Provision of social care in extra care housing: the ECHO study

- The flexible nature of care provision offered by Extra Care Housing (ECH) was appreciated by most older people participating in the study
- Care workers described the support they provided in terms of 'task and time' which might undermine the flexible nature of care provided in ECH
- There was some reported increase in care needs among residents moving into ECH, potentially undermining the original purpose of enabling residents to maintain their independence
- Commissioners of ECH face financial pressures, increasing need for care and support, competing demands for land and the higher national living wage, which resulted in increased workforce costs
- ECH has the potential to support quality of life for people living with dementia if sufficient and flexible resources can be provided

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BACKGROUND

Extra Care Housing (ECH) is housing with care, a community-based alternative to residential care. There is no definitive model of ECH. It is generally aimed at people over 55; residents have their own apartments usually with a small kitchen area; planned care and support is normally available 24 hours a day, 7 days a week; most schemes provide communal facilities such as a café, laundry and communal space, plus social activities for residents. Care and support is normally provided by an on-site team, but residents can choose to have them provided by an external agency.

To function effectively ECH is thought to need a balance of care needs between residents including some with no/minimal needs; those with medium levels and some with what is often referred to as high care needs.

Providing housing with care is a key element of contemporary adult social care policy. This two-year study (2015–2017) explored how care is negotiated and delivered within ECH schemes.

REFLECTION

The longitudinal qualitative nature of the study worked well to explore, in depth, how care is negotiated and delivered within mainstream ECH from the perspective of residents, managers/ care workers and commissioners of housing with care.

The design also enabled changes in the policy and organisational context to be considered. However, this approach was not as effective with residents of a specialist ECH scheme for people with dementia.

Methods

Four ECH schemes were recruited, one a specialist dementia facility.

51 residents from the four schemes were interviewed on up to four occasions: 10 residents were male; ages ranged from 54–96; 22 were widowed; 14 were divorced/separated, 8 were married, and 7 single. Interviews explored reasons for moving into ECH, care received, changes in needs and experiences of living in ECH.

Managers and five care staff from each scheme, as well as local commissioners of ECH, were interviewed to explore strategic and operational issues including the impact of changes in funding and how care work is organised.

FINDINGS

RESPONSES TO CHANGING CARE NEEDS

The data revealed similarities across all the sites in how changes in the care needs (unplanned care) of residents of ECH were identified and how these were negotiated and responded to by service providers and care workers.

Changes in care needs were sometimes raised by residents, or their families, and discussed with care workers or managers or, in other cases, resulted from a specific medical intervention. However, in most cases changes in need were identified by care workers who either noted a developing additional need, such as social isolation, or responded to an immediate need for more care, for example if a fall impeded mobility and self-care.

Unplanned care needs were logged with managers and, if care was publicly funded, council social services were informed. Generally local authority staff were reported to respond positively to requests for increased funding. However, the speed of response varied, with the consequence that managers had to cover increased care costs until the request was granted, with payments often, but not always, backdated. If residents funded themselves, discussions about formally changing care plans and associated financial consequences were discussed with the resident and/or their family.

The flexible nature of care provision to respond to changing needs offered in ECH was appreciated by most older people participating in the study, indeed many reported that this was one of the reasons that they had chosen to enter extra care.

Some residents reported receiving additional care and support on a temporary basis, for example daily visits after discharge from hospital which ended after several days, or help with cleaning their apartments following a bout of illness. For some residents the changes in their care needs were more significant, requiring permanent changes to the care they received.

FINDINGS

Changes in residents' care needs did not always necessitate an increase in care provision. For example, for some residents, improved health allowed for a reduction in the hours of care they received, while others altered what tasks were to be carried out by care workers within the same timeframe.

Whether changes in care needs were temporary or permanent, in most cases, older people told us that they were responded to in a timely manner.

Most residents told us they were aware of how to request additional care or support if required. However, a small number of residents at two sites reported being declined additional care or support they required during the night time. This was due to fewer staff being available on site at night. Given the increasingly complex needs of residents entering ECH, organisations may need to review the numbers of staff working at night.

THE ORGANISATION OF CARE

Care workers across all sites described the support that they provided to residents by reference to 'task and time', reminiscent of the ways in which some domiciliary care workers describe their work in the community.

Care workers at three sites routinely described that their work was organised as a 'run' and, although this term was not used at the remaining site, workers there described the same pattern in which care was organised. At the beginning of a shift, all care workers received a 'run' which listed the time, duration and nature (task) of each visit they were to make and the order in which these visits were to be carried out.

The organisation of care in this way was a source of stress to many care workers, particularly if the scheme was short staffed or if a resident required unplanned care immediately. Many workers reported feeling frustrated that they were unable to spend time talking to residents even when they appeared lonely or distressed.

Almost all the residents we spoke to were positive about the care they received and appreciative of the workers providing the care. However, some residents alluded to the impact of the organisation of care in 'runs' on the care workers as well as the care which they received. For example, workers were often described as being 'busy' with no time to talk to residents.

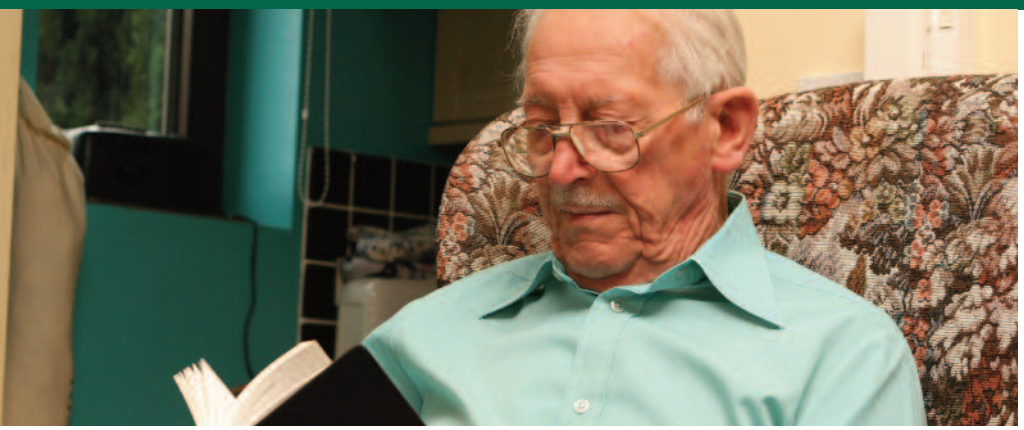
We were also told that visits were sometimes late, rearranged and, on rare occasions, didn't happen. In these instances, residents were generally understanding of the pressures that care workers were under and some saw these as symptomatic of the economic pressures facing the care sector.

THE CHANGING NATURE OF ECH: PEOPLE ENTERING WITH HIGHER CARE NEEDS

Residents, care workers and managers at the three non-dementia specialist sites reported an increase in care needs among residents moving into extra care. Several factors appeared to have influenced this development:

- changes in local authority policy regarding the requirement of publicly-funded residents to have care needs on entry;

FINDINGS



- local authorities using their nomination rights to nominate people with complex care needs (for example, individuals with a history of alcohol misuse and/or mental health problems); and
- people delaying their entry into ECH.

Managers of ECH schemes told us that the 'balance of care needs' among residents was changing. While they were unable to quantify these changes they told us that the number of residents with no/low care needs had reduced.

Consequences to these changes in the balance of care needs were recognised by residents as well as care workers and managers, and included fewer residents engaging in social activities and in the running of the scheme, and greater pressure being placed on care workers.

Additionally, one manager reflected on the challenges of managing the finances of ECH when the local authority didn't respond quickly to requests for care needs to be reassessed or for increased payments.

DEMENTIA CARE AND ECH

Study findings suggest that ECH has the potential to respond to the care needs of residents living with dementia as they change over time.

Achieving this while still maximising opportunities for independence and control requires sufficient resources, including time, to offer a truly person-centred approach and comprehensive dementia-specific training for care staff.

Well thought out environmental design and positive organisational approaches to risk taking are also key.

ECH can offer valuable opportunities for social interaction and participation in activities. However, some residents with dementia who we interviewed appeared to be isolated and lonely.

Several care workers mentioned having attended dementia training and they appeared to recognise that care and support for residents living with dementia should be delivered in a way that provides consistency and maximises their independence.

There was also a view that ECH is a good place for people with dementia because of the opportunities it provides for meaningful activity and social interaction.

However, the findings also suggest that, despite increasing awareness of dementia, there is still considerable stigma and prejudice in relation to the condition among other residents.

This study augments existing evidence for the potential of ECH to support people with dementia. It also provides valuable new information about the direct experiences of residents with dementia as their abilities and preferences change. Valuable lessons are also drawn about conducting longitudinal research with ECH residents who have dementia.

COMMISSIONING

Interviews with commissioners of ECH explored views about the national and local policy background to the provision of social care in ECH settings and how it had changed in the period after the 2015 general election, a time of uncertainty about future funding arrangements for housing and the implications for care under the Care Act 2014.

Financial pressures were identified as the most important influences on the work of commissioners, together with the consequences of the ageing of the UK population and competing demands for land.

The introduction of the higher national living wage was a cause for concern in terms of increased workforce costs while the availability of less demanding work for similar rates of pay made it difficult to recruit staff in both areas.

Finally, both commissioners indicated that the right for service users to choose a Direct Payment was recognised, but noted that a package of on-site care provided a number of advantages over individual care arrangements. For example, 24-hour cover and a greater degree of control over quality. Consequently there was little take-up of Direct Payments.

Plans for the future development of ECH were affected by the need to embed affordable housing in larger ECH schemes aimed primarily, although not exclusively, at self-funders who are in a position to purchase properties. There was a concern about levels of private provision. For example, the development of retirement housing rather than extra care (Area 1) and geographical preferences for more desirable parts of the local authority.

CONCLUSIONS & IMPLICATIONS

The ECHO project demonstrates that the extra care model of housing continues to offer flexible care and support to older people and plays a valuable role in contemporary adult social care policy and practice.

In particular, residents of ECH valued the ability to vary the care and support they received, on a permanent or temporary basis, depending on their changing needs. They also valued the communal facilities and social activities offered in ECH.

However, not surprisingly given the financial pressures facing adult social care, the findings suggest that this model of housing with care is under pressure, particularly in settings supporting publicly-funded residents.

Managers reported being under pressure to accept new residents with existing care needs, which distorts the 'balance of care' between residents which is traditionally thought to underpin ECH.

Additionally, some managers reported that changes to the funding of housing and support were impacting the support which they could provide to residents, particularly in terms of social activities.

These pressures were also noted by many residents and care workers. Established residents often commented that they thought newer residents were moving in with higher levels of need than they had in the past and that many of these newer residents chose not to, or couldn't, engage in social activities. Additionally, at two of the four sites residents reported that there were fewer activities to take part in.

Care workers also thought that residents were moving in with more complex needs. Many described how their work was organised into structured 'runs' reminiscent of how domiciliary care is provided. Not only did they feel under pressure to complete their 'runs' in the time allocated but they implied that the organisation of their work in this way undermined the flexible nature of care intended to be provided in ECH.

COMMENT

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Managing Director, FRSA
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The ECHO project research greatly advances our understanding of the experiences of people living in extra care housing. And, for the first time, it also demonstrate how services have been commissioned to enable people with increasing dependency lead more independent lives in a housing with care setting – including those experiencing early onset dementia.

With the adult social care green paper coming out shortly, I believe that the findings provide an invaluable opportunity for this research to inform policy development.

RESOURCES

Launched at the Future of Extra Care Housing Workshop, two videos, which focus on the ECHO Project, are part of the Housing LIN's crowdfunded 'Spotlight on Extra Care' video series:

Listening to residents in extra care housing: findings from the ECHO research project
www.housinglin.org.uk/Topics/type/Listening-to-residents-in-extra-care-housing-findings-from-the-ECHO-research-project

Influencing policy and operations: outcomes from the ECHO research project
www.housinglin.org.uk/Topics/type/Influencing-policy-and-operations-outcomes-from-the-ECHO-research-project

Smith R, Darton RA, Cameron A, Johnson EK Lloyd L, Evans S, Atkinson TJ, Porteus J (2017) Outcomes-based commissioning for social care in Extra Care Housing – is there a future?, *Housing, Care and Support*, 20, 60–70.

Smith R (2015) Longitudinal studies and housing with care in England: a review, *Housing, Care and Support*, 18, 1–11

School for Social Care Research

The School for Social Care Research was set up by the National Institute for Health Research (NIHR) to develop and improve the evidence base for adult social care practice in England in 2009. It conducts and commissions high-quality research.

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www.bristol.ac.uk/sps/research/projects/completed/2018/echo

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