

Remodelling sheltered housing and residential care homes to extra care housing

Key points

Remodelling as an option needs to be a careful choice when other alternatives including rebuilding have been considered

Architecture

- Remodelling was far from straightforward and numerous delays occurred during construction. Two major issues were in evidence; unforeseen structural/constructural problems on site and, in six schemes, tenants remaining in situ made it necessary to phase the remodelling process.
- Nine out of 10 projects overspent the original budget.

Accessibility and AT

- Compliance with accessibility standards in Part M of the building regulations was patchy. In some cases there was no space for wider corridors or larger lifts. In others it is not clear why standards were not met.
- The generalised impact of not providing full accessibility was an increase of staff support and a reduction in socialization that even the use of assistive technology could not bridge. Poor accessibility can potentially lead to falls and other accidents.

Social aspects

- All of the schemes assessed new entrants on the basis of how many paid care hours per week were needed when at home but this seemed arbitrary as it was common for tenants to need less paid care after admission. On the other hand, some people admitted needed a very high level of care.
- Tenants admitted to an extra care scheme since remodelling were generally enthusiastic about what a scheme offered but tenants remaining in situ during the remodelling process were generally angry that their home had become an extra care scheme.

- A hot daily meal was offered in only four schemes while a further three had a commercial kitchens not in use. When no communal hot meal was available, most tenants relied on a frozen microwave meal heated by care staff.

Costings

- For the schemes for which detailed costings were available, the average cost per flat in a remodelled scheme was £64,300. It cannot be assumed that remodelling is a cheaper option than new build.

Finally

- For many tenants, especially those who had moved in after remodelling to extra care, the scheme gave a better quality of life than they had previously experienced.
- Examples of good practice, together with the lessons learned from when things did not go so well, can lead the way for future remodelling projects to be more successful.

The research team

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The aims of the study

The research was carried out by a multi-disciplinary team; two social gerontologists, two architects, a rehabilitation engineer, an occupational therapist and an economist. Funded by the Engineering and Physical Sciences Research Council, the aims were to:

- examine how a sample of 10 local authority and housing association sheltered housing and residential care homes had been remodelled to become extra care housing
- audit buildings to see how the remodelled schemes had been adapted
- identify social and architectural problems resulting from the remodelling
- explore tenants' experiences of living in a remodelled extra care scheme
- elicit care and support staff views of how well a remodelled extra care scheme works in practice.

A sample of 10 schemes remodelled since 2000 were identified from diverse sources. Eight schemes were housing association and two, local authority. Eight schemes had been remodelled from sheltered housing and two had originally been residential care units integral to a sheltered housing scheme.

Background

Extra care is a significant policy development in both the support and housing available to older people. In essence, schemes allow people to live in their own flats or bungalows with a range of facilities and support designed to meet their needs. One of the difficulties in discussing extra care is the lack of a universally agreed definition. Also, housing associations and local authorities have their own definitions of eligibility and what kinds of support should be provided. Extra care is commonly seen as an alternative to institutional care. A Department of Health annual report (2005), for example, described extra care housing as giving choice to very frail or disabled people whose care needs might traditionally have been met by residential care.

Extra care housing is rooted in local authority sheltered housing which was widely developed in the 1950s and 60s reflecting older people's different aspirations from those of today. Very sheltered housing emerged during the 1970s and 1980s for those needing a higher level of care and support. This is the forerunner of extra care and, in some regions, remains the preferred term.

Recent governments have both cut local authority funding and restricted their borrowing powers to improve housing stock. Consequently, many local authorities, unable to meet the costs of maintaining

and updating buildings, have transferred sheltered housing to housing associations. Unlike local authorities, housing associations have been able to apply to the Housing Corporation for funding to improve stock. Several major housing associations have had remodelling programmes partly to address unpopular outdated building designs of yesteryear and partly in response to government policies to develop housing with care schemes. Several government departments have competitive grant programmes for developing extra care schemes. Partnerships of social services departments, social housing providers and private or voluntary sector care providers have competed for these grants.

Why extra care?

Demographic projections show a significant increase in the numbers of people aged 80 and over. Government Actuary (2006) figures show a threefold increase between 2004 and the mid 2050s; 2.6 million to 7.4 million. As people age, they are at risk from age-related diseases and more likely to find it difficult to cope in ordinary housing. In many areas, extra care schemes are undoubtedly being seen as preferable to care homes. The high cost of care in a care home is a significant government policy driver.

Findings Architecture

For most of the building professionals involved in the remodelling, it was their first encounter with the concept of extra care. Remodelling was far from a straightforward process and numerous delays occurred during the construction process. Two major issues were in evidence; unforeseen structural and constructional problems on site and, in six schemes, tenants remaining *in situ* made it necessary to phase the remodelling process. On average, six unforeseen problems were encountered per build, the most common being the discovery of asbestos. These unforeseen problems inevitably caused delay which could be as little as two or three weeks and, in one case, as long as 18 months. The two main contract options to procure remodelling were a 'traditional' form of contract with Bills of Quantity and 'design and build'. The former gives the client control over the quality of the building but not the price. The latter gives the client a secure price for the work but a loss of control over how the contractor actually carries out the work. All but one project overspent the original budget. The aspects of remodelling that appeared to have worked best were the structure and appearance of the building, the access and circulation,

communal facilities, individual flats and the upgraded kitchens and bathrooms. Two issues posed particular challenges in these remodelled buildings; the inclusive and accessible design of the individual flats and the incorporation of assistive technology. For example, heavy fire front doors to flats meant that some tenants had difficulties getting in and out and either never left their flat or left their front door permanently open. A remote controlled, self-opening door would have solved this problem.

A new extension had been added to most remodelled schemes and communal and staff facilities had usually been improved. Although all the schemes met the minimum requirement for accessibility, most fell short of the recommended 1500mm width for corridors. An existing lift had usually been retained which provided insufficient space for wheelchair users and their escorts and was often too small to take a stretcher. Tenants living in the extensions were usually a considerable distance from the original lift and found the distance intimidating. Most of the remodelled flats had just the one bedroom and in one scheme several small bed sits had been retained. Although the average flat sizes were increased through remodelling, the majority still fell short of the current spatial standards for new build. A wide discrepancy usually existed between the sizes of individual flats in the same scheme. Remodelling does not necessarily cost less than building a new scheme nor does it necessarily save time.

Assistive Technology

The rehabilitation engineer, an occupational therapist and one of the architects carried out a detailed accessibility and assistive technology audit of the different types of flats and of the communal areas in the ten remodelled schemes. Tenants in these flats had commonly paid for items of assistive technology. The most common items in the audited flats were crutches and walking sticks, tea trolleys, recliners, reachers, manual wheelchairs and toilet frames with a raised seat. Compliance with accessibility standards was patchy, impacting on an increase in the need for support from care staff, for example, with showering. Because of the difficulty in using lifts independently, some tenants could not move about the scheme easily. Approximately one in five of the tenants in the flats visited reported that they would like to cook but could not access the kitchen. No wheelchair accessible kitchen was found in any of the ten schemes. Showers were often less than adequate, lacking grab bars or seats and were too small to wheel someone in. Toilet seat heights were often lower than

the height recommended in Part M. Several toilets lacked grab bars. Poor accessibility, especially in and around bathrooms, is associated with potential falls and scalding accidents. An important issue was the way in which tenants communicated with staff. The community alarm was often inappropriately used for internal communication with staff. In most cases, staff laundry facilities were more accessible than those for residents; probably because of compliance with health and safety at work regulations. Most schemes had insufficient space for the number of scooters (buggies) in use by residents. This mode of transport has become popular and is essential for residents with mobility problems who want to reach local shops.

Social Issues

Each of the 10 remodelled schemes was unique in many respects. Eight were called 'extra care' and two 'very sheltered' housing'. Assessment was based on the number of paid care hours per week needed at home. At one extreme, eligibility was four hours of paid care per week while at the other extreme, the criterion was 10.5 hours. Two extra care models were in evidence; one aimed at a dependency spectrum (four schemes) while the other (six schemes) had a minimum dependency threshold. The eligibility criteria seemed arbitrary as so many tenants reportedly often needed far less paid care after admission. A flat providing better access to bathrooms, kitchens and bedrooms than a family home often reduced the need for carer support.

Only four schemes routinely provided a regular optional communal lunch. Ironically three other schemes had a commercial-size, fully equipped, kitchen but the housing provider concerned was unwilling to employ a cook.

Tenants admitted to the schemes since remodelling were generally enthusiastic about extra care, having individual flats, being able to exercise choice and relieved that it was unlike residential care. A frequent comment was that the move had reduced their own and their children's worries about the hazards of living alone. Some tenants remaining *in situ* during the remodelling process in six schemes had inevitably experienced considerable noise, mess and inconvenience. Strong bonds had developed between these tenants. They were, however, generally angry that their home had become an extra care scheme. This resentment could reach extreme proportions with 'old' tenants refusing to participate in communal meals or activities involving 'new' tenants.

Although most of the tenants interviewed were enthusiastic about the care provided, there were

exceptions. Tenants in one scheme expressed concern that private agency carers had their own interpretation of extra care often refusing to undertake basic care tasks on the basis that their role was to encourage residents to do more for themselves. Housework was a bone of contention with tenants often complaining that carers refused to clean because they considered their role to be providing personal care.

Costings

For the schemes for which detailed cost information was available, the average cost per flat was £64,300. Four remodelled schemes had average costs per flat within the range from £47,000 to £53,000. Flats differed in size between schemes. If this is allowed for by calculating average costs per square metre and multiplying by the average floor area of flats in the remodelled schemes, the calculated average cost would be £62,000 per flat; three schemes having costs per average sized flat within a range of £43,000 to £47,500. The highest was £94,000 in a heritage building. Two schemes had costs per average sized flats between £82,000 and £84,000, and one scheme costs per average sized flat of £35,000. This low figure is the result of many of the flats being refurbished rather than remodelled.

Conclusions

Extra care housing is clearly an important development in the care and support of older people. There are major differences between localities in what is described as an extra care scheme and the criteria for admission. National guidelines about what should be provided would make it easier for older people and their relatives to understand what extra care is and whether it would be appropriate for them. It was surprising to find that over half of the schemes in our sample did not provide an optional communal lunch particularly when some already had a fully equipped commercial kitchen.

The issue of some tenants remaining on site during the remodelling process is a difficult one. It is important to respect the right of people to remain in a building that is their home. Nevertheless, the research indicates that there is a price to pay. Not only is the remodelling construction process delayed, there are consequent social difficulties as 'old' tenants resent the admission of 'new' tenants often with a high level of disability. Remodelling a building is fraught with unforeseen problems, which affect the time taken and the price paid. All except one remodelled scheme went substantially over budget.

Although all the remodelled schemes in the sample met many of the minimum requirements for accessibility, some of the deficiencies had consequences, reducing opportunities for independent socialization and even increasing the amount of care needed by some tenants. Similarly the average flat sizes in most schemes fell short of the current spatial standards for new build. Bathrooms were often inadequately equipped which can have serious safety consequences in terms of falls or scalding.

Information was obtained about two housing associations and two private enterprise new build schemes. It is not possible to conclude that remodelling has lower costs than new building if like is compared as far as possible with like but nor is it particularly more expensive.

Finally, there were a number of examples of good practice that were found in the case studies. This was very encouraging. These, together with the lessons learned from when things did not go so well, can lead the way for future remodelling projects to be more successful, providing appropriate and good quality spaces to foster the well-being of both tenants and staff.

About the project

The research took place between 2005-7 in 10 case study areas. In-depth tape recorded interviews were carried out with the following key people: 31 building professionals (architects, surveyors and contractors), 23 senior housing and social care managers, 10 scheme care managers, nine scheme housing managers, 14 care assistants and a sample of 96 tenants (76 women and 20 men). Interviews were transcribed and analysed thematically. Architectural drawings before and after remodelling were analysed. Each remodelled scheme had a range of different flat types and each type of flat was visited and evaluated by an architect, an occupational therapist and a rehabilitation engineer for accessibility and assistive technology. An economist costed the schemes and made some comparisons with new build.

References

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