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Some social consequences of remodelling English sheltered housing and care homes to 'extra care'

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ABSTRACT
Across the United Kingdom, new build and remodelled 'extra care' schemes are being developed in many areas on the assumption that they offer older people with care needs an alternative to residential care. This paper reports an evaluation by a multi-disciplinary team of 10 extra-care schemes remodelled from sheltered housing or residential care units. The evaluation audited buildings and identified social and architectural problems. No two schemes in the sample were alike; some aimed for a dependency balance and others set a dependency threshold for admission. The three criteria used for assessing eligibility were the number of paid care hours the older person had at home, their property status and the type of disability. This article focuses on the wide variation in assessing eligibility for an extra-care place and on some social consequences of remodelling. A number of tenants remained *in situ* during the remodelling process in six of the schemes. Building professionals were unanimous that retaining some tenants on site caused significant development delays and increased the remodelling costs. There was also a social price to pay. 'Old' tenants resented their scheme changing into extra care and were hostile towards 'new' tenants who had obvious needs for support. In some extra-care schemes, 'old' tenants were refusing to participate in meals and all social activities.

KEY WORDS – extra-care housing, remodelling sheltered housing, tenant hostility to newcomers.

Introduction

In recent years, housing-with-care schemes have been a significant housing and social policy development in the United Kingdom (UK). As yet,

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no universally agreed terminology applies to these schemes. Although 'extra care' is commonly applied (as in this paper), 'very sheltered housing', 'Care Plus', 'Assisted Living' and 'Category 2.5 housing' are also used. Housing with care schemes are being developed to give choice to very frail or disabled people whose care needs might until recently have been met by residential care (Department of Health (DH) 2005). Although many extra-care schemes are new build, a considerable proportion has been remodelled from sheltered housing complexes and residential care homes. Remodelling outdated public-sector housing is attractive to many housing providers because the UK, like other European countries, has a legacy of 1960s and 1970s housing designed to meet older people's expectations. It is still common to find sheltered housing schemes for older people with the equivalent of 'bed-sit' accommodation, few if any communal facilities and inadequate or non-existent lifts.

As older people today have higher expectations, many such schemes have become difficult to let. Several housing providers have obtained government grants to remodel such buildings to meet the needs of older people with complex health problems and many more providers plan the same. Remodelling sheltered housing or a residential care home to an extra-care scheme raises architectural, economic and social-care issues. A research project, funded by the UK Engineering and Physical Sciences Research Council (EPSRC), was carried out by a multi-disciplinary team from King's College London and University College London to identify and explore significant issues arising in 10 English extra-care schemes remodelled since 2000. The research team included social gerontologists, architects, a rehabilitative engineer, an occupational therapist and an economist. This paper critically examines the criteria being adopted for admission to extra-care places and explores some important social issues arising from the remodelling. The paper begins by describing the background to the development of extra-care housing in the United Kingdom.

The background

The roots of extra-care housing

Extra-care housing has its roots in local authority sheltered housing for older people (Tinker *et al.* 2007) which developed during the 1950s and 1960s. The basic design parameters, which specified hybrid accommodation midway between self-contained dwellings and hostels with accommodation for a warden, were published by central government in 1958, and set the tenor for the next 30 years (quoted in DH 2004). Bed-sit

accommodation was common and in many cases kitchens, bathrooms and toilets were shared by two or more tenants. More detailed central government guidance that categorised different types of sheltered housing was produced in 1969 (Ministry of Housing and Local Government 1969). Grouped housing for more active older people was classified as Category 1, and accommodation for the less active (with a warden's office and accommodation, an alarm system, laundry and communal facilities) as Category 2. Category 2.5 or 'very sheltered' housing emerged during the 1970s and 1980s for older people needing a higher level of care and support. Very sheltered housing was the forerunner of current extra-care schemes and, in some areas, remains the preferred term for housing with care.

As older people's expectations of acceptable retirement housing changed, Category 1 and Category 2 sheltered housing in certain areas became more difficult to let, particularly if containing bed-sits (Tinker, Wright and Zeilig 1996). By 1994, a Department of the Environment (DOE) national study of the housing needs of elderly and disabled people concluded that there was a potential over-provision of ordinary sheltered housing but an unmet need for very sheltered housing (McCafferty 1994). From an analysis of the factors in the falling demand for sheltered housing, the Audit Commission (1998: para. 42) concluded that 'better housing stock and rising expectations mean that some older people will struggle to remain in their own homes rather than move to sheltered accommodation with shared or poor-quality facilities (which represents around 16 per cent of the sheltered stock)'.

The extra care vision

Not only is there no standard terminology for housing-with-care schemes, there is considerable variation in what they provide. A recent literature review pointed out that different provider organisations placed different emphases on the housing or care element, depending on whether they were trying to promote schemes as alternatives to residential care, remodelling existing provision or setting out to promote something felt to be conceptually different from what had gone before (Croucher, Hicks and Jackson 2006: 9). Nevertheless, some commentators have set out what they consider to be the basic ingredients of a housing- with-care scheme. For example, Oldman (2000) identified three key factors that distinguish 'very sheltered' from 'sheltered' housing; the provision of a meal, additional services and the possibility of a more barrier-free environment. The first fact sheet of the Housing, Learning and Improvement Network (LIN) set up by the DH to encourage further development of extra-care schemes, set out a far more ambitious vision (Riseborough and Fletcher

2004). It included tenancy rights separate from care, flexible care, a care team based on the premises, 24-hour support and staff working with, not doing for, the residents.

Extra-care housing is different in important respects from care homes. People in extra care have greater security than care-home residents. Their tenancy rights are separate from the care provided and there is security of tenure. A housing provider would need a court order to evict an extra-care tenant who did not agree to move out. In contrast, a care-home resident usually has only a licence to occupy a place and care-home providers can (and do) simply require a resident to leave. The accommodation is different. An extra-care tenant has a self-contained flat or a bungalow but a care-home resident only has one room which may or may not be shared and may or may not have an en-suite toilet or bathroom. The meal provision is quite different. Extra-care tenants should have access to meals. In some schemes there is an optional communal lunch but in others care staff shop for and prepare food individually for those unable to do so. In contrast, care-home meals are provided usually in a communal setting. The care provision is quite different. Care-home residents are looked after both day and night by care staff but an extra-care tenant would usually have care and support at specific agreed times and for specific kinds of care. At certain times there may be no care staff on the premises leaving the extra-care tenant with the option of using an alarm in an emergency. Night cover may be minimal.

Why extra care is being developed in the UK

Extra care is undoubtedly seen by many as preferable to care homes for many frail older people who have difficulties coping at home. One significant policy driver is the high cost of institutional care. Older people in extra care are estimated to cost the state less than if living in a care home. A cheaper alternative to institutional care is inevitably attractive to government, particularly given the projections for a significant increase in the number of very old people. People aged 85 or more years are the fastest growing age group and will nearly quadruple by 2051 to approximately four million, when they will form some six per cent of the UK's population (Department of Work and Pensions (DWP) 2004). As people age they are at risk from age-related diseases and more likely to find it difficult to cope in ordinary housing and to consider moving.

A second policy driver is the profoundly negative image of care homes in the UK. Disquiet about care homes has a long history. Studies of care-home life have portrayed daily life as depersonalising with residents exercising little control over their own lives and care homes managed

for the convenience of the staff rather than the residents (*e.g.* Townsend 1964; Willcocks, Peace and Kellaher 1987). This negative image of care homes was emphasised by Dr Stephen Ladyman (2005), Parliamentary Under-Secretary of State for Community, when announcing awards for extra-care developments at a *Help the Aged* conference:

> But this is not just about bricks and mortar, about extra places. For a start, this is introducing sustainable, long-term improvements to the stock of housing supported by care. But more importantly, much more importantly, this is about an additional 3,000 plus older people who have front doors, private facilities, maintaining their dignity, control and respect. It is about demonstrating once again that care homes are certainly not the inevitable solution for those older people requiring care and support (Ladyman 2005).

How extra-care schemes are being developed

Central government has been encouraging the development of extra care in recent years with competitive grant programmes from the DH, the Office of the Deputy Prime Minister (ODPM) (now the Department for Communities and Local Government), and The Housing Corporation (HC). Partnerships of social services departments, social housing providers and private-sector or voluntary-sector care providers have competed for these grants which can be for new build or remodelled schemes. The DH's Extra-care Housing Fund amounted to £87 million for 2004–06 and £60 million for 2006–08. In 2004–06, the HC made £93 million available to housing associations for extra-care developments and allocated £136 million for 2006–08. As successive governments have cut local-authority funding and restricted their borrowing powers, many local authorities, unable to meet the costs of maintaining and updating buildings, have transferred stock to housing associations. Some local authorities have now replaced all their care homes with extra-care housing. Unlike local authorities, housing associations have been able to apply to The Housing Corporation for funding both for new and for remodelled housing developments. Extra-care housing is still a relatively small proportion of sheltered housing. As there is no universal agreement on what actually constitutes extra-care housing, the statistics can only be approximate. Using a broad definition, the Elderly Accommodation Counsel (*sic*. EAC) (2007) estimated that there are 828 schemes built or under construction in England providing a total of 33,293 dwellings.

The *Supporting People* programme, launched in April 2003, has accelerated the expansion of extra-care schemes. This funding meets the cost of housing-related care and support (*e.g.* community alarms and housing manager support) but not the cost of personal care. Recipients may be

living in ordinary or specialised housing such as sheltered or extra-care schemes. *Supporting People* funding is administered by the housing departments of local authorities (unitary authorities and counties in areas with two-tier local government) that contract with partner organisations such as National Health Service trusts, local authority social services, and housing associations to facilitate and enable independent living. It offers housing support to a wide group of vulnerable people including homeless people, those with mental health problems or on probation as well as older people.

The research project

The aims of the research project were to:

- Examine how a sample of local authority and housing association sheltered housing and residential care homes have been remodelled to become extra-care housing.
- Audit buildings to see how the remodelled schemes have been adapted.
- Identify social and architectural problems resulting from the remodelling.
- Explore the tenants' experiences of living in a remodelled extra-care scheme.
- Elicit the care and support staff's views of how well a remodelled extra-care scheme works in practice.

As there is no national database of remodelled extra-care schemes, various sources were used to identify a sample of 10 public-sector English schemes remodelled since 2000. A few were identified through the EAC database but most were identified from other sources such as major housing associations, local-authority housing departments and the LIN network. Although the original plan was to identify five local-authority and five housing-association remodelled extra-care schemes, so much stock transfer had occurred that only two schemes in the sample were local-authority controlled. Five of the 10 schemes had always been housing association but three were originally local authority before transfer to a housing association. Eight schemes had originally been sheltered housing and two were sheltered housing with an integral residential-care home. As far as the latter were concerned, remodelling in one scheme involved changing residential-care bedrooms to 16 one-bed extra-care flats but the 24 sheltered-housing flats were untouched. In the second scheme, existing sheltered flats had been refurbished but residential-care bedrooms had been remodelled into one-bedroom self-contained flats. Of the remaining eight schemes, the main remodelling had entailed converting bed-sit accommodation into self-contained flats. Most had just one bedroom and,

in one scheme, several small bed-sits had been retained. Although the amount of space available to the individual tenant was increased through remodelling, the majority of the flats still fell short of the current space standards for new build. In many cases, there was considerable variation in the sizes of individual flats in a scheme. Individual flats usually had upgraded kitchens and bathrooms. Two issues posed particular challenges in these remodelled flats: the inclusive and accessible design of the individual flats and the incorporation of assistive technology. For example, the heavy front fire-doors meant that some tenants had difficulties getting in and out and either never left their flat or left the front door permanently open. Although a remote controlled, self-opening door would have solved this problem, none had been installed.

Remodelling often involves extending beyond the original building lines (or footprint) in various ways such as extending corridors or putting additional rooms on the front or back of a building. One scheme, constrained to the original footprint by planning requirements, had been extended upwards rather than outwards and several residents' flats created beneath the roof on the second floor. Most of the schemes in the sample had acquired improved communal and staff facilities. Access and circulation had usually been improved by the remodelling: all the schemes met the minimum requirement for accessibility, but most corridors fell short of the recommended 1,500 mm width. An existing lift had usually been retained which provided insufficient space for wheelchair users and their escorts and was often too small to take a stretcher. Tenants living in the extensions were usually a considerable distance from the original lift and many found the distance intimidating.

Remodelling schemes that are peoples' homes brings many complications. All the tenants had been moved out of four schemes either before remodelling or early in the process. Whatever they felt about it, those tenants lost their home and were moved elsewhere. As they were usually being moved from bed-sit accommodation to one-bedroom flats in other schemes, it is possible that they were pleased by the move. Moving tenants out was an option only for housing providers with other local sheltered housing with vacancies. A number of the tenants remained *in situ* during the remodelling process of six schemes. As we shall see, this generated difficult problems both in the remodelling process and in the social relationships between 'old' and 'new' tenants.

The respondents

Tape-recorded in-depth interviews were carried out with 31 key professionals involved in the remodelling process of the 10 schemes, including

architects, surveyors and contractors, and with 23 senior housing and social-care managers connected with the remodelled schemes. Scheme care managers (10), housing managers (9) and care assistants (14) were also interviewed. Interviews were carried out with 96 tenants (76 women and 20 men). Five respondents had moved with a dependent spouse into extra care because they had not had adequate or appropriate support from care staff in their own homes. Most tenants were aged in the late seventies, eighties or nineties. Five people were below retirement age and had serious physical disabilities. As under the UK *Data Protection Act 1998* lists of tenants cannot be provided for research purposes, a scheme manager distributed project descriptions and an invitation to take part in the research to all the tenants. A modest voucher was offered to those willing to participate. Interviews were transcribed and analysed thematically. The prevalent themes in the tenant interviews included reasons for moving into the scheme, satisfaction or otherwise with the design of individual flats and the scheme as a whole, uses of the grounds if any, relationships with other tenants, satisfaction or otherwise with support of care staff during the day and night, support from family members, views of any communal activities and satisfaction or otherwise with any communal meals or coffee mornings.

The sampled extra-care schemes

A literature review of housing with care schemes concluded that there were various definitional problems and that very few schemes were exactly alike (Croucher, Hicks and Jackson 2006). Our research also found wide variation in the models being developed and their designations. Eight schemes in the sample were called 'extra care' and two 'very sheltered housing'. One fundamental difference was that in four schemes all the housing units were designated extra care/very sheltered housing while six schemes had mixed housing units with some units designated extra care while the remainder were ordinary sheltered housing units (Table 1). In two mixed schemes, a wing or a floor had been designated extra care, but in the other four, extra care units were scattered among the sheltered housing units.

Assessment for an extra-care place

Each scheme had individual admission criteria and local assessment panels (composed of managers from housing providers, local authority housing departments and social services) set local criteria for admission. Generally, a local panel met to consider appropriate applicants from the waiting list when a vacancy or void occurred. The three key considered

TABLE 1. *The terminology and number of housing units in the studied extra-care schemes*

Scheme	Terminology	Number of housing units	Number of extra care units
A	Extra care	50	10
B	Extra care	42	42
C	Extra care	16	16
D	Extra care	29	29
E	Extra care	39	25
F	Extra care	32	16
G	Extra care	30	15
H	Extra care	123	19
I	Very sheltered housing	30	30
J	Very sheltered housing	32	16

factors – dependency level, property status and type of disability – illustrate the wide variation among extra-care schemes. The dependency level of applicants was important for the four schemes trying to achieve a dependency balance and for the six with a dependency threshold.

The 'dependency balance' schemes

A recent Laing and Buisson (2006, para. 1.1.1) report on the extra-care housing market suggested that a subjective test for a scheme being extra care was whether it provided an alternative for most people who would otherwise enter a care home. Four of the sampled extra-care schemes certainly did not meet these criteria because they aimed for a dependency spectrum of one-third of the tenants with low or no dependency, one-third medium dependency, and one-third high dependency. Such a wide dependency spectrum has become well established in very sheltered housing. A DOE national survey of very sheltered housing carried out more than a decade ago reported that one-in-five recent entrants were able-bodied with no mental or physical impairment (McCafferty 1994). As far as the four dependency balance extra-care schemes in our study were concerned, the management ideals were to avoid creating a scheme that replicated a care home and to achieve a 'balanced community'. The expectation was that older people who were physically and mentally fitter would exercise leadership.

A significant factor in aiming for a balanced community was the staffing cost. Typically each scheme was allocated a specific number of care hours per week and the care team had to manage within that allocation. In order to cope with those people needing a package of high care, the scheme needed some relatively independent residents. When a void occurred in a

dependency spectrum scheme, the care manager assessed how the care staff team was coping with the care and support in the scheme as a whole. If a high dependency tenant moved out and the manager thought the scheme's dependency profile unbalanced, a person with low or no dependency could be offered a place. A local-uthority senior social services manager responsible for developing a county's extra-care schemes described the policy:

> The aim of the allocations policy is to sort of create and then sustain the balanced community. So just because a high band dependency person has died and there's a vacancy, we wouldnt automatically fill it with a high-band dependency person if we felt that other people had actually moved on from say a middle band to a high band. So we try and think of the needs in these sorts of three segments and place people accordingly.

A significant problem reported for all four dependency balance schemes was that there were few applicants on the waiting list with low or no dependency. Waiting lists consisted of people who were in real difficulties coping at home and were causing concern to relatives and social workers. One reason why fitter older people have not been applying must be that extra care is still relatively unknown. Even when older people with little or no disability have heard about schemes, they are likely to be intimidated by the image of a facility predominantly for tenants with a moderate or severe disability.

Dependency threshold schemes

The aim in six schemes was a minimum dependency threshold for all new extra-care admissions based on the number of hours of paid care people had been having in their own homes. This qualifying threshold varied among the schemes. In two schemes, older people with at least four hours paid personal care per week at home were eligible for an extra-care place, a surprisingly modest criterion – amounting to little more than half-an-hour per day. At the other extreme, three schemes had an eligibility threshold of 10.5 hours personal paid care per week. The managers in all six schemes, however, reported that it was common for tenants to need fewer hours of care after admission than they had previously needed in their own homes. Referring to this common situation, one scheme manager said 'in fact we've had several now that came in with a care package, and now don't have it at all. They've opted out. I mean sometimes you do anticipate that when people move in they may well regain independence and improve.' Another remarked, 'I can't think of a single tenant in those extra-care flats who, when they first moved in there, didn't actually improve to a certain degree from when they first moved in'.

The literature indicates that following admission to extra care, the number of needed care hours reduces (Croucher, Hicks and Jackson 2006). The evidence from our study suggests two factors for this response: the more accessible setting and, for many tenants, a substantial amount of support from relatives. On the whole, the extra-care flats in the remodelled schemes enabled easy movement between bedroom, bathroom, kitchen and sitting room. Typically an extra-care flat had a level-access shower, direct access between bedroom and bathroom, and a kitchen opening off a lounge. The interviewed tenants commented on how living in extra care was different from living at home. Although most regretted leaving a familiar home, great enthusiasm was expressed about the removal of common environmental barriers such as stairs to the bathroom and bedroom, an ordinary bath and a kitchen at a distance from the living room.

A surprising amount of practical support by relatives was described by many of the interviewed tenants. Daughters, daughters-in-law, sons, sons-in-law, and granddaughters were all mentioned. Taking a tenant out in a car to a local supermarket to do a week's shopping was most commonly mentioned, but relatives undertook all sorts of practical tasks such as washing clothes and cleaning the floors. Several tenants mentioned a flat being redecorated by relatives before they moved in. The relatives' considerable involvement in practical support in an extra care setting has been commented on in other studies such as the Berryhill Retirement Village study (Bernard *et al.* 2004, 2007). Discussing housing issues in later life, Heywood, Oldman and Means (2002) argued that what marks out residential care from housing-based models is the involvement of relatives in the latter, considering their support to be a major factor in a disabled person's ability to keep going. A high level of relative involvement is in marked contrast to the situation in care homes where research has shown the relatives' role to be largely one of companionship, handling finances and checking the quality of care (Wright 1998). As relatives were not interviewed as part of the study, it is difficult say why so much support was given.

Tenure status

All 10 schemes were public-sector housing. In six, however, older home owners were admitted on the same basis as those who had been renting. Most such homeowners had to pay the full cost of personal care and housing support because they received a significant capital sum following the sale of their previous home. In the remaining four schemes, the situation was more complicated. People who could self-fund from savings

were never accepted in one scheme, but in a second, anybody with more than £150,000 savings would not be admitted. Even more complicated criteria had been adopted by a third housing provider, which accepted very elderly property owners into extra care if their disabilities made it difficult to continue living at home and if they were considered too old and frail to undertake the purchase of a more suitable property. A senior manager of one housing provider organisation explained the position:

> But then we do almost a test of reasonableness, which is: How reasonable is it to expect somebody in their eighties to actually go hunting to buy a flat, sort out their own care, just because they're selling a house that's reasonably valuable? And I mean we don't think that is reasonable, you know. At that stage in life people are trying to make things simple, and its traumatic enough moving.

A fourth housing association, bound by the local authority's criteria, was prepared to assess the care needs of both older homeowners and renters but gave priority to the latter when care needs were equal.

Types of disability

There has recently been a substantial increase in older people using wheelchairs in the United Kingdom, but wheelchair users were likely to be regarded as inappropriate for admission to most of the remodelled extra-care schemes in the sample. Only one scheme had been remodelled to a full wheelchair standard with a concealed track in every room to accommodate a hoist for easy transfer. This scheme was relatively large and had 30 flats. The main reasons for wheelchair users being assessed as inappropriate in the other remodelled schemes were inadequate corridors and lifts in the main building, individual empty flats being too small, and the individual needing too much help from the care staff to effect a transfer between wheelchair and bed. As far as corridors were concerned, space standards had been compromised in the remodelling process. Although all the schemes now met the minimum corridor width requirement for circulation, but the majority were narrower than the recommended 1,500 mm. An existing lift had usually been retained which provided insufficient space for wheelchair users and their escorts and excluded wheelchair users unable to travel alone. Although the average flat sizes were increased through remodelling, the majority still did not meet current space standards for new build. Internal corridors were too narrow in some flats to manoeuvre a wheelchair.

Among the comments from senior scheme managers that reflected these limitations were: 'These flats are okay if you've just got a walking stick', and 'If somebody moves into, say, a flat, then all of a sudden their disability gets worse, the size of the flat could depend on whether we can

get a hoist in and everything. And I think if it came to that and we couldn't use a hoist it could be a case that that the person would have to be moved on.' Given that extra-care schemes have been described as 'homes for life', it is ironic that a too-small remodelled flat could precipitate an admission to a care home if a tenant fell and broke a hip or limb and had to use a wheelchair temporarily.

There were several instances of wheelchair users being admitted to inappropriate flats which had implications for the amount of care staff needed and the quality of the tenant's life. In one scheme, a wheelchair user in a flat with a small shower and toilet room had to be transferred by hoist several times a day to a large communal toilet at the end of the corridor. In another scheme, care staff spent much time each day helping a man with a double amputation to use the toilet in a small shower room. The bedroom was too small to accommodate a portable hoist. Two care assistants were involved several times a day. As a care assistant remarked:

> So we're actually hoisting six times in one transfer. We hoist from his sitting room chair, onto a wheelie commode. We wheel the commode into the bedroom. With the commode in the bedroom, we've had to have an overhead hoist fitted over the bed, because we couldn't manage to lift him off the commode, and then wheel him over to his toilet. And then the same process all the way back. Back from the toilet onto the bed to clean him, and to put his clothes back on. Back again, another hoist, then into the room, then a transfer again with the manual hoist into the chair.

For this tenant, the rooms were so small that a significant part of the day was spent accessing and using the toilet. Many organisations impose a health and safety rule that two care assistants must be present to effect a hoist transfer. Most of the extra-care schemes in our sample were small and two care staff were not always in the building at the same time. In one scheme a wheelchair user had been accepted because although two care assistants were needed for a transfer, this was at regular set times. If wheelchair users needed hoisting at unpredictable times, it is unlikely that they would be offered an extra-care place in several of the case study schemes The care manager of one scheme considered that wheelchair users should only be admitted to nursing homes. She said, 'I assess all the new extra care clients. So if I feel that they need some more nursing needs, like hoisting, you know two carers, and any time they want it, that's a nursing need and they would not be admitted.' None of the 10 case-study schemes would have accepted anyone with severe dementia. Managers in several schemes, however, said they were prepared to admit people with mild dementia on the assumption that they would become familiar with the scheme and be tolerated by the other tenants.

Development complexities in the remodelling process

As mentioned earlier, all the tenants of four schemes had been moved out either before or early in the remodelling process, and six schemes had residents remaining *in situ* during the remodelling. The number involved could be relatively small, *e.g.* one scheme had only eight residents remaining, but in two of the larger schemes nearly three-quarters of the tenant population had remained. The senior scheme managers for these schemes argued that such continuity was positive for the sense of community. One said, 'If you remodel you still allow the existing community to stay in place and kind of maintain a community', and another remarked that 'the tenants who lived here were so insistent that their community stayed together'. The managers also described many positive aspects to the remodelling process for tenants remaining on site. As one eloquently put it, 'Those living on site were all part of it. It was sort of almost the Dunkirk Spirit'. There were reports of builders' cranes coming on site and tenants excitedly watching the process. A common comment was that tenants enjoyed interacting with the workmen but slowed down the building process by making them cups of tea. One of the building contractors thought that living on a building site relieved the boredom of the tenants' everyday life. He said:

> Some older people actually enjoy it hugely. I mean they really enjoy the activity of watching things happen. Because when you're older not much happens in your life and some of them got very friendly with the building workers. Of course the other thing that happens is that the builders go and do all sorts of little jobs for people, in their own flats, that they shouldn't really be doing.

The interviewed tenants who had lived through the remodelling process did not however describe a positive experience. Most complained about the dust and noise and the length of time that builders were on site. One aspect of the process that many found particularly upsetting was being moved to different flats as remodelling the whole scheme had to be done in phases.

The building professionals' perspective

For most of the building professionals involved in the remodelling, it was their first encounter with the concept of extra care. Remodelling was far from a straightforward process and numerous delays occurred during the construction process. Two major issues were in evidence; unforeseen structural and construction problems on site and, in six schemes, tenants remaining *in situ* making it necessary to phase the remodelling process. On average, six unforeseen problems were encountered per scheme, the most common being the discovery of asbestos. This obviously entailed closing

off parts of the building to workmen and tenants for specialist work to remove the asbestos, which inevitably slowed down the project. The delay could be as little as two or three weeks but in one case extended to 18 months. Not surprisingly, virtually all the architects and the building contractors interviewed had reservations about tenants remaining on site during remodelling. Inevitably a prime concern was health and safety issues for both tenants and builders. Efforts had to be made to exclude tenants from parts of the building during the process but this was difficult because 'Do Not Enter' signs could easily be ignored and tenants were inevitably curious about what was happening to their home. Electricity and gas supplies had to be maintained for those tenants remaining in the building when it would have been much easier to cut the supply. Keeping these services live inevitably made the remodelling more hazardous for the workmen. All the professional staff interviewed where residents had remained *in situ* during the remodelling argued that costs had increased because residents had to be moved around the scheme as different parts of the building were developed. It would have been simpler and more cost and time effective if development work could have been carried out on an empty building.

The managers were keen to emphasise both that tenants had been consulted about the design of the remodelled building and that those remaining on site were regularly informed about the stages of the remodelling process. Various examples were given of how tenants influenced building design. These included suggestions about changing the position of the lift shaft so that noise of the lift would not be heard in tenants' bedrooms, creating a second communal lounge that could be reserved solely for tenants when people from outside occupied the main lounge and choosing colour schemes for corridors and communal lounges. Tenants remaining in one scheme had moved into the finished flats and were critical about the way storage cupboard doors opened and the bathroom layout. Their criticisms were helpful in improving the design of the remaining flats.

The enthusiasm of the 'new' tenants

Most older people admitted to extra care after remodelling were very positive about the move. Although there were differences between schemes and between flats in the same scheme, a common design feature – good access between bedroom, bathroom and sitting room – was particularly praised. A frequent comment was that the move had taken away their own and their children's worry of the potential consequences of living alone in ordinary housing in the community. Many of the residents

interviewed felt the move had given them a new lease of life. It was common for tenants to emphasise their gratitude that schemes were unlike care homes. What they particularly liked about extra care was having privacy but also the option to mix with others by taking part in informal activities such as coffee mornings. As mentioned earlier, a few tenants were younger people with chronic diseases such as multiple sclerosis, a stroke and cerebral palsy. All of them were keen to emphasise their relief at living in an extra-care scheme rather than a care home, but they were not very enthusiastic about living in a scheme dominated by very old people. Complaints were made about other tenants' hearing loss and the need to shout to be heard.

The 'old' tenants' antagonism to new tenants

It was apparent from the interviews with the care and housing managers and the continuing tenants themselves that remodelling the building and changing it into extra care was often deeply resented. First, many of the 'old' tenants had lived in a scheme for years and resented the disruption of the building work. It may be difficult to let bed-sit accommodation but many of its occupants have come to like that way of living. Certainly tenants in one of the schemes protested that their bed-sits had been far larger than the lounges of the new one-bed flats that had been developed. Secondly, many of the interviewed 'old' tenants expressed anger at the change from sheltered housing to extra care. They resented the implication that they themselves needed care and identified extra care as in reality a care home. A significant issue in all six schemes where tenants had remained on site was antagonism to those new tenants who had obvious physical and mental problems in coping independently. Managers in all six schemes saw this hostility as a management challenge. As one said, 'It's because you've got residents here who really begrudge their home being turned into an extra care. And at the end of the day I've heard comments passed such as, "We didn't have a choice; we've been put in a home". And they say, "We have to live in a home and it wasn't our choice. We wouldn't have had this, you know".' A care manager remarked that it's 'quite interesting that some of the original residents, who are probably older and frailer than … some of the new residents say, "What are they doing here?". [Once I heard] "People like that being put here … what are you putting all those old people in here for?" from a gentleman who's old and very doddery'.

'Old' tenants often complained bitterly in the interviews about the newcomers and about having to live in an extra-care scheme. There was considerable nostalgia for how schemes had been before remodelling. One

tenant said, 'I hope, when I say that there's not a lot of people here who I would really associate with. You know, after the extensions, we got a lot of sick people, and I suppose people don't want that really.' Another tenant said, 'So they're [the 'old' tenants] not such a friendly community for them. You see a lot of them [new tenants] are very, very deaf and very disabled in various ways. So it's not the sort of company that it was.' The 'old' tenants' hostile behaviour on occasion was intense. In one scheme, the 'old' tenants refused to eat lunch in the dining room because 'new' tenants would be there. They also boycotted all organised activities in the scheme. The care manager reported that 'old' tenants made offensive personal remarks directly to 'new' tenants with obvious disabilities. Although this level of overt hostility was not found in the other schemes, many 'old' tenants were reported as declining to take part in activities such as coffee mornings because 'new' tenants would be there. It is well established that sheltered housing tenants have negative feelings towards others who are more disabled. Such reactions suggest a tendency to exclude others whose dependency threatens self esteem.

Conclusions

Extra-care housing is clearly an important innovation in the care and support of older people in the United Kingdom. Although our research project focused on 10 remodelled schemes, some of the conclusions apply to both new and remodelled schemes. There is enormous variation in what is described as an extra-care scheme and in the criteria for admission. This must make it very difficult for older people and their relatives to know whether they are eligible for a place and exactly what will be provided. Four of the studied schemes aimed to have a dependency balance and six applied a dependency threshold. As far as the latter were concerned, the dependency measure was based on the number of paid care hours older people had had in their own homes. For some schemes, four hours care at home gave eligibility but at the other extreme for others the measure was 10.5 hours. This seems an inappropriate way to determine eligibility given a common management experience of a significant drop in the number of care hours needed after admission to an environment with fewer barriers to independent living. Another of the findings is likely to be more appropriate to remodelled schemes. Most of the schemes we looked at provided a poor environment for wheelchair users. There was considerable variation between individual flats in the one remodelled building. Many bathrooms, kitchens and bedrooms were too small for a wheelchair user. However, any older person can be in a situation of using a wheelchair temporarily.

Remodelling sheltered housing to extra care has occurred in many areas in the past and is likely to be adopted more widely. The issue of some tenants remaining on site during the remodelling process is a difficult one. It is important to respect the right of people to remain in a building that is their home. Nevertheless, the research indicates that there is a price to pay. The construction process became complicated as tenants had to be moved around the building. Remodelling had to be tackled in phases and the unforeseen problems such as asbestos made it necessary to exclude tenants and building workers from certain parts of the building. There are consequent social difficulties in retaining some tenants on site as 'old' tenants may be opposed to the idea of extra care and resent the admission of 'new' tenants with a high level of disability.

References

Audit Commission 1998. *Home Alone: The Role of Housing in Community Care*. Audit Commission, London.

Bernard, M., Bartlam, B., Biggs, S. and Sim, J. 2004. *New Lifestyles in Old Age: Health, Identity and Well-being in Berryhill Retirement Village*. Policy, Bristol, Avon.

Bernard, M., Bartlam, B., Sim, J. and Biggs, S. 2007. Housing and care for older people: life in an English purpose-built retirement village. *Ageing & Society*, **27**, 4, 555–78.

Croucher, K., Hicks, L. and Jackson, K. 2006. *Housing with Care for Later Life: A Literature Review*. Joseph Rowntree Foundation, York.

Department of Health 2004. *Extra-care Housing for Older People: An Introduction for Commissioners*. Department of Health: London.

Department of Health 2005. *Independence, Well-being and Choice: Our Vision for the Future of Social Care for Adults in England*. Department of Health, London.

Department for Work and Pensions 2004. *Opportunity Age*. Volume 2, *A Social Portrait of Ageing*. Department for Work and Pensions, London.

Elderly Accommodation Counsel 2007. *Statistics on Extra-care Housing in England*. Elderly Accommodation Counsel, London.

Heywood, F., Oldman, C. and Means, R. 2002. *Housing and Home in Later Life*. Open University Press, Buckingham.

Ladyman, S. 2005. Supporting Older People: Meeting Changing Care and Housing Needs. Speech at Help the Aged Conference, 23 February 2005. Available online at http://www.dh.gov.uk/en/News/Speeches/Speecheslist/DH_4105330 [Accessed May 2008].

Laing and Buisson 2006. *Extra-care Housing Market Report 2006*. Laing and Buisson, London.

McCafferty, P. 1994. *Living Independently: A Study of the Housing Needs of Elderly and Disabled People*. Her Majesty's Stationery Office, London.

Ministry of Housing and Local Government (MHLG) 1969. *Housing Standards and Costs: Accommodation Specially Designed for Old People*. Circular 82/69, MHLG, Her Majesty's Stationery Office, London.

Oldman, C. 2000. *Blurring the Boundaries: A Fresh Look at Housing and Care Provisions for Older People*. Pavilion, Brighton, East Sussex.

Riseborough, M. and Fletcher, P. 2004. *Extra-care Housing: What Is It?* Fact Sheet 1, Housing, Learning and Improvement Network, Department of Health, London.

Tinker, A., Wright, F. and Zeilig, H. 1996. *Difficult to Let Sheltered Housing*. Joseph Rowntree Foundation, York.
Tinker, A., Zeilig, H., Wright, F., Hanson, J., Mayagoitia, R. and Wojgani, H. 2007. Extra Care: a concept without consensus. *Quality in Ageing* **8**,4, 33–44.
Townsend, P. 1964. *The Last Refuge: A Survey of Residential Homes and Institutions for the Aged in England and Wales*. Routledge and Kegan Paul, London.
Willcocks, D., Peace, S. and Kellaher, L. 1987. *Private Lives in Public Places*. Tavistock, London.
Wright, F. 1998. *Continuing to Care: The Effect on Spouses and Children of an Older Person's Admission to a Care Home*. Joseph Rowntree Foundation, York.

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