The Essential Ingredients of Extra Care

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Summary
This paper presents findings from a survey that set out to identify and rank order the essential ingredients of extra care housing schemes and their associated services, that was conducted among the members of the Department of Health (DH) Housing Learning and Improvement Network (LIN) during the Spring of 2006. The literature on extra care housing offers numerous definitions of the features that are considered to be either essential or optional to any extra care housing scheme and, in practice, the range of housing and support that is actually provided in such schemes is extremely wide. Yet despite the wealth of advice currently contained in guidelines and embodied in demonstration projects, the concept is beset by 'confusions and complexities', (Tinker *et al*., submitted). Based on the relevant literature, the survey proposed a checklist of twenty-five essential ingredients for extra care that respondents were asked to score on a five point Likert scale. As well as allowing these to be ranked in terms of their overall perceived importance to the extra care housing model, the survey identified seven additional criteria that were not strongly represented in the literature. Whilst there was a large measure of agreement about the three highest ranking features - flexible care, self-contained dwellings and a 'homely' feel to the building - some of the middle ranking features – communal lounge, kitchen and dining room, guest room, assisted bathrooms and laundry room - generated opposing viewpoints that are reported in the paper. Other contentious topics included the use of amenities provided in extra care settings by older people living in the surrounding local community and the value for money that extra care represents as compared to alternative models of housing and support such as telecare, that can be delivered to people living independently in their own homes.

Keywords: extra care, housing, support, defining features, design issues

Background to the survey

In a previous paper, (Wojgani *et al*., 2006), twenty-five key features of extra care housing and support were derived from a careful analysis of the relevant literature. The literature review from which these features of extra care were drawn, included both web-based and library resources that had been published within the last ten years, that were written in English and that related primarily to UK policy or practice. A feature was only included in the checklist if it was mentioned in several publications. **Table 1**, below, lists the features in alphabetical order.

Table 1: Key features of extra care		13	Guest room
1	Activity co-ordinator	14	Laundry room
2	Activity room	15	Lifts
3	Assisted bathrooms	16	Lively locality
4	Balanced community	17	Living at home, not in a home
5	Communal dining space	18	On-site support staff
6	Communal kitchen	19	Rebuilds skills for independent living
7	Communal lounge	20	Scheme manager
8	Consulting room	21	Self contained dwellings
9	Culturally sensitive service	22	Smart and assistive technology, social alarm
10	Day centre	23	Twenty four hour on site support
11	Flexible care	24	Well being facilities
12	Flexible design	25	Wheelchair accessible throughout

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The features were then modelled by means of a Venn diagram, to show how each contributed to the design of an extra care building and to the design of its social life and service delivery (Parry and Thompson, 2005), see **Figure 1** below. The same twenty five features were also modelled to show how each contributed to the core values of the extra care housing model, namely independence, social inclusion and support/care, see **Figure 2**, below. Whilst these diagrams are helpful in revealing the interdependence of the various features listed, modelling them in this way does not show the relative importance that each might have in contributing to the overall success of an extra care scheme.

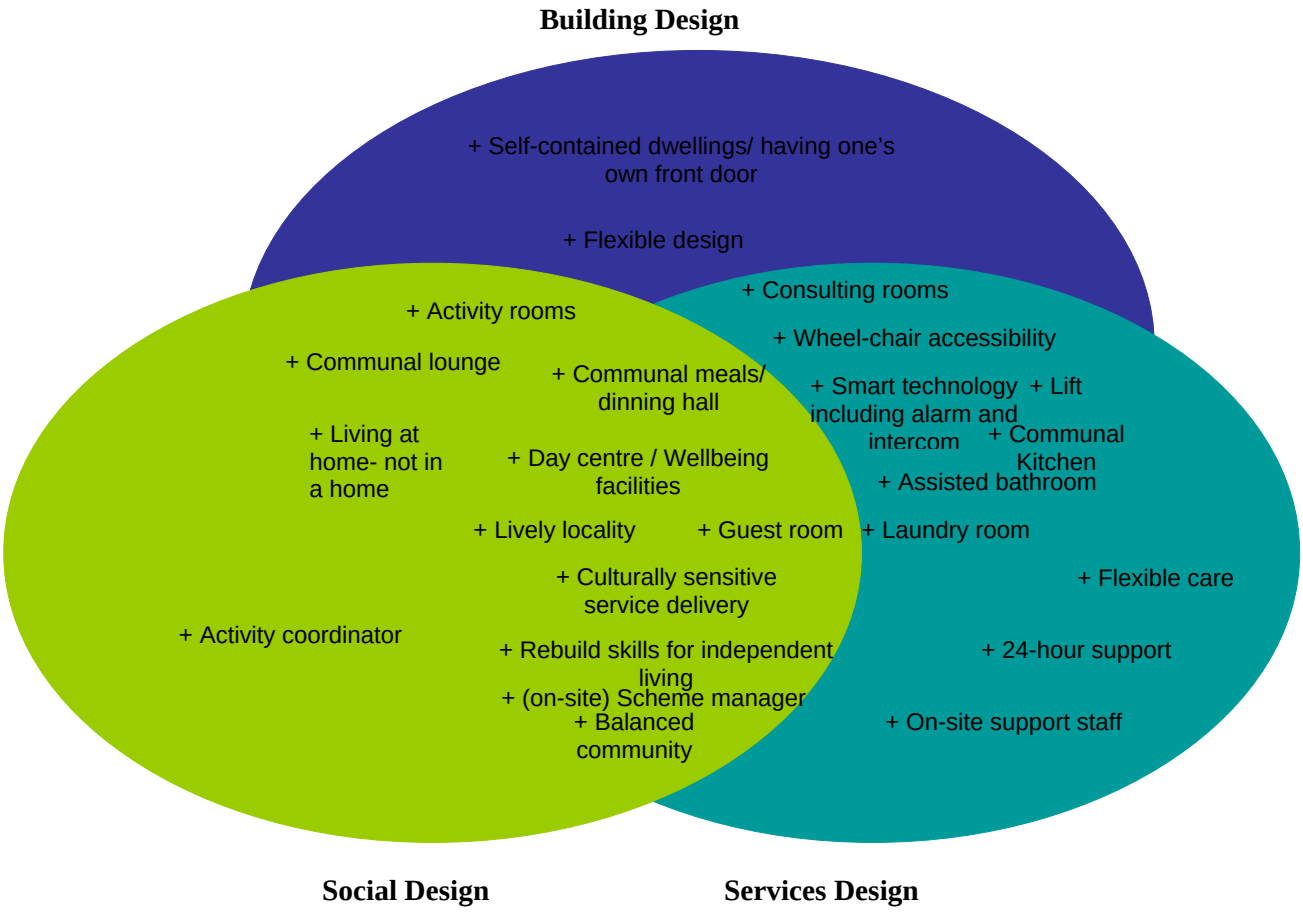

Figure 1: Diagram showing the interrelationships between the design components of extra care

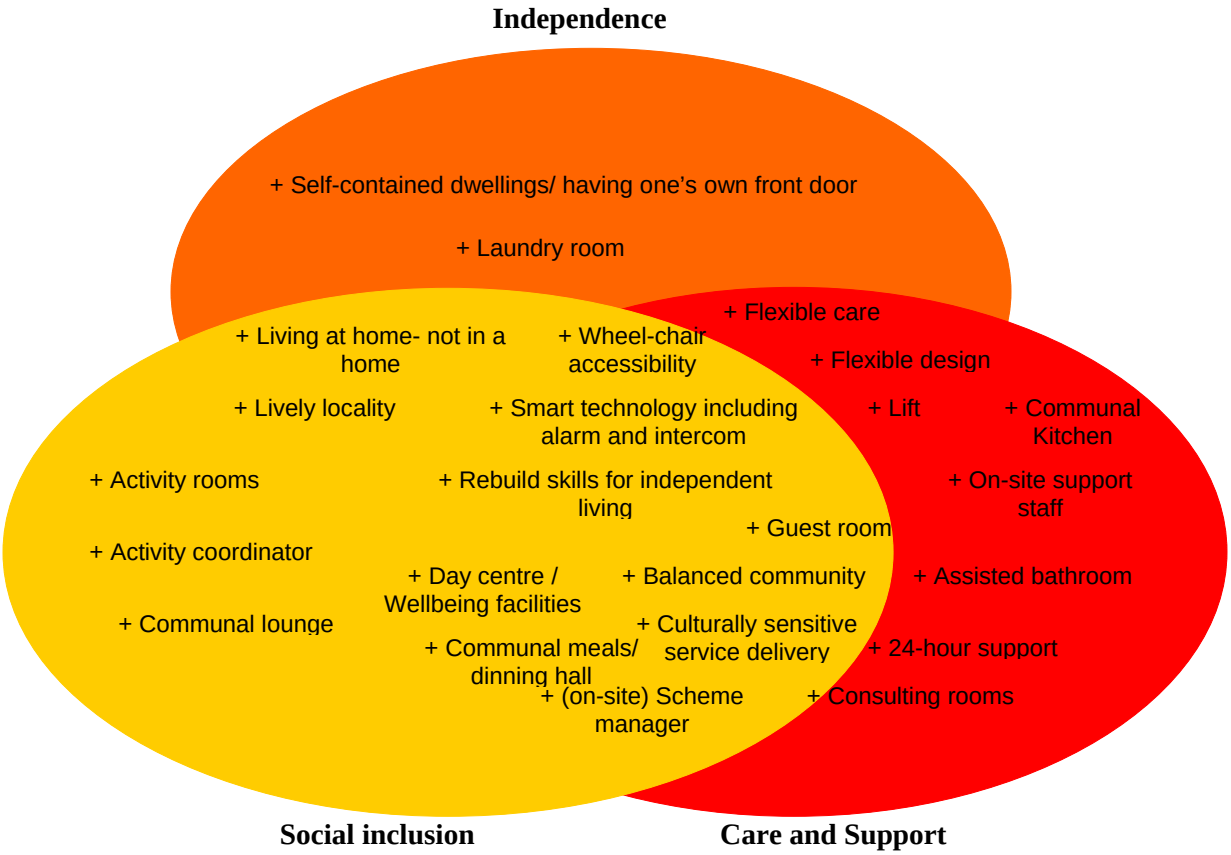

Figure 2: Diagram showing the interrelationships between the core values of extra care

In order to determine the relative importance of each feature, an email survey was therefore conducted amongst the membership of the DH Housing LIN in the Spring of 2006. The Housing LIN was established in 2002 under the auspices of the Health and Social Care Change Agent Team in the Care Service Improvement Service (CSIP), as a national network for promoting new ideas and supporting change in the delivery of housing, care and support services for older and vulnerable people. It is responsible for supporting the implementation and sharing of learning from the Department of Health's Extra Care Housing Grant arrangements and related housing, care and support capital and revenue programmes. Its regional and national networks bring together health, social care and housing commissioners and senior managers from the public, private and voluntary sectors involved in the planning, commissioning, development and delivery of housing, care and support solutions for older and vulnerable people.

A total of 137 responses was received from the members of the network. The survey asked each respondent to rate each of the twenty five features shown in **Table 1**, according to whether it was perceived as very important, important, neither important or unimportant, unimportant or very unimportant to the concept of Extra Care. Space was left for each respondent to add up to five additional features not previously mentioned in the survey. In practice, some of these overlapped with features that were named and so they were discounted, but seven genuinely new features emerged from the process of

consultation. These can now be added to the list, but they cannot be rated as not all the respondents had an opportunity to consider them in the same way as the original features.

Respondents were asked to provide details of their current position and job title, so that the responses could later be sorted according to whether the respondent was engaged in providing housing, care and support, financial services or strategic advice to their employer, and also according to whether they worked for a Local Authority, Housing Association, support and care provider or health authority. Many respondents took the opportunity to feed back to the team qualitative comments that further elaborated on their voting pattern.

Rank Order of Features

The mean and standard deviation was found for each feature in the survey (n=137[2]) and the means were then ranked to show the highest scoring answer first and the lowest last, see **Table 2**, below. The descriptive statistics were generated 'blind', that is, without reference to the actual questions, and these were only coded after the analysis had been completed.

Table 2: Rank order of features ranked by mean score

Question number	Mean	Standard deviation	Rank of mean	Rank of st. dev.
22	3.9343	0.2487	1	25[3]
2	3.9265	0.262	2	24
1	3.9044	0.2951	3	23
13	3.8905	0.3573	4	22
15	3.8686	0.3989	5	21
24	3.7794	0.5401	6	19
20	3.7059	0.5036	7	20
3	3.6277	0.5425	8	18
19	3.5401	0.556	9	17
4	3.5329	0.5822	10	16
7	3.5147	0.6884	11	14
11	3.367	0.6976	12	13
6	3.3235	0.8247	13	7
23	3.3185	0.8865	14	2
12	3.1752	0.8035	15	9
9	3.1544	0.7188	16	12
18	3.1314	0.6622	17	15
10	3.1297	0.7715	18	11
14	3.0584	0.9056	19	1[4]
17	3.0511	0.8687	20	4
21	2.9852	0.8809	21	3
8	2.8613	0.8061	22	8
25	2.8	0.8621	23	5
5	2.6861	0.7929	24	10

[2] [2] Missing cases were excluded list-wise in each test described below where missing cases needed to be taken into account therefore n=130.

[3] The smallest range (shown at the bottom of the rank order) translates into the greatest measure of agreement

[4] The widest range translates into the greatest discord

The first point to note from **Table 2** is that none of the twenty-five features scored over 4 (i.e., were generally agreed to be Very Important). This suggests that most of the features are necessary, but that there is not a strong hierarchy among them that would allow a few particular features to be singled out as being much more important than the rest. Most of the features listed gained a mean score of 3 or above (i.e., were generally agreed to be Important) and only five features scored below 3 (i.e., were generally agreed to be Neither Important nor Unimportant). This suggests that all the features identified in the survey can be considered as equally valid features of an extra care scheme. A more detailed description of the rank order of the features is set out in **Table 3** below.

Table 3: Rank order of features

Rank	Feature	Score
1	Flexible care, responsive to tenants' fluctuating care needs	3.9343
2	Self contained dwellings. Control of one's own front door.	3.9265
3	Living at home, not in a home. A 'homely' feel.	3.9044
4	Premises that are wheelchair accessible throughout	3.8905
5	Lifts to upper floors so that the whole scheme is 'visitable'	3.8686
6	24 hour support on site for those who need it	3.7794
7	Flexible design to adapt to changing needs of tenants	3.7059
8	Providing a culturally sensitive mode of service delivery	3.6277
9	Smart and assistive technology for independent living, including social alarm / intercom	3.5401
10	Rebuilding tenants' skills for independent living.	3.5329
11	On-site support staff who assist tenants with daily chores	3.5147
12	Communal lounge to promote social activities	3.3670
13	Scheme manager to co-ordinate care and support teams	3.3235
14	Assisted bathrooms for use by frail tenants	3.3185
15	Communal dining room where tenants can share meals	3.1752
16	Activity room for use by tenants and local community	3.1544
17	Well being facilities - hairdresser, gym, chiropody etc	3.1314
18	Balanced community, that mixes abilities and types of tenure	3.1297
19	Guest room available for tenants' friends and family to stay	3.0584
20	Communal (commercial) kitchen to serve a fresh mid-day meal on site	3.0511
21	Communal laundry room for the tenants' use	2.9852
22	Activity coordinator to organise tenants' social activities	2.8613
23	Consulting room for visiting health / care professionals	2.8000
24	Lively locality. Scheme located in a well-established neighbourhood	2.6861
25	Day Centre incorporated in the scheme to boost social life	2.5109

Qualitative account of the features of extra care

The actual rank order of the features is striking. Some features that received a great deal of stress in the literature received a lower mean score than others that were not singled out in the literature as topics for lengthy theoretical discussion, implying that they were rather less important. The commentaries that accompanied the survey responses and that are summarised below, may help to shed light on some of these apparent anomalies. Just under half of all respondents (67, 49%) did not make any additional suggestions using the open 'other' category, but 26 individuals (19%) provided one or two additional points, 40 (30%) suggested three to five additional points and 4 (3%) suggested more than five points, with one individual suggesting twelve additional features that could be incorporated into an extra care scheme.

Fifteen people elaborated their accounts by email, and six supplemented their responses to the survey by reference to documents that gave specific details of the extra care policies and practice of their own organisation. All of these have helped to flesh out the raw figures in the quantitative survey by providing important insights into the rationale

that underpins translation of the extra care 'concept' into working practices. There was considerable overlap between the commentaries, and after having worked through about half the responses these began to replicate one another, suggesting that the expanded list of features that has arisen from the consultation process is close to saturation. Statistical tests to determine if there were any noticeable differences in the patterns of scoring according to the respondents' job titles or the types of organisation for which they worked did not reveal any significant differences. This also indicates that a consensus is held by the members of the Housing LIN about the essential ingredients of the extra care concept.

Flexible Care (1)

A large number of additional comments were made in relation to flexible care, ranked most important in respect of the 'extra care' model and also the feature about which the respondents were most in agreement. Stress was laid on the importance of providing person-centred care and the need to develop personal care plans. Respondents spoke about the need to develop an operational policy that emphasised an individualised approach to assessment and care, whilst others stressed the need for joint support and care plans or for a 'seamless service'. One respondent pointed out that, in order to achieve this, clear 'care pathways and protocols' need to be developed. Others pointed to the need to provide housing-related support as well as care, and a benefits information service for residents. In this respect the principle of a 'core and flexi-budget' to meet varying needs of tenants was proposed.

However, opinions differed on the best way to deliver this goal. One respondent stressed the need for a 'team approach, irrespective of the organisation that the staff actually work for', and another advocated a dedicated multi-disciplinary care team that included a social worker, occupational therapist, physiotherapist and community nurse. Some argued for a separately commissioned care team or for an integrated care and support team, whilst one respondent described a situation where care teams and support teams worked separately but were managed together. Other respondents stressed the need to develop 'well thought-through and negotiated links' with local primary care services, hospitals and social services departments or described the potential that an extra care approach might have for on-site support and care team to develop links into local community to provide 24 hour support into people's homes, in order to reduce the need for them to move into the extra care scheme itself should their health deteriorate.

The point was made that flexible care should encompass the possibility for support and care to increase with failing health, to avoid a move to a care home or hospital. One respondent stressed the need for through to end-of-life planning and in-house support through to death. Another advocated the need for extra care to address and meet residents' spiritual needs.

Yet others spoke of the related concept of providing a 'home for life', not to be confused with a 'Lifetime Home'[5]. A small number of respondents pointed to a need to focus on provision for older people's mental health, including dementia and Altzheimer's disease. It was pointed out that this would require a sensitively designed building that supported the residents with wayfinding techniques and appropriate use of colour, signage and suchlike.

Self-contained dwellings (2)

[5] A specific set of 16 inclusive design criteria that should ensure that a dwelling is able to accommodate residents with a very wide range of abilities and requirements. However, it should be relatively easy to deliver even quite intensive support/care packages into a Lifetime Home because it has been well-designed in the first place.

In this regard, it was considered important for residents in an extra care scheme to have an en-suite bathroom, and a separate sleeping and sitting area, and definitely a threshold over which the resident has control. It was pointed out that individual kitchens are important for those likely to want to prepare their own meals, but that if meal preparation is likely to be a group activity, shared kitchens may be preferable. Several respondents stressed the need for good design and high space standards in individual apartments. One individual suggested that self-containment might not necessarily be appropriate for a person with dementia.

Living at home, not in a home (3)
There was very little elaboration of this point, but one respondent who referred to the importance of designing with a 'bring me sunshine' concept in mind, may have captured the essence of this feature.

Premises that are wheelchair accessible (4)
It was pointed out that, not only should a scheme be wheelchair accessible, but that it should be designed inclusively throughout so that it could be used by disabled people. Several respondents echoed this viewpoint by suggesting that as well as being wheelchair accessible, the design of the scheme should be dementia-friendly throughout, whilst others noted the need for the scheme to be suitable for people with sensory impairments. Another admitted that, though desirable, this is very difficult to achieve in building conversions. New schemes, however, should be built to 'Lifetime Homes' standards.

Lifts (5)
One respondent advocated two lifts to ensure that access can be maintained at all times to the upper floors of the scheme. Others pointed out that the lift needs to be equipped with an alarm and should be capable of taking a stretcher.

24 hour support on site (6)
Support that is available 24/7 was seen by many as a key defining feature of extra care. However, several respondents questioned why this support needed to be provided on-site, as the care packages currently provided by local social services departments should mean that care can be provided 24/7 in an individual's own home, irrespective of where that home is located. One added, 'In our experience this is often more acceptable than on site care and provides more individualised care and less likelihood of schemes developing into 'care homes'. The point was made that user-friendly alarm systems are also important.

Flexible design (7)
In one respondent's view, this extended to being able to change communal areas to dwelling units if they are under utilised.

Cultural sensitivity (8)
One respondent stressed that this should extend to providing support staff that reflected the cultural mix of the residents, and to offer culturally appropriate meals.

Smart and assistive technology (9)
Several respondents pointed out that this should include computer and internet facilities, either as an internet café or by providing access to the internet within each flat. Others remarked that satellite TV and broadband should be provided as standard. One respondent pointed to the 'huge benefits' of assistive technology, but added that it was an under-used resource, possibly due to funding difficulties. Others mentioned the need for the scheme to have suitable transport for outings.

Rebuilding life skills (10)

In this respect, one respondent pointed to the benefits of the philosophy of 'positive ageing'. Another spoke positively of 'a culture of enablement'. One drew attention to the importance of incorporating rehabilitation facilities such as an 'activities of daily living' kitchen within the scheme, and the availability of trained therapists to ensure maximum benefit is derived from the facility. However, it was suggested by others that rebuilding life skills would only be important if the scheme were developed as a rehabilitative model, or for groups with learning disabilities or as a replacement for residential care.

On-site support staff (11)

Some respondents thought that it was not necessary for the staff to be based on the site of the extra care scheme, so long as domestic services were provided. This could be through community teams. The point was also made that such on-site support staff could reach out to support older people living in the local community beyond the extra care scheme, thereby reducing the need for them to move into the scheme itself.

Communal lounge (12)

This was seen as an important focus for the scheme, and not necessarily just for formal social activities. Some felt that the lounge should be for the exclusive use of residents, whilst others suggested it could be a shared room for residents and the local community. One respondent neatly resolved this by suggesting that the residents themselves should decide who to invite into their communal lounge. Another observed, 'I think the communal lounge and communal dining room are important. However, people should have an option, therefore the accommodation we provide for older people needs to be of a much higher specification with much more space, therefore giving them an option to use communal space.'

Scheme manager (13)

The relationship of the scheme manager to care management provoked a number of observations, including the view that, whilst scheme managers might monitor care, they do not necessarily manage it. Some providers advocated a joint scheme/care management role as one of the essential ingredients of extra care, and it was pointed out that there should be genuine co-ordination if the scheme manager and care manager are regarded as separate roles, as there is a considerable 'cross-over of responsibility'. One respondent clarified that this may depend on the size of the scheme, as 'anything above 40-50 residents may be too much for one person to manage'. It was suggested that part of the role of a scheme manager might be to refer residents on to professional or voluntary groups where extra support was required.

Assisted bathrooms (14)

Although these are used well in some schemes, one respondent felt that this was only because residents' own accommodation either could not be adapted to fit a hoist or because such adaptations are not considered necessary due to there being a communal assisted bathroom within the scheme. Some people strongly argued that in the future everybody's accommodation should incorporate a bath or walk-in shower room that would allow for residents to be helped to bathe in the privacy of their own home, thus rendering an assisted bathroom obsolete. The point was made several times that bathrooms in the individual flats should be designed to support independent living, possibly as a wet room, and that carers should be able to provide this type of intimate support in residents' own flats. One respondent cautioned against even using the term, as older people dislike the connotations associated with assisted bathing.

Communal dining room (15)

It was pointed out that some stakeholders prefer a model where people eat in the privacy of their own homes, but on the other hand for people with dementia there are 'enormous benefits in terms of quality of life' to be derived from schemes that have on site restaurants. It was suggested that this facility should also be available to guests.

Activity room (16)
One respondent suggested that, rather than having separate spaces for day care, treatment rooms or communal meals, one large multipurpose activity room, capable of being screened off for different everyday uses, should suffice. Another made a telling point that if the activity room is used by members of the local community, the building may cease to feel like their own home, and so progressive privacy 'is a must'.

Wellbeing facilities (17)
It was pointed out by several respondents that wellbeing facilities should include health facilities, not necessarily on site, though this may be important in some cases, but certainly easily accessed by residents if they are off site. The phrase 'health resources for healthy lifestyles' possibly sums up this approach. One respondent advocated the use of exercise classes to maintain levels of functional ability.

Some respondents felt strongly that on-site facilities should be open to wider community, to encourage the involvement of the local community within the scheme. A wide range of appropriate facilities was suggested, including a local GP surgery, social care surgery, Citizens' Advice Bureau, and a day centre, Age Concern Centre, or basic IT classes, a corner shop for residents and members of the local community, a pool or spa, hairdressing services and a cash machine. However, one respondent cautioned that, if too much is provided the resident may never go out.

Tenant mix (18)
Here, several respondents advocated the development of a mixed client group, though this could be interpreted in several ways: in terms of mixed ages including both older and younger people; a mix of abilities that included people with learning disabilities and cognitive, physical and sensory disabilities, as well as older people. Some suggested that a scheme should comprise a mixture of sheltered and extra care housing, a 'true mixed community' without any distinction between extra care and sheltered housing, or that the tenure should be both private and social, and it was pointed out that affordable housing options should be included. One respondent suggested that the 'mix' should include an intermediate care unit for people who are returning home from hospital but who need a period of rehabilitation in a non-institutional setting and another advocated a residential care home on an adjacent site. One respondent argued strongly and convincingly that in years to come mixed tenure communities will be the norm, adding that 'the majority of older people are home owners, and it is unlikely that they will aspire to become council or housing association tenants. We must change the mindset that sees sheltered housing and extra care housing as social housing only.'

Guest room (19)
The issue of a guest room provoked a clear divergence of views between those who thought that this was a very necessary feature of extra care, and those who felt strongly that the concept of a guest bedroom was outmoded and that it would be preferable to provide ' two large bedrooms' so that residents could host visitors in their own home. A typical comment along these lines was that, 'there should be none of this type of accommodation, as older people's flats/bungalows/houses should be a minimum of 2 –3 beds to allow them to have the

option to have folk to visit and stay with the same freedom and choice just like you and me.' It was also pointed out that two bedroom properties were needed for couples who found it difficult to share a bedroom due to differences in their sleep patterns, or to permit different generations to stay together. A second bedroom would also allow a carer to be accommodated. Opinions differed as to the proportion of two bedroom flats that should be provided, from a majority of the flats to be capable of accommodating diversity (i.e., to have a second living or bedroom) to as few as 15% of dwellings. One respondent pointed out that the Housing Corporation (2003) has prioritised this, as it requires three habitable rooms to be provided in all new extra care flats[6].

Communal kitchen (20)

A small number of respondents objected to the very concept of a communal kitchen, which they felt smacked somewhat of an institutional approach, and advocated the alternative terms 'café' or 'restaurant', possibly open to the public as well as to the residents of the extra care scheme. Another respondent pointed out that, if there is to be a communal kitchen on the site, this needs to be designed to a commercial/professional standard, and another stressed the need for it to be adequately staffed and funded, so that it can provide a 'proper' meals service. However, one respondent remarked that it was not good practice to impose a service charge to tenants for this service, irrespective of whether they make use of the facility. Others remarked that a method of cross-subsidy needs to be found to resource on-site meals preparation, such as a 'lunch club' or the provision of meals on wheels service to the local community. Finally the point was made that there also needs to be a tea/coffee making facility in the residents' lounge.

Communal laundry room (21)

Whilst one respondent pointed out that the laundry room can be 'a good meeting point' another preferred individual kitchens to be designed with integral 'white goods', including a washing machine. Another stressed that it is important that tenants are able to have their own laundry facilities, if they so wish, with the benefit that carer could also do the laundry in a resident's own home if required. This turned out to be the strong view of a small minority, who felt either that a communal laundry room was an outmoded concept or that it should be a staff facility to be utilised mainly or exclusively by care/support workers. It was felt that, in practice, in an on-site facility where laundry is undertaken as part of a care plan the facility is not often used by tenants, more so by staff. In this respect, it was pointed out that such a laundry would require a very large capacity washer and dryer for washing duvets, blankets and the like. The suggestion was made that care supporters could use the communal laundry to do laundry for people living in the community who had care/support needs.

Activity co-ordinator (22)

This concept received a mixed reception, with some respondents being warmly disposed to the role and others stressing that it is preferable to encourage and support residents to organise their own events and not be dependent on a co-ordinator. Social activities and community engagement are important activities, but it is not necessary that these be provided by a designated co-ordinator. Another pointed out that the role of activity co-ordinator does not meet with Supporting People goals in that it is not possible to fund an activity co-ordinator to organise tenants' social activities, but only someone who will aid the tenants to do this for themselves. Therefore if a traditional activity co-ordinator role is provided, this would have to be funded from elsewhere, e.g. grant, service charges, rental income etc., which may not be acceptable to the tenant.

[6] A policy that can be traced directly to Hanson's earlier (2002) research on older people's housing.

Consulting room (23)
There was some disagreement about the need for a separate consulting room within an extra care scheme, as it was pointed out by several respondents that professionals should generally visit clients in their own homes. However, another pointed out that in view of the government's recent White Paper on social care, consulting rooms will become increasingly important as extra care schemes act as a 'hub' for the delivery of community health services.

Lively Neighbourhood (24)
This was one of the features that scored far lower than the research team had anticipated. However, most respondents stressed the need for an extra care scheme to be an integral part of the local community, not separate from it, close to local shops, the doctor, community centre etc., and that there should be a good (walkable) route to the local facilities and on public transport routes. It was pointed out that, although living in a lively neighbourhood may be ideal, how important it is in practice depends on the scale and range of facilities, services and activities provided at the scheme so that it is much more important for a small scheme with a limited range of on-site provision to be in a 'lively' location than if it is a larger care village. Most people thought that the opportunities for interaction with the wider community need to be positively created and maintained. This may include providing transport for shopping, outings, medical appointments etc., ensuring that buses are accessible to residents with mobility needs. Another respondent pointed out that older people from rural areas may prefer tranquillity, and that it was a question of enabling choice so that both could be achieved.

Day centre (25)
Initially, it was quite surprising to find that this feature was the lowest rated of all those on the list, but the accompanying comments helped to explain why this is so. One respondent expressed the views of several respondents by commenting that it may be more appropriate to build a Day Centre as a separate premises attached to the extra care scheme, rather than to make it integral with the scheme, as this would allow external people to use the centre without upsetting the balance of privacy and independence within the housing scheme itself.

Comparison of the rank order of features with the two models shown in Figures 1 and 2
In Wojgani *et al*. (2006), the point was made that some of the twenty-five features of extra care identified through the literature were relevant to only two dimensions of the core values / design areas, whilst others had a multidimensional impact. It is therefore of interest to see how the rank order of features derived from respondents' voting patterns relates to where each feature has an impact in terms of the design and strategic vision for extra care, see **Table 4** below. It has already been pointed out that it does not follow that a feature that impacts on several facets of extra care should not be assumed to be more important than one that has limited impact, because that impact may still be vital to the successful delivery of the vision that extra care represents, and this is confirmed by the rankings shown below. No feature impinges on every aspect of service delivery, and for each of levels 5-2, some features were ranked high in the overall order of importance whilst others received, relatively speaking, a lower ranking.

Table 4. Rank order of dimensionality of features by rank order of mean score of each feature								
		Core Values			Design areas			
Total	Feature	independence	care & support	social inclusion	building design	service design	social design	Ranked
5	Wheel-chair accessibility	X	X	X	X	X		4
5	Culturally sensitive service		X	X	X	X	X	8
5	Smart technology	X	X	X	X	X		9
5	Rebuild skill for independent living	X	X	X		X	X	10
5	Communal dinning space		X	X	X	X	X	15
5	Wellbeing facilities		X	X	X	X	X	17
5	Guest room		X	X	X	X	X	19
5	Lively locality	X		X	X	X	X	24
5	Day Centre		X	X	X	X	X	25
4	Living at home – not in a home	X		X	X		X	3
4	Lifts	X	X		X	X		5
4	Scheme manager		X	X		X	X	13
4	Mixed community		X	X		X	X	18
3	Flexible care	X	X			X		1
3	Flexible design	X	X		X			7
3	Communal lounge			X	X		X	12
3	Assisted bathrooms		X		X	X		14
3	Activity room			X	X		X	16
3	Communal Kitchen		X		X	X		20
3	Laundry room	X			X	X		21
3	Consulting rooms		X		X	X		23
2	Self-contained dwellings	X			X			2
2	24-hour support		X			X		6
2	On-site support staff		X			X		11
2	Activity coordinator			X			X	22

Additional features not mentioned in the survey

Most suggestions made under the category 'other' could be subsumed to the list of twenty-five key features derived from the literature, but respondents had decided to draw attention to them by proving a more elaborate or nuanced account that reflected their particular concerns. Seven points were genuinely new features and so, even though it is not possible to add these to the rank order of mean scores[7], these will be considered qualitatively in the account that follows and may be incorporated into future models of extra care developed by the research team. The order of reporting these reflects the likely impact that each may have on process management in extra care housing and support.

Shared vision among all the stakeholders

One respondent pointed to the need for a shared vision between the housing provider, care provider and social services, where these organisations are different. Another suggested that a shared vision or ethos needed to be translated into operational agreements.

User consultation at all stages of design and management

It was advocated that, where possible, the intended residents (and their relatives) should be consulted about the scheme design and its facilities. Consultation with the local

[7] Although the individuals who drew attention to these features had usually scored them in terms of their perceived importance, these scores cannot be regarded in the same was as the original 25, as not every respondent had an equal opportunity to score them. Indeed, most represent just one or two people's viewpoints.

community was also advocated at the design stage, so that the scheme would be perceived as 'owned' and supported by local people. Once the scheme was occupied, residents should be involved in choosing the things they like to do and to take part in, possibly through a mechanism such as a tenants' forum. Another individual highlighted the need for residents to have choice and control of all aspects of service provision. A 'tenants' forum' was suggested as a way to achieve this.

Clear information at the point of access
One respondent stressed the need for clear information at the point of access, to ensure that customers' expectations match the service provided, so that once resident the customers of an extra care scheme can judge those services against clear standards.

Assured tenancy agreements
One respondent argued forcefully that an essential ingredient of extra care was security of tenure, achieved through an assured tenancy or lease. Likewise, care should not be a condition of the tenancy, so that individual residents can refuse it. A small number of respondents suggested that a good extra care scheme should have a pet policy and, presumably, this could be part of such a tenancy agreement.

Well-trained staff
It was pointed out by one respondent that a well-trained staff is an essential ingredient of any successful extra care scheme. Another advocated that all staff should be trained in basic mental health support skills. In this respect, it is interesting to note that a few respondents drew attention to the need for well-designed staff accommodation such as an office for the scheme manager, staff room, changing room, overnight sleep-over room and meeting room for four to six people, all placed in a strategic location, not 'tucked away by the boiler room'.

Safe and secure scheme
Several respondents highlighted the importance of security issues. The scheme itself needs to be safe and secure, without overt security or containment. Parking areas and grounds need to be secured, as well as the actual buildings. Other suggestions included 24/7 porter security, CCTV and secure grounds and parking. One or two individuals referred specifically to 'secure by design' criteria. Other suggestions that fell under the rubric of security included the idea that staff should receive safety awareness training and that there should be regular home safety checks on residents identified as vulnerable, coupled to appropriate advice to limit or reduce risk.

Cost effectiveness
One respondent drew attention to the importance of extra care as offering good value for money, adding that 'the only real way to make such schemes cost effective is to adopt a large scale approach, such as the retirement village community design or a core and cluster model…around existing supported housing services for older people.'

Incorporating these additional seven criteria into the Venn diagrams shown earlier in **Figures 1** and **2**, give rise to the diagrams shown in **Figures 3** and **4**, below.

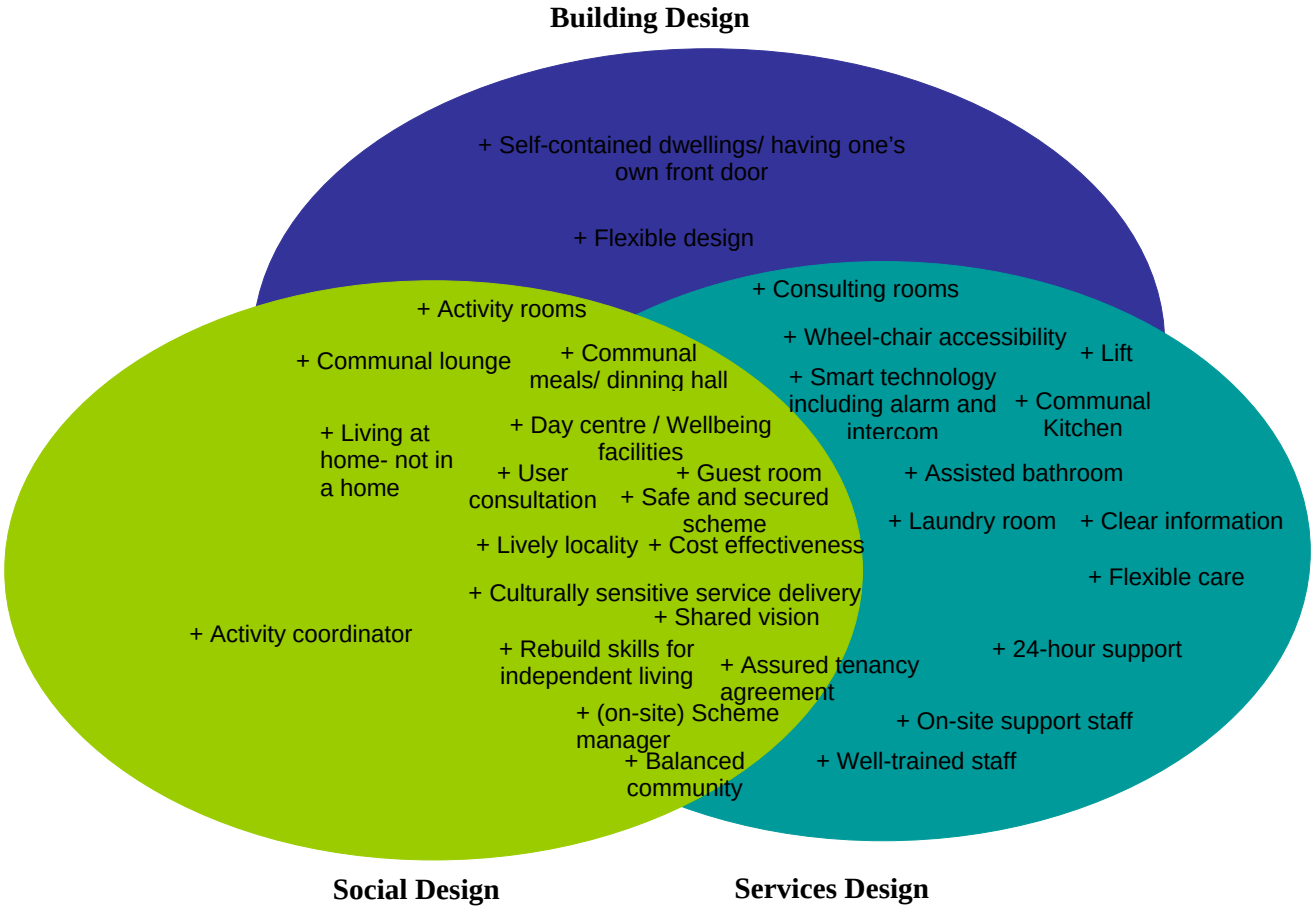

Figure 3: Diagram showing the interrelationships between the design components of extra care

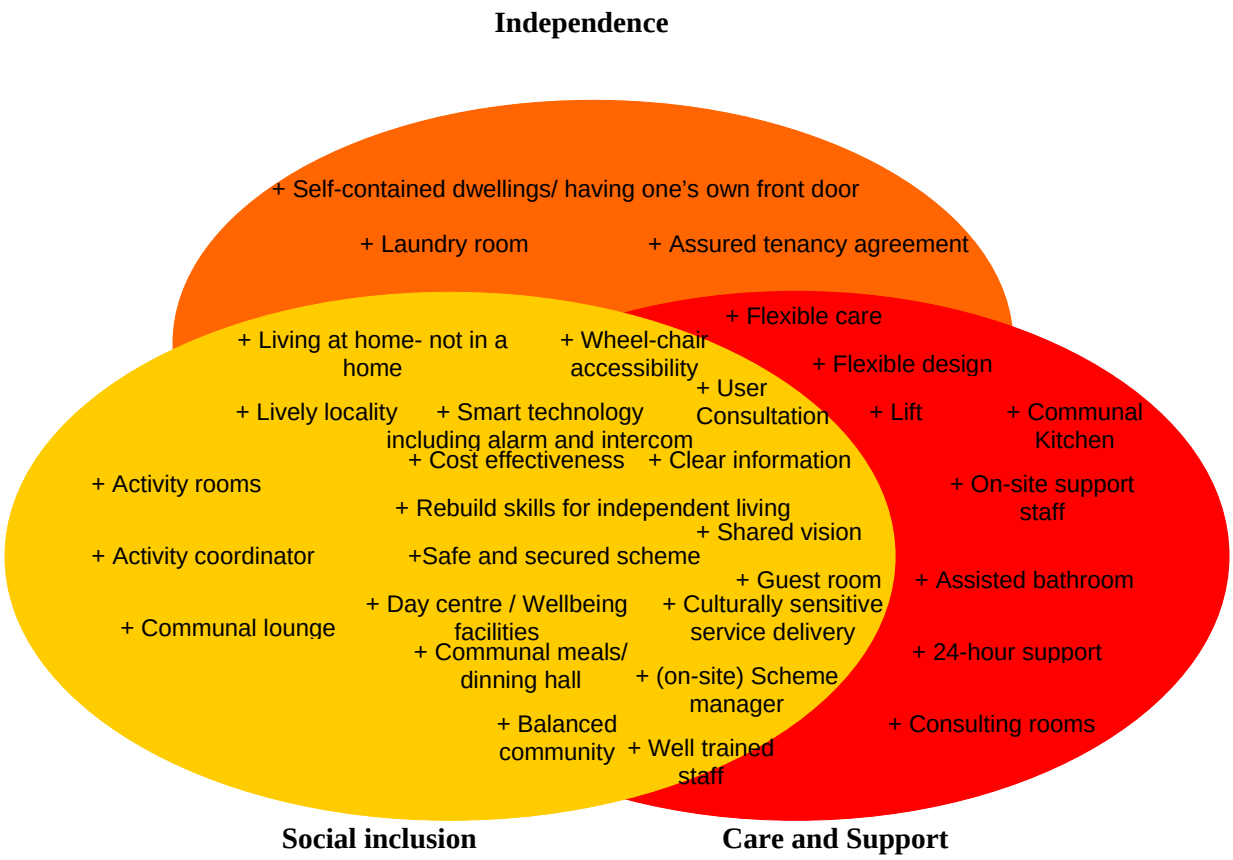

Figure 4: Diagram showing the interrelationships between the core values of extra care

Design Issues

Several respondents elaborated on issues that touched directly on the architectural design of an extra care scheme, either at a strategic or a detailed level. Strategic design issues affect the layout of the entire scheme, and require consideration at scheme inception, as they involve philosophical or principled decision-taking. Detailed design points were made both in respect of the communal areas of an extra care scheme, and with regard to the design of the individual flats. Several of the latter related to Lifetime Homes considerations.

Strategic design

Three strategic issues were raised: non-institutional design; progressive privacy and the design of external spaces. In respect of non-institutional design, the point was made that the circulation areas of an extra care scheme should feel like 'streets', not corridors. Generally the buildings should be designed to work with people, not against them. The public areas should 'feel like a 4 star hotel' and all areas of the scheme should be safe and wheelchair accessible.

Progressive privacy is a concept that is intended sensitively to manage the relationship between residents and visitors to a residential setting. Originally developed to design the circulation areas of

residential care homes, (Torrington, 1996) its relevance to extra care settings is in respect of the proposition that the scheme should encouraged access by members of the local community. Progressive privacy is intended to achieve this in a natural and unforced manner, without compromising the sense of 'territory' of the scheme's permanent residents. Progressive privacy is developed through a three level spatial hierarchy comprising a shallow area that is open to the public and contains all the rooms that visitors might normally be expected to access, a deeper area that is accessed only by the residents of the scheme, and is closed to members of the public and finally the private rooms of individual residents, see **Figure 5** below.

The third strategic design issue concerned the provision of an accessible and welcoming residents' garden or courtyard. The point was made that this could include a special feature that served as a focal point, such as a bowling green. To encourage active gardening, the garden could contain a greenhouse, raised flowerbeds, sensory garden areas and sheltered outdoor seating areas where people could sit out and enjoy the sunshine. Balconies to upper floor flats should be big enough to sit out on. People's flats should have a good view of the space outside.

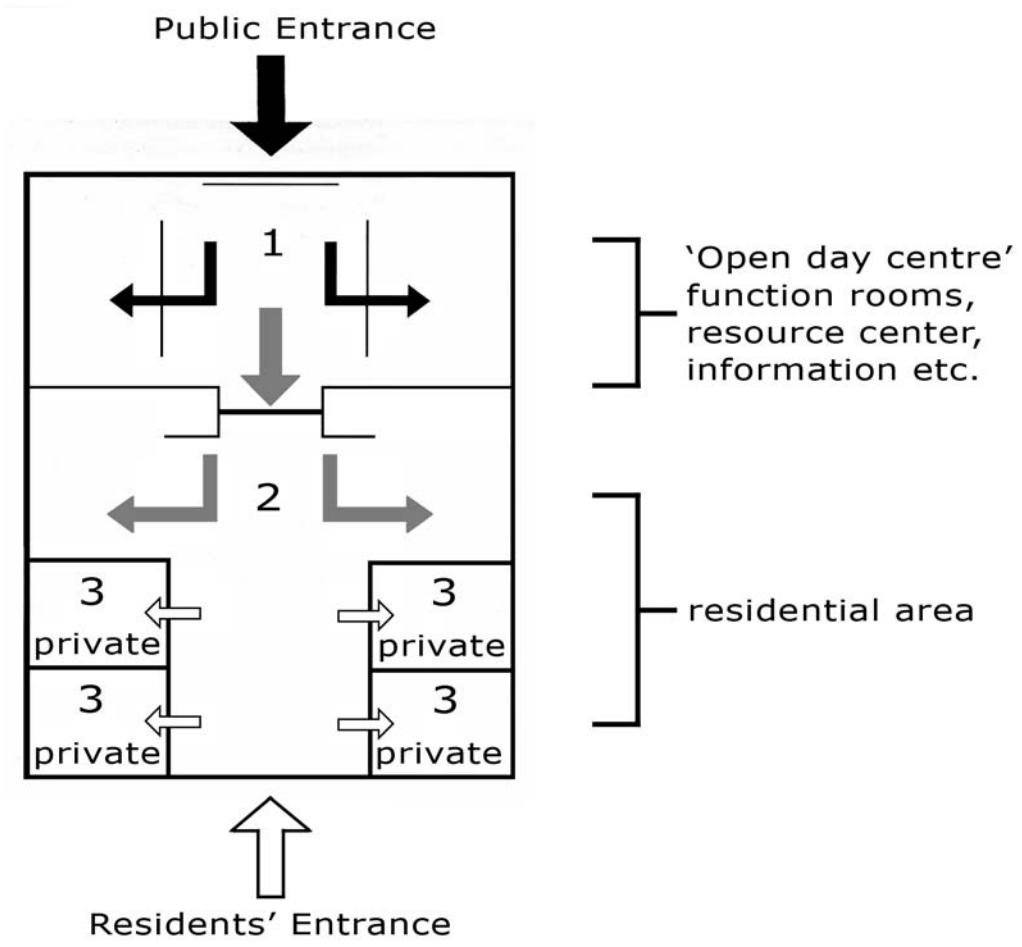

Figure 5: Concept diagram of progressive privacy (after Torrington, 1996)

Detailed design

Several aspects of detailed architectural design that could make an extra care scheme functionally more attractive and easier to access were also singled out by respondents. In respect of the communal areas, these included the need for an information area or room

displaying leaflets and an accessible WC, both located close to the main entrance and communal areas, lightweight fire doors, a scooter store / wheelchair charging room and clear signage that is helpful but not patronising. Others pointed to the need for adequate external and internal illumination to all parts of the scheme and that the décor and lighting levels should be suitable for people with impaired vision. The need for a stimulating environment was also mentioned.

Within the individual flats, it was suggested that low windows should be linked to an interesting feature outside, such as a bird table and that a drying rail in the apartments would be useful, 'as old ladies like to hand wash their 'smalls''. Another respondent stressed the need for generous space standards in the individual flats, as this 'alleviates challenging behaviours'. It was also suggested that the bedrooms need to be distinctly separate from the living room and the bathroom. Other suggestions included the need for walk-in showers in the flats and provision for a hoist to be installed over the bed space.

Discussion

There was unanimity about the three features that scored highest in the rank order of features: flexible care, self-contained dwellings and homeliness. This chimes in well with the findings of Croucher *et al.* (2006) who have defined extra care as 'models where the 'housing component' allows older people to be tenants, owners or leaseholders, with private living space that is theirs and theirs alone, and where the 'care' component is flexible and can address a spectrum of care needs from very low to very high dependency levels that might formerly have resulted in admission to residential care'.

At the same time, a strong divergence of views was identified in respect of several middle-ranking features, including the assisted bathroom, laundry room and guest room. In traditional sheltered housing, these features were usually thought to enhance the facilities provided by the scheme and some service providers still believe this to be the case today, but in terms of the model of extra care others argue that, because today's and tomorrow's older people would most probably prefer these activities to be accommodated in the privacy of their own home where they will be under the direct control of the resident and her family or carers, including these shared service features could actually reduce the perceived quality of the scheme. Similar issues emerged in relation to the communal dining room and kitchen, where the terminology appeared to some respondents to be suggestive of an institutional setting, but where substituting the concept of a restaurant or café would convey a more customer-orientated philosophy of care.

Further areas of debate were identified in respect of the amenities that it is appropriate to include within an extra care scheme, particularly in relation to how to justify the resources these consume. Whilst it is undoubtedly attractive to offer a wide range of resources and activities that promote wellbeing, health and engagement, as well as more standard facilities such as a restaurant and residents' lounge, these were often justified in terms of the added value they would provide to the local community as well as for the residents of the scheme. Frequently, in the case of facilities like a GP surgery, corner shop, Internet café and even a restaurant, it was admitted that the customer base would have to be widened beyond the residents of the scheme to justify the provision of the amenity in financial terms and to make it cost-effective. This raises the thorny issue of who exactly are the customers for the extra care scheme, the residents or the local community?

In this respect, it may be relevant to note that the concept of progressive privacy was developed precisely because of past experiences that over time a perceived conflict of interests could develop between the residents of the scheme, who exerted a territorial claim over the communal facilities and incomers from the local community, who could be perceived as intruders by the resident population. This may go some way to explain the unexpectedly low ranking of features such as consulting rooms (23), a lively locality (24) and a Day Centre (25). There are clear architectural design implications here, not only in respect of physically accommodating a wide range of amenities but also in terms of how to relate them to the main entrance, reception and public areas of the scheme.

Finally, some respondents raised the issue of needing to demonstrate supply and demand in respect of the extra care model of housing and support. If the supply of this particular model of housing with care exceeds demand then it is likely that in future some properties will become difficult to let due to over-provision. The extra care model needs to be evaluated against alternative models of support such as telecare and telehealth, as well as with regard to the more traditional models of sheltered / retirement housing and residential care homes / nursing homes. One respondent therefore warned against regarding extra care as a panacea for all the problems associated with later life living arrangements and suggested that in addition to dimensioning the concept itself, it is important to address and answer the question of how extra care fits into the whole spectrum of care support needs in respect of living independently and purpose built housing.

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