Retirement Village and Extra Care Housing in England: Operators' Experience during the COVID-19 Pandemic

RE-COV Study

Full Report

April 2021

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St Monica Trust

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Contents

1 Foreword by Susan Kay

A depressingly recurring theme of the scientific commentary of recent months is that COVID won't be the last pandemic we'll experience. It's therefore essential that we learn the lessons of this one so that we're better prepared. The only way we'll do that is for organisations – however they are funded and owned: private, public or third sector - to work together openly and in the interests of the individuals they serve to share experiences and information. That's why we're delighted to have been able to support this piece of research[1] (spanning both publicly and privately funded providers) and to share it. A huge thank you to those organisations who gave of their time so generously and participated in this research during what has been the most challenging of times.

What is striking about the messages and recommendations set out with such clarity here is their sheer diversity, ranging from housing and infrastructural design and regulation to the small things that can make a big difference in building resilient and supportive communities and contributing to the well-being of isolated and lonely people.

But it's also sobering that some of the issues encountered and their solutions (such as those around housing design and use of technology) were already well known. Take a look at the Housing LIN's resources on designing extra care housing, for instance, and you'll see how thoughtfully designed and well-planned facilities can contribute to positive health outcomes for older and vulnerable people. Yet, despite the fact that we have an ageing population, there is still much to be done in the area of local and national building regulation to capture more of these, very clear, benefits.

We hope that this contribution to the growing body of evidence around the impact of the pandemic, and sharing the solutions that work, will not only be useful to providers who put the real needs of older and disabled people at the heart of their services, but also to government so that it can provide the financial, policy and regulatory infrastructure - and an accessible and helpful communications framework - to enable those providers to continue to do so.

Learning the lessons means acting on them. So please also look out for two more major pieces of work we're supporting: the Commission on the Role of Housing in the Future of Care and Support, led by the Social Care Institute for Excellence and the Technology for an Ageing Population Panel for Innovation, led by the Housing LIN. The former, steered by a cross-sector panel of Commissioners, was established to develop a blueprint for how we address many of the issues set out in this report - and more - and the latter to help seize the opportunity created by the pandemic to drive the 'digital revolution' across housing, health and care and transform the landscape of everyday living environments for older and disabled people. We'll be reporting on those later in the year.

Susan Kay
Chief Executive
Dunhill Medical Trust

[1] We have also supported the National Care Forum in collaboration with the University of Leeds in the COVID-LESS study focusing on the experiences of care homes.

2 Acknowledgements

We would like to thank everyone who completed the RE-COV online survey; we are extremely grateful they were able to take the time to provide their information and insight during what turned out to be highly challenging operating conditions mid-way through the 'second wave' earlier this year.

We also want to thank the members of our advisory groups for their involvement, advice and guidance which has been invaluable in helping us to steer this research and ensure that it is the most useful and informative account of the impact of COVID-19 on retirement villages (RVs) and extra care housing (ECH), and how they experienced and responded to it.

A sincere thank you as well to the Dunhill Medical Trust who, recognising this as an important piece of research, were able to provide the funding to make it happen.

We acknowledge the acute pressure and the lasting effects that the pandemic has had on people, not least those who have lost family, friends, residents and colleagues during this time.

3 Summary of Main Findings

3.1 Operators' pandemic response and its effectiveness

The RV and ECH sector operational responses to the challenges posed by COVID-19 have been proactive, innovative and extensive. New ways of working, adaptations of environments in villages and schemes, enhanced communications, and rapid creation of alternative services, facilities and support are among the wide range of changes implemented.

- **More than half of the operators locked down before the 23 March**, the start of the national lockdown, 35% of those had locked down at least a week before.

- **Operators furloughed more staff during March to July** (an average of around 6) and fewer between August and December (an average of around 2.2).

- **There was consistency across the operators in the range of key measures they put in place to protect the health and well-being of their residents and staff.** The most common were:

  - The use of PPE.
  - Social distancing.
  - Closing communal areas and services.
  - Shielding individuals and restricting visitors.

  Around half indicated that they prohibited visitors, asked residents not to leave the village/scheme, and/or they re-designed spaces or facilities. Many disallowed or discouraged staff car sharing or use of public transport (one respondent pointed out they provided pool cars and some taxis).

- **Additional special measures were put in place to help maintain residents' general health and key aspects of daily living**. The most common being the provision of:

  - Social calls, and advice and information on government guidance.
  - Take away services, delivery of meals, weekly food boxes, shopping, help with access to internet shopping.
  - Village/scheme practice and procedures.
  - Benefit/financial advice, and help with access to GPs, dentists, hospital services and other specialist health professionals.

- **Extra measures were implemented to help maintain residents' mental and emotional well-being**. The most commonly mentioned were: increasing access to and help with digital technology, providing social activities in a different way, enabling social contact with family, friends, neighbours, new befriending, and helping with access to local NHS or social care services for non-COVID-19 related needs.

- **There was evidence of operators continuing their existing step down provision during the pandemic**. One even had extended theirs across more schemes. Others were in the process of setting up step down facilities or looking into doing so. Several respondents indicated they would be able to support the NHS by providing step down facilities for non-COVID-19 patients to smooth discharges from hospital and support their ongoing recovery and rehabilitation.

There is evidence that the operators' response was effective in affording protection to their residents. This is indicated in particular by:

- The overall lower proportion of RE-COV survey participants' residents who died from COVID-19 in comparison to people with the same age profile living in the general population in England (see below for details).
- The positive effects of the lengths that operators and staff took to help support residents' activities of daily living, social engagement, community and personal activities, and create other opportunities for positive experiences.

Their response also generated overall positive experiences for residents and a great deal of positive feedback (described in the 'residents experience' sections).

3.2 COVID-19 cases, deaths and testing

- **Fewer village/scheme residents died from confirmed COVID-19 (0.97%) than expected** from March to December 2020 when compared to people with the same age profiles as village/scheme residents[2] living in the general population in England (1.09%).

  Given the generally higher levels of health, care and support needs of ECH housing residents this is a very positive outcome. The residents of RV-only operators had the lowest COVID-19 death rate (0.51%).

  The highest monthly death rates among residents were experienced in April (0.3%, 42 of 14,580), December (0.2%, 30) and March (0.16%, 24).

- Overall, the majority of operators had no or very few confirmed and strongly suspected COVID-19 cases during each month in 2020; 74% had fewer than 1% of residents with COVID-19 in any of their villages/schemes through to November.

  The total for the year was 545 confirmed COVID-19 cases among 14,580 residents[3], equivalent to 3.74% of the resident population.

- The proportion of residents with COVID-19 varied between operators but there was no apparent association with their total number of residents, or number of villages/schemes, or with other variables asked about in the questionnaire apart from housing type:

  - Operators with both RVs and ECH had 4.76% residents with confirmed COVID-19 in 2020.
  - ECH-only operators had 4.52%.
  - RV-only operators had 1.69%.

  One of the main (or the main) causal factors for this difference is likely to be the higher levels of health, care and support needs among ECH residents.

- The proportion of residents with COVID-19 in 2020 varied between operators but there was no apparent association with the total number of residents or number of villages/schemes, or with other variables asked about in the questionnaire, apart from housing type.

[2] 8% under 70, 29% between 70-79, 48% aged 80-89, and 15% over 90; sourced from ARCO and ProMatura, UK Retirement Communities: Customer Insight report 2019)

[3] Based on data from 31 respondents who provided COVID-19 case numbers and their village/scheme resident population figures.

- There were higher proportions of confirmed resident COVID-19 cases in 2020 among the RV&ECH operators (4.76%), followed by the ECH operators (4.52%), and the least among the RV-only operators (1.69%).

  One of the main (or the main) causal factors for this difference is likely to be the higher levels of commissioned health, care and support needs among ECH residents.

- The most highly suspected sources of resident COVID-19 infections were hospital visit/stays, residents visiting people or shops off site, visitors, and external professionals.

  As with care homes, village and scheme operators had residents coming out of hospital who not been tested or had tested negative but had become ill with COVID-19 very shortly afterwards. One operator commented, "one scheme was massively impacted by deaths in March/April - local hospital appeared to be link."

3.3 What proved effective

The factors operators deemed the most effective at affording protection were:

- Closing communal facilities/activities or restricting residents' access to areas.
- Full PPE/correct use of PPE.
- Restricting and closing to visitors and family when necessary.
- Regular/increased cleaning.

Other protective factors included:

- Asking residents not to leave the village or scheme.
- Social distancing.
- Offering a full delivery service from the site's shop/restaurant to individual apartments.
- Clear and regularly updated resident guidance.
- Encouraging residents and visitors to follow the guidance.
- Monitoring and isolating people quickly if they were showing any signs of potential COVID-19 infection.

Important learning and plans for further localised or national lockdowns shared by operators largely concerned:

- Having in place a set of plans, a model and/or a framework of processes and templates.
- Having plans for specific aspects such as a dedicated COVID-19 command team or governance arrangement in place, team, safe operating procedures, reduced visiting, closure of communal spaces, and home deliveries for residents.
- Effective communication and communications.
- Risk assessments to protect residents and staff.

Effective practice examples given by operators included:

"A structure of operational guidelines, risk assessments and SLA for each tier that can be quickly implemented on a local or national level as guidance changes."

"A central crisis management team who are emotionally removed providing support and consistent advice at all times."

"We contacted each resident daily, for a welfare check and to take their orders for shop and meal deliveries. We have sent out weekly updates and had regular meetings with the residents' association to discuss all changes to the village due to the COVID-19 guidelines." [RV operator].

3.4 The importance of building design

The building design characteristics most respondents felt were important in regard to COVID-19 were:

- A range of communal lounges and other spaces.
- Outdoor spaces.
- Progressive privacy.
- Security.
- Separate entrances.

Other characteristics highlighted were:

- Having doors to apartments' patios, wide corridors (aids social distancing).
- Good ventilation (helps to dissipate the virus if present).
- Shop and food services.
- Pharmacy and GP in close proximity.
- Being able to see people in their homes from corridor.
- Centrally located facilities that can be locked.
- Staff reception at main entrance, staff facilities and office space.

One operator said they had benefited from having care homes on their sites providing expertise in infection and prevention control. In addition, there were important benefits of the self-contained accommodation afforded by individual apartments which ensured residents had control of their own space and the ability to socially isolate if they needed to.

Design characteristics mentioned as being problematic during the pandemic were:

- Communal open plan areas as they could be difficult or impossible to close down.
- Not being able to stop visitors accessing the building.
- Inability to be able to implement one-way systems as most schemes only have one main entrance.
- Not having balconies in all schemes.
- A lack of suitable work/office facilities for staff.

3.5 Main pressures and challenges experienced

- **The major pressures experienced** by villages, schemes and organisations during the pandemic were:

- Anxiety	76%
- Stress	62%
- Nº of staff off work self-isolating	62%
- Nº of staff off work shielding	53%
- Staff shortages	53%
- Keeping up with the changes	50%
- Adapting to the changes	47%
- Low morale	44%
- Burnout	35%
- Staff sickness	35%

- **The lack of availability of PPE caused problems during the first wave for 96% of respondents**: 'a huge amount' of problems for 23% of operators (all ECH or RV&ECH), and 'a lot' or 'quite a lot' for 20%.

  Among the problems caused were cost and logistical issues, anxiety, stress, worry and confidence issues among staff. An operator with eight ECH schemes said, "We made contact with over 600 PPE suppliers and eventually had to spend over £200,000 for bulk orders to secure suitable equipment".

- **Very few residents or staff were tested for COVID-19 until November and December**. The average number of staff who were tested more than trebled in November, to 13 per operator, and again in December, to 37 per operator.

  The availability of tests increased steadily through the year from being 'mostly' or 'always' available in March (from just 5% for staff and 22% for residents) to around 93% for both staff and residents in December.

- **Staffing was a main issue for many operators** due to staff off sick, isolating or shielding, on top of the volume of additional work and tasks needing to be carried out in order to protect people from the virus and support residents during times when facilities, services, and family/friend visits were reduced. Some local authorities provided some compensation for this, but others did not.

  The number of staff with either confirmed or strongly suspected COVID-19 averaged at around two per operator between March and April, and between October and November; there were very few during June to August, but in December there was a higher average of four cases per operator.

- **The biggest challenges** commonly mentioned by operators were:

  - Residents and visitors not understanding or adhering to guidance.
  - Maintaining the well-being and safety of residents' and staff; staffing / staffing levels.
  - The constantly changing government guidance, volume of guidance, and keeping up with all the changes of which one operator said, "there was in excess of 40 between March and May".

  Also listed by several were:

  - Lack of availability of testing.
  - Accessing PPE.
  - Lack of government leadership and guidance specific to RVs and ECH which caused a lot of discrepancies and work.

  There were a variety of additional difficulties mentioned such as, "complexity of testing when it finally arrived" and, "maintaining occupancy levels".

- **Many issues were caused by the lack of understanding or awareness of housing with care**.

  More than half of operators, a mixture of RVs and ECH, said they had encountered issues due to local health and social services not fully understanding what retirement villages and extra care housing offer, or how they operate. For example,

  "Initially there were challenges in everyone being on the same page as to what the EC schemes could and could not offer, especially around the hospital discharge of individuals with COVID-19 and the ability for ourselves as landlords to control the extra care environment." [an operator with over a hundred ECH schemes].

  - Nearly half of operators said that they had made use of their Local Resilience Forum(s) during the pandemic, the majority (73%) were ECH operators. However, respondents' comments indicated that **the forums were not always helpful, or able to help**. One said,

  "We encountered issues due to capacity in social care and health services."

  and another,

  "Local Resilience Forums expected housing operators to pick up customer needs, health and social care assumed a higher level of service provision on discharge from hospital."

- **Working out when and how to bring services and facilities back online** in a safe and practicable way was included by a few operators as a significant challenge ahead.

3.6 Financial impact of the pandemic

The impact of the pandemic has been financially damaging for both RV and ECH operators and, furthermore, many of the additional costs and losses it has generated are still on-going.

Up to February 2021, the major financial pressures have resulted in:

- An estimated average loss of -£723 per resident and -£327,415 per operator.
- An estimated overall loss of -£12.5 million for the group of 38 operators who participated in the study.

More concerning is that these figures are likely to be underestimations; many of the operators' stated cost figures were not fully comprehensive of all additional costs that would have been incurred.

The main sources of any costs, losses, savings and financial support are shown below.

- **Highest costs due to the pandemic were:**
  - PPE and hand sanitiser (90% said this was 'very/quite high').
  - Additional cleaning and laundry (82% 'very/quite high').
  - Additional staffing* (53% 'very/quite high').

  * Additional staffing needed, for example: to cover for staff who were off sick, shielding or isolating; for the additional time required to plan, implement and carry out procedures and tasks incorporating enhanced safety and updated guidelines; and to take on residents' unmet needs arising from the absence of family or friend's visits.

  Other additional costs specified by operators were signage, equipment, void losses, paying overtime at enhanced rates and the top up on furlough.

- **Largest sustained losses were from:** 'reduced village or scheme occupancy' (indicated mostly by ECH respondents) and 'reduced or suspended restaurant or café services'. The other main causes of losses specified were closed/reduced facilities and services, fewer sales and reduced income from rent.

- **Savings: many operators stated no savings had arisen from the pandemic for them**. Only ten respondents identified sources of savings with furlough by far the most common (chosen by nine of the respondents, the vast majority of them RV operators). Reduced restaurant/café food purchases were also mentioned by three.

- **Financial support**: almost three quarters said they had not received any financial support, this included organisations across the range of sizes and housing types.

  What is more, lack of funding, and inconsistent processes of funding, were both mentioned as being among the biggest challenges they were facing. Some operators said they had been able to access some funding from the Government's *Adult Social Care Infection Control Fund* via Local Authorities.

  One RV&ECH operator said their Local Authority had provided 10% of their income in first lockdown to enable them to provide more support in a flexible way.

3.7 Residents' experience

Residents have clearly gained great benefit during the pandemic from the community, care and special support provided by the villages and schemes who, in the words of one resident, went 'above and beyond' in order to help protect their health and well-being. Outcomes for residents included a high proportion feeling safe, supported, and comforted knowing other people were around, as well as enjoyment from organised outdoor activities.

In order to keep their residents as physically, mentally, and emotionally well as possible operators and staff demonstrated considerable commitment, ingenuity and resourcefulness. As well as offering constant COVID-19-related guidance and support, they have provided an extensive amount of additional help, facilities and resources. These have ranged from supplies of hand sanitiser stations, digital tablets and hot meals delivered to apartments, to help with shopping, getting online and keeping in touch with family and friends. There were many examples of special diversions and thoughtful extras being organised such as sing-alongs on balconies/in gardens, ice cream van visits, and gifts of spring flowers and chocolate eggs at Easter.

Such activities and support would have helped to alleviate some of the negative effects of the pandemic being experienced by older people in the general community as well, such as loneliness, worry and boredom. It may have particularly benefited the groups of residents who operators felt were more adversely affected through the lockdown periods: those shielding, living with dementia or other long-term condition, or without family or people who could visit.

Large numbers of operators were also very active in helping their residents to access the hospital and community health services for non-COVID-19 issues. Residents had experienced 'a great deal' or 'quite a lot' of difficulty accessing services such as GPs, dentists, opticians, and physiotherapists, particularly during the first lockdown. The range of support provided in one village inhabited by 100 residents included staff picking up dozens of prescriptions for residents and driving 3,100 miles taking them to appointments.

Residents and their families have shown a great deal of satisfaction and appreciation to village and scheme staff. These are some examples of the large numbers of thankyous received by operators,

"We felt very safe and well looked after during lockdown. All our friends said they wished that their conditions had been as good as ours!"

"All the extra work organised and carried out to keep us safe has been amazing."

"Staff were all excellent all the way through. The concierge kept us all cared for – so much patience, nothing was too much trouble."

"We have received overwhelming feedback and gratitude for the way in which we have managed the pandemic both within the villages and the local communities. Most feel that the pandemic has confirmed that their decision to move into a retirement community was the right thing to do. This has been echoed by family members."

3.8 Key concerns going forward

The vast majority of key concerns going forward listed by operators related to:

- Resident well-being.
- Staff well-being.
- Loss of revenue.
- Financial pressures.

The particulars frequently mentioned included:

- Isolation, loneliness, reduced social contact, impact on mental and physical health, ongoing frustrations and weariness, staff morale, workload and ongoing stresses.
- The impact of delays on unit/property sales or lettings, and costs of cleaning.
- Getting vaccinations completed, worries about how long they will protect for, whether they will lead to complacency, and how many may not want to have the vaccine; recruitment to frontline roles and how 'non-essential' services can be reintroduced safely.

Less than half of operators agreed they had 'quite a lot' or 'a great deal' of confidence that the NHS 'track and trace' app[4], and increased testing, for staff would help them to minimise the incidence of COVID-19 in their villages/schemes in the coming months.

3.9 Who took part in the study?

38 operators took part in the RE-COV survey, submitting completed questionnaires between 16 December 2020 and 16 February 2021; 58% were ECH, 24% were RV, and 18% were operators of both RV&ECH.

As a group **they were providing 62 RVs and 387 ECH schemes for older people, with altogether more than 25,864 residents**. This represents around 41% of the known retirement village market, and 33% of the extra care housing market.

The operators included a range of small, medium and large sized organisations; the majority (68%) were from the not-for-profit sector. They provided a wide range of sizes of villages and schemes located across all the main regions in England.

[4] The name of the NHS COVID-19 contact tracing app when it was launched October 2020 (https://www.ncic.nhs.uk/news/please-download-nhs-covid-19-track-and-trace-app).

4 Introduction

4.1 Purpose of the study

When the COVID-19 pandemic began in March 2020, it created particular challenges and experiences for those living and working in retirement villages (RVs) and extra care housing (ECH) and continues to do so more than a year on. Very little robust evidence existed in the public domain about what the pandemic's impact had been in these housing-with-care settings.

- How had it affected the housing-with-care operators, their staff and residents?
- How had operators responded to the pandemic?
- What had their innovations and successes been, and what were the key ongoing challenges?

Funded by the Dunhill Medical Trust, undertaken by St Monica Trust and supported by the Housing LIN (Learning and Improvement Network), this RE-COV study aimed to address these gaps with the view to sharing evidence to inform future operational decisions and practices, influence national policy developments, and raise awareness of the RV and ECH COVID-19 experience in England.

4.2 Timeframe and significant dates

The survey questions related to the period from the beginning of the 'first wave' (March 2020) to mid-way through the 'second wave'. This was largely prior to the introduction of the vaccination regime and covered two national lockdown periods.

Significant dates in 2020 arising from the pandemic	
23 March	England entered first lockdown.
10 May	Public message is switched from 'stay at home' to 'stay alert'.
13 June	The first 'social bubble' scheme announced: single person households allowed to meet and stay overnight with another household.
15 June	Non-essential shops and places of worship reopened.
4 July	Pubs, cinemas and restaurants reopened.
24 July	Wearing face masks became mandatory in shops.
6 September	Largest UK daily figure of COVID-19 cases since 22 May reported (2,988).
14 October	The number of new COVID-19 cases in a week increased to 224,000. England moved to a three tier COVID system with areas separated based on infection rates and subject to different lockdown restrictions.
5 November	England entered second lockdown.
2 December	A more stringent three tier system of COVID-19 restrictions came into force as the second lockdown ended.
8 December	First member of the public received COVID-19 vaccination.

4.3 About retirement villages and extra care housing

RV and ECH schemes both provide self-contained, age-designated[5] accommodation for independent living, with access to a range of communal facilities (cafés, restaurants, leisure facilities) and care services. Also known as housing-with-care, RVs and ECH are completely different settings compared with care homes (some retirement villages do however have care homes within them): residents have their own self-contained home within a village or scheme, either as a tenant or owner. Their ethos, environments and services focus on independence, well-being and enabling best later life living.

The majority of apartments in RVs are for sale while much of the provision in ECH is social rental apartments with links to Local Authority adult social care commissioning. This difference results in higher levels of need and frailty among those living in ECH. The average age of both village and scheme residents is around 83 years of age; approximately 8% are under 70, 29% are between 70-79, 48% are aged 80-89, and 15% are over 90[6]. There are no officially recognised definitions of RVs and ECH however they have the typical characteristics outlined below.

ECH schemes typical characteristics

- ECH is mainly provided by housing associations and other types of social landlords including charities. There are a small number of private operators.
- The majority of residents in ECH are tenants; a minority are leaseholders. Most rental properties are run by local councils and housing associations who have a set of eligibility criteria to qualify for a place.
- In general, ECH is designed to accommodate older people who have some care and support needs when they move in.
- Most ECH schemes have provision for on site 24-hour care that is predominantly for older people who are likely to be eligible for local authority funded care, however ECH schemes also accommodate older people who self-fund their care. ECH schemes are not usually co-located with a care home.
- Most ECH services require the provider to be registered for the regulated activity 'Personal care' and sometimes also 'Accommodation for persons requiring nursing or personal care', and care services are inspected by the Care Quality Commission (CQC) (who also inspect care homes).

RV typical characteristics

- RVs are mainly provided by private sector organisations with some operated by not-for-profit organisations.
- RVs put emphasis on attracting customers who are looking for an active lifestyle after retirement with added peace of mind that any help or assistance they might need in the future is close at hand.
- Most RV schemes have on site care that is predominantly for older people who self-fund their care.
- A majority of residents in RVs are owner occupiers (typically leaseholders); a minority rent (at market rents and/or at social rents).
- Some RVs are co-located with a care home.

[5] This study focused on ECH for older people.
[6] ARCO and ProMatura, UK Retirement Communities: Customer Insight report 2019

The following operating models occur in both ECH schemes and RVs:

- All services operated by one organisation, i.e. a single housing and care provider.
- Services provided by different organisations, i.e. separate housing and care providers.

There are currently around 280 operators of RVs and/or ECH schemes for older people in England, together providing an estimated 151 RVs and 1,300 extra care schemes.

4.4 Collaborators involved in the study

Study Team Members

- Rachael Dutton from the St Monica Trust was the study's research proposal writer, Project Manager and led on the questionnaire design, data analysis, interpretation and report writing.
- Darius Ghadiali, Lois Beech, Ian Copeman and Jeremy Porteus from the Housing Learning and Improvement Network were study partners who led on the survey implementation and communications with the RV and ECH operators, and contributed to the project development, reporting and dissemination activities.
- The Dunhill Medical Trust, the study's project funders.

See *Partner organisations* on 70 for more information.

Advisory Group Members

- Jane Ashcroft: Chief Executive, Anchor Hanover & Board Member, National Housing Federation (NHF).
- Kathleen Dunmore: Housing Policy Consultant, Retirement Housing Group.
- Aileen Evans: Group Chief Executive, Grand Union Housing Group, and President, Chartered Institute of Housing (CIH).
- John Galvin: Chief Executive, Elderly Accommodation Counsel (EAC).
- Shirley Hall: Head of Innovation and Wellbeing, ExtraCare Charitable Trust.
- Liz Jones: Policy Director, National Care Forum (NCF).
- Michael Voges: Executive Director, The Associated Retirement Community Operators (ARCO).
- David Williams: Chief Executive, St Monica Trust, and Board Member, National Care Forum (NCF).

4.5 Acronyms used

ARCO	The Associated Retirement Community Operators
EAC	Elderly Accommodation Counsel
ECH	Extra care housing
HLIN	Housing Learning and Improvement Network
RV	Retirement village
RV&ECH	Retirement village and extra care housing (in relation to respondents who operate both).

5 Aims and Objectives

Study Aims

- To understand how UK retirement village/extra care housing scheme operators and their residents have experienced and responded to the COVID-19 pandemic.
- What measures have been taken to preserve staff and resident well-being and the effectiveness of these.
- To share organisational learning about key challenges, innovations and accomplishments so far, as well as concerns, requirements and plans for the next 6-12 months.

Study Objectives

To discover:

- How many residents and staff have had confirmed or strongly suspected COVID-19 in each village/scheme.
- How many residents have died from COVID-19 in each village/scheme?
- Extent of testing and difficulties accessing testing.
- The top challenges and pressures villages and scheme operators faced and are facing now.
- What their key protocols, innovations and successes have been.
- Views (with evidence where possible) on whether residents felt living in a retirement or extra care village during the pandemic made a positive difference for them and helped to keep them safe.
- What the financial impact of the pandemic has been on each village/scheme or organisation.
- The additional steps taken by operators to support staff and residents' well-being and daily living during lockdown.
- Views on the key factors that made the biggest difference in protecting their residents from catching COVID-19, helping their residents adapt to the lockdown and pandemic, and helping their residents to maintain their well-being.
- What financial and other local or national support they have received.
- What specific learning points, concerns and unmet needs they have for the next phases going forward.
- To inform and influence government policy, guidance and good practice in relation to COVID-19 and the RV/ECH sector.

6 Study Approach and Research Methods

The study sought information and insight via an online questionnaire survey, with a sampling frame provided by the Elderly Accommodation Counsel (EAC)[7] and administered by the Housing Learning and Improvement Network (HLIN)[8].

Questionnaire data collection tools

Two questionnaires were developed by the COVID-19 National Research Project Lead at St Monica Trust in partnership with the HLIN and the EAC. Feedback and suggestions on aims, objectives, content and approach were sought from a range of other operators, and several reviewed the final drafts.

There was a 'main' questionnaire for operators to complete, and a short 'village/scheme level' questionnaire for operators or their villages/schemes to complete for individual sites if they were able to do so.

The survey

An invitation letter to take part in the survey was sent on 16 December 2020 by the HLIN to all known RV and ECH for older people operators (around 270 in all).

Links to the two questionnaires, to be completed online on SurveyMonkey, were contained in the letter and email message, as well as wider promotion on the HLIN's website and weekly bulletin.

In addition, the Associated Retirement Community Operators (ARCO)[9] promoted the survey to their membership offering, for those who wanted to remain completely anonymous, to collate and forward on their submitted information.

Given the further intensification of challenging circumstances due to the new, more contagious COVID-19 variants taking hold at the time of the survey, its completion deadline was extended twice in order to give more operators the opportunity to be able to participate.

Notifications about deadline extensions and reminders about the survey were sent out by email. A final alert to operators, emailed on 1 February, notified that the survey would need to close on 8 February.

In addition, the HLIN team followed up individually with a) the largest operators, b) operators who had started but not yet completed a questionnaire, and c) others who had previously shown interest in taking part but had not yet started to fill out a questionnaire on SurveyMonkey.

The survey sample

Details of retirement villages and extra care scheme operators in England, along with number of villages, schemes and units, was provided by the EAC and the HLIN.

The study's survey sample dataset included 271 housing operator organisations who operate around 1,450 retirement villages and schemes (schemes comprising of, or containing, extra care housing) with 63,794 ECH units housing an estimated 100,000 residents.

[7] http://www.eac.org.uk/
[8] https://www.housinglin.org.uk/
[9] https://www.arcouk.org/

Data analysis and reporting

Comparisons of responses based on housing type, size of operator and other key variables were carried out during the analysis and any noticeable differences included in the report.

Questions where respondents were asked to tick items from a list to show which applied to them, response percentages were calculated based on the 34, the number of survey respondents who answered most of the question; four respondents had mainly answered the first sections only (i.e. providing details of their services, residents, staff and COVID-19 cases, deaths and testing).

Some finer details have purposefully been left out in the reporting of findings so that individual operators or villages/schemes cannot be identified in order to maintain the anonymity of all survey participants.

Advisory Group

A range of individuals representative of older people's housing and care sectors kindly accepted invitations to join the RE-COV study advisory group.

They offered valuable insight and advice to help guide the work of the project, the final reports and dissemination of findings. The group met three times between January and April.

7 Survey Findings

Very few of the shorter 'individual village/scheme' questionnaires were returned (these asked for data regarding details of the site along with numbers COVID-19 cases, deaths, people tested and furloughed staff only). There were too few unfortunately to provide any meaningful findings therefore this report focuses on analysis of data from the returned 'main' questionnaires, completed at an organisation-wide level.

7.1 Survey participants

Response rate

38 operators submitted completed questionnaires between 16 December 2020 and 16 February 2021[10], a 14% response rate. This exceeded expectations[11], especially given the fact that the main questionnaire was lengthy, and housing and care operators' resources were particularly stretched during that time following the emergence of the new COVID-19 variant.

Named and anonymous respondents

34 respondents completed they survey online through SurveyMonkey, all of whom had provided the name of their organisation. The majority had filled in most of the sections, including their number of residents (important for calculating rates per resident for COVID and financial figures).

Four retirement village operators chose to complete their questionnaire offline before sending it to ARCO to be forwarded on anonymously. Their resident figures, number and location of villages were not included by these operators individually but were supplied by ARCO separately as a total for the group of four together.

Importantly, the submissions received provide a good representation of the sector.

The operator participants together operate 62 RVs and 387 ECH schemes. They:

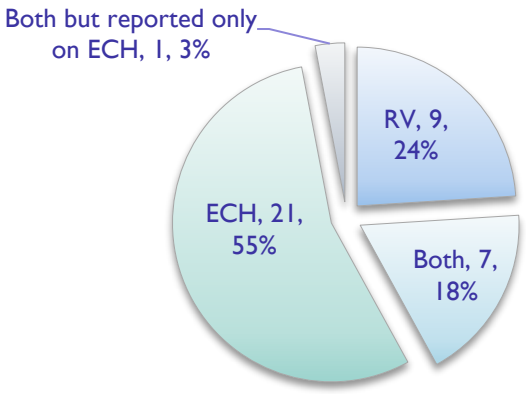
- Represent around 36% of the RV/ECH market share, with approximately 41% of the retirement villages in England and a third of all extra care schemes in England.
- Represent around half of the largest 40 organisations operating RVs and ECH for older people.
- Comprise a range of small, medium and large organisations.
- Have RVs and ECH covering all areas of England.

[10] A further 3 had started but had only provided information about the characteristics of their schemes so were discarded from the main dataset.
[11] Average response rates for external and online surveys range between 10% - 30% depending on the survey type and other variables.

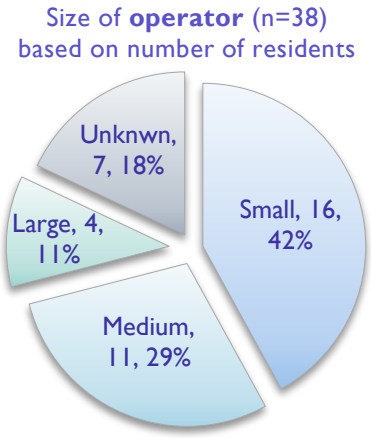
7.2 Operator Organisations' Characteristics

Housing type operated

- 21 of the operators (55%) operated extra care housing schemes.
- 9 operators (24%) operated retirement villages.
- 7 operators (18%) operated RV&ECH.
- 1 operator (3%) operated RV&ECH but reported only on their ECH when completing the questionnaire.



Size of operators based on their number of residents



For the purposes of this report, the sizes of the operator organisations have been categorised in the following way:

Small: up to 250 residents (42%)
Medium: 251-999 residents (29%)
Large: 1000+ residents (11%)

Number of retirement villages

The 38 respondents indicated they were operating **62 retirement villages** between them, 41% of the known 150 to be in operation in England (EAC 2020). The number they had ranged from zero to six, *although some of the four anonymous RV respondents are very likely to have had more*:

- 47% (18 operators) stated they did not have any RVs (they were ECH only).
- 18% (7) had one.
- 6% (2) had two to four.
- 8% (3) had five or six.
- 21% (8) did not give a reply, among them were the four anonymous RV respondents who as a group had 24 retirement villages between them.

Number of extra care housing schemes

Operators who completed the main survey indicated they had a **total of 387 ECH schemes**, equating to around a third of the extra care housing market in England. There is a wide variance in the number of schemes the respondents each have, from zero to around 140:

- 24% did not have any ECH (they were RV only).
- 68% operated between one and 15 ECH schemes.
- 8% operated over 100 ECH schemes.

Table 1 (right) provides the number of extra care schemes operated.

Table 1: Number of extra care schemes operated

Nº of schemes	Nº of operators	% of operators
0	9	24%
1	7	18%
2-5	11	29%
6-15	8	21%
40-50	1	3%
100-140	2	5%
Total	38	100%

Type of provider

66% (25 organisations) were operators in the not-for-profit sector, 11% (4) in the private sector, 8% (3) were in the statutory sector[12], and 15% (6) of the operator organisations were of unknown status.

On site care services

58% (18) of the 33 responses said other organisations provided their care services in their villages or schemes. 39% (12) provided the care themselves, and 3% (1) provided the care along with other organisations.

Table 2: Who provides care services for operators' village/schemes

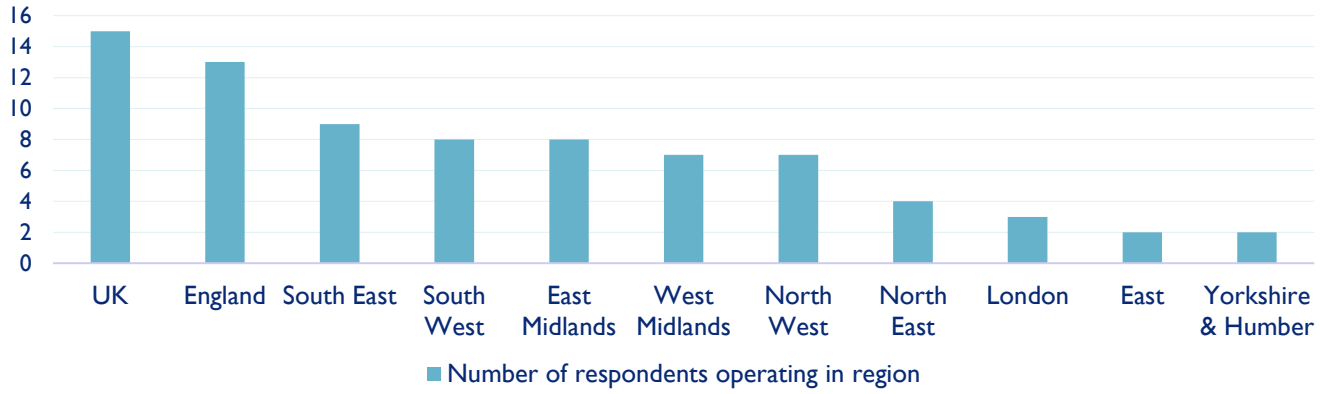
On site Care Operator	Nº of operators
Other organisations	18
The operator themselves	12
The operator plus others	1
(blank)	7
Total	38

[12] information provided from an EAC dataset and desktop research.

Regions of England with villages/schemes operated by respondents

Chart 1 (below) shows the minimum number of operators by geographical area; location details were not given by five operators, and four selected 'England' or 'UK' only but did not confirm the regions covered.

Chart 1: Geographical locations of respondents' (n=33) villages and schemes



Design and service features of the villages/schemes

This section presented a list of the key design and service features that could affect:

- How easy or difficult it is to prevent COVID-19 from entering or spreading within a village or scheme, and
- The measures that could be put in place to help keep residents and staff safe and well.

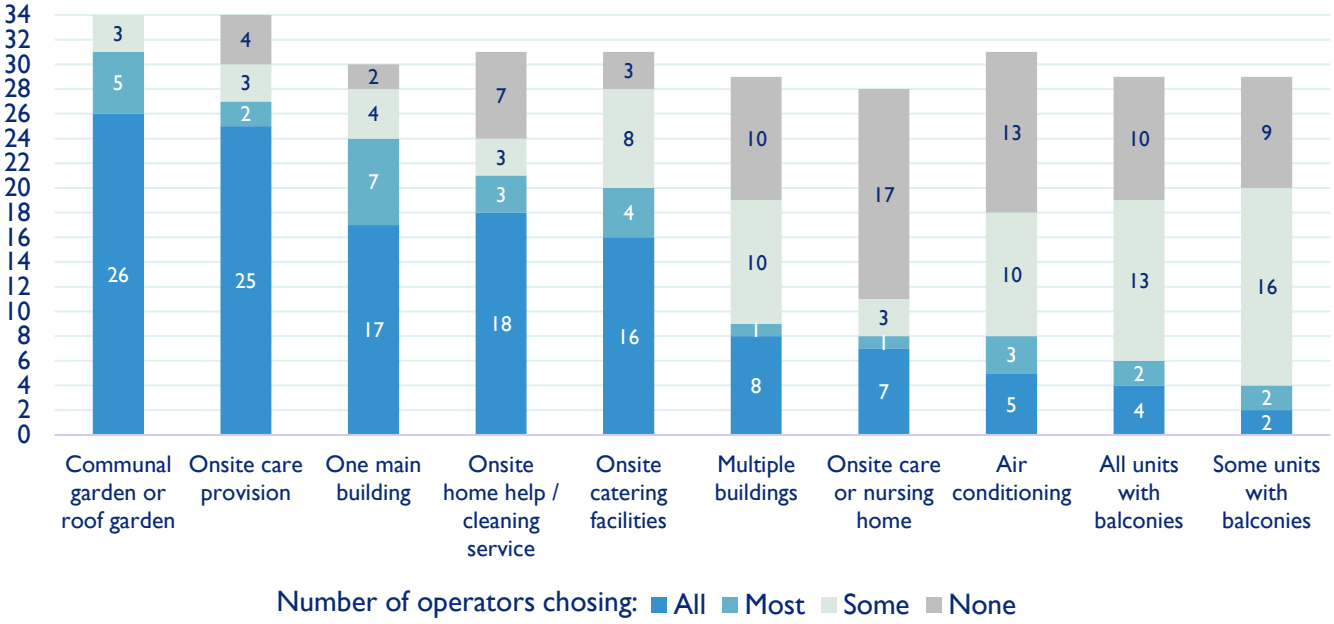
Between 28 and 34 operators ticked a response choice for the features in the list. Table 3 (below) shows the proportion of those who chose 'all' or 'most' (rather than 'some' or 'none'):

Table 3: Characteristics of operators' villages/schemes, with percentage of respondents who chose 'all' or 'most'

Characteristic	% of respondents
A communal garden/roof garden	91%
On site care provision	79%
One main building	80%
On site home help or cleaning services	68%
On site catering facilities	65%
On site care or nursing home	29%
Air conditioning	26%

Chart 2 (overleaf) shows the full breakdown of responses relating to the operators' village/scheme design and service characteristics.

Chart 2: Design and service characteristics of operators' (n=28 to 34) villages/schemes



Additional building/design characteristics deemed important in relation to COVID-19

Participants were asked if there were any other building or design characteristics that they felt are important in relation to COVID-19 other than those listed in the previous question. 29 replied (with 8 saying they could not think of any others).

The most common additional characteristics mentioned were: having a range of communal lounges and other communal spaces, outdoor spaces, progressive privacy and security, and separate entrances. Comments included:

"A range of communal spaces which became important for limited socialisation and exercise"
[ECH operator, 100+ schemes]

"Communal gardens ensure a safe environment for tenants and enabling them to have exercise and fresh air."
[ECH operator, 7 schemes]

Other characteristics cited included having spacious buildings, wide corridors, staff reception at main entrance, good ventilation, and shop(s) on site:

"The village shop was a lifeline as I couldn't get a delivery slot for 6 weeks. I think it is very useful to have essentials onsite, particularly for those shielding or with no transport."
[RV resident]

Table 4 (overleaf) shows the additional building/design characteristics that are important in relation to COVID-19, and the number of operators who cited each one:

Table 4: Other building/design characteristics important re. COVID-19 mentioned by operators

Important characteristic	Nº of operators
Range of communal lounges/spaces	6
Outdoor space(s)	5
Progressive privacy/fob entry/secure (important for limiting ad hoc visitors)	4
Separate entrances	4
Individual apartments	2
Downstairs doors to apartments' patio	2
Spacious buildings (aids social distancing)	2
Wide corridors (aids social distancing)	2
Staff reception at main entrance	2
Staff facilities and office space	2
Partly bungalows	2
Good ventilation (helps to dissipate the virus if present)	1
Care homes onsite providing expertise in infection and prevention control	1
Village shop and on site food services (preventing residents from needing to leave site)	1
Pharmacy and GP next to complex	1
Centrally located facilities that can be locked and ones that are not open plan - secure and enclosed	1
Being able to see people in their homes from corridor	1

Number of residents living in respondents' village/schemes

A total of more than 25,864 residents were living in the 38 respondents' village and schemes. This figure excludes residents from 9 ECH schemes run by two operators who did not provide a figure. It does however include the anonymous RVs for which resident numbers were subsequently provided as a total for the four operators.

The total resident numbers per operator ranged from 64 to over 7,000 (see Table 5). The majority (72%) had between 50 and 499 residents.

Table 5: Number of village/scheme residents of the 32 operators who each provided a figure

Total nº of residents	Nº of operators	% of operators
50 – 99	6	19%
100 – 249	9	28%
250 – 499	8	25%
500 – 999	5	16%
1,000 – 2,500	2	6%
4,500 – 4,999	1	3%
7,000 – 7,499	1	3%
Total	32	100%

7.3 Resident COVID-19 cases

Confirmed and strongly suspected resident COVID-19 cases

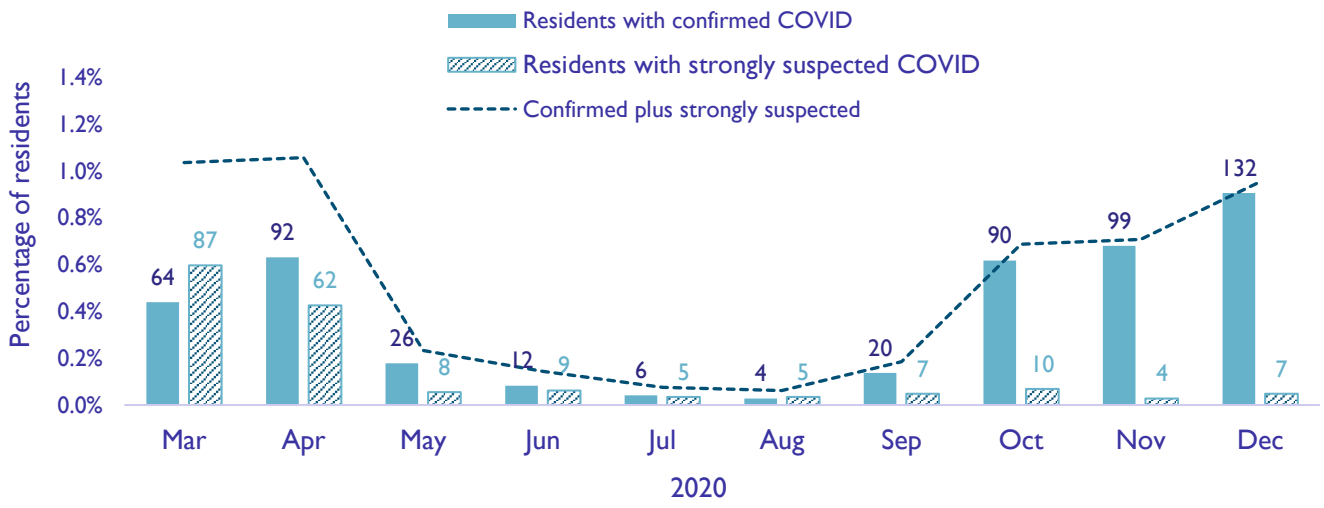
Within a group of 31 operators[13], between March and December 2020 there was a total of:

- 545 confirmed COVID-19 cases among 14,580, equivalent to 3.74% of the population
- 762 confirmed and strongly suspected cases among 14,580 residents, equivalent to 5.23% of their population.

The highest proportion of residents with confirmed COVID-19 in any month was in December (0.91%), followed by November (0.68%), April (0.63%) and October (0.62%) (see Chart 3).

During the first wave of the pandemic there was less access to testing, hence the higher numbers of strongly suspected cases seen during April and May (these were submitted by five respondents, one an ECH operator with over 1,000 residents). The confirmed plus strongly suspected cases (represented by the dashed line in Chart 3 below) peaked at 1.15% in March and 0.93% in December. Very few residents had known or strongly suspected COVID-19 during May to September.

Chart 3: Percentage of 31 operators' village/scheme residents (n=14,580) with COVID-19, confirmed and strongly suspected, by month (actual number of cases shown above the bars)

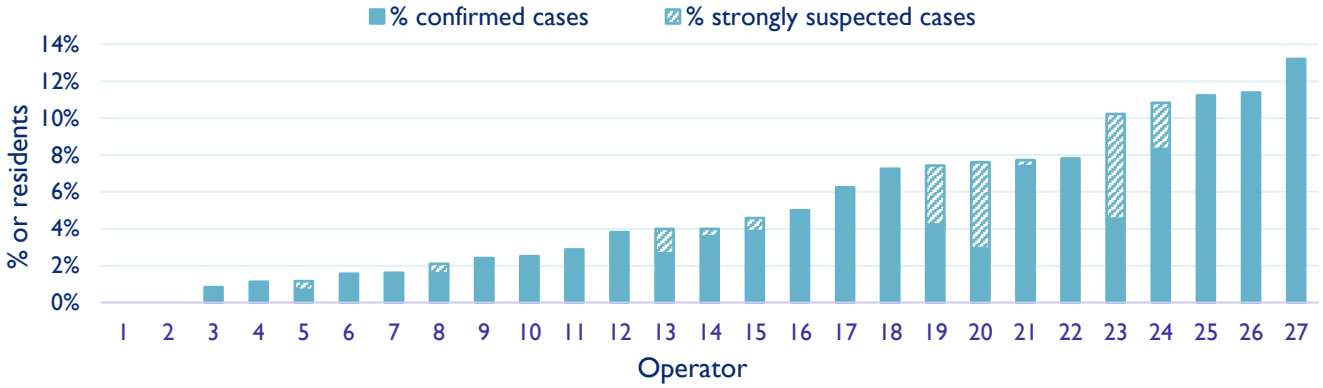


Looking at each of the 27 operators whose resident numbers were known, the proportion of residents each of them had with confirmed and suspected COVID-19 in total in 2020 varied widely, ranging from 0% to 13.2% (see Chart 4). Fifteen of them had a yearly total of less than 5%, seven had 5% to 9%, and five had 9% to 13% residents with confirmed or strongly suspected COVID-19.

There were two operators with no cases at all, one with 65 residents in an ECH scheme, the other with around 150 residents in a RV. The five operators with the highest proportion of confirmed/strongly suspected resident cases comprised 3 ECH operators, 1 RV operator, and 1 RV&ECH operator with resident numbers from 80 to 500.

[13] survey participants with known COVID-19 case numbers and resident population figures (as a group for some)

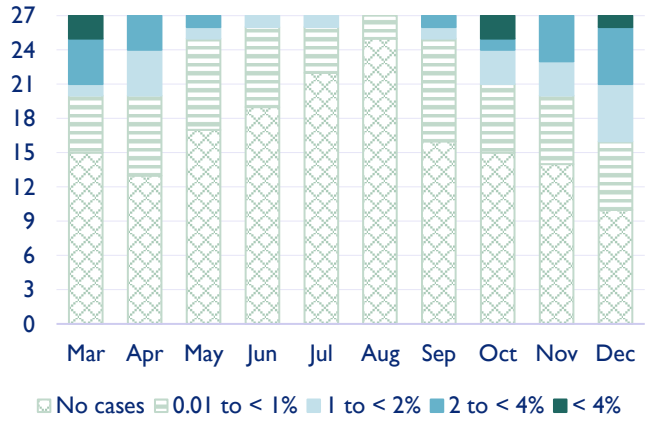
Chart 4: Proportion of residents per operator (n=27) with confirmed and strongly suspected COVID-19 in 2020, in ascending order



Looking at the totals within each month, the majority of operators had no or very few confirmed and strongly suspected COVID-19 cases (see Chart 5, right).

- In any one month 74% of operators[14] had fewer than 1% of residents in all their villages/schemes with confirmed or strongly suspected COVID-19 through to November, many of them had with no cases at all.
- In March, there were six operators with over 2%: four with between 2% to 3.8%, one with 4.5%, and one with 7.8% (the highest per operator in any one month during 2020).
- In December, again six operators had over 2%: five had between 2% to 3.99%, and one had 4.17%.

Chart 5: Number of operators (n=27) by proportion of residents with confirmed or strongly suspected COVID-19 by month in 2020



Associations with resident COVID-19 cases, and details regarding the lowest and highest case rates

No overall associations were found between the number of confirmed, or confirmed plus strongly suspected resident COVID-19 cases and the other variables asked about in the questionnaire[15], apart from housing type which is reported on in the next section (page 30).

That is not to say no other links or dependencies exist between any of the variables, or groups of variables, but it would require a large dataset at individual village/scheme level in order to uncover what they were.

To provide additional insight, the rest of this section presents case study details of the operators who had the lowest and highest proportions of residents with COVID-19 in 2020.

[14] 20 of the 27 operators whose resident numbers were known for each

[15] including numbers of residents, numbers of villages/schemes, building design features, availability of PPE, suspected sources of infection, availability of testing, and air conditioning.

The three operators with the least percentage of residents with COVID-19 interestingly all had only one village/scheme, and all said they had experienced only 'a small amount of problems' from lack of availability of PPE.

Two of these had no cases at all throughout 2020 and both had just one village/scheme situated in the South West (likewise for three of the other 27 operators):

- One had a RV with around 250 residents, multiple buildings with separate entrances, and all apartments with balconies. They said tests for both residents and staff were mostly available when they needed them. Top challenges were making sure everyone obeys the rules and, "keeping staff happy as very busy".

- The other had an ECH scheme with around 70 residents, one main building, no balconies, and an on site care or nursing home. Tests were mostly or always available for residents only in November and December, but during most of the months for staff. Top challenges were keeping up with the changes initially, staff morale and anxiety, delivering meals to residents, and covering shifts whilst staff were shielding or isolating.

Both of these schemes had:

- Communal garden or roof garden.
- On site care provision.
- On site home help/cleaning service.
- On site catering facilities.

A third operator (RV) had no cases until December when 1.14% of their residents were confirmed with COVID-19. They also had just one village, with around 90 residents. It had multiple buildings, gardens, and a care or nursing home.

This operator provided the care themselves. They said that tests for residents were 'never' or 'seldomly' available when they needed them until September, and that they experienced 'quite a lot' of problems due to lack of availability of PPE. They strongly suspected the sources of infection were:

- Hospital stays.
- Other residents.
- Residents visiting people or shops off-site.
- External professionals and visitors.

As their biggest challenges, they cited "lack of government guidance and leadership" and "lack of testing".

The two operators with the total highest proportion of residents with confirmed/strongly suspected COVID-19 cases in 2020 had higher numbers of villages/schemes. However, **the operator with the third highest cases** only had one village/scheme.

The highest proportion (13.2%) was experienced by an RV&ECH operator with around 300 residents. They had cases during March to May then September to December. They had around 12 villages/schemes, all with one main building, gardens, and on site care provided by another organisation; some had a care or nursing home.

They did not specify if a lack of PPE caused any problem and said that tests for residents were 'mostly' available in May, and 'always' by July. They strongly suspected the following were sources of infection:

- Hospital stays.
- Other residents.
- Residents visiting people or shops off-site.
- External professionals and visitors.

The second highest proportion (11.4%) was experienced by an ECH operator with around 500 residents and eight schemes. Their cases were March to May and September to December (the same as the case above).

Most of their schemes consisted of one main building, all with gardens, multiple communal lounges, their own on site care, catering and home help/cleaning. Tests for residents were only 'mostly' available from August and 'always' in December.

They were 'certain/almost certain' infection sources were:

- Hospital stays.

And 'strongly suspected':

- Residents visiting people or shops off-site.
- Visitors coming into schemes.

Lack of PPE caused 'a huge amount' of problems. The biggest challenges they listed included access to PPE, keeping up with changes and, "Inconsistent response from PHE in relation to outbreaks and response required."

The third highest (11.2%) was experienced by an RV operator with just one village and around 90 residents. The cases occurred in March, May, September (peaked here at 5.6%) and December.

The village has individual houses and bungalows with communal gardens, no on site care but had on site home help/cleaning. Tests for residents were 'mostly' or 'always' available, and the same for staff from April.

The operator was 'certain/almost certain' a source of infection was

- Hospital stays.

and 'strongly suspected'

- Residents visiting people or shops off-site.

A lack of availability of PPE only caused 'a small amount' of problems.

One of their stated top challenges was, "encouraging some individuals to socially isolate, when they don't want to and refuse to accept the danger."

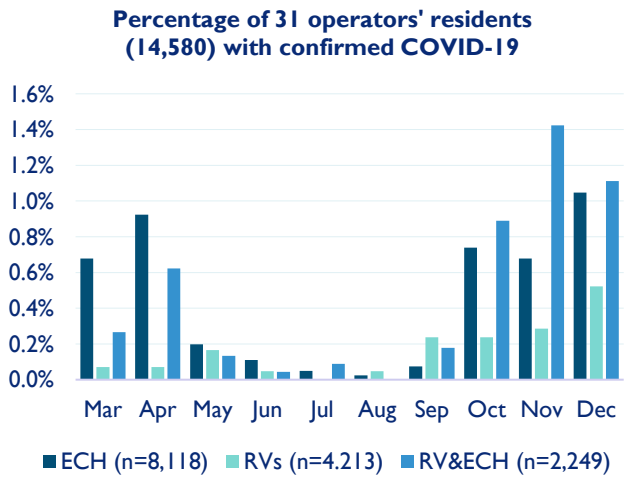
Variations in numbers of resident COVID-19 case rates by housing type

By housing type, there were proportionately more residents with confirmed COVID-19 during 2020 among RV&ECH operators, and the least among RV-only operators:

- 4.76% RV&ECH operator residents were confirmed to have COVID-19 (107 of 2,249).
- 4.52% ECH operator residents (367 of 8,118).
- 1.69% RV operator residents (71 of 4,213).

The higher level of health, care and support needs among ECH residents is likely to be a main causal factor for this difference; within the housing type groups there was a range of sizes of operator, number of villages/schemes, and known building/design characteristics. Chart 6 below shows the percentage of residents with confirmed COVID-19 by type of housing operator for each month in 2020.

Chart 6: Confirmed resident COVID-19 cases in 2020, by housing operator type



In the first wave ECH-only operators had the highest percentage of resident cases, peaking in April at 0.9% (75 cases). In the second wave RV&ECH operators had the highest, peaking in November at 1.1% (25 cases).

RV-only operators had a lot fewer cases in comparison. Rates were mostly very low, with slightly higher proportions in May (0.17%, 3 cases) and September to November (around 0.26%, 11 cases), which doubled in December to 0.5% (22 cases).

The different fluctuations in the proportions of residents with confirmed/strongly suspected COVID-19 throughout the year for the ECH-only and RV-only operators are shown in Chart 7 and Chart 8 (below).

Chart 7: ECH-only operator residents

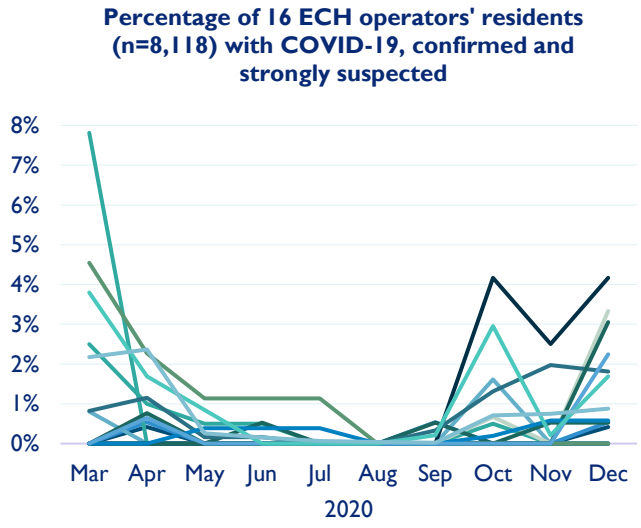
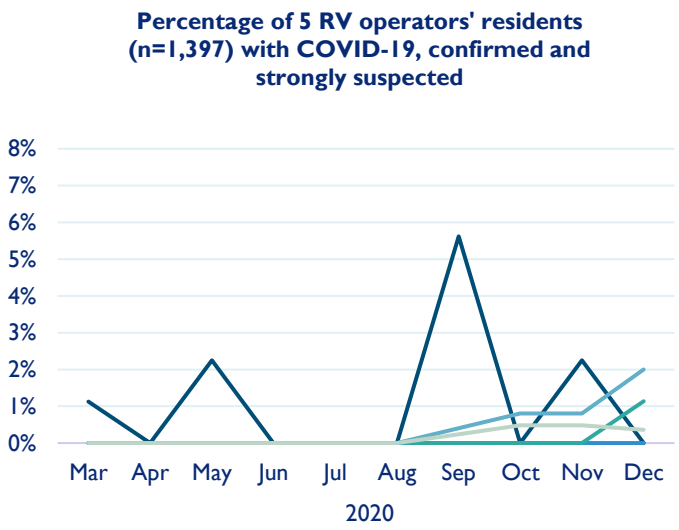


Chart 8: RV-only operator residents



7.4 Resident COVID-19 deaths

Respondents were asked for the number of their residents who had passed away with COVID-19 confirmed as the primary cause of death.

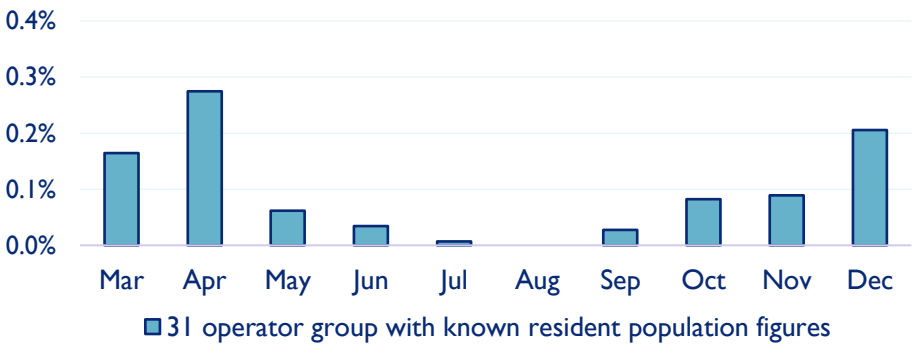
Within a group of 31 operators[16], between March and December 2020 overall there were:

- 141 confirmed COVID-19 deaths among 14,580 residents, equivalent to 0.97% of the population.

This compares favourably with the proportion of older people in the general population in England who had died within 28 days of a positive COVID-19 test which, when adjusted for the estimated age profile of the ECH and RV population in England[17], was 1.09% during March to December 2020. *This is despite the village/scheme residents being more likely to have higher health, care and support needs, particularly those living in ECH.*

Looking at each month, a higher number of the 31 operators' resident deaths occurred in April (0.29% of residents), followed by December (0.21%), and March (0.16%). There were none in August (see Chart 9)

Chart 9: Percentage of 31 operators' residents (n=14,580) with confirmed COVID-19 deaths in 2020



[16] with known total resident population figure (27 operators known individually plus 4 anonymous RVs known as group)
[17] UK Retirement Communities: Customer Insight report 2019

By housing type, overall there were proportionately more confirmed COVID-19 deaths among residents of RV&ECH operators, and the least among residents of RV-only operators (as was the case for confirmed resident COVID-19 cases). The percentage of confirmed resident COVID-19 deaths in 2020 for each housing type were:

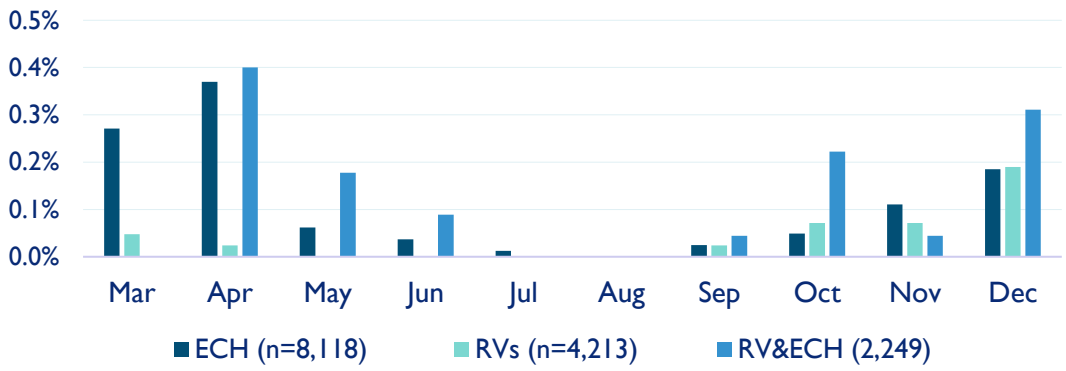
- 1.29% RV&ECH operator residents (29 of 2,249 residents).
- 1.12% ECH operator residents (91 of 8,118 residents).
- 0.51% RV operator residents (22 of 4,312 residents).

Compared to the 1.09% who died in the older population in England (adjusted for typical RV/ECH resident age profiles[18]):

- The 16 ECH-only operators had slightly more COVID-19 deaths (1.12%).
- The RV-only operators had less than half (0.51%).

The death rate by month in 2020 for each housing type is presented in Chart 10 below.

Chart 10: Percentage of 31 operators' residents (n=14,580) with confirmed COVID-19 deaths, by month and housing operator type



RV&ECH operators (n=6):

Among the RV&ECH operators, there were no recorded resident deaths in March, but they had their highest rate in April (0.4%).

The rates fell more slowly in May and June than the ECH-only or RV-only operators and climbed more steeply in October and December (when their rate reached 0.31%).

ECH-only operators (n=16):

The majority of ECH resident deaths occurred in the first wave during March (0.27%) and April (0.37%), with very few in May to October (none in August).

Rates in the 2nd wave did not climb so high, increasing in November to 0.11% and in December to 0.18%.

RV-only operators (n=9):

RV operators had lower rates that the other two during March-November, particularly so in the first wave. A very low proportion of RV residents died in March (0.05%) and April (0.07%) and there were no more occurrences until September (0.02%).

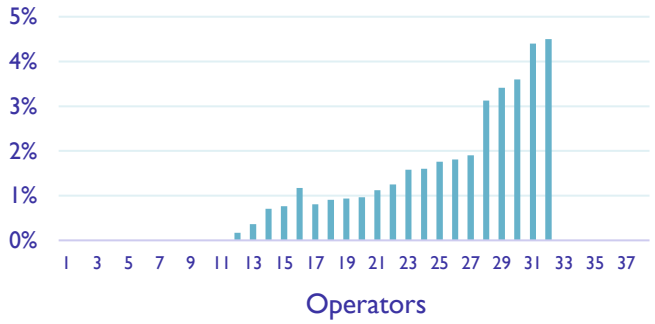
The highest rate was seen in December (0.19%), about the same as ECH but lower than RV&ECH operators.

[18] 8% under 70, 29% between 70-79, 48% aged 80-89, and 15% over 90; sourced from ARCO and ProMatura, UK Retirement Communities: Customer Insight report 2019)

Chart 11 below shows the total 2020 COVID-19 death rates for the individual 27 operators for whom resident numbers were known. 56% of operators had 1% or less (including zero) of residents who died from COVD-19, and there were 30% with no deaths:

- 30% of the 27 operators had no confirmed COVID-19 deaths among their residents.
- 26% had between 0.3 and 0.99%.
- 26% had between 1 and 1.99%.
- 18% had between 2 and 4.5% (all either ECH or RV&ECH operators).

Chart 11: Percentage of confirmed COVID-19 resident deaths per operator (n=27) in 2020, in ascending order

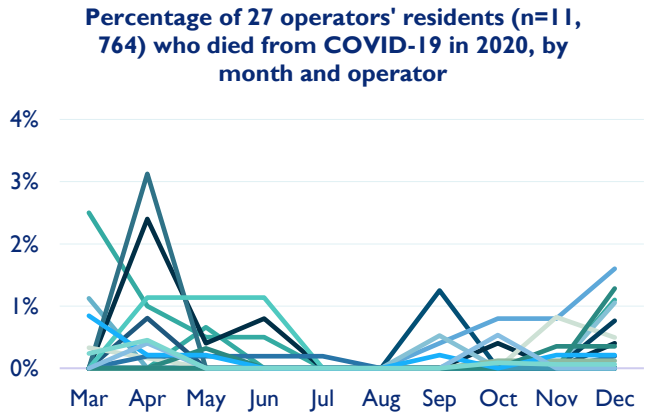


There was variation between operators in the percentage of their residents who died from COVID-19 during each month March – December (see Chart 12).

The highest death rate per operator in one month was 3.13% (ECH operator, 2 schemes with 64 residents), in March, they did not however have any other confirmed resident COVID-19 deaths during the rest of 2020.

The second highest rates were experienced by two operators, one in March (2.5%), the other in April (2.4%); one had around 250 residents living in 6 ECHs and 6 RVs, the other 200 residents in 5 ECH schemes. Both these operators also had the highest rates for the year overall (4.5 and 4.5%).

Chart 12: Resident confirmed COVID-19 deaths per operator, by month



7.5 Suspected sources of infection for any of the resident COVID-19 cases

On a list of possible sources of infection, respondents were asked to indicate how strongly they suspected each had occurred in their village/schemes.

The most highly suspected sources of infection were hospital visit/stays (94%), residents visiting people or shops off site (88%), visitors (86%) and external professionals (63%). See Table 6 below for more detail.

Table 6: Suspected sources of COVID-19 infections within the operators' villages/schemes

Possible source of infection:	*Certain & strongly suspect*	*Certain/ almost certain occurred*	*Strongly suspect occurred*	*Not sure*	*No. who answered*
From a hospital visit/stay	**94%**	52%	42%	6%	33
Resident visiting people/shops off site	**88%**	18%	71%	12%	17
Visitor(s)	**86%**	23%	64%	14%	22
External professional(s)	**67%**	28%	39%	33%	18
Another resident(s)	**63%**	13%	50%	38%	16
Staff member(s)	**50%**	6%	44%	50%	16
Bank/agency staff	**31%**	8%	23%	69%	13

Other possible sources of infection were added by four operators:

- Care team (certain/almost certain).
- Care team (strongly suspect).
- Care staff - not housing staff (did not give certitude).
- Community (certain/almost certain).

"One scheme was massively impacted by deaths in March/April - local hospital appeared to be link. One customer was discharged, passed on COVID-19 to wife and both passed away."

"Major risk from care provision by external carers where no control over measures in place."

'One extra care scheme was able to protect customers, but another was not.'

[ECH operator, 5 schemes; different organisation provided care]

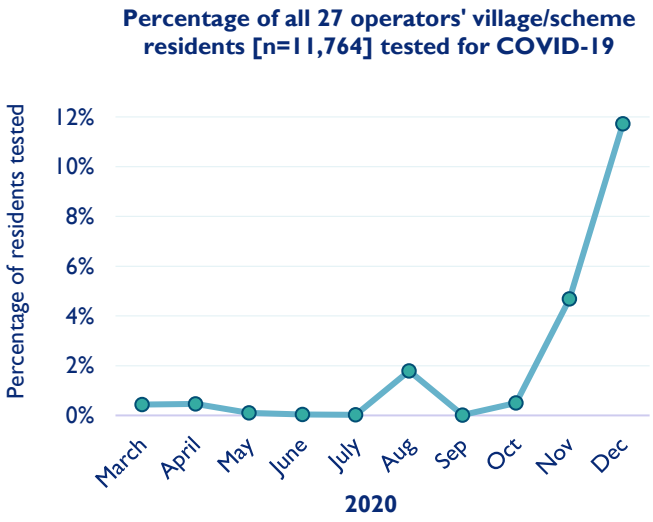
7.6 Resident testing for COVID-19

The number of residents tested for COVID-19

Very few of the 11,276 residents in the group of 27 operators[1] had a COVID-19 test until November and December.

Only around 0.4% were tested in March and April (52 residents). The first increase was seen in August when 1.8% of residents had a test but they dipped again in September only beginning to increase more significantly in November (4.7% of residents) and December (11.7%, 1,379 residents); see Chart 13 below:

Chart 13: Village/scheme residents tested, by month in 2020



Operators' access to COVID-19 tests for residents

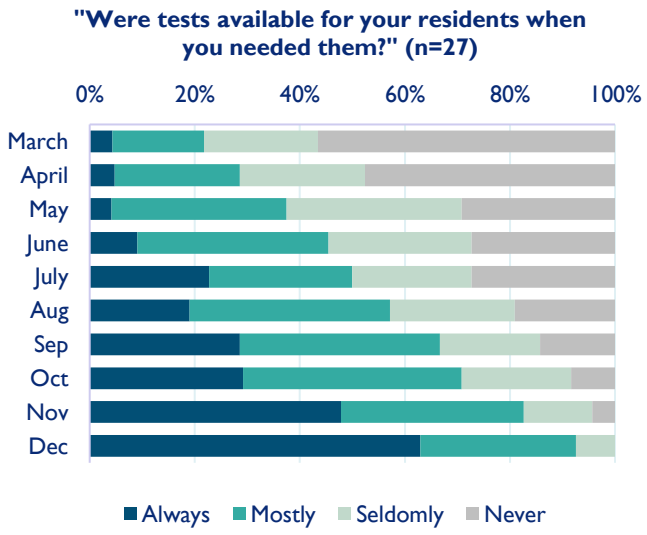
Participants were asked if COVID-19 tests were available for residents when they needed them, 27 answered.

Overall, the proportion of the respondents choosing either 'mostly' or 'always' increased steadily from 22% in March to 57% in July and up to 93% in December.

79% (18) indicated that COVID-19 tests for residents were never or seldomly available in March.

This continued to be the case for over half of the respondents up until July, but slowly improved through the rest of the year. By December it was the first time tests were 'never' available, but they were still only 'always' available for 63% of respondents, and 'seldomly' for 7% (2 operators).

Chart 14: Availability of tests for residents

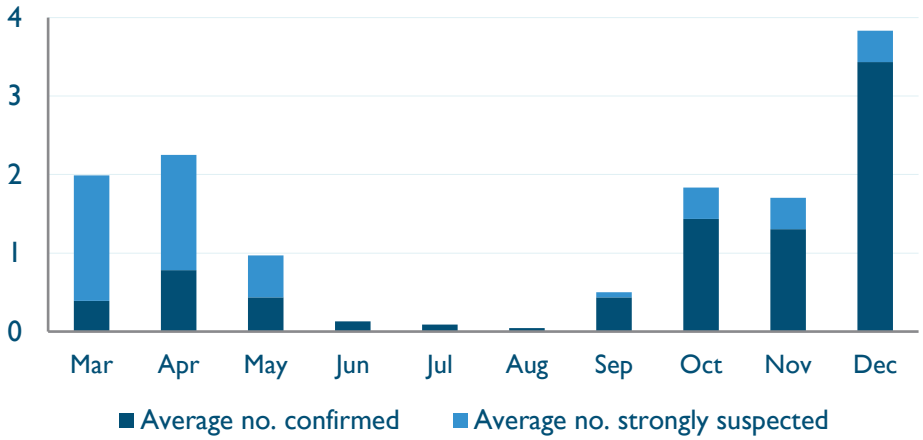


7.7 Staff COVID-19 cases

Reliable data for numbers of operator's staff was not available so, instead of percentage of staff with COVID, the results are presented as an average number of staff per respondent.

As can be seen in Chart 15 around two village/scheme staff per operator had confirmed or strongly suspected COVID-19 in March, April, October and November. This increased in December to an average of 4 staff per operator. There were a lot more strongly suspected cases during March and April when there was very little availability of COVID-19 testing for staff.

Chart 15: Average number of staff with confirmed COVID-19 (23 answered) or strongly suspected but not tested (15 answered), by month, March-December 2020

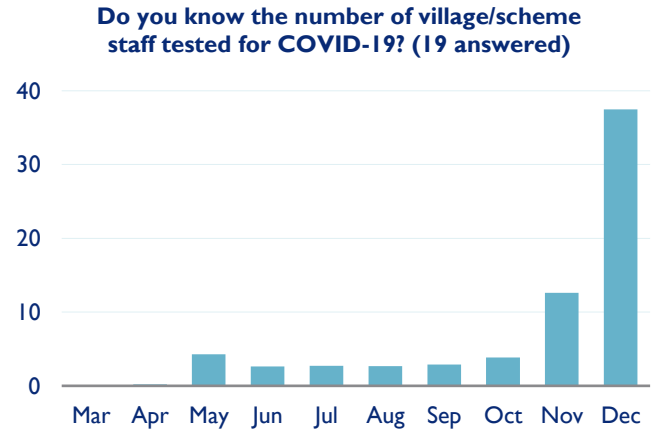


7.8 Staff testing for COVID-19

The number of staff tested for COVID-19

Very few staff were tested for COVID-19 until November when average numbers of staff tested per operator more than trebled to 13 per operator, and then sharply up to 37 in December. They were averaging only at 0.1 in March, 0.2 April, four in May, and around 2.7 June to October (see Chart 16).

Chart 16: Average number of staff tested per operator by month, March-December 2020



One RV operator explained:

"We struggled to get regular weekly testing for staff as our CQC registration prevented us from being recognised as an operator of extra care services."

Operators' access to COVID-19 tests for staff

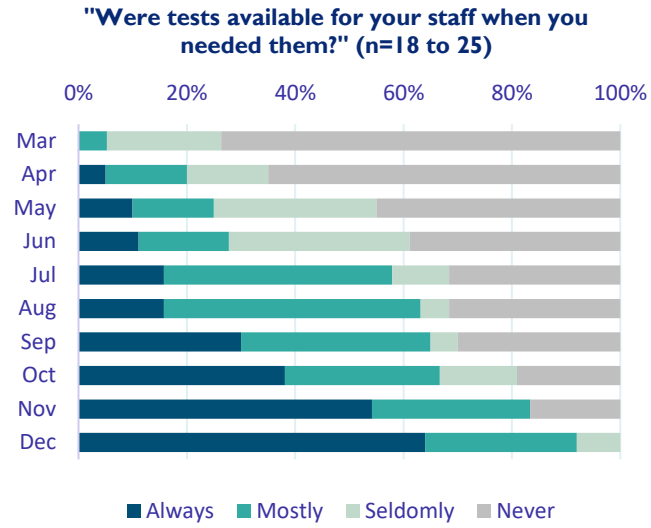
Participants were asked if COVID-19 tests were available for their staff when they needed them, between 18 and 25 answered (it varied for each of the months).

Overall, the proportion of respondents choosing either 'mostly' or 'always' increased steadily from 5% in March to 58% in July and up to 92% in December.

95% (18 respondents) indicated that tests for staff were never or seldomly available in March. This continued to be the case for over 50% of the respondents until July when there was a marked improvement. This was followed by slower improvements until November and December when availability of tests was greatly improved.

December was the first month where no respondent ticked 'never' available, but tests were still only 'always' available for 64% (16 of respondents), and 'seldomly' for 8% (2 operators).

Chart 17: Availability of tests for staff

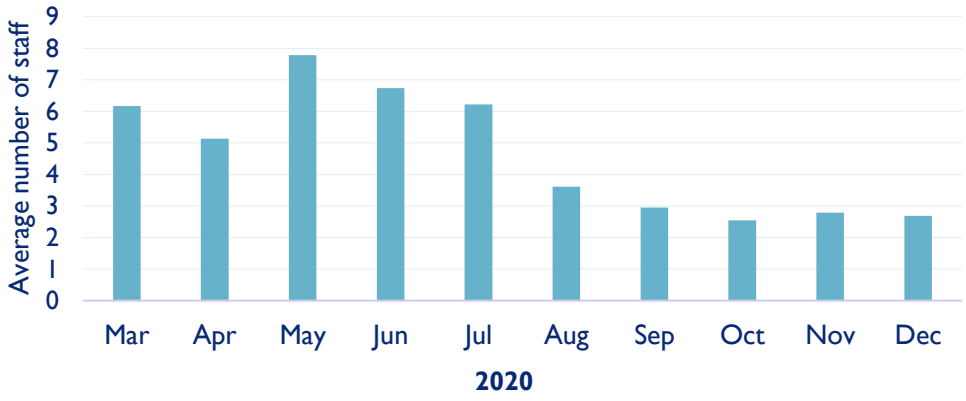


7.9 Number of staff furloughed

Operators had the most staff furloughed between March and July (around 6 on average), with fewer during August to December (around 2.2 on average).

23 respondents gave the number of village/scheme staff who had been furloughed. Average numbers per operator were around six staff from March to April, and around three staff from August to December.

Chart 18: Average number of all operators' (n=23) staff furloughed by month in 2020



7.10 Operational response and experience

Date villages and schemes locked down in the first wave

More than half of the operators locked down before the start of the national lockdown on the 23 March 2020. 35% of them had locked down more than a week before, the earliest on the 1 March 2020.

47% (15/32) locked down either during the 23 March 2020 or a day either side. Two respondents indicated the much later dates of 1 April and 19 May 2020.

Further details:

- Their earliest lock down date was 1 March (ECH) and the next was over a week later on the 9 (RV).
- Six locked down on the 16 March (ECH, RV, RV&ECH).
- 23 March was the most popular with nine locking down, plus six more doing so on the days either side (ECH, RV, RV&ECH).
- The latest dates given after that were 1 April (1 RV&ECH operator) and the 19 May (one RV operator).

All the dates given are shown in Table 7 (below).

Table 7: Dates villages/schemes were locked down in the first wave

Date villages/schemes locked down in the first wave	Nº who locked down
1 March 2020	1
9 March 2020	1
10 March 2020	2
15 March 2020	1
16 March 2020	6
17 March 2020	1
19 March 2020	1
20 March 2020	1
21 March 2020	1
22 March 2020	3
23 March 2020	9* Commencement date of first national lockdown
24 March 2020	3
1 April 2020	1
19 April 2020	1
Number of respondents	32

Policies around staff work commutes since the start of the pandemic

91% of operators either disallowed staff to car share (29%) or discouraged them from doing so (62%). The majority (74%) discouraged the use of public transport, and one operator disallowed staff to use it. One respondent said they provided pool cars and some taxis, where risk assessed as appropriate.

Participants were asked to indicate which directives regarding staff commutes they had introduced since the start of the pandemic. Of the 34 who responded:

- 74% (25) ticked 'Public transport discouraged'
- 3% (1) ticked 'Public transport not allowed'
- 62% (21) ticked 'Car share discouraged'
- 29% (10) ticked 'Car share not allowed'.

Four operators ticked 'other' giving the following details:

- "Flexibility to avoid peak travel times, individual risk assessments for all"
- "All have own transport or walk"
- "Some team members staying on site"
- "Provision of pool cars and limited provision of taxis, where risk assessed as appropriate. Internal messaging about safety on transport and commute (e.g. masks, social distancing, etc - early comms)".

Major pressures in relation to staff for operators' schemes or organisation

The following were chosen from a list by the majority of respondents as being major pressures for their schemes or organisations during the pandemic: 'anxiety' (76%), 'stress' (62%), and 'numbers of staff off work self-isolating' (62%), 'numbers of staff off work shielding' (53%), 'staff shortages' (53%).

Between 25-50% identified these as major pressures: 'keeping up with the changes' (50%) and 'adapting to the changes' (47%), and 'low morale' (44%). A quarter to third of identified 'burnout' (35%), 'staff sickness' (35%), 'allowing annual leave' (29%), 'sustaining the service' (24%), and 'ensuring quality' (24%).

'Staff sickness' was ticked by a higher proportion of survey respondents who were ECH operators (35%, 8/21) and RV&ECH operators (43%, 3/7) operators compared to the RV operators (11%, 1/9).

Major pressures for a few operators were: 'number of staff furloughed' (15%), 'access to training' (15%), and 'access to agency staff' (6%). None chose 'suspending annual leave' (see Chart 19).

Chart 19: Operators' response choices for major pressures they faced in relation to staff

Three operators added a further major pressure:

- "Challenges of managing resident and visitor behaviours. i.e. not complying with guidance".
- "Had to manage extensive fire safety works also".
- "Contract restrictions/KPIs".

Problems caused by the lack of availability of PPE during the first wave

30 out of the of 38 answered this section.

The lack of availability of PPE during the first wave caused a 'huge amount' of problems for 23%, 'a lot' or 'quite a lot' for 20%, and 'a small amount' for 53% (one respondent selected 'I don't know'). None of the RV-only respondents chose a 'huge amount'.

Two of the operators thought that a lack of PPE had led to infections among their staff, and one other thought that it had led to infections among their residents.

Anxiety, stress, worry and confidence issues were other problems that a lack of PPE caused (mentioned by six), e.g.

"The worry of not having sufficient supplies, we never ran out completely."

"Just anxiety for staff around if we ran out and what is the safest PPE/mask to use."

"Anxiety and frustration - we were fortunate in being able to access supply chains via the care and residential division of the organisation."

Cost and logistical issues with getting supplies were also problems (mentioned by two):

"Mostly logistical issues with getting stock to the right places, and issues with purchasing limits on contracts"
[Operator with 4 ECH schemes].

"We made contact with over 600 PPE suppliers and eventually had to spend over £200,000 for bulk order to secure suitable equipment. This was early in the pandemic, where testing is limited so it is impossible to tell the impact (especially considering prevalence of asymptomatic infected)"
[Operator with 8 ECH scheme].

The biggest challenges for schemes and organisations

"Morale of staff and residents due to excessive pressure of the situation"
[Operator with 5 villages/scheme]

"Complete focus on older age care homes, almost entirely at expense of extra care settings"
[Operator with 4 ECH schemes]

34 operators entered at least one biggest challenge in four text response boxes in this section; 71% of them filled in at least three. The challenges have been listed in Table 8 (overleaf) by theme, in descending order of the number of respondents whose comments came under each one.

The most commonly mentioned themes were:

- Residents and visitors understanding and adhering to guidance, not complying with or resenting government guidance.
- Maintaining residents' and staff well-being.
- Staffing/staffing levels.
- Constantly changing government guidance/volume of guidance /keeping up with the changes.

Table 8: Biggest challenges faced by operators and number of participants who mentioned each one

Theme of biggest challenges	No.
Residents and visitors understanding and adhering to guidance, not complying with or resenting government guidance, e.g. - "making sure everyone obeys the rules" - "challenging relatives over restrictions" - "customers initially understanding the importance to social distancing" - "encouraging some individuals to socially isolate" - "customers not understanding the scheme is not a 'household'" - "managing family and visitors' expectations or not adhering to the rules" - "supporting residents living with dementia or cognitive impairment to understand the required behaviour changes"	21
Maintaining residents' well-being (morale, anxiety, loneliness, boredom), e.g. - "providing meals with restaurants closed" - "reassuring residents & mental health problems" - "combatting social isolation with communal areas closed" - "tenants feeling isolated and this having an effect on their health and well-being" - "maintaining a quality of service for people who were lonely and bored"	18
Staffing/staffing levels, e.g. - "staff shielding or isolating due to track and trace" - *mentioned by three* - "managing the balance of encouraging staff who are vulnerable to work from home and yet still provide support - "increased workload but not readily available additional staff" - "staff availability during outbreaks"	13
Maintaining staff well-being (morale, stress, anxiety, workload), e.g. - "keeping staff happy as very busy" - "reassuring staff when anxious on site" - "general anxiety and stress with pandemic"	11
Constantly changing government guidance/volume of guidance /keeping up with the changes, e.g. - "avalanche of guidance both external and internal" - "ensuring up to date with government guidelines constantly changing and feeding information to relatives, residents and staff" - "keeping up with changes (in excess of 40 between March and May)"	9
Lack of government leadership, guidance and clarity for ECH & RV settings, e.g. - "lack of clarity on applicability of guidance/just plain lack of guidance for extra care settings" - "discerning what guidance applies to our sector (parts of dom care, parts of care home)" - "one of the main challenges is that the focus of government guidance has been on care homes and "light" for Supported Housing particularly in the earlier days … so operators had to interpret as best as possible"	7
Safety of staff and residents, e.g. - "controlling the risk of infection to residents (and colleagues, care/cleaning/ catering) from visitors" - "maintaining COVID-free schemes" - "maintaining cleaning standards"	7
Lack of access to testing, e.g. - "unable to access whole site testing as an extra care operator"	6

Theme of biggest challenges	No.
Obtaining enough PPE	5
Some residents' dissatisfaction with communal facilities being closed, e.g. - "closure of communal areas - frustration by some residents"	4
Funding (PPE, staffing requirements), e.g. – "lack of funding to support additional costs"	3
Lack of understanding of extra care model, e.g. - "we have felt that extra care is not understood by a lot of health professionals and have felt overlooked by government" - "there has appeared at times to be a complete misunderstanding of both extra care and the wider adult social care landscape" - "expectations by some of our care operator partners to "close down" schemes and prohibit visitors and enforce breaches of government measures. we have not closed down schemes per se given tenancy/owner rights and schemes as we are not care homes and ditto that we have done everything we can to encourage, explain, support and educate and take a more assertive approach where there are obvious and blatant breaches but we can't enforce and it is managing the expectations of others that we can."	3
Design of building not suitable for implementing practical COVID measures, e.g. - "one way systems as most schemes only have one main entrance and difficulties closing down communal areas where open plan were eaten" - "not having balconies in all schemes"	3
Learning/implementing a new way of remotely supporting the villages and residents, e.g. - "change from face-to-face delivery of support service to phone based service wherever possible"	3
Maintaining business as usual with care and customer service, e.g. - "continue to deliver high quality service with extra pressures and different ways of working"	2
Mixing, influx of visitors/Unable to stop visitors accessing the building	2
Financial loss - food outlets, vacancies, etc	2
Other biggest challenges mentioned:	
- Inconsistent processes for funding across Local Authorities	1
- Extra workload to ensure everyone had food, laundry, medication completed in absence of family support	1
- Statutory services (social care, fire service) not seeing residents in person; waiting time for assessments	1
- Delivering meals as restaurant closed with delivery only	1
- Accessing shopping services/online deliveries	1
- Deaths at the scheme, not through COVID-19. Impact on residents and families re. funeral arrangements	1
- Maintaining occupancy levels	1
- Lack of suitable work/office facility	1
- Complexity of testing when it finally arrived	1
- Inconsistent response from PHE in relation to outbreaks and response required	1

7.11 Financial implications for operators due to the pandemic

Overview of financial implications

Due to the pandemic up to February 2021, the 19 respondents who answered this section experienced major financial pressures resulting in an estimated average overall loss of:

- -£723 of deficit per resident, and
- -£327,415 of deficit per operator.

Table 9 below shows the detail around the calculation of operators' costs, losses, savings and financial support received due to the pandemic.

Table 9: Operators' costs, losses, savings and financial support received due to the pandemic (up to Feb 2021)

	Amount per resident		Average amount per operator	
Additional costs*	£335	19 operators 7,752 residents	£136,768	**19 operators** 7,752 residents
Loss of income	£620	13 operators 4,596 residents	£311,321	**15 operators** >4,596 residents
Amount saved	£155	11 operators 3,604 residents	£71,107	**14 operators** >3,604 residents
Financial support	£77	16 operators 9,516 residents	£49,567	**19 operators** >9,516 residents
Average estimated deficit/gain	**-£723** Average per resident		**-£327,415** Average deficit per operator (n=14 to 19)	

* many operators stated that the cost figures they were able to provide were not fully comprehensive of all the additional costs they would had incurred.

Extrapolating these findings to the group of 38 operators who responded to the survey, the have incurred an estimated overall loss of -£12,441,770 based on:

- Additional costs of £5,197,184*.
- Losses of income of £11,830,198.
- Savings of £2,702,066.
- Financial support of £1,883,546.

* many operators stated that the cost figures they were able to provide were not fully comprehensive of all the additional costs they would had incurred.

The majority (68%) of those who answered indicated they had not received any financial support; this included organisations across the range of sizes and housing types.

Additional costs due to the pandemic

The total estimated additional cost due to the pandemic (up to Feb 2021) for the 19 operators who gave a figure was £2,598,591. This equates to:

- An average additional cost of £335 per resident (n=7,752), or
- An average additional cost per operator of £136,768 (n=19).

Extrapolating to all survey respondents gives an estimated total of £5,197,184 in additional costs for the group of 38 operators.

Operators additional costs per resident ranged from £15 to £1,012 (see Table 10 for details).

Note: These additional costs are likely to be underestimates; information given by the respondents showed variation as to what operators had been able to include in their cost figures due to, e.g. some costs being difficult to identify, tease out, calculate, or were not known at the time.

Table 10: ADDITIONAL COSTS due to the pandemic, sorted by amount per resident

Operators' estimated additional costs	Operators' nº. of residents	Operators' additional costs per resident	Housing Type
£759,000[19]	750	£1,012	RV&ECH
£365,439[20]	474	£771	ECH
£200,000	312	£641	ECH
£90,000	150	£600	ECH
£100,000[21]	284	£352	RV&ECH
£80,000	240	£333	ECH
£653,000	2,816	£303	RV
£175,000			RV
£5,000			RV
£20,000			RV
£15,000	64	£234	ECH
£30,000	190	£158	ECH
£10,000	131	£76	ECH
£4,600	64	£72	ECH
£10,000	140	£71	RV
£50,000	830	£60	RV
£10,000	186	£54	ECH
£12,500	513	£24	ECH
£9,052[22]	608	£15	ECH
Total: £2,598,591	Total: 7,752	Average: £335	All

Details of costs

Operators were asked to indicate the level of additional costs for PPE, sanitiser, cleaning, and staffing. Responses from 32 operators (see Chart 20) show that:

- Expenditure on PPE and hand sanitiser were very high or quite high for 90% (27/30] of respondents.
- Expenditure on additional cleaning and laundry was very high or quite high for 82% (23/28) of respondents.
- Expenditure on additional staffing was very high or quite high for 53% (16/30) of respondents, and 43% (13/30) indicated there had been no change.

[19] Costs include additional staff costs, additional purchased costs of PPE, hand sanitiser, medical supplies, laundry, cleaning and other equipment to support staff and residents [RV&ECH, 5 villages/schemes].

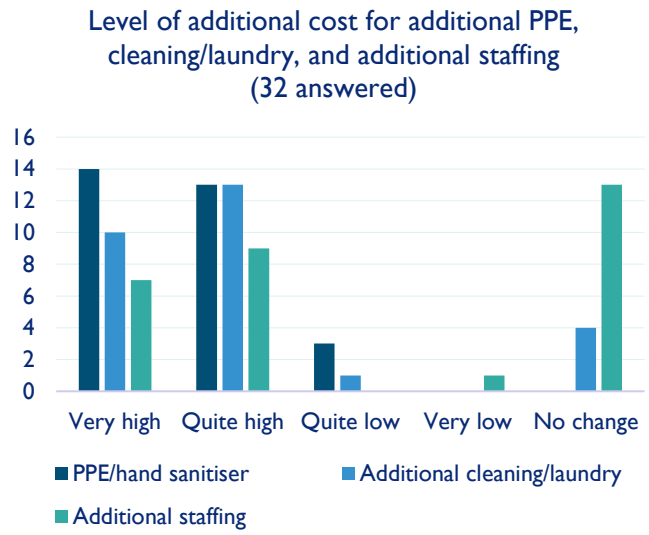
[20] "Costs based only on couriers for PPE, recruitment costs and overtime payments *and do not* include cleaning costs as they have not been charged yet so unknown." [8 ECH schemes]

[21] "Figures are estimated, the costs or hidden costs of COVID-19 are likely to be higher" [1 RV, 3 ECH schemes]

[22] "Mainly due to increased cleaning" [10 ECH schemes]

No differences were apparent in response option choices based on housing type (RV or ECH) or the operators' number of residents.

Chart 20: Scale of additional costs for key items



Further additional costs specified by operators were signage, equipment, void losses, paying overtime at enhanced rates and the top up on furlough.

Example comments:

"Void loss, and extended move out times, first lock down unable to move anyone in so had rent loss"

"Mobiles for all team members. Laptops to work in alternative spaces/remote".

One operator said that they had been able to limit their additional costs by re-deployment of other staff.

Estimated income losses due to the pandemic

The total estimated loss of income due to the pandemic (up to Feb 2021) was £4,669,820 for the 15 operators who gave a figure. This equates to:

- An average loss of £311,321 per operator (n=15).
- An average loss of £620 per resident (n= 4,596).

Extrapolating to all survey respondents gives an estimated total of £11,830,198 income loss for the group of 38 operators.

Individual operator's loss of income ranged from £7,000 (ECH operator) to £1,720,000 (RV operator), see

Table 11 for details.

Table 11: LOSS OF INCOME due to the pandemic, sorted by amount per resident

Amount of loss of income	Operator nº of residents	£ lost per resident	Housing Type
£1,720,000	Unknown	Unknown	RV
£200,000	88	£2,273	RV
£1,030,000	750	£1,373	RV&ECH
£400,000[23]	474	£844	ECH
£500,000	830	£602	RV
£160,000	312	£513	ECH
£247,000	608	£406	ECH
£100,000	284	£352	RV&ECH
£100,000	Unknown	Unknown	RV
£38,820	131	£296	ECH
£17,000	80	£213	RV&ECH
£40,000	190	£211	ECH
£90,000	513	£175	ECH
£20,000	150	£133	ECH
£7,000	186	£38	ECH
Total: £4,669,820	Total: > 4,596	Average: £620*	All

* Based on the 13 operators whose resident numbers were given

[23] Rough estimate based on occupancy rates reduced by 5% and number of void days almost doubling.

Main causes of income losses

59% of respondents (17/29) chose 'reduced village or scheme occupancy' as a main source of income loss, only one of them was an RV-only operator.

The higher resident COVID-19 death rates experienced by ECH and RV&ECH operators are likely to have contributed to a much greater proportion of them stating this as main source of income loss.

48% of respondents (14/29) chose 'reduced or suspended restaurant/café services'.

Other main causes of financial losses specified by operators related to closed/reduced facilities and services, fewer sales and reduced income from rent:

- Care and support income.
- Number of hours lost in care packages as social calls due to the closure of shops, clubs and social venues.
- Duration of time we couldn't sell or build, extending the day running costs and capital lock up – extended sales and build periods.
- Lost income from holding voids when lettings were not permitted.
- Inability to open the restaurant/bar to residents or guests and lost property sales.
- Salon income, reduced use of laundry facilities, guest room and meeting room rentals.
- Inability to offer hairdressing services.
- Sales may have dropped and restaurant continued but delivered meals.
- Covered delivery costs and meals for first lockdown period.
- Guest suites not being used.
- Closure of leisure facilities to external customers.

Estimated savings due to the pandemic

The total estimated savings due to the pandemic (up to Feb 2021) were £995,500 for the 14 operators who gave a figure. This equates to:

- An average of £71,107 of savings per operator (n=14), or
- An average of £155 of savings per resident (n=3,604).

Extrapolating to all survey respondents gives an estimated total of £2,702,066 in savings for the group of 38 operators.

Individual operator's amounts of savings ranged from £0 (for 6 operators, all ECH) to £418,500 (an RV operator), see Table 12 for details.

Table 12: AMOUNT SAVED due to the pandemic, sorted by amount per resident

Amount saved	Operator nº of residents	£ saved per resident	Housing Type
£418,500	Unknown	Unknown	RV
£180,000	88	£2,045	RV
£228,000	750	£304	RV&ECH
£100,000	830	£120	RV
£31,000	284	£109	RV&ECH
£20,000	Unknown	Unknown	RV
£15,000	140	£107	RV
£3,000	64	£47	ECH
0	240	£0	ECH
0	350	£0	ECH
0	64	£0	ECH
0	186	£0	ECH
0	608	£0	ECH
0	Unknown	£0	ECH
Total: £995,500	Total: > 3,604	Average: £155*	All

* Based on the 11 operators whose resident numbers were given.

Sources of savings

Ten operators signified that savings for them were mainly due to:

- Furloughed staff [9 operators]; ticked by a much higher proportion of RV survey respondents (67%, 6/9), compared to only one of the ECH respondents (5%, 1/21).
- Reduced restaurant/café food purchases [3], two RV and one RV&ECH respondent.
- Other sources were detailed by 8 operators as:
  - Grants [1]
  - Transport, Spa [1]
  - Maintenance [1]
  - Decreased travel and accommodation costs [1]
  - No savings incurred [4].

Amount of financial support received due to the pandemic

"We have received financial support from all 14 Local Authorities towards additional costs associated with dealing with the pandemic which included covering missed/cancelled calls and Infection Control Funds." [RV operator]

A total of £941,765 in pandemic financial support (up to Feb 2021) was received by the 19 operators who gave a figure. This equates to,

- An average of financial support of £49,567 per operator (n=19), or
- An average of £77 per resident (n= 9,516).

Extrapolating to all survey respondents gives an estimated total of £1,883,546 received by the group of 38 operators.

The majority of those who replied (68%) had not received any financial support**.** They included various sized organisations providing ECH, RV or RV&ECH**.**

Amounts received ranged from £0 (for 13 operators) to £353,142 (an ECH & RV operator), see Table 13 for details.

The main financial support received by operators would have come from Local Authority grants for infection control and PPE, and savings if any staff were furloughed.

Table 13: FINANCIAL SUPPORT due to the pandemic, sorted by amount per resident

£ support received	Operator nº of residents	£ per resident	Housing type
£278,123[24]	474	£587	ECH
£353,142	750	£471	RV&ECH
£208,000[25]	Unknown	Unknown	RV
£78,500	284	£276	RV&ECH
£19,000	186	£102	ECH
£5,000	64	£78	ECH
0	517	£0	ECH
0	89	£0	RV
0	140	£0	RV
0	240	£0	ECH
0	4650	£0	ECH
0	350	£0	ECH
0	64	£0	ECH
0	190	£0	ECH
0	608	£0	ECH
0	830	£0	RV
0	80	£0	RV&ECH
0	Unknown	£0	RV
0	Unknown	£0	RV
Total £941,765	Total: > 9,516	Average: £77	All

[24] The operator specified that furlough figures were included in their financial support figure.

[25] LA Grants for infection control and PPE.

7.12 Measures taken during the first wave to protect residents and staff from COVID-19

Measures implemented

During the first wave PPE, social distancing, closing communal areas and services, shielding individuals and restricting visitors were the most common key measures operators put in place to protect their staff and residents from COVID-19; they were chosen from a list by over 88% (30] of the 34 respondents (see Chart 21).

Smaller operators were more likely to close lounges altogether rather than restrict use of them.

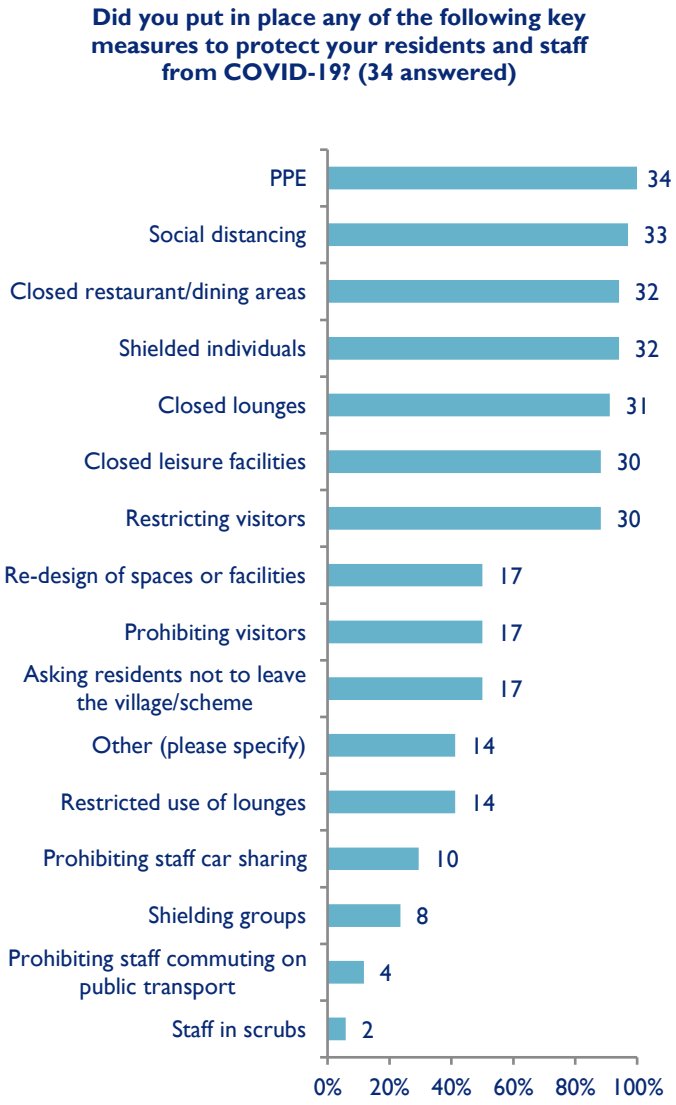
50% (17/34) indicated they prohibited visitors, asked residents not to leave the village/scheme, and/or re-designed spaces or facilities.

Two operators (one large ECH, one medium RV&ECH) explained that during the national lockdown their residents were free to move around their village/scheme and garden grounds, but should leave only for essential purposes in line with government guidelines.

The two operators locked down a very small number of villages/schemes following signs of infection spreading. Within these residents were asked to stay in their apartments and had all meals delivered to them.

30% (10/34) prohibited staff from car sharing and 12% (4/34) prohibited them from commuting on public transport, all four of them were RV-only or RV&ECH operators. Two operators had their village/scheme staff in scrubs (one 'ECH', and one RV&ECH operator who also had some care homes).

Chart 21: Key measures chosen from a list that operators put in place during the first wave to protect residents and staff



Additional key measures added by respondents included increased cleaning regimes, limiting inter-site staff, delivering meals in individuals in their apartments, and posters and information (see Table 14 overleaf).

Table 14: Other key measures mentioned by respondents put in place to protect residents and staff during the first wave

Other key measures implemented	
▪ **Increased cleaning regimes (x 3).** ▪ **Limited staff inter-site (x 3):** - Housing and maintenance staff confined to visiting one scheme only to avoid cross contamination. - Increased recruitment to allow bank staff to be single-service specific, max limits on staff rooms and offices. ▪ **Delivering meals to apartments (x 2).** ▪ **Posters and information/education (x2).** ▪ **Asked staff to work on site 1 day per week for compliance to reduce risk to both customers and staff.**	▪ Introduced mask wearing on site for all communal areas earlier than legal enforcement. ▪ Closed day centre to customers inside and outside the scheme. ▪ Restrictions on use of communal garden. ▪ Daily well-being calls, delivering parcels. ▪ Closed communal toilets and all communal spaces including coffee lounges. ▪ Outdoor activities.

What made the biggest protective difference(s)

"PPE and the closing of communal spaces ... as it was very hard to restrict visitors"

32 operators wrote down what they thought had made the biggest protective difference against COVID-19.

The most commonly mentioned aspects were (see Table 15 for details):

- Closing communal facilities/activities or restricting residents access to areas.
- Full PPE/correct use of PPE.
- Restricting and closing to visitors and family when necessary.
- Regular/increased cleaning.

Table 15: The factors operators thought made the biggest protective difference, with the number and % of respondents who mentioned them

Biggest protective difference	No.	%
Closing communal facilities/activities or restricting residents access to areas	18	56%
Having sufficient PPE/correct use of PPE	11	34%
Restricting and closing to visitors and family when necessary - "locking down early during first wave" (x3)	10	29%
Regular/increased cleaning - "We cleaned all touch point areas every hour"	7	22%

- "We introduced sanitise stations and increased touch point cleaning"		
Asking residents not to leave the village/scheme	4	13%
Social distancing	3	9%
Offering a full delivery service from shop/restaurant to individual apartments	3	9%
Clear/regular updated guidance for residents	3	9%
Encouraging residents and visitors to follow guidance	3	9%
Communicating with residents on daily/weekly basis	2	6%
Separate care teams/assigning staff to areas	2	6%
Keeping residents on board with decisions/ buy in to the need to follow government guidance	2	6%
Limiting numbers in certain areas	1	3%
Face masks	1	3%
Staff training - COVID-19 policy	1	3%
Daily welfare calls for all residents	1	3%
Monitoring - staff team looking out for early signs	1	3%
Isolating quickly	1	3%
Having a crisis management team to oversee and review our COVID-19 response on a daily basis	1	3%
Perspex screens	1	3%
Safe working practices by staff	1	3%
Team dedication to residents	1	3%
Moving away from face-to-face contact wherever possible	1	3%
Risk assessments	1	3%
Having self-contained accommodation	1	3%

7.13 Residents' health, well-being and experience

Maintaining residents' general health and key aspects of daily living

"A comprehensive community plan was maintained for each scheme, detailing the identification of individuals who lacked an adequate support network or had increased vulnerabilities"
[Large RV&ECH operator]

Provision of advice and information on government guidance, social calls, meals, shopping, and help with access to internet shopping were the most common additional or special measures operators put in place for their

residents to help maintain their general health and key aspects of daily living; these were chosen from a list by over 70% (25) of the 34 respondents (seeChart 21 below).

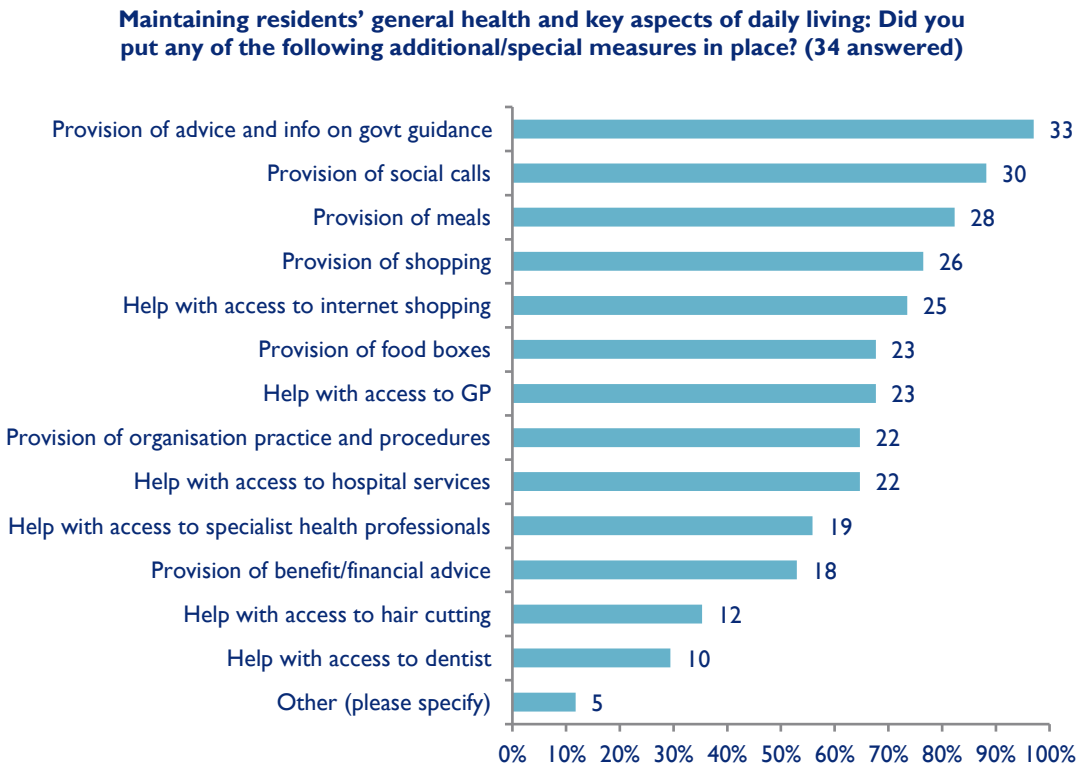
Between 50-70% (18-23 respondents) said they provided food boxes, help with access to GPs, organisation practice and procedures, help with access to hospital services and specialist health professionals, and benefit/financial advice. Some helped with access to hairdressers (35%, 12/34) and dentists (29%, 10/34).

A much higher proportion of ECH operators indicated that they provided help with 'access to specialist health professionals' and the 'provision of benefit/financial advice'; RV operators were more likely to help with 'provision of shopping'. This is likely to be a reflection of ECH having larger proportions of residents with higher levels of need.

Five operators added their own items to the list:

- "A comprehensive community plan was maintained for each scheme, detailing the identification of individuals who lacked an adequate support network or had increased vulnerabilities."
- "Signposting, support to access statutory and community services, well-being calls, tablets for social connection, befriending service and an ongoing programme of mental and social stimulation such as puzzle and craft packs."
- "Activities to tackle social isolation when we were able to Jul – Oct"
- "Daily well-being calls, delivering parcels".
- "Referred tenants for assistance from the Council hub where appropriate".
- Our catering staff prepared hot meals and put together vegetable and meat boxes, both available for residents to order via their respective kitchens and be delivered to their home.

Chart 22: Key measures chosen from a list that operators put in place during the first wave to protect residents and staff



Additional/special measures put in place – maintaining residents' mental and emotional well-being

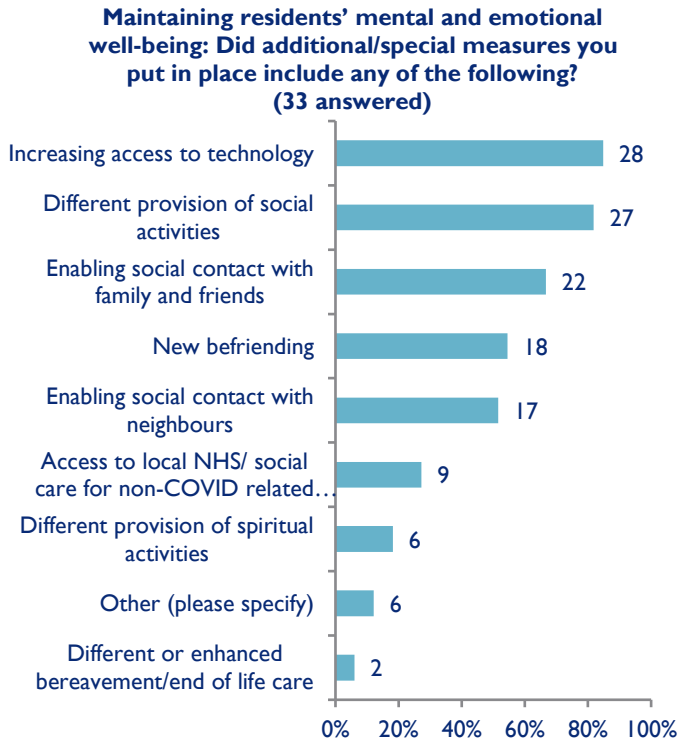
"Daily welfare calls - specific questioning around loneliness and well-being"

Increasing access to technology, difference provision of social activities were the most common additional or special measures operators put in place for their residents to help maintain their mental and emotional well-being; these were chosen from a list by over 82% (27) of the 33 respondents (see Chart 23).

Between 50-70% (17-22) enabled social contact with family, friends and neighbours and with new befriending.

27% (9/33) helped with access to local NHS or social care services for non-COVID-19 related needs.
Two operators, both ECH, implemented different/enhanced bereavement or end of life care.

Chart 23: Additional/special measures chosen from a list that operators put in place for residents since the start of the pandemic



Proportionally, more ECH operators helped with 'access to local NHS and social care for non-COVID-19 related needs'. Again, this is likely to be a reflection of larger proportions of residents with higher levels of need living in ECH.

Six operators added in other additional/special measures which they had put in place:

- Daily welfare calls - specific questioning around loneliness and well-being.
- Weekly quizzes, newsletters.
- Internal telephone system to call friends and neighbours.
- Offers/links on online activities.
- Delivery service of meals.
- Well-being packs.
- Teams are regularly phoning residents to check they are ok.
- "During lockdown we developed a new online resident activity hub offering a range of activities ranging from how-to guides, games, and virtual tours, to church services (also distributed on CDs/DVDs) and exercise classes from our physios on video messaging. Volunteering service meet-ups with residents, music therapy, etc took place over the phone rather than home visits."
- "Activities Coordinators are regularly phoning residents for a chat, sending out newsletters, emailing and circulating weekly quizzes and links to music, and 'non-tech' ideas such as photographing or drawing/painting/writing a poem."
- "To help keep residents' spirits up we delivered surprises such as easter eggs and flowers to their apartments."

Evidence of residents' experience

"[The village] could not have done anything better given the unprecedented nature of COVID-19. The management and staff went above and beyond in every aspect to protect, support and assist all residents."

This section presents evidence shared by operators regarding how their residents felt about living in a village/scheme during the pandemic.

Feedback from residents of a large ECH operator

"We have received overwhelming feedback and gratitude for the way in which we have managed the pandemic both within the villages and the local communities.

Most feel that the Pandemic has confirmed that their decision to move into a retirement community was the right thing to do. This has been echoed by family members.

This has come about as a result of the way in which we have managed the pandemic coupled with the low incidences among both owners and team members."

Feedback from residents, relatives and staff from a medium-sized RV&ECH operator

Many residents have sent thanks or pinned notes to their windows,

"THANK YOU … for looking after us all so well."

Letter received from RV resident's daughter:

"I would like to thank you and your team for the amazing way you have been managing the virus impacts at [the village]. Although I have not been able to visit, my mother has been keeping me up-to-date. In the face of an extraordinary threat to all your staff, residents and visitors, you have managed to put measures in place to help keep everyone as safe as possible in a measured, respectful and timely way. Everyone has had to seek innovative solutions, but few on the scale that you have. I have no doubt that it has been and continues to be all-consuming in terms of time and effort …I take my hat off to you and thank you and your team for their continued professionalism and hard work."

Thank you note from resident:

"I would like to thank you, from the bottom of my heart, for all the care and help received from every member of the management and staff here at [the village] during the pandemic. All the extra work organised and carried out to keep us safe has been amazing …"

A very big thank you … from a very grateful resident alive and kicking in your tender care."

Feedback from staff member:

"Residents [with dementia] are so happy to see their loved-ones on FaceTime now visits aren't possible".

Written feedback from resident:

"A huge thank you for all the thoughtful and helpful ways that you are assisting us. Your efforts are practical and imaginative… we are particularly touched by the spring flowers just delivered."

Evaluation of a retirement village

An evaluation carried out in one of the respondent's retirement villages (where around 100 residents were living) exemplifies the extent and range of support that was being provided by retirement housing operators. The services and offerings provided by staff within the village included:

- driving 3,100 miles taking residents to appointments
- picking up for residents 50 prescriptions for residents
- delivering 4,390 of hours of care
- serving 1,560 takeaway coffees
- delivering 750 meals from the restaurant to residents, and 160 easter eggs
- organising six visits from an ice cream van.

66% of the village residents returned a completed questionnaire giving feedback on the organisation's response to COVID-19 so far:

- 90% said they felt safe
- 90% said staff were supportive
- 90% found the takeaway and delivery services useful
- 89% said they benefited from the village shop
- 86% enjoyed the outdoor activities organised
- 88% said the operator kept them informed with government updates.

40 residents regularly took part in outdoor Zumba**,** and 20 in outdoor Qi Gong.

Examples of comments made by the village residents:

"As a new resident I was impressed by the trouble and expense [the village] have gone to, and by how all residents adhered to the instructions thereby keeping us all safe."

"We felt very safe and well looked after during lockdown. All our friends said they wished that their conditions had been as good as ours!"

"The village shop was a lifeline as I couldn't get a delivery slot for 6 weeks. I think it is very useful to have essentials on site, particularly for those shielding or with no transport."

"Staff were all excellent all the way through. The concierge kept us all cared for – so much patience, nothing was too much trouble."

"[The operator] could not have done anything better given the unprecedented nature of Covid-19. The management and staff went above and beyond in every aspect to protect, support and assist all residents."

An academic evaluation commissioned by a large ECH operator

To understand the impact of COVID-19 and the effect of the operator's lockdown measures, an online survey was sent to all residents with an email address, asking questions regarding the first wave national / location lockdown and the operator's response to keeping residents safe. 199 completed surveys were returned, the largest proportion (49%) from the 75-84 age group.

The vast majority,

- agreed the operator was right to close its locations to the public a week before national lockdown in March (90%)
- felt safe living in an ECH scheme during the pandemic (84%)
- felt comforted knowing that staff and other residents were there with them (80%)
- agreed that staff had tried to keep residents mentally well and physically well during lockdown (67%)
- felt supported in getting essentials such as groceries and medication (80%)
- agreed the operator communicated well with them during lockdown (68%).

Almost all residents said they communicated daily with someone outside of the village.

For exercise, residents reported that they,

- walked (inside or outside in grounds; particularly outside village in countryside when possible/allowed)
- did exercises (stairs/corridors - not using lift, online/Joe Wicks, outside when possible)
- did weights - outside gym instructor/balcony exercises
- volunteered around their village (e.g. deliveries or dog walking).

Regarding the impact of Covid-19 and lockdown on mental and physical health, findings highlighted a noticeable deterioration in physical health, not helped by boredom/restrictions (e.g. pre-lockdown was very active but became almost inactive),

- 85% reported feeling sad at not being able to see children/grandchildren
- 77% reported being worried about friends and family members
- 41% reported feeling socially isolated during lockdown
- 39% reported that COVID-19 had negatively affected their mental health.

Resident groups more adversely affected and/or less able to cope or accept changes

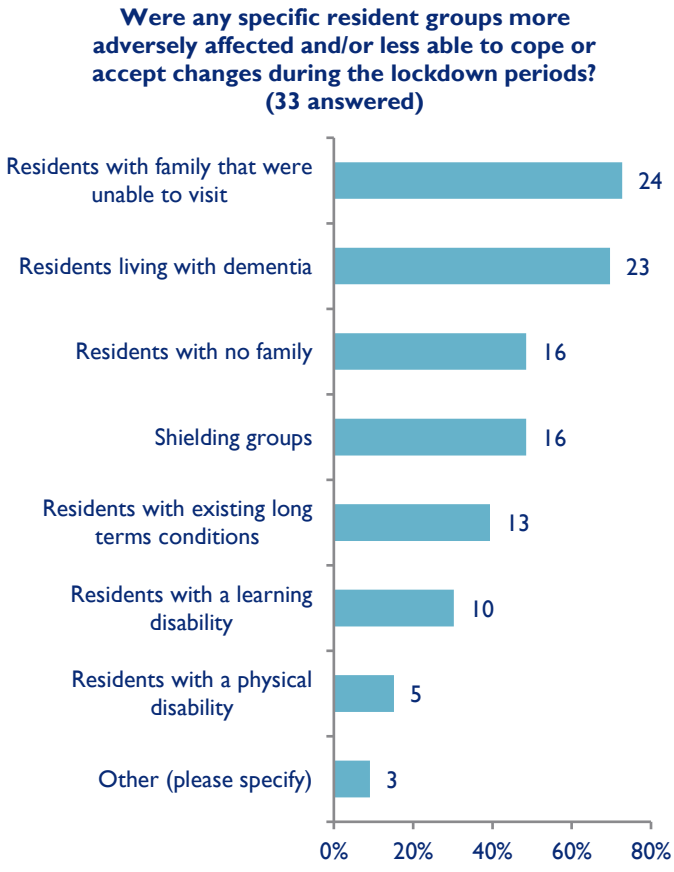
33 provided answered this section.

Chosen from a list of options, over 70% of respondents indicated that their 'residents with family that were unable to visit' and 'residents living with dementia' were the groups more affected and/or less able to cope or accept changes. Proportionately more of them were ECH operators (15 ECH v. 5 RV, and 16 ECH v 3 RV).

Other groups considered to have been more affected were:

- 'Residents with no family' and 'shielding groups' (48%).
- 'Residents with existing long terms conditions' (40%), proportionately more RV operators ticked this (67% of the RV survey respondents compared to 24% of the ECH and 28% of the RV&ECH survey respondents).
- 'Residents with a learning disability' (30%), all were ECH (9/10) or RV&ECH (1/10) operators.
- 'Residents with a physical disability' (15%), all were ECH (4/5) or RV&ECH (1/5) operators.

Chart 24: Specific resident groups chosen from a list as being more adversely affected during the periods of lockdown



Three operators specified other groups of residents who they felt had been more adversely affected by the lockdowns:

- Residents with existing life limiting diagnosis and those living with specific existing mental health condition such as depression.
- Residents with pre-existing mental health conditions.
- Residents with unpaid care (e.g. family or friend) where commissioned alternative was deemed less suited to meet the need. Result was service picking up unmet needs.

Residents experience accessing health services for non-COVID-19 health issues

34 respondents selected a response choice in reply to the question:

> *'Have any of your residents had difficulty accessing these health services for non-COVID-19 health issues: Dentist, Optician, Chiropodist, Physiotherapist, GP, Specialist NHS health support they would normally receive, Outpatient hospital appointment?'*

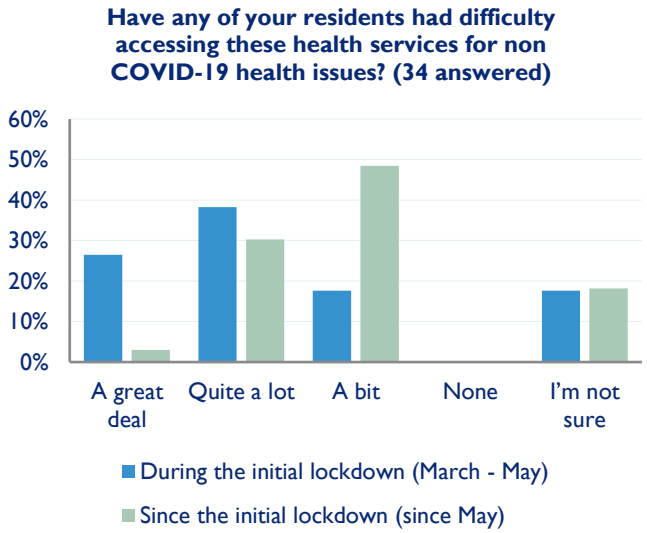
All but six, who were not sure, indicated residents experienced continuing difficulty accessing health services for non-COVID-19 issues both during and since the first lockdown (see Chart 25).

Of the 28 who were sure:

- 78% said 'a great deal' or 'quite a lot' of difficulties were experienced by residents during the initial lockdown compared to 41% after the initial lockdown.
- 'A bit' of difficulty increased from 21% to 59% post-lockdown.

No respondents indicated that their residents had not had difficulties accessing the non-COVID-19 health services.

Chart 25: Difficulty residents have had accessing non-COVID-19 health services during and since the initial lockdown

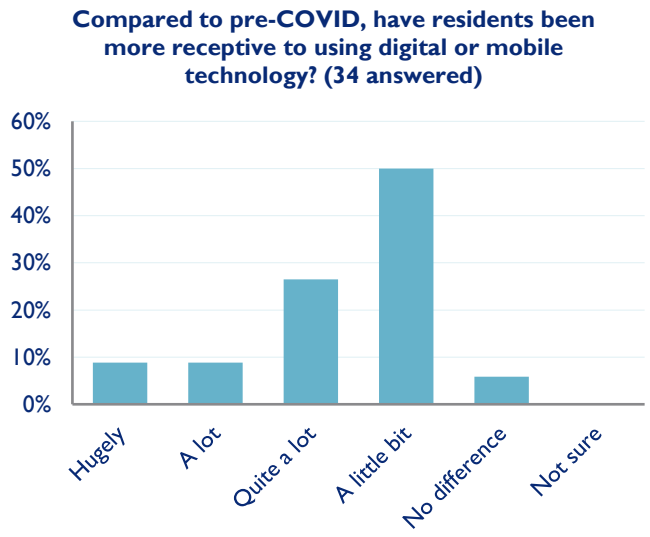


Residents use of digital of mobile technology

96% of 34 respondents indicated that their residents were more receptive to using digital or mobile technology compared to before the pandemic.

Most (50%) said residents were 'a little bit' more receptive, 35% said 'quite a lot' or 'a lot', and 9% (3/34) said 'hugely' (see Chart 26).

Chart 26: Residents' attitude to using digital or mobile technology since the start of the pandemic



"Some individuals have had direct benefit from the use of digital technology and will no doubt continue to use it ... access for others has been limited and the traditional barriers remain of paying for an individual internet connection and having the necessary support to facilitate the effective use of equipment. The inability of staff to work in close proximity with residents had made it more challenging to support residents to use technology during lockdown"
[large ECH operator]

Further details provided by respondents
[number of operator's villages/schemes in brackets]:

- "Our teams have helped many residents connect to their families, join digital exercise classes, quiz nights etc." [6 RVs]
- "Some video calls with family." [1 RV, 3 ECHs]
- "Facetime calls." [RVs]
- 'They used Zoom/Microsoft Teams & Village/ Leisure apps'. [RVs]
- "More devices were supplied to the sites and training." [4 RVs and 1 ECH]
- "We reintroduced digital inclusion sessions to train them in use of mobile tech - more take up than when previously delivered." [1 RV and 1 ECH]
- "Where they have the capability and are digitally included." [1 ECH]
- "Lack of interest and/or ability to use technology." [2 ECHs]
- "We have had some positive engagement with digital inclusion, particularly where hardware is the issue (we have provided iPads etc.). Where IT skills or the benefit is not seen, education has been hard to administer. There has been some success however and we are currently entering into several partnerships to engender learning remotely (click silver)." [8 ECHs]
- "We distributed tablets to the sites pre-installed Skype, Zoom, Chrome and YouTube to help residents stay in touch with their loved-ones. Dedicated IT support was made available to residents to help them with these and their own devices and other IT issues." [4RVs, 1ECH]
- Another operator felt there had been a noticeable increase in residents' confidence with the use of digital applications such as video calling and social media. An online residents survey they carried found that almost all respondents said they communicated daily with people outside the location via the telephone (95%), video calls (62%), and social media (52%).

7.14 Working with NHS, other health and social services

Access to funding from the NHS or local authority where operators villages/schemes are located

Around 35% of operators (12 respondents) ticked that they had been able to access funding to meet any additional expenditure their organisation has made to respond to COVID-19 in their villages and schemes, slightly more of the ECH operators (28%) and EV&ECH operators (36%) ticked this than the RV operators (22%).

One respondent said that the:

"LA provided plus 10% income in first lockdown so we could provide more support in a flexible way."
[operator with 1 RV and 3 ECH schemes]

Contact from social services about residents' planned care needs

Around 35% of operators (12 respondents) ticked that they had been contacted by social services about the planned care needs of their residents in their developments/schemes. This represented: 45% of the survey's ECH respondents and 43% of the RV&ECH respondents.

Use of Local Resilience Forum(s) during the pandemic

Around 44% of operators signified that they had made use of their Local Resilience Forum(s) during the pandemic, the majority (73%) of them were ECH operators. The 15 who answered were made up of:

- 50% of the ECH total number of survey respondents.
- 33% of the RV&ECH.
- 22% of the RV.

However, the Forums were not always helpful as shown by these comments from an ECH operators,

"Local Resilience Forums expected housing operators to pick up customer needs, health and social care assumed a higher level of service provision on discharge from hospital"

"We encountered issues due to capacity in social care and health services".

7.15 Challenges due lack of awareness among local health and social services of the RV and ECH offer

Around 56% of operators (19 respondents) said they had encountered challenges because their local health and social services do not fully understand what retirement villages and extra care housing offer (similar proportions of RV, ECH and RV&ECH respondents).

Other respondents' comments give examples of the range of issues experienced:

"Initially there were challenges in everyone being on the same page as to what the EC schemes could and could not offer, especially around the hospital discharge of individuals with COVID-19 and the ability for ourselves as landlords to control the extra care environment"
[operator 100+ ECH schemes]

"We have been pushing for vaccinations for the wider village (where the average age is c.80); some councils/NHS trusts have understood the model, but many have pushed back and told us residents will have to wait until their age category is invited"
[operator with 6 RVs]

"We had social workers refusing to visit and particularly mental health services"
[operator with 2 ECH schemes]

"Initially there was a lot of pressure from some local authority commissioners and care operators to 'lock down' our schemes and monitor/control all visitors."
[operator of 100+ ECH schemes]

There was one positive comment from an ECH operator (9 schemes) who wrote:

"Local advice and assistance where necessary from PHE/local Infection Control teams has been very good and they have understood the model".

Possibility that village/schemes could offer 'step down' facilities to smooth the discharge of non-COVID-19 patients

21% of respondents (7/33) said 'yes' they could support the NHS by offering 'step down' facilities to smooth the discharge of non-COVID-19 patients, 36% (12/33) 'possibly' could, and 36% said 'no' (proportionately more of them were RV operators).

The 57% that could or might be able to offer 'step down' were made up of:

- 75% of the RV&ECH total number of survey respondents.
- 60% of the ECH.
- 44% of the RV (all answered 'possibly' only).

Nine respondents gave details and all who had said that they could offer step down facilities were already doing, so or looking to do so, see Table 16 below:

Table 16: Details provided by operators regarding their current or potential 'step down' facilities for non-COVID-19 patients

Response	Detail provided	Housing type	Nº of residents
Yes	There are 2 social care assessment apartments within the complex.	ECH	Up to 250
Yes	This was rolled out across the country and utilised by a number of schemes. A 'grab and go' pack (inc. agreement and license templates, procedures etc.) designed for colleagues in the very early stages of the first lockdown. A number of guest rooms on schemes were used in the beginning and there continues to be extended use of them and some otherwise void apartments. Some local authorities have expressed an interest in making these a permanent arrangement.	ECH	1000+
Yes	We have one scheme at present that has step down apartments. We are looking to introduce step down units at a further two extra care schemes.	ECH	Up to 250
Yes	Currently operate 5 Neighbourhood Apartments.	ECH	Up to 250
Yes	We are in discussions with North Tees NHS.	ECH	251-999
Yes	We are currently running a pilot with five flats available for short stay through hospital discharge.	RV&ECH	251-999
Possibly	Only where we had rental properties available and we were fully reimbursed for void loss and the service we would provide.	RV	1000+
Possibly	Discharge beds - we have move on beds in place.	ECH	251-999
Possibly	Subject to capacity of care operators.	ECH	251-999
Possibly	We have a Neighbourhood Apartment as step down – concern over discharge of people still testing positive (although people may also be self-isolating in same building - issue with perception).	ECH	Up to 250

7.16 Operational matters: looking forward

Important learning or plans should there be further localised for national lockdowns

29 respondents answered this section.

The mains themes of their learning or plans from the experience to date were (and the number who mentioned each one):

- Have a set of plans, a model and/or a framework of processes and templates in place. [15]
- Have plans for specific aspects (a dedicated COVID-19 Governance team, safe operating procedures, reduced visiting, closure of communal spaces, home deliveries for residents, etc). [12]
- Effective communication and communications. [11]
- Risk assessments. [8]
- Permanent changes to working practices made. [5]
- Ensure access to and use of PPE. [4]
- Harness technology (for residents or operations). [3]

"We contacted each resident daily, for a welfare check and to take their orders for shop and meal deliveries. We have sent out weekly updates and had regular meetings with the residents' association to discuss all changes to the village due to the COVID-19 guidelines."
[RV operator, anon]

"One important supportive action is the identification of the most vulnerable individuals who may be at risk of malnutrition/ dehydration from eating alone. This concern led to putting in place COVID-19 secure communal dining arrangements to support those individuals most at risk."
[ECH operator, over 100 schemes]

Table 17 (overleaf) outlines operators' key learning or plans, with number of respondents who cited each them.

Table 17: Operators key learning or plans, with number of respondents who cited each theme

Key Learning or plans	No	Details and examples
Have a set of plans, a model and/or a framework of processes and templates in place	15	▪ We created a suite of Continuity Plans for care, catering and maintenance. ▪ We have a fully scoped four stage plan which covers all services, facilities, development, maintenance, construction, support etc. - fully prepared. ▪ Business Continuity Plans utilised for learning. ▪ A structure of operational guidelines, risk assessments and SLA for each tier that can be quickly implemented on a local or national level as guidance changes. ▪ Enhanced Business Continuity Plans to reflect both local/regional group wide scenarios. ▪ Updated within 48 hours every time guidance changes. ▪ Clear guidance/processes/well-being for both staff and residents. ▪ Mobilisation and demobilisation plans to deliver effective service and be responsive to changes. ▪ Pre drafted comms, online rapid recruitment processes, 'heat maps' for staffing level stress, outbreak procedure, communication and decision making framework, ongoing crisis response and management.
Have plans for:	12	▪ A *central crisis management team* who are emotionally removed providing support and consistent advice at all times. ▪ We set up a *dedicated COVID-19 governance team* led by operations and decision making/changes introduced as/when required. ▪ More resilient continuity plan. ▪ Cleaning standards. ▪ Clearer emergency planning process. ▪ Delivering activities to residents. ▪ Home deliveries set up where not already in place. ▪ Outbreak contingency. ▪ Proactive response. ▪ Reduced visiting. ▪ Closure of communal areas (x2). ▪ Suspension of reletting properties. ▪ Safe operating procedures.
Effective communication (staff, residents and other stakeholders)	12	▪ Good communication with residents, staff and other stakeholders ▪ Weekly phone calls with front line managers, to share ideas, concerns and offer advice. ▪ Communication was key to ensure we followed latest guidance. ▪ Phased plan to enable swift communication to colleagues and customers. ▪ Keeping in touch with residents by phone and through newsletters ▪ Ongoing regular communications with residents and visitors . ▪ Weekly team meetings. ▪ Improved communications plan for residents. ▪ Robust communications to staff. ▪ All staff are consulted and changes are implemented as a team and all are willing to adapt to changing guidelines.
Risk assessments	8	▪ Risk assessments for staff. ▪ Risk assessments for outbreaks in place. ▪ Robust risk assessments have been put in place to protect staff and customers.
New normal working arrangements /permanent changes to working practices	5	▪ Minimum service provision standards. ▪ Option for more remote working. ▪ Less unnecessary travel. ▪ We have collected lessons learnt as the experience has changed some of our working practices permanently.
PPE	4	▪ PPE measures. ▪ Ready access to PPE. (x3)
Technology	3	▪ Online access for all customers to a tablet or laptop, ensuring all customers can Zoom or log in to information online about staying healthy, keeping in touch and reassurance. ▪ Plans to support moving forward in a more digitalised approach if possible.
Local partnerships	1	

Operators' key concerns going forward

"Reduced social interaction for residents and impact on well-being"

"How best to improve morale and well-being of staff"

"Will the vaccine still work next year?"

"Contracts for commissioned services do not allow for the additional pressures on staffing"

32 respondents answered this section, the majority (60%) detailing concerns in all four open text boxes, citing 118 key concerns in all.

The most common key concerns related to:

- Resident well-being (20%).
- Staff well-being (16%).
- Loss of revenue and financial pressures (16%).

The details of operators' stated key concerns going forward, grouped by theme, are provided in Table 18 below. It displays the number of respondents who mentioned a related item and the percentage of the total items (118) within each theme.

Table 18: Operators' key concerns going forward, with number of respondents who cited each theme and % of total items mentioned

Theme	No	Details and examples
Well-being – residents **Emotional, mental, physical, and financial**	24	▪ Isolation/loneliness/reduced social contact (x 11) ▪ Ongoing tenant isolation especially when in outbreak ▪ Loneliness of single residents ▪ Impact on mental health (x 6) ▪ Further deterioration of mental health in residents ▪ Long term impact on physical well-being (x 3) ▪ Decline in residents mobility leading to more hospital admissions ▪ Deterioration of health and well-being ▪ Ongoing stresses/resilience if pandemic continues (x4) ▪ The impact on customers well-being due to the length of the pandemic ▪ Residents' frustrations and weariness (x3) ▪ Understandable frustrations of some residents about not being able to use communal areas ▪ Weariness about on-going restrictions ▪ Residents fear of socialising ▪ Financial impact on service charges and on-costs to residents

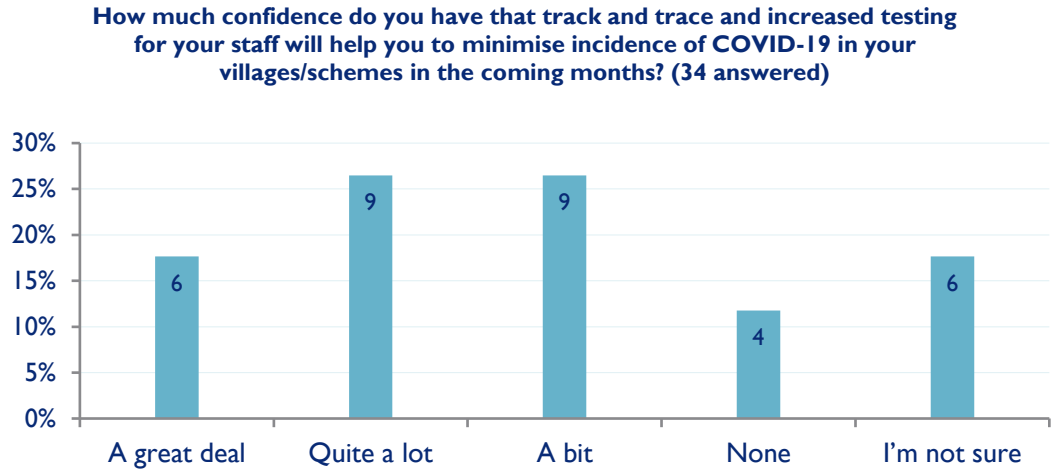
Well-being - staff	20	▪ Mental health/further deterioration/long term impact on mental health in staff. (x5) ▪ Staff burnout. (x3) ▪ Team/staff morale. (x4) ▪ Team work-life balance. ▪ Ongoing stresses/anxiety if pandemic is prolonged. (x3) ▪ Staff isolation. ▪ Face to face interaction with staff/colleagues. ▪ Impact on staff well-being due to the length of the pandemic.
Loss of revenue/financial pressures	20	▪ Prolonged financial impact/additional costs/loss of revenue. (x6) ▪ Impact and delays on unit/property sales or lettings. (x6) ▪ Cost of cleaning bill/higher costs of cleaning and PPE. (x5) ▪ Reduction of referrals and nominations. ▪ Contracts for commissioned service do not cover additional staffing needs. ▪ Losses resulting from closed services. ▪ Long term funding cuts due to damage in the economy. ▪ Continued funding through the infection control fund.
Vaccine/vaccinations	9	▪ Vaccinations completed for all residents and staff. (x5) ▪ Length of immunity the vaccine provides. (x2) ▪ Vaccinations being delivered on time. ▪ Staff and customers may not take the vaccine. ▪ Vaccine hesitancy.
Staffing	7	▪ Staff sickness and absence. (x2) ▪ Staff leaving due to the risk or stress. (x2) ▪ Recruitment to key frontline roles. ▪ Increase staffing levels not sustainable.
Continued lockdown/how long the pandemic will last	5	▪ Continued lockdown(s). (x3) ▪ Recurrent imposing of restrictions. (x2)
How to …	5	▪ How to safely reintroduce 'non-essential' services into scheme. ▪ How to safely re-open communal areas. ▪ How to unlock what the new normal will look like after vaccination. ▪ How to best improve morale and well-being of staff.
Complacency/going back to normal life too soon	4	▪ Complacency as vaccine rolled out. (x4) ▪ Customers may not wait until it is safe to reconvene day to day life and increase the infection among themselves. ▪ Maintaining infection control in event of community perception of decreased risk (for example if restrictions are lifted and visitors and residents 'return to normal too soon' or behaviour ignores visitor rules (visitor bans are not especially enforceable outside of national restriction). ▪ People who are vaccinated not adhering to restrictions and putting others at risk.
Other	4	▪ Access to the PPE portal. ▪ Impact of lateral flow testing on staffing and administration of it to residents. ▪ Re-opening hospitality services. ▪ Sustaining the all scheme testing approach within EC.
Safety of staff and residents	4	▪ Ensuring schemes are safe/COVID-19 free. (x3) ▪ Restricted access to health professionals increasing need for hospital admissions.
Spikes in COVID-19 cases/increased strains and risk of infection	4	▪ More waves of increased COVID-19 cases. ▪ New variants annually.
Maintaining and covering frontline services/visits	4	▪ Delivering front line services if staff reduced (particularly care). ▪ During increased levels of infection. ▪ Sustaining the current support mechanisms to reduce loneliness and isolation.
Fear/worries/concerns	3	▪ Fear of future pandemics. ▪ In-house concerns about other teams accessing the enclosed buildings/schemes. ▪ That this is now a permanent situation, and that the repercussions will remain for years.

Perceptions of extra care/concept of older people's housing	3	▪ Any lasting change in the perception of EC **and how this affects occupancy**. ▪ Concept of older people's housing. ▪ The antipathy towards care homes moving forward, putting older people at greater risk of accidents and loneliness.
Change of village/scheme culture	2	▪ Rebuilding a sense of community.
Future of housing and care for older people	2	▪ Not enough planning for our older generation to support them in older age. ▪ Recession and subsequent lack of confidence in the housing market - leading to less homes that are suitable for older persons being built.
Need clear guidance specific to housing-with-care/extra care	2	▪ Guidance that recognises joint agency working between care and housing staff.

Confidence in NHS track & trace and increased testing for staff

44% of 34 respondents said they had 'quite a lot' or 'a great deal' of confidence that track and trace[26] and increased testing for staff would help them to minimise incidence of COVID-19 in your villages/schemes in the coming months; 26% said 'a bit' (see Chart 27 for details).

Chart 27: Operators' confidence in track and trace



[26] The name of the NHS COVID-19 contact tracing app when it was first launched in October 2020.

8 Conclusions

Effectiveness of the operators' pandemic response

The efficacy of RV and ECH operators' response to the pandemic is evident from the positive feedback and overall positive experiences of residents, and the level of protection afforded to them; resident COVID-19 death rates were lower than expected when compared to people of similar ages residing in the wider community

This has been achieved despite the lack of guidance or support felt by operators, together with the significant challenges and pressures they have faced (many in common with those experienced by care homes) at an unprecedented time.

Operators have demonstrated high levels of proactivity, competence and resilience, as well as large amounts of innovation, flexibility and care. They have gone to great lengths to maximise their ability to support the health and well-being of their residents, staff and visitors during the pandemic.

This has included providing regular well-being phone calls for residents and increased support mechanisms to reduce loneliness and isolation arising from the necessary reductions in social contact opportunities.

Severe pressures and challenges

The COVID-19 pandemic has exerted a huge strain on operators. In common with care homes, many of the major operational pressures and challenges they faced related to anxiety, stress, numbers of staff off work self-isolating or shielding, staff burnout, staff shortages, managing expectations, lack of availability of PPE, and striving to protect health and well-being.

The volume of government rule and guidance changes meant the need for continuous decision-making, and adapting of practice, procedures, policy, guidance and communications.

Particular to the RV and ECH sector were difficulties caused by a lack of access to financial support, the lack of inclusion in national guidance (especially early on), the lack of inclusion of housing setting care and support staff in regular retesting from the summer, and then in access to vaccinations.

Furthermore, a range of important disparities and issues were caused by the lack of awareness of the RV or ECH models among some local hospitals, local authorities, and health and government departments.

Distinctive challenges also arose from the fact that RVs and ECH schemes provide independent living for residents who own or rent their apartments and are, under normal circumstances, able to come and go as they choose.

Operators had to manage complexities and strike a balance between maintaining the individual rights and freedoms of residents whilst maximising the safety of those living and working in the village and scheme communities. For this, it was essential to continuously work and communicate effectively with staff, residents, their families and visitors, including contractors.

Inevitably, there were some residents and visitors who either did not understand or did not want to comply with COVID-19 rules and regulations and this caused a lot of pressure and work for operators.

Maintaining the morale, well-being and safety of residents and staff were top of the agenda last year for operators and will remain so, they say, for the foreseeable future.

Operators hit hard financially by the pandemic

The costs and losses incurred due to the pandemic have far outweighed any savings or funding received, and many costs are still on-going.

This will have led to tough business conditions and difficult decisions being made such as suspending recruitment to non-frontline roles and making staff redundant.

Nearly 70% of operators said they had not received any financial support, this included organisations across the range of sizes and housing types.

Both the lack of funding or access to grants, such as local resilience grants, and inconsistent processes of funding were among the biggest challenges being faced by operators.

Measures for successfully managing any new localised or national lockdowns in the future

Successful measures shared by operators focused on having a framework of emergency command, plans, processes, procedures and templates ready in place.

Highlighted as being especially important were implementing comprehensive risk assessments, ensuring access to PPE, and the means for effective communication to all stakeholders (particularly residents, their relatives and staff).

Consultation was considered very beneficial for keeping people included in the decision-making, up to date and on board with changes.

Operators' concerns for the next phase

There are major concerns for operators going forward regarding resident and staff well-being, loss of revenue and other financial pressures, especially if further lockdowns ensue. There is concern regarding how long the vaccines were going to afford protection, how many will agree to be vaccinated, and how difficult it will be to maintain infection control in the event of premature community perception of decreased risk. Continued vigilance, protective measures and restrictions will be needed for some time to come meaning enduring repercussions, financially for operators, and on daily life for residents and staff.

What is housing-with-care?

A clear legal definition of housing-with-care would have aided the sector's response to the COVID-19 pandemic. Unlike in care homes, for example, the lack of legal definition for housing-with-care schemes meant that no specific guidance or regulation was produced for the sector.

There was guidance for supported living which has some read across to housing-with-care (for example on visits); however residents in supported living schemes are frequently working-age disabled people, who may be living in individual homes or shared bungalows, and where the scale of the scheme and the services offered may be very different to those in RVs and ECH schemes for older people.

Despite the vulnerability of residents, housing-with-care schemes did not receive priority in the infection control fund guidance. It became apparent that government and local authorities were also not aware of the location of all housing-with-care settings and did not hold central data on their populations and needs. ARCO provided assistance to government in

gathering this data so those settings which had more vulnerable populations could be identified and asymptomatic whole scheme testing arranged.

The lack of central information may have led to many RV and ECH residents having to attend vaccination appointments in the community, whereas they could have been offered in-scheme vaccination on a par with that delivered in care homes. What is more, a register of housing-with-care schemes may have allowed both testing and vaccination to have been rolled out more quickly.

The lack of definition additionally meant that it was more difficult to obtain exemptions and special arrangements in regulations and guidance to meet the needs of the sector. A definition of "extra care housing" was eventually provided in the 2 December 2020 "Tiers" Regulations, in order to allow restaurants to remain open for residents where this was necessary for their mental or physical welfare, but even this definition did not cover all schemes.

9 Recommendations

Some of the major challenges and difficulties faced by operators could be overcome by:

- A shared awareness and understanding of the housing-with-care model (including a widely publicised and consistently used legal definition), which reflects its important role in the broader care sector, and the extent of the frailty, health and care needs they provide for.
- The inclusion of the housing-with-care sector in all relevant policy and guidance ensuring, where required, that any guidance is specifically tailored to RVs and ECH as well as to care homes.
- Government rules and guidance being developed in consultation with experts, communicated clearly and consistently, with realistic and practical notice periods to implement them.
- The provision of better access to funding to alleviate large financial deficits incurred by RVs and ECH due to the pandemic.
- Consistent processes of funding across local authorities.
- Flexibility built into contracts for commissioned services so they cover costs of essential additional staffing if need arises.
- Future villages and schemes should be 'pandemic ready'. Buildings should be designed to allow for enhanced infection control, adaptable for social distancing and the reduction of virus risk.

  This includes the ability to introduce 'one way' systems, reduce footfall, enhance ventilation/air quality, restrict or prevent entry to visitors when necessary.

  Also important are appropriate work and office spaces for staff, as well as facilities of particular benefit for resident well-being such as apartment balconies and outdoor spaces.

10 Appendices

10.1 The RE-COV main questionnaire and summary report

The **RE-COV Summary Report** (April 2021) is available for download from,

https://www.housinglin.org.uk/Topics/type/RE-COV-Study/

https://www.stmonicatrust.org.uk/re-cov-study

where a PDF version of the operators' **RE-COV questionnaire** can also be found.

10.2 Partner organisations

St Monica Trust

The St Monica Trust is a Bristol-based charity with a reputation for providing high quality accommodation and innovative care for older people. The Trust employs over 1,200 staff to ensure that they give the best support possible to those living in their retirement communities and care homes. In addition, the Trust's Community Fund distributes more than £750,000 each year to individuals, families and organisations across the region to help tackle issues that affect the lives of older people.

For more information visit https://www.stmonicatrust.org.uk/

Housing LIN

The Housing LIN is a sophisticated network bringing together over 25,000 housing, health and social care professionals in England, Wales and Scotland to exemplify innovative housing solutions for an ageing population. Recognised by government and industry as a leading 'ideas lab' on specialist/supported housing, our online and regional networked activities, and consultancy services:

- Connect people, ideas and resources to inform and improve the range of housing that enables older and disabled people live independently in a home of their choice.
- Provide insight and intelligence on latest funding, research, policy and practice to support sector learning and improvement.
- Showcase what's best in specialist/supported housing and feature innovative projects and services that demonstrate how lives of people have been transformed.
- Support commissioners and operators to review their existing provision and develop, test out and deliver solutions so that they are best placed to respond to their customers' changing needs and aspirations.

To access related resources on the Housing LIN Coronavirus Info Hub visit:
https://www.housinglin.org.uk/Topics/browse/HealthandHousing/coronavirus-info-hub/

Or email us at: info@housinglin.org.uk.

The Dunhill Medical Trust

The Dunhill Medical Trust funds remarkable science and the radical social change needed for healthier older age. We support researchers and communities, systems and services, fundamental science and applied design.

We're committed to applying our resources to inspiring and enabling academic researchers (from across the disciplinary range) and health and social care professionals to apply their knowledge and skills to:

- Improving the quality of life, functional capacity and well-being for older people now, or
- Creating the context for change in the future: preventing, delaying or reducing future health and social care requirements.

We also want to play our part in informing and influencing the collective understanding of "what works" and enabling community organisations to develop innovative, evidence-informed and best practice ways of delivering care and support for older people and drive systemic change needed to secure a healthier later life for us all.

For more information visit: www.dunhill.medical.org.uk

10.3 Useful reading

Extra care housing – what is it in 2015? (HLIN, 2015)
https://www.housinglin.org.uk/_assets/Resources/Housing/Housing_advice/Extra_Care_Housing_-_What_is_it_2015.pdf

Housing with care Guidance on regulated activities for providers of supported living and extra care housing (Care Quality Commission, 2015)
https://www.cqc.org.uk/sites/default/files/20151023_provider_guidance-housing_with_care.pdf

Housing LIN Coronavirus Information Hub
https://www.housinglin.org.uk/Topics/browse/HealthandHousing/coronavirus-info-hub/
Safe, Happy and Together: Design ideas for minimising the spread of infection whilst nurturing social interaction in later living communities (PRP architects, July 2020)
https://www.housinglin.org.uk/_assets/Resources/Housing/OtherOrganisation/Minimising-Infection-Later-Living-Communities.pdf

Housing LIN resources on designing extra care housing
https://www.housinglin.org.uk/Topics/browse/Design-building/Design/

Design Principles for Extra Care Housing, 3rd edition (Housing LIN, June 2020)
https://www.housinglin.org.uk/_assets/Resources/Housing/Support_materials/Factsheets/Design-Principles-For-Extra-Care-Housing-3rdEdition.pdf

Design and Cost Considerations for Extra Care Housing (Housing LIN, July 2020)
https://www.housinglin.org.uk/_assets/Resources/Housing/Support_materials/Reports/Design-and-Cost-in-Extra-Care-Housing_June-2020_RevC.pdf

Housing, Health and Care, the Health and Wellbeing Benefits of Retirement Communities (ARCO and ProMatura, 2019) https://www.arcouk.org/resource/housing-health-and-care

Guidance - COVID-19 Guidance for Supported Living (Department of Health & Social Care and Department of Public Health, Updated March 2021) https://www.gov.uk/government/publications/supported-living-services-during-coronavirus-covid-19/covid-19-guidance-for-supported-living

Guidance - Supported Housing: National Statement of Expectations (Department for Work & Pensions and Ministry of Housing, Communities & Local Government, 20 October 2020)
https://www.gov.uk/government/publications/supported-housing-national-statement-of-expectations/supported-housing-national-statement-of-expectations