Housing and Adult Social Care

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Scoping Review

Improving the evidence base for adult social care practice

The School for Social Care Research

The School for Social Care Research was set up by the National Institute for Health Research (NIHR) to develop and improve the evidence base for adult social care practice in England in 2009. It conducts and commissions high-quality research.

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ABSTRACT

The potential contribution of housing to the goals of social care has been recognised for some time, although in practice housing and social care have often existed in separate silos with little overlap and some duplication. In the context of public sector austerity and the policy push for integration, there is a need for greater understanding of the research and where the gaps are in the evidence base. As the NIHR School for Social Care Research approached the completion of its first five years of operation, it commissioned a scoping review of the evidence on housing and adult social care.

While not a systematic review, we carried out a wide-ranging review of the available literature – academic and grey[1] – gathering evidence published in the UK over the last 10 years from 2003. Evidence covered: housing and prevention of the need for adult social care; housing and delaying the need for adult social care; alignment of housing with the integration of health and adult social care; and cost and cost-effectiveness studies. The review was desk-based, involving a search of online databases using key words, web-sites and the research team's knowledge of completed and current research projects. A total of 119 articles, reports and other documents were identified as relevant and were included in the review.

The review revealed some good evidence about the role of a number of housing interventions, such as housing with care for older people, aids and adaptations, and handyperson services in preventing and/or enabling people to live independently in their own homes. There were also cost-benefit studies across the UK indicating that the former Supporting People programme yielded net benefits for most groups who use social care, mainly by the assumed delay or avoidance of long-term residential care.

Most of the evidence identified focused on a particular service or intervention with regard to a specific client group – mainly older people – rather than an overarching theme such as prevention or enabling independent living. Thus, the research often reflected the actual silos that affect the sector.

The review revealed gaps in the evidence base, particularly around:

- private sheltered and extra care housing,

- recent changes in the nature of sheltered/retirement housing,

- specific client groups – for example, people with mental health needs and/or learning disabilities, and

- the alignment of housing with the integration of health and social care.

The great majority of research studies were conducted in England.

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1 Grey literature is broadly defined as everything except peer reviewed journals.

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In terms of the research covered by the review, many of the items identified as part of the search activity were not robustly designed research projects published in peer-reviewed journals. Much of the material retrieved came from bodies with an interest in the area and public sector organisations. It is possible that the search terms (which were focused on outcomes) may not have picked up articles concerned with a specific intervention or client group; therefore, some relevant studies may have been omitted.

Overall, the range of methodological approaches within the research studies was limited. There were very few randomised controlled trials, cross-sectional or longitudinal studies. Much of the research evidence comes from evaluations of a small sample or a single case study.

Some of the key gaps in terms of the outcomes of prevention, enabling independent living, integration and cost-effectiveness are briefly summarised below.

Prevention

There is a lack of long-term research on the role of housing in preventing or delaying the need for adult social care. While there is evidence about the role of extra care housing in delaying older people's need for residential and nursing care, there is little information about how effective it is for other client groups, in particular people with learning disabilities. Little is known about the role of informal carers in either sheltered or extra care housing in contributing to the goals of prevention or enablement.

More research is needed about which types of low-level services that enable independent living are most cost-effective at preventing or avoiding the need for care, and whether some client groups may benefit more than others. This would assist the targeting of available resources.

More research is needed to identify new forms of housing that can promote self-care and self-help, and prevent a move to more long-term care, for example, exploring models of co-housing.

Enabling independent living

There is some good evidence from housing with care, aids and adaptations, and handyperson schemes for older people, that these services have enabled people to live independently, but there has been little research on either the preventive or enabling role of private sector extra care or sheltered housing. There is a gap in the evidence base about the role of extra care in enabling independent living and addressing the future housing and care needs of older people from black and minority ethnic communities; older single men; people with learning disabilities; and informal carers. There continues to be a question about the extent to which extra care housing is a 'home for life', under what circumstances should people be expected to move on to different forms of care provision, and who makes the decision.

Further research is needed to explore the impact of changes to the resident 'mix' of tenant profiles in sheltered housing (including residents under pension age; residents with a wider range of support needs; residents who are very old/frail/with high care needs). We know least about people living in private sector sheltered or retirement housing or private rented retirement housing, the majority of whom are self-funders.

There is little systematic evidence about the effectiveness of housing related support and low-level interventions in enabling independent living for some client groups, including people with learning disabilities, people with mental health needs, homeless people, and people who misuse substances.

Integration

More research is needed into the role of housing in relation to the integration of health and social care, although there are few working examples in practice. The available research on Home from Hospital services has been conducted by provider organisations, and there is a lack of robust, independent evidence about the outcomes and cost-effectiveness of these services.

In addition, there has been little research into the most effective management arrangements for housing with care: whether separate, combined or integrated staffing models are more effective at enabling independent living. In general, the organisation and management of housing with care and other forms of retirement communities are not widely discussed in the research literature.

Cost-effectiveness

Although there have been a growing number of studies involving some element of cost-effectiveness or value-for-money analysis, the evidence base is still weak in relation to housing and adult social care and frequently involves some heroic assumptions about the cost offsets or what has been prevented. Many benefits are difficult to cost and are likely to accrue over time, while many of the wider costs are also difficult to quantify and to attribute to a particular measure. While there have been several cost-benefit studies of the Supporting People programme, there has been little attempt to cost the benefits beyond the assumed avoidance of higher cost forms of care.

Evidence on cost-effectiveness is stronger in some areas of activity (for example, aids and adaptations and handyperson services) than it is for floating support or telecare, where it often appears to complement rather than substitute formal and informal care, and information and advice.

Little is known about the cost-effectiveness of different sizes, designs and models of organising and managing care in extra care housing. There is a need for a better understanding of which types and organisational models offer the best quality from the residents' perspective and are most cost-effective. No studies were identified which looked at how more efficient procurement of extra care housing could be achieved.

More research is needed to quantify the costs and benefits over time to specific client groups of housing interventions which include control or comparator groups, and measures for 'softer' outcomes such as enabling independent living.

KEYWORDS

Prevention, independent living, integration, cost-effectiveness, housing, adult social care.

BACKGROUND

As the NIHR School for Social Care Research approached the completion of its first five years of operation, it commissioned a number of scoping reviews to review the contribution of its current research projects, identify gaps in knowledge, and inform the research agenda for the next period of activity.

With the significant policy and economic challenges facing the sector, this review is focused on housing and adult social care with the aim of:

■ Establishing the size and robustness of the evidence base about housing and care services considered to be good practice for adults;

■ Ascertaining whether these have been evaluated and summarising their findings; and

■ Identifying gaps and weaknesses in the evidence base and what further research is needed.

The approach adopted in order to address these objectives predominantly took the form of a desk-based review supplemented by the authors' knowledge of the sector and expert contacts.

The report is structured as follows:

Firstly, we introduce a brief account of the policy context related to housing and adult social care, followed by a brief description of the methodology adopted for the review, and thirdly, discussion of the key terms employed in the report. We then set out the findings of the scoping review.

The review revealed a lack of evidence relating to some of the major themes. This is discussed in the first section of the findings in an overview of the nature of the evidence base. We then move on to examine the findings according to the following themes: prevention, enablement, integration, and cost-effectiveness, before examining the evidence in relation to specific housing and care interventions, and a brief consideration of the available evidence in terms of service user groups. We conclude with a discussion of the key points that emerged from the scoping review, the major implications of the review for future research, and the key research questions that need more evidence and further investigation.

Overall, the aim has been to provide both an up-to-date review of the research evidence relating to housing and adult social care, and to identify the main areas of interest for future research, policy and practice.

POLICY CONTEXT

The potential contribution of housing to the goals of social care has been recognised in policy documents for some time. However, this has mainly been in relation to older people rather than other client groups. The role of an older person's home in preventing or delaying the need for social care, and enabling them to continue to live independently, is assumed in a raft of both housing and social care policy documents. There is a frequent presumption that a more joined-up approach to prevention and enablement, and integration of social care, housing, and health will achieve efficiencies. However, there has been little policy development concerned with the integration of housing (in particular) and social care. While there has been a growing push for integration between health and social care across the different countries comprising the UK, the drive for integration between housing and social care is less evident.

Both the *Independent Living Strategy* (Office for Disability Issues 2008) and *Lifetime Homes* (Department for Communities and Local Government 2008) provided funding and forceful arguments for the role of housing in supporting people with disabilities and older people to maintain independent lives. Similarly, the Department of Health (DH) has emphasised the need for a '*whole system*' approach to achieve a strategic shift towards prevention and early intervention which included the full range of local authority departments and other stakeholders. In addition, the DH established the Extra Care Housing Fund which supported the development of almost 90 schemes between 2004 and 2010[2] and provided guidance on developing a strategy for extra care housing (DH 2004).

The high-profile Housing our Ageing Population: Panel for Innovation (HAPPI) was established in June 2009 to tackle the question of what further reform is needed to ensure that new-build specialised housing meets the needs and aspirations of older people of the future. The two HAPPI reports provided a range of innovative examples and principles for good design to support the argument that there are far reaching benefits to developing good quality housing and communities for older people, including a reduction in health and social care costs (Homes and Communities Agency 2009, All Party Parliamentary Group on Housing and Care for Older People inquiry 2012).

The DH's *Vision for Adult Social Care* (2010) developed a set of seven principles for a '*modern system of social care*' that identified housing as a key partner in terms of the principles of partnership and plurality. The Department of Communities and Local Government's (DCLG) *Laying the Foundations: A housing strategy for England* (2011) set out a package of reforms to improve housing options for older people that included: encouraging a wide range of housing to suit local communities, such as retirement/sheltered housing and extra care; investing £51 million over five years in handyperson services to maintain independent and safe living at home; and working with

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2 www.housinglin.org.uk/Topics/ECHScheme/

industry to produce guidance on home adaptations and on local strategic planning and delivery for high quality housing for older people based on robust evidence of needs.

The importance of recognising housing (as well as health) as a key partner in the delivery of adult social care and support has been highlighted in recent reports across the UK: Joint Committee on the Draft Care and Support Bill in England (House of Commons 2013); by the Welsh Government (2011); by the Joint Improvement Team in Scotland (Newhaven Research 2012); and by the Compton Review in Northern Ireland (DSSPSNI 2011).

In addition, the Care Act (2014) identifies a preventive role for housing and its potential to contribute to wellbeing. The Act includes a requirement on local authorities to consider the suitability of a person's home when reviewing their wellbeing, and a requirement for local authorities to provide care and support with the aim of integrating social care with NHS services or '*other health related services such as housing*'.

More recently, the £3.8 billion Better Care Fund, announced by the Care Services Minister, allocated £220 million to better integrate health and social care investment at a local level from 2015. This fund will include monies for aids and adaptations to promote independent living through the administration of Disabled Facilities Grants. At the time of writing (late 2014), the government has also announced a contestability fund[3] to attract external advice from expert advisers on housing policy development.

However, the wider context of austerity measures in housing and social care, coupled with the uncertainty about the impact of welfare reform on the housing circumstances of the most vulnerable in society, means that capital budgets have been reduced, while revenue budgets are under pressure. Simultaneously, the number of disabled and older people with care and support needs is increasing, while expectations of greater choice and control are growing.

In practice, housing and social care services are often siloed, and there is little incentive to intervene in one sector if the savings generated are likely to be achieved elsewhere. Developing a strong evidence base on the relationship between housing and social care may provide a greater impetus to more integrated working between the two sectors.

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3 www.publicfinance.co.uk/news/2013/10/dclg-looks-to-financial-markets-for-lgps-advice/

METHODOLOGY

This scoping review was commissioned with the aim of providing a structured analysis and overview of what research has been done on housing and adult social care, and to ask what is the current state of knowledge in terms of key issues, and what are the implications for future research.

The brief for the review was to cover evidence of what works in terms of good practice and/or effective outcomes (including value for money) from studies of:

- Housing and prevention of the need for adult social care;

- Housing and delaying the need for adult social care;

- Housing and enablement of independent living;

- Alignment of housing with the integration of health and adult social care; and

- Cost and cost-effectiveness studies.

This included a range of client groups: older people, people with dementia, people with learning disabilities, people with physical impairments, people with mental health needs, homeless people, people who misuse substances; and a range of tenures: social housing, private rented, and owner occupied sectors.

In total, 111 articles and reports were identified that met the inclusion criteria. A key challenge was sifting the broad range of available material relating to housing that touches on social care and vice versa. More limited were studies that were focussed on the interface between housing and adult social care and the potential role of housing to prevent the need for social care and enable independent living for those already in need of care and support. Details of the methodology are provided in the Appendix.

KEY TERMS

What is prevention?

The concept of levels of prevention is widely used in health, and an earlier scoping review (Emerson *et al.* 2011) applied the concept of primary, secondary and tertiary prevention to the social care environment where:

- Primary prevention aims to eliminate or reduce need by reducing the probability of it initially occurring. For example, the requirement for social housing to be built to Lifetime Homes standard aimed to reduce the need for people to have to move home at the onset of disability;

- Secondary prevention seeks to eliminate or reduce need by intervening in the early stages of the development of the need in order to reduce the probability of it escalating. This may involve active case-finding of people 'at risk'. For example, aids and adaptations may reduce the need for personal care by enabling a person with a disability to bathe themselves, or avoid a fall;

- Tertiary prevention seeks to eliminate or minimise need by providing effective support to people who already experience such a need to prevent further disability or disadvantage and, as far as possible, to restore functioning. Housing with care aims to enable independent living for people who might otherwise have required residential care.

Most current health and social care expenditure and activity relates to tertiary prevention. Housing interventions tend to be related to either secondary or tertiary prevention.

Proving that something has been prevented is difficult in research terms. The concept of prevention in social care is complex and multi-dimensional, including both the idea of delaying and avoiding the need for care. In practice, as Hudson and Henwood (2008) observe, terms such as prevention and early intervention in social care are used very loosely. They frequently refer to different things in different circumstances and cover a continuum of activities from 'low-level' interventions and community services supporting social inclusion at one end of the spectrum, to intermediate care services at the opposite end (Curry 2006).

Additional obstacles to robust research on prevention in housing and social care are the need for a long-term perspective and the range of confounding variables, including changes in policy and practice, which may intervene. Ensuring consistency in implementation is another challenge. These challenges in measuring the effectiveness of preventive approaches were well illustrated in the National Evaluation of Partnerships for Older People Projects where a study of 146 different core projects over a two-year period was undertaken (Windle *et al.* 2009).

The factors which have focused interest in the value of prevention have primarily been those concerned with establishing that a particular investment can generate longer-term

savings for public expenditure. These objectives may coincide with improved outcomes for people needing social care, but this is not axiomatic. As Hudson and Henwood (2008) observe:

> It has been notoriously difficult to attribute cause and effect to preventive interventions, and to demonstrate cost-effectiveness (p.16).

What is integration?

The framework document, *Integrated Care and Support: Our Shared Commitment,* defined integration from a user-focused perspective:

> I can plan my care with people who work together to understand me and my carers, allow me control, and bring together services to achieve the outcomes important to me (NCICS 2013).

However, integration is subject to a variety of interpretations, mainly concerned with integration within health or across health and social care. The National Evaluation of the Department of Health's Integrated Care Pilots suggests that:

> Integration is not a matter of following pre-given steps of a particular model of delivery, but often involves finding multiple creative ways of reorganising work in new organisational settings to reduce waste and duplication, deliver more preventative care, target resources more effectively or improve the quality of care (Rand Europe 2012, p.ii).

Thus, integration is perceived as linked to a preventive and cost-effective approach.

Other conceptual frameworks for integration are covered by a range of authors concerned with health and social care: for example, the *Integrated Care Network's Guide to Integrated Working* categorises integration in terms of the level of organisation, service or professional team, and scale (Thistlethwaite 2008); Ham and Curry (2011), meanwhile, distinguish between real integration, where organisations merge their services, and virtual integration, where providers work together through networks and alliances. Petch (2012) provides a useful review of different frameworks for the analysis of integration in health and social care proposing a continuum from relative autonomy to full structural integration. Apart from Hudson (2006), no other studies were identified that looked at service models involving integration between housing, health and social care.

In practice, integration presents many challenges. For example, in an individual housing with care scheme, there are often a number of separate organisations with different contractual relationships to each other providing care, support, and housing management (and catering). The funding, commissioning and regulatory environment is complex, and frontline workers may struggle to work across professional and organisational boundaries to provide a seamless service.

What is enablement of independent living?

The role of housing in contributing to people's capacity to remain independent is highlighted in much of the research evidence. The concept of enabling, or supporting, independent living as a service outcome is widely used in the material covered by the scoping review. A specific formal definition of enablement was not found in the academic literature, although '*enablement*' services are widely available across the country.

Implicit in much of the literature is the idea that an enabling approach reflects what people feel is important for them to live independently: a *subjective* perception requiring qualitative study, although objective measures based on specific criteria may also be needed.

Enablement may cover assistive technology, aspects of building design and other housing related interventions, but it will depend on the service user *feeling* whether or not they have been 'enabled'. Organisations promoting choice and control emphasise the importance of enabling people to make informed choices themselves as a key goal for those seeking to embed independent living (e.g. Sitra, In-Control, the Social Care Institute for Excellence (SCIE), Office for Disability Issues).

What is cost-effectiveness?

A full economic evaluation involves the comparative analysis of alternative social care interventions in terms of both their costs (resource use) and their consequences (beneficial and adverse effects) (Drummond *et al.* 2005). Economic evaluations may be divided into three main types: cost-effectiveness evaluations, cost-benefit analyses and cost-utility analyses. Most of the relevant studies on housing and adult social care have looked at cost-effectiveness or cost-benefit rather than cost utility of interventions.

If a service is concluded to be cost-effective, then this usually indicates that good quality outcomes have been delivered at an acceptable cost, that it has taken advantage of economies and efficiencies available, and that the way in which those delivering the service have worked has also been effective in producing the results/outcomes required and providing good value for money.

Cost-effectiveness is a less contested concept than some of the other terms covered in this review. However, in practice it is difficult to measure due to the range of uncosted elements, questions of attribution and causality, and choice of counter-factuals.[4] According to Francis and Byford (2011), few single-index, preference-based outcome measures currently exist in social care. They note that those that do (such as the Adult Social Care Outcomes Tool) are relatively new and validity and reliability are still being tested. Francis and Byford recommend that economic evaluations in social care should always value the cost of unpaid care associated with the services or interventions under

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4 Counterfactual – meaning what would have happened in the absence of the intervention.

evaluation, while outcomes should be defined from the perspective of people who use services and their carers. In practice, this rarely happens.

In the current context of financial austerity and growing demand for social care, cost-effectiveness appears to be an increasingly frequent element of evaluation studies.

The assessment of cost-effectiveness poses challenges in terms of both data availability and theoretical issues (Jones and Pawson 2009). Whereas the balance of costs and benefits may be clear, conclusions are often conditional or dependent on local circumstances. Major analytical constraints include difficulty of costing some benefits, especially ones that accrue over time. Many of the wider costs are very difficult to quantify and attribute to a particular measure.

Definitions – challenges

Definitions of these key terms can be further complicated, as care and support services are often combined with the physical provision of housing. In specialist accommodation, the overlap between housing and care may be:

- *conceptual* (e.g. adaptations, on-site support, wardens, telecare and other services may be intrinsic elements of specialist accommodation for particular groups such as older people, people with learning disabilities, frailty or dementia);

- *financial* (e.g. funding may originate from the individual, the NHS, social care, public health, other local authority budgets or charities); and

- *organisational* (e.g. many housing providers will run a combination of housing, care, health promotion and support services, as well as providing both mainstream and specialist accommodation).

Extra care housing is an example of this with care and specialist needs embedded in the design of accommodation, making it almost impossible to separate the two, and funding for places may also be through social care, self-funding, owner occupancy, or NHS Continuing Care.

FINDINGS

Overview

Research in this area can be categorised in terms of: the outcome (e.g. prevention, integration, enablement); the service or intervention (e.g. housing with care, aids and adaptations etc.); the client group (e.g. older people, people with mental health needs etc.); and tenure, housing design, and/or dwelling type.

Most of the evidence focuses on a particular service or intervention with regard to a specific client group – mainly older people. There were a number of literature reviews that examined the evidence in relation to the themes of prevention or cost-effectiveness (e.g. Pleace 2011, Newhaven Research 2012).

Pannell and Blood's (2012) comments regarding their evidence review on supported housing for older people could be applied to many of the aspects of housing and adult social care covered in this review:

> We were disappointed that we could not find better quantitative data that covered housing, care and support holistically: the data reflects the silos that affect the sector (p.55).

In general, the range of methodological approaches within the research studies was limited. There were few randomised controlled trials, cross-sectional or longitudinal studies. Much of the research evidence comes from evaluations of a small number of case studies. The overall conclusion from this review is that, while there is some good evidence relating to housing and adult social care in terms of housing with care for older people, the cost-effectiveness of housing with support, adaptations and handyperson schemes, there is little concerned with other client groups or other services.

This section of the review presents the research evidence on a range of services and interventions in terms of the themes of prevention, enabling independent living, integration, cost-effectiveness and gaps in the evidence base. This is followed by a review of the research related to specific client groups.

HOUSING WITH CARE

A range of terms are used to describe housing with care or specialist accommodation that offers support and the facilitation of care services. Housing with care can be called: extra care, assisted living, very sheltered, close care or continuing care. The most widely used term in the public sector is extra care housing (ECH).

Extra Care Housing

ECH represents a relatively new model of housing with care for older people, replacing or complementing housing with support that includes traditional sheltered or retirement housing.

According to Kneale (2011), the average age of residents entering ECH tends towards the high 70s, although the average age of residents living in these properties can reach as high as 85. Some two-thirds of residents are women, and about three in ten residents enter as part of a couple.

In practice, there are many different models of extra care in existence in terms of services provided, building design and tenure (social or private rented, leasehold and shared ownership). The flexibility of this form of provision is one of its key strengths, but conversely, this very flexibility makes extra care hard to define. As Croucher *et al.* (2006) observe, the definitions of housing with care vary because no one scheme is quite the same as another:

> Even when schemes are run by the same organisation and share similar design features and facilities, they can be fundamentally different in regard to the type of needs that the schemes are intended to meet (reflected in the varied allocation criteria described in the literature), the services that residents can access and the levels of dependency that can be accommodated. This appears to relate to how particular schemes were developed, the local partnerships that were established, and local priorities in terms of funding and service development (p.9).

This can make any comparative and generalisable research a considerable challenge.

The Housing LIN (2010) identified some distinctive features of ECH, particularly focusing on the delivery of care:

- The provision of 24 hour care and support: this is one of the features of ECH which distinguishes it from domiciliary care provided in the community and from the support generally available in ordinary sheltered housing;

- Flexibility and responsiveness: although the care and support will be based on care and support plans, flexibility needs to be built in to enable staff to respond to individual preferences and choices, to fluctuations in need, and to emergencies. The development of outcomes-based care planning particularly supports this approach;

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- The promotion of independence is central to ECH, and means supporting people to do things for themselves rather than simply doing things for people. This includes enabling independence through wheelchair accessible design;

- Holistic care, which goes beyond the provision of care and support and considers the individual's holistic needs. For example, staff will enable participation in social and leisure activities and will not be bound by rigid service demarcations.

Similarly, King (2004) summarised the defining features in terms of: design and assistive technologies, flexible care packages as required, catering facilities and provision of one or more meals a day, access to 24 hour care and support, communal facilities and staff offices. Riseborough and Fletcher (2003) highlight four distinctive features of ECH: principles; design; care and leisure; and assessment and allocation. The last presumably related to social rented ECH.

Evans (2009) distinguishes smaller extra care housing from larger retirement villages with over 100 units of housing, although schemes described as retirement villages may be much smaller than this and may be completely extra care or have some or no extra care accommodation (Laing and Buisson 2013). Whether in the non-profit sector, such as Hartrigg Oaks (see Croucher *et al.* 2003), or the private for-profit sector, retirement villages offer accommodation for sale, as well as for rent, and offer a 'lifestyle' choice that is more likely to appeal to some owner occupiers than smaller extra care schemes.

There has been a considerable amount of research on ECH, including a cluster randomised controlled trial (Brooker *et al.* 2009); a couple of longitudinal studies (Kneale 2011, Vallely *et al.* 2006); multi-site evaluations (Croucher *et al.* 2007, Netten *et al.* 2011, Bäumker *et al.* 2011) and several case studies of individual schemes (Bäumker *et al.* 2008, Croucher *et al.* 2003). In addition, there have been a number of reviews of the literature (Croucher *et al.* 2006, Institute of Public Care 2007, Dutton 2009, Wright 2007, Evans *et al.* (unpublished)) and an annual report on the UK ECH housing market published by Laing and Buisson (2013).

Dutton (2009) identified a number of case studies and evaluations of single schemes observing that they were largely descriptive and, due to their nature, lacked scientific rigour and generalisability. Many of the existing evaluation studies have been commissioned or carried out by provider agencies to evaluate their own schemes.

Prevention

There is convincing evidence that ECH can delay admission into a care home by providing alternative accommodation at the point where someone has to leave their original home and as a means of enabling them to live independently for longer; evidence that it can prevent admission to residential or nursing care altogether is less clear. Overall, the evidence indicates that for a proportion of people, a final move into a specialist elderly mental health care home, or a care home with nursing, may be inevitable.

Research by Kneale (2011) draws on longitudinal data on almost 4,000 residents of ECH, supplied by three ECH providers, and examines the outcomes for residents. It is one of the

first studies to examine the outcomes for extra care residents using longitudinal data tracking the outcomes for residents who, in some cases, moved into ECH up to 15 or more years ago up to the present day.

Kneale found that about 8% of residents in ECH in the study entered long-term accommodation from ECH after five years of residence. Compared to those living in the community in receipt of home care, those in ECH were less likely to enter long-term accommodation (10% aged 80 and above compared with 19% living in the community in receipt of home care).

Based on a small sample of residents in one ECH scheme, Kneale also identified health benefits, including a reduced likelihood of falling and a lower likelihood of admittance to hospital for an overnight stay compared to a matched sample living in the community. At the time of writing, a research team at Aston University (led by Carol Holland) is undertaking research with ExtraCare Charitable Trust to quantify the health 'dividend' and possible savings to the health economy.

A number of studies provide evidence of the role of ECH in offering an alternative to residential care. Darton *et al.* (2012), drawing on an evaluation of 19 ECH schemes, concluded that although extra care housing may be operating as an alternative to care homes for some individuals, it provides for a wider population who may be making a planned move rather than reacting to a crisis. While ECH could support residents with problems of cognitive functioning, most schemes appear to prefer residents to move in before the development of more severe cognitive impairment. Weis and Tuck (2013) found that 63% of people in ECH schemes in East Sussex would have been placed in long-term care if they had not been in ECH. A survey by the Institute of Public Care (IPC) of a group of older people who recently moved to residential care found that in 28 of the 36 cases the decision to enter a care home followed a critical event such as a fall and/or hospital admission. It was estimated that two-thirds of those surveyed could instead have entered extra care either currently or at the time of an earlier move (Stilwell and Kerslake 2004). An evaluation of Dray Court (commissioned by Guilford Borough Council), a scheme which is specifically aimed at avoiding moves to residential care, showed that 29% of residents had been successfully moved from a residential care home (Grimwood and Andrews 2004). Evidence from the Joseph Rowntree Housing Trust's Hartrigg Oaks retirement village suggested that, although difficult to quantify, flexible provision of care to people in their own homes prevented hospital admissions and in some cases delayed a move to residential care (Croucher *et al.* 2003). Vallelly et al's (2006) longitudinal study for Housing 21 concluded that, in most cases, ECH is working for people with dementia as an alternative to residential care.

IPC's study for Oxfordshire County Council (IPC 2010), which involved an audit of 115 moves to care homes, found that where information about housing was available, in nearly one-third of cases (30%) the person's current housing was not seen as appropriate. It appeared that greater availability of ECH could have delayed moves to a care home by meeting the needs of couples and people with dementia.

Housing and adult social care

Although poorly defined in the literature, a number of authors have considered the question of whether or not ECH can provide a 'home for life' and thus enabling people to avoid the need for residential or nursing care completely (see for example IPC 2007, Poole 2006). Croucher *et al.* (2006) did not locate any studies that identified or evaluated housing and care schemes in the UK where residents could age in place under *any* circumstances. While many housing with care schemes may aspire to offer a home for life, current evidence suggests that this may be problematic. IPC's (2007) review of ECH, involving a survey of 35 managers, found that nearly a third of residents moved to more intensive settings, and four schemes were unable to support people with sensory impairment.

In particular, people with severe dementia or high levels of dependency are not always able to remain in ECH (Croucher 2006) – although this may be influenced by other factors, such as the dependency mix of the residents at any one time and the ability of the scheme to deliver the required level of care as well as the perceived risk to other residents. This is echoed by Dutton (2009) who identified similar common factors in her review which included:

- 'challenging behaviours' and their impact on staff and other tenants;
- difficulties in providing the necessary levels and flexibility of care in response to increasing care needs;
- availability of resources, including increasing demand for carers time;
- the level of community nursing services available to tenants;
- targets for dependency mixes, and maximum numbers of high-dependency tenants, that can be cared for in schemes;
- the availability of places in other facilities;
- the willingness of funders to pay for increasing levels of care for individuals.

Dementia-type illnesses were frequently highlighted across the studies as a cause for seeking alternative care settings, and there is much debate regarding the capacity of housing with care to meet the needs of people with dementia and how their needs can be balanced against those of other residents. For example, the needs of people with dementia-type illnesses, particularly those with challenging or wandering behaviours, could not easily be accommodated within the schemes evaluated by Croucher *et al.* in their 2007 study.

The only UK longitudinal study looking at how people with dementia fared in ECH over a three-year period showed that residents (of Housing 21) with dementia and their relatives were very positive about extra care as an experience (Vallelly *et al.* 2006). However, over half the people with dementia they followed were admitted to other care settings during the first two years. Reasons for moving on were given as challenging behaviour, conflicts with staff and other residents, and the appearance of distress on the part of the person

with dementia (Vallelly *et al.* 2006). The authors concluded that:

> extra care is providing a home for life for half of its occupants with dementia although some people do move on.

Although there are housing with care schemes that are specifically designed for people with dementia, Croucher *et al.* (2006) found no evaluations of such schemes in the public domain and concluded that the evidence that ECH can be an alternative to, or replace, residential care was not conclusive. Dutton (2009) concluded that, while extra care is able to offer some people with dementia an alternative, more independent lifestyle than is possible in a care home, there is strong evidence that it is not appropriate for people to enter extra care when they already have advanced dementia.

More recently, the Orbit Charitable Trust commissioned research looking at how social landlords can work with care, charity and community partners to improve support for older people living with dementia to improve their quality of life and maintain their independence for longer (Riseborough 2014). The resultant guide provides guidance on creating an action plan to become a 'dementia friendly' organisation and offers examples of promising initiatives piloted by housing providers across the country.

Enabling independent living

The research to date provides meaningful evidence of the benefits to most residents of ECH in terms of enabling independent living. For example, Croucher and colleagues (2006) found a considerable body of evidence across the studies covered in their review based on interviews, surveys and discussions with residents across a variety of settings that indicated that one of the main advantages and most valued aspects of housing with care is independence. They noted that it was the combination of independence and security that older people seem to particularly value.

A literature review by Evans and Vallely (2007), combining a review of the literature with 36 in-depth interviews with extra care residents and managers from six ECH schemes in England, identified benefits for residents in ECH that supported independent living. Key themes emerged including: opportunities for friendship and social interaction, the role of family carers in providing support, taking part in the wider community, and design features.

Summarising the results of a DH-funded evaluation of 19 ECH schemes, Netten *et al.* (2011) reported generally positive outcomes for people including a good social life, new friends and a range of social activities. People had a range of functional abilities on moving in and were generally less dependent than people moving into residential care, particularly with respect to cognitive impairment.

Kneale (2011) found that about a quarter of the residents who entered ECH with additional social care needs, or who developed additional social care needs within ECH, later went on to experience an improvement; for example, moving from a high intensity social care package to a low intensity social care package. Many more experienced stability in care needs and did not exhibit the decline that usually necessitates higher

levels of social care. Kneale concluded that this highlights the efficacy of extra care in supporting people with a diverse range of support needs and leads to substantial savings in social care budgets.

One study that provides some useful evidence is the recent evaluation of the DH-funded ECH scheme in Blandford Forum, Dorset (Goswell *et al.* 2014). Using the Adult Social Care Outcome Tool (ASCOT), it found that older residents' quality of life vastly improved following a planned move into the newly opened scheme.

A small survey of ECH managers by IPC (2007) found that all of them identified an improved sense of independence in some or all of their residents as well as an improved sense of health and well-being. In addition, they universally agreed that extra care promotes the independence and autonomy of the individual. The majority of scheme managers reported a reduction in personal care hours needed, increased levels of self-care, and a reduction in the level of practical daily living support required by some residents.

Not everyone appears to benefit from a move into ECH. According to Evans and Vallelly (2007), there is evidence that marginalised groups, particularly those who are very frail or with cognitive and/or physical impairments and single men, may be less integrated socially in ECH and reported feeling isolated and lonely at times. Dutton (2009) and Croucher *et al.* (2006) also noted the risk of social isolation for some residents, including people with cognitive impairment and mental health problems.

There is little research on the role of informal carers in ECH in preventing people who are sick or disabled from needing higher levels of care or enabling independent living. Several of the studies reviewed by Croucher (2005) draw attention to the advantages that housing with care provides carers, especially in enabling family members to continue to give considerable support for older relatives, but at the same time allowing the responsibility for caring to be shared with others (Croucher *et al.* 2006). IPC's review (2007) found a lack of evidence about the extent to which ECH benefited informal carers, although the great majority of managers felt that ECH enabled couples to stay together.

A research consortium of the universities of Worcester, Kent and Bristol was funded by SSCR to look at new types of accommodation that could boost well-being and independence among people from diverse groups as part of the ASSET project: Adult Social Services environments and settings.

Integration

There is evidence of the difficulty of delivering a joined-up service and the consequent effects on residents in relation to both older people and people with learning disabilities in ECH. In research into housing with care across the UK, Blood (2013) found that just under one-third of the older people she interviewed described problems that were linked to service boundary issues. Despite national differences in regulation, funding and policy context, similar themes emerged across the four nations of the UK. These arose in different aspects of people's lives in housing with care: from settling in to moving out or

end-of-life; from buildings to social activities. Sometimes, boundary issues were experienced as gaps in service provision: one older person described a "no man's land" in which it was not clear who, if anyone was responsible for a particular task. In other cases, older people described delays whilst communications were passed around between the different organisations or teams.

From the management perspective, there has been little research into the most effective management arrangements for housing with care. Housing and care services in ECH can be delivered by integrated or separate staff. Netten *et al.* (2011) found that combined care and housing management arrangements were associated with lower costs, but little is known about the extent to which integrated management models enable more or less independent living than separate management arrangements.

Another review by Dutton (2009) looked at the research evidence on people with dementia living in ECH. Covering literature in the UK and US, Dutton's review highlighted the importance of key organisational and operational aspects of schemes, including person-centred care, developing staff knowledge and expertise in dementia, strong partnership and joint working, integrated strategies between social care, health and housing, and simple and robust assistive technology, which is integral to service and care planning.

One small study found that a majority of scheme managers agreed that ECH resulted in more opportunities for efficient delivery of services and enabled easier targeting of health promotion and prevention activities (IPC 2007).

People with a learning disability are sometimes moved in ECH; however, there has been little research on the effectiveness of these settings in preventing the need for more intensive care or in enabling independent living, apart from King and Maxwell's (2008) largely descriptive evaluation of the DeH's Extra Care Housing Programme for people with learning disabilities. Studying 10 diverse schemes, including four based on private sector housing or ownership, they found a number of common themes. These included: gains from partnerships between the leading agencies; how helpful local 'champions', such as family carers, can be; the development of better understanding between social care and housing colleagues with long-term benefits; and the potential in re-cycling existing housing stock, including sheltered housing, derelict general needs property, private rented sector and owner occupied property in three projects.

King and Maxwell's (2008) evaluation of ECH for people with learning disabilities found that those involved in social care singled out the importance of the improved partnership working with housing colleagues or agencies, and how the ECH projects had contributed to better, closer relationships. A frequent theme was the difficulty of getting suitable housing in the absence of these relationships or housing expertise within a social care authority.

Cost-effectiveness

The *Vision for Adult Social Care* cites a number of initiatives which are considered to demonstrate that:

> Supported housing and extra care housing offer flexible levels of support in a community setting, and can provide better outcomes at lower costs for people and their carers than traditional high cost nursing and residential care (DH 2010).

In their review of the literature, Croucher *et al.* (2006) did not find evidence that housing with care offers a cost-effective alternative to residential care or care in the home. However, their review was completed before the national evaluation of ECH. Since then, the evidence on the cost-effectiveness of housing with care has grown, although it remains entirely inconclusive. This may be in part because, as Croucher *et al.* argue, although one of the purposes of extra care is to provide a better quality of life, independence and autonomy, this is not fully understood and costed in studies of cost-effectiveness. These issues need to be brought into the costing equation, as recommended by SCIE (Francis and Byford 2011).

The DH-funded evaluation of 19 ECH schemes by Netten *et al.* (2011) found considerable variability across schemes in the costs of health and social care. Their research found that higher costs were associated with higher levels of physical and cognitive impairment and with higher levels of well-being. However, when residents were matched with a group of equivalent people moving into residential care, costs were the same or lower in ECH. They somewhat cautiously concluded that the better outcomes, and similar or lower costs of ECH compared with residential care, indicated that ECH was a cost-effective alternative for people with the same characteristics who currently move into residential care.

The longitudinal study by Kneale (2011) of ECH residents identified fiscal benefits from a lower rate of hospitalisation and falls, and decreases in social care packages received over time compared with a sample of older people receiving home care. Considering social care costs alone, they concluded that although the upfront social care costs for residents of ECH may be higher in the short-term, the social care costs within the domiciliary care sample were higher after nine years, as there was a greater likelihood that residents within that population would have entered long-term care.

Studies of the cost-effectiveness of extra care have also highlighted that ECH can be associated with a reduction in social care spending (for example, Garwood 2008). In a case study of Reeve Court retirement village, Garwood concluded that taking the scheme as a whole, a simple comparison with likely domiciliary care costs indicated that the local authority was getting value for money and, in fact, likely to be saving money. A recent Housing LIN review of East Sussex County Council's extra care housing strategy (Weis and Tuck 2013) found that the cost of ECH was on average half the gross cost of the alternative settings, although the financial analysis report was confidential to the council.

However, in their study of Hartrigg Oaks, Croucher *et al.* (2003) found that staff and services appeared to be providing substitutes for NHS care, thus demands were being

redirected rather than reduced. The detailed case study of a scheme in Bradford by Baumker and colleagues (2008 and 2010) for the Joseph Rowntree Foundation looked at the comparative costs before and six months after 22 residents moved into the scheme. Overall, the team found that costs increased as a result of moving into the scheme from £380 to £470 per week per person. However, these were associated with improved social care outcomes and reported quality of life. The increased social care costs were mainly attributable to the additional cost of support services provided to residents, such as social activities, staff providing 24-hour cover, and to a two-fold increase in the cost of home care.

A two year cluster randomised controlled trial covering ten ECH schemes was conducted by Brooker *et al.* (2009) to evaluate a new approach to living with dementia and other mental health problems called the Enriched Opportunities Programme (EOP). Key facets of the 18 month programme included a specialist staff role, 'the EOP Locksmith'; staff training; individualized case work; liaison with health and social care teams; activity and occupation; and leadership. Comparing the results of those receiving the EOP and those receiving a placebo intervention, the researchers reported a positive impact of the EOP from both a quality of life and economic perspective. The benefits of the EOP were that residents were:

- Half as likely to have to move out into a care home;

- Far less likely to spend time in hospital as an in-patient;

- More likely to have a GP visit;

- More likely to see a community physiotherapist, occupational therapist and a chiropodist;

- More likely to have their mental health problems diagnosed;

- Rated their Quality of Life more positively;

- Reported decreased symptoms of depression over time; and

- Reported greater feelings of social support and inclusion.

Gaps in the research

Despite central government funding to stimulate growth in the private rented sector more generally[5], there has been little academic research in private sector ECH; there is also a gap in the evidence base about the role of extra care in addressing the future housing and care needs of older people from black and minority ethnic communities and older single men.

Croucher *et al.* (2006) found very little literature that considered care services utilisation in housing with care schemes and noted that the organisation and management of

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5 DCLG (2013) Build to Rent Fund programme

retirement communities is not widely discussed. Little is known about the cost-effectiveness of different models of organising and managing care in ECH. There is a need for a better understanding of which organisational models offer the best quality from the residents' perspective and are the most cost-effective. Porteus (2012) recommends that housing providers should follow a 'living lab' approach where customers drive innovation in real life test environments.

Netten *et al.* (2011) comment on the relatively low levels of supply of ECH. The IPC study (2007) found that more than 60% of managers reported a lack of available extra care places in their area. While supply and procurement of housing with care appears to be a challenge in many areas, it is notable that no studies were identified which looked at how more efficient procurement of ECH could be achieved.

There continues to be a question about the extent to which ECH is a 'home for life' and how this can be facilitated. There is also scope for more research into the role of informal carers in extra care and the degree to which they are enabled to support residents to live independently.

There is a lack of research regarding the experiences and outcomes of people with dementia in ECH in relation to the key variables, such as the design of the building and the environment, the organisation of care, recruiting and training staff, and the management of transitions to and from schemes. However, opportunities may exist in the future to encourage the Housing and Dementia Research Consortium[6] to identify further research gaps among its members.

Extra care housing has been used to provide independent living for people with learning disabilities. However, apart from King and Maxwell's evaluation for the DH (2008), there has been little exploration of how effective it is in enabling independent living for this group – from the perspective of the residents or their families.

And finally, more evidence is needed about what determines moving into and out of ECH; equally on where residents move from, and where they go, including in relation to end of life care.

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6 http://housingdementiaresearch.wordpress.com

HOUSING-RELATED SUPPORT

Supported housing or housing-related support aims to enable people to live independently, avoiding or reducing the need for care services. It covers a wide range of client groups and services, from sheltered housing and floating support to telecare, aids and adaptations.

Supporting People

The Supporting People programme was designed to fund services that work with vulnerable individuals to help them gain the skills needed to live more independently, with ongoing support where this is needed, and to find and keep their own homes. According to the Vision for Social Care:

> Supporting People provides housing related support to help individuals to live independently in their own home and avoid more costly interventions. These preventative services improve outcomes for individuals and return savings to other areas, such as housing, health, social care and the criminal justice system (DH 2010).

The Supporting People (SP) programme was introduced by DCLG in 2003, and the funding (which was ring-fenced until April 2009) has been used to assist with the delivery of housing related support to vulnerable people with the aim of helping them to gain the skills to live more independently. Since April 2009, the grant has been identified as a separate line in the overall grant allocation to single-tier and county councils. From April 2010, the allocation has been included in the area-based grant to councils with adult social care, but, as it is no longer ring-fenced, key concerns are that funds are being subsumed by more intensive services, and funding for low-level, preventive housing related support is being squeezed as councils are faced with pressures on care.

Much of the research evidence on housing related support since 2003 has been focused on the cost-effectiveness of the SP programme. There has been little research into its potential preventive or enabling role beyond what is assumed in the cost-effectiveness studies. The limited research in these other aspects may reflect the nature of the SP programme, which has funded a broad range of services for more than 10 different client groups. Sheltered housing and a number of other interventions receive SP funding, but are covered separately in this review.

Enabling

A qualitative study by Fyson and colleagues (2007) raised questions about the enabling role of Supporting People in relation to people with learning disabilities. Fyson *et al.* examined how local Supporting People teams in four different areas were interpreting national guidelines in relation to the provision of housing related support and explored the impact that this was having on housing and support for people with learning disabilities. They found that although the programme provided a much-needed injection of cash into services for people with learning disabilities, which enabled the development

of an increasing number of supported living services, the most important decisions continued to be made by service managers and commissioners. They noted that schemes based on shared tenancies with accommodation-based support were sometimes little different from the registered care homes they had replaced. The research highlighted the continuing failure of most service providers to adequately support the social integration of people with learning disabilities within their local communities.

Integration

Given the connection between housing and social care implicit in the Supporting People programme, it is surprising that there appears to be little specific research on integration and Supporting People, apart from Cameron et al's evaluation of the Supporting People Health Pilots programme (2007). The programme was established to demonstrate the policy links between housing support services and health and social care services by encouraging the development of integrated services. Cameron *et al.* (2007) found that the ability of the pilots to work across organisational boundaries to achieve their aims and objectives was associated not only with agencies sharing an understanding of the purpose of the joint venture, a history of joint working and clear and efficient governance arrangements, but on two other characteristics: the extent and nature of statutory sector participation and whether or not the service was defined by a history of voluntary sector involvement. In particular, the pilots demonstrated how voluntary sector agencies appeared to be less constrained by organisational priorities and professional agenda, and more able to respond flexibly to meet the complex needs of individuals. The evaluation concluded that integrating services to support people with complex needs works best when the service is determined by the characteristics of those who use the service rather than pre-existing organisational structures.

Cost-effectiveness

Research from across the UK indicates that Supporting People delivers a net benefit. A study commissioned by DCLG used financial modelling to conduct a revenue-based estimate of the financial benefits of the Supporting People programme (Ashton and Hempenstall 2009). The findings of this work were that the best overall estimate of net financial benefits from the Supporting People programme was £3.41 billion per annum for the client groups considered (against an overall investment of £1.61 billion). In all but three cases, the provision of the Supporting People intervention was estimated to provide a net financial benefit – i.e. the financial benefits of supporting the individual using the most appropriate positive alternative to Supporting People were higher than, and outweighed, the costs of doing so using Supporting People services.

There were net benefits to all groups except teenage parents, young people leaving care, and homeless families with support needs. The groups for whom the benefits were greatest were people with learning disabilities, older people in sheltered housing, older people receiving floating support, and people with mental health problems. The analysis suggested that, within the overall net benefit of £3.41 billion, the removal of Supporting People services would lead, among other things, to: increased costs in the areas of

homelessness, health and (in particular) residential care packages; and corresponding reductions in cost in the areas of Supporting People services, housing, social services care, welfare benefits and related services and other services.

However, the authors acknowledged that findings are best estimates rather than certainties. A large proportion of the financial benefit arises from the assumed avoidance of residential care packages (although avoidance of these packages also introduces costs because living independently adds to housing, social services and living costs).

The Welsh Assembly Government also conducted a cost-benefit analysis of the Supporting People programme (Matrix 2006). No primary data collection was undertaken, and the authors noted the lack of a strong evidence base on which to form assumptions of the impact of Supporting People. In addition, the study did not take into account variations in the intensity and type of support offered to service users or postulate alternative services that may be implemented in the absence of Supporting People. Only savings made within a single year were included; benefits were not included where there was insufficient data to allow inclusion in the models or where benefits had not been quantified by previous research. This study calculated a net financial benefit of nearly £73 million, a saving of £1.68 for every £1 spent.

The costed benefits of independent living accounted for 34% of the total value of benefits as calculated by this study. The value of benefits in relation to social care accounted for 1.4% of the total value of benefits (compared with 26% for health benefits).

A number of un-costed benefits common across the eight client groups in the study that were not quantified included: improved quality of life for the individual, including greater independence; lessened dependence on relatives and carers; independent living, including a greater choice for individuals around accommodation, lifestyle and the provision of skills to enable this choice; and increased ability to participate in the community. A similar study in Scotland also concluded that the Supporting People programme delivers a net financial benefit to the public purse (Tribal 2007).

In terms of the benefit realisation of capital investment, a Homes and Communities Agency study looked at the financial benefits of investing in specialist housing with a focus on capital spending (Frontier Economics 2010). Frontier Economics concluded that the total net benefit of specialist housing was about £640 million. The largest single benefit was estimated for the older people client group with significant positive benefits for people with mental health problems and people with learning disabilities. As in Ashton and Hempenstall's 2009 study for DCLG, the groups where there was a net cost were teenage parents, young people leaving care and young people at risk.

Frontier Economics found the source of the benefits from specialist housing varied by client group. For older people, the primary benefits were in reducing reliance on health and social care services. For people with mental health problems, the benefits of specialist housing were primarily associated with health services; and for those with learning

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disabilities, a reduction in the use of social care services delivered the most significant savings. The most significant benefits were achieved where the provision of specialist housing reduced the use of long-term care, including residential and social care, particularly for older people.

The Audit Commission reviewed the impact of the Supporting People programme (2009). Drawing on the findings of inspections carried out between 2005 and 2009, widespread consultation and interviews with stakeholders, one of the review's major findings was that Supporting People had brought improvements in a number of areas, including the balance of local provision of housing related support, service quality, value for money, tailored support and outcomes for service users.

A different approach was taken in a study in Yorkshire and the Humber (Yorkshire and the Humber Housing Related Support Group 2010). This was based on in-depth case studies of eight service users representing different client groups. Using counterfactual costing, it concluded that over 900 people with mental health problems were helped to maximise their incomes and manage their debts in one year; over 70 people with learning disabilities were enabled to improve their physical health; and over 250 people with drugs problems were helped to maintain settled accommodation.

Gaps in research

Despite a policy direction of maximising at home care and support, no large scale evaluations of housing related support for any specific client groups were identified in the review, and there also appears to be a gap in the research on the level of impact that these services have on the quality of life and need for care of those receiving them. In particular, although there has been major policy development in the field of learning disabilities[7], and a spotlight on the sector following the abuse at the Winterbourne View hospital[8], there is little evidence about whether or not housing-related support for people with learning disabilities has a cost-effective enabling role.

There is also an opportunity to build on SSCR funded research, led by Anthony Holland, on supporting people with learning disabilities who have offended to live safely in the community.

Sheltered and retirement housing

A report by Age UK (2012) suggested that:

> at the moment, there is no clear national vision or leadership on the future of sheltered and retirement housing. This is exacerbated by uncertainty around funding for preventive care and support services (p.4).

Across the UK there are nearly 18,000 developments and around 550,000 dwellings (480,000 in England) housing around 5% of the older population. Around three-quarters

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7 www.gov.uk/government/publications/valuing-people-now-summary-report-march-2009-september-2010

8 www.gov.uk/government/publications/winterbourne-view-hospital-department-of-health-review-and-response

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of dwellings are for social rent, and one-quarter for sale, with a small but growing market for private rent. There are significant variations by region and country, with much less retirement housing for sale in Scotland and the north of England, and hardly any in Northern Ireland (Pannell and Blood 2012).

Sheltered housing includes a range of both built form and support provision, including at a minimum having a process to assist tenants accessing support services (Pannell and Blood 2012). In some schemes, all residents have regular face-to-face contact with support staff (unless they deliberately opt out); elsewhere, contact is mainly by phone or from community alarm staff. In many schemes, only a minority (those with an assessed support need) will receive any regular formal contact from support staff. Croucher *et al.* (2008) note the complexity around definitions of sheltered housing. However, they identify two broad dimensions:

- physical attributes of the property (e.g. meeting disability standards, etc.);

- service provision associated with the property (e.g. community alarm, warden).

According to Pannell and Blood (2012), over a quarter of existing residents of sheltered housing are aged 85 and over, many of whom are likely to be receiving social care. Croucher *et al.* (2008), in their survey of over 1,200 residents of social rented and owner occupied sheltered housing in six local authorities in Scotland, found that in social rented schemes, one in four residents received home care; one in ten regular nursing input; and 40% get help with housework and shopping. All these figures were much lower for private sector residents, i.e. owner-occupiers. Likewise, in a study of recent residents of owner-occupied retirement housing, Ball *et al.* (2011) found that most were over pension age and from similar backgrounds to those in earlier studies. Significant numbers had health and care needs.

A survey by Ford and Rhodes (2008) of 2,000 recent tenants and leaseholders in Hanover Housing Association sheltered/retirement housing and housing with care schemes found that 43% of residents moving into their retirement housing did so because they principally needed some help but wanted to remain independent. Overall, across single and couple respondents, around 60% could not climb stairs; around a third had sensory impairment; over 40% had memory problems; and 20–30% could not walk short distances. Two-thirds of single respondents needed help with cleaning, and a third of two-person households (where both were in poor health) needed help with cooking and cleaning.

A study by Boyle (2012) for the Northern Ireland Housing Executive found that increased numbers of people with mental health problems and alcohol or other addictions are now living in sheltered housing. In addition, the survey of tenants highlighted poor health amongst 50% of males and 38% of females. Overall, the study found that the needs of tenants have changed since sheltered housing was first developed, and Boyle concluded that the widening age span and range of reported other needs, e.g. learning disability, alcohol addiction, loneliness and depression, had implications for both management and service delivery. Comparable up-to-date studies in other parts of the UK do not appear to

have been carried out.

Prevention

There has been little recent research on sheltered or retirement housing in terms of either its preventive or enabling role. Lloyd (2006) argued in a discussion paper that sheltered housing has a key role to play in preventative care for older people. At the time of writing, the Housing LIN and the Chartered Institute of Housing are updating their good practice tool on the value of sheltered housing in meeting the prevention agenda (forthcoming). However, this is based on local examples of service and sheltered housing scheme reviews rather than robust research.

Integration

In the last decade, there has been a major change in the operation and management of sheltered housing with the widespread withdrawal of resident warden services and the move to mobile or floating support. Pannell and Blood (2012) cited a range of sources that suggest this can result in poor communication between housing, social care and health services, leading to problems, particularly around hospital discharge. There has been some work undertaken by individual provider organisations (National Housing Federation 2012, National Housing Federation and Family Mosaic 2013), but there have been no comparative independent studies.

Cost-effectiveness

A number of studies mentioned earlier have looked at the cost-effectiveness of housing related support for older people as part of wider cost-benefit analyses of the Supporting People programme. Matrix (2006), Frontier Economics (2012), Tribal (2007), and Cap Gemini (2009) identified substantial cost benefits for older people, largely due to assumed savings on residential care costs and the number of people in scope.

Gaps in the research

Overall, there is limited knowledge of who is living in sheltered housing, levels of disability, their health, care and support needs, and what care is provided to them. There have been few studies of owner-occupied retirement housing and none on private rented retirement housing. Little is known about the role of owner-occupied and private-rented retirement housing, or the views of residents, across the not-for- profit and private sectors.

Apart from the lack of much recent research on sheltered or retirement housing, despite significant changes to sheltered housing over the past decade, Pannell and Blood (2012) noted that there is limited data on health, disability, care and support needs. There is a general lack of information about the profile of residents of sheltered housing, for example, in terms of the extent of mental health problems, dementia, learning and other disabilities. Equally, little is known about the ethnicity of residents of sheltered and retirement housing across all tenures.

Apart from a study by King *et al.* (2008) for Help the Aged and Boyle (2012), and given the range of sheltered and retirement housing models, little is known about the relative costs and benefits of the different models, or the effect that changes to warden/scheme manager/support services in social rented sheltered housing are having on residents (particularly those with high support needs)

Pannell and Blood (2012) suggested further research is needed to explore the impact of changes to the resident 'mix' of tenant profiles in sheltered housing (including residents under pension age; residents with a wider range of support needs; residents who are very old/frail/with high care needs).

In addition, with a drive towards co-production in adult social care, the housing sector has been slow to support residents to assess their longer-term housing needs and aspirations. More research is needed to identify new forms of housing that can promote self-care and self-help, and prevent a move to more institutional care, for example, exploring models of co-housing.

Floating support

'Floating support' covers a very wide range of services on a cross-tenure basis. The support that may be provided includes: advice and information about housing and related matters; help with accessing other services including health and social work services; low intensity support for people with dementia; help in managing finances; and peer support and befriending. There appears to be little research on the preventive or enabling role of floating support, and the evidence on cost-effectiveness is mainly derived from the Supporting People studies mentioned earlier.

The data available on the costs of floating housing support services suggest that costs can be variable (Wood *et al.* 2007). Comparing two Scottish local authority floating housing support services for older people, Wood *et al.* found variations in the level of service and costs (from £7.30 an hour to £10.40 an hour). Differences were attributed to differences in the wages that the two different providers of floating housing support services offered, shift patterns, and skill mix. However, the report did not look at cost-effectiveness.

In Northern Ireland, an evaluation of floating support was carried out by RSM McClure Watters (2012) which concluded that floating support helps people who use the service to live independently and that the costs were much lower than accommodation based services for all categories receiving support, except older people. The authors noted that older people with support needs needed a more flexible type of support which could adapt to changing needs over time.

Shared Lives

Shared Lives is a service provided by individuals and families who provide care or support to people placed with them in their own home by the local authority. Placements provide committed and consistent relationships between the carer and the person placed with them that aims to provide a mutual benefit. Carers can support up to three people at any

one time and may not employ staff to provide care to the people placed with them. The Shared Lives scheme is used for a wide range of people including people with learning disabilities, older people and people with mental health needs.

Enabling

An evaluation by NAAPS UK (formerly the National Association of Adult Placement Schemes) and Improvement and Efficiency South East (2009) indicated that the scheme enabled service users to achieve a number of positive outcomes. Comparing Commission for Social Care Inspection ratings for Shared Lives schemes in south east England with care home ratings, the evaluation found that 79% of Shared Lives schemes were rated excellent or good compared with 69% of care homes. Service users in all four schemes in the evaluation identified a number of successful outcomes: living the life they wanted; having choices and being in control; developing confidence/skills/independence; and having different experiences.

Cost-effectiveness

In making the business case for Shared Lives, NAAPS/IESE (2009a) estimate that to develop a scheme that could support 85 service users would require an investment of £620,000 for a five-year period. Over the same period, the study estimates that a scheme could generate net savings of £12.99 million by reducing the need for costlier services and residential care in particular. Potential savings were also indicated by the 2009 study for other types of Shared Lives placements, such as day-time support and floating support; however, the financial data are less reliable.

An independent study funded by SSCR, and led by Lisa Callaghan and Ann Netten into the outcomes, processes and cost-effectiveness of Shared Lives, will report shortly.

LOW LEVEL SERVICES TO ENABLE INDEPENDENT LIVING

A range of housing based interventions exist that enable people to live independently and reduce the need for more intensive levels of care. Although cause and effect is not easy to demonstrate, and isolating the single factor of a housing intervention among a complex interplay of other factors is problematic, there are a number of good studies on this aspect of housing and adult social care.

Low-level support services, such as improvements to an older person's home, adaptations and telecare, will often not be used in isolation. These preventative support services are often part of a package of health, social work and other preventative support services, especially for older people with higher needs who might be at heightened risk of hospital admission, a need for residential care or ECH. This means calculation of any net savings compared to institutional care or specialist housing must take account of the total cost of a package of support, of which preventative support services are just one part.

The potential contribution of low level services was highlighted by an inquiry funded by the Joseph Rowntree Foundation which drew together personal testimonies and experience from older people and professionals to identify gaps in service provision for older people living in their own homes (Haynes *et al.* 2006). The final report proposed a 'baker's dozen' of small ways that could help older people living at home.

A couple of evidence reviews have looked at a range of low-level services. Pleace (2011) reviewed the evidence on the costs and benefits of preventative support services for older people, contrasting them with the costs of specialist housing options, such as sheltered and extra care housing and also with the costs of health services. Services included in the review were: handyperson schemes; adaptations; alarm systems and telecare models; and floating housing support services. He concluded that preventative support services have specific roles in supporting the choice of older people to live independently in their own homes. These roles are summarised as: creating a home environment that minimises risks to health and well-being; providing low-level support that enables an older person to live independently; installing telecare and alarm system technologies that allow monitoring of the safety and well-being of older people and which can summon help; and helping to adapt an older person's home to suit needs that have arisen due to illness or disability.

A review of the evidence on the contribution and benefits of housing services for the Scottish Joint Improvement Team concluded that:

> there is meaningful evidence that Supporting People services, adaptations, handyperson services, alarm services, and improvements to the physical condition of a property and its environs can have beneficial (outcome enhancing and health/social care cost reducing) outcomes, but these are specific to local circumstances, may be poorly recorded, can be negated by implementation failures and are extremely difficult to generalise (Newhaven Research 2012, p.33).

Telecare/Assistive technology

Assistive technology (AT) is an umbrella term for any device or system that allows an individual to perform a task they would otherwise be unable to do or increases the ease and safety with which the task can be performed (Royal Commission on Long-Term Care, 1999), while telecare involves the use of electronic sensors and aids that make the home environment safer, enabling people to live at home, independently, for longer. Sensors can automatically raise alarms through call centres, wardens or friends and family (DH 2009). There is a continuum of services that begins with basic dispersed alarm systems, and extends into more advanced technologies. Lloyd (2012) reported that 375,000 people used personal alarms and 715,000 used alerting devices in England in 2007–08 among those aged 50 and above, and considered that this is a conservative estimate.

The claimed beneficial impacts for assistive technologies on social care include: increased choice, autonomy, control and independence; maintenance of ability to remain at home; reduction of the burden placed on carers; and improved support for people with long-term health conditions (Beech and Roberts 2008).

Allen and Miller (2014) found that telecare, telehealth and/or other technology based interventions were amongst the top three interventions in six local authorities. Much of the evidence on telecare is based on local studies (e.g. Housing LIN case studies), while the national evaluation is inconclusive.

Prevention

The national evaluation of the Whole Systems Demonstrator project involved a cluster randomised trial comparing telecare with usual care (Steventon *et al.* 2013). Participants were followed up for 12 months and analyses were conducted as intention-to-treat. This exceptionally large scale study concluded that telecare as implemented in the Whole Systems Demonstrator trial did not lead to significant reductions in service use, at least in terms of results assessed over 12 months. No randomised studies of telecare exist on a comparable scale.

A University of York review, commissioned by the Scottish Government in 2009, reported evidence that the National Telecare Development Programme had reduced unplanned hospital admissions and reduced the need for residential care. However, the review also reported that data collection was in need of development and obtaining robust data had been problematic (Beale *et al.* 2009). This research estimated that the programme had reduced care home admissions by 518 and unplanned hospital admissions by 1,220, reducing expenditure by some £6.8 million.

Another more recent piece of work reviewed the national Telecare Development Programme (TDP) for Scotland. This estimated that during the period 2006–2010 a very significant gross financial benefit of some £48 million had resulted from an investment in telecare of some £12.6 million nationally (including match-funding). The collective impacts of telecare were estimated as having included: avoidance of 6,600 unplanned hospital admissions; avoidance of 2,650 residential care and nursing home admissions; and

avoidance of 411,000 home check visits to monitor the well-being of older people and other groups (Newhaven Research 2010a).

Enabling

There is limited evidence about the extent to which telecare users themselves feel that they have been enabled to live independently.

A survey of 461 telecare users in Scotland found that 70% felt more independent, about one-third felt they needed less help from their family, and 27% reported that their health had improved since they received telecare services (Beale *et al.* 2009).

The AKTIVE project (Advancing Knowledge of Telecare for Independence and Vitality in Later Life) will report shortly. The project explored the way telecare can be developed to help older people live a full and independent life with a particular focus on people who are prone to falls and memory problems. It also looked at how telecare may support care staff and informal carers.

A literature review by Brownsell *et al.* (2007) concluded that telecare has a significant role to play in supporting older people alongside traditional care services and assistive technologies. However, they commented that integrated mainstream services, which embrace telecare, are rare.

Cost-effectiveness

Evidence from early evaluations of local telecare interventions indicated savings around emergency hospital and residential care admissions. Thus, Bowes *et al*'s (2006) evaluation in West Lothian reports cost savings of £85,837 as a result of reduced bed days. Evaluators linked the reduction to the Rapid Response service, which was integrated with the West Lothian smart technology programme.

Newhaven Research (2010) estimated an annual saving of some £26,000 compared to the cost of residential care for a hypothetical man in his late 80s experiencing the onset of dementia and physical health problems (the cost of the package, including telecare, was £6,500 compared to a cost of £32,500 for the total estimated time he would have to spend in residential care).

The research evidence indicates that telecare is just one component of a response to an older person with high support needs; while it may reduce the level of interventions by health and social work funded services, it does not remove the need for them entirely.

An earlier study by Tinker (2004) looked at social housing (sheltered and mainstream) and at the costs, outcomes and implications of introducing AT into existing homes. She concluded that care-reducing AT paid its way (and could lead to significant savings in care costs even in the shorter term), improved quality of life, and could be funded from savings in formal care costs. However, there was significant variation in the costs of AT depending on property type and the needs of the user.

In a scoping review, Tinker *et al.* (2014) has explored a vision for alternatives to institutional care as part of the Technology Strategy Board's Long-term Care Revolution

programme. In particular, she identified several innovative technology and design solutions that could form new kinds of housing. These include services that support older people and those with a long-term condition to stay at home, such as:

- home sharing;

- home modifications;

- co-housing;

- purpose-built specialist housing;

- telecare and telemedicine;

- smart and HAPPI housing.

Henderson *et al.* (2013) have provided benchmark data on the unit costs of telecare (and telehealth) based on the evidence from the three local authority areas included in the Whole System Demonstrator project. Further work from the project will be published in the near future on the cost effectiveness of telecare.

Gaps in the research

Although telecare has been widely researched, the quality of the research and the strength of data on costs have been questioned. To date, evidence about the outcomes and effectiveness of assistive technologies and telecare in the UK is inconclusive. There is a need for more evidence about the extent of the enabling role of telecare, particularly for people living alone with disabilities and/or dementia. This is also noted by Dutton (2009) who identified a gap in our knowledge of the value of telecare for the quality of life and independent living of people with dementia.

There is a need for further research on the role of telecare and other assistive technologies, their usefulness and acceptability to residents in ECH and other forms of housing related support and their impact on staffing requirements. There appears to be little research on how people use different types of telecare, for example, willingness to wear and use pendant alarms.

Handyperson schemes

Handyperson schemes offer a range of services, and some agencies offer a more comprehensive and extensive range than others. These services can provide low level repairs and adaptations to homes, i.e. literally provide or arrange for a 'handyperson' or have a wider role that includes more significant repairs and improvement to older people's housing. This can include addressing issues such as damp, poor insulation or inadequate heating. These services can be called 'Handyperson services', 'Care and Repair' services or 'Staying Put schemes'. They are often part of a range of services offered by a home improvement agency.

A study by Clough *et al.* (2007), based on consultations with older people for the JRF, found that older owner occupiers worried about how they would cope in the future with

doing all the things to maintain a house that they had carried out before, particularly repairs and maintenance. They had concerns about how they were to manage: minor household tasks; safety and security measures; grab rails, ramps and other aids to mobility. A handyperson scheme may address these kinds of concerns.

Prevention

The National Evaluation of the Handyperson Programme found that key areas of work where the low cost preventive interventions provided by handyperson services offer the potential to reduce demand for health and social care services included:

- Small repairs and minor adaptations that reduce the risk of falls and enable independent living;

- Home security measures that prevent burglaries and increase people's sense of security in their own homes;

- Hospital discharge schemes where a swift response to requests for the installation of key safes, grab rails, temporary ramps, or moving a bed or other furniture can reduce the length of hospital stay;

- Energy efficiency checks and measures which lead to improvements in health and wellbeing, safety, comfort and expenditure on fuel (Croucher *et al.* 2012).

O'Leary *et al.* (2010) estimated that 9% of older people whose housing had not been improved or adapted would need to make a move to sheltered housing during the course of one year. This compared to a rate of 5% of those whose housing had been improved or adapted by care and repair services. O'Leary *et al.* also estimated a 10% reduction in the number of older people requiring personal care funded by social services.

Enabling

Croucher *et al*'s (2012) evaluation provided good evidence that handyperson services assist large numbers of older, disabled and vulnerable people to live independently in their own homes for longer with greater levels of comfort and security. The authors concluded that:

> they enhance the effectiveness of health and social care provision through the delivery of often very simple and very low cost interventions....Handyperson services can and do support the preventive agenda. This evaluation has demonstrated that handyperson services provide value for money, and while this is the overriding message, the "value-added" aspects of services can only strengthen the case for supporting these services (p.12).

The evaluation involved surveys of local authorities, service providers and service users, and case studies focusing on a number of different services. In future, with the emergence of the Better Care Fund, such a study might include Health and Wellbeing Boards and Clinical Commissioning Groups.

Cost-effectiveness

In terms of value for money, the National Evaluation concluded that based on conservative modelling assumptions, the benefits achieved by the handyperson programme outweighed the costs of providing the programme by 13%. The biggest costs avoided by the delivery of a handyperson service were in social care.

Gaps in the research

The handyperson evaluation provides a robust evidence base; however, Moriarty and Manthorpe (2012) question what happens to people who do not meet the criteria for assistance. They suggest that future research may seek to identify if schemes seeking to promote social capital, for example, through time banks, are able to exchange services such as minor repairs. In addition, little is known about alternatives to handyperson schemes, such as voluntary sector listings of vetted or 'reliable' tradespeople.

With an increasing emphasis on benefits to local health economies, there is a need for evidence about the role of handyperson schemes in facilitating savings through hospital to home services.

Aids and adaptations

An adaptation is a modification to a dwelling that removes or reduces a disabling effect that the dwelling has on an older person. For example, the installation of a stair lift may reduce or remove the disabling effect of losing the ability to climb stairs. Adaptations can range from the addition of a grab rail through to the provision of ramps, stair lifts, specially adapted bathrooms and kitchens. Aids and adaptations (along with handyperson services) are frequently delivered by a local Care and Repair service. An evaluation for the Scottish Government noted that there was a lack of clarity about what defined Care and Repair (Scott *et al.* 2009). Funding for aids and adaptations through Disabled Facilities Grants will in future be administered through the Better Care Fund as part of the new landscape of integrated care.

Findings from the English House Condition Survey suggest that nearly one million households in England require some level of adaptation for one or more of their residents. The estimated cost of meeting all eligible needs according to this figure was estimated at £1.9 billion in 2005.

Much of the research has been focused on the cost-effectiveness of aids and adaptations based on assumptions about their role in prevention.

Enabling

A local authority study in Nottingham involving a survey of people who had had major adaptations to their home showed how those who had received adaptations felt the work had increased their independence, including, in some cases, the ability to manage their home without any or with considerably less help (Watson and Crowther 2005). However, there was no information about costs.

Integration

In Wales, a review of the Rapid Response Adaptations Programme (RRAP), which provides a fast small repairs and adaptation/repairs service to older and disabled owner-occupiers and private tenants and identified by health and social care staff as at-risk of hospital admission or awaiting hospital discharge, identified significant savings in home care costs, mainly in relation to younger (including younger old) disabled people (WAG 2005).

Assuming 10% of repairs and adaptations led to a hospital discharge or avoided an accident and hospital admission, the total cost saving to health and social care was estimated at £15 million in one year. This was achieved by enabling people to return home from hospital and care, and in preventing admissions and re-admissions. The greatest savings were found where informal carers were enabled by the adaptations/equipment to manage without the need for night-time professional care workers.

A more recent evaluation for Care and Repair of a similar scheme concluded that Home from Hospital projects are a good way to ensure that older people can leave hospital safely and comfortably through the provision of short/long-term care, equipment and adaptations, and that a cross-sector partnership where housing help was integrated into the discharge system could achieve savings to social care and health providers (Green 2012). The service targeted older people, their families and carers, and involved the provision of housing and care service information to patients, initially via a Going Home from Hospital pack combined with local Care & Repair (or similar voluntary sector service) staff undertaking regular 'ward rounds' to top up packs, talk to ward staff and take direct referrals of older people who wished to discuss their housing and care options and/or who needed practical housing related help in order to be discharged from hospital. Green concluded that integration of housing services worked best when hospitals allow housing information and advice service providers to become an integral part of the hospital setting with housing advisers visiting wards to meet staff and patients.

Minter (2012) also considered the issues raised in terms of integration by the development of local housing and hospital linked projects.

Cost-effectiveness

There is a wide evidence base on the cost-effectiveness of aids and adaptations, including the widely quoted work by Heywood and Turner (2007), which explored the research evidence on aids and adaptations. While acknowledging the difficulties of disaggregating the impact of complex interventions, the authors concluded that the provision of housing adaptations and equipment for disabled people could produce savings to health and social care budgets in four major ways:

• reducing or completely removing an existing cost (specifically around residential care and intensive home care);

• preventing an outlay that would otherwise be incurred (notably prevention of accidents such as hip fractures), and prevention of admission to residential care;

- preventing waste;
- better outcomes for the same expenditure.

As the authors comment:

> Not all adaptations save money. But when they are an alternative to residential care, or prevent hip fractures or speed hospital discharge; where they relieve the burden of carers or improve the mental health of a whole household, they will save money, sometimes on a massive scale (p.14).

More recently, a study funded by the British Health Care Trades Association suggested that an annual spend of around £270 million on Disabled Facilities Grants is worth up to £567 million in health and social care savings and quality of life gains (Snell *et al.* 2012). The study quotes evidence of a range of practical low cost initiatives on adaptations and equipment that resulted in significant savings. One local authority saw a reduction in care cost of £1.98 million over five years for a £110,000 investment in just 20 level access showers.

Other evidence (cited in Heywood and Turner 2007) includes a report from Essex concerning a package of £37,000 spent on equipment for a total of 183 people during a three-week period in January–February 2005. Without the equipment provided, residential costs of £635 per week would have been necessary for three people and residential nursing care (£757 per week) for seven others. Even assuming that with the equipment provided each of these people still needed a high support package (cost £230 per week), the savings in care costs per week of providing the equipment to these ten people amounted to £4,902 or £25,490 each per year.

A multidisciplinary Engineering and Physical Sciences Research Council (EPSRC) funded study relating to social rented housing involved an audit of 82 different dwellings which enabled the research team to model costs for typical adaptations that took into account both building types and levels of impairment and their progression over time, and to model the social care costs for a range of likely tenants with and without the adaptation (Lansley *et al.* 2004). In most cases the initial investment in adaptations and equipment, including AT, was recouped through subsequently lower care costs within the average life expectancy of a user. The authors concluded that appropriately selected adaptations and AT can make a significant contribution to the provision of living environments, which facilitate independence. They can both substitute for traditional formal care services and supplement these services in a cost-effective way.

Gaps in the research

The available research on Home from Hospital services has been conducted by provider organisations, and there is a lack of robust independent evidence about the outcomes and cost-effectiveness of these services.

Information, advice and guidance

Successive policies, including Dilnot's Commission on Funding of Care and Support (2011), have identified the importance of trusted, independent, impartial information and advice to enable older people to make informed decisions. This includes being able to navigate, consider and shape personal and public expenditure on care and the home environment.

FirstStop Advice is an independent, free service offering advice and information to older people, their families and carers about housing and care options in later life. A national evaluation of the service identified a number of benefits to the individuals who used the services included: prevention of housing related health problems, e.g. falls and unplanned and unwanted moves into care homes; feeling more informed and more able to choose between different options; being empowered to live in the housing that clients felt suited them best and giving them wider choices; some clients were financially better off through receiving financial advice and/or benefits checks; improved well-being and quality of life (Burgess 2011).

Prevention

Bowey and McGlaughlin (2007) explored the views of older carers of adults with a learning disability about planning for the future. Their findings show that more than half were not ready or were unwilling to make future plans. Barriers included a lack of awareness of timescales involved in securing housing options. They concluded that there is a need for a proactive approach to information and support provision to enable these families to work through a process of making plans for the future – essential to avoid the need for emergency placements in response to crisis and to ensure genuine choice and involvement for adults with a learning disability.

Enabling

FirstStop case workers freed up social worker and occupational therapist (OT) time (Burgess 2011). Many of the particularly vulnerable clients had been on the books of social workers and/or OTs for some time, but their problems did not easily fall under the remit of these departments, nor did they have time to provide the sort of support needed. The local project case workers were able to take over the cases and provide the time and support needed to resolve the issues. Burgess concludes that the savings to the public purse may be realised over a number of years, for example, where someone is assisted to remain living independently in their own home rather than making a premature move to a residential home.

Integration

Evidence about the role of information and advice for carers of people with learning disabilities is available in Gilbert et al's (2008) qualitative study involving 28 older carers. The findings indicated a need for information about housing options, a lack of practical support and feelings of marginalisation. The conclusions suggest key roles for social services in providing proactive support and advice to family-carers, and a greater degree of joint working between social services departments and housing agencies.

Housing and adult social care

A rare study related to housing for people with a learning disability (Bowey *et al.* 2005) involved focus group discussions with carers and professionals working with adults with a learning disability. The researchers explored family and professional views about housing and choice and found that:

- Examples of problematic relationships between professionals and carers, created a barrier to choice;

- Risk was a fundamental concern when considering independent housing;

- Although opportunities for choice were generally supported, many argued for the need to assess the ability to make informed decisions;

- Carers needed involvement, information and support during the development of housing plans.

Gaps in the research

There is a lack of research on the cost-effectiveness of information and advice on housing and social care. Little is known about alternative sources of advice and information and their effectiveness. In the past, many self-funders seeking advice or help from their local authority have been signposted elsewhere. There is a lack of evidence about where they have gone and what has happened to them.

Built environment and design

The built environment has a potentially critical role in enabling or disabling people with mobility and/or cognitive impairments, and there are a number of qualitative studies which indicate the role of the built environment in either facilitating or hindering independent living, as well as a range of design manuals and case studies by architects and designers on the Housing LIN and elsewhere.

Enabling

A qualitative study by Barnes *et al.* (2012) as part a research project that aimed to evaluate the design of housing for older people identified two over-arching themes for residents of ECH: how the building supports the lifestyle, and how the building design affects usability (Lewis *et al.* 2010, Orrell *et al.* 2013). Independent living was compromised by building elements that did not take account of reduced physical ability and made movement difficult around the schemes. Other barriers to independence included poor kitchen design and problems doing laundry. The study concluded that, while the design of extra-care housing met the needs of residents who were relatively fit and healthy, those with physical frailties and/or cognitive impairment could find the building restrictive resulting in marginalisation.

Dutton's (2009) scoping review highlighted issues in the design of extra care schemes which affected people with dementia. She identified key aspects of successful extra care schemes as (i) specialist design for dementia, and (ii) having adequate space within flats and within the building as a whole. Pleasant, homely and easy to understand

environments that offer opportunities for residents to improve their functioning could increase independence, mobility and encourage food and fluid intake, while larger schemes could be disorientating and confusing for tenants but were more likely to be able to provide a wider range of amenities and facilities.

Other research studies have provided evidence of the enabling role of the built environment in relation to older people, and people with dementia. Burton *et al.* (2010) explored the impact of design in bathrooms for older people. The qualitative research revealed concerns about safety in the bathroom, bathroom furniture causing access problems, lack of space, and anticipation of future needs and subsequent economic considerations.

Findings from a review of two EQUAL projects suggest a more creative approach to the management of buildings would enhance the well-being of residents; under-use of facilities was common (Torrington 2006). Quality of life was shown to be poor in buildings that prioritised health and safety. In contrast, buildings that positively supported activity by providing good assistive devices, giving people control of their environment and affording good links with the community had a positive association with well-being.

A case study describing new practice in responding to the needs of older people with dementia noted that dementia-proofing and retro-decorating can help to significantly improve the mood and feeling of well-being of clients who live with dementia (Chaplin 2011). The techniques can boost the socialisation of clients, and residents become more inclined to visit family and take part in social sessions at day-care centres and memory clinics. Retro-decorating and dementia-proofing interventions can also bring about an increase in an individual's short-term memory, particularly their ability to complete routine tasks such as feeding themselves and maintaining personal hygiene. Caseworkers reported seeing home-based reminiscence therapies helping people with dementia to remain in their own homes for longer.

The EPSRC has funded a call to consider ways in which better design of the built environment can facilitate and enable mobility, physical activity and physical connectivity of older people within the community.[9]

Gaps in the research

There is a lack of comparative evidence about the outcomes and cost-effectiveness of different size and types of design of ECH.

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9 www.epsrc.ac.uk/funding/calls/2012/Pages/designforwellbeing.aspx

CLIENT GROUPS

Older people

As the earlier sections indicate, much of the available research evidence on housing and social care is concerned with older people. Older people are the largest consumers of housing with care and housing related support and have therefore tended to dominate the research base. However, relatively little is known about owner occupied and private rented housing in relation to older people and social care, black and ethnic minorities, or older men in these housing environments.

Allen and Miller (undated) found that a range of interventions were seen as being effective locally in preventing older people from requiring any or additional social care services. However, they highlight the fact that the number and scope of studies is limited and there continues to be a considerable evidence gap.

Studies of people with dementia have been mainly concerned with ECH. Less is known about the role of housing interventions and housing related support to enable older people with dementia to live independently, or to prevent or delay the need for more intensive care in either owner occupied, private or social rented housing.

End of life care is inevitably a sensitive area for research, raising as it does a number of ethical concerns (Goodman *et al.* 2012). This largely explains the paucity of research in the area. However, one evaluation has looked at a pilot service aimed at improving end of life care in a small number of ECH schemes and found two key issues that need to be addressed:

- Knowing what tenants would like to happen, which in turn relies on asking them about and recording their wishes, and then ensuring these are known, respected and adhered to by all involved, whether family or paid professional;

- Everyone involved needs to have a shared understanding of their individual role(s) in helping the tenant achieve what the tenant wants at the end of his or her life (Easterbrook and Vallelly 2008).

Physical and sensory impairment

Much of the research on people with physical and sensory impairments in relation to housing and social care has focused on the role of the built environment in enabling people to move around their home and use its facilities. Most of the studies are concerned with physical impairments, although the Pocklington Trust has made research on housing and built environments that support the independence of people with sight loss a priority and has funded research on the design of ECH for people with sight loss in the past. In addition, an SSCR-funded project, led by Karen Croucher, on dementia and sight loss and the question of what social care can do to offer better support, including housing solutions, is due to report shortly.

Learning disability

Research on housing and social care in relation to people with learning disabilities has been largely limited to: cost-benefit analyses of Supporting People (Matrix 2006); an evaluation of the Government funded programme of ECH for people with learning disabilities (King and Maxwell 2008); and evaluation of the Shared Lives programme (NAAPS/IESE 2009).

There has been limited research since 2003 into the most appropriate housing and care model for people with learning disabilities. McGlaughlin and Gorfin (2004) suggested that ordinary housing with small numbers is the preferred model and that appropriate support is highly valued. They found clear evidence that the service users in the study felt powerless in making choices with decisions being taken on their behalf by professionals and carers.

The cost-benefit analyses of Supporting People programmes across the UK estimated significant net benefits of the programmes for people with a learning disability. In the Welsh study by Matrix (2006) the evidence for people with learning disabilities was qualitatively based and many of the benefits could not be modelled, such as an improved quality of life for the individual and their families. The largest quantifiable impact was on the use of residential care and adult placement services. However, Fyson *et al.* (2007) expressed concern that the rapid expansion of supported living schemes for people with learning disabilities may have diluted the meaning of support, while other schemes were little different from residential care.

David Roe (2011) observed that:

> The key question about the size and configuration of shared housing, and its impact on the effectiveness of support provided for residents is, surprisingly, one which does not seem to have been very well researched. There may therefore be a presumption that larger housing means less effective support, but this may not necessarily be the case, depending on the way people are being supported. It is also likely that the nature and level of needs will have a bearing on this. It should also be recognised that individual living preferences are also important to take into account, alongside effectiveness of support (p.12).

People with mental health needs

There have been some recent evidence reviews related to housing, housing support and mental health (O'Malley and Croucher 2005a, Bowpitt and Jepson 2007, Palfrey 2005). However, the evidence base appears to be underdeveloped.

The available research suggests strong support for a distinct positive effect on mental health in re-housing the most vulnerable (Johnson 2013). This might seem to imply the likelihood of an equally positive effect in mainstream housing stock improvements for those with less intensive needs; but, the evidence is unclear. What studies there are suggest significant benefit, particularly in improved housing for the more vulnerable. In

the case studies assessed by the Care Services Efficiency and Delivery programme (2008), five out of nine projects identified as exemplars of potential savings for health and social care were either mental health-specific or mental health-related.

Johnson found that the available evidence gives conditional support to policies accentuating empowerment at individual and community levels; early intervention; locality or place-based interventions; and integrated working practice. He commented that the complexity of methodological issues emerges as a key challenge for research in this field and for the prospect of evidence-based national policy.

A number of reports and surveys indicated a widespread view, derived primarily from the lived experience of mental health service staff and service users, that both housing and housing related support have a significant impact on mental health, although Johnson observed that the research studies would not meet the gold standard of clinical research.

The evidence review of supported housing by Pannell and Blood (2012) indicated that, overall, one in eight Supporting People funded residents received support to 'better manage' their mental health, 2% to manage their substance misuse and 5% to minimise harm or risk of harm from others. Pleace and Wallace (2011) conducted a rapid evidence assessment of housing support for people with mental health problems and found that there was some evidence that low intensity services that provided help and support in maintaining independent living could counteract the risks of someone with mental health problems experiencing a cycle of crisis and hospital readmission.

The existing evidence from models of the cost-effectiveness of individual housing support services for people with mental health problems indicate that there are significant savings to be made. However, Pleace and Wallace (2011) found that there was considerable variation in the provision and nature of housing support services for people with mental health problems. The evidence on the outcomes of housing support services for people with mental health problems in terms of prevention and enabling is weak. A consequence of this is that it is not clear to clinicians and health service commissioners how housing support services can potentially support and complement the work of the NHS and deliver important health outcomes (Pleace and Wallace 2011).

The weakness of the evidence base is confirmed by Chilvers *et al.* (2009) in a recent review for the Cochrane Collaboration. They considered the evidence on the effectiveness of support for people with severe mental illness through supported housing schemes with the intention of increasing treatment success rates and reducing cycles of hospital readmissions. Many of these initiatives were based on informal reports of effectiveness and were costly in terms of development, capital investment and on-going care provision. They concluded that there was insufficient evidence to establish whether or not the benefits of supported housing options outweighed the risks. It was unclear whether they increased or reduced levels of dependence on professionals and provided greater or less exclusion from the community. Chilvers *et al.* concluded that there is an urgent need to assess the effectiveness of these schemes using well-conducted longitudinal research involving comparative or control group methodology.

A recent qualitative study by Burgoyne (2014) examined how the nature and quality of housing affect adults receiving support for mental health problems, focusing on the less considered structural aspects of housing. He concluded that there are three main determinants of whether housing was a setting that enabled users to benefit from support and enjoy a good quality of life: 'autonomy', 'domain', and 'facilitation'. Another small qualitative study by Bowpitt *et al.* (2011) involved 12 formerly homeless men with a variety of mental health conditions in a residential hostel. The findings revealed that three things were of particular importance to stakeholders: residents' willingness to engage with support services; increased stability in residents' lives; and increased independence. Moving into independent accommodation with appropriate support has been found to be the most effective pattern of provision for homeless people experiencing mental health problems to avoid homelessness, manage their medical condition and generally live a more settled existence (Power and Attenborough 2003).

The Warm Front evaluation team assessed the mental health impact of cold homes on adults and found that the temperature of the home has an effect on mental health, in particular anxiety and depression (Green and Gilbertson 2008). The study showed that as average bedroom temperatures rose, the chances of occupants avoiding depression increased. Residents with bedroom temperatures at 21°C are 50% less likely to suffer depression and anxiety than those with temperatures of 15°C.

At the time of writing, the DH has announced a £43 million capital allocation from the Care and Support Specialised Housing Fund[10] to develop wider housing choices for people with mental health problems and learning disabilities as an alternative to residential care and community based services.

People who misuse substances

The government recognised the role of housing in supporting recovery in its drugs strategy *Reducing Demand, Restricting Supply, Building Recovery: Supporting People to Live a Drug Free Life* (Home Office 2010). It explicitly stated that recovery required a 'whole systems approach', including housing alongside health, probation, education and wider support services.

There is an overlap with other client groups, such as people with mental health problems and homeless people. Apart from the cost-benefit analyses of Supporting People, no relevant studies were identified concerned specifically with people who misuse substances in relation to housing and social care. However, the Chartered Institute of Housing (2012) produced a practice compendium that made the case for appropriate housing and related support as critical factors in supporting recovery, based on a variety of case studies. The Advisory Council on the Misuse of Drugs (2012) evidence review found emerging evidence that stable housing is beneficial to recovery, although much of the evidence came from the US. Specifically, the reviewers identified evidence that floating support services are

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10 www.homesandcommunities.co.uk/ourwork/care-support-specialised-housing-fund

effective at helping some substance misusers sustain housing. However, they found a lack of evidence on the impact of housing on recovery outcomes and noted that more work is required on the contribution of housing to recovery.

Homeless people

SSCR has taken a lead in funding research into homelessness by funding studies on supporting formerly homeless people to achieve independent living (Crane et al. forthcoming); and a longitudinal study of the service use and need of homeless women (Williamson 2014). At the time of writing, the NIHR was seeking proposals for a programme of research into healthcare interventions and integrated services for homeless people.[11]

However, beyond these research streams, apart from the cost-benefit analyses of Supporting People, there are few other recent studies relating to people who are homeless and their housing and social care. There have been few rigorous studies of the effectiveness of resettlement services for single homeless people, particularly older people, and little is known about the types of housing and support that increase the chance of success. Although there has been a rapid growth of tenancy support for resettled homeless people, there is little evidence on outcomes for older people or other groups. The authors of the Welsh study of the Supporting People Programme (Matrix, 2006) observed that there is evidence that the provision of housing-related support can prevent both new and repeat homelessness; however, there is little evidence around the type and duration of service that works best.

A large study by Warnes *et al.* (2013) examined the influences of biographical, behavioural, housing and neighbourhood attributes on housing satisfaction, settledness and tenancy sustainment for 400 single homeless people who were resettled into independent accommodation. It used evidence on resettlement outcomes over 18 months from London and three other cities. The researchers found that tenure greatly influenced tenancy sustainment with moves into private-rented accommodation having the lowest rate of success. Several housing and neighbourhood characteristics had strong associations with the outcomes.

The support priorities of multiple excluded homeless people and their compatibility with support agency agendas was explored by Bowpitt *et al.* (2011). They found that homeless people felt that the most effective help was offered when agencies and their staff were not constrained by enforcement or conditionality agendas. Such help was most often found in soup runs, day centres, outreach teams and support workers in specialist hostels where an unconditional personal commitment to homeless people can be exercised.

The 'Housing Support, Outreach and Referral' service was developed to support people living with HIV who were homeless or at risk of homelessness. The service was set up as

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11 www.nets.nihr.ac.uk/news/all/2013/funding-available-for-research-homeless

part of the Supporting People Health Pilot programme established to demonstrate the policy links between housing support services and health and social care services by encouraging the development of integrated services. Cameron's (2008) qualitative evaluation of the service emphasised the importance of the local joint working context, the involvement of the voluntary sector, and the role of the support workers as factors that accounted for positive outcomes in terms of accessing and maintaining tenancies. Those using services placed most emphasis on the flexibility of the support worker role. Interviews with professionals and those using services suggest that the role of support worker incorporates two dimensions – those of networker/navigator as well as advocate – and that both dimensions are important in determining the effectiveness of the service.

CONCLUSIONS AND AREAS FOR FUTURE RESEARCH

Overview

The review has revealed some good evidence about the role of a number of housing interventions, such as housing with care for older people, aids and adaptations, and handypersons services in preventing or enabling people to live independently in their own homes. There have also been cost-benefit studies across the UK indicating that the Supporting People programme, providing a range of housing related support, has yielded net benefits for most groups who use social care, mainly by the assumed delay or avoidance of long-term residential care. However, the review has also revealed gaps in the evidence base, particularly around private sheltered and extra care housing, recent changes in the nature of sheltered/ retirement housing, specific client groups, and the alignment of housing with the integration of health and social care. The great majority of research studies were conducted in England.

There may be little interest among providers in research that compares their approach with that of their competitors and a reluctance to share information regarded as commercially confidential. However, providers are interested in innovation in housing with care, as illustrated by their engagement with the Housing LIN. The formation of the Associated Retirement Community Operators organisation (http://arcouk.org/) in 2012, which currently includes 22 providers and 50% of schemes, may provide a means of engaging providers in future comparative research.

In terms of the research covered by the review, many of the items identified as part of the search activity were not robustly designed research projects in peer-reviewed journals. Much of the material retrieved came from bodies with an interest in the area and public sector organisations. Even some of the articles retrieved from academic journals were largely descriptive. It is possible that the search terms (which were focused on outcomes) may not have picked up articles concerned with a specific intervention or client group; therefore, some relevant studies may have been omitted. Overall, the range of methodological approaches within the research studies was limited. There were very few randomised controlled trials, cross-sectional or longitudinal studies. Much of the research evidence comes from evaluations of a small number or a single case study.

A key challenge of the review was sifting the broad range of available material relating to housing which touches on social care and vice versa. There were far fewer studies that focussed on the interface between housing and adult social care and the potential role of housing to prevent the need for social care and enable independent living for those already in need of care and support. Most of the evidence identified focused on a particular service or intervention with regard to a specific client group – mainly older people. The research often reflected the actual silos that affect the sector. A number of literature reviews examined the evidence in relation to the overarching themes of prevention or cost-effectiveness.

Housing and adult social care

One of the most striking gaps is the lack of research on owner occupiers in relation to preventing the need for social care and enabling independent living. As a growing number of owner occupiers enter old age with a significant asset and high expectations, little is known about how they are preparing for growing older and what models of housing and care or support will be attractive to them and best meet their needs.

This leads us to conclude that there are several key themes that would benefit from further investigation as part of SSCR's next five-year research programme (see below).

Prevention

Prevention frequently refers to different things in different circumstances – both delay and avoidance of need. Because of the different activities that it embraces, from 'low-level' interventions and community services supporting social inclusion at one end of the spectrum to intermediate care services at the other end, prevention in social care is difficult to conceptualise and, therefore, to research. In addition, there is the need for a long-term perspective, and there is a range of confounding variables which may come into play. Proving that something has been prevented is difficult in research terms, and much of the research available involves some heroic assumptions. There is a lack of long-term research on prevention.

There is little evidence about the efficacy and cost-effectiveness of preventive interventions in a number of areas related to housing and adult social care. Research evidence rarely addresses the counterfactual. In addition, the research literature tends to focus on interventions that promote physical health rather than prevent the need for social care or supporting independent living in a housing setting.

There is little research on the role of informal carers in either sheltered or extra care housing in preventing people who are sick or disabled from needing higher levels of care or enabling independent living. It is not known which types of scheme provide the best support to informal carers to help them do this.

There is a lack of evidence about which type of low-level services that enable independent living are most cost-effective at preventing or avoiding the need for care and whether some groups can benefit more than others.

More evidence is needed about what determines a move into or out of ECH; equally, where residents move from and where they go, including in relation to end of life care. End of life care is inevitably a sensitive area for research, raising as it does a number of ethical concerns, but there is a need for more research into which models of housing with care are best suited to prevent an inappropriate or unwanted move at the end of life.

There is also a need for more evidence about the relative merits of integrated and segregated ECH facilities for people with dementia, for them and for other residents.

More research is needed to identify new forms of housing that can promote self-care and self-help, and prevent a move to more long-term care, for example, exploring models of co-housing.

Housing and adult social care

Lastly, much of the research related to prevention is concerned with older people; we know less about the role of housing in preventing the need for social care for other groups, such as people with mental health problems and/or learning disabilities and other groups.

Enabling independent living

Enabling independent living as an outcome is often used as an objective for many housing interventions, but this largely depends on the service users' perception of whether or not they feel enabled to be independent. There is some good evidence from housing with care and supported housing, adaptations, and handypersons for older people that these services have enabled people to continue to live independently.

Despite central government funding to stimulate growth in the private rented sector more generally, there has been little research on either the preventive or enabling role of private sector extra care or sheltered housing.

There is a gap in the evidence base about the role of extra care in addressing the future housing and care needs of older people from black and minority ethnic communities (for example, how well do different models of housing with care work for older people from different ethnic groups?); and older single men in what have been largely white, female environments.

There continues to be a question about the extent to which ECH is a 'home for life', under what circumstances should people be expected to move on to different forms of care provision, and who decides? Equally, there is a lack of evidence about who is best served in a housing with care environment: is it appropriate for both the fit and the frail, or just frail older people?

Little is known about the extent to which older people (or other client groups) provide peer-to-peer support and care in housing with care and supported housing.

As with prevention, and with the exception of older people, we know relatively little about the role of housing with care in enabling other client groups to live independently or to support informal carers in their role. For example, there has been little research on the effectiveness of housing with care in either preventing the need for more intensive care or in enabling independent living of people with learning disabilities. In addition, there is a need to know which housing with care model is the most appropriate for people with learning disabilities.

There has been little recent research on sheltered or retirement housing in terms of either its preventive or enabling role, and there is limited knowledge of who is living in sheltered housing in terms of ethnicity, gender, levels of disability, their health, care and support needs, and what care is provided to them. Further research is needed to explore the impact of changes to the resident 'mix' of tenant profiles in sheltered housing (including residents under pension age; residents with a wider range of support needs; and residents who are very old/frail/with high care needs). We know least about people

living in private sector sheltered or retirement housing, or private rented retirement housing.

Despite a policy direction of maximising care and support at home, no large scale evaluations of housing related support for any specific client groups were identified in the review, and there also appears to be a gap in the research on the level of impact that these services have on the quality of life and need for care of those receiving them. For example, little is known about the role of housing interventions and housing related support to enable older people with dementia to live independently, or to prevent or delay the need for more intensive care in either owner occupied, private or social rented housing. And, although there have been major policy developments in the field of learning disabilities, and a spotlight on the sector following the abuse at the Winterbourne View hospital, there is little evidence about whether or not housing related support for people with learning disabilities has a cost-effective enabling role.

The evidence on the outcomes of housing support services for people with mental health problems in terms of prevention and enabling is also weak. There is insufficient evidence to establish whether or not the benefits of supported housing options (funded by local authorities as well as charities) outweigh the risks for people with severe mental illness.

There have been few rigorous studies of the effectiveness of resettlement services for single homeless people, particularly older people, and little is known about the types of housing and support, or duration of service, that increase the chance of success, (although a couple of forthcoming NIHR SSCR studies are expected to address this). Equally, there is a lack of evidence on the impact of housing on recovery outcomes for people who misuse substances.

There is a need for more evidence about the extent of telecare's enabling role, particularly for people living alone with disabilities and/or dementia: what is the value of telecare for the quality of life and independent living of people with dementia? There is limited understanding about the extent to which telecare users themselves feel that they have been enabled to live independently and a lack of knowledge about how they use the different types of services when they are provided – for example, people's willingness to wear and use pendant alarms. Related to this is the need for further research on the role of telecare and other assistive technologies, their usefulness and acceptability to residents in ECH and other forms of housing related support, and their impact on staffing requirements.

In terms of low-level services, little is known about alternatives to handyperson schemes, such as voluntary sector listings of vetted or 'reliable' tradespeople or the potential for timebanks to offer repairs services as part of their offer to older participants. In the past, many self-funders seeking advice or help from their local authority have been signposted elsewhere. There is a lack of evidence about where they have gone, what has happened to them, and where else did they obtain advice and information. The Care Act will mean a greater need to research communication of information and advice on housing and social care, and how people choose between the options available to them.

Housing and adult social care

There are some current evaluations of experimental dementia-friendly communities, but more research is needed on how to make communities and neighbourhoods more age-friendly and enabling.

Integration

There are many different levels and types of integration, from co-location of staff to full structural integration, but there remain few working examples of successful integration of health and social care where housing has a recognised role.

Inevitably, the lack of working models limits the amount of research that has been carried out into the role of housing in relation to the integration of health and social care. From the service users' perspective, there is some research evidence that integration is a concern, mainly from studies of ECH. The available research on Home from Hospital services has been conducted by provider organisations, and there is a lack of robust independent evidence about the outcomes and cost-effectiveness of these services. With an increasing emphasis on benefits to local health economies, there is a need for evidence about the role of handypersons in facilitating hospital-to-home services. There has been little research on approaches to aligning housing with the integration of health and social care. From the service users' perspective, there is some research evidence that integration is a concern, mainly from studies of ECH.

Hudson's (2006) evaluation of a programme to integrate health, housing and social care staff on a locality basis in Sedgefield offered some support for the validity of the model, although social workers, district nurses and housing officers tended to inhabit separate professional and organisational universes; were unaware of one another's role and contribution; were mutually inaccessible; and simply did not know each other as individuals. No other studies were identified that looked at service models involving integration between housing, health and social care.

From the management perspective, there has been little research into the most effective management arrangements for housing with care: whether separate, combined or integrated staffing models are more effective at enabling independent living. In general, the organisation and management of housing with care and other forms of retirement communities are not widely discussed.

Cost-effectiveness

Although there have been a growing number of studies involving some element of cost-effectiveness or value for money analysis, the evidence base is still weak in relation to housing and adult social care and frequently involves some heroic assumptions about the cost offsets or what has been prevented. Major analytical constraints include the availability of comprehensive cost data and the difficulty of costing some benefits, especially ones that accrue over time. Many of the wider costs are difficult to quantify and to attribute to a particular measure. Thus, although there have been several cost-benefit studies of the Supporting People programme, there has been little attempt to cost the

benefits beyond the assumed avoidance of higher cost forms of care.

Evidence on cost-effectiveness is stronger in some areas of activity (for example, aids and adaptations and handyperson services) than it is for floating support, telecare (where it often appears to complement rather than substitute paid and informal care), and information and advice (where it may be more difficult to compare like with like).

Little is known about the cost-effectiveness of different sizes, designs and models of organising and managing care in ECH. There is a need for a better understanding of which types and organisational models offer the best quality from the residents' perspective and are most cost-effective. No studies were identified that looked at how more efficient procurement of ECH could be achieved.

More research is needed to quantify the costs and benefits over time to specific client groups of housing interventions, which include control or comparator groups, and measures for 'softer' outcomes such as enabling independent living.

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GLOSSARY

Aids and adaptations: these are aids or adaptations to properties that enable people to continue to live independently. Examples include replacing entrance steps with ramps, providing level access showers, providing grab rails or raised toilet seats.

Assisted living: see Extra care housing below.

Assistive technology or AT: this term is used to describe any product or service that is designed to enable independent living, ranging from simple products such as calendar clocks or pill dispensers to more sophisticated movement sensors or flood sensors.

Co-housing: this is a form of community living where residents have their own private homes but also have some shared facilities and sign up to an element of community living. Shared facilities could include, for example, a common house, gardens, car pools or micro renewable energy schemes.

Extra care housing or ECH: "Extra care housing", "assisted living" or "housing with care" are terms used to described various models of retirement housing for older people who choose to live in an environment where support can be provided and/or who can no longer live completely on their own but do not need 24-hour complex medical supervision. There are a range of models and names used to describe this form of housing, but it is typically designed to enable independent living and includes the provision of care and support either on-site or on-call as needed. A variety of tenure options currently exist, but they are predominantly social rented or leasehold schemes.

Floating support: this is a form of housing-related support that enables people to live independently and is not linked to a specific property but rather the individual being supported. Support tasks can include benefits advice, help managing a tenancy and supporting access to other services.

Handyperson services: these are services which provide help with small practical jobs around the home, such as repairs, home security, and energy efficiency.

Homes and Communities Agency: The national housing and regeneration delivery agency for England.

Hospital to home services: also known as home from hospital services, these are typically multi-disciplinary services focusing on rehabilitation with the aim of enabling people to return to living independently in the community after a stay in hospital.

Housing-related support: this is support that enables people to live independently in the community and is either provided as "floating support" or is linked to a specific form of supported housing. It has traditionally been funded separately to care, and included different tasks, but there is a move towards a more holistic care and support service in some forms of housing.

Housing with care: see extra care housing above.

Informal carers: family carers and other carers who provide support without payment.

Leasehold: these are properties where the freehold is retained by a landlord who will also have some responsibilities for maintaining the property. Leasehold options include "shared ownership" where only a percentage is bought with the remainder rented from the landlord.

Owner occupation: one form of tenure where an individual owns and lives in their home.

Private rented housing: a form of housing tenure where an individual rents their home from another individual or organisation at a market rent (i.e. at a level set by the market locally).

Retirement housing: a general term used to describe housing designed specifically for older people, typically aged over 65 (but in some cases over 50 or over 55). It can include retirement villages as well as retirement communities and schemes.

Scheme managers (or wardens): the name given to the staff member who co-ordinates mainly housing related services in a sheltered or other form of specialist housing for older people. Traditionally, this was a resident member of staff, but this has shifted towards a visiting member of staff with a role focused on the assessed need of individuals and supporting independent living without carrying out care tasks.

Sheltered housing: a group of flats or bungalows forming a retirement community, and typically with some basic communal facilities and an alarm call system.

Social rented housing (or social housing): a form of subsidised housing generally provided by registered providers (or housing associations) or local authorities for people on low incomes. The allocation of this housing is normally governed by local authority policies or by individual provider's charitable or other objectives.

Supported housing: this is a form of housing where some element of housing related support is provided to vulnerable residents to enable them to live independently and sustain their tenancy.

Telecare: the use of technology, including monitors and sensors, to promote independent living and support to people in need of care to live longer at home, in homely environments and in their communities. This may include returning home after a period of illness. Examples include fall sensors and pendants.

Telehealth: the use of equipment in the home to monitor health and help the management of long term conditions in the home. Results are transmitted to a doctor or nurse who will then advise if an intervention is needed. Examples include monitoring blood pressure, blood glucose levels and weight.

Tenancy sustainment: services that aim to support an individual to manage their home and tenancy, including financial and more general welfare support.

APPENDIX I – METHODOLOGY

This scoping review was commissioned with the aim of providing a structured analysis and overview of the current evidence base on housing and adult social care and to ask what is the current state of knowledge in terms of key issues; and what are the implications for future research. A scoping review is not a systematic review, but is as comprehensive and methodical as possible in the time available.

The methodological framework for scoping reviews provided by Arksey and O'Malley (2005) was applied, which may be summarised as:

- Identifying the research question;

- Identifying relevant studies;

- Study selection;

- Charting the data;

- Collating, summarizing, and reporting results including gaps in the knowledge base and implications for future research.

This approach aims to allow for the inclusion of a wide range of publications. In terms of quality, greater weight was given to the peer reviewed and more empirically sound studies. Grey literature was included, but individual perspectives and opinion pieces were not within the remit of the review.

Scope

The brief for the review was to cover evidence of what works in terms of good practice and/or effective outcomes (including value for money) from studies of:

- Housing and prevention of the need for adult social care;

- Housing and delaying the need for adult social care;

- Housing and enablement of independent living;

- Alignment of housing with the integration of health and adult social care;

- Cost and cost-effectiveness studies.

This included a range of client groups: older people, people with dementia, people with learning disabilities, people with physical impairments, people with mental health needs, homeless people, people who misuse substances; and a range of tenures: social housing, private rented, and owner occupied sectors.

Personalisation was not specifically part of the brief; however, it is relevant to much of the research and topics covered.

Services which span across the housing and social care interface were included, such as housing with care, aids and adaptations, assistive technology and aspects of the built

environment (accessibility and adaptability). A substantial collection of material on handyperson schemes has been synthesised in recent reviews by the national evaluation (Croucher *et al.* 2011 and 2012) and by Moriarty and Manthorpe (2012, 2013). To avoid duplication, this work is mentioned briefly.

Qualitative and quantitative studies were included where they met the quality considerations mentioned above. UK literature from 2003 onwards, concerned with adults and older people, was included. Studies related to children and young people were excluded, as was non-UK research and research concerned with the integration of social care and health.

Search strategy

We adopted a set of search criteria using a set of search terms such as: housing OR supported housing AND social care AND integrat* OR prevent* OR independent living OR vulnerably housed OR cost effect* OR delay* OR enablement.

Searches were conducted of relevant databases for evidence from 2003 onwards, including Web of Knowledge, Social Care Online, Social Services Abstracts, and Applied Social Sciences Index and Abstracts on the Web (ASSIA).

In addition, articles and project reports were reviewed from a variety of sources, including: SSCR funded research projects, relevant websites, such as the Joseph Rowntree Foundation, Social Care Institute for Excellence (SCIE), the Housing Learning and Improvement Network (LIN), National Housing Federation (NHF), and the Housing and Ageing Alliance. This enabled the authors to identify recent evidence and unpublished material, as well as better known research studies.

In total, 111 articles and reports were identified that met the inclusion criteria.

A key challenge was sifting the broad range of available material relating to housing, which touches on social care and vice versa. More limited were studies that were focussed on the interface between housing and adult social care, and the potential role of housing to prevent the need for social care and enable independent living for those already in need of care and support.

Many of the items initially identified as part of the search activity were not robustly designed research projects in peer-reviewed journals. Much of the material retrieved came from bodies with an interest in the area and public sector organisations. Even some of the articles retrieved from peer-reviewed journals were discussion pieces or largely descriptive rather than robust, empirical evaluations.

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