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Collaborative Housing and Innovations in Care (CHIC project)

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About the CHIC project

Later life housing often polarised between fully independent community dwelling, and specialist retirement housing.

'Collaborative housing' sits between these – benefits of group living, but with more autonomy than retirement communities or extra care etc., with residents in control.

Our question: in what ways might collaborative housing meet the social care and support needs of older people?

- Care and mutual support in 6 collaborative housing communities in England over a 30 month period.
- In-depth case study research over nearly 3 years, with a longitudinal element, 100+ interviews, focus groups and other visits

Case studies: cohousing

Case 1: Hazel Lanes Cohousing
South England

Completed in 2016
25 flats (1-3 bed)
~26 women, aged 50s-90s
17 owner-occupied + 8 socially rented, community own company freehold
No formal care, mutual support

Case 2: Meadowridge Cohousing
Eastern England

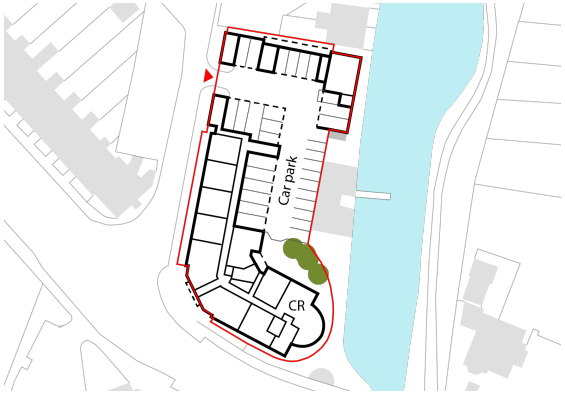
Completed in 2019
23 houses + flats (1-3 bed)
31 members, aged 50s-80s
All owner-occupied, community own company freehold
No formal care, mutual support

Case 3: Sundial Yard Cohousing
South West England

Completed in 2003
34 houses + flats (1-5 bed)
71 residents, intergenerational children-90s
Mostly owner-occupied + rented / lodgers, community own company freehold
No formal care, mutual support

Case studies: other models

Case 4: Greenways self-managed retirement devpt.
South West England



- Built in 1990s, Right to Manage 2008
- 54 apartments (1-2 bed)
- ~60 residents, aged 60s-90s
- All residents leaseholders and directors of Right to Manage Company
- On-site manager

Case 5: Crescent Crofts self-managed 'very sheltered hsng'
West Midlands

- Completed in 1985
- 53 bungalows
- ~60 residents, aged 55+
- All residents leaseholders and shareholder of not-for-profit management company
- CQC registered social care services, 24 hour duty manager

Case 6: Cedarbank older person's housing co-operative
North West England

- Formed in 1985
- 64 bungalows + flats (1-2 bed)
- ~63 residents, aged 60s-90s
- A non-profit registered social landlord, residents co-op members that rent home
- On-site manager, shared maintenance services

Key (early) findings - cohousing

- High proportion of those living without significant support from children or family, especially due to geographic location of schemes
- Strong social organisation through shared activity, resource pooling and housing design
- A *preventative* health and wellbeing role
- Mutual support practices, **reduced need for longer hospital stays**
- Agreed limits to mutual support, and is NOT personal care, but in practice often goes further, even palliative care.
- **Advocacy or brokerage role**
- But also support from the community for others, “caring for the carers”
- Model not cheap, but no built-in care services

Key (early) findings - 'Others'

- More affordable and accessible than cohousing model?
- Paid support staff play essential role
- … more 'embedded', even becoming ersatz social workers
- Self-management important for some, but no commitment to collective life
- Neighbourly support, helped by *process* of self-management?
- **Self-management of buildings, finances and services in turn means control over care: staffing, choice and quality.**
- E.g. (Cedarbank) retaining staff and managers, even becoming a hub for the wider community.

Transitional analysis of key cases

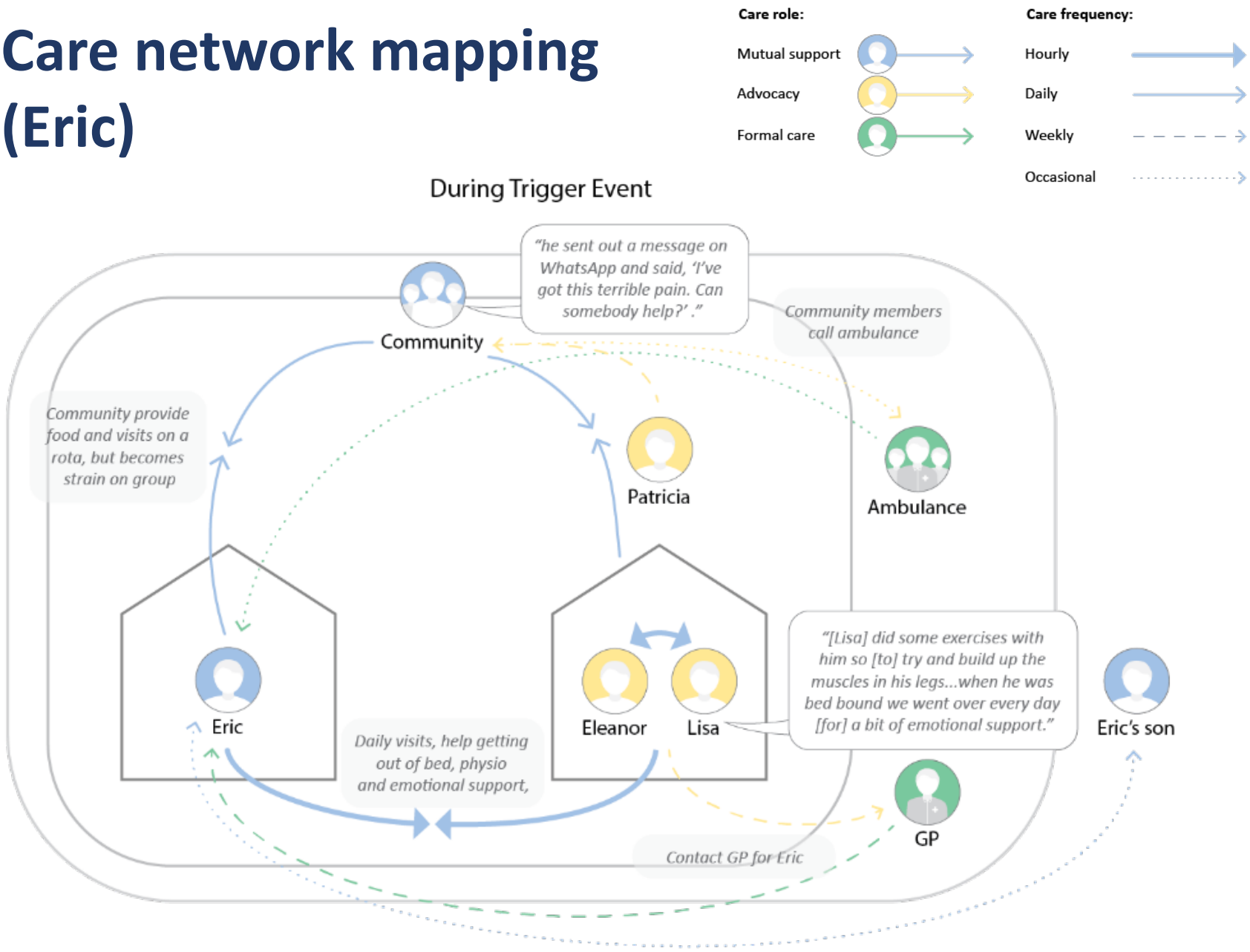
Each cohousing community has had at least one member experience a major transition.

We're using key cases to illustrate and understand how care is given and received over time.

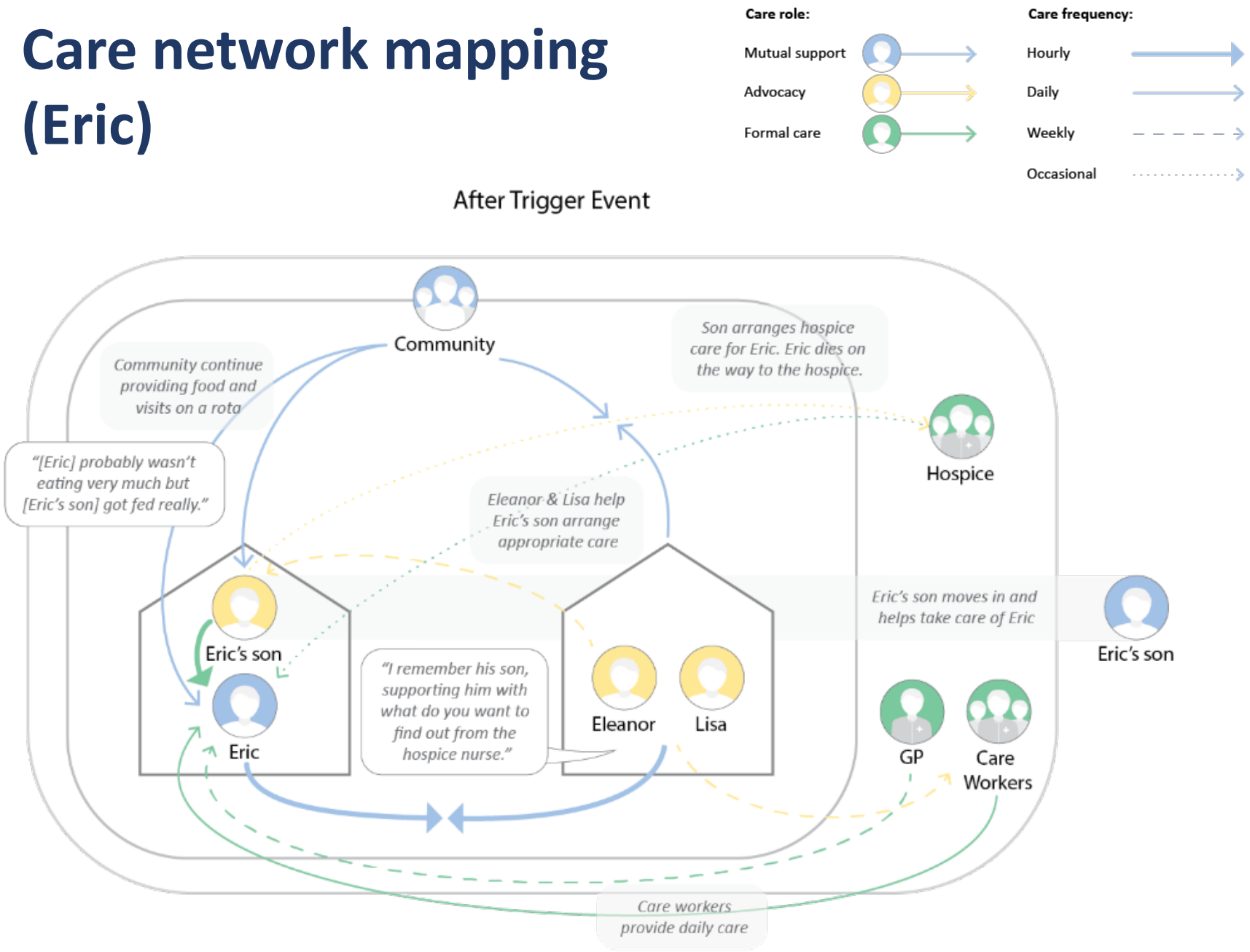
- broader ' shallower' **mutual support** by many group members
- full **advocacy role** by a smaller ' inner circle' of friends and family
- **formal medical care** by GP, external care workers and hospice.

Type of Care	When	Event
	Five years ago	Wife died, and son lived abroad. Eric lived on this own. Involved in community from an early stage. Involved in finding the site.
Mutual Support	2019 Dec 2020	Moved into the site. Eleanor and Lisa moved to scheme, Eric supports them when they have a leak in their flat and moved into the common house. Go to meditation group together. They become good friends.
	Mar 2020	The Pandemic begins.
Advocacy Role	*Trigger event	Mark, Ellie and Ed call an ambulance for Eric after he had been experiencing terrible pain. Diagnosed with lung cancer during lockdown.
		Group provide support for Eric but it becomes a strain on the group. John and Patricia (retired doctor) support Eric after a fall. Members of the group provide meals and visits by a rota. Eleanor and Lisa provide daily visits, help getting out of bed, physio, emotional support.
		Eleanor and Lisa are in contact with Eric's GP
	6 weeks before death	Eric contacted his son, who travels from abroad to move in with him for the rest of his illness. This was a relief to community. There is a delay to getting appropriate levels of care due to lockdown. Eleanor / Lisa coordinate contact numbers and relevant care services with son.
		Group continue to support with rota, food and visits.
Formal Care		Care workers come in to provide daily care for Eric, however the care isn't always suitable.
		Eleanor/Lisa continue to play an important advocacy role for arranging care and supporting Eric. Eleanor, Lisa and Patricia all have had previous healthcare roles, but make a clear distinction in interviews that they are not Eric's carers.
	March 2021	Son arranges Hospice Care for Eric with the support of Eleanor and Lisa. Eric died during the transfer to the hospice – he was at home until the last day.

Care network mapping (Eric)



Care network mapping (Eric)



Conclusions and further questions (1)

All models offer clear benefits that better support members as they age and as care needs increase, from cohousing's informal mutual support to the more formalised built-in services of the 'other' models.

For ***cohousing***:

- Evidence of a reluctance to *plan* for future care needs as groups age. But could groups benefit from external support services, and even advocacy support?
- Could 'succession' planning be improved, to avoid the whole community ageing as a cohort?
- Should housing designs factor in room for live-in care?

Conclusions and further questions (2)

To different degrees, the ‘other’ models are better set up for practical response to transitions to more serious care need.

- But does the ability to defer to staff lead to less group agency and mutual aid, compared to cohousing?
- Is there an over-reliance on key figures, instrumental in the creation and running of such schemes?
- How fair are such schemes on the staff themselves, as they seem to take on a greater burden than their counterparts elsewhere?

This presentation summaries independent research by the National Institute for Health Research School for Social Care Research.

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