This has implications for the findings of this study in relation to several of the factors that have been identified as important to social well-being. The research literature suggests that people who are physically frail and those with cognitive impairments tend to have lower levels of social interaction (Gilbart and Hirdes, 2000). Our study confirms this finding in the extra care housing setting and has explored the reasons for this in more depth. Through its design and layout, and with a person-centred model of care, extra care housing is an extremely supportive environment for people who are physically frail. It can provide an accessible design that offers good opportunities for social interaction within the scheme and can support the use of a range of walking aids.

This study has confirmed previous research highlighting that an important element of successful ageing is engagement in the community and the opportunity to take part in activities that connect residents to the outside community (Wistow *et al.*, 2003; Owen, 2006). However, it also demonstrates the difficulties tenants sometimes face in their attempts to go further afield, particularly where there is a lack of accessible

community transport. Participants in the study mentioned several community-based transport schemes that they used to access local facilities and services. These services were highly valued by tenants, who often went in groups and also did shopping for others who could not get out so easily. However, demand for this kind of service far exceeds supply, and it can be difficult to book transport when it is needed. The Sure Start to Later Life agenda recognises the value of community transport schemes, and these are especially important in rural and isolated areas. Cost is also an issue; although most schemes are subsidised, tenants have to meet some of the cost and can find it hard to afford. One tenant described a subsidised bus service that took her to a local supermarket, but it only ran once a month, and she was reluctant to take a taxi instead because of the cost.

There are therefore many challenges to promoting independent social interaction for tenants with physical frailties. These challenges tend to be greater for schemes that are isolated owing to their physical location or the nature of the site on which they sit.

This highlights the need for more research that examines the issues of community integration and participation in housing with care settings. Promoting social well-being for tenants is therefore a complex matter which needs careful consideration. By taking into account a comprehensive range of factors such as these as early as possible in the development of a housing scheme, the social needs of tenants can be given the prominence they require. It is therefore essential that social well-being is considered as a central factor in the commissioning, planning, designing and managing of extra care housing and other forms of housing and care provision.

7 Implications for practice

This study has identified a range of good practice examples in terms of promoting social well-being, as well as exploring some of the potential barriers and challenges.

This final section of the report draws on the main themes from the findings to identify some implications for good practice. These take the form of examples of good practice (Table 2), potential barriers to social well-being (Table 3) and a summary of the key messages from the study. It is envisaged that these will be relevant to a range of stakeholders, including commissioners, providers, care staff, designers, planners and researchers. Although the research was carried out in the setting of extra care housing, it is believed that many of these good practice points are also relevant to other housing and care settings.

Table 2 Good practice in promoting social well-being

■	Provide restaurants, shops, gardens and other on-site facilities as venues for tenants to interact and also to attract people from the local community into extra care schemes.
■	Provide some small 'pod' lounges or similar spaces which tenants can use in ways they choose in order to create a feeling of ownership and belonging.
■	Establish links with local schools and arrange for the children to hold a Christmas concert at the scheme.
■	Encourage community groups to use the facilities for meetings, lunch clubs, healthy living days, religious services and parties.
■	Organise a range of regular and one-off activities, including music sessions, dance workshops, exercise classes, and arts and craft sessions.
■	Provide roomy, well-designed flats that create a suitable environment for visits from other tenants, family members and external friends.
■	Incorporate a well-designed reception area that provides a friendly welcome for visitors from the local community.
■	Ensure good access to local footpaths, bus routes, post boxes and pedestrian crossings in order to allow tenants to get out and interact with the local community.
■	Operating a key worker system that maximises the opportunity for social interaction through the development of a stronger relationship between tenants and staff.
■	Incorporate detailed information on care and support plans about the individual, their interests, hobbies and preferences for activities.
■	Include 'local connection with the area' as part of the allocation assessment criteria. Having common points of reference, schools, work-places and local landmarks can stimulate a sense of community, belonging and friendship among the resident population of extra care schemes.
■	Encourage volunteering: find ways to enable people in the local community to help out with specific events and take part in fund-raising activities. Former staff or residents' family contacts and friends can be 'champions' for promoting voluntary work within extra care settings

Table 3 Potential barriers to promoting social well-being

■	Bingo is fine but it is not enough! If only a narrow range of social activities is available, not all tenants will be willing or able to take part.
■	Limited funding can make it difficult to put on an interesting and varied range of activities and external trips. Imaginative approaches to fund-raising are required.
■	Misunderstanding the aim and nature of extra care housing can lead to social exclusion. It is important that marketing and other information is clear about the value of diversity in terms of supporting tenants with different care needs, levels of dependency and aspirations.
■	A lack of on-site facilities can limit opportunities for social interaction: a shop, a restaurant and an accessible garden are particularly important in this respect.
■	Poor design and location can restrict opportunities to access the wider community, particularly for tenants with impaired mobility and reduced cognitive function.
■	A lack of affordable, accessible transport can be a barrier to tenants who want to access facilities and social networks in the wider community.
■	Lower levels of staffing in the evenings and at weekends can restrict opportunities for tenants with impaired mobility to socialise with other tenants because no-one is available to help them get around.
■	An overcautious approach to risk management can limit opportunities for social interaction, particularly for tenants with impaired mobility.
■	For some tenants, care staff are a major source of social interaction. Task-led systems of care provision can limit the opportunities for staff and tenants to interact.
■	Hilly sites, uneven pavements and poorly situated pedestrian crossings are all examples of potential barriers to getting around, and these can have a particularly negative impact on people with impaired mobility.
■	The absence of a comfortable and affordable guest room can discourage friends and relatives from visiting tenants and providing essential social contact.

Key messages for promoting social well-being

- 1 The social well-being of tenants is an important factor that needs to be taken into account fully in the planning, designing and managing of extra care housing. It is particularly important to assess and review policy and practice for promoting social well-being for tenants with impaired mobility and reduced cognitive function.
- 2 Some tenants are at particular risk of social exclusion, including people who have recently moved in, people who do not receive regular contact from family or friends and people who have impaired mobility. Tenants likely to come into these categories should be identified and offered appropriate additional support.
- 3 There is scope to develop an indicator of risk of social exclusion; criteria could include impaired mobility, low levels of contact with friends and relatives, cognitive impairment and single men.

- 4 Organised activities offer the main opportunity for social interaction for many tenants. It is therefore important to provide and facilitate activities that are adequately funded and cater for a range of interests and abilities. Good practice could be standardised through the specification of activity requirements in contracts with local authorities. Careful consideration needs to be given to how activities are organised. Staff-led and tenant-led models both have advantages and disadvantages, and the choice depends to a large extent on the preferences and abilities of tenants in any particular housing scheme.
- 5 Good, accessible design throughout a housing scheme is central to promoting social interaction for all tenants, particularly those with physical impairments and reduced cognitive function. The opportunity to develop and maintain a social life that is independent of the housing scheme is also crucial. This means facilitating tenants to engage with the wider community through, for example, accessible design and transport.
- 6 Facilities provide an important venue for social interaction and can support independence. Restaurants and shops are particularly important in this respect and can also attract people from the wider local community into a scheme. Restaurants and shops should, therefore, be considered in the core specifications when commissioning a scheme. Funders and providers should also give careful consideration to including a range of other amenities.
- 7 A person-centred approach to care provision can contribute towards social well-being. This should be based on comprehensive personal profiles developed in collaboration with tenants, their relatives and referrers. Referral forms and care plans often pay scant reference to this, but it is crucial to providing services that promote well-being and link to the new commissioning agenda and the personalisation agenda. This also marks good practice related to self-directed support.
- 8 Key working systems can maximise the benefits of interaction with staff, particularly for tenants at the greatest risk of social exclusion. Staff need appropriate training and support to enable them to promote social well-being.
- 9 Diversity is a key feature of extra care housing in terms of age, care needs, health status, cognitive functioning and aspirations. Social well-being depends on a range of stakeholders understanding and tolerating this diversity, including tenants, family carers and professionals across housing, health and social care. Clear information and good communication are key to achieving this. Owing to the small scale of this study, it has not been possible to address specific issues

concerned with ethnicity and culture. However, housing providers need to think increasingly about cultural diversity in reference to the services and facilities they provide.

- 10 Extra care housing is a relatively new and increasingly popular choice for older people. The evidence for its effectiveness is still thin and further areas suggested for study include: the impact of systems of care provision; how to maximise support for couples; an evaluation of the value of extra care to the wider community it serves; gender issues; and the role of specific facilities in supporting independence and quality of life.
- 11 It is important that an evidence base of good practice is developed and disseminated. The involvement of designers, local planners, service providers and other interested parties at an early stage of development is crucial to achieving schemes that are integrated with the local community.
- 12 It is important that care and support services are provided and maintained outside core hours of work (9 a.m. to 5 p.m.). In addition to ensuring that sufficient paid staff are available at these times, a number of creative solutions have been indicated in this study, such as engaging volunteers and local people with a connection to the scheme to provide activities.
- 13 The findings of this report suggest the need for information on supporting social well-being to be included in profiles of extra care housing and other long-term care options. This information could be disseminated through the EAC database, as part of the forthcoming Extra Care Kite Mark scheme and used as part of the housing provider's marketing material.
- 14 Extra care housing is well-placed to deliver the strategic objectives outlined in *Opportunity Age* (2005) of promoting well-being and the health of older people in the communities it serves. More research is needed to explore the impact that extra care has within the wider community.

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Appendix A: Scheme profiles – case study sites

Scheme A: Oak House, Nr Ipswich, Suffolk

Location

Oak House is in a predominantly rural area of Suffolk. The scheme opened in March 2004 and is situated in Stutton, a small village on the Shotleigh Peninsula about six miles outside Ipswich. The village has two pubs, a hairdressing salon and a veterinary surgery but no shop. Three miles away is a larger village which has more amenities, including a post office.

Description (size and type of accommodation, facilities, activities, etc.)

The building has a very modern European style design, mainly of wood, brick and glass. It has a spacious, airy feel and benefits from plenty of natural light. Communal areas are homely and include lots of sofas and chairs. There are also a number of smaller 'pod' lounges near to tenants' flats. There is a pleasant, well-planted garden with a number of seats and a paved circular walk.

Oak House is one of several 'very sheltered housing with extra care' schemes that have been developed as part of Suffolk County Council's strategy on older people. Oak House itself is a re-provision of an older residential care scheme which was located close to the new site. Several tenants and staff moved from the previous facility to Oak House.

Oak House has 38 flats, two of which are allocated for respite/intermediate care. Eight of the flats have two bedrooms, and all others have one. A specialist 'extra care' unit, designed to meet the specific needs of people with dementia, is incorporated into the scheme and has an additional set of key fob-controlled security doors. Like the rest of the scheme, each flat within the specialist unit has a lounge, kitchen, shower room and one or two bedrooms.

Activities and facilities

Scheme facilities include a restaurant, three assisted bathrooms, all with hoists and one with a jacuzzi bath, five small 'pod' lounges, a hairdressing salon, a laundry for staff and tenant use, and a guest room. A large room is available for day services three days a week, one of these days for specific needs – mainly dementia and mental health.

Catering services were not available at the time of opening but commenced approximately a year later. Community transport is available if booked in advance.

An activities coordinator is funded half time through Supporting People. Activities include music nights, games and entertainment by local schools.

Staffing

At the time of the research, the scheme manager was on secondment to a new Housing 21 scheme in the South East and her post was covered by a deputy. She is employed by Housing 21, but her post is half funded by Social Services. Care staff are seconded from Social Services. An administrative assistant post is part funded by Social Services. A key-worker system operates whereby each support worker 'keyworks' several tenants, and each senior support worker supervises several support workers. senior support workers lead on care plans.

Health care

District nurses visit once or twice a day and see about eight tenants. A local GP has been allocated to the scheme and visits weekly, as well as being on call. The scheme also has access to a psychogeriatrician. A number of tenants are under a community psychiatric nurse (CPN), who is also on the allocations panel. There is a contract with a local chiropodist who visits regularly.

Scheme B: Cedar Court, Lewisham

Location

Cedar Court opened in 2001 in Grove Park, Lewisham, London. It is situated in a suburban, residential area with a 15 minute uphill walk to the local shops on a busy main road.

Description (size and type of accommodation, facilities, activities, etc.)

Cedar Court has 40 flats; 38 are one bedroom and two have two bedrooms. The scheme is light and airy and designed with colours and signs to aid orientation for people with cognitive impairments. There are security doors to prevent unwarranted access, but tenants can use a press pad to exit during the day.

Each flat comprises a lounge, kitchen, shower room and one or two bedrooms, and there is an emergency alarm pull cord in every room. Three of the flats are respite apartments for people discharged directly from hospital as a temporary measure.

The building has a very modern design, mainly of brick and glass. There is a separate lounge and activities room and small dining room with a hatch servery. These communal areas are designed to be inviting and comfortable, and have lots of easy chairs. There is a small pleasant, planted garden tended by contractors.

Activities and communal facilities

There is an on-site day centre, which is accessible to tenants if specifically referred. The day centre provides a service to many older people in the local community and provides a range of activities, including music therapy, exercise classes, arts and crafts.

The scheme also has a hairdressing salon, chiropody/optician room and a laundry for staff and tenant use.

The carers provide activities when time allows, and this tends to be coffee mornings and afternoon tea. The scheme has established good links with local community organisations. Some tenants attend regular 'aqua-fitness' sessions – part of a service organised by a local voluntary group that provides transport. Additionally, local church groups offer outings and coffee mornings to some residents.

Referrals and allocation

Social Services have 100 per cent nomination rights, and the district council coordinates housing applications. Referrals come from Lewisham Social Services, and Housing 21 undertake an assessment for suitability as well as clarifying care plans. The allocation panel sits fortnightly and includes the scheme manager, a district council representative and Social Services. The scheme manager has the

final say of who takes a tenancy. The minimum age for tenancy is 60 years, but exceptions can be made for people registered disabled over 55 years old.

Staffing

The scheme manager is employed by Housing 21 and is responsible for both housing and care management. A key worker system is in place, and care plans are coordinated by senior support workers.

Health care

District nurses visit once or twice a day and see about eight tenants. Each resident has their own GP and visits on demand. There is a contract with a local chiropodist who visits regularly.

Scheme C: Fountain Court, Gateshead

Location

Fountain Court opened in 2004 and is located in Bensham, a suburban area two miles out of Gateshead town centre.

Description (size and type of accommodation, facilities, activities, etc.)

Fountain Court consists of 40 one-bedroom apartments, each of which can accommodate couples. The scheme is designed to be fully wheelchair accessible. The building is a modern construction of brick and glass, designed to give a light and welcoming atmosphere, particularly on the ground floor where most of the communal amenities are located. The scheme was designed with the wider community in mind, including an open plan reception area.

Activities and communal amenities

Communal facilities include a lounge, a dining room, a small shop, a hair salon, a restaurant, a guest accommodation suite, a health care suite, a laundry for use by staff and residents, a well-maintained garden and a community centre.

There are a range of activities on site to suit a wide range of needs and aspirations. Regular social activities include a lunch/tea club, cinema nights, bingo and quiz evenings. The restaurant is open daily and is also open to the public, along with the shop and the hair salon. A visiting greengrocer sets up stall in the reception area one day a week, offering local fresh fruit and vegetables for sale. The scheme has previously been awarded funding for various innovative activities, including a community arts project which was funded by the Baltic art gallery in recognition of the fact that older people often lose the potential for developing and consolidating skills in arts and crafts when they move to specialist accommodation. Though this project has now ceased, the scheme still runs an arts and crafts afternoon every Monday.

Additionally, a resident committee organises activities and events for residents as well as raising funds.

Referrals and allocation

All residents have a care package of at least four hours per week and/or a carer/partner who needs more structured support or respite services. Allocation criteria also look at housing-related needs, such as the need for supported housing and connections with the local area. Gateshead MBC have full nomination rights to the scheme.

Staffing

The scheme manager manages both the housing and care services. She is supported by an administrative officer and a Housing 21 Care Options team with two seniors /care supervisors.

Health care

All residents have their own GP – no one practice is ascribed to the scheme. A mobile dentist, chiropodist, CPN, district nurses and an optician all visit regularly, often using the health suite as a consulting room facility.

Scheme D: Winton Court, Gateshead

Location

Winton Court is situated in Winlaton, a suburb which was at one time a small village. Bus stops for local routes are very close by, just outside the perimeter of the scheme grounds. The on-site shop and restaurant are used frequently by residents and the wider community.

Description (size and type of accommodation, facilities, activities, etc.)

Winton Court was developed in partnership with Gateshead MBC and opened in 2003. The scheme comprises 40 one-bedroom flats designed for occupation of one or two people and is fully wheelchair accessible. The scheme is a modern brick and glass construction, designed to have a light and airy feel.

Activities and communal facilities

The communal facilities include a lounge, a restaurant (open 8.30 a.m. to 6.30 p.m.), a shop, guest facilities, a laundry for use by staff and residents, a well-maintained garden, a community centre and an activities room. The restaurant and shop are open to the wider community.

There is a broad programme of social activities and events designed to involve the wider community and to suit a wide range of diverse needs. A lunch club is held regularly, and a men's group, open to the local community, is held fortnightly. Additional activities include bingo, arts and crafts, singalongs and quiz evenings.

Referrals and allocation

All residents have a care package of at least four hours per week and/or a carer/partner who needs more structured support or respite services. Allocation criteria also look at housing-related needs, such as the need for supported housing and connections with the local area. Gateshead MBC have full nomination rights to the scheme.

Staffing

The scheme manager (non-resident) is responsible for housing management and on-site care services.

Health care

All residents have their own GP – no one practice is ascribed to the scheme, and a range of other health care professionals visit on a regular basis.

Scheme E: Brookside House, Liverpool

Location

Brookside House is in the Knotty Ash suburban area of Liverpool, about three miles from the city centre. There is a bus stop about 500 metres away, providing regular services into the city.

Description (size and type of accommodation, facilities, activities, etc.)

Brookside House opened in 2004. It is an innovative scheme, having been developed by Housing 21 in partnership with the Liverpool Housing Action Trust. The scheme has a ground-breaking design, based on an 'indoor street' layout, and it links to a tower block that houses older people in sheltered accommodation and a community centre providing a range of services. The extra care scheme has 40 flats designed to be occupied by one or two people. Half the flats have two bedrooms, and the remainder have one bedroom.

Activities and facilities

The scheme has a range of communal facilities including a restaurant, a tenants' lounge, a hairdressing salon, a laundry, a health care suite, a small gymnasium, a resource centre, an IT centre, a sun terrace, private landscaped gardens and day care on site. Many of the amenities are open to the wider community. A local Residents' Community Association, which includes representatives from the adjoining sheltered housing scheme, works in partnership with Housing 21 staff to manage and deliver a range of services and activities.

Referrals and allocation

Referrals are made via Liverpool Social Services Department. All residents have a care package (minimum four hours per week or a visit by carers once a day) and a need for supported housing. The allocation criteria also prioritises people who have a local connection to the area, and – where couples are concerned – takes account of the needs that carers have for structured support or respite. The allocations panel consists of the scheme manager and representatives from the local Social Services department.

Staffing

The non-resident scheme manager is responsible for managing both the housing and on-site care services. Care is provided by a Housing 21 Care Options team.

Health Care

All residents have their own GP – no one practice is ascribed to the scheme. A mobile dentist, chiropodist, district nurses and an optician all visit regularly.

Scheme F: Foyle Bank, Portland, Dorset

Location

Foyle Bank was opened in October 2005. It is situated on the Portland peninsula and is thus in a fairly remote location. A bus stop located 500 metres away from the scheme has a regular local bus service linking the 'island' to the 'mainland'. Close by is a local community centre and a GP practice. The 'island' is generally hilly and the scheme itself sits on a fairly exposed slope overlooking the sea.

Description (size and type of accommodation, facilities, activities, etc.)

The scheme comprises 37 flats for rent and 11 bungalows, which are available on a shared ownership basis. It is designed to fit in with the distinctive local character of the built environment in the area. There are 19 two-bedroom flats/bungalows, and the remainder have one bedroom.

Activities and facilities

The scheme includes a lounge, a dining room, a hair salon, a treatment room used by visiting opticians, chiropodists and dentists, guest facilities and a private, well-maintained garden. The dining room is not a full catering facility, and meals are provided by a local delivery service. Regular social activities include bingo, games and quiz afternoons, coffee mornings, outings and on-site sales. The local bakery visits once a week to sell a range of cakes, pastries and breads to residents. The paper delivery service also deals with ad hoc requests for shopping. A beautician also visits weekly, providing manicures, facials, massages and a range of 'treatments to enhance well-being' for residents. A mobile library service calls every six weeks.

Foyle Bank has established a tenant committee, and this group raises funds and provides activities and outings for residents. Additionally, support staff work informally with residents when time allows, facilitating reminiscence sessions and informal get togethers.

Referrals and allocation

A joint allocations panel consists of the scheme manager, the housing department and local health and social care representatives. To be eligible to be considered for a tenancy at Foyle Bank, people must be on the Dorset Housing Register and have a local connection with Portland. The leasehold criteria are different.

Staffing

During the period that the research was carried out, the care was provided off site by local social care agencies. However, the care contract went to tender in autumn 2006, and Housing 21 won the contract, so an on-site Housing 21 team will be established from mid-May 2007. The scheme manager oversees both the housing and care services and does currently have a team of on-site support staff.

Health care

The scheme is adjacent to a GP practice and has a very positive relationship with the practice, with which all residents are registered. The local chemist provides deliveries to residents twice a week, a mobile dentist visits the scheme frequently, and a local chiropodist visits every six weeks.

Appendix B: A quantitative measure of ‘social well-being’

To put the findings from the qualitative work in context, a tool was sought to give an overall rating to social well-being for all the participants. Having reviewed various indices for calculating a score for psychological well-being, the authors selected the Bradburn Affect Balance Scale (Bradburn *et al.*, 1965) for the following reasons. First, it is a long-standing and well-established tool, having been devised in the 1960s, and has been used in many studies and different settings, thus it should enable comparability of data arising from this study to other similar studies. Secondly, the index is short, containing only ten questions, and the scoring system is simple.

The research process was designed to be simple and not time consuming. Respondents were asked whether they would complete the short questionnaire when the interview commenced, and they were given the choice of self-completion or an assisted completion by the interviewer. A quarter of the participants declined to complete the questionnaire and, of those that did, some left questions incomplete. Thus we have a data set containing 15 cases which is not sufficient to make inferences on the profile of the sample as a whole.

Of the ten questions on the Bradburn scale, four caused particular problems, thus resulting in missing data. The questions and number of respondents who completed them are detailed in Table A1. The table shows that only six of the ten questions presented no problems to respondents. Additionally, there were several questions that the interviewers had to paraphrase so that the meaning was clear. The ‘on top of the world’ question presented particular difficulties to respondents, and interviewers questioned the appropriateness of asking someone who is wheelchair bound whether they felt ‘so restless that they could not sit long in a chair’. In both cases, interviewers frequently re-phrased the questions, which placed a further limitation on the value of the resulting data.

With the list of caveats discussed above, the value of the data is clearly limited. None the less, it is interesting to note that the questions which yielded the highest level of agreement were to do with pride due to the compliments of others and pleasure at having achieved something. The first question, in particular, clearly relates to social well-being. Only two respondents felt lonely or remote, and only one person said they felt depressed. It may be the case that respondents were reluctant to disclose negative feelings to interviewers. The data were coded to result in an overall happiness score. This is detailed in Table A2 and Figure A1. Fifty-three per

cent of the 15 respondents were reasonably happy, though 20 per cent were not. In a bigger study, it would be useful to compare this finding to other variables such as demographics and locations. However, the small size of the data set in this study makes this level of comparison unrealistic and could compromise the anonymity of respondents.

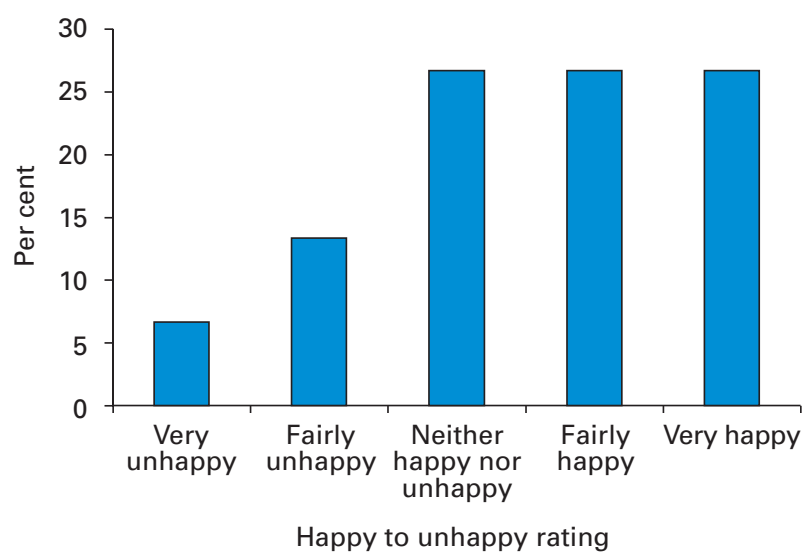
The experiences of using a quantitative measure of social well-being in this study with 'frail' older people indicates a clear need for a more 'user friendly' tool.

Table A1 Completion rates for the Bradburn Affect Balance Scale

Question	% who said 'yes'	No. of completed cases	No. of missing values
Did you feel particularly excited about something?	33	11	4
Did you feel so restless that you couldn't sit long in a chair?	33	15	0
Proud because someone complimented you on something?	87	15	0
Very lonely or remote from other people	13	15	0
Pleased at having accomplished something	67	13	2
Bored	33	15	0
On top of the world	33	9	6
Depressed or very unhappy	7	15	0
That things were going your way	33	9	6
Upset because someone criticised you	27	15	0

Table A2 Scores on overall happiness rating ('Affect Balance Score')

	Frequency	Per cent	Valid %	Cumulative %
Very unhappy	1	6.7	6.7	6.7
Fairly unhappy	2	13.3	13.3	20.0
Neither happy nor unhappy	4	26.7	26.7	46.7
Fairly happy	4	26.7	26.7	73.3
Very happy	4	26.7	26.7	100.0
Total	15	100.0	100.0	

Figure A1 Happiness ratings by percentage of respondents

Appendix C: Interview topic guides

Interview schedule 1: tenants

START

- A. What is it like living at (name of scheme)?
 - How long have you lived here?
 - Where did you live before you moved here?
- B. Tell me about how you spend your time in (name of housing scheme)
 - What activities do you take part in?
 - Are there activities you don't take part in and if so why not?
 - Are there other activities you would like to be offered?
 - How much time do you spend away from your home here?
- C. Tell me about your social life at (name of scheme)
 - How do you get on with the other tenants?
 - Did you know any of the other tenants before you moved in?
 - Do you have any family and friends who live nearby?
- D. What facilities do you use at (name of scheme)?
 - Are there facilities you don't use and if so why?
 - Are there other facilities you would like to see provided?
 - Do you use any facilities in the local community?
 - Do you think the scheme is in a good location?
- E. Do you receive any care and support services here?
 - How helpful are these services?
 - Are there any ways in which these services could be improved?
- F. How would you describe your quality of life?
 - Do you feel you have a say in how the scheme is run?
- G. Is there anything else you would like to say about living at (name of scheme)?

END

Interview schedule 2: managers

START

A. How would you describe the social well-being and quality of life of the tenants of (name of scheme)?

What do you think are the main factors in promoting their well-being?

How easy is it for tenants to have an independent social life?

To what extent do tenants have a say in the running of the scheme?

B. What activities are provided for tenants?

How easy is it for tenants to access these?

Who arranges the activities?

Are there other activities which you think should be provided?

C. What facilities are provided for tenants?

How well are they used?

Are there other facilities you think should be provided?

What facilities are there in the local community?

Do you think the scheme is in a good location?

D. How do you feel tenants get on with each other generally?

How much contact do tenants have with the outside community?

E. What care and support services are available to tenants?

How helpful are these services?

To what extent do they influence social well-being?

Are there any ways in which these services could be improved?

F. What do you think are the main barriers to social well-being for tenants?

END

