

The development of social well-being in new extra care housing schemes

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This report investigates the development of social well-being for older people moving into 15 new-build extra care housing schemes.

There is increasing interest in extra care schemes for older people as a way for them to live independently while receiving care and support, and having more opportunities for social interaction. Extra care has the potential to promote social well-being, but the evidence base, although growing, is somewhat limited.

This report:

- describes how schemes had begun to develop social activities and community during their first six months, identifying facilitators and barriers to social participation;
- considers the social climate or 'atmosphere' of the schemes one year after opening;
- discusses differences in individual social well-being one year after opening.

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Executive summary

Background

Extra care housing is a model of housing with care that aims to meet the housing, care and support needs of older people, while helping them to maintain independence within their own private accommodation. Communal and social facilities are often provided, with the aim of addressing social isolation and building community in the scheme. Extra care encompasses key government policies of promoting independence, control and person-centred care.

We report on a study, conducted between 2006 and 2009, which aimed to add to the evidence base by exploring social well-being for older people moving into 15 new extra care housing schemes that were allocated funding as part of the first two rounds of the Department of Health's Extra Care Housing Funding Initiative (2004–06). The sample included 13 smaller schemes, with the number of units ranging from 35 to 64, and two village-style schemes, with 258 and 270 units each. The schemes support residents with a range of levels of disability, as well as providing facilities and services for members of the local community.

Aims and methods

The project focused on the first year after each scheme opened, and aimed to identify how schemes had begun to develop community and social activities during their first six months. Following this, differences in the social climate and individual social well-being in schemes one year after opening were identified.

The first stage of the project involved conducting a literature review (Callaghan, 2008) and consultation with residents, in order to ensure that the project captured relevant information. 'Social well-being' was defined as the area of overall quality of life involving social relationships,

social participation, social networks and social support.

Data collection was in two stages. At six months, exploratory interviews were conducted with 75 residents and 26 staff. These interviews aimed to discover what approach to social activity provision was being put in place and identify facilitators and barriers to participation (including both social and design factors), and thus start to build up a picture of the social life at each scheme.

At twelve months, questionnaires were received from 599 residents and follow-up interviews were conducted with 166 of these residents. The aim was to find out about the social climate of the schemes and measure individual social well-being. We chose the following as 'indicators' of social well-being:

- levels of social participation;
- whether or not the individual had made friends at the scheme;
- how often the individual had contact with friends;
- how often the individual had contact with relatives;
- how often the individual took part in an activity or attended a group;
- whether the individual was occupied in activities of their choice;
- levels of social support.

Overall well-being or quality of life was also measured, using a single question in the questionnaire and the CASP-19 scale (Hyde *et al.*, 2003) in the follow-up interview.

Research findings

Residents valued the combination of independence, security and opportunities for social interaction afforded by living in extra care housing.

Quality of life and social well-being

Two-thirds of the residents indicated that they had a good quality of life. Quality of life was related to the majority of our indicators of social well-being, but not to individuals' frequency of contact with family.

The majority of residents had good levels of social well-being, with around 90 per cent having made friends since moving. Eighty-five per cent felt positively about social life and did not feel lonely; 75 per cent were fully occupied in activities of their choice and were not bored; and 70 per cent took part in an activity at least once or twice a week.

Villages and schemes

Overall, it seemed that people living in the villages had higher levels of social well-being than those in the schemes, although there was no difference in friendship formation.

However, this finding may be linked to the fact that most village residents moved in without a need for care and so are likely to be in better health and less dependent. Villages appeared to suit more able, active older people very well, but the evidence was not as clear for those with some level of dependency. In villages, there were some links between lower social well-being and worse self-perceived health and higher levels of dependency.

Communal facilities

The communal facilities available at the schemes were important for facilitating social well-being. Restaurants and shops helped to encourage friendship development, particularly when a scheme first opened. Communal lunchtime was an important opportunity for social interaction in many of the smaller schemes.

Social activities

Social activities were valued by residents and – particularly in the smaller schemes – were important for friendship development. In both schemes and villages, friendship was cited as the

primary benefit of participation in social activities and events, followed by mental stimulation.

Residents' feelings about their social life were related to how often they took part in an activity or attended a social event, with more frequent participation linked to reporting that their social life was 'good' or 'as good as it could be'.

Some schemes encountered difficulties in providing activities for the diverse range of people living in extra care. Nonetheless, even if certain activities were not to a particular resident's liking, they could still provide a venue for social interaction and promote the development of community.

Resident-led social activities

All schemes took a user-led approach to providing social activity, with resident involvement being key. However, there was considerable variation in how this approach was implemented, depending on levels of staff and resident involvement. Some schemes had a full-time member of staff responsible for coordinating the scheme's social life, such as an activities coordinator. In other schemes, although there was no specific activities coordinator or similar, care and/or support staff at the scheme had some of their time dedicated to the support and facilitation of the scheme's social life. In the remaining schemes, the manager was responsible for the scheme's social life, with widely varying degrees of resident involvement.

Having dedicated activities staff was valuable in the early stages of a scheme's development, with more activities being set up sooner after opening in those schemes with such staff. However, having dedicated activities staff was not associated with better individual social well-being at twelve months. This may be because social activities and friendships had become established by this stage.

Active resident involvement in running social activities was beneficial, giving residents more control and ownership over their social lives, encouraging other residents to participate and providing a satisfying role for those on residents' committees. It is important to note, however, that residents who took the lead were more likely to have lower levels of physical impairment; in some schemes there were challenges in accomplishing a truly 'user-led' approach, with the most notable barrier being the frailty of some of the residents.

Although it is beneficial to encourage resident involvement from an early stage, it is crucial to have adequate staffing and resources to support them in this role, not only at the beginning, but also over time as levels of frailty increase.

Social isolation

Although the findings paint a generally positive picture, a minority of residents stated that they were 'socially isolated and often lonely' or 'sometimes lonely'. This group were more likely to be in receipt of care services and rated their health as worse. In addition, people who were socially isolated were less likely to be married and more likely to be living in one of the smaller schemes than in the villages. However, in our main sample, there was little difference in levels of social well-being for men and women.

Residents mentioned some barriers to social participation, including health and mobility problems, and receiving care at particular times. There were examples of good practice in overcoming these barriers. For example, in some schemes, additional staff or volunteers had been employed to help residents to get around as needed. Alternatively, some schemes built in time for care and support staff to assist residents to participate.

Local community

Many residents mostly valued maintaining or building up links with the local community, but lack of accessibility and appropriate transport proved a barrier for some to getting out.

The location of schemes was important in determining the extent of involvement that had developed. Schemes benefited from being at the centre of a community and providing a needed service to the local area such as a shop or café/restaurant.

There were mixed opinions from residents about local people coming into the schemes to use facilities. It is important that schemes make potential residents aware of intentions regarding links with the local community.

Conclusions and key messages

While there are some limitations to the study, the findings suggest that extra care housing can provide an environment supportive of social well-being. Key messages for those involved in commissioning, developing and running extra care schemes are the following.

- Communal facilities, particularly restaurants and shops, should be operational when schemes first open. Social activities should ideally begin to be set up soon after opening.
- A wide range of social activities should be developed reflecting the diversity of residents living in extra care. Resident involvement in organising and running social activities should be encouraged from an early stage.
- Adequate staff time and resources for supporting social activities (and wider social well-being) are crucial, both when schemes first open and over time as levels of resident frailty increase.
- Activities coordinators, when in place, could be a shared resource between a number of schemes.
- Schemes need to ensure that there is adequate support to address social isolation and prevent health and mobility problems from becoming barriers to participation for residents.
- Care should be commissioned and delivered in a flexible way to ensure that the care process does not form a barrier to participation.
- Schemes should aim to make links with the local community. The implications of location and local context for such links need to be borne in mind when new schemes are being planned.
- Schemes need to ensure that prospective residents are clear about the aims of the scheme and what to expect on moving in.

1 Introduction

Background

Housing and care for older people are rapidly developing areas of government policy. In particular, policy emphasises the personalisation of services, placing individuals at the centre of the process of bringing housing, health and social care together, with the aim of giving people greater choice and control over the services they receive (Department for Communities and Local Government, 2008). In addition, a number of policy initiatives have focused on well-being and social inclusion (e.g. Office of the Deputy Prime Minister, 2006). Five areas have been identified as being of crucial importance to well-being in later life: lack of discrimination, participation in meaningful activity, supportive relationships, good physical health and income (Lee, 2006). Social isolation has been recognised as a particular risk factor for poor mental health in old age (Lee, 2007).

Extra care housing is a model of housing with care that aims to meet the housing, care and support needs of older people, while helping them to maintain independence within their own private accommodation. While there is no exact definition, extra care housing encompasses key government policies of promoting independence (accommodation is self-contained, with one's own front door), control (residents have tenancy rights) and person-centred care (flexible domiciliary care packages can be provided and couples can be accommodated together). Communal and social facilities are often provided, with the aim of addressing social isolation and building community in the scheme.

The evidence base around housing with care, although growing, is somewhat limited. Research into extra care has tended to focus on individual schemes (e.g. Kingston *et al.*, 2001; Croucher *et al.*, 2003; Bernard *et al.*, 2004; Evans and Means, 2007), although recently Croucher and colleagues conducted a comparative investigation of seven

schemes (Croucher *et al.*, 2007). In addition, Evans and Valletly have carried out studies of several schemes managed by one provider, including a study of social well-being in six schemes, also commissioned by the Joseph Rowntree Foundation (Valletly *et al.*, 2006; Evans and Valletly, 2007).

'Social well-being' refers to the area of overall quality of life involving social relationships, social participation, social networks and social support. Feelings of having a 'social role' may also play a part in this aspect of well-being. Research into quality of life and well-being in older people has indicated that social factors are particularly important (e.g. Age Concern, 2003; Bowling *et al.*, 2003; Gabriel and Bowling, 2004). Older people themselves indicate that having good social relationships, having a 'social role' and taking part in social activities are crucial to their quality of life.

The importance of friendships and social support to older people's lives has been well documented. Although practical and financial social support is most likely to come from relatives (Greenblatt *et al.*, 1982; Seeman and Berkman, 1988), close friends often provide emotional support (e.g. Lee, 1985). While family support can be crucial in old age, social well-being in older age is closely tied to the ability to create and maintain social relationships of other kinds, such as friendships (Phillipson, 1997).

Close, emotionally supportive relationships are important for well-being in later life (Strain and Chappel, 1982; Croucher *et al.*, 2006; Duner and Nordstrom, 2007), but there is evidence too that casual relationships, which provide regular interaction and companionship, are also important, particularly in the housing with care setting (e.g. Potts, 1997; Evans and Valletly, 2007). Indeed, research in assisted living facilities in America suggested that new relationships formed within the facility were more important for well-being than the continuation of past relationships (Street *et al.*, 2007).

Participation in social activities has been found to be linked to levels of social support and friendships among older people (e.g. McKee *et al.*, 1999; Tait and Fuller, 2002). Research suggests that it is the quality of social ties and the supportiveness of the social network associated with participation in social activities that is related to well-being, rather than frequency of participation or any other factor associated with the activity. (Litwin, 2000; Litwin and Shiovitz-Ezra, 2006).

Social activities may be particularly important in housing with care settings, as they can provide an opportunity for friendship development and social interaction, and activities are valued by older people in these settings (e.g. Bernard *et al.*, 2004; Evans and Vallely, 2007). However, the choice not to participate is also appreciated, and the combination of privacy alongside the opportunity for social interaction in these settings welcomed (e.g. Croucher *et al.*, 2007; Evans and Vallely, 2007).

Social activities are particularly important for frailer older people and can significantly enhance their quality of life (Croucher *et al.*, 2006). However, it can be difficult for residents who are frail or disabled to take part in social activities, for reasons including sensory impairment and wheelchair use (Croucher *et al.*, 2003, 2006). In housing with care settings, it has been found that people who are less likely to participate and more likely to be socially isolated are more likely to be frail, cognitively impaired or have mobility problems (e.g. Stacey-Konnert and Pynoos, 1992; Croucher *et al.*, 2006, 2007; Evans and Vallely, 2007). There is also some evidence that men may be less likely to participate and at greater risk of social isolation (e.g. Croucher *et al.*, 2007; Evans and Vallely, 2007).

Housing with care schemes are often keen to promote a 'user-led' approach to providing social activities in order to promote independence and prevent the schemes from taking on an institutional feel (Croucher *et al.*, 2006). This approach seems popular with residents, giving them ownership and control over their social lives, and promoting more participation (Croucher *et al.*, 2003; Evans and Vallely, 2007). However, the success of the user-led approach depends on there being an adequate number of residents to take on this role.

Older and less active residents are not always able to organise social activities, and would be glad of more formally arranged activities and events (e.g. Croucher *et al.*, 2003, 2007; Bernard *et al.*, 2004; Evans and Vallely, 2007).

Other features of housing with care schemes can have an impact on social well-being. For example, research across various types of housing for older people has indicated that the way in which such developments are designed can influence opportunities for social interaction (Zaff and Devlin, 1998; Percival, 2000; Sugihara and Evans, 2000; Evans and Vallely, 2007). In addition, communal facilities such as shops, lounges and restaurants can provide useful venues for social interaction. Restaurants in particular seem to be important in the development of friendships (e.g. Williams, 2000; Croucher *et al.*, 2006; Evans and Vallely, 2007; Tinker *et al.*, 2007). In addition, facilities that are open to non-residents from the local community can provide opportunities for social interaction, although there can be tensions around people coming in for this purpose (e.g. Croucher *et al.*, 2003, 2007). Making and maintaining links with the wider community have been shown to be important for people living in extra care housing, although the location of the scheme and accessibility of the local area can often determine how easy it is for residents to socialise away from the scheme (Bernard *et al.*, 2004; Evans and Vallely, 2007).

An important consequence of moving into a care setting (such as extra care) is that older people's levels of activity and social well-being are particularly reliant on that community; as people become older (and frailer), their lives become gradually more affected, and even defined, by their immediate physical and social environments (Godfrey *et al.*, 2004). So, a move into extra care housing provides both challenges and opportunities for improvements in people's social well-being. Features of the scheme such as its size, design, facilities and organisation and management are likely to have an influence on the social climate or 'atmosphere' that develops, and on the friendships and activities of people living in the scheme. These relationships may be particularly important in the early stages of a scheme's life, when new communities are being

formed. To help us understand how these complex relationships may interact, we developed the conceptual model shown in Figure 1. This model shows the way in which we expected various characteristics of the scheme to interact with personal characteristics and life events to affect social well-being and overall quality of life.

Evaluation of the Extra Care Housing Funding Initiative

The Personal Social Services Research Unit (PSSRU) is currently undertaking an evaluation of the first round of the Department of Health's Extra Care Housing Funding Initiative (2004–06), evaluating 19 new-build schemes that received support from the fund and that opened between 2006 and 2008 (see Darton *et al.*, 2008).

The main aim of the evaluation (which is referred to hereafter as 'the main evaluation') is to examine the development of schemes from their implementation and to track residents' experiences and health over time. The schemes being evaluated put forward a variety of proposals for addressing activity and community participation, including user-led approaches and the provision of a range of communal facilities. This presented a unique opportunity to add to the data being collected as part of the main evaluation, by investigating the development of the social life of these schemes and exploring the social well-being of residents.

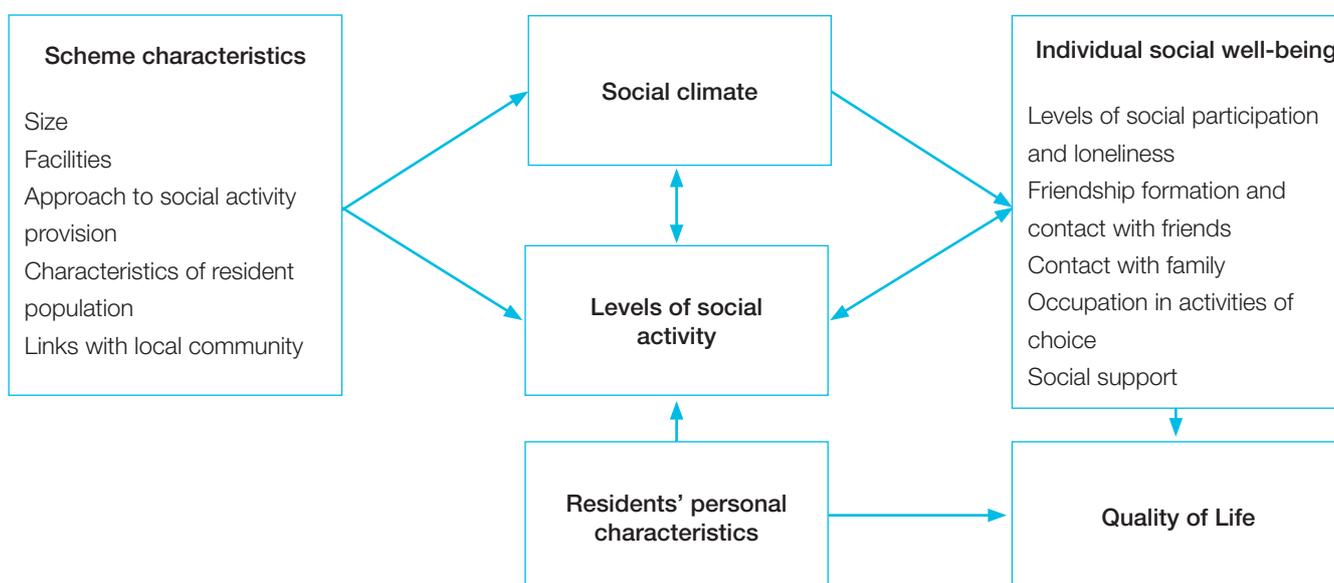
Research aims and methods

The project focused on the first year after each scheme opened. It aimed to identify:

- how the variety of approaches to developing social activities and community involvement were implemented in practice, and what residents' experiences were of these approaches;
- the relative effectiveness of different approaches in terms of friendship formation and activity participation among individual residents;
- the variation in social climate and individual well-being twelve months after opening.

The project involved 15 of the schemes included in the main evaluation. The main evaluation is collecting two sets of information about people moving into the schemes. First, information on residents' demographic characteristics and physical and cognitive functioning is collected on moving in, and then followed up at later stages. Second, new residents are asked to complete a questionnaire about their experiences of moving into the scheme and their expectations of extra care. Demographic information and details of residents' physical functioning and care and

Figure 1: Model of social well-being in extra care housing



support needs collected as part of the main evaluation are used to give context to the findings in this report.¹ Residents' physical functioning was measured by the Barthel Index of Activities of Daily Living (Mahoney and Barthel, 1965), with scores ranging from 0 (maximum disability) to 20 (minimum disability). In addition, cognitive functioning was measured by the Minimum Data Set Cognitive Performance Scale (MDS CPS; Morris *et al.*, 1994), with scores ranging from 0 (intact) to 6 (very severe impairment).

As part of the main evaluation, local fieldworkers were recruited to assist with data collection in the schemes, and received appropriate training. For the social well-being project, these fieldworkers were involved in assisting residents with questionnaire completion as necessary and carrying out a proportion of interviews. Participation was subject to the participant's informed consent and data collection was carried out at a time and location of the participant's choosing. The research procedures received ethical approval from the University of Kent's departmental ethical review committee.

The first stage of the project involved conducting a literature review (Callaghan, 2008) and consultation with residents, in order to ensure that the project captured relevant information. Data collection then followed in two stages.

Data collection at six months

Approximately six months after each scheme opened, four residents and two members of staff were interviewed using semi-structured, exploratory interviews. As it was expected that there would be some variation within schemes in the degree to which residents participated, selection of residents was carried out in liaison with the local fieldworker and scheme manager in each scheme. The aim was to ensure that we captured the views of a range of individuals – that is, those who participated on a regular basis, sometimes or rarely. In each scheme, we also interviewed the scheme manager, as well as another member of staff best placed to reflect on the activities in the scheme, such as an activities coordinator.

The interviews with staff and residents aimed to discover what approach to social activity provision was being put in place, and identify facilitators and barriers to participation (including both social and

design factors), and thus start to build up a picture of the social life at each scheme.

Data collection at twelve months

Twelve months after each scheme opened, all residents were invited to complete a questionnaire, which included questions about the social life at the scheme, levels of participation and barriers to taking part, contact with friends and family, as well as overall quality of life and self-perceived health. The local fieldworker in each scheme was available to offer support in completing this questionnaire and in fact many residents preferred to take up this option.

Following this, more in-depth information about residents' experiences and the scheme was collected through face-to-face interview. Interviews were conducted with a sample of residents, the aim being to interview up to ten residents in each of the smaller schemes and 30 in the village-style schemes. Interviewees were asked to indicate at the end of the questionnaire whether they would be interested in taking part in a follow-up interview and were then selected by the local fieldworker in each scheme who aimed to choose a range of participants.² The interview included questions on the social climate of the scheme, individuals' well-being, relationships and social support.

The schemes

Details of the 15 schemes involved in the project can be seen in Appendix 1. The sample included 13 smaller schemes, with the number of units ranging from 35 to 64, and two village-style schemes, one with 258 and one with 270 units. All of the schemes were new-build, although two also involved the upgrading/remodelling of existing buildings. The schemes have been developed to support residents with a range of levels of disability, as well as to provide facilities and services for members of the local community. The schemes offer a mixture of housing tenures, including rented accommodation and leasehold and shared ownership arrangements. The villages provide relatively more accommodation for sale than the smaller schemes and three of the smaller schemes provide only accommodation for rent. We use fictitious names for the schemes throughout the report so as to protect their anonymity.

The participants

Participants at six months

At the six-month stage, interviews were carried out with residents and staff in all 15 schemes. Interviews were conducted with 75 residents and 26 staff. Of the residents, 44 were female, 31 were male and there were eleven married couples who were interviewed together. The interviews with staff involved scheme managers for 14 of the schemes (in one scheme, the scheme manager was unavailable for interview) and, whenever possible, another member of staff who was involved in some way in the social life of the scheme. These staff members included an additional manager, a community participation officer, two care team leaders, three activities coordinators, one integrated support worker and four care and support staff. Of the managers, 13 were female and one was male. Of the other staff members, ten were female and one was male.

Participants at twelve months

At twelve months, data was collected from 14 schemes, as it was not possible to collect information from one of the smaller schemes at this stage. In total, 599 questionnaires were returned and 166 interviews conducted.

Table 1 shows the characteristics of the residents who completed a questionnaire and the subgroup who took part in an interview.³ We were unable to obtain dependency information from all residents, because some residents (chiefly those with no care and support needs) did not receive an assessment on moving in and therefore did not participate in the element of the evaluation involving the collection of information on residents' demographic characteristics and physical and cognitive functioning; this was the case for the majority of people living in the two villages.

The demographic characteristics of those returning questionnaires and those interviewed were broadly similar, as can be seen in Table 1.

Table 1: Characteristics of questionnaire and interview respondents

	Questionnaire		Interview	
	No.	%	No.	%
<i>Age group</i>				
Under 65	53	9.3	25	15.7
65–69	59	10.4	15	9.4
70–74	99	17.4	25	15.7
75–79	108	19.0	27	17.0
80–84	117	20.6	30	18.9
85–89	82	14.4	28	17.6
90 and over	50	8.8	9	5.7
<i>Gender</i>				
Male	212	36.4	61	37.7
Female	371	63.6	101	62.3
<i>Marital status</i>				
Single	51	9.1	18	11.8
Married/living as married	261	46.8	58	37.9
Divorced/separated	54	9.7	22	14.4
Widowed	192	34.4	55	35.9
<i>Care receipt</i>				
Receiving care (schemes)	116	56.6	62	58.5
Receiving care (total)	145	24.2	75	45.2
Receiving care (villages)	29	7.4	13	21.7
Total sample	599		166	

The ages of residents in both groups ranged from 51 to 103, with an average age of 77.4 for those who completed the questionnaire and 76.3 for those who took part in an interview. Information obtained regarding residents' ethnicity was particularly poor, but we know that less than 1 per cent of the questionnaire sample and less than 2 per cent of the interview sample were of non-white ethnic origin; information from the local fieldworkers confirms that the vast majority of people in our sample were white.

One noticeable difference between the groups is that 24 per cent of the questionnaire sample was in receipt of care at the scheme, compared with 45 per cent of the interview sample. Although, as noted above, we did not have information on dependency (measured using the Barthel Index) for all residents, if we assume that those for whom we did not have information (and therefore were most likely not to have had a care assessment) are given a score of 20 (indicating minimum disability), we find that dependency was lower for people in our main sample of questionnaire respondents than in the follow-up interview sample (with 78.3 per cent

and 66.7 per cent respectively being categorised as having very low dependence). In addition, 88.9 per cent of questionnaire respondents and 84 per cent of interview participants had no cognitive impairments. In interpreting the results of our study, it is important to note that the main sample was dominated by the large proportion of physically able and mentally alert people living in the villages, while the follow-up sample includes a higher proportion of people from the smaller schemes and reflects a higher proportion of people in the villages with impairments and care needs.

Villages and smaller schemes

The two villages were different from the smaller schemes in a number of ways. Apart from the difference in size, the villages have a larger number and broader range of facilities and space for social interaction. In contrast to the smaller schemes, the majority of residents moved into the villages without any care and support needs. Table 2 shows the differences between participants living in the smaller schemes and those in the villages.

Table 2: Characteristics of residents in schemes and villages

	Schemes		Villages	
	No.	%	No.	%
<i>Age group</i>				
Under 65	24	11.9	29	7.9
65–69	22	10.9	37	10.1
70–74	21	10.4	78	21.3
75–79	36	17.8	72	19.7
80–84	40	19.8	77	21.0
85–89	35	17.3	47	12.8
90 and over	24	11.9	26	7.1
<i>Gender</i>				
Male	75	37.9	137	35.6
Female	123	62.1	248	64.4
<i>Marital status</i>				
Single	31	15.8	20	5.5
Married/living as married	64	32.7	197	54.4
Divorced/separated	27	13.8	27	7.5
Widowed	74	37.8	118	32.6
<i>Care receipt</i>				
Receiving care	116	56.6	29	7.4
Total sample	205		394	

The average age of participants from the schemes and villages was very similar (77.9 and 77.1, respectively), although there were significantly more residents in the 70–74 age group living in the villages and the villages had fewer people at either end of the age spectrum. There was no real difference in the proportions of men and women in schemes and villages. However, there were significantly more married people and fewer single people in the villages than in the smaller schemes. In addition, there were markedly fewer people in receipt of care in the villages than in the smaller schemes. In terms of physical functioning, again assuming minimum disability where no assessment questionnaire was available, participants in the smaller schemes were more dependent than those in the villages (with 49 per cent and 93 per cent being categorised as having very low dependence, respectively). In addition, 66 per cent of scheme residents had no cognitive impairments, compared with 99 per cent of village residents.

Structure of the report

In the following chapters we present the findings from our study. In Chapter 2, we discuss the development of social life at the schemes six months after opening, presenting the views of residents and staff. In Chapter 3, we describe the schemes at twelve months, focusing on the social climate. In Chapter 4, we present findings on individual social well-being as measured one year after opening. Finally, in Chapter 5, we discuss our findings and draw out the main lessons for those developing and running extra care housing schemes.

Throughout the report we refer to people living in the schemes and villages as ‘residents’, to cover the range of terms used to describe people, including ‘tenants’, ‘clients’, ‘customers’ and ‘residents’.

2 Social life at the schemes six months after opening

In this chapter, we present findings from the interviews with residents and staff, which took place six months after each scheme had opened. The interviews generated a wealth of information about the development of the social side of life at the schemes. Here we discuss findings relating to the approach to activity provision at the schemes; how schemes had attempted to make links with their local communities; the facilities available and which seemed particularly helpful in promoting social interaction; and supportive factors in, and barriers to, the development of the schemes' social lives at these early stages.

In general, residents were very positive about their experience of moving into the extra care housing schemes. The combination of independence and security, coupled with opportunities for social interaction, was particularly valued, as explained in the following quotes from residents from different schemes:

I think more people should know about [extra care] ... It's far better than sitting by yourself. We get together and talk about all sorts of things, and there's entertainment. And there's always somebody around you; there's people next door, even if you can't hear them, you know there's somebody in the rooms. And you've got a bell on there to push if you need anybody. No, it couldn't be better.

(Female resident)

I didn't have a social life when I was at home ... and now I've got the friends I've made in here, we have little dos and some of us, we do use downstairs at night, the television ... put DVDs on and have a drink or two.

(Male resident)

Approaches to social activity provision

All 15 schemes described themselves as taking a 'user-led' approach to providing social activity, with resident involvement being key. Nonetheless, there was considerable variety in the way this approach was being put into practice, depending on levels of staff and resident involvement in planning, organising and running social activities and events. This led us to categorise the schemes according to the approach they seemed to be taking into three broad types: schemes where there was a full-time member of staff responsible for coordinating the scheme's social life (e.g. an activities coordinator); schemes where care and support staff had some of their time specifically dedicated to the support and facilitation of the scheme's social life; and schemes where the scheme manager was responsible for developing the scheme's social life. These approaches are described in Box 1.

Box 1: Approaches taken to social activity provision

Small schemes with activities staff

Schemes: Rushmead Gardens, Jasmine Court, Cedar Gardens.

Approach: Activities coordinated by dedicated activities staff.

Staff: Activities coordinator (one scheme); integrated support worker (one scheme); support assistant responsible for social activities (one scheme).

Staff involvement: Activities staff led most activities or brought in outside provider.

Resident involvement: Residents consulted about what activities and events they would like; planned that residents would take lead in future.

Social activities: Two schemes had social activities each weekday morning and afternoon; one had two to three activities each week.

Villages with activities staff

Schemes: Redwood Village, Greenfields Village.

Approach: Activities coordinated by dedicated activities staff.

Staff: Activities coordinator (both villages).

Staff involvement: Activities coordinator oversaw activities and events at scheme; some activities run by staff or outside providers.

Resident involvement: Residents' groups consulted before opening about social activities to be put in place; residents organised and ran some activities.

Social activities: Multiple activities each day.

Schemes where care/support staff facilitated social activities

Schemes: Fairfax Court, Beechwood Court, Abbey Court, Rosewood Gardens, Sycamore House.

Approach: Care and/or support staff have some time dedicated to facilitation of social life.

Staff: Care staff (two schemes); support workers (two schemes); community participation officer (one scheme).

Staff involvement: Care/support staff shared responsibility for facilitation of social activities with manager.

Resident involvement: Residents consulted about what activities and events they would like; in four of the schemes, residents had begun to lead some activities, either by taking over from staff or initiating themselves.

Social activities: Two schemes had an activity on most days (including weekends); in three schemes there were three to four activities each week.

Schemes where manager facilitated social activities

Schemes: Jubilee House, Granary Court, Willowbank Court, Pinewood Court, Hawthorne Court.

Approach: Scheme manager responsible for oversight/facilitation of social activities.

Staff: Scheme manager.

Staff involvement: Varied. Granary Court: minimal; Jubilee House, Willowbank Court, Pinewood Court: manager organised and ran some activities; Hawthorne Court: manager organised and ran all activities.

Resident involvement: Varied. Granary Court: organised and ran all activities; Jubilee House, Willowbank Court, Pinewood Court: consulted, organised and ran some activities; Hawthorne Court: invited to give suggestions; invited to join committee (although no one had come forward).

Social activities: Varied. Granary Court: daily coffee morning, one to two others; Hawthorne Court, Pinewood Court: one to two per week; Jubilee House, Willowbank Court: two to three per week.

As seen in Box 1, there were some differences in the way schemes implemented the user-led approach to providing social activity, with resident and staff involvement varying across the schemes.

There was no consistent pattern according to scheme provider, although the two villages were run by the same organisation and both had an activities coordinator. It is likely that the approach taken to providing social activity is affected by local partnerships between the provider, the local authority and other parties, and the funding available.

In those schemes where there were dedicated activities staff, and to some degree where care and support staff had time available for this role, respondents reported that there were more activities and events in place six months after opening. This was particularly the case in the two villages, where it was recognised by staff that, in larger schemes such as these, there are likely to be many people with skills to bring:

*Some residents run activities; they may have initiated them and run them themselves ...
Within a village like ours, we have a vast pool of expertise.*

(Scheme manager)

It may be that, where managers are solely responsible for the oversight of social activities, the development of the social life can get sidetracked because of more immediate concerns such as ensuring a smooth move and settling in period for residents, and ensuring they are receiving the correct amount of care. This situation was explicitly described by staff from two of the schemes, and is illustrated in the quote below:

I think the social aspect has – not willingly – has been a bit hands-off because we've been concentrating on the care, and making sure that the care packages are in place and suitable for the individuals, and then the social sort of comes on the back of that. And obviously now that everybody's in we can concentrate on the social aspects more because people are settled.

(Staff member)

Scheme managers spoke of the benefit of having support for social activities from staff. Two scheme managers from schemes where there was no such support felt that it would be useful to have an activities coordinator or similar:

What the schemes would benefit from is a specific activities organiser, because organising activities does take a lot of time. As court manager, especially when things are changing a lot, you don't always have the time that you need to do that; you do what you can.

(Scheme manager)

Another benefit of having dedicated activities staff, or care/support staff with time built in for supporting social well-being, is that they can spend time with residents. There were examples of these staff going round and spending time getting to know residents and discovering what they enjoyed doing, to ensure that the activities that were organised were the right ones, as well as spending time chatting to those residents who didn't participate in communal activities:

The two support assistants I have, I would say probably about 50 per cent of their time is spent on social activities, whether it's as group activities or visiting those who have no visitors

or friends and don't come out of their flats and anything – going and socialising with them, find out if there is anything they would like to do, stuff like that.

(Scheme manager)

In terms of resident involvement in leading social activities and events, it did seem that this had not yet taken off in the smaller schemes with activities staff. However, staff from these schemes were keen to encourage residents to take more of a lead over time – for example, through residents' committees or by supporting residents to run classes or workshops in future:

What I would love to see would be the people that live here taking over that role – so basically I'm working myself out of a job! Not without organisation and foundation, but that's ultimately what I would like to see – them taking over more and more.

(Staff member)

Ensuring resident input and involvement in the scheme's social life can mean that it takes some time for the social life to get up and running. Residents need time to settle in after the move, and it takes time for friendships to be built up and social committees to start.

However, when residents do lead activities, there is the potential benefit that they can take more 'ownership' over the activities that are in place. Interestingly, in one of the schemes where the manager supported activity provision, although staff had set up an initial programme of activities, by six months some of the residents had taken over and had put in place activities that were more to their interest:

We've set up this rota ... the coffee mornings are still standing strong, but the other aspects of it, people weren't interested or only one would turn up. So I think that's where the tenants themselves have stepped in and said, 'that's not really what we want, we prefer to do it like that'.

(Staff member)

In addition, organising social activities can give residents a specific role to play within the scheme,

enable them to use their skills and provide a sense of satisfaction, as described in the following quote:

Younger residents, who may have had to finish work early, are keen to get involved in the residents' association. It gives them something to plan and develop ... The residents' association, because they are active and interested, is organising and running certain activities.

(Scheme manager)

Where residents were taking an active role in leading social activities, there was generally a committee made up of at least some younger, fitter residents. There were some concerns raised by residents and staff that these people might not always be able to fulfil this role over time. In one of the schemes, residents took the lead with minimal manager involvement. It was felt by one of the managers at the scheme that this was in fact not the best approach to social activities and that they should be able to get more involved in the social life if residents were not able to run the social life themselves, which may be the case as residents become frailer:

We should have a say ... because they need a social life don't they, they need to have something. If they're not able to do it, I think it should be down to us.

(Scheme manager)

It is important to remember that the schemes had been open for only six months when these interviews were conducted; given the upheaval involved for residents in moving house and the fact that schemes were newly built, it is likely that this was very early in schemes' lives for a fully user-led approach to be in place and for any issues to have been resolved.

Links with the local community

Many of the schemes sought to promote links with the local community. Across the schemes there were varying degrees of community interaction, with some being particularly keen to become a community resource. It was recognised by

residents and staff that links could benefit both people living at the scheme and people from the local community:

A lot of [the residents] were quite isolated before, so it's good for them to have the interaction with people other than those they live with.

(Scheme manager)

What we'd like to do, once we've got the bingo machines and these social evenings going, is to encourage residents from round here to come and participate ... I know for a fact that there are elderly persons living on their own in and around this area, and if we could utilise the facilities here for them, even to come out for an afternoon or at night-time, and get them home safely, I'm sure they would come.

(Male resident)

Examples of links that schemes had made with their local communities included inviting local people to open days, fairs or bazaars and coffee mornings, holding religious meetings at the scheme, inviting residents of other sheltered housing or extra care schemes to visit or join activities and linking with local schools. Examples of services or resources that schemes sought to provide to the local community included day centres, shops and restaurants and, in one scheme, a doctor's surgery was planned. In some cases, schemes also provided a place to hold clinics (for example, with the community nurse or a 'Healthy legs' clinic) for the benefit of both local and scheme residents.

Many residents and staff members felt that six months was early for links with their local communities to have built up, particularly as people in the local community might be unsure about what extra care was and what facilities and services might be available for them to use.

Some schemes took a cautious approach to linking with the local community. One scheme manager in particular cited the nature of the locality and the difficulty of monitoring who would come in and when as reasons for this:

I'm not sure whether people coming in from the community is a good idea. There was a lot of talk about the internet café being open to the community ... Do we really want young kids from round here walking in and out of the building? No. Nobody thought it through, we don't want that. It's fine if people want to come and do things here and the tenants can join in, but I would be very careful of who and what groups would use it.

(Scheme manager)

This highlights the importance of the setting and context of the scheme to its relationship with the people in the community it is situated in. For example, if a scheme is located in an area where there are other extra care or sheltered housing schemes, it is more probable that people from outside the scheme will come in, as activities are more likely to be of interest to them. In addition, a scheme's location at the heart, or on the edge, of a community can influence the likelihood of the scheme being used by the local community, as highlighted by the following quotes:

Interviewer:

Has anything been particularly helpful in establishing links with the local community?

Yes, I think, because of where it is situated, you're in the middle of the community, so ... that's been helpful. If we'd have been placed on the outskirts, it would have done the opposite, whereas you're central to the community here.

(Scheme manager)

Similarly, if the scheme can provide a service to the surrounding area, local residents will have a reason to come in and making links might feel more natural:

We're going to have a doctor's, and that will make a big difference, we'll be having the estate coming in. And the café ... I think the idea of just coming in, unless there's a reason or an invitation to come in, may not be very easy to accept.

(Female resident)

What we do tend to find is used quite a lot is the restaurant and shop, because in the local vicinity there isn't anything – there isn't a shop unless you walk nearly a mile up the road. So you get schoolchildren at school time that come and use it, and you get people in and out during the day.

(Scheme manager)

There were mixed feelings from residents across the schemes about people from the local community coming into the scheme, particularly regarding shared use of facilities. Some residents were keen to encourage links, recognising the potential social and financial benefits, while others felt resentment towards others coming into their home and using what they perceived as being 'their' facilities:

None of us want to be old people shoved out of the way. I think the idea of meeting with the community as often as possible without them feeling we're a nuisance ... I think this [the scheme] is so much in the centre of [local area] that, if we can offer facilities for them and they can come and help us, it must be good.

(Female resident)

Some people think it's great and that we should encourage money and that to come into [the scheme] and I think others feel a bit pushed out. Just today there was an argument about seats and one of the residents turned round and said, 'well I actually live here'. It depends on the people really.

(Staff member)

Some scheme managers emphasised the importance of explaining the aims of the scheme as regards linking with the local community to residents before they moved in so that they would be aware of what to expect. The following quote also emphasises the importance of good design to ensure a balance between openness and privacy:

They were aware from the start that the ground floor is a public arena ... Most of them like the idea that it's a public domain – they know they

have their privacy upstairs; you can't get up there without a fob ... I tell them, 'once you go upstairs, you lock your door in the same way as on a street – if you want to talk to your neighbours you can, but you don't have to, it's totally up to you'.

(Scheme manager)

As well as bringing the community into the scheme, residents and staff recognised the importance of being able to access their local community and maintain any links they might previously have had; the following quote suggests, as we might expect, that it is easier for residents to have connections outside of the scheme if they have lived locally before moving:

Well it's my part of the world. I've spent most of my life here, only when I was away at the railway. We farmed two-and-a-half miles up the road. And I'm a churchman, I go to chapel and I've friends there, they come to see me.

(Male resident)

Residents across the schemes went out into the community for a number of reasons, including visiting the doctor's surgery and other such appointments, going shopping, attending day centres, going to church and also visiting family or friends (although it seemed to be more the case that family and friends came into the schemes). Some residents had their own cars, while most others used local taxi and bus services. For some residents with mobility problems, however, the location of their scheme or the lack of a nearby bus service meant that getting out was more difficult, as indicated by this resident, who said:

Some can get on the bus, there's one up the road, but I can't. I can't even get up to the shops. I find it a bit isolated.

(Female resident)

However, there were examples of support for residents to access the local community, although the latter quote also highlights funding as a potential barrier:

I'm looking forward to the warmer weather when I can go down [into the town], and it's

nice that somebody'll go with me if I'm a bit uptight first time.

(Female resident)

The ones who tend to go out are the ones who are more independent. My concern is, we have a large quota of people who don't get out like they should be, and we don't seem to have the facilities to facilitate it ... If I do take a group out, it would have to have care staff, they have to pay for that facility, so that puts a dampener on it.

(Staff member)

Scheme facilities

There was a range of different facilities available across the schemes, with the two villages naturally having the largest number and variety (see Appendix 2). Of interest in this project was whether particular facilities served as meeting places for residents and helped to foster social interaction and friendship development. Certain facilities seem to be important in this respect. Shops can provide an opportunity to meet other residents, as the following quotes from staff from a scheme and a village illustrate:

The shop has been a catalyst to getting people integrating well together.

(Staff member – scheme)

The shop is quite a central, chatty area ... It's all volunteers and mainly residents that work in there, so again it's a place where people congregate for a chat.

(Staff member – village)

Residents from one scheme who organised and ran the shop themselves seemed to particularly value the social interaction centred on the shop, as illustrated in the quote below:

Oddly, I think the shop has become a social activity. Not only is it nice for people to be able to buy for themselves, but often people come down and chat.

(Female resident)

However, in two of the schemes, there were difficulties in running the shops, as they were reliant on resident volunteers who were not always willing or able to help out.

Many residents and staff also felt that restaurants played an important role in friendship development, particularly when all residents ate a midday meal together, as illustrated by the quote below. There was also some suggestion from staff in the smaller schemes that it was beneficial to have the price of a meal included in residents' rent or service charge, as this encouraged all to attend.

Interviewer:

Are people starting to develop friendships?

Yes definitely. I think a lot of it is down to the dining room at lunchtime, because they have to come down and eat their meal together, that's where they form their friendships – they're getting out and meeting people, which is a really good thing, otherwise a lot would be in their flats all day and wouldn't meet people. Lunchtime is a really good positive part of the day.

(Scheme manager)

Residents seemed to value mealtimes, as illustrated below. Indeed, for some residents, as indicated by the scheme manager above, lunchtime is their main opportunity to meet people.

It's fun really, the meal is at 12.30 but we all start coming at 12.00, which I think indicates that we like the social activity, and those who have time stay for a cup of tea. It's the social event of the day really. It's one of the best things – for all of us, cooking a main meal is beyond us; you do get one really good main meal.

(Female resident)

In one scheme where the restaurant was temporarily shut at six months because of financial reasons, the loss to the scheme's social life was noticed by both residents and staff. The manager of the scheme commented that:

The restaurant was a really good social area ... It was a big blow when it shut. They did miss it, the ones who had lunch.

(Scheme manager)

Similarly, in one of the village-style schemes where there was a large restaurant that was not open in the evenings, one resident felt that the impact on social life at the scheme was significant:

I find that it's difficult to get friends to come here; there's no restaurant open in the evenings so I can't invite them over ... I think it's sad because a restaurant in the evening could be the hub, you wouldn't have to make too many events happen, they would happen normally, people would mix and join each other.

(Female resident)

In some schemes, shops and restaurants were open to members of the local community, and so provided additional opportunities for residents to interact with other people, as discussed earlier.

All of the schemes had a large communal lounge. These spaces were regularly used for social activities and in some schemes seemed to have become the main 'hub' of social activity. The quotes below indicate how location and design features of these areas are important for facilitating social participation:

We do the games in [the lounge] and the dominoes, we do the baking down there. People find that an easier place ... it's in the middle of the building and, if we're doing something up here [in the activities room], you've got to get people from the main lounge up to here, in wheelchairs and things like that.

(Staff member)

The main lounge is the place to be at [scheme]! The way the building's designed is that both the main lounge and the restaurant are opposite each other, and it's not a brick wall with a door, it's all glass and all very open so, when you walk past, you don't have to physically go in to see who's in there, which I think is a really good idea, because you do see people walking past, look in, and see, 'oh somebody's sitting in there, I'll go and join them'.

(Scheme manager)

In general (although not universally), large communal lounges did not seem to be used

as informal meeting places. One reason often given for this was that the building was new and residents had not yet taken full 'ownership' of the communal spaces. In one scheme, residents met informally for coffee in a smaller first-floor lounge and, in other schemes, entrance ways and circulation areas were popular meeting places:

We meet for social reasons at about 5 o'clock down in the hallway. I know it sounds daft when we've got lovely lounges, but we meet there and we talk about anything ... I started it off, by going down to read my book, then others joined me ... and yet it doesn't take off in the lounge. I think what they like is seeing people coming in and out, passing through, saying hello; they wouldn't see that in the lounge.

(Female resident)

In most of the schemes, six months after opening, outside spaces were not yet regularly used for social activities and as places for interaction; of course, when some of the schemes were visited, they had not yet been open during the warmer months. However, there were plans for using outside spaces for gentle exercise such as walking, and for gardening and summer barbeques. In some of the schemes, gardens were already in use and very much valued; the quote below shows how outside seating areas can encourage social interaction:

The garden is champion, so much so that, when we had that little spate of good weather, most folk were going out. We've got tables and chairs out there, so it encourages them to go and sit out, and invariably you get one or two more coming out, and then family and friends come up and they get involved. We've had some good times out there so far.

(Male resident)

Barriers to, and supports for, social well-being

Challenges in the development of schemes' social lives

Although the schemes had largely been successful in setting up activities and beginning to develop a social life, challenges had also been encountered.

An often-mentioned issue was the health and mobility of residents. It was recognised by both residents and staff in the schemes that, for a significant number of extra care residents, getting involved in setting up or running activities might be difficult:

[Social activities are] tenant-led. The problem we have with extra care is that the residents are frail and it's getting people that are able to do that. We're lucky here because we have some residents from [sheltered housing scheme previously on site] who are in better health. If it wasn't for them there wouldn't be a social life.

(Scheme manager)

I didn't think to be honest we'd get involved in [organising the scheme's social life], but, if we don't do it, who's going to do it? Because there are residents in their 70s and 80s, some in their 90s – they'll be interested in doing [activities], and probably be grateful for what you do, but there's no way they're going to be chasing round, making this phone call, organising this and doing that.

(Male resident)

There was some concern that those residents who were involved in the organisation of social activities and events would not always be willing or able to continue this indefinitely, as mentioned earlier. This highlights the importance of having a mix of 'residents with different dependency levels', as seen in the quotes below:

I think there's not enough mixture of a few able-bodied (I'm calling myself able-bodied, I'm not really!) ... There are so many in wheelchairs, there isn't enough [of a] mix with people who want to go out and do things.

(Female resident)

[Having a mix of dependency levels] is essential to keep it going. It's essential for the activities, that the less able people get the support from people that can help, there's more social interaction, there's more people going out into

the community, bringing things back – there's more shared relationships.

(Scheme manager)

The fact that many residents in the schemes received care restricted the type of activity that it was possible to put on in some schemes, as well as the time of day that activities could take place. In one scheme, the high levels of dependency, coupled with an initial mismatch in the number of care hours, had meant that there were relatively few social activities in place at six months, as described in the quote below. It should be noted, however, that this problem was being resolved at the time of the interview:

The care tasks have to come first and we don't really have enough care hours in at the moment, because we do have quite high dependency, so obviously the care side of things has to take preference to activities.

(Scheme manager)

Another challenge mentioned was a lack of funding and resources to support social well-being, as indicated in the quote below. Even in schemes with dedicated activities support, this could be an issue:

I'd like to see a tailored programme that can meet everybody's needs, but sometimes funding gets in the way of that – you haven't got the resources to be able to go and buy different things that you want for activities, and that's been a bit of a barrier for us.

(Scheme manager)

Factors aiding the development of schemes' social lives

There were a number of factors that appeared to have contributed to the successful features of the development of schemes' social lives during the first six months. In particular, residents themselves were seen by staff in many of the schemes to have been a big help; specific factors mentioned included having interested residents, having residents who could bring existing skills and expertise into the scheme, and the practical help and support that residents gave:

Interviewer: Has anything been particularly helpful in setting up activities?

Residents... they'll tell me what they like and don't like. When I first came, I stood near the noticeboard and there was a feeling among certain residents that activities were more Benidorm than Barbados. More Blackpool. So we've been able to turn that around.

(Scheme manager)

In three of the schemes, staff described how the enthusiasm of one or two residents could help to motivate or involve others, highlighting the importance of resident involvement and ownership over their scheme's social life:

[Some of] the tenants ... tend to give people a knock late at night and say, 'just to remind you, it's such-and-such a thing tomorrow' – I think that's one of our good things, that we've got people like that in here who are willing to give things a go and try and get people down.

(Scheme manager)

Other useful factors mentioned by some of the schemes were having helpful staff, the assistance of friends, relatives and other volunteers, and links with other organisations such as social services or the local Lions Club. The quote below highlights the benefit of having links with other local schemes in terms of sharing resources:

We have a store of equipment, but the other schemes also have stores of equipment, different equipment, so we can mix and match amongst the various schemes, so that's good – we haven't got our own curling set, but another scheme has, so we borrow that.

(Staff member)

As discussed above, particular facilities in the schemes, such as shops and restaurants, could also facilitate the development of a scheme's social life.

Barriers to and supports for participation

Even within the supportive, enabling extra care environment, barriers can exist for some residents and prevent them from taking part. Interviews

indicated a number of potential barriers, but also highlighted support for participation and some ways in which barriers were being overcome.

One barrier to participation for some residents was their health and mobility problems, which they felt restricted their social lives. A particular problem in some schemes seemed to be getting people to and from activities and events:

The biggest problem is [needing] the carers to get you to anything.

(Female resident)

Whether mobility problems formed a real barrier depended on whether staff had time available to move people around when needed. In one village, additional staff had been employed specifically for this reason. Another scheme hoped to recruit volunteers to give this practical support:

I would say 60 per cent, probably more, need staff to physically bring them to activities ... It has caused a few problems, but we are getting over that. I will use my domestic support staff to bring them down in wheelchairs, I'll bring them down myself, and the care team will bring them down in between visits. But that's why the volunteers – we're desperate for them, it's all hands on deck really.

(Scheme manager)

In some schemes, it seemed that care staff had time built in for this kind of practical assistance in getting people to social activities and supporting them while there or taking residents to visit friends in the scheme:

Interviewer: Is there anything at the moment that prevents you from taking part in activities when they are on?

No, because the carers come and they take me out of the flat, and the carers tell me what's on – helpful.

(Female resident)

[The carers] help to bring people down. If we're having an afternoon thing, and the resident's

on medication, they must have their medication so the care team will take them up, give them their medication and bring them straight back down.

(Scheme manager)

There were also examples of non-practical support for participation, such as encouraging new residents to participate, as shown in the quote below:

The first few days I came here, the attendants kept coming across to make sure I was alright and that was lovely, you know – somebody cared. And then they knocked on the door and said 'come to the coffee morning' and they took me across, which was nice, and of course I was introduced to everyone and you get going.

(Female resident)

In addition, staff from a scheme and a village described extra support for people with memory loss and dementia:

We've also employed [a member of staff] whose job is to work with people on a one-to-one basis, primarily people with memory problems, but will also work with people who are just maybe a bit slower or maybe just need a bit of support.

(Staff member – village)

If somebody who we know has got dementia is going to a social evening, we'll really encourage them to put their medication in their bag or we often remind them and ask them nearer the time, 'are you coming down to the social evening?', and just pop in on them periodically, make sure they're alright.

(Staff member – scheme)

Closely linked to health and mobility, is the care that residents receive. The quotes below indicate how this can hinder participation:

There are only about twelve at the coffee morning. Again, you have to get your carers to

push you down and take you back. Everything comes down to if it's on your care plan, it's a bit hard.

(Female resident)

and they all preferred to have an afternoon tea. So now, once a fortnight, we have an afternoon tea.

(Scheme manager)

It would be nice to have a system where the carers have flexibility to take people downstairs for impromptu reasons, but they are tied to times. So it would be nice to have the flexibility of a nursing home [in terms of staff deployment] but with the independence of extra care, it would be fantastic. I hate saying to people that their carers can't do something because it isn't paid for, it's so sad.

(Scheme manager)

Five schemes in particular mentioned the fact that, because of the timing of care visits or the availability of staff, it could be difficult to have activities and events in the evenings:

The carers are doing all the teatime calls and the evening stuff, so to do any sort of activity in the evening is going to be exceedingly difficult, because then it puts the care routine out.

(Scheme manager)

My carer comes at half past 8 in the evening, so she'll help me get ready for bed and I'm stuck aren't I? ... And the same applies to a lot of people. So the day finishes before that time. I really don't like that, but I don't know how you get around it unless you have them working later, which is not going to go down well is it, and fair enough.

(Female resident)

Interviewer:

Does the care routine have any impact upon residents' social life?

Staff member A:

No. Our activities start after everyone's up and dressed, and if they're not up and dressed they just join us whenever they're ready.

Staff member B:

You see we don't have formal starts and formal finishes. We're not that disorganised, but it's not set in stone – 'if you're not here by 10.30 you don't attend' – it's just not like that. It's their home, why can't they drift in and out if they choose to?

(Staff members)

Social participation was also supported by the flexibility in the delivery of care in some of the schemes, as described below:

I consider myself pretty lucky here. If we've got something on the go ... we work in conjunction with the care team and, if we know that we've got to be out, then they will reschedule the care that goes in ... So we work together like that, with the residents, so they don't miss out just because they've got to have their bath or whatever done.

(Scheme manager)

However, the type of problems mentioned above can sometimes be overcome. Some schemes deliberately scheduled activities at times that were accessible to all residents or were flexible about the time activities would start:

We did start with a coffee morning every week, but that has proved not good, because some of the residents who have a lot of care are not able to get down here early ... I asked them

[When there is] a social evening, staff will go and remind people, 'there's a social evening tonight, do you want to come down? Don't forget to take your medication with you, then you don't have to come back up', that type of thing, and, if somebody needed access to the toilet, for example, once they were in that social evening, they'd have access to it – there wouldn't be a staff member in the social

evening, but, if they press the buzzer or let a member of staff know beforehand, 'could you come by about 8 if possible please', and I think that's where the flexibility of the service, that's another benefit for them.

(Staff member)

A different type of barrier can stem from the nature of the activities themselves; some activities and events are simply not of interest to a number of residents. This is of course down to personal taste, but can be linked to the fact that schemes often have residents covering a wide range of ages. However, even when activities were not to a resident's taste, there was recognition that they could serve a social purpose, as indicated in these quotes from residents of two schemes:

We have the usual things, like bingo; I never thought it would be popular, but it is ... It makes money for the residents' association, as well as giving people something to do for a couple of hours.

(Male resident)

They had a singer once ... terrible. I go for the sake of the community, whether I really enjoy it or not. People singing is not ... I wouldn't pay to hear them. But it's community down there, we've all got to try and help it.

(Male resident)

Some scheme managers mentioned the difficulty of providing activities that were attractive to men and getting single men in particular involved. However, staff were trying to overcome this barrier, as illustrated by the quote below:

Getting men to join in is very hard ... We are trying to get someone to come and do a risk assessment so we can have a greenhouse, which hopefully'll get the men involved. We've just bought a magnetic dartboard, so we'll see if we can have a darts competition, maybe get the men down. We'll see how that goes – we'll give anything a try.

(Scheme manager)

Finally, financial constraints were mentioned by residents in a small number of schemes as being a barrier to their participation in activities. The final quote indicates how financial considerations could have an impact on residents' social interaction with care staff:

They said, 'you've got to mix with people', but you see it's still money every time, you don't get all this free, you still pay, it's only £2 a time, but you add that over all the weeks and months, it can soon add up.

(Female resident)

Well, [the care staff] used to [sit and chat], yes, but they're not now because it was costing me that much – it's so much a minute in here! I was having my cups of tea, I used to love having a chat with them, cup of tea on a night, but, when I found out what it was costing me, I had to knock that on the head straightaway.

(Male resident)

Summary

- Residents valued the combination of independence, security and opportunities for social interaction afforded by living in extra care housing.
- All schemes took a resident-led approach to providing social activity, but there were differences in how this was put into practice, depending on levels of staff and resident involvement.
- In schemes where there were dedicated activities staff, and to some degree where care and support staff had time dedicated to this role, there were more activities and events in place. In those schemes where managers were responsible for setting up social activities, this could not be prioritised because of other demands of running the scheme.
- Residents in some schemes were actively involved in organising and running their

scheme's social life. This had the benefit of encouraging residents to take ownership of the activities in place and increasing participation. In addition, residents gained satisfaction from taking on this role.

- Many of the schemes had begun to make links with their local communities; it was felt that both residents and the local community could benefit from this interaction. The location and context of a scheme were important in determining the extent of community involvement that developed.
- Communal facilities were important in the development of the social life at the schemes. Shops can provide an opportunity to get to know other residents and restaurants can aid friendship development, particularly among residents who eat a midday meal together.
- The location and design of communal spaces (for example, lounges, circulation areas) was important for facilitating their use. Lounges located centrally, which were easily accessible and easy to see into, were valued.
- The health and mobility of some residents made getting involved in leading the organisation of social activities difficult for them. It was seen as important to maintain a balance of residents with different levels of need in order to sustain social activities over time, particularly when residents took an active role in their organisation.
- Lack of physical support for social participation (for example, assistance for residents to get to and from social activities) was a barrier for some with health or mobility problems. In some schemes, however, there were adequate resources to help people get to activities and support them while there, which was valued by residents and scheme managers.
- For some residents, the fact that they received personal care at specific times meant that they could not always participate, particularly in evening activities. However, there were

also examples of flexible care provision aiding participation.

- For a small number of residents, financial constraints were a barrier to taking part in social activities and to social interaction with care staff.

Clearly, six months after opening, the development of schemes' social lives and new friendships was at a very early stage. However, already the schemes appeared to be taking different approaches and facing different challenges. In the following chapter, we describe the schemes at twelve months and attempt to assess the impact of some of these early features on the social climate or 'personality' of the schemes one year after opening.

3 Villages and schemes at twelve months

In this chapter, we describe the schemes twelve months after opening, using information from the questionnaire to all participating residents and the follow-up interview with a smaller sample. We describe the social climate of the schemes and villages, and the schemes' links with the local community one year after opening.

As shown in the model presented in Chapter 1, we expected social climate to be linked to various factors of the scheme, such as its size (whether village or smaller scheme) and the approach taken to activity provision, as well as the rate (or availability) of social activities and social well-being. It is also likely that the health and dependency of schemes' residents will have influenced the type of social climate that developed.

Social climate

Residents' experiences of the extra care schemes they live in are likely to influence their perceptions of the social climate, the atmosphere or 'personality', of that scheme. Moos and Lemke (1996), in describing the concept of social climate, explain that:

The social climate perspective assumes that each individual environment has a unique 'personality' that gives it unity and coherence. Like some people, some social environments are friendlier than others ... a judgement of friendliness might stem from whether residents greet each other in the lounge, help each other, participate in activities, and so on.

(Moos and Lemke, 1996, p. 110)

In residential care, the atmosphere of a home is of vital importance to the people living there and affects their quality of life (Netten *et al.*, 2001). We expected that this would also be the case in extra care housing, given that, as people become older and frailer, their lives become gradually more

influenced by their immediate physical and social environments (Godfrey *et al.*, 2004).

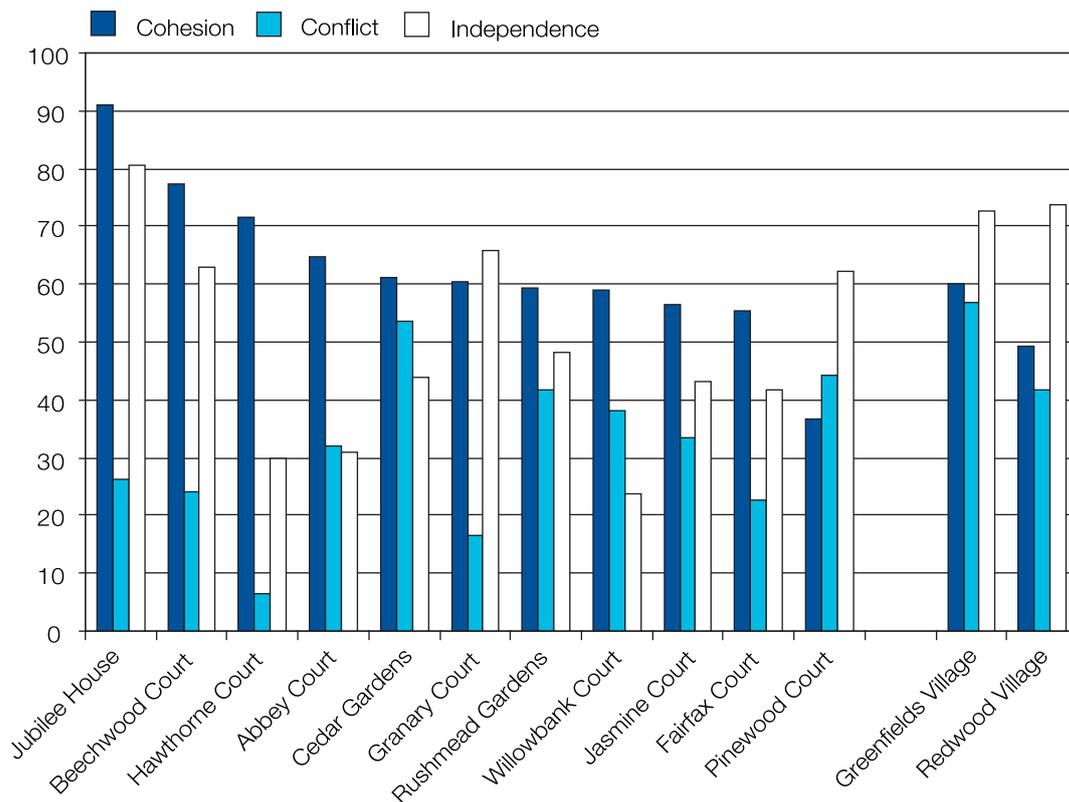
We attempted to measure each scheme's social climate as a way of describing the diversity of the schemes in our sample. Although there were some difficulties in measuring the social climate, as explained below, the results suggested an interesting picture in terms of the dimensions and their relationship with the characteristics of schemes.

We measured the concept of social climate using the Social Care Environment Scale (SCES; Moos and Lemke, 1996) (see Appendix 3). As part of our follow-up interview to the twelve-month questionnaire, we asked residents questions reflecting the three subscales of the SCES of most relevance to newly opened extra care schemes.

- Cohesion: how helpful and supportive staff members are towards residents, and how involved and supportive residents are with each other.
- Conflict: the extent to which residents express anger and are critical of each other and of the facility.
- Independence: how self-sufficient residents are encouraged to be in their personal affairs and how much responsibility and self-direction they exercise.

Individual responses to the questions were combined to give overall scores for each scheme on each of the dimensions,¹ giving each scheme a score (out of 100) for levels of cohesion, conflict and independence (shown in Figure 2). Cohesion scores ranged from 37 to 91, with an average score of 60; conflict scores from 7 to 57, with an average score of 37; and independence scores from 30 to 80, with an average score of 59. There was considerable diversity in scores across the

Figure 2: Social climate scores by scheme



Schemes are ordered according to cohesion score (highest to lowest), with the exception of the two villages, which are presented at the right-hand side of the figure.

schemes, as might be expected. There was also, however, large variation between individual scores within the schemes, which reflects residents' naturally different perceptions of their environment.²

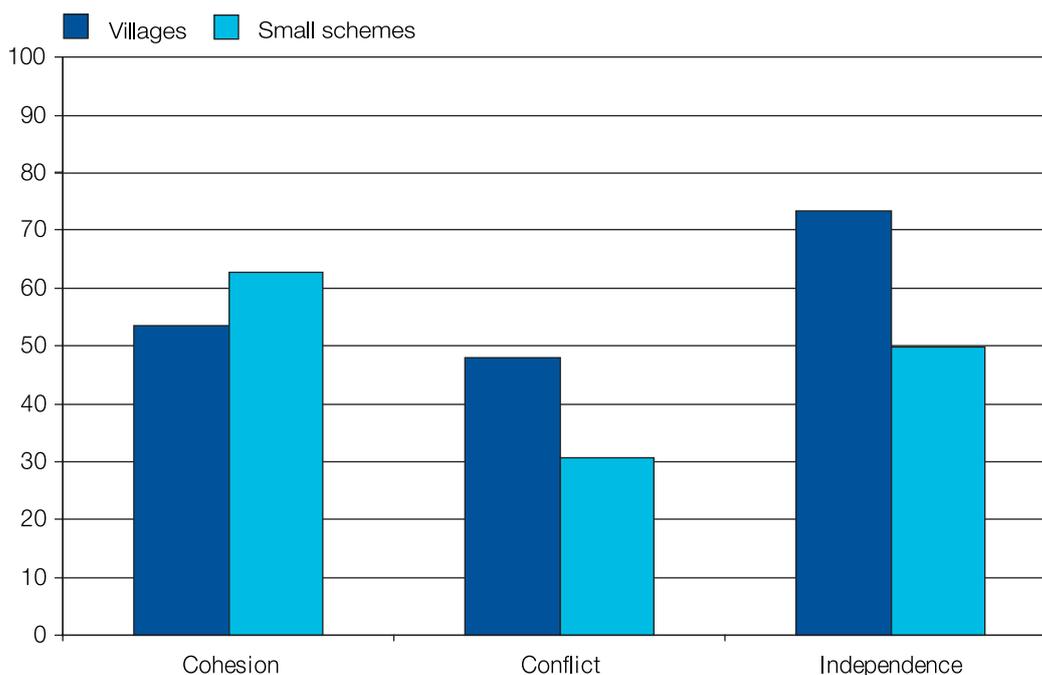
We might expect that the 'ideal' social climate would have high levels of cohesion and independence, and low levels of conflict. Three of the schemes seem to conform to this pattern: Jubilee House, Beechwood Court and Granary Court. As we describe in the next chapter, this pattern was linked to higher levels of overall quality of life and to various indicators of social well-being for our sample. The two villages are notable for their high levels of independence combined with relatively high levels of conflict and this, together with differences in their populations, led us to treat schemes and villages separately in our analysis. When we analysed the whole sample, some findings were in fact reflecting the differences between villages and schemes, rather than the influence of variations in social climate.

Social climate in schemes and villages

Figure 3 shows that, on average, residents in small schemes rated cohesion as higher than those in villages, while village residents rated conflict and independence higher than residents of smaller schemes. The difference in average levels of cohesion is not likely to reflect a 'real' difference between smaller schemes and villages, however, as a number of the smaller schemes had similar scores on this measure to the villages. Nevertheless, both villages had noticeably higher levels of independence and conflict than most of the smaller schemes.

Intuitively, these findings appear to make sense, reflecting fundamental differences in the nature of the village and small schemes' communities. In both villages, one year after opening, there were some tensions to do with the diverse mix of residents in terms of care and support needs. The majority of residents moved into the villages without any care and

Figure 3: Comparison of social climate scores for villages and smaller schemes



support needs, but there was a feeling from some residents that (contrary to expectations) an increasing number of people with disabilities were moving in; the following comment was typical:

The village seems to me to be becoming a nursing home rather than a retirement village, which was not expected before moving here.
(Male resident)

Where there are a larger number of people living together, as in the villages, it is perhaps unsurprising that there may be higher levels of conflict on average. A number of residents in both villages were particularly concerned about the high staff turnover, at both senior management level and among care workers. There was also criticism of management and a feeling that local managers were influenced by senior management at the organisation's 'head office':

They say it's our village, but we think it's controlled by head office. The managers want to do things, but their hands are tied by head office. Because the managers keep getting replaced, we've formed a residents' association so that we could have a say – we felt we were getting pushed around a lot.
(Female resident)

It should be noted that, while the SCES treats conflict as an inherently negative factor, it is possible that some level of conflict may bring about needed change; the formation of a residents' committee mentioned in the quote above may be an example of this. However, long-term conflict is unlikely to be positive.

The difference in levels of independence is likely to reflect the fact that the majority of people move into the villages without a need for formal care and support, and may reflect the culture of the organisation that ran both villages, as it placed a particular emphasis on active, independent ageing. However, there was no clear pattern in social climate scores when grouping the smaller schemes according to provider.³

Given these differences, and the difference in the characteristics of residents in villages and schemes, it makes sense to treat villages and smaller schemes as separate groups.

Factors associated with social climate in smaller schemes

In the light of our findings about the development of the schemes six months after opening, we expected a number of factors to affect the social climate of the smaller schemes. Any effects

were difficult to ascertain, however, because of the relatively small number of residents with complete social climate scores, and not all of our expectations were borne out. For example, we anticipated that, as communal lunchtime was mentioned as being an important occasion for social interaction in many schemes, cohesion might be lower than average in schemes where there was no restaurant and higher in schemes where meals were included as part of the service charge. However, this was not the case. In the one scheme where the restaurant was closed at six months, the restaurant had reopened and had been running some time before the scheme had been open for a year, and cohesion was at a similar level to other schemes. In another scheme, where the restaurant was shut twelve months after opening because of financial difficulties, levels of cohesion were also around average.

We were interested in the effect that the presence of an activities coordinator might have on the social climate of the scheme, expecting that this might be associated with a more positive social climate, given the indications at six months. Perhaps surprisingly, levels of conflict were significantly higher in schemes where there was an activities coordinator and, while the differences were not statistically significant, cohesion and independence were lower in these schemes.

While none of the four schemes with the highest levels of independence had an activities coordinator, three of these schemes had active residents' committees at six months who played a large part in the social life of those schemes.

Jubilee House was the scheme with the highest levels of independence in our sample (including the two villages). At six months, the manager and residents' committee worked together to provide social activities at the scheme. The committee was led by a particularly enthusiastic couple, who were keen to get people involved and to bring about a sense of community in the scheme. At twelve months, the residents' committee was still very active and social activities and events were happening regularly. Granary Court also had high levels of independence; again, at six months, the residents' committee ran the scheme's social life with the managers taking a 'hands-off' approach. Pinewood Court also had an active residents' committee and was also the

scheme where, at six months, residents had 'taken over' the running of some aspects of the social life from staff in order to put on activities and events that were more to their choice. On the other hand, in Beechwood Court, where there were also high levels of independence, at six months, social activities were facilitated by care and support staff, with little resident input. There was some indication that residents had begun to be more actively involved by twelve months by occasionally organising social evenings, however.

As noted above, it is likely that the abilities of the residents in the schemes had an influence on the type of social climate that had developed. In our sample of smaller schemes, lower levels of physical impairment among residents and higher levels of self-perceived health were associated with higher ratings of independence. Again, not surprisingly, higher levels of cognitive impairment were associated with higher levels of conflict. It may be that average levels of health and dependency in the schemes affected some of the findings described above, particularly those related to levels of independence.

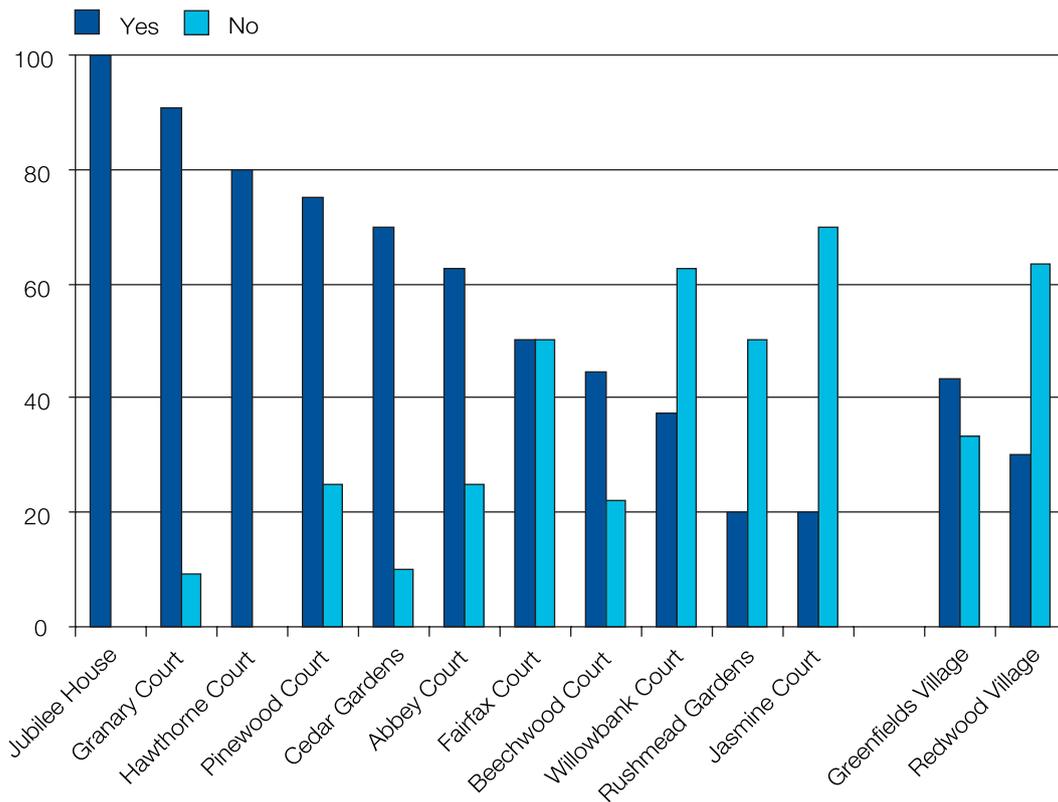
Links with the local community at twelve months

As we saw in the previous chapter, the schemes were making links with their local communities in various ways and in varying degrees. In our interviews at twelve months, residents were asked about the role of the scheme in the local community. Figure 4 shows that there was considerable variation in how people responded to the question, 'Do you feel that the scheme is a part of the local community?'

Figure 5 shows the responses when we asked residents how involved they personally felt in their local community. Three of the schemes where residents themselves were most likely to report feeling personally involved had the highest proportion of residents feeling that their scheme was a part of the local community.

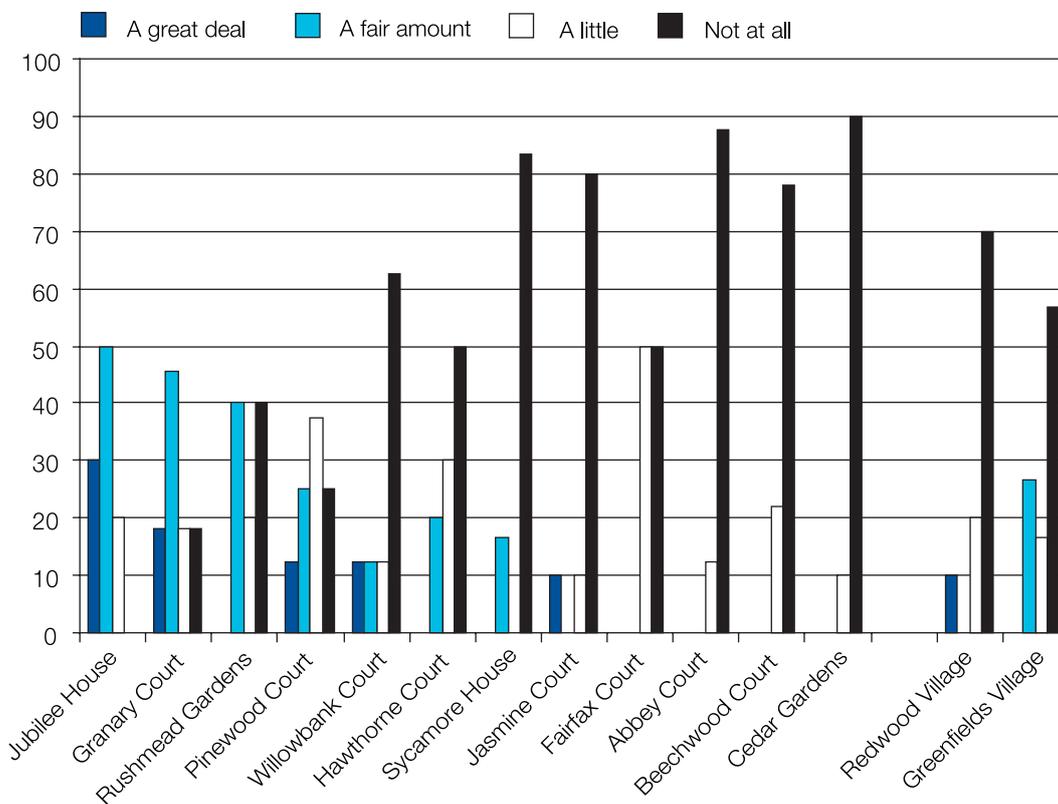
Residents were also asked how they felt about people from the local community coming into the scheme to use the facilities or take part in social activities (see Figure 6).

Figure 4: Is the scheme a part of the local community?



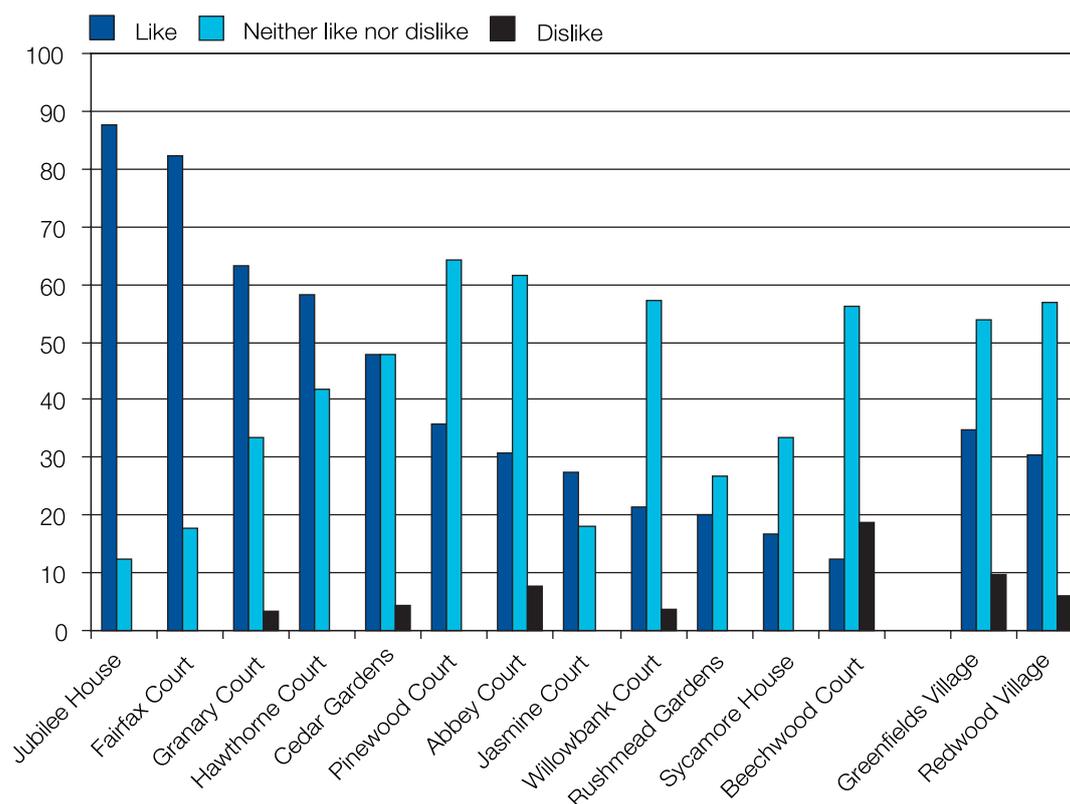
Schemes are ordered (highest to lowest) according to percentage of residents feeling that their scheme was a part of the local community, with the exception of the two villages, which are presented at the right-hand side of the figure. There were no valid responses for Sycamore House.

Figure 5: Extent of residents' involvement in the local community



Schemes are ordered (highest to lowest) according to the percentage of residents who were involved in the local community 'a great deal' or 'a fair amount', with the exception of the two villages, which are presented at the right-hand side of the figure.

Figure 6: Residents' feelings about non-residents coming into the scheme



Schemes are ordered (highest to lowest) according to percentage of residents who like non-residents coming in, with the exception of the two villages, which are presented at the right-hand side of the figure.

Of the schemes where many residents felt involved in the local community, felt the scheme to be part of the local community or liked non-residents coming in, four (Jubilee House, Pinewood Court, Cedar Gardens and Fairfax Court) were already encouraging links at six months, while the other two (Granary Court and Hawthorne Court) were keen for links to develop in future. The scheme where only 13 per cent of residents liked people from the local community coming in was Beechwood Court where, at six months, the scheme manager had described how the nature of the local area meant that they were cautious about building up links (see Chapter 2).

Summary

- Social climate – measured as levels of cohesion, conflict and independence – varied across the schemes. Three of the schemes had the ‘ideal’ pattern of social climate scores, with high levels of cohesion and independence alongside low levels of conflict.
- Social climate in the villages was different from that in the smaller schemes. Villages had slightly lower cohesion on average and higher conflict and independence than smaller schemes. This was reflected in some anecdotal evidence about the villages. Levels of physical and cognitive ability also varied between villages and smaller schemes and might be partly responsible for this difference.
- In smaller schemes, scheme levels of physical and cognitive impairment were associated with social climate, with schemes with lower physical impairment and better average levels of self-perceived health having higher levels of independence. In addition, schemes where there were higher average levels of cognitive impairment also had higher levels of conflict.
- In smaller schemes, levels of independence were no higher with an activities coordinator, the highest levels being found in schemes where residents took an active role in organising activities with support from the

scheme manager. These schemes were also those with lower than average levels of dependency.

- Levels of local community involvement across the schemes could be linked with findings about the development of initial links at six months. Some of the schemes in which residents felt positive about these links were those where links had begun to build up at six months.

Having described the schemes' social climate and local community links at twelve months, we turn now to residents' individual social well-being.

4 Social well-being at twelve months

In this chapter, we focus on residents' social well-being one year after the schemes opened, drawing on information from the questionnaire to all participating residents and the follow-up interview with a smaller sample.

Overall quality of life and well-being

We measured overall quality of life in two ways. In the questionnaire we included a single question asking participants to rate their overall quality of life on a seven-point scale (Bowling, 1995), while in the follow-up interview we used the CASP-19 scale, which is summed to give an overall score from 0 to 57 (Hyde *et al.*, 2003).

As shown in Table 3, over two-thirds of the residents in our sample rated their quality of life

as either 'good' or 'very good', reflected in an average composite score (out of 7) of 5.0. A further quarter considered their quality of life to be 'alright', with a minority responding at the negative end of the scale. On average, village residents rated their quality of life as slightly better than those living in smaller schemes, reflected by composite scores of 5.2 and 4.7, respectively. The main difference was that more people in the villages than schemes rated their quality of life as 'very good', while more people in the schemes than the villages felt their quality of life to be 'alright'. Results using the CASP-19 (only available for the interview sample) followed a similar pattern, with residents in the villages on average having slightly higher levels of quality of life than people living in the schemes (42.3 compared to 37.4).

Table 3: Residents' overall self-rated quality of life

	Whole sample (n = 599)			
	No.		%	
<i>How would you rate your quality of life as a whole?</i>				
So good, it could not be better	31		5.2	
Very good	197		33.3	
Good	180		30.5	
Alright	150		25.4	
Bad	22		3.7	
Very bad	5		0.8	
So bad, it could not be worse	6		1.0	
	Schemes (n = 205)		Villages (n = 394)	
	No.	%	No.	%
<i>How would you rate your quality of life as a whole?</i>				
So good, it could not be better	7	3.4	24	6.2
Very good	41	20.1	156	40.3
Good	68	33.3	112	28.9
Alright	69	33.8	81	20.9
Bad	12	5.9	10	2.6
Very bad	4	2.0	1	0.3
So bad, it could not be worse	3	1.5	3	0.8

Scores on our two measures of overall well-being were strongly related, with high scores on one related to high scores on the other. As the number of residents who took part in the questionnaire and responded to the quality of life question (591) was much higher than the number who took part in the interview (166), we focused on the single question as our overall indicator of well-being in subsequent analysis.

Social well-being

We used a number of 'indicators' of social well-being, measured by a single question each time, except for in the case of social support, which was measured using a set of seven questions summed to give an overall score. The indicators were as follows.

- Levels of social participation: whether the individual felt that they had a good social life or was, at the other extreme, socially isolated and often lonely.
- Whether or not the individual had made friends at the scheme.
- How often the individual had contact with friends from inside or outside the scheme (either meeting up with or hearing from them).
- How often the individual had contact with relatives (either meeting up with or hearing from them).
- How often the individual took part in an activity or attended a group (at the scheme or outside).
- Whether the individual was occupied in activities of their choice or was, at the other extreme, unoccupied and often bored.
- Levels of social support: whether the individual experienced no lack, some lack or a severe lack.

The first six indicators were included in the questionnaire to all participating residents, while questions designed to indicate levels of social support were asked in the follow-up interview.

When examining social support levels, the differences between these two samples, and in particular the fact that more people in the follow-up sample than the main sample were receiving care, need to be borne in mind.

Six of the indicators were related to quality of life, such that more positive social outcomes were related to a better quality of life. This confirms the importance of these social factors in overall quality of life for individuals in our sample. Surprisingly, the frequency with which individuals met up with or heard from relatives was not significantly associated with quality of life. Given the lack of relationship in our sample between frequency of contact with relatives and quality of life, we did not use this as an indicator of social well-being in our analyses.

The associations between our indicators of social well-being and overall quality of life were found in both smaller schemes and villages. However, when we discuss the findings in greater detail, for the most part the sample is divided into those residents who lived in the two villages and those who lived in the smaller schemes. Again, comparisons need to be interpreted with caution, given the fact that these groups were as a whole somewhat different, as described in previous chapters.

Table 4 shows the responses of residents in the schemes and villages to the social well-being questions listed above.

Our findings suggest that, for the majority of residents in our sample, levels of social well-being were high. Around 40 per cent reported that they had a 'good' social life, while a further 40 per cent reported that it was 'as good as it can be' (this response intended to reflect a good quality of life despite, perhaps, circumstances such as ill health). Over half felt that their social life had changed for the better following their move to extra care housing and 90 per cent had made or were making new friends at their scheme. Overall, although results were positive for many residents in both settings, the residents living in the villages seemed to have better social outcomes than those living in the schemes, according to most of our indicators of social well-being.

Table 4: Individual social well-being in schemes and villages

	Schemes (n = 205)		Villages (n = 394)	
	No.	%	No.	%
<i>How would you describe your social life?</i>				
Have a good social life	56	27.5	187	48.1
Social life as good as it can be	98	48.0	153	39.3
Have social life, sometimes lonely	28	13.7	33	8.5
Feel socially isolated, often lonely	22	10.8	16	4.1
<i>How is your time occupied?</i>				
Fully occupied in activities of choice	140	68.3	311	82.5
Fully occupied, not activities of choice	20	9.8	31	8.2
Not enough to do to keep occupied	26	12.7	23	6.1
Not occupied, usually bored	19	9.3	12	3.2
<i>How often do you take part in an activity or group?</i>				
On most days	41	20.0	136	35.7
Once or twice a week	82	40.0	166	43.6
Once or twice a month	33	16.1	34	8.9
Less than once a month	18	8.8	17	4.5
Never	31	15.1	28	7.3
<i>Do you feel you have made/are making friends at scheme?</i>				
Yes	182	89.2	353	91.7
No	22	10.8	32	8.3
<i>How often do you hear from or meet up with friends?</i>				
On most days	61	29.9	127	33.2
Once or twice a week	53	26.0	148	38.7
Once or twice a month	24	11.8	61	16.0
Less than once a month	18	8.8	13	3.4
Several times a year	23	11.3	25	6.5
Never	25	12.3	8	2.1
<i>Levels of social support (schemes, n = 99, villages, n = 57)</i>				
No lack	71	71.7	32	56.1
Some lack	13	13.1	19	33.3
Severe lack	15	15.2	6	10.5

Social participation

Residents were asked to describe their current social life. Responses from people living in the villages and those living in the smaller schemes were different. The majority of people living in the villages stated that they had a ‘good social life’, compared with a majority of people in the schemes believing their social life to be ‘as good as it can be’. More people in the schemes than in

the villages said they were ‘sometimes’ or ‘often lonely’ (25 per cent compared with 13 per cent).

Social activities

Unsurprisingly, we found that residents’ feelings about their social life were related to how often they took part in a social activity or attended a social group; people who felt more positive about their social life took part in an activity or group more frequently. More people living in the villages

than in the schemes took part in a social activity on most days, although similar proportions took part once or twice a week. Fifteen per cent of people living in the schemes never participated, compared with 7 per cent in the villages.

The majority of residents indicated that their time was fully occupied in 'activities of their choice' (these being anything that they felt occupied their time, including social/leisure activities but also formal, voluntary or unpaid work). Eighty-three per cent of village residents were fully occupied in activities of their choice, compared with 68 per cent of people living in smaller schemes. Of people living in the smaller schemes, 13 per cent said that they did not have enough to keep them occupied, while 9 per cent said they were often bored. This compares with 6 per cent and 3 per cent, respectively, of village residents.

Table 5 shows the type of activities residents told us they took part in. In the smaller schemes, the most popular were social gatherings such as coffee mornings, games such as bingo and cards, attending entertainment and events, informal socialising with friends and exercise. In the villages, exercise was the most popular, followed by games, arts and crafts, sports (most commonly bowls) and voluntary work within the village. We asked the follow-up sample of residents what they felt they got out of the activities and groups that they were involved in. In both schemes and villages, friendship was seen as the main benefit, followed by mental stimulation. In the schemes, this was followed by company, an opportunity to get out of their flat or apartment and exercise. In villages, friendship and mental stimulation were followed by exercise, a sense of helping or feeling useful and a sense of achievement.

Table 5: The social activities that residents participated in

	Schemes (n = 205)		Villages (n = 394)	
	No.	%	No.	%
Games (e.g. bingo, cards)	70	34.1	90	22.8
Sports (e.g. bowling, snooker)	8	3.9	79	20.1
Voluntary work at scheme	14	6.8	65	16.5
Religious/spiritual	31	15.1	32	8.1
Interest/support groups	19	10.7	38	9.6
Social gatherings (e.g. coffee mornings)	77	37.6	16	4.1
Entertainments and events	46	22.4	46	11.7
Gardening	4	2.0	29	7.4
Exercise	32	15.6	149	37.8
Dancing	9	4.4	41	10.4
Arts and crafts	23	11.3	81	20.6
Literature/poetry groups	6	2.9	4	1.0
Music (e.g. choir, orchestra, karaoke)	7	3.4	43	10.9
Outings	14	6.8	10	2.5
Drama	1	0.5	10	2.5
Computing	1	0.5	10	2.5
Reminiscence	2	1.0	17	4.3
Informal socialising with family	8	3.9	12	3.0
Informal socialising with friends	37	18.0	45	11.4

Friendship and social support

One particularly positive finding, as mentioned above, was that the vast majority of people in our sample had made friends since moving. Despite the fact that, often, social well-being was better for village residents, there was no significant difference between villages and schemes in the proportion of people who had made friends.

As we would expect, how often residents took part in a social activity or group was significantly linked to friendship formation, with those who had made friends participating more regularly, and also with the frequency with which residents had contact with friends, more frequent participation being linked to more contact. This was the case for all residents, whether they lived in smaller schemes or in the villages.

Overall, people living in the villages had contact with friends more regularly than those in the schemes, with 72 per cent of village residents having contact with friends at least once a week, compared with 56 per cent of those living in the smaller schemes. On the other hand, 12 per cent of scheme residents never had contact with friends, compared with 2 per cent of village residents.

We were interested in discovering how residents had initially begun to get to know the friends they had made, a topic that we explored in the follow-up interviews. Comments from residents living in the smaller schemes indicated that friendships had developed mainly through attending activities and social events at the scheme, and also by meeting at lunchtime in the communal restaurant. Residents also suggested that they had come to know each other through simply living in the same place and seeing each other around the scheme in the corridors and communal lounges.

People living in the villages often commented that they had begun to get to know other residents before moving into the village – for example, through the ‘Friends’ groups set up prior to opening for prospective residents, as described by this resident:

We built a community by meeting once a week for three years before we came in here. The

choir started before we moved in, as part of the Friends group.

(Village resident, female)

Meeting in the communal areas and when using the facilities was also mentioned by village residents as a means of getting to know people, along with attending social activities and volunteering within the village.

To investigate residents’ sources of social support, we asked them who they would feel able to ask for advice, count on for help and confide in about things that were important to them. Again, results were different in small schemes and villages (see Table 6). Although around 70 per cent of all residents turned to family as a source of advice, people living in the schemes were more likely than those in villages to turn to staff, while more people in the villages would seek advice from their spouse¹ or friends at the scheme. This pattern was the same when people were asked about sources of help and people they would confide in, although smaller numbers in both villages and schemes said they would confide in staff.

In our follow-up interview, we measured social support using the Perceived Social Support Scale (Tait and Fuller, 2002).² Scores were grouped to indicate whether residents had no lack, some lack or a severe lack of social support. Overall, two-thirds of residents in our sample had no lack of social support, with 21 per cent and 13 per cent indicating some lack or a severe lack, respectively (see Table 4 earlier in this chapter). There was a significant difference between people living in schemes and villages, with 13 per cent and 15 per cent of scheme residents indicating some lack or a severe lack, respectively, compared with 33 per cent and 11 per cent of those living in the villages indicating some lack or a severe lack, respectively.

Interestingly, this measure of social support was the only one of our seven indicators of social well-being that produced a more positive picture for residents in the schemes than for those living in villages (with no difference in friendship formation). Given that more residents in schemes than villages described themselves as ‘socially isolated and often lonely’ (in response to a question in the questionnaire given to all participating residents),

Table 6: Sources of social support

	Schemes (n = 205)		Villages (n = 394)	
	No.	%	No.	%
<i>Who would you feel able to ask for advice?</i>				
Staff at scheme	156	76.8	219	57.6
Friends or other people at scheme	52	25.6	197	51.8
Friends outside scheme	56	27.6	100	26.3
Spouse or partner	34	16.7	169	44.5
Other family members	141	69.5	260	68.4
No one	0	0.0	3	0.8
<i>Who would you count on for help?</i>				
Staff at scheme	166	81.4	212	55.1
Friends or other people at scheme	44	21.6	206	53.5
Friends outside scheme	49	24.0	111	28.8
Spouse or partner	35	17.2	173	44.9
Other family members	141	69.1	282	73.2
No one	1	0.5	0	0.0
<i>Who would you confide in about things that are important to you?</i>				
Staff at scheme	78	38.2	86	22.3
Friends or other people at scheme	21	10.3	80	20.8
Friends outside scheme	32	15.7	80	20.8
Spouse or partner	36	17.6	177	46.0
Other family members	148	72.5	283	73.5
No one	5	2.5	10	2.6

this result was surprising. However, it might be explained by the difference in the characteristics of our main and follow-up samples. As described in Chapter 1, in our follow-up sample 22 per cent of village residents were receiving care, compared with 7 per cent in the main sample. If we take care receipt to indicate a certain level of disability, it may be that people with disabilities feel they have less social support in villages. In addition, the set of questions designed to measure social support are likely to tap into emotional social support received from close friends and family, as opposed to feelings of having a good social life versus being socially isolated measured in the single question.

Social well-being and residents' characteristics

While the overall results for the most part suggest a very positive experience, clearly there is some variation in people's experiences of living in

extra care housing. As identified in our model (see Chapter 1), we expected that some of this variation would be associated with personal characteristics of the individual residents. We examined the association between social well-being and gender, marital status, age, care receipt, dependency levels, and self-perceived health.

Gender

Across almost all of the social well-being indicators discussed earlier in this chapter, there were no differences between men and women. However, among the follow-up sample, men living in the smaller schemes were more likely to have experienced some or a severe lack of social support than women; 22 per cent of men compared to 9 per cent of women reported some lack, while 24 per cent of men compared with 9 per cent of women reported a severe lack. This difference was not found in the villages. However, it is important to note here the smaller number

of people in our follow-up sample (106 in the schemes, 60 in the villages); for example, '24 per cent of men' equates to nine individuals.

Marital status

Perhaps unsurprisingly, married people were more likely to report higher levels of social well-being. In our main sample of residents living in the smaller schemes, 91 per cent of married people stated that they had a good social life, or that it was as good as it could be, compared with around two-thirds of single, widowed and divorced people who chose one of these two options.

Among village residents, feelings about social life also differed according to marital status. Here, 96 per cent of married people reported that their social life was good or as good as it could be, compared with around 80 per cent each of single, widowed and divorced people – a similar pattern to that seen in the small schemes.

For residents in both schemes and villages, there was no difference according to marital status in frequency of participation, occupation in activities of choice or friendship formation. In terms of the frequency with which residents had contact with friends, in both schemes and villages, more single and divorced people reported never seeing friends than did married or widowed people.

Similarly, in our follow-up sample, single people were more likely than others to have a severe lack of social support – around 50 per cent of single people in both schemes and villages. However, it is worth noting that being married did not appear to offer complete protection from lack of social support, with 26 per cent of married people in smaller schemes and 39 per cent in the villages having some lack of social support.

Age

There was a complicated set of associations between age and social well-being that was related to whether people were living in villages or smaller schemes. We found that, in both schemes and villages, older age was associated (albeit quite weakly) with less positive views of current social life. Frequency of participation was not associated with age in either setting and neither was frequency of contact with friends.

However, there were differences according to setting in the relationship of age to the rest of our

social well-being indicators. For people living in the villages, older age was related to less occupation in activities of choice; this difference was not, however, found among residents of the smaller schemes.

For village residents, the average age of residents who had made friends was slightly (but significantly) lower than those who had not; 77 compared with 81, but, again, this difference was not found in smaller schemes. In terms of social support in the follow-up sample, while this time there was no difference according to age for village residents, for people living in smaller schemes, older age was in fact associated with better social support.

Self-perceived health

Again, the picture in terms of self-perceived health was dependent on where people were living. For residents in both smaller schemes and villages, better self-perceived health was related to more frequent participation in activities. For residents living in the smaller schemes, there were no associations between levels of self-perceived health and the other indicators of social well-being.

Results were different for our sample of village residents, however. For village residents, better self-perceived health was related to more positive feelings about social life and with more positive feelings about occupation in activities of choice. In villages there was also a difference in terms of friendship formation, with 28 per cent of those who had not made friends rating their health as bad, compared with 3 per cent of those who had made friends. Likewise, better health was related to more frequent contact with friends. However, using our social support measure, we found no significant difference according to health.

Care receipt

Residents who were in receipt of personal care, in both smaller schemes and villages, were less likely to report that they had a good social life or that it was as good as it could be. In the smaller schemes, 67 per cent of those who were in receipt of care answered this way, compared with 86 per cent of those not receiving care; in the villages, 75 per cent of those who were in receipt of care reported a good or good as possible social life, compared to 88 per cent of those not receiving

care. Sixty-one per cent of residents receiving care in small schemes reported being fully occupied in activities of their choice, compared with 76 per cent who were not receiving care. There was a similar pattern in the villages, with those in receipt of care less likely to report being fully occupied in activities of their choice, although the difference was not statistically significant.

Interestingly, across schemes and villages, there were no differences associated with care receipt in terms of frequency of participation, friendship formation or frequency of contact with friends. In the small schemes, although over 70 per cent of those receiving care and those not receiving care had no lack of social support, more residents in receipt of care than not fell into the 'severe lack' category (21 per cent compared with 7 per cent). In the villages, there were also more people receiving care than not who had experienced a severe lack of social support (17 per cent compared with 9 per cent), although this difference was not statistically significant.

Dependency³

In both smaller schemes and villages, higher levels of dependency (indicated by lower scores on the Barthel Index) were associated with more negative feelings about social life (feeling sometimes lonely or feeling socially isolated and often lonely), although these relationships were not particularly strong.

Among people living in the schemes, there were no other associations between dependency and our indicators of social well-being. However, the picture was different for village residents. Although there was no difference in friendship formation, higher dependency was associated, albeit weakly, with less contact with friends. In addition, higher dependency was associated with less frequent participation in activities and less occupation in activities of choice. There was no association between levels of dependency and social support levels for people in villages or schemes.

People who were socially isolated

While most residents clearly had a good social experience, where there are problems, it is important to understand what these are associated

with, so that those involved in developing and running extra care housing can be aware of potential difficulties and ways to address these.

As described above, social well-being was generally good for the people in our sample. Nonetheless, there were 38 residents (6 per cent) who reported being socially isolated and often lonely, and a further 61 (10 per cent) who said that, although they had a social life, they sometimes felt lonely.

In the group who were socially isolated and often lonely, there was no significant difference in the proportions of men and women or according to age. However, this group were more likely than the rest of our sample to be receiving care. They were also more likely to rate their health as bad, although there was no difference in average dependency levels. They were more likely than the whole sample to be single, divorced or widowed and less likely to be married. They were also more likely to be living in one of the smaller schemes than in the villages. This pattern of results was the same when also including those residents who indicated that they had a social life but were sometimes lonely.

It should be noted that there were slightly different results when looking at the people in our follow-up sample who had experienced a severe lack of social support, as measured by the Perceived Social Support Scale. These people were statistically more likely to be men and also to be living in the villages. As mentioned earlier, these findings might be to do with the differences between the main and follow-up samples, or to do with the different concepts underlying the questions.

Scheme characteristics and social well-being

We have already seen that whether people are living in villages or smaller schemes is associated with different experiences of activities, social life and social well-being. Now, we turn to other characteristics of the schemes – the approach they took to activity provision and the social climate. As indicated in our model (see Chapter 1), we expected that these would have an effect on individual social well-being.

Approach to activity provision

Analysis of the whole sample (taking villages and schemes together) seemed to suggest that the approach to activity provision at six months had an effect on social well-being at twelve months, with the presence of dedicated activities staff (such as an activities coordinator) linked to better social well-being. However, when looking at just the small schemes, it became clear that this was not the full picture. There was no difference according to the approach taken to activity (whether facilitated by activities staff, care and support staff or the manager) in feelings about social life, frequency of activity participation, occupation in activities of choice or levels of social support. This was a surprising result given the picture at six months, where the presence of dedicated activities staff was linked with more social activities and events taking place.

Social climate

In our sample of small schemes, social climate was related to individual experiences of social well-being. Although associations were rather weak, we found that higher levels of scheme-level cohesion were associated with more positive feelings about social life and better social support. Higher levels of scheme-level conflict were related to less contact with friends. Higher levels of independence at the scheme level were related to more positive perceptions of social life, more frequent activity participation and more participation in activities of choice.

In the previous chapter, we identified three of the schemes as having the 'ideal' pattern of social climate scores, with high cohesion and independence and low conflict (Jubilee House, Granary Court and Beechwood Court). We compared the social well-being of people living in these schemes with those living in the rest of the small schemes. We found no difference in levels of social participation, activities participation, friendship formation or levels of social support. However, a larger proportion of people living in schemes with the 'ideal' social climate stated that they were fully occupied in activities of their choice (79 per cent compared with 63 per cent) and fewer said that they had nothing much to do and were bored (1 per cent compared with 13 per cent). In addition, residents living in the 'ideal'

schemes were more likely than those who were not to be in contact with friends on most days (42 per cent compared with 25 per cent). There was also a difference in overall quality of life, with 78 per cent of those in the schemes with the 'ideal' social climate profile rating their quality of life as 'good', 'very good' or 'so good, it could not be better', compared with 48 per cent of residents in the other schemes. It should be noted, however, as pointed out in the previous chapter, that these schemes had lower average levels of dependency.

Summary

- Overall, residents in our sample indicated that they had a good quality of life. Quality of life was related to the majority of our chosen indicators of social well-being, but not to individuals' frequency of contact with family.
- Most residents in our sample had good levels of social well-being, with around 90 per cent having made friends since moving.
- Overall, it seemed that people living in the villages had higher levels of social well-being than those in the schemes, although there was no difference in friendship formation.
- Residents' feelings about their social life were related to how often they took part in an activity or attended a social event, with more frequent participation linked to feeling that their social life was 'good' or 'as good as it could be'.
- Results at twelve months confirmed our findings at six months that social activities and communal facilities were important for friendship development.
- In general, there was no difference in social well-being between men and women, although men in smaller schemes were more likely than women to report a severe lack of social support.
- Married people had higher levels of social well-being according to some of our indicators,

although friendship formation was not linked to marital status.

- Being older was related to more negative feelings about social life in both schemes and villages. In villages, older age was also linked to more negative outcomes on slightly more social well-being indicators than in smaller schemes.
- In both schemes and villages, residents who were receiving personal care (and therefore had some level of disability) were in many ways less positive about their social well-being.
- In both schemes and villages, those who felt that they were healthier tended to have more positive feelings about their social life. In villages, self-perceived health was linked to a number of other indicators of social well-being.
- Similarly, although higher dependency was related to more negative feelings about social life in both settings, among people in the villages it was associated with a number of other indicators of social well-being.
- A minority of residents said that they felt socially isolated and often lonely. This group were more likely to be in receipt of care services and rated their health more negatively. In addition, people who were socially isolated were less likely to be married and more likely to be living in one of the smaller schemes than in the villages. However, in our main sample, there was little difference in levels of social well-being between men and women.
- The approach to activity provision in place at six months had little effect on individual social well-being at twelve months.
- A positive social climate was linked, albeit weakly, to higher levels of social well-being as measured by our set of indicators. Residents living in the schemes with the ideal pattern of social climate scores had better social well-being, although this is likely to be influenced by the lower average levels of dependency also present in these schemes.

Clearly, there is a complicated relationship between features of the schemes, personal characteristics (such as age and health status) and individual social well-being. In the final chapter we bring together some of the main findings and draw out the key messages.

5 Discussion and implications

As we identified in Chapter 1, social well-being is an important aspect of overall quality of life. Extra care housing is seen as having the potential to promote social well-being for older people and address social isolation. Our research aimed to explore social well-being for older people moving into 15 new extra care housing schemes that were allocated funding as part of the Department of Health's Extra Care Housing Funding Initiative (2004–06),.

Following a review of the literature (Callaghan, 2008), we developed a conceptual model to help us understand the potential associations between aspects of the extra care schemes and individual characteristics and experiences that may contribute to social well-being. We expected that individual social well-being would be affected by features of the schemes, the social climate and levels of social activity, and residents' personal characteristics.

Our research is unique in its scale and in investigating newly opened schemes. It also benefited from the wide range of schemes involved, from different providers and across a variety of settings. There are, however, a number of limitations that need to be borne in mind when interpreting our results. In particular, although our sample at six months was intended to be representative of the range of people living in the extra care housing schemes, the sample of residents who completed the questionnaire at twelve months was an 'opportunistic' sample. We aimed to recruit as many people as possible and two-thirds of the sample that we attained was made up of people living in the two villages, the majority of whom were likely to have been in relatively good health. Our follow-up sample at twelve months was more balanced in terms of reflecting the range of physical abilities of people living in the schemes, but it is likely that the project as a whole under-represented the most frail people living in extra care housing. In particular, there were

very few residents in our whole sample with severe cognitive impairment and very few in villages with mild cognitive impairment.

Despite these reservations, there were clearly some very positive findings. Many residents appeared to have benefited from their move to extra care housing, and valued the care and support available. The combination of privacy and security, and the added opportunities for new friendships and social interaction were particular positives described by residents. One year after schemes had opened, almost two-thirds of the residents in our sample rated their quality of life as 'good' or 'very good'. The vast majority of residents across villages and schemes had made new friends, felt positively about their social lives and were taking part in activities of their choice. We found that levels of social support were high, though it was interesting that contact with relatives was not associated with quality of life. It is possible that these environments might have an important role to play for those with limited family to draw on for support. However, it is important to note that the majority of residents indicated that a member of their family would be the person they would confide in about important issues, highlighting the continued importance of family relationships in older age. Schemes need to ensure that residents are able to maintain these relationships and facilitate contact with family and friends from outside of the scheme.

This positive picture became more complicated when comparing people living in the villages with those living in the smaller schemes, with some differences in individual experiences and social well-being becoming apparent. It seemed that, overall, people living in the villages had better social well-being than those in smaller schemes. This ties in with Croucher *et al.*'s (2007) suggestion that, while no model of housing with care has yet emerged as being better than another, there may be some advantages in terms of social well-being

for those older people who live in larger village-style schemes.

However, villages and smaller extra care housing schemes are very different, both in their physical environment and in the resident population, a fact also noted by Croucher *et al.* (2007). Villages are, by their nature, able to provide a wider range of facilities such as gyms, cafés and spaces geared to specific hobbies (for example, woodworking), and are more likely to have the resources and funding available to sustain such facilities. It is unlikely that facilities such as restaurants or shops would become unsustainable, which is not always the case in smaller schemes where resources are more limited. In addition, the majority of people who moved into the villages were in better health and less dependent than those who moved into smaller schemes.

It is difficult to disentangle the effects of the setting from the characteristics of the residents. Is it the fact of living in an extra care village that produces these effects? Is it due to personal characteristics, such as being less frail, or is it due to something else? Our findings suggest that villages suit the more able, active older population very well, but that the evidence is not so clear for those moving in with some level of disability or dependency. Although higher dependency was associated with less positive feelings about their social life for residents in both schemes and villages, none of our other social well-being indicators was affected by dependency in the smaller schemes. In contrast, we found that, for people living in the villages, higher dependency was associated (albeit somewhat weakly) with less positive outcomes in terms of frequency of participation, occupation in activities of choice and contact with friends. These results might seem surprising given that there were no differences associated with care receipt, but might be explained if there were a proportion of residents who, while having some need, were able to support themselves with, for example, mobility aids and perhaps simply through being in the supportive extra care environment; these are likely to be the people being picked up in the findings around impairment.

We also noted some particular tensions in the two villages regarding attitudes to frailty and

disability, with some residents being surprised that less active, frailer people had also moved in. This has been found to some degree in previous research (e.g. Bernard *et al.*, 2004; Croucher *et al.*, 2007), and highlights the importance of clear marketing of villages and schemes to prospective residents. Following their research into social well-being in the extra care setting, Evans and Vallely (2007) recommended that marketing should be clear regarding schemes' aims to support a range of people with diverse needs, in order to avoid potential difficulties and social exclusion, and our results would seem to support this. The challenge of maintaining a diverse community, which provides high levels of care alongside promoting independence, and one that remains attractive to prospective residents over time, has also been recognised in previous research (e.g. Bernard *et al.*, 2004; Croucher *et al.*, 2007).

We must be cautious in interpreting our findings, given the issues with our sample noted above. In particular, in our main sample, the experiences of frailer people living in the villages are likely to be somewhat under-represented. Our follow-up sample was more balanced, however, and it was among these people that we found a greater lack of social support among village residents than scheme residents.

Social activities were valued by residents and, particularly in the smaller schemes, were important for friendship development. In both schemes and villages, friendship was seen as the primary benefit of participation in social activities and events. It is unclear how 'deep' friendships were after one year and whether they would therefore provide the close emotionally supportive relationships that have been shown to be significant in older age (Strain and Chappel, 1982; Croucher *et al.*, 2006; Duner and Nordstrom, 2007). Nonetheless, as noted in Chapter 1, even casual social acquaintances have been shown to be important in the housing with care setting (Potts *et al.*, 1997; Evans and Vallely, 2007; Street *et al.*, 2007).

There was a difference between residents living in the villages and schemes in the activities they preferred. In the smaller schemes, the most popular activities were social gatherings such as coffee mornings, games such as bingo and cards, and attending entertainment and events. In the

villages, exercise was the most popular, followed by games and arts and crafts. The popularity of exercise in the villages may reflect the aim of the provider to promote healthy, active ageing. All of these activities are likely to have social benefits, important for well-being (Litwin, 2000; Litwin and Shiovitz-Ezra, 2006); exercise, while having physical benefits, also has social ones through meeting new people and maintaining social networks (Stathi *et al.*, 2002). Even if certain activities were not to a particular resident's liking, they could still provide a venue for social interaction and promote the development of community.

All scheme staff felt that they were taking a 'user-led' approach to developing their scheme's social life, but there was much variation within this, with residents' involvement ranging from being invited to give suggestions and feedback on activities, to organising and running all activities and events with minimal input from staff.

At six months, having dedicated activities staff (such as an activities coordinator) was linked to more activities and events being in place. We had expected that the presence of dedicated activities staff might contribute to a positive social climate at twelve months, but our results did not support this.

Active resident involvement in leading social activities and events did seem to have a number of benefits, including giving residents more 'ownership' over their social lives and promoting independence, encouraging other residents to join in and giving residents (particularly those on residents' committees) a defined and satisfying role. However, in some schemes, there were challenges in accomplishing a truly 'user-led' approach, with the most notable barrier being the frailty of some of the residents. There was concern that residents would not always be willing or able to continue this role as they became older and frailer, and therefore maintaining a mix of people with different levels of dependency was seen as important. It is notable that the schemes that appeared to have the 'ideal' social climate were those with lower levels of impairment; similarly, those with active residents' committees were likely to have a core of less frail residents able to take on that role.

We found some associations between a positive social climate and individual social well-

being twelve months after schemes had opened. However, the approach taken to social activity provision appeared to have very little effect on individual social well-being by this time. It may be that, once schemes have been open for a year, their social life is more established and friendships have had time to develop. The positive impact of activities staff may be more evident early on, in initially getting things started up and providing a focus for social interaction. However, it is helpful to encourage and support residents in taking the lead at an early stage, with staff – whether activities coordinators, care and support staff or managers – taking an enabling role.

Activities coordinators could be used as a shared resource between a number of schemes, which would mean that they had less of a 'presence' in one particular scheme, thereby encouraging and allowing residents to take ownership of their own social life. However, as noted above, it is crucial that there are sufficient resources (in terms of funding and staff time) in place to support residents in leading the scheme's social life at the beginning, but also over time and particularly if levels of frailty increase. As Evans and Vallely (2007) recommend, staff need to be aware of when additional support is needed.

The facilities provided in the schemes were also important for friendship development. In the smaller schemes, restaurants and shops were of particular importance early on in encouraging friendship development, with residents and staff often mentioning the significance of lunchtime in providing structure to the day and a venue for social interaction.¹ This is in line with previous research indicating the importance of such facilities (e.g. Williams, 2000; Croucher *et al.*, 2006; Evans and Vallely, 2007; Tinker *et al.*, 2007). Communal lounges were used mainly for social activities and events, and in some schemes had become the 'hub' of social activity. In addition, entrance ways and circulation areas were used as meeting places by residents. These findings were reflected by residents' comments at twelve months about how they had come to know friends at the scheme.

In the villages, facilities in general were mentioned by residents as a means of initially getting to know other residents and building up friendships. A particular feature of the villages was that resident volunteers were encouraged

to get involved in helping to run facilities such as the shop, café or library, which in turn helped to build up friendships. Of course, in the villages, it may be easier than in the smaller schemes to find residents able to assist in this way (and there are more people to draw on); in some of the smaller schemes, respondents had noted the fact that it could be difficult to rely on frailer residents to assist in this way. This links in with the point made above about the greater availability of resources and funding in village-style schemes.

Previous research has indicated the value of schemes making links with their local communities (e.g. Croucher *et al.*, 2003, 2007). Our study confirmed this, showing that residents valued the opportunity to go out into the local community and maintain previous links. However, lack of accessibility and appropriate transport proved a barrier for some to getting out, with good local access and suitable transport needed to encourage interaction between scheme residents and the local community.

Our findings also highlighted the importance of the local context in determining the extent of community involvement that develops. Schemes at the heart of their communities may find it easier to build up links, as indicated in previous research (e.g. Evans and Vallely, 2007). In addition, the provision of restaurants open to the community, and shops in schemes where such facilities are lacking, may encourage local people to come into the schemes.

At six months there were mixed opinions among residents about local people coming in to use the facilities at the schemes, a finding echoed at twelve months. As found in previous research (e.g. Croucher *et al.*, 2003, 2007), some residents welcomed local people coming into the scheme as an added chance for social interaction and a link to the outside world, but others felt that it was unfair for them to be expected to share facilities. The importance of marketing the schemes appropriately and ensuring residents know what to expect is also relevant here, as suggested by Croucher *et al.* (2007).

A minority of residents said that they felt socially isolated and often lonely. This group were more likely to be in receipt of care services and rated their health as worse. This, along with what residents told us at six months about particular

barriers to social participation, confirms previous research, which has indicated that those who are socially isolated in settings such as extra care tend to be frailer or with impaired mobility, although, as described in Chapter 2, schemes were attempting to address these issues. In addition, people who were socially isolated were less likely to be married, which might mean that they were more likely to be lacking the type of emotionally close relationships found to be important for social well-being. They were more likely to be living in one of the smaller schemes than in the villages. However, in our sample, there was little difference in levels of social well-being for men and women; in our main sample, men were no more likely than women to describe themselves as feeling socially isolated and lonely. This is not an unequivocal finding, however, as, in our follow-up sample, men in the smaller schemes were more likely than women to be experiencing a severe lack of social support. Nonetheless, given that some previous research has indicated that men may be at greater risk of social isolation in housing with care settings than women (e.g. Bernard *et al.*, 2004; Evans and Vallely, 2007), the fact that we did not find convincing support for this in our sample is encouraging.

It is clear that there is a complicated relationship between aspects of the extra care environment, residents' individual characteristics and social well-being. While our findings do suggest that social well-being is facilitated by the extra care setting, the analysis is based on comparisons between schemes and between specific subgroups of residents within schemes. Multilevel analysis, taking account of variations within and between schemes simultaneously, would provide a more comprehensive picture of schemes as a whole and is an area for further research. In addition, given that our project focused on newly opened schemes and the development of new communities, further work is needed to examine social well-being in these schemes over time – in particular, what is the experience of people moving into the schemes at later stages, once friendships and communities have already developed?

Nonetheless, this research has contributed to the evidence base regarding the social well-being of older people in the extra care setting

and suggested that extra care housing can provide an environment supportive of social well-being. In addition, it has confirmed many of the recommendations made by Evans and Vallely (2007) regarding good practice for promoting social well-being in extra care housing.

Key messages and implications

- Extra care housing has the potential to facilitate social well-being for older people and promote a good overall quality of life.
- Communal facilities at the schemes, in particular restaurants and shops, are important for facilitating residents' social well-being, especially for helping friendships to develop. They can also bring people from the local community into the scheme, which may increase residents' opportunities for social interaction and provide a link to the wider community. Sufficient funding is needed to ensure that such facilities are operational when schemes first open.
- Social activities are valued by residents and help friendships to develop, and should ideally begin to be set up soon after opening. A wide range of social activities should be developed to ensure that there is something to suit the wide range of residents living in extra care. In particular, schemes need to be sure that activities cater for men as well as for women, and for people of different ages.
- Resident involvement in organising and running social activities is beneficial, giving residents ownership over their own social lives, supporting independence and encouraging other residents to participate. Resident involvement should be encouraged from an early stage. However, in schemes where there are not enough residents willing and able to take on this role, more support will be needed from staff.
- Adequate staff time and resources for supporting social activities (and wider social well-being) are crucial, both when schemes first open and over time as levels of resident frailty increase. Staff (whether care and/or support staff, or the scheme manager) need to have time specifically allocated to the support of social well-being and to be able to enable residents' involvement. Activities coordinators, when in place, could be a shared resource between a number of schemes.
- Health and mobility problems, as well as the need for care input at particular times, can make social participation more difficult for some residents. Staff or volunteers should be employed to help residents get around the scheme as necessary and to assist their participation. In addition, as much flexibility as possible should be built into individual care plans, so that residents do not have to miss opportunities to socialise.
- Both smaller and larger schemes need to ensure that supports (such as the employment of additional staff) are in place to maximise social participation for more dependent residents, and particularly to ensure that they do not 'fall through the net'.
- Schemes should ensure that they facilitate family relationships and make relatives welcome.
- Schemes should aim to make links with the local community and, when new schemes are being planned, thought should be given to the potential location and local context of the scheme. Schemes sited in the centre of a community, or where there is an existing need for services that can be provided through the new scheme, are likely to find it easier to build up links. There should be good local access to ensure that there are minimal barriers for residents in getting out and about in the local community.
- Schemes need to ensure that prospective residents are clear about the aims of the scheme and what to expect on moving in. Where schemes aim to support a diverse group of older people with a range of care

and support needs, this should be clearly explained. In addition, residents should be aware of any plans to encourage people from the local community to use facilities and services provided at the scheme.

Notes

Chapter 1

- 1 Data from the initial assessment questionnaire was used, rather than from the six-month follow-up, as data from this stage was available from a greater number of residents.
- 2 In some instances, the number of people who indicated that they would be interested in taking part in an interview was ten or below; in this case purposeful sampling was not possible. This was not the case in the two villages, where a large number of residents offered to take part in the follow-up interview.
- 3 Although the intention had been to contact residents for an interview following their response to the survey, there were six residents who took part in an interview without first completing a survey.

Chapter 3

- 1 Unfortunately, we were not able to achieve as many responses for all the schemes as recommended and had to exclude one scheme (Sycamore House, see Appendix 3). This should be borne in mind when interpreting the findings discussed below.
- 2 This variation again suggests that results should be interpreted with caution.
- 3 The smaller schemes were run by six other providers, one of which owned three of the schemes and another four.

Chapter 4

- 1 There were more married/cohabiting people in the villages that in the smaller schemes.
- 2 Originally designed for use in the Health and Lifestyles Survey (Cox *et al.*, 1987).

- 3 This section discusses physical dependency. As described in Chapter 1, numbers of residents with cognitive impairment were relatively low, meaning that it was not possible to determine any relationships between cognitive functioning and social well-being.

Chapter 5

- 1 We were unable to clarify the potential benefit of the presence of a restaurant on social climate, as we would have needed to have a number of schemes in our sample without a functioning restaurant, which was not the case. Nonetheless, respondents' comments at six months certainly indicated the value of restaurants for social interaction.

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Appendix 1: The schemes – opening dates, sizes and tenure

	Rented units (social or market rent)	Buy or shared ownership units	Intermediate/ respite care units	Total number of units
Jubilee House	24	6	9	39
Granary Court	29	10	1	40
Fairfax Court	33	0	5	38
Willowbank Court	34	0	6	40
Beechwood Court	50	5	9	64
Abbey Court	48	0	0	48
Rushmead Gardens	32	14	0	46
Jasmine Court	41	4	0	45
Rosewood Gardens	22	13	0	35
Cedar Gardens	36	0	6	42
Pinewood Court	39	8	1	48
Hawthorne Court	38	0	1	39
Sycamore House	35	0	0	35
Redwood Village	125	145	0	270
Greenfields Village	100	158	0	258

Appendix 2: Facilities available in the schemes at six months

	Jubilee House	Granary Court	Fairfax Court	Willowbank Court	Beechwood Court	Abbey Court	Rushmead Gardens	Jasmine Court
Main lounge	✓	✓	✓	✓	✓	✓ +bar	✓	✓
Small lounge/quiet room	✓	✓ ¹	✓	✓	✓			
Restaurant/dining room	✓	✓	✓	✓	✓ ³	✓	✓	✓
Café								
Shop	✓		✓	✓		✓	✓	✓
Hair/beauty/therapy salon	✓	✓	✓	✓	✓	✓	✓	✓
Gym/fitness room				✓ ⁶		Planned		
Library			✓	✓	✓	✓	✓	
Computer/IT room		✓		✓	✓ ⁷	Planned	✓	✓
Activities/hobbies room				✓	✓	✓	✓	✓
'Village hall'								
Cinema			✓			✓		
Garden	✓	✓		✓	✓	✓	✓	✓
Greenhouse								
Snooker/pool room							Planned	
GP surgery			✓					
Faith room			✓					✓
Day centre		✓			✓		✓	

	Rosewood Gardens	Cedar Gardens	Pinewood Court	Hawthorne Court	Sycamore House	Redwood Village	Greenfields Village
Main lounge	✓	✓	✓	✓	✓	✓	✓
Small lounge/quiet room	✓ ✓ ²	✓	✓	✓	✓	✓	✓
Restaurant/dining room	✓	✓	✓	✓	✓	✓	✓
Café						✓ ⁴	✓ ⁴
Shop			✓	✓	✓	✓	✓
Hair/beauty/therapy salon	✓ ⁵	✓	✓	✓	✓	✓	✓
Gym/fitness room						✓	✓
Library			✓			✓	✓
Computer/IT room						✓	✓
Activities/hobbies room	✓	✓	✓ ⁸		✓	✓	✓
'Village hall'						✓	✓
Cinema							
Garden	✓	✓	✓	✓	✓	✓	✓
Greenhouse						✓	✓
Snooker/pool room							✓
GP surgery							
Faith room						✓	
Day centre			Planned				

1 Quiet room not used, so is now used as surgery for community matron.

2 Has a small lounge and a quiet room.

3 Not operational at six months; closed down as not financially viable. Reopened April 2007.

4 Café/bar.

5 Within activities room.

6 Fitness room not used; suitable equipment would not fit in. Instead, used as a health and beauty room.

7 Internet café planned but not implemented.

8 A section of the lounge.

Appendix 3: The Sheltered Care Environment Scale (SCES)

The SCES (Moos and Lemke, 1996) is designed to measure the social climate of a care facility, reflecting the degree to which such environments are seen as cohesive, supportive and fostering independence, conflict and resident influence. The SCES is based on participants' appraisal of their environment rather than objective information about it; it is an evaluative measure (Lemke and Moos, 1987).

In the UK, the SCES has been used in a number of studies to describe and evaluate a variety of care environments for older people (Benjamin and Spector, 1990; Netten, 1993; Schneider and Mann, 1997; Mozley *et al.*, 1998; Netten, *et al.*, 2001). Box A3.1 describes the seven dimensions of the SCES.

Box A3.1: Subscale and dimension descriptions of the SCES

Relationship dimensions

Cohesion

How helpful and supportive staff members are towards residents, and how involved and supportive residents are with each other.

Conflict

The extent to which residents express anger and are critical of each other and of the facility.

Personal growth dimensions

Independence

How self-sufficient residents are encouraged to be in their personal affairs and how much responsibility and self-direction they exercise.

Self-disclosure

The extent to which residents openly express their feelings and personal concerns.

System maintenance and change dimensions

Organisation

How important order and organisation are in the facility, the extent to which residents know what to expect in their daily routine and the clarity of rules and procedures.

Resident influence

The extent to which residents can influence the rules and policies of the facility and are free from restrictive regulations.

Physical comfort

The extent to which comfort, privacy, pleasant decor and sensory satisfaction are provided by the physical environment.

We aimed to achieve ten responses in the smaller schemes and 30 in the villages, ten responses being the minimum recommended (Moos and Lemke, 1996). Unfortunately, this was not possible in four of the schemes. In Sycamore House, the response was so poor that we were unable to calculate SCES scores and so this scheme was not included in the analysis on social well-being.

In addition, where there were three responses or more missing from an individual's answers to items on any given scale, their response should not be included in the calculation of scheme scores. We have used the responses of those where there was sufficient data but this additional caveat means there were less than ten full observations for eleven of the schemes. In future, multiple imputation could be used to bring the number of responses in these schemes up to the full ten. We anticipate little difference in the average score for each scheme as a result.

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