

# Elderly Accommodation Counsel

## 'Steps to Success' report

### Final Draft

## 1 INTRODUCTION

This report is part of a wider 'Raising the Stakes' project, funded by the Housing Corporation and the Department of Health, to look at a number of aspects of Extra Care Housing (ECH) with the aims of improving public information and profile, improving knowledge of what works and moving toward the setting of industry standards. The project partners were the Elderly Accommodation Counsel, Peter Fletcher, Moyra Riseborough and the Institute of Public Care (IPC).

IPC's roles within the project were to

- Review the current literature on Extra Care Housing (ECH) to identify how far some of the achievements claimed for it are evidenced in practice.
- Begin to consider what are the 'Steps to Success'; if extra care is delivering good outcomes, how is this achieved? Which aspects of ECH seem to be key?
- Begin to identify the measures currently used by providers to identify whether success is being achieved.

This document reports results from a survey of Extra Care scheme managers to further contribute to evidence of the success of ECH (the literature review is a separate document), to identify their views on what contributes to this success, and to review how far schemes operate systematic information recording and measurement to evidence whether they are meeting their aims.

This survey represents one contribution to the raft of associated research currently being undertaken. For example, as this report was being finalised the Joseph Rowntree<sup>1</sup> study of different housing with care models was published.

## 2 METHODOLOGY

The original intention was to undertake structured interviews by telephone with scheme managers. As it proved difficult for scheme managers to release the time for these conversations, a number of postal questionnaires were completed instead. Altogether 12 telephone interviews were undertaken, and 23 questionnaires completed, giving a total of 35 responses. The findings reported are based on the views of the scheme managers.

Extra care schemes run by the following organisations participated in the survey and IPC gratefully acknowledge their interest and time:

Anchor Trust  
Bedfordshire Pilgrims Housing Association

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<sup>1</sup> *Comparative evaluation of models of housing with care for later life* by Karen Croucher, Leslie Hicks, Mark Bevan and Diana Sanderson, Joseph Rowntree Foundation, 2007

English Churches Housing Group  
First Wessex Housing Group  
Guinness Care & Support  
Hanover Housing  
Hounslow Homes  
Housing 21  
Joseph Rowntree Foundation  
Kennet Housing Society  
Leeds Jewish Housing Association  
Methodist Housing Association Care Group  
New Link Housing Trust  
Octavia housing and care  
Orbit housing association  
St Monica Trust  
Sanctuary Care  
Thomas Pocklington Trust  
Tuntum Housing Assoc

### 3 HOW STRONG IS THE EVIDENCE FOR SUCCESSES OF EXTRA CARE HOUSING?

#### 3.1 The findings from the literature review

The following table summarises the findings from the earlier literature review as to how far common claims for the achievements of ECH have been substantiated by previous research. More detail can be found in the full review.

Table 1: Strength of evidence within literature review

Extra Care housing is able to:	Claim supported	Jury's out	Insufficient sources identified
Provide a home for life for its occupants		X	
Provide a realistic alternative to care home admission	X		
Improve the health and well being of occupants or the capacity to sustain health	X		
Reduce social isolation of older people and encourage active engagement and involvement		X	
Improve the quality of life of its occupants	X		
Enable the continued involvement of family carers	X		
Reduce or maintain levels of need for formal support and health services, reduce hospital admission and speed up early discharge.		X	
Improve staff recruitment and retention and impact positively on the local market.			X
Offer a sustainable return on investment for commissioners, providers and occupiers.			X

Through the scheme survey we wished to:

- Further test these findings where the literature review had found 'claim supported'.
- Find further evidence where the literature review had found 'jury's out'.
- Identify more contributions where the literature review had found 'insufficient sources' on which to form a judgement.

### 3.2 Survey results on the achievements judged as 'Claim supported' in the literature review

In those areas where the literature review had found the claim supported, the survey results reflected the same position<sup>2</sup>. 'Home for Life'<sup>3</sup> was the only claim to move position from 'Jury's out' to 'Claim supported'.

#### 3.2.1 ECH is able to provide a 'home for life' for its occupants

The length of occupancy quoted by managers ranged from 1 month to 192 months and averaged 36 months. This is the CSCI estimate of average length of stay in a residential care home,<sup>4</sup> although IPCs findings from a recent piece of consultancy was that over 60% of residents stayed less than 2.5 years.

However, the main test of home for life is the identification of whether occupants had to move on into more intensive forms of care. The vast majority of schemes had only had 10 or fewer people moving on in the previous 12 months, and almost half of these had lost less than 5. The most common reasons and places are shown in the tables below.

Table 2 : The most common reason for moving<sup>5</sup>

Reason	Death	Dislike of scheme	Hospitalisation	Care hours too high
Number of schemes	24	1	4	5

Table 3 : The most common place residents moved on to

Place	Number of schemes
Residential care	2
Nursing care	7
Relatives	1
Death	24

The data suggests that ECH does provide a 'home for life' in the majority of cases. However, in line with Phillips & Williams' 2001 just under one third of people moved to more intensive settings, suggesting that there are some circumstances under which ECH is unable to meet resident needs.

<sup>2</sup> We have not separately addressed 'improves the quality of life of its residents' in this report as, in effect, that is the sum of the parts of the other elements considered. The survey suggested it remained in claim supported column.

<sup>3</sup> 'home for life' is used in the literature review and retained for ease of reference in this survey report. However, other terms may be more appropriate, such as prolonged residence.

<sup>4</sup> Care Homes for older people in the UK" May 2005 OFT

<sup>5</sup> Where numbers do not add up to 35 questions were left unanswered

Table 4: Needs schemes are NOT able to support<sup>6</sup>

Type of need	Number of schemes
Low care and support needs	0
Moderate care and support needs	0
High level care and support needs	5
Nursing care needs	27
Moderate levels of dementia	4
High levels of dementia	27
Blindness	4
Deafness	4

The more intensive types of care needed are nursing input, and/or high levels of dementia support, particularly when associated with challenging behaviour. That four schemes felt unable to support people with sensory impairment may indicate the wide range of schemes currently describing themselves as extra care.

### 3.2.2 Extra Care provides a realistic alternative to care home admission

All 35 managers stated that they saw EC as a positive alternative to residential care. Scheme managers were asked what, if any, factors prevented ECH from being an alternative to residential care in all instances.

Table 5: The factors that prevent ECH from being the alternative in all instances to residential care

Factors	Number of schemes
Lack of available EC places in the area	22
Local EC schemes unable to support people with a high level of needs	8
Local EC schemes are too expensive	2
EC should not be seen as an alternative, but one of many housing options for older people	22
Other	7

This supports the literature review, and the previous section of this report, which highlighted that there will always be a number of people for whom a move to long term care is unavoidable but that the inability of ECH to be an alternative to residential care in all instances, is in large part simply due to a lack of schemes nationally.

### 3.2.3 ECH improves the health and well being of occupants or the capacity to sustain health.

The majority of scheme managers stated that either for all, or for some, occupants there were improvements in the areas identified in the table below.

<sup>6</sup> Where numbers add up to more than 35, managers were able to identify more than one aspect or reason

Table 6: Areas in which health or well being were enhanced or maintained

Area of Improvement	Number of schemes		
	In all cases	In some cases	In no cases
Greater interaction & involvement	15	14	
Improved self care	6	26	
Sense of improved health & wellbeing by the individual	14	21	
Improved mobility function	3	27	1
Increase in sensory ability	3	23	6
Improvement in being able to undertake daily living function	9	26	
Improved sense of independence	20	15	
Improved mental health	4	25	5
Increased feelings of happiness & enjoyment	16	19	

Actual practical enhancements seem less achievable than more generalised feelings. For example, most people are deemed to have an improved sense of independence, but far fewer to actually improve their self care. See also section 3.3.3 below.

#### 3.2.4 Extra Care enables the continued involvement of family carers

The number of occupants who were living as a couple in the various schemes ranged from zero to 30 couples. The average was 3.

Most managers felt that ECH encouraged the continued involvement of family carers; and had the space and privacy for this; which supports the evidence in the literature review. The majority of residents received at least weekly visits, mostly from family or friends living outside the scheme.

Table 7: Who people receive regular visits from

Who from	Number of schemes
Children	26
Partner	12
Neighbour	27
External friends	31

The literature review noted that there was a lack of evidence of the direct benefits to family carers. When asked this question many scheme managers responded that EC allowed family members to be involved but without having the stress of the direct care responsibilities. Scheme managers clearly indicated that they saw supporting family involvement as a crucial part of their job.

### 3.3 Survey results on the achievements judged as 'Jury's out' in the literature review

#### 3.3.1 Extra Care improves staff recruitment and retention in comparison to equivalent jobs in other care sectors.

The survey results appear to move this claim from 'insufficient sources of evidence', to 'Jury's out'. The majority of managers stated that they did not have any job vacancies in their schemes. The number of staff who had left in the previous 12 months ranged

from zero to 10 and averaged 1. The number of staff who had joined in the previous 12 months again ranged from zero to 10 but averaged 2.

17 managers had previously owned or managed a care home or home care service. There was a range of opinions as to whether retention and recruitment problems were the same as in residential care. Some managers felt that there was no difference at all whilst others felt that retention was higher because staff gained more job satisfaction as they felt that they were really working in a way that enabled and empowered the residents.

### 3.3.2 Extra Care reduces social isolation of older people and encourages active engagement and involvement.

The other 2 'jury's out' findings from the literature review remain in that position following the survey.

The majority of managers stated that residents frequently engaged in activities within the scheme. However, less than 1 third stated that residents frequently engaged in activities outside of the scheme.

Table 8: Activities residents engaged in

Activities	Number of schemes		
	frequently	occasionally	never
Act within	27	6	1
Act outside	11	21	2
Visit family	25	6	
Visit internal friends	21	9	
Visit external friends	16	14	

19 managers felt that at least one resident had experienced difficulties integrating into the scheme.

Table 9: Reasons residents found it hard to integrate

Reason	Number of schemes
Resident was from a BME group	1
Resident was suffering from dementia prior to entry	8
Not enough male companionship within the scheme	4
Resident not motivated or encouraged by staff to get involved	6
Resident of a solitary nature	10

One manager commented that differences in social class had caused difficulties.

The survey also asked about the level of occupant involvement in the running of the scheme itself. While this is lower than engagement in more general activities, it does suggest that many occupants are actively exercising their stake in the scheme.

Table 10: Level of resident involvement in schemes

Level of resident involvement	Number of schemes
High	15
Medium	15
Low	4

Table 11: The nature of resident involvement

Nature of involvement	Number of schemes
Resident organisations	14
Running of shops & facilities	7
Organising of social & leisure activities	27

Another aspect of engagement is the scheme being experienced as part of the wider community within which it sits. 23 managers stated that their schemes were open to the community in some way, although very few actively offered outreach to other vulnerable people.

Table 12: Facilities open to the community

Facilities open to Community	Number of schemes
Outreach care & support	3
Café	15
Health services	11
Leisure	13
Assisted bathing	10
Hairdressers/shops	18

However, less than half of the schemes that were open to the community were actually used by the community on a daily basis which suggests an underused resource.

Table 13: Frequency of use by the community

Frequency of use	Number of schemes
Daily	10
Twice weekly	7
Weekly	3
Monthly	3

### 3.3.3 Extra Care reduces or maintains levels of need for formal support and health services, reduces hospital admission and speeds up early discharge.

The literature review found that ECH can play a key role in maintaining and promoting health and provide opportunities for more efficient delivery of care services. The findings from the survey support this. The majority of scheme managers agreed that ECH resulted in more opportunities for efficient delivery of services and enabled easier targeting of health promotion and prevention activities. Only one manager felt that it put increased pressure on local resources.

It is clear that ECH does not reduce support in all cases, but most schemes identified that in at least some cases the levels of need for formal support reduced following entry of residents to the scheme. The area seen as least likely to improve is confidence in medication use.

Table 14: Areas where formal support was reduced

Areas of support	Number of schemes		
	In all cases	In some cases	In no cases
A reduction in personal care hours needed	1	32	2
A reduction in the level of practical daily living support required	1	29	3
Increased confidence in medication use	1	25	8
Increased levels of self care	3	31	

Most managers felt that ECH was able to reduce inappropriate admission to hospital and enable early discharge.

### 3.4 Survey results on the achievements judged as 'insufficient sources' in the literature review

There was little information forthcoming from this exercise on return on investment; although it seems reasonable to infer that if most people don't move on to care homes, and if there appears less call on formal services, this is repaying the investment for commissioners.

Nearly half the managers saw ECH as enabling more effective use of staff resources in comparison to other forms of care:

- Care is flexible
- People tend not to be employed full-time. Lots of split shifts.
- Staff can spend more quality time with residents on a one-to-one basis.
- Management is centralised, accessible and flexible.
- There is greater flexibility than in care homes and less travel than in home care.

However, others commented that: ECH:

- Enables more effective use than home care but less compared to nursing care.
- Uses staff less effectively than residential care because in residential care, when the care is completed, staff do cleaning and other domestic tasks.

One manager noted that placement in ECH can result in social services not allocating enough care hours. The result being that the burden falls on scheme managers who end up filling the gaps.

## 4 FINDINGS ON THE 'STEPS TO SUCCESS'

There were two elements to the survey's review of what achieves success. First, where managers identified that they were achieving the outcomes such as 'alternative to residential care', 'reduction in social isolation' etc, they were asked to identify which aspects of extra care they felt were having those beneficial effects. Secondly, managers were specifically asked to comment on the relative importance of different aspects of ECH using the 'common language' developed by Peter Fletcher and Moyra

Riseborough<sup>7</sup> and revised further for other aspects of the Raising the Stakes project, notably the 'Quality of Information' mark.

#### 4.1 How the successes are achieved

Table 15: How schemes can support people with dementia

Factors	Number of schemes
Specialist training of staff	19
Purpose built	5
Assistive Technology	9
Enabling design	14
Early entry of residents with dementia	18
Balance of needs within the scheme	21

Table 16: Factors that prevent schemes supporting people with dementia

Factors	Number of schemes
Scheme aims to provide for only one client group	7
Lack of facilities at scheme	1
Accessibility of flats	2
Accessibility of communal areas	1
External access into the scheme	1
Environment not appropriate for people with dementia	11
No specialist support available for people with dementia	17
Difficulty recruiting/retaining levels of staff required	4
Too expensive for self funders	2
LA not willing to fund	7
Other	5 (behaviour)

Table 17: How ECH is a realistic alternative to residential care

Potential Benefits	Number of schemes
Promotes independence & autonomy of the individual	35
Supports the principles of choice & control	34
Services are built around individuals outcomes	34
Enables couples to stay together	34
Care & support is flexible & available 24 hours a day	30
It works with, not doing for the residents	32
Purpose built provision, with up to date facilities, equipment and technology	30

Table 18: How ECH maintains or improves health & well being

Reasons	Number of Schemes
Philosophy of schemes	29
Accessible design of scheme	28
Secure / safety features of scheme	32
Flexible access to care & support	31

<sup>7</sup> From 1999 onwards, eg Ingredients for Extra Care

Reasons	Number of Schemes
Services organised around individuals outcomes	29
Access to leisure facilities	19
Access to social activities	31
Encourages/facilitates people to retain social networks / interests	31
Promotes self care	31
Focus on re-ablement and rehabilitation	24
Access to assistive technology	16
Availability of onsite advice and information	28

Table 19: How ECH can benefit staff recruitment and retention

Benefits	Number of schemes		
	Great benefit	Some benefit	Little benefit
Regular hours	21	10	1
Support of a wider team	27	5	1
Getting to know clients & their families	25	8	
Ability to provide enabling form of care	22	11	
Use of facilities on site	13	9	7

Table 20: How ECH is able to reduce hospital admission

Reason	Number of schemes
Early identification of condition	25
Environment which prevents accidents	20
Flexible provision of care & support which can be increased if required	26
Promotes self care amongst those residents with long term conditions	16

Table 21: How ECH enables early discharge from hospital

Reasons	Number of schemes
Accessible environment	25
24 hour care and support	31
Assistive Technology	12
Equipment	23

#### 4.2 Views on the relative importance of specific domains and criteria

An associated element of the Raising the Stakes project was the development by Peter Fletcher and Moyra Riseborough of a common language for describing the different aspects of quality and success in Extra Care Housing. This was used as a framework for surveying scheme manager views on what were the key factors in achieving beneficial outcomes. The results are set out in the table below.

Table 23: Importance of different criteria in achieving success

Criterion	Number of managers			
	Very important	Important	Neither important nor not important	Not important
<b>CUSTOMER BASE</b>				
Vibrant community	11	15	6	0
Balanced dependency levels	17	15	1	2
A mix of tenures	0	6	13	11
Philosophy of prolonged residence/ageing in place	25	9	0	0
<b>SERVICES</b>				
Service philosophy which promotes independence, autonomy, and principles of choice and control	30	5	0	0
Information to promote self help	17	18	0	0
Services built around individuals outcomes	25	9	0	0
Access to practical services	20	14	1	0
Flexible access to 24hr personal care and support	28	6	0	0
Service/care team on site	27	7	1	0
Access to assistive technology and solutions	10	18	4	0
Access to one main meal per day	21	12	2	0
<b>ENVIRONMENT</b>				
Internal environment which is accessible and sustainable for the future	22	13	0	0
Internal environment which protects privacy of residents	26	8	1	0
Built of lifetime home standards	17	16	2	0
Good location	14	17	4	0
Access to local services	21	12	2	0

Criterion	Number of managers			
	Very important	Important	Neither important nor not important	Not important
Sufficient parking	11	17	6	1
Outward looking	9	22	4	0
Attractive setting	11	20	4	0
Secure externally	27	8	0	0
<b>LIFESTYLE</b>				
Clear statement of purpose/philosophy of scheme	26	8	1	0
Ethos which encourages positivity, individuality and mutual tolerance	28	7	0	0
Customer focused	29	6	0	0
Environment which is friendly and warm	28	7	0	0
Environment which is comfortable and hotel like	14	11	8	1
Environment which encourages healthy lives	26	8	1	0
Environment which encourages sociability	22	11	2	0
Tolerance of and provision for variety of faith and values	27	7	1	0
Access to social activities	20	13	2	0
Encouragement/facilitation of people to retain social networks and interests	19	13	2	0
Encouragement of social activities with external community	12	18	4	1
Emphasis on leisure	8	11	16	0
Close to leisure facilities	6	13	16	0
Leisure facilities on site	7	13	13	1

Most of the scheme managers agreed that most of the criteria of ECH within this framework were either important or very important. The main outliers are those criteria

associated with leisure; where just under half saw them as neither important nor not important; and mixed tenure, which nearly a third of respondents saw as not at all important.

Criteria seen by most managers as important rather than very important, are the encouragement of activities with the external community, and what might also be seen as associated criteria – attractive setting, good location, outward looking, sufficient parking. These seem to echo the other findings of this survey, that there is limited exchange with the surrounding community.

Finally managers clearly do not see assistive technology as being very important, and again this also shows very clearly in the previous section of this report in the more specific responses to questions about enabling factors around hospital discharge, support of people with dementia etc.

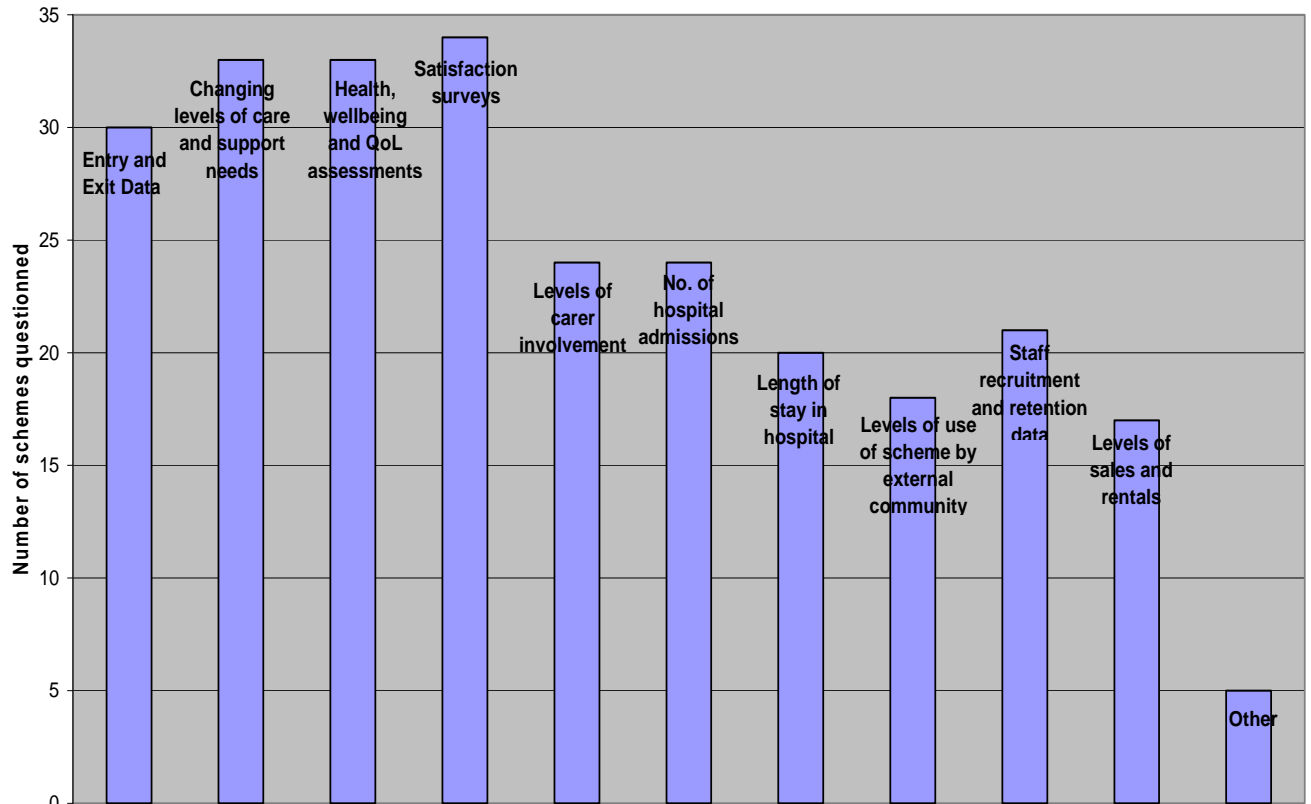
## 5 FINDINGS ON MEASURES BEING USED

### 5.1 Survey findings

Clearly part of the difficulty in determining the successes of ECH; and what contributes to them; is lack of systematic evidence. Managers were asked what information they currently recorded, how they recorded it, and what they then did with the information.

#### Graph One

What information do schemes currently measure, monitor and record?

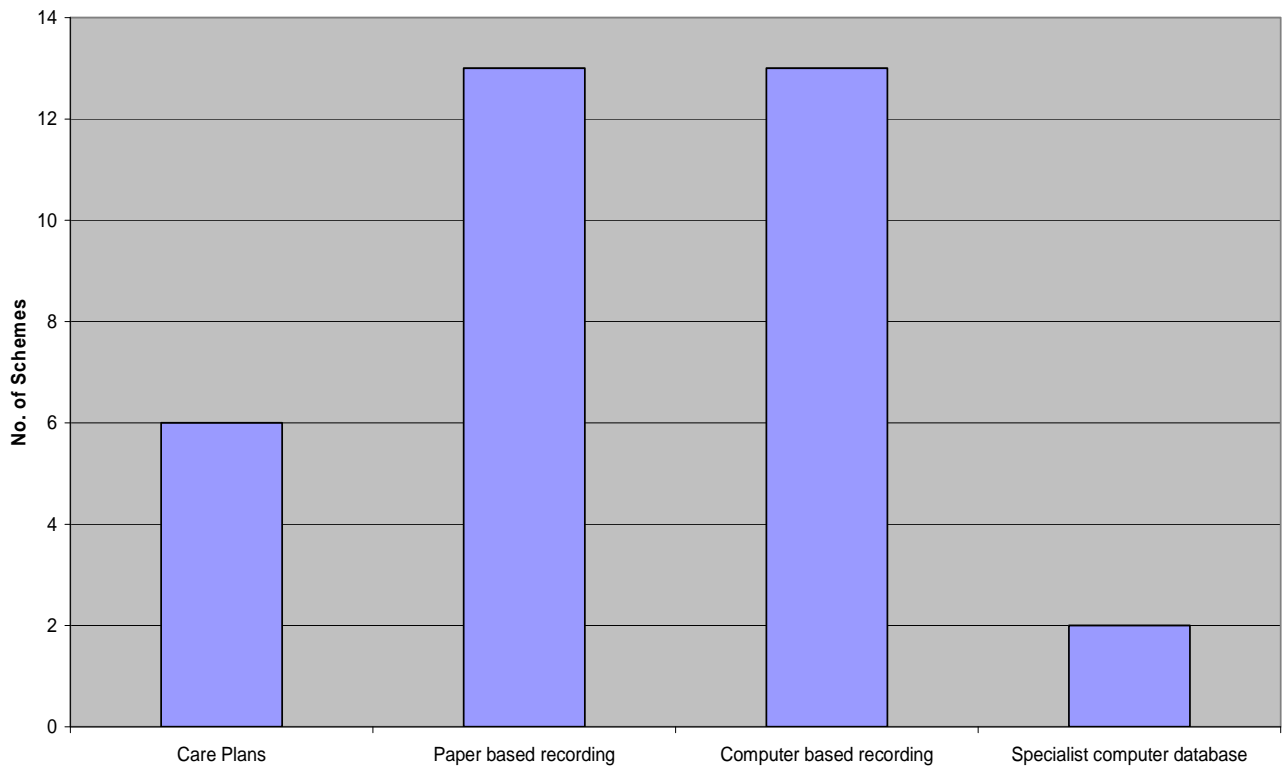


Other information that managers recorded included; Complaints and complement data; budget and management data; repairs data; referrals to day centre; use of other services on site e.g, chiropodist and hairdresser and staff supervision information.

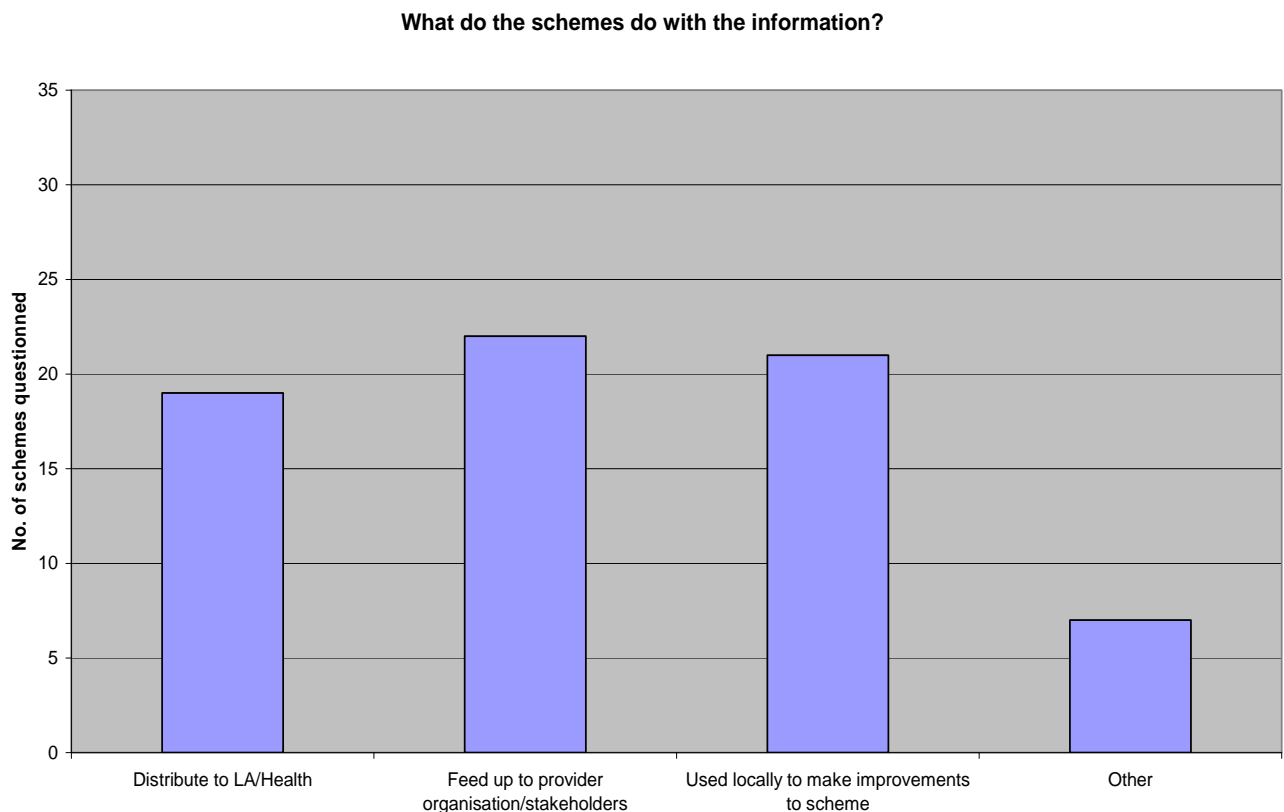
Schemes were then asked to list what systems they used to record information. This question remained unanswered in a number of the questionnaire returns. It is unclear as to whether this is because schemes do not have any formal systems to record information.

## Graph Two

Systems used by schemes to record information



### Graph three



More detailed description of uses included; to track care hours, to provide information to Board members, for internal monitoring reports, to provide government with statistics on future need for ECH, Supporting People.

#### 5.2 Comment

Most schemes do appear to record some of the information needed to evidence success, such as entry and exit data, changing levels of need, admissions to hospital, etc. However, much of this is recorded on paper, which is likely to make it harder to collate and interrogate, particularly when attempting to look across different elements of information. It seems that some elements may only be on case files or in supervision notes, which would make it even harder to access.

Finally, less information is actively used than is gathered. Schemes, provider organisations, their commissioners, and those interested in the bigger picture of the successes of extra care, would benefit from a clear identification of:

- Required outcomes.
- What would indicate their achievement.
- What data needs to be collected and analysed to measure this.
- How is this going to managed.