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Adult Social Services Environments and Settings

Adult Social Care in Housing with Care Settings: A review of the literature

Simon Evans, Teresa Whitehurst, Robin Darton, Randall Smith,
Ailsa Cameron, Jeremy Porteus, Ann Netten, Theresia Bäumker,
Rachael Dutton

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The affiliations of the project team are as follows:

- Simon Evans, Senior Research Fellow, Association for Dementia Studies, University of Worcester
- Robin Darton, Senior Research Fellow, Personal Social Services Research Unit, University of Kent
- Jeremy Porteus, Director, Housing Learning and Improvement Network
- Rachael Dutton, Research Manager, Housing 21
- Randall Smith, Honorary Professorial Research Fellow, School for Policy Studies, University of Bristol
- Ailsa Cameron, Senior Lecturer, School for Policy Studies, University of Bristol
- Ann Netten, Director, Personal Social Services Research Unit, University of Kent
- Theresia Bäumker, Research Officer (Research Fellow from October 2012), Personal Social Services Research Unit, University of Kent
- Teresa Whitehurst, Research Fellow, Association for Dementia Studies, University of Worcester

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1. Introduction

The literature review reported on in this document was carried out as part of the ASSET project, which aims to explore how Adult Social Care is commissioned and delivered in housing with care settings in England. The broad aim of the review is to provide the context for the ASSET project and inform the development of a survey of adult social care commissioners and housing with care providers. The report provides some background context for the provision of adult social care in housing with care settings and then goes on to describe the methodology used in carrying out the review. The findings are presented in two sections: the peer reviewed literature and the policy and practice literature, including 'grey' literature where available. The report concludes with a discussion section that summarises the main themes that have emerged from our analysis of the literature and concludes that there is currently very little evidence to indicate how adult social care is commissioned and delivered in housing with care.

2. Background

Changes in family size and geographical dispersion as a consequence of the Industrial Revolution in England began to shape the way families provided care for elderly relatives. Whilst some forms of close community associations were still able to achieve care within the family, many families began working away from home and there was a shift towards more societal responsibility for the provision of care. Social policy evolved and began to define the way in which people received care, but in doing so created a system of support dominated by the prevailing medical model with a subsequent society of older people who historically have had little control over the services they receive and little autonomy in their own lives. In recent years this has been exacerbated by a social care system which has become cumulatively more complex and costly to deliver, resulting in fragmented services that have not always delivered the outcomes that people want or need (ADASS, 2012).

Society has been forced to reconsider the way in which it provides care for elderly people in response to changing demographics and increasingly constrained financial resources. This has led to a timely reversion back to a care option that aims to empower individuals to make informed and personal choices, supported by policy revisions and funding streams which set out to make such aspirations achievable. For example, new measures proposed in the Dilnot Report 'Fairer Funding For All' (Commission on Funding of Care and Support, 2011) describe a different financial framework to support a new long term care system.

Both nationally and internationally preparing for an ageing society is perceived to be one of the most pressing challenges facing Governments today (DCLG, DH, DWP 2008; WHO, 2007). The projected change in the ageing population is substantial with those over 65 years estimated to rise from 10.1million to 16.7 million over the next 25 years and the number of people aged 90 and 95 tripling and quadrupling respectively (Counsel & Care, 2011).

These same demographic changes also mean that the provision of sufficient and appropriate housing for older people has become a policy priority. With older people wanting to 'live well at home by remaining independent and in control of how and where they live their lives' (op cit), various new models of retirement housing have emerged in recent years. These are often described as 'Housing with Care'. Detailed information about this type of housing can be found later in this report. For the purposes of this introduction it is sufficient to note that the two main forms of housing with care provision are retirement villages and extra care housing schemes, and that key characteristics include independent living in groups of self-contained housing units, the availability of 24 hour care, and access to a range of communal

facilities. From a policy perspective, housing with care has been described as falling somewhere between sheltered housing and residential care homes (Housing LIN, 2007a).

3. Methodology

Inclusion criteria: The review focused on UK literature but also included international literature written in English where it was thought to add useful perspectives to the topic being addressed. The search covered documents published since 1990 to ensure that initiatives related to the introduction of community care were included as well as studies of what was then known as ‘very sheltered housing’, an early form of extra care housing.

Rapid Evidence Assessment: The research team applied a system of Rapid Evidence Assessment to peer reviewed articles to enable the collection and analysis of both quantitative and qualitative evidence. Abstracts were reviewed by a dedicated researcher, following which five members of the project team reviewed relevant full articles using an Evidence Assessment Framework (see Appendix for template).

This review covers two categories of literature: peer reviewed documents and the grey literature.

3.1 Peer Reviewed Papers

An initial search of reference databases was carried out by an Information Specialist at the University of Bristol. This process used IBSS, ASSIA, Social Care Online, Campbell collaboration and Medline databases as well as government and third sector websites and hand searching through relevant social care and housing journals. One of the challenges of the review was the differences in the terminologies used to describe housing with care. Our specific focus on ‘social care’, ‘extra care housing’ and ‘retirement villages’ made the choice of search terms for the UK literature relatively straightforward. However, in exploring the international literature for relevant documents we needed to expand our terms in an effort to include equivalent forms of housing. An initial scoping of the literature identified three main areas of the world where models of older people’s housing similar to housing with care in the UK are common: other parts of Europe, North America, Australia and New Zealand. Further exploration identified the following terms that are commonly used to describe similar types of housing-based provision: ‘assisted living’; ‘retirement villages’; ‘independent living’; ‘elderly housing’; ‘service housing’. These were therefore added to the list of search terms. A full list of terms used can be found in the Appendices.

This search identified 2594 documents after the automated removal of duplicates. A breakdown by database searched is provided in Table 1 below.

The full list of 2594 documents was checked for broad relevance to the subject of ‘housing with care’ by three members of the project team, using reference management software, focusing solely on journal articles. This process included the removal of additional duplicates that had not been identified through the automated process. As a result, 1551 articles were rejected, 206 were identified as ‘possibles’ and 837 as ‘definites’. Articles were rejected for a range of reasons including sociological/urban/statistical studies of community; younger age-group; specialised medical studies; studies of older people but not related to housing.

Table 1: Peer Reviewed Literature by Database

Database searched	Date searched	Number of results
MEDLINE (Ovid) 1990 to 9/3/12	16/3/12	635
PsycINFO(OVID) 1990 to March week 4 2012	30/3/12	278
IBSS (Proquest) 1990 to March 2012	30/3/12	491
Social Care Online 1990 to April 2012	10/4/12	618
Sociological Abstracts (Proquest) 1990 to March 2012	3/4/12	893
Social Services Abstracts (Proquest) 1990 to March 2012	3/4/12	889
Campbell Library searched 10/4/12	10/4/12	0
Social Science and Science Citation Indexes (Web of Knowledge)	16/3/12	331
Open Grey 1990 to 2012	11/4/12	0
Total		4135
After de-duplication		2594

The refined list of 837 references was analysed to identify the main focus of each document, as shown in Table 2. These categories are not mutually exclusive. For example, a single document could come under 'health', 'care home' and 'England'. Filtering at this stage began to identify that there were very few articles with a focus on matters relating to adult social care in housing with care settings.

Table 2. Refined list of 837 using keywords in abstracts.

Main Topic	Number of articles
Health	290
USA	269
Assisted Living	227
Cost	95
Workforce/staff	92
Extra Care	61
Care home	32
Social Care	29
England or United Kingdom	28
Retirement Village	25
Australia	19
Canada	11
Sweden	10
Netherlands	8
Germany	4
New Zealand	3
Finland	1

United Kingdom Literature

A more detailed search of the 837 references was performed to identify articles which focused on the United Kingdom, resulting in a revised list of 260 references. These were then reviewed by a dedicated researcher to identify those of direct relevance to the ASSET project (i.e. empirical studies with elements of both adult social care and housing). This produced a final UK list of 92 references.

International Peer Reviewed Literature

The search identified 23 articles from the rest of Europe, as shown in Table 2. These were checked for relevance and four were selected for detailed review. This was a lower figure than expected, which led to a member of the research team undertaking a detailed exploration of provision of housing with care or its equivalent in European countries, based on email correspondence with academics and researchers in several countries. Any additional papers identified through this process were explored for relevance, which led to two being added to the literature for analysis. This work included an interesting consideration of the use of different terminologies in Scandinavian countries.

In addition, 272 documents were identified from the US literature. Using reference manager software these documents were sorted under the same themes generated from the UK peer reviewed literature. A filter was applied to all peer reviewed literature to identify those articles originating in the United States of America. This filter yielded 272 articles, reduced to 261 after the removal of duplicates. 74 of these were discounted as being non-empirical studies, articles which contained no relevance to housing or care, or articles which did not originate in the United States of America. The remaining 187 articles were categorized as shown in Table 3 below.

Table 3. USA peer reviewed articles by topic

Main topic	Number of articles
Quality of Life	55
About assisted living	54
About residents	40
Care and support	13
Built environment	11
Demographics	6
Staffing/workforce	5
Typology	3
Total	187

As a result of further filtering, using a similar process to that adopted for the English literature, nine international papers were included in the final review. These came from Australia (3), Canada (3) and New Zealand (3).

A full list of all peer-reviewed articles included in the review is included in the Appendices.

3.2 The Grey Literature

A search of the grey literature was conducted using the following categories:

- Central & Local Government
- National Health Service/health
- Housing Providers
- Housing Learning Information Network
- Consultancies
- Consumer Campaigning Organisations (Age UK, Counsel & Care, etc)
- Policy & Research Organisations (e.g. International Longevity Centre, Joseph Rowntree Foundation)
- Professional Bodies (e.g. Royal Institute of British Architects, Chartered Institute of Housing)
- Research reports and Newspaper Articles

All sources were searched using the following terms:

Social care; supporting people; housing with care; extra care housing; housing support; supported housing; very sheltered housing; retirement villages; assisted living; older people.

Relevant document information was compiled on a spread sheet. This process led to the identification of 195 documents after the removal of duplicates; these were checked for relevance to the review, which produced a final list of 75 documents in the following categories: 16 Policy, 15 Briefing, 44 Practice. A further breakdown is provided in Figures 1 and 2 below. A full list of these 75 documents can be found in the Appendices.

Figure 1: Breakdown of grey literature (Policy)

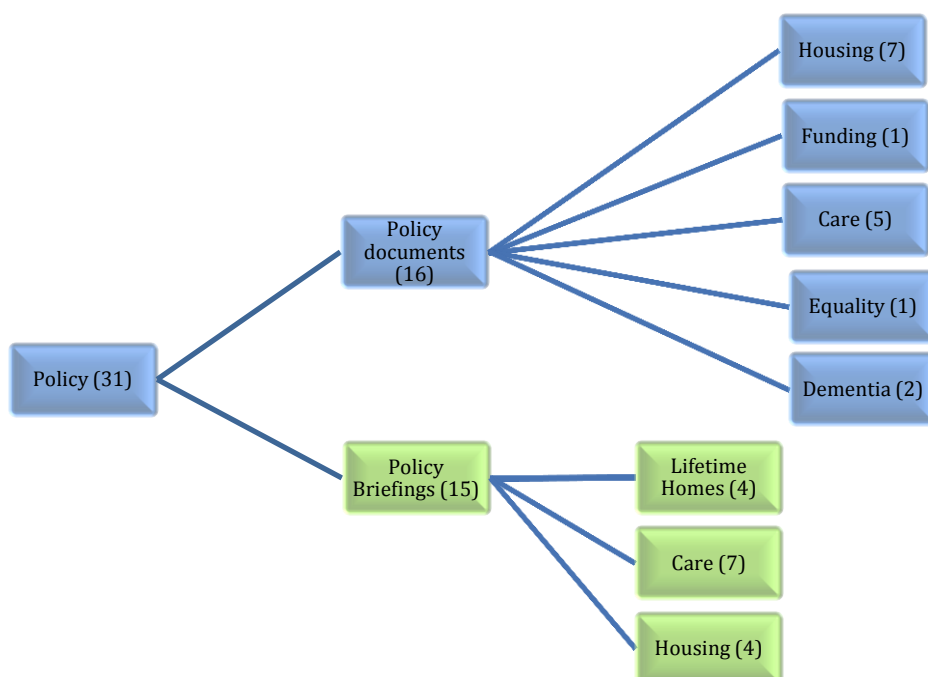
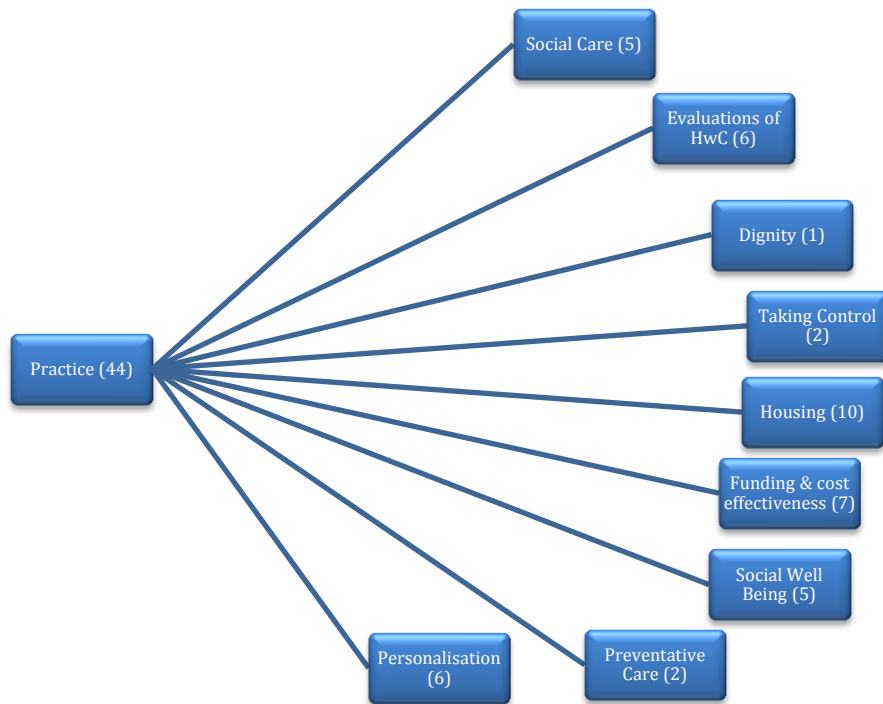


Figure 2: Breakdown of grey literature (practice)



4. Findings

4.1 Themes from the peer reviewed literature

One overarching theme that emerged from the peer reviewed literature is the lack of clarity concerning definitions of housing with care generally and extra care housing in particular. This is reflected in North American literature that focuses on assisted living facilities and is largely due to both the relatively recent emergence of these types of retirement accommodation and the fact that the models continue to evolve at a rapid rate. We report on further themes in the remainder of this section, under the following headings: care and support; about housing with care; the built and natural environments; and resident perspectives on living in housing with care settings.

4.1.1 Care and support

Our review identified five UK articles that specifically addressed the issue of care and support provision in housing with care settings. In potentially the most relevant paper reviewed, Wright et al (2010) reported on interviews with staff, residents and building professionals associated with ten extra care schemes in order to explore key social care issues in this relatively new type of provision. The authors noted that the absence of an agreed definition of 'extra care' makes it difficult for older people, their relatives and social workers to decide whether this form of provision is appropriate. They concluded that extra care schemes differ considerably in what they offer and that the care provision may not suit all older adults. For example, although all extra care housing offers 24 hour care the exact nature of provision varies considerably and for some schemes this means a sleep-in carer at night. For someone who regularly requires attention at night, they suggest, a care home may be more suitable. Similarly, not all extra care schemes have communal dining areas and an older person who has become lonely at home might not find the levels of social interaction that they desire in a scheme that lacks this facility. They also found that on average the care needs of residents were reduced after admission. More attention should be paid to design, they suggested, because quality of life can be compromised by poor design especially for those with mobility issues or sight loss.

A further two papers were based on a study by Brooker and her colleagues. In one of these (Brooker et al. 2009), they explored the mental health needs of extra care housing residents and found relatively high levels of mental health problems. The authors reported that the majority of residents who were identified as being most vulnerable lived alone. They called for a more proactive approach to people's mental health in order to be serious about maintaining a good quality of life for all. This work led to the development and experimental evaluation of an intervention called the Enriched Opportunities Programme, as reported in the second article (Brooker et al 2011). This initiative adopted a whole scheme approach to supporting people with dementia that included specialist staff, leadership, staff training, individualised care-work, community liaison and the provision of appropriate activities. The authors reported that those receiving the service were less likely than residents in the control sites to move to a care home or to be admitted to a hospital inpatient bed. They were also more likely to be seen by a range of community health professionals. They concluded that the EOP had a positive impact on the quality of life of people with dementia in well-staffed extra care housing schemes.

Means and colleagues (Means et al. 2006) focused on the ability of extra care housing to provide care and support for people with dementia. While they concluded that it can promote a good quality of life for

people with dementia, the authors also identified three issues that require particular consideration: access to health care, training of staff and providing a sufficiently stimulating environment. Dutton (2010) summarised the findings from a number of studies in this area and found strong evidence that certain aspects of extra care have a positive impact on the well-being of residents with dementia. These included person-centred care, maximising dignity and independence, effective communication and meaningful social interactions. She also reported an overall lack of evidence from the UK, particularly around the relative merits of different models and designs of extra care, the provision of end of life care, and comparing segregated and integrated models of supporting people with dementia. A scoping review by O'Malley and Croucher (2005) explored the evidence base for housing provision for people with dementia and identified a number of gaps also, particularly in relation to end of life care and the effectiveness of integrated and segregated models of provision. They also suggested that the development of extra care housing has neglected the longer term future of people with dementia.

Our review also identified several international papers that added useful evidence to the subject of care provision. One of these came from Australia and was based on a study exploring the provision of instrumental support to older people living in retirement villages and the community (Buys et al 2006). The authors reported that retirement village residents were far more likely to rely on paid assistance for help with everyday household chores and had less direct contact with family members than older people living in the community. In the second paper (Peri et al 2008) based on a study of five low-level dependency residential care homes in New Zealand, the authors concluded that a repetitive exercise programme based on activities of daily living can improve health status for residents in the short term. The third paper (Eales et al 2001) reported on a qualitative study from Canada that explored the views of residents of adult family living and assisted living programmes. The authors concluded that three main factors can improve the practice of client-centred care: having choices about models of care; appropriate staffing levels and training; and recognition of family contributions.

Another paper in this area (Reimer et al 2004) reported on a matched-group study comparing quality of life for people with dementia in 24 long-term care centres and 4 designated assisted living environments in western Canada. The authors concluded that quality of life for adults with middle- to late-stage dementia is the same or better in a specialist assisted living facility than in traditional institutional settings. Writing about a study that explored social engagement in retirement housing in the USA, Zimmerman et al (2003) found a strong relationship between the provision of social and recreational activities and social engagement. They also reported that social work is not visible in retirement villages or assisted living facilities, and that this reflects a lack of perceived need, resources and staff. The authors also note that the shortage of social workers with the commitment to and experience of working with older adults is well documented in the USA. Hoof et al (2009) reported on trends in the provision of housing and care for people with dementia in the Netherlands, where there has been a move towards small scale group accommodation. Key elements in the provision of care are facilitating the involvement of family carers, the use of technology and making modifications to the living environment.

The remaining papers address different aspects of housing with care and are not of direct relevance to our topic of adult social care. They are, however, of interest in terms of context and background and the evidence they present is summarised below within four main themes:

- About housing with care – characteristics; models; provision; policy.
- The role of the built and natural environments;

- Resident perspectives on living in housing with care settings.
- Costs and cost-effectiveness

4.1.2 About Housing with Care

King (2001) explored different models of extra care housing and identified four key variables that combine to create a model:

The housing and care provider relationship

A range of options are described, including (i) the housing and care are provided by the same organisation; (ii) housing and care are split and the care provider has a contract with social services; (iii) one separate housing provider and social services provide in-house care; (iv) one housing provider and multiple care providers which relate to individual care package funded by social services. King argues that splitting functions ensures you can use specialist care provider, and is less likely to raise the possibility of a need for registration, but it can make it difficult to integrate services.

- *Building type.* Buildings could be all purpose built, a mix of sheltered and very sheltered in distinct groupings or mixed together; the development could be any size from 40 to 300;
- *The scale, range and dispersion of facilities.* There is usually a core and cluster arrangement of buildings i.e. core facilities and then clustered units, or it could have dispersed facilities.
- *Lettings policy and tenure.* Lettings policies range from all higher care needs to a mix of abilities. Tenure varies on a continuum from 100% rented to mixed tenure.

The issue of tenure has been taken up by Hollywood (2005), who described mixed tenure as a relatively new model in extra care housing with much potential. She identified a range of issues to be considered in its development including layout (e.g. clustering of tenures compared with a more integrated approach), and the potential for residents of different tenures to have diverse characteristics (e.g. different aspirations, lifestyles and levels of frailty).

King (2001) also provided a useful description of capital and revenue funding for housing with care, although it is important to note that this is now out of date in some respects. He listed a range of capital funding sources, including Social Housing Grant, private finance (e.g. bank loans), local authority contributions (often in the form of land), charitable donations, and advance sale of equity in property to residents. Sources of revenue funding included Housing Benefit and Income Support, State Pensions and Attendance Allowance. King anticipated a forthcoming change planned for 2003 whereby the Supported Housing Management grant was transferred to Supporting People, as administered by local authorities, along with the element in the rent related to warden support. This would leave only the pure rent element plus management and maintenance costs to be met through Housing Benefit payments.

Dawson et al. (2006) provided some statistics on extra care provision at that time, estimating that there were 400-500 schemes in England, providing accommodation for 19,324 people. They highlighted the relatively low level of provision compared with residential care and identified various challenges to development, including a lack of capital and/or revenue funding, a lack of new and buildings suitable for

remodelling, and difficulties getting planning approval. They also suggested that good working relationships between Social Service Departments and housing providers are a significant factor in successful development.

Darton (2011) reported on various characteristics of residents of extra care housing schemes compared with care home settings. Overall levels of physical impairment were lower in extra care schemes than in care homes but a minority had similar levels of physical impairment. Levels of cognitive impairment were substantially lower in extra care schemes with 3% being severely cognitively impaired compared with 39% of care home admissions and 54% of nursing home admissions.

Various authors have commented on the development of housing with care as a relatively new form of specialist older people's housing in the UK. Riseborough and Porteus (2003) outlined the following key steps in successful planning and commissioning: Identifying the level of need; agreeing the commissioning process; clarifying which providers will provide which services; and agreeing capital funding. They also described the policy aspiration that extra care should be positioned within an overall strategy to provide better services, and requires planning for local populations that are not traditionally part of health and social care planning and commissioning.

Sanderson (2006) focused on private sector provision of housing with care including independent living, close care and sheltered housing. He explored how such schemes have been marketed and compared relatively high levels of consumer resistance in the UK compared to the USA, Australia and New Zealand, where downsizing to a retirement community is widely seen as a positive choice. The article concludes with a call for greater levels of provision, more choice of models and increased public awareness of the benefits of housing with care. Payne (2002) focused on the need to conduct market research to test demand for and the affordability of housing with care models. He suggested that an increase in scale enables provision of more specialist staff and results in a wider range of skills among residents. He argued that most schemes were largely designed to meet the needs of physically frail older people and suggested that future villages would need to develop facilities for people with mental health needs.

Hollywood (2005) commented that while extra care had been recognised by the Government as a preferred housing option for older people, a shortfall in places would lead to unsustainable demands on home care services. She felt there was a need for greater analysis of housing and care needs of the very old, locally and regionally, and called for more flexible tenure options for older home buyers.

Two papers raised fundamental questions about the value of housing with care as a retirement housing model. Percival (1999) reported conflicting evidence for the benefits of age segregated housing, including mixed findings about its impact on the self-esteem of residents. Abbot et al (2000) argued that specialist housing and care provision is inappropriate because it works against the inclusion of older people in the economic, social and political lives of their communities. He called for universal design backed up with universal services, with flexibly configured support services that do not depend on any critical mass of people living within any single building.

Vallely and Manthorpe (2009) considered extra care housing in the context of a continuing policy drive towards personalisation. They argued that the key characteristics of extra care, on-site care and support and 24 hour provision represent an important extension of choice for older people. Similarly, the

importance of the 'added value' of extra care – the sense of community and feelings of well-being for people who may have been lonely and isolated – fulfil an important element of the broad personalisation agenda. Housing providers should focus their efforts on communicating to commissioners the benefits of extra care in terms of enhancing choice and control.

From the international literature, Zimmerman et al (2003) describe the challenges of finding a common definition of assisted living in the USA that mirrors a similar issue for extra care housing in the UK. They describe a range of models of assisted living that vary in terms of the extent to which they promote independence, provide a homelike environment and support ageing in place. In another article, Sook Park (2006) proposed a typology of assisted living based on a study across four American states, identifying three key criteria of these housing with care models: structure – the capacity of the facility to provide care, including physical amenities and human resources; process – how the facility delivers care, i.e. the activities that occur between care providers and residents; and resident case mix – the proportion of residents who are functionally dependent. Applying these criteria to 193 assisted living facilities led to the development of six clusters: those with fewest facilities; those with the highest proportion of residents on Medicaid; those with the highest proportion of residents with functional, cognitive and behavioural impairments; the larger schemes (which also had higher levels of environmental quality and social activity); those with the highest rate of staff turnover; and those with the fewest licensed nursing hours (which also had the lowest staff turnover rates). The authors suggested that a useful test of the practical relevance of these clusters would be the outcomes in terms of resident quality of life.

Giarchi (2002) suggested a typology comprising 21 models of older people's housing across Europe on a scale from independence, through assisted living to dependence, spanning public, private and voluntary sectors. He concluded that a consistent approach to elder-housing is lacking across the EU, largely as a result of the range of different philosophies and attitudes regarding social care and the welfare state.

4.1.3 The built and natural environments

The role of environmental factors is another strong theme in the housing with care literature. For example, Torrington (2006) highlighted the role of architecture in promoting quality of life in care homes and extra care housing settings. Reporting on two research projects, she suggested that a more creative approach to the management of buildings would enhance the well-being of residents. Quality of life was shown to be poorer in buildings that prioritise safety and health while buildings that support activity positively by providing effective assistive devices, giving people control of their environment and affording good links with the community have a positive association with well-being. Barnes et al (2012) held focus groups with extra care housing residents to discuss the role of design in meeting the needs of residents with a range of levels of cognitive and physical ability. They concluded that design is a key factor in supporting residents who are ageing in place and that poor design can lead to the marginalisation of residents with physical frailties and/or cognitive impairment. Outdoor spaces were also important to residents, including gardens, balconies and courtyards, because they provided additional space as well as opportunities to take part in activities such as gardening. Stoneham and Jones (1997) explored the views of residents in a range of retirement housing and found that grounds and landscape were important to the vast majority of residents, including 15% who said they didn't actually use them.

Tinker et al. (2008) reported on the remodelling of extra care from residential care homes and found mixed results, with satisfaction reported by many new tenants, anger by some existing ones, challenges at every

stage of the project for design and construction teams, and issues over the provision of assistive technology and care. Nearly all the schemes experienced unexpected problems during the course of construction. The authors concluded that remodelling is not necessarily faster or cheaper than commissioning a purpose-designed new building, but that it may be the only viable option for some unpopular or outdated schemes. The social consequences of remodelling were evident when some 'old' clients had been retained during the remodelling causing a divide between 'old' (existing) clients and 'new'. Wright (2010) reported on a study of 10 extra care schemes and concluded that more attention should be paid to the design of extra care housing because quality of life can be compromised by poor design, especially for residents with mobility issues or sight loss.

Clarke (2004) also explored the remodelling of extra care from sheltered housing schemes and found that successful approaches shared a range of features. These included a clear technical and design brief, resident support and involvement, taking account of strategic needs of the area, and active inter-agency support. Remodelling was found to result in a reduction in the number of units, but capital cost were lower than for new build.

Several papers have focused on the role of assistive technology (AT) in housing with care settings. Lansley et al (2004) reviewed the use of AT and adaptations in various settings including extra care housing. They concluded that they can both supplement and substitute for care services and that for many older people adaptations and AT can be cost effective, with relatively short investment pay-back periods. Barlow et al (2005) explored the role of telecare in supporting independence and suggested that it has implications for the construction of extra care facilities, because it can cover dispersed properties as well as single sites.

The international literature included several papers that contributed to the evidence in this area. Nord (2011) reported on a case study project that explored the relationship between the architectural design of an assisted living facility in Sweden and the care provided by the staff to the residents. The author concluded that, despite the constraints created by architectural features, staff used a number of spatial strategies to promote the residents' privacy and sense of personal space. Van de Voordt (1997) focused on housing with care for people with dementia in the Netherlands. He highlighted the importance of the scale of schemes, arguing that bigger developments can provide more facilities but also tend to be less integrated with existing communities. This paper concludes that no exact blueprint of ideal housing is possible, but it is important to match the housing type with the needs of its target group.

Two papers from Australia focused on questions about the design of retirement villages. McLaughlin and Mills (2008) evidenced the importance of the design of retirement villages in supporting the changing needs of older people, and questioned the practice of building more of the same in order to relieve the demands of an ageing population. Petersen and Warburton (2012) explored retirement villages in Queensland and argued that age-segregated housing of this sort can be seen as both a cause and effect of ageism. They called for greater consideration of this issue among gerontologists and consideration of alternatives for older people's housing.

4.1.4 Resident quality of life and well-being

Several of the papers reviewed explored the views and experiences of housing with care residents. Reporting on an evaluation of Hartrigg Oaks retirement village, King (2003) found that 83% of residents were satisfied or very satisfied, and that some of the most valued features were privacy, the availability of

help close by, independence, access to amenities, social activities (and a lack of pressure to participate in them), and low levels of crime. There were also positive views of scheme design and an appreciation of the ability to retain control over their own lives. Most residents reported finding it easy or quite easy to afford to live there, but 20 percent found it quite or very difficult. Care and support services received high levels of praise, but there was some uncertainty about the ability of the scheme to support people with dementia.

A paper by Peace (2004) drew on two research projects, including a study of Berryhill retirement village. Resident concerns about their health was one of the main reasons for moving to this setting and those with a long-term illness appeared to function better than similar residents in the community. They valued the companionship that came from friendships with other residents, but some reported feeling lonely. Family were the most important source of help and support overall, especially for women, but there were questions about the extent to which the social needs of men were met. Other concerns related to diversity among residents and particularly variations in fitness and frailty.

Five further papers addressed the issue of why people move into housing with care settings. Burholt and Windle (2007) asked older people in Wales about their future housing aspirations and plans in relation to five domains: privacy and physical space; physical care; domestic services; security; social activities and control/autonomy. They found that extra care housing was viewed as more likely to meet participants' needs across four of these domains compared with sheltered housing and care homes. The one exception was the domain of social activities. Reporting on data from 19 extra care housing schemes of varying sizes, Darton et al (2012) found that the most important attractions were the security that schemes offered, flexible care and support, accessible living arrangements and the tenancy rights provided. Residents with care needs seem to move proactively when independent living was proving difficult rather than when staying put is no longer an option. The level of dependency of residents did not appear to affect the relative importance of these push and pull factors. Holland and Katz (2010) used focus groups to explore attitudes towards extra care housing among the Jewish community in three parts of England. They found that knowledge of extra care varied widely and the majority had no plans for future housing, but would rather defer this until their health failed or other reasons necessitated action.

Shipley (2003) reported that retirement village residents had moved in due to concerns about security, social isolation, property maintenance, a lack of stimulation, and the need to release equity. In comparison, sheltered housing did not meet their expectations and extra care was viewed as more appropriate for people with greater care needs. Petch (2007) also focused on the retirement village sector in reporting on a study by Croucher and colleagues, who found safety to be a primary factor in deciding to move in. At the same time, a range of negative characteristics of this setting were identified including tensions between those on state benefits and self-funders, and social isolation of the most frail residents.

Evans and Vallely (2007) identified six key factors that promote social wellbeing in extra care housing: opportunities for social interaction; connections with the wider community; good design and location; the involvement of family carers; staff training and cultures of care; and the provision of facilities. They suggested that all of these should be considered in commissioning, planning, designing and managing extra care housing, and felt that it is important to identify tenants who might be isolated for reasons such as limited mobility and a lack of close family ties. The article concludes by calling for more research into a range of issues including the impact of care systems on the effectiveness of provision.

Three further papers take up the theme of social interaction and a sense of belonging that for many residents is a key attraction of housing with care settings, as well as being a major selling point in marketing material. Evans (2009) reported on an evaluation of a retirement village that had adopted a clustered approach to the mixed tenures that it provided. He found that community belonging was linked to tenure type within a scheme rather than the whole scheme and called for more research into alternative designs, such as 'pepper potting' whereby different tenures sit side by side rather than in clusters.

Focusing on their study of Berryhill retirement village, Bernard et al (2012) concluded that the concept of a cohesive retirement community based on consensus is an unrealistic ideal. However, studying housing with care settings through the community lens and the dimensions of place, interest and identity offers useful insights into residents' experiences and perspectives on belonging. In their article on the role of community in later life, Means and Evans (2012) draw on a range of evidence including a study of a retirement village in concluding that while communities of interest play a growing role in the lives of many older people, it is not helpful to view them as the present-day alternative to communities of place. Instead they suggest it is important to explore the complexities of how the two interact and overlap.

The international literature included a paper by Horner and Boldy (2008) that reported on an action research study of an aged care community in Western Australia. They found that ageing in place was critical to quality of life for residents and an important component of social connection. A study carried out in New Zealand (Grant 2007) found that the residents of 12 retirement villages valued the sense of belonging to a secure and supportive community and felt that it contributed towards their identity and quality of life. A paper from Canada (Mahmood et al 2008) based on a comparative study between older adults in ethno-specific seniors' housing and community-dwelling older adults in Vancouver highlighted the importance of bonding social capital through the emergence of a South Asian social support network within the seniors' housing community. The authors also reported a strong preference for ethno-specific assisted living and residential care facilities. Finally, a paper drawing on an ethnographic study (Ericsson et al 2011) explored how people with dementia interact with cognitively intact persons in housing with care schemes in Sweden. The authors found that awareness in people with dementia seemed to be greater than others perceived, which often meant that interaction was adversely affected by frequent well-intentioned corrections and comments. They concluded that positive interaction can be encouraged by assuming that residents with dementia are aware of their situation and how others behave toward them.

4.1.5 Costs and cost-effectiveness

Our review found very little peer reviewed literature focusing on the costs of housing with care options. Bäumker and colleagues (2010), reporting on a case study of an extra care housing scheme, found that the overall cost per person increased after a move to extra care housing, but that this increase was associated with improved social care outcomes and improvements in quality of life. Netten et al. (2012) commented on the importance of reflecting outcomes of publicly funded services and the lack of a standard measure of the cost-effectiveness of social care. They report on the development and testing of the Adult Social Care Outcomes Toolkit (ASCOT), which has been shown to provide an estimate of a social care equivalent to the quality adjusted life year (QALY), which is widely used as a measure when evaluating health interventions.

4.2 Themes from the grey literature

4.2.1 Introduction

Care homes are not the accommodation of choice for people living longer, healthier lives (Sanderson, 2012). Older people are beginning to demand a social infrastructure which supports them through their retirement giving them real choices about the places they live and the care and support they receive. A cultural shift in the way society views and provides for older adults is in the early stages of changing our philosophy and practice in relation to how we build a world fit for the future.

Extra care housing and retirement villages, known cumulatively as 'housing with care' have emerged as a recent alternative to traditional care homes in providing a flexible approach which allows older adults to choose from a range of tenancy options with graded care packages to suit individual needs and budgets, both of which can change over time. A greater participatory approach has enabled services and built environments to be more responsive to the living aspirations of older adults and this is reflected in the diversity of resources currently provided. Taking such an individual approach in a system which is funded through a variety of means and through social care and health systems which are often delivered as a parallel process has inevitably led to differing models of how adult social care is experienced in housing with care settings. Croucher, Hicks, Bevan and Sanderson (2007) note 'there is no single blueprint for housing with care schemes.....provider organisations across the statutory, not-for-profit and private sectors have undertaken various new developments or re-modeled existing schemes, often taking quite different approaches to type of tenure, care services and provision of amenities and facilities' (p,1). Consequently, it is difficult to find a unified definition of housing with care. The Department of Health (2004) acknowledges this broad range of terms defining extra care alongside very sheltered housing stating that:

Very sheltered housing, extra care housing and a range of other terms are used interchangeably to describe a style of housing and care for older people that falls somewhere between established patterns of sheltered housing and the accommodation and care provided in traditional residential care homes (p 9)

The Housing and Learning Information Network (Housing LIN, 2007a) define extra care housing as schemes with:

- Self-contained specialist housing units (whether tenancies, private purchase leasehold or shared ownership/equity)
- A care team on site providing 24 hour care, seven days a week
- Access to communal facilities, such as a restaurant or activities room.

It is useful to set these definitions within the key points identified by Garwood (2010a) in relation to housing with care:

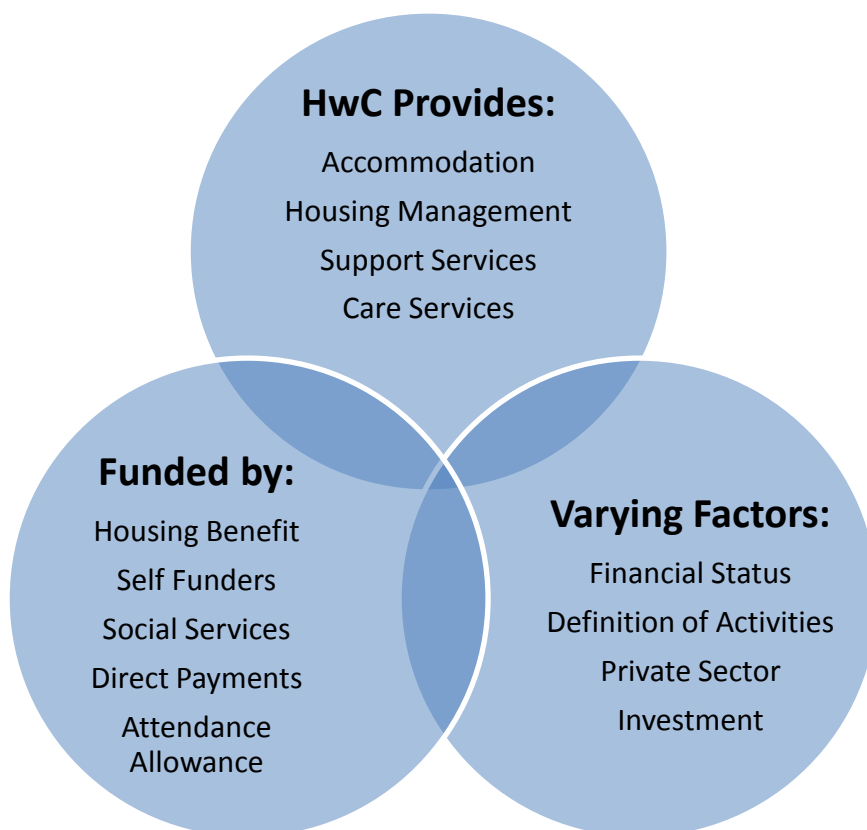
- It is a housing model, not residential care – its stated ethos is to support and promote independence, occupants have security of tenure and should have the right to control who enters their property and to choose the form their support should take.
- In another sense it is a hybrid – it does not have its own unique category in legislative and regulatory terms, and is covered by a raft of housing-related, community care and more general legislation and guidance which does not always dovetail.
- Similarly, in terms of staffing and service provision, it is different from both sheltered housing (with standard domiciliary care) and residential care, and has a very mixed workforce.

- In the context of the wider social care transformation agenda, housing with care is in a state of flux. The effect of personalisation on service commissioning and the uncertainty of core ‘block’ contracting of care means the future care delivery arrangements are not clear.
- No two housing with care schemes are the same – despite common elements, there is great diversity in every aspect of the provision including: scale; ethos; target groups and entry criteria; “move-on” practices; level and type of services; staff disciplines and skills; and financial arrangements and tenure. Thus, caution is needed in making generalisations.

Congruent with the current exploration of the provision of adult social care in housing with care, the Department of Health (2004) further note:

The proliferation of jargon and brand names in this area makes it difficult to achieve precision in identifying the facilities and services actually provided in any particular scheme. This difficulty extends to identifying the arrangements for care delivery and management, or the mechanisms for funding the various elements of the service (p 9).

The provision of services within extra care housing and the means by which these are revenue funded are captured in Figure 1 below.



Responding to older people as consumers

Listening to the wishes of older adults has been high on the agenda of key decision makers and providers with 'listening events' now informing the direction of policy and practice. The Local Government Group (2010) have identified the following needs of older people with regard to housing:

- Having a voice and influencing decisions
- Personalisation and choice
- Information & advice
- Inclusive design
- Affordable homes
- Joined up services
- Access to neighbourhoods, amenities, friends and family - ready access to neighbourhoods that are safe, welcoming and which have all the amenities they need, in particular health and social care.

People want to remain active, remain in active employment if they choose to, have sufficient finance to pay for their care needs and be able to stay in control of their own lives (Department for Work & Pensions, 2010). Lifetime Homes, Lifetime Neighbourhoods (DCLG, 2008) cite the following criteria as important to older adults:

- Housing should be well designed with ageing in mind; it should meet the needs of all age groups and build adaptable 'homes for life'
- Space is important: there needs to be room to accommodate visiting family or a carer and good storage space
- Housing design should be user-friendly, low maintenance and safe – a downstairs WC and bathroom with shower and bath are especially important. Homes should be affordable to heat
- Access to green, private space, and a safe neighbourhood is important, as is housing that is accessible to good local transport, facilities and amenities
- Access to independent information and advice about housing options is needed. Support is necessary for people to stay living in their own homes. A reliable repairs and adaptations service is needed for that bit of help around the home
- But above all, people want to be listened to, to be involved in the design of everything that will affect them, from planning and Lifetime Homes Standards, to the creation of safer environments, to testing new equipment and IT devices

More recently, the Housing LIN and ADASS have published a useful Resource Pack, 'Strategic Housing for Older People: Planning, designing and delivering housing the older people want' (Housing LIN, 2011). The Pack sets out a framework for local councils to develop Market Position Statements to address the above concerns and begin to shape the way housing, care and health respond to the needs of and are informed by older adults.

Our review of the grey literature aimed to capture current policy and practice in relation to housing with care schemes. In order to arrive at the current position it is important to be able to trace the recent history and consider the policies which have shaped the way things are today. Our analysis is presented in this section under these two headings.

Policy can be considered in relation to five main areas:

- Housing
- Care & Support
- Funding
- Dementia
- Equality

The practice documentation focuses on nine core elements:

- Personalisation and taking control
- Preventative care
- Funding & cost effectiveness
- Social well-being
- Dignity
- Social care
- Housing
- Planning
- Evaluation of housing with care

4.3 Policy Literature

Achieving integrated care which facilitates seamless provision with a person- centred approach is at the heart of new Government legislation.

Over the last decade a number of key policies have been introduced which have paved the way for a more holistic perspective on the needs of an ageing population. These aim to provide directives on health, care, funding and housing with a recognition that these components are interdependent but more importantly with an appreciation that these may be more effectively delivered through the provision of housing which is built for purpose and reflects the needs of a changing older population. These developments reflect the principles embedded in 'Putting People First: a shared vision of commitment to the transformation of Adult Social Care, (2007) and have been further articulated in the government White Paper Caring for our future: reforming care and support (2012b) which aims to reform health and social care for the elderly.

4.3.1 Housing

Housing has been a central tenet of the previous government's policy for addressing the needs of older adults and continues to do so within the policies of the new coalition Government both in terms of the changing demographics and in response to the search for more cost effective ways to support their needs. The essence of recent government policy to address this can be tracked through the following key documents:

- Housing & Community Care: Establishing a strategic framework (Department of Health & Department of the Environment, 1997)
- Quality & Choice for Older People's Housing: A Strategic Framework (Department of Health, 2001)
- Lifetime Homes, Lifetime Neighbourhoods: A National Strategy for Housing in an Ageing Society (DCLG, 2008)
- Ageing Well Programme (2011)
- Laying the Foundations: Government Housing Strategy (DCLG, 2011)

Housing & Community Care: Establishing a strategic framework (DH & Department of the Environment, 1997) identified the significance of bringing together housing, social services and health authorities to establish joint strategies for housing and community care so that co-ordination between respective parties could be achieved.

Quality & Choice for Older People's Housing: a Strategic Framework (Department of Health, 2001) identified that 'the focus of social care and health policy has shifted towards promoting independence and in providing care and support services 'close to home' as opposed to 'institutional' solutions' (p7). Objectives were set out around this premise to ensure older adults could secure and sustain a home suitable for their needs and to support them to make active and informed choices with five key areas; Diversity & Choice, Information & Advice, Flexible Service Provision, Quality and Joint Working.

These themes were built upon by *Lifetime Homes, Lifetime Neighbourhoods: A National Strategy for Housing in an Ageing Society* (DCLG, 2008) which sought to focus on not only the types of houses that people would wish to live in and how these were funded and sustained but also the types of community that were important to develop and foster social well-being. The document sets out the cross-government vision for providing solutions which are preventative and proactive rather than crisis driven and acknowledges that the personalisation agenda is 'likely to shape the future delivery of adult social care and for specialized housing' (Housing LIN, 2008, p10). The concept of Lifetime Homes is based on ideas pioneered by the Joseph Rowntree Foundation and the Habinteg Housing Association which identified five overarching principles: inclusivity (regardless of age, gender or disability), accessibility, adaptability, sustainability and good value ensuring homes are accessible, adaptable and age-friendly (Goodman, 2011). These were incorporated into government policy which sought to create Lifetime Homes Standards to make homes more flexible and functional with a target that all public-funded housing should be compliant by 2013. This is merged together with the concept of a Lifetime Neighbourhood which 'provides all residents with the best possible chance of health, well-being and social inclusion, particularly as they grow older' (International Longevity Centre, 2007) by ensuring homes are located within neighbourhoods which are well thought out, address the concerns of older adults and provide good peripheral infrastructures. These approaches build on the concept of age-friendly cities (WHO, 2007) and have recently been extended as a catalyst for the development of dementia friendly communities (Department of Health, 2012a).

The strategy advocated specialized housing such as extra care housing and identified increases in funding to support its development.

A new duty was placed on the National Health Service and local authorities to work together on a Joint Strategic Needs Assessment (JSNA). This was identified as a conduit for ensuring housing and care was commissioned on the basis of local need which began to draw together the policy drivers and strategy for health, care and housing.

The strategy's two principles for reform were Social Sustainability and Economic Sustainability. The latter, focusing on maximizing resources and empowering people to remain in their own homes, would aim to address the serious concern over the rise in long term care expenditure estimated to be around 325% between 2002 and 2014 due to falls, delayed discharges and moves into care (Housing LIN, 2008 p2).

A key thread running through the policy focuses on older people as having an active role to play in the development of Lifetime Homes and Lifetime Neighbourhoods not merely acting as recipients of their benefits.

However, three key challenges arise from the Strategy, as identified by the Housing LIN:

- It makes reference to the financial provision which has been identified to support new and diverse models of specialist housing to be developed and identifies that that these will need to be responsive to the growth in numbers of older people and those with Dementia but is not specific as to how this will be achieved.
- Funding issues to support models of specialized housing across different tenures have been identified but not synthesized
- It remains unclear how the personalisation agenda will impact on the financing and design of specialised housing.

The Ageing Well Programme was developed in 2011 by the government and is designed to support local authorities to improve their services for older people. It will be delivered by Local Government Improvement and Development (LGID, formerly the IDeA). The Ageing Well programme has three components:

- helping local authorities diagnose what areas of work need to be prioritised
- providing a 'menu' of improvement products and opportunities
- collecting and sharing a wide range of information and good practice.

Taken together, these components provide an individually tailored support programme to meet the range of needs particular to each local authority and its partners.

Laying the Foundations (DCLG, 2011) is the latest National Housing Strategy for England from the Conservative and Liberal Democrat coalition government, drawing on the principles of Lifetime Homes, Lifetime Neighbourhoods (DCLG, 2008) and weaving this together with current Government initiatives. The Strategy includes a section setting out a 'New Deal for Older People' (as highlighted below). This incorporates the findings of the All Party Parliamentary Group on Housing and Care for Older People 'Living Well at Home Inquiry' (Counsel and Care, 2011) which set out the following recommendations:

- A new 'Living Well at Home' Strategy for older people
- Planning and 'Age-Friendly' communities
- Sustaining advice and information services
- Raising the stakes in equity release
- Adopting a more integrated approach
- Maximizing choice and personal control
- Strengthening the strategic links between housing, health and social care.

The recommendations clearly bring together the various strands which run through prior, existing and future Government drivers to synthesize health and social care but with a prioritized focus around housing as the conduit to delivering these services. This document identifies not only the importance of housing but also the components of care, personalisation, funding, autonomy and choice which are so fundamental to providing holistic and integrated service options that enable older adults to choose the model which best meets their current and continuing needs and preferences.

A number of features of the 'Laying the Foundations' Strategy are of particular relevance to housing for older adults:

- The introduction of the 'New Deal for Older People' to ensure they are able to live comfortably in their own homes.
- Its emphasis on the importance of good housing design to promote well-being, connect people to local services and amenities and create safe and inclusive neighbourhoods
- A focus on the Government's commitment to:
 - ensuring local authorities make provision for a wide range of housing types across all tenures including specialized options such as sheltered and extra care housing.
 - working with planners and developers to facilitate industry-led guidance to enable local strategic planning and delivery of diversity of provision (incorporating the HAPPI Panel report (DCLG, 2009) and National Planning Policy Framework (DCLG, 2012).
- The identification of the need for a greater supply of homes and the need for a wider range of innovative, high quality housing for older people
- The opportunity for local communities to have more say over new housing developments
- Recognition of the role of good housing in supporting early intervention and prevention to maximize health and well-being.
- An emphasis on the pivotal role of services such as Home Improvement Agencies and handyperson services.

4.3.2 Care and Support

Meeting individual's needs within the community, either in people's existing homes or within specialist housing provision, through a range of preventative services over which people have choice and control is seen as the key to tackling the challenge posed by an ageing population. Yet this is contingent upon a 'complex interplay of factors' without which the 'demand for acute and substitute care will continue to rise' (ADASS, 2012, p6).

Our Health, Our Care, Our Say (Department of Health, 2006) provided an opportunity for consultation on changes to the provision of health and social care in its most holistic sense. Amongst other things this White Paper reasserted the need to bring care into the community, to provide for those with long term care needs and to provide joined up care through better communication between the health service, social care and the local authority. The paper identified the need to address silo working with primary care processes in NHS commissioning being separate from social care processes facilitated by the local authority through a change in the procurement procedure to underpin a commissioning framework for health and well-being.

The Health and Social Care Act (Department of Health, 2008a) set essential standards for safety and quality and brought into play a new regulatory body, The Care Quality Commission (CQC) which drew together existing regulators from the fields of health and social care with enhanced powers to uphold the new standards.

Under the new coalition government, the move towards an agenda incorporating personalisation was embedded in *A Vision for Adult Social Care; Capable Communities & Active Citizens* (Department of Health, 2010b) which took personalisation as one of its six principles:

- *Personalisation*: individuals not institutions take control of their care. Personal budgets, preferably as direct payments, are provided to all eligible people. Information about care and support is available for all local people, regardless of whether or not they fund their own care.
- *Partnership*: care and support delivered in a partnership between individuals, communities, the voluntary and private sectors, the NHS and councils - including wider support services, such as housing.
- *Plurality*: the variety of people's needs is matched by diverse service provision, with a broad market of high quality service providers.
- *Protection*: there are sensible safeguards against the risk of abuse or neglect. Risk is no longer an excuse to limit people's freedom.
- *Productivity*: greater local accountability will drive improvements and innovation to deliver higher productivity and high quality care and support services. A focus on publishing information about agreed quality outcomes will support transparency and accountability.
- *People*: we can draw on a workforce who can provide care and support with skill, compassion and imagination, and who are given the freedom and support to do so. We need the whole workforce, including care workers, nurses, occupational therapists, physiotherapists and social workers, alongside carers and the people who use services, to lead the changes set out here

Recognition that care has been treated as the poor relation to health was embodied in the previous Labour government's White Paper *Building the National Care Service* (Department of Health, 2010a). This document acknowledged the difficulties in accessing high quality affordable care, predominantly in later life but also for those with disabilities. It also addressed the misconception that care and support is offered primarily through the National Health Service. The document set out a structured step change in stages; providing care at home and in communities, re-ablement services and protection from high care costs leading ultimately to a full National Care Service where care can be accessed without cost by all those who need it. However, a decision by the new Coalition Government not to bring into effect the previous administration's Personal Care at Home Act 2010, which sought to provide free care at home for over 400,000 vulnerable adults, has meant that the mechanisms and parallel processes for the implementation of this White Paper have been undermined.

The State of Health and Adult Social Care in England (Care Quality Commission, 2011) is an annual report covering the period from April 2010 to March 2011 (the most recent at the time of writing) which is provided annually to Parliament by the CQC as part of their role created by the Health & Social Care Act 2008. The report has four main sections; the shape of care provision; access to care and services; choice and control; and quality and safety. The Report predominantly focuses on care within NHS settings and has little to add to the understanding of the provision of adult social care within community settings, although it is noted that the number of residential care services fell by 10% between 2004 and 2010, there were 4,608 care homes with nursing facilities, 13, 475 care homes without nursing facilities and 5,894 domiciliary home care agencies in July 2011.

The *Health and Social Care Act 2012* is now in place and brings radical reform primarily to the NHS through the abolition of Primary Care Trusts and Strategic Health Authorities, strengthening the role of the CQC and placing greater commissioning powers in the hands of GPs. Whilst its focus is not directly on adult social

care, the fact that older adults are the largest population utilizing health care resources forces an appreciation by clinicians of the growing needs of this patient group and a need for better integration of health and care provision. However, a roundtable report asserts that in 80% of cases the integration between health and social care simply does not happen (Andalo, 2012).

More recently the coalition government consulted with people who use care and support services under the banner *Caring for our future: Shared ambitions for care and support* (Department of Health, 2011), drawing together recommendations from the Vision on Adult Social Care, the Commission on Funding for Care and Support (see below) and the Law Commission. The Paper identifies key areas where improvements can be made including personalisation, integration, prevention and the shaping of local care services and is seen as 'an opportunity to put housing at the centre of a sustainable care system' (Swan, 2012). The drive is towards more ambitious integration of housing, health and social care with the National Housing Federation (Swan, 2012) identifying five key areas that the White Paper should include:

1. Join up housing, health & care; stress the value of housing to health and social care throughout the planning, commissioning and delivery of care services. This includes linking housing with health and well-being boards and incorporating the need for housing and related services in local commissioning strategies and needs assessments for care and support. A diversity of provision is central to personalisation and choice. It is only with this leadership that the White Paper will be truly meaningful for the housing sector.
2. Stimulate the local market for specialist housing; highlighting paths local partners can take through the challenges in planning and funding this type of housing, and commissioning the services involved.
3. Build on the recommendations of the Dilnot Report (see below); set out the path to a single, user-focused assessment of need. This is vital to ensuring fair, transparent processes that help all those groups who need care to access it.
4. Incentivise a focus on prevention; a £1.6bn annual investment in housing-related support services generates an annual cost savings of £3.4bn to the public purse, including huge savings in health and social care. The White Paper needs to provide leadership to local government and the NHS in pooling budgets and bringing staff together to jointly commission preventative services with an emphasis on housing and independent living.
5. Provide more effective ways of delivering adaptation services; support local authorities to make timely adaptations to properties. These vital services get people home from hospital more quickly, prevent readmissions and facilitate the delivery of care in people's own homes. Government also needs to build adaptations into a wider strategy on reablement, identifying transitional housing services as key to helping people recover their independence as quickly as possible.

With the Government White Paper *Caring for our Future: Reforming Care & Support (2012b)* now in place many of the issues raised by older people are being addressed. Chapter 3 of the White Paper specifically refers to the synergies between housing, care and health. The Paper aspires to make improvements in providing information to help people make informed choices, create better housing options and provide more support within communities. This is underpinned with the promise of £200 million to be invested in specialist housing over the next five years giving greater choice in housing options for older people and disabled adults.

4.3.3 Funding

Fairer funding for all (Commission on Funding of Care and Support 2011) was produced by the Commission on Funding for Care & Support chaired by Andrew Dilnot, who was tasked by the Government to review funding in the UK. The report highlighted the need for radical reform in order to protect those who need care and emphasised the need for greater forward planning (p.61). Dilnot stated '*We should be celebrating the fact we are living longer..... But instead we talk about the 'burden of ageing' and individuals are living in fear, worrying about meeting their care costs*'. The report proposed introducing new measures to cap individual contributions, recommending this figure be set at £35,000 whilst the means testing threshold be increased from £23,250 to £100,000. Recommendations from this report were considered by the new coalition government in *Caring for our Future: Progress Report on Funding Reform* (Department of Health, 2012c) who noted that whilst they agreed in principle to the notion of capped costing to protect people from the anxiety of care related costs this was not something they would immediately be able to address without finding alternative sources of funding. They did however commit in this Paper to the introduction of a universal system of deferred payments for residential care and a national eligibility threshold for adult care and support by 2015 together with improvements in the availability of information to older adults and a commitment to improved integration between health and care, with funding of £300 million over the next three years to enable areas to develop innovative integrated services to support care, health and well-being.

4.3.4 Dementia

With an estimated 750,000 people living with dementia in the UK (The Health Foundation, 2011), the National Strategy *Living Well with Dementia* (Department of Health, 2009) followed by *The Prime Minister's Challenge on Dementia* (Department of Health, 2012) aim to improve the quality of dementia care. Both policies highlight the need for high quality, expert care to be delivered either in care homes or within a person's own home, for housing to be prioritized and for the creation of dementia-friendly communities and cities. However, a recent report from the Alzheimer's Society (2012) notes that two-thirds of people with dementia (over 500,000) in the UK live in their own homes in the community and that much of existing housing is poorly suited to the needs of older people and people with dementia in particular. Amongst their recommendations they note that there should be a choice of housing options and tenures available, including mainstream and specialist housing, with more research to investigate the limits of housing with care for people with dementia.

The National Dementia Strategy (2009) is supported by the Prime Minister's Challenge on Dementia (2012a) to ensure that housing across all tenures improves so that older adults including those with dementia can continue to live in the place of their choice, for longer. If homes are truly to be 'lifetime homes' then the challenge is to build not only homes which support those with physical disabilities (currently part of the Lifetime Homes standard) but also built to support those with cognitive and sensory difficulties (Mitchell, 2012). The literature flags up some concerns regarding the ability for extra care and retirement villages to successfully meet the needs of older people with dementia. Whilst some schemes have been reported success in integrating people with dementia there is still concern that the needs of those with severe dementia may be better met within a care home environment (Midland Heart, 2011). There are debates around the creation of 'dementia wings' within extra care schemes but this is fraught with issues of segregation, isolation and loneliness.

4.3.5 Equality

The Equality Act (2010) encompasses all forms of equality and has specific provision in relation to age discrimination. In their consultation document Age UK note that the policy will effectively eradicate age discrimination in the provision of health and social care by 2012 but 'achieving equality in health and social care will require a whole-system' approach to change (Age UK, 2010, p 1).

4.3.6 Summary

Government policies aspire to work together to create holistic, seamless provision with a 'cross government' approach which reflects the interdependence of housing, health & care increasing the long term housing supply & promoting better health (Housing LIN, 2008). The raft of policies launched over the last decade has built on its objectives to attempt to synergize a drive towards integrated care and support (Humphries & Curry, 2011) which aims to reduce health inequalities (The Marmot Review, 2010), provide better structures for the funding of health and social care (Commission on Funding of Care and Support 2011; Department of Health, 2012c), provide lifelong homes and neighbourhoods where people can live the remainder of their lives (DCLG, 2008) with a greater vision around prevention, protection, personalization, partnership, productivity & people (Department of Health, 2010), which tackles the challenges faced by the NHS (Health & Social Care Act, 2012) promotes age equality in the delivery of health and social care (Equality Act, 2010) and focuses on the way society provides for and supports those with Dementia (Department of Health, 2009; Department of Health, 2012a).

These aspirations are set against the challenge of delivery through a multiplicity of partnerships in the housing, care and health sectors which traditionally have not had a shared language to build a culture around shared care.

4.4 Practice Literature

There are a number of major threads from policy which run through the provision of social care and housing for older adults including personalisation, preventative care, well-being, dignity, funding issues and planning. Whilst Policy documents dictate the world as we would wish it to be, practice documents often identify how these aspirations translate into reality. For the purposes of this literature review each section will be dealt with separately and a summary provided of how these strands come together to inform our understanding.

4.4.1 Personalisation and Taking Control

Personalisation and taking control are key elements which underpin the future of social care provision yet they are not 'systematically embedded in the policies and practices of mainstream housing providers, local authority housing providers or of strategic housing authorities (ADASS, 2010 p6). An iterative process has developed between housing and personalisation where advocacy from service users has shaped the way housing and care services are developing, demanding that housing providers plan and shape their services more responsively. In its most holistic sense, this not only has implications for all consumers of the housing market needing social care and support but also has implications for changes in delivery models and organizational approaches. These changes are implicitly linked to ensuring delivery of a personalized approach but mean providers may encounter changes in the balance of control in decision making, decreases in block contracts from Local authorities, more flexibility around core services balanced with individual choices and flexible housing options which enable older adults to use accrued existing property equity and increase the number of options available to them as their needs change (Social Care Institute for

Excellence and the National Housing Federation, 2009). Focusing on prevention, personalisation and housing in turn means councils are being encouraged to focus more of their resources on preventing the need for residential care and less on residential care itself (ADASS, 2010 p5). In order to deliver tailored services in times of austerity, there will be greater focus on commissioning and provider roles requiring dynamic co-operation and effective partnership working (Chartered Institute of Housing, 2011).

It is anticipated that changes in the way services are delivered through a range of housing options will have symbiotic benefits to the individual and to adult social care. As more of their clients' needs and aspirations are met by housing providers, the quality of life for individuals improves thus reducing the necessity for intervention. In addition, as residents become more settled in accommodation better suited to their needs other areas of their lives also improve, again reducing the need for services (ADASS, 2010). However, caution should be exercised in merely seeing personalisation as a cost cutting exercise as in practice it is noted that at least in the short term there are additional costs to be borne in mind in setting up such individualized services (Age UK, 2010; ADASS, 2010).

Three key elements have been identified as essential for older adults to facilitate personalisation; 'firstly proper assessment of their needs through a mechanism in which they have control, secondly good information and independent advice to enable them to make informed decisions and thirdly access to a range of quality services which meet their needs and promote dignity and choice' (Housing 21, 2009, p 9). Information to make clear choices in advance is a key component as many older adults are faced with the need to make housing related choices at a time of crisis or vulnerability (ADASS, 2010).

The move towards self-directed care has been a core component in focusing care on the 'individual and their wishes, rather than the service-based and prescriptive approach that has previously dominated provision' (Help the Aged, 2008 p2). This model has its roots in the independent living movement, a reaction by disabled people to the 'disabling services' they experienced which resulted in them establishing their own community and taking control of funding their own services in the 1970s – a move which led to direct payments (SCIE, 2012). 'Personal budgets' encompass both 'direct payments' which are paid by the individual directly to the service provider and 'individual budgets' which are held by a third party but used under the direction of the individual. The power of personal budgets, however, goes beyond the mere control of money. Personal budgets are a vehicle towards personalisation but much more is required than the mere presence of a personal budget to make personalisation happen. The ability to access a personal budget, however, can empower individuals to take control of their lives, affording flexibility, choice and ownership of services rather than being passive recipients of the process.

Despite its aspirations and stories of success, the move to personalisation is not without barriers and obstacles to implementation:

- Personalised services are subject to individual interpretation leading to a fragmented delivery approach which varies considerably from area to area (SCIE, 2012). Housing 21 (2009) note that in practice there has been little evidence of change in specialist housing settings with 'transformation' more likely to be a word used by policy makers and senior managers, but..... little used by people working directly with older people in extra care and sheltered housing, or.... by older people themselves' (p 13).
- Although personalisation aims to empower older adults, this may come at a time of crisis when the frailty and vulnerability of their situation means they see 'taking control' as an added burden; 'a

potentially substantial proportion of older people may experience taking responsibility for their own support as a burden rather than as leading to improved control' (Glendinning, 2008 p.44).

- It is important to ensure that older adults are made aware of the choices available to them around personal budgets so that they do not feel under pressure to take on responsibilities where these are perceived to be too onerous. This is particularly important in light of performance indicators set by Government to achieve higher numbers of people transferred onto personal budgets with the target set at 100% of those eligible by April 2013 (Department of Health, 2010b). Age UK advocate that there will be a much greater need for brokerage services to help older adults benefit from the advantages of financial flexibility and choice without the burden of responsibility.
- Whilst personal budgets and information may facilitate choice, there is often limited choice for older people who want to move to both specialist and alternative mainstream housing, in terms of tenure, location, size, affordability and type of care or support (Pannell, Aldridge & Kenway, 2012).
- Whilst the goals of personalisation should lead to better universal services, prevention, social capital, control and choice in reality the majority of an older adult's individual budget may well be spent on high care needs leaving little surplus for leisure activities, wider social well-being, etc.

The notion of social capital is emerging as a strong driving force and is a key component of the White Paper 'Caring for our Future: Reforming care and support (2012b) on adult social care. Small scale initiatives fostering social capital are quite widespread amongst a variety of housing with care schemes including using retirement housing as a community hub; supporting inter-generational relationships and learning; structuring volunteering through time banks; and giving more power to tenants and leaseholders in planning personal care, scheme management or local strategy (Blood, 2012) yet there appears to be a lack of evidence demonstrating how these smaller scale initiatives can be translated into larger programmes (O'Shea, 2012)

4.4.2 Preventative Care

Preventative care has been defined as 'services which delay or reduce the need for more costly intensive services' and 'strategies and approaches which promote the quality of life of older people and engagement with the community' (HousingLIN, 2006a, p.4) and has been closely linked with housing provision. Whilst these definitions are helpful, our understanding is enhanced by considering the detail of what is meant by preventative care in a more practical sense. This may be better understood as the contribution that services make to optimizing gains and compensating for losses experienced in later life (Housing LIN, 2006a). Whilst much can and is done within the housing market through housing with care, the extent to which these services are funded is limited. Funding is most appropriately applied to services which are evidence based and cost effective delivering robust outcomes and value for money. The lack of quantifiable evidence in this field means that often services are lacking because there is currently limited evidence of what works (Housing LIN, 2011). With local authority budgets dramatically reduced 'services are often focusing on those in the most critical need for care....(leaving)... local providers to find solutions to fill in the gaps and strips away a vital layer of preventative support (Swan, 2012).

4.4.3 Funding & Cost Effectiveness

Funding in relation to housing with care can be considered from a number of perspectives:

- Funding the built environment of housing with care
- Funding individuals to access services and support within housing with care

- Commissioning services
- How funding in the future will be structured to meet the demands of the growing number of older adults.

Capital funding

Considerable sums of money have been made available for the provision of specialised housing through the Department of Health for a number of years; £147 million between 2004 and 2008 with an additional £80 million between 2008 and 2010 (Evans & Vallely, 2007; Department of Health, 2008b). This funding supports Local authorities and their housing providers to create new extra care housing facilities. Funding however may come from other sources which historically have included Social Housing Grant (available only to Registered Social Landlords via the HCA), institutional borrowing, and free/low cost land (Housing LIN, 2005).

In the current economic climate, however, the financing of housing development is likely to be challenging (Housing LIN & ADASS, 2011, p12). In their 2005 survey of 13 Local authorities, the PSSRU found all of the councils with extra care housing had schemes managed by Registered Social Landlords (that is, non-profit making organisations registered with the Housing Corporation – now the HCA - and charged with providing decent, affordable housing), five had schemes managed by the local housing department and one council had schemes managed by private sector housing developers. Reasons offered for this negligible involvement by private providers included the high price and lack of land, lack of awareness of developments in the public sector and greater interest in selling rather than managing new developments (Dawson, Williams and Netten, 2006).

Funding for care and support

‘Times of austerity’ may be a relatively recent addition to our vocabulary but it is certainly not a new experience in the world of social care. Since the reforms of the Community Care Act in the 1990s Local authorities have faced reduced budgets with ever increasing demand for services.

In 2002, Age UK reported that the majority of funding was targeted towards those with high care needs, predominantly in long term care settings, with little left to assist those with lower level needs. Reductions were also seen in preventative care, services in the home and help with domestic tasks. Their report identified that most of the problems experienced by older adults accessing social care related to budgetary constraints:

- Information on services available and how to access them varies
- Eligibility criteria for services had been tightened and services restricted or cut completely
- The provision and quality of care for older people was poorer than for other user groups and older people’s expectations were low
- Services varied from one area to another in terms of what was available and at what cost
- Charging policies varied between authorities and caused problems for some of the most vulnerable older people; there were concerns that people may have been discouraged from accessing services or asking for more help for fear of the charges that may be levied

- Some groups within the older population, such as those from minority ethnic communities, people with mental impairments and those in rural areas, were experiencing greater problems accessing services
- Reductions in staffing levels had resulted in increased waiting times for assessment and services.

At this time, it was also noted that in order to purchase services some people were fully funding themselves, some were accessing funding streams, some feared accessing services due to costs, and some refused to pay for services but accessed them anyway! (Age UK, 2002) With provision of care services locally determined access to resources was not equally or universally available. These issues resulted in gaps in service provision, unmet needs (even in the group with higher care needs), differences in provision geographically and a lack of choice overall. Similar experiences were highlighted in a report published by the Joseph Rowntree Foundation (Hirsch, 2006), which identified three key deficiencies of the care system; its inadequacy, its unfairness and its incoherence. These issues were addressed in the Dilnot Commission Report with clear guidance set in place. However, there is some hesitancy as to how these recommendations are to be implemented through the new coalition government White Paper for adult care reform (2012b). The situation is now reaching ‘crisis’ proportions with the increased and projected number of older adults juxtaposed with cuts in spending on care services. As noted by Age UK (2012), ‘spending has decreased by over £300 million in real terms this year alone ...(and) in order to keep up with increasing need for services the shortfall is £500 million in real terms’ (p4). In broad terms, an individual paying for accommodation and services within housing with care environments may expect the costs to be met in a variety of ways:

Type of Running Cost	Potential Source of Funding
Accommodation e.g. Monthly Rent or purchased fixed lease & Housing Management/service charge	Housing Benefit Personal Income (Pension, pension credits, savings, etc.)
Housing Support	Supporting People (no longer available) Personal income Attendance allowance
Personal Expenses e.g. utility bills, social activities, meals etc.	Personal income Benefits & allowances
Personal Care	Local authority core funding/individual or personal budgets (for FACS eligible) Client contributions Self-Funded Care Attendance Allowance

(from Staffordshire County Council, 2010, updated 2012)

Commissioning services

The new model of housing with care presents difficulties for those commissioning services who find the new structures do not sit easily with current regulatory frameworks or pricing policies and that as a result of a variety of funding streams even an integrated service may need to have separate account and charging systems (Housing LIN, 2007a). However, the point is made that ‘the core characteristic of extra care housing is the ability to provide individually tailored, flexible and responsive care and support services to

individuals in their own homes, cost effectively and efficiently. It makes sense for the funding, contractual and charging arrangements in extra care schemes to promote and support this unique flexibility and responsiveness, rather than merely replicate the normal arrangements for domiciliary care services' (op cit p 4). Some local authorities are beginning to call this "flexi-care", where the "extra" in extra care housing is tailored around the individual and not a description of the scheme (for example those in Staffordshire, Hertfordshire and Suffolk).

Cost effectiveness

Caring for an ageing population is a challenge faced both nationally and internationally. With limited and diminishing financial resources, more cost effective ways of providing care and support are continually being sought. It is imperative, therefore, that where services are provided that these represent value for money and can be measured in terms of the outcome to the individual and the cost benefit that represents. For example, providing a tailored service within a specialist housing provision could result in a net benefit of £444 per person per year for older people (Homes and Communities Agency, 2010). Whilst the net benefit of £444 in the older adult group is not the largest figure per head, it does represent the largest cost saving when multiplied by the large number of vulnerable older adults. At an individual level, work undertaken by the Personal and Social Services Research Unit to develop the Adult Social Care Outcomes Toolkit (ASCOT) offers the opportunity to 'provide a variety of approaches to identifying and monitoring value across the range of social care interventions' (Netten et al, 2010 p.4). Working in this instance in care home settings for older adults and for homes catering for those with learning disabilities, Netten et al. (op cit) introduce a method for measuring the Social Care Related Quality of Life (SCRQOL) that residents are currently experiencing and the SCRQOL 'gain' by comparing that measure with what they would have experienced in the absence of care and support services. The approach uses face to face interviews with residents together with observations. The tool provides an opportunity to consider a number of domains and look for changes over a period of time in a given setting, thus providing a measure of cost effectiveness for specific services or interventions.

Netten, Darton, Bäumker & Callaghan (2011) note that at an individual level higher costs were associated with:

- Living alone
- Higher levels of physical and cognitive impairment
- Need for nursing-type care
- Presence of a long standing illness
- Higher levels of well being

At a scheme level they noted that higher costs were associated with:

- Separate housing management and care arrangements
- Higher staff turnover
- Larger housing association size
- Being located in London.

These points give a clear indication of where cost benefits can be accrued and costs reduced.

4.4.4 Social Well-being

Social well-being is closely linked with quality of life, mental well-being and general well-being. Well-being is relatively easily defined with Callaghan, Netten, Darton, Bäumker & Holder (2008) identifying five areas of crucial importance; lack of discrimination, participating in meaningful activity, supportive relationships, good physical health, and income. Social well-being can be distinguished as that which relates to social contact and relationships (Evans, 2008) encompassing a range of factors including social relations, social interaction, relationships, friendship networks and social support (Evans & Vallely, 2007). Housing with care would appear to provide a natural environment to foster such core components of personal life with the benefit of independent living set within the context of a community life. Factors identified by Evans & Vallely (2007) which play a part in promoting social well-being in older adults include:

- Friendship and social interaction
- The role of family carers
- Engaging with the wider community
- The role of facilities
- Design, location and layout
- Staffing issues and the culture of care

Emerging from this are a number of implications for practice:

- Social well-being should be taken into account in planning, design and management of extra care housing.
- Activities should be adequately funded and cater for a range of interests and abilities.
- Developing and maintaining a social life independent of the housing scheme is crucial.
- An evidence base of good practice for supporting social well-being is needed.
- Restaurants and shops are important as venues for social interaction and should be considered when commissioning a scheme.
- Those at risk of social exclusion should be identified and offered appropriate additional support.
- A person-centred approach to care provision can contribute towards social well-being.
- Key-worker systems can maximise the benefits of interaction with staff
- Diversity is a key feature of extra care housing which requires a level of understanding and tolerance from all stakeholders.
- Care and support services must be provided and maintained outside core hours of work.

The ethos of extra care housing and retirement villages which promote independent living, choice and flexibility may provide a space for social well-being to flourish particularly addressing issues of social isolation. As older people begin to experience higher level care needs and frailty, their reliance on the ability of this type of community to provide for their social well-being becomes magnified (Callaghan et al, 2008) placing greater significance on the ability of such organisations to manage social inclusion well. The evidence base demonstrating the effectiveness of such schemes to address issues of social well-being is currently limited (Callaghan, Netten & Darton, 2009) but in a report of the same date the authors identify that 'extra care housing can provide an environment supportive of social well-being' (p.7) particularly when activities are user-led, schemes have communal facilities operational from inception and there is an identified lead for social activities. Croucher, Hicks & Jackson (2006) note that whilst there is evidence to suggest that housing with care can have a positive impact on well-being and health this has generally been ascertained through self-report methodologies with more robust measures of quality of life lacking in the evidence base.

4.4.5 Dignity

Dignity is a basic human right. The Royal College of Nursing define this as being ‘concerned with how people feel, think and behave in relation to the worth or value of themselves and others..... to treat them as being of worth, in a way that is respectful of them as valued individuals’ (RCN, 2008). Dignity should be implicit in the way all types of care are delivered irrespective of whether this is at home, in hospital, in care homes or in housing with care. Failures to deliver dignity have been highlighted on numerous occasions in recent years leading to a consultation paper commissioned by the NHS Confederation (2012), *Delivering Dignity*. Whilst this report’s focus is on NHS healthcare settings the recommendations address issues both in hospitals and care homes. The recommendations for care homes are equally applicable to any setting where care is delivered and are congruent with the values of housing with care; putting the person first, enabling access to the wider community, good use of supportive technology, training for staff, end of life care choices and buildings which are fit for purpose (op cit, p7). Interestingly, the report advocates the development of a care quality forum (similar to the nursing quality forum) together with a rating scheme to establish benchmarks and standards.

With more specific focus on care settings the Social Care Institute for Excellence published an online guide entitled *Dignity in Care* (SCIE, 2010) which identifies the following key factors:

- Choice & control
- Communication
- Eating & nutritional care
- Pain management
- Personal hygiene
- Practical assistance

The guide prompts practitioners to consider not only what dignity means but what promotes and what threatens dignity. Interestingly, whilst dignity appears in the domains comprised within the Adult Social Care Outcomes Toolkit (ASCOT) (Netten et al, 2010) it is measured only by current resident experiences as this aspect is not relevant in the absence of care services. Netten et al note that ‘when care is present our sense of self is as likely (indeed it is arguable that it is more likely) to be undermined as enhanced by the way that people supporting us behave towards and treat us’ (p.7).

Whilst much is said about dignity in health and social care settings, less has been noted about the role housing has to play in promoting dignity (Housing LIN, 2006b). This report from the Housing LIN, in line with other reports, identifies key ‘facets of dignity’ which can be promoted when the environment, frameworks or service:

- Maximises privacy and protects an individual’s modesty
- Enables maximum independence, choice and control over his or her own life
- Creates a sense of worth, visibility and significance in the individual – “I matter” or “I count”. “I am not ignored or treated like a non-entity”
- Boosts confidence, self-esteem and self-respect including sense of safety and security
- Provides a sense of belonging – of being part of something

Furthermore, they note the following domains which provide opportunities for success or failure within housing environments:

- Assistive technology
- Building design and physical environment
- Ethos and culture
- Housing management and support – policies and procedures
- Housing management and support – attitudes and practice
- Opportunities for inclusion
- Information
- Legal and financial status of individual
- Resource allocation – organisation’s priorities and macro commissioning decisions
- Service type – what services are or are not available

In addition to citing examples of good practice the document also provides a comprehensive overview of barriers to dignity.

4.4.6 Models of Social Care Delivery

The National Health Service Act 1946 effectively marked the disengagement of the union between the health and social care system that had operated in the United Kingdom up to that point. Whilst the health of the nation became enshrined in legislation, social care became an arbitrary process delivered in a fragmented fashion through a host of different and disparate organisations. This has remained true to the present day despite a raft of legislation and guidance which seeks to provide for delivery of a new vision of adult social care which is better resourced, more accessible, more affordable and better prepared to support the needs of the projected increase in the older adult population.

Despite the aspirations of such legislation, the emphasis has continued to lean towards health rather than social care with an emerging concern around the ability of present funding and structures to support the demographic changes which will occur in the near future. A report from Age UK (2007) suggested the partnership model advocated in the Kings Fund report (Wanless, 2006) would provide a solution to funding social care broadly in line with a 20/80 split between personal funding and state funding. The report identified a large number of recommendations including ‘tighter timescales, streamlining the assessment system, providing clarity about which elements in the public sector are responsible for what services, and working with the voluntary and community sector to develop improved consumer information and advice’ (p2). It was hoped that these measures would relieve the burden on families to provide funding for care, encourage the utilization of personal budgets with more information available to support this, identify what elements of care fell within the NHS remit and keep care person centred not service driven. In addition to the funding issues they further noted that the quality of care was not fit for purpose and needed to be improved.

Delivering care closer to home and a move away from traditional care homes is part of the vision for the future of a modern, fit for purpose, adult social care service (Department of Health, 2008c). The creation of lifetime homes (and more recently HAPPI designs) would see housing as a conduit to delivering synergized health and social care in a person centred manner set, or ‘care ready’ within the context of the wider community. However, as the Housing LIN (2007b) note ‘collaboration between housing, health and social care is often focused on systems issues with an assertion or assumption of patient / user benefit. Meanwhile there are differing priorities across health, housing and social care agendas which obscure the common or shared agendas of quality of life, and revenue and capital funding cycles which are not synchronised. Both inhibit collaboration across agency boundaries’ (p8). The picture is further frustrated

where housing and social care sit within different bodies thus creating a challenge to achieving a fully joined up approach.

Housing with care, in practice, addresses a number of issues around delivering care in a home environment which is person centred and preventative offering choice and enabling retention of independence. The Housing LIN (2007b) cites an example in practice of an older adult with dementia choosing an extra care housing provision where she is able to access care as and when needed but also retain independence visiting shops and cafes on site whilst receiving visits from family and friends.

Models of care delivery differ widely even within housing with care environments and whilst these are all seen as successful, identifying common denominators to practice may be challenging. For example, care provided through housing with care environments may consist of:

- Telecare and Telehealth services
- On call care services within the housing with care setting
- Day care provision through extra care housing (Leadon Bank, Orchard Lane, Ledbury, Herefordshire) including specialist dementia day care (Japonica Court, Ash, Guildford) and a multi-cultural day centre offering day services and awareness raising activities within the local communities (Mary Seacole Court and Close, Bradford)
- Handyperson funded through the extra care housing scheme service charge to assist with general maintenance tasks, house moves, curtain hanging, etc. (Aspen Gardens, Hardwick, Stockton on Tees)
- Independent Living Adviser offering dedicated support to frail people in the community on a day service basis with short term care available for those coming out of hospital (Meadow Court, Frodsham, Wirral)
- Community Centres/Activity centres within housing with care environments acting as a hub for socialization and service delivery for the wider older adult community including interest groups, GP Surgery, cafés etc. (New Larchwood, Coldean, Brighton, Beacon Centre for the Blind).

As models of extra care housing and housing with care in general are all very individual, Garwood (2010a) notes that ‘within the increasingly complex social care and supported housing landscape, commissioners and providers need to navigate a complex array of rules and regulations, some of which are not complementary, in order to develop models which are compliant, but which at the same time are cost effective and provide good outcomes for the people who live there’ (p 6). Demonstrating the effectiveness of the delivery of social care within the housing with care environment therefore may need to draw together the elements of provision which are most effective and consider how these are commissioned, delivered and received. Of paramount importance in considering these issues is an understanding of the models of care available within housing with care environments. Garwood (2010a) identifies at least six possible models; however these models are not mutually exclusive with hybrids of approaches and variations within single models:

Model of Care	Key Elements	Advantages	Disadvantages
Spot Purchasing	Provider takes on risk of providing round the clock care. relies on sufficient take-up of on-site provision by private purchasers, personal budget-holders or local	Excellent partnership working, a relationship characterised by trust and an appreciation of one another’s legitimate concerns.	Unlikely to work if imposed by the local authority. May challenge provider’s ability to staff sufficiently to

	<p>authority spot-purchases</p>	<p>Works well in larger schemes & where some aspects of cover are subject to a fixed charge by the provider</p> <p>Maximises freedom of choice</p> <p>Minimises Council money tied up in block contracts</p>	<p>provide a flexible and responsive service</p> <p>Many providers, particularly of smaller schemes may be unable to take the risk</p>
<p>Core and Add on</p>	<p>Council commissioned fundamental core services Additional planned care or support can be purchased either from the on-site provider or an off-site alternative Core Services need to be carefully defined</p>	<p>Keeps block contracting to a minimum while still ensuring that the essential features of Extra Care (round-the-clock care and support) are provided.</p> <p>Good quality service at a competitive price.</p> <p>Occupants have an open choice: they do not have to opt out of something to exercise that choice.</p> <p>If the service being offered meets the occupants' aspirations and standards, the on-site provider will be chosen</p> <p>Going off-site for activities, or people coming in from the wider community to run or take part in communal activities is something which already occurs in Extra Care, so spending PBs on such things could only be of benefit.</p>	<p>In smaller schemes, depending on what the core comprises, this approach may be less cost effective.</p> <p>Depending on the choices occupants make there may not be the same degree of co-ordination, synergy, cohesion and cost-effectiveness as there would be if most or all the care and support were provided by a single provider.</p> <p>If many off-site providers were used building security may be more difficult to maintain,</p> <p>For people with dementia where flexible, responsive services rather than planned units of care are particularly important, a minimal on-site core provision may be not be a good model</p> <p>It may be more difficult to recruit, train and keep staff where</p>

			<p>demand is less predictable</p> <p>Slight risk of registration as a care home</p>
<p>Block contract the whole service but allow freedom of choice</p>	<p>Block contracts for a whole service will vary but importantly occupants can choose to use their PBs to purchase the on-site block-contracted service or use it to purchase services from elsewhere.</p>	<p>Optimises the benefits of extra care whilst ensuring occupants retain choice and control.</p> <p>Ensures that a round-the-clock care and support service exist on site for occupants to choose using a transparent approach.</p> <p>Provides an incentive for the on-site service to be of high quality, with the flexibility, responsiveness and personally tailored services</p> <p>Retains the benefit of a care team – cohesion, staff continuity, stability, and flexibility and responsiveness in meeting support needs</p> <p>Provides more of an incentive for partners to work together prior to the scheme opening to plan arrangements at the interface between the care and other services.</p> <p>Keeps the accommodation and care contractually</p>	<p>Breaking the service up into component parts can undermine the service and result in fragmentation and tension within the community.</p> <p>There would also need to be clarity as to the implications of withdrawing from the service</p> <p>Potential risk of double-paying</p> <p>Over-generous block contracts can cultivate a dependency culture which is counter-productive and a waste of resources.</p> <p>It may not satisfy the requirement to minimise block contracting</p>

		separate.	
Block contract the whole service – choice is made on point of entry by selecting extra care housing	The full care and support provision is block contracted by the council and this is the service occupants in the scheme are expected to use for their care and support.	<p>Allows choice upstream so that there is a stable, funded service.</p> <p>It can offer a more cohesive service because the separate service components do not have to be individually itemised and costed.</p> <p>Ensures the advantages that apply with a minimum number of providers on site – effective communication and co-ordination, synergy, flexibility, responsiveness and economies of scale.</p> <p>Choice and personally tailored service delivery are possible within the constraints of the on-site provision and people have the freedom to use their disposable income in whatever way they choose.</p>	<p>This approach may be tantamount to “personal care and accommodation provided together”, even though contracts for accommodation and care are separate, and may therefore be required to register as residential care.</p> <p>Each occupant may have a personal budget but it is not portable – occupants do not have the choice to spend it in another way.</p> <p>Can be a lack of clarity and transparency about what the service covers and what occupants can expect.</p> <p>If the on-site service is flexible, responsive and personalised, most occupants are likely to see the benefit of using it anyway, and will only choose to use their personal budget differently if they have a particularly individual requirement.</p> <p>Occupants may feel lumbered with an unsatisfactory provider.</p>
Co-production or social enterprise models	Some kind of co-operative approach could be used. This is an approach which could evolve from any of the other models. It could involve different degrees of co-production from simply influencing the shape of the service, to joining together as a group to directly	<p>Enables the resident group to shape the services they receive, their cost and who provides them.</p> <p>Increases participation, choice and possibly control - on a group basis democratically</p>	<p>Many occupants of Extra Care schemes may be too frail to play an active part in decision-making of this sort.</p> <p>A co-production model which enables members to develop a structure and service together</p>

	procure it or employ a particular provider.	<p>exercised, rather than on an individual basis.</p> <p>Some co-production models may lend themselves best to people who have the energy and motivation to get involved.</p> <p>This may be a good approach as a supplement to a core service.</p>	from scratch could not apply to the core extra care service if it is to be in place from the start, unless the resident group is known sufficiently in advance of it opening.
Pump priming model	<p>The core or full support service is block contracted for a pre-determined period, thus ensuring that 24/7 care and support is in place from the outset, and that the provider's infrastructure is in place. Once the block contract comes to an end, the arrangement converts to spot-purchasing using PBs or private funds.</p>	<p>It ensures that the core service is available from the time that the scheme opens and can attract and meet the needs of a wide range of people.</p> <p>It combines reassurance and certainty at the start to justify the provider's investment, with an incentive for them to make sure the service remains of high quality and competitive.</p> <p>It can be a pre-cursor to a number of other approaches, including a coproduction approach and spot-purchasing</p>	The council may need to step in if, for whatever reason, the round-the clock service was floundering; not to rescue the provider, but to rescue occupants whose well-being and health may be jeopardised if the service were lost.

A recent addition to the models identified above is that of 'flexicare' which has been adopted by some regions (Hertfordshire, Staffordshire) to identify approaches to extra care housing which 'better reflect the flexible, outcome-focused approach expected of care and support services and also in response to feedback from tenants that the term 'extra care' housing is misunderstood, particularly the assumption that it is only for people with very high care needs' (Adult Care Services, Hertfordshire, 2009, p2). Key elements of Hertfordshire's Flexicare model include:

- Balanced communities & flexible support
- Better outcomes & more choice
- Financing an outcomes-focused approach
- Flexicare design principles

- Workforce development

This model at Hertfordshire is supported by strong partnership collaborations between Hertfordshire County Council, ten district and Borough Councils, voluntary & private organizations with evaluation provided through the Institute of Public Care at Oxford Brookes University. Funding for services is effected through a new banding system:

- Low Band = preventative
- Medium Band = direct alternative to community care
- High Band = direct alternative to residential care

Commissioners in Bristol who have been providing extra care housing since 1999 are considering a ratio split of 40/40/20 ratio with 40% high care needs (10-20 hours per week), 40% medium care needs (5-10 hours per week) and 20% of the tenants with low care needs (0-5 hours per week). However, at present, data available to Bristol suggests that provision is around 23% high care needs, 12% medium, 35% low and 30% with no care needs (Russell, 2012, p1). These ratios are an important consideration; where only high care needs are catered for there is a danger that extra care housing can begin to resemble a care home style environment. There may also be a need to question how these hours are determined. The recent literature on Fair Access to Care, e.g. Commission for Social Care Inspection (2008), identifies the continuing problem of service-led rather than needs-led approaches, and defining care needs in terms of hours of input seems to perpetuate this. There is an onus on maintaining balance with its inherent social capital gains in an environment which balances those with and without care needs. However, this may come at a personal cost and lead to environments which become segregated and isolating for those with higher level needs such as advanced dementia.

Staffordshire County Council (2010, p10) in adopting a Flexicare approach identify the following benefits:

- Providing quality housing and communities that are suitable for the needs of older people and some other more vulnerable groups
- Providing a wider range of choices for housing and support
- Freeing up larger properties in the housing chain
- Promoting independence, choice and control
- Reducing social isolation and enabling social inclusion and fulfillment
- Early intervention and prevention - of avoidable deterioration and use of higher dependency services
- Improving the quality of life for people who use the service
- Improving the health and well-being of people who use the service
- Reducing depression
- Reducing the demand on community and acute health services
- Enabling more effective, coordinated and integrated service delivery
- Providing an alternative to residential care for many people and nursing care for some
- Keeping carers and the person they care for together Providing most people who use the service with a 'home for life'
- Providing an environment for safety and dignity
- Supporting people at their 'end of life'
- Achieving benefits from partnership working across housing, social care and health

- Assisting organisations in delivering priorities and meeting key Performance Indicators

However, Staffordshire have noted realistic limitations to their current model of flexicare provision including:

- The confusing charging policy for Flexicare is unpopular as it uses a two band system, "spot charging", which is seen as unfair to those people receiving low packages of care
- Support costs within schemes vary considerably and show no positive correlation between staffing ratios and costs applied
- The current models of commissioning do not support personalisation
- Little evidence of involvement of the NHS in the commissioning and development of Flexicare housing
- Low public awareness of Flexicare housing developments and what they can offer people
- Front line staff are sometimes unclear as to the role of Flexicare housing and the context in which people should be referred

It would appear that many of these issues have been overcome in the model adopted by Hertfordshire and much could be learnt by cross-fertilisation of ideas between Authorities.

4.4.7 Housing

A recent Joseph Rowntree report noted that there are 7.3 million older households in mainstream or specialist housing in England (excluding care homes) which contain no one below the age of 55 (Pannell, Aldridge & Kenway, 2012). There are only about 7% of older households (530,000) living in specialist housing mainly in the social-rented sector with some support facilities to give residents practical day to day help (Shelter, 2012). The majority of the remainder are owner occupiers of mainstream housing, much of which is under-occupied (i.e. single or couple households with three or more bedrooms) (Pannell et al, 2012). There is very little specialist housing available to buy or rent privately, and very little mid-range specialist housing for older people who are not wealthy but do not rent socially (Shelter, 2012). Housing with care would appear to provide a natural alternative for the majority of older adults offering responsive, flexible care as needs change. However, these types of provision currently represent only a small percentage of the types of housing available and do not appear to satisfy the needs of both present and future market trends. Specialist housing represents 5% of housing in England with extra care housing being a relatively scarce component of that profile, amounting to only 1% of housing occupied by older adults (Counsel & Care, 2011 p8). A survey undertaken by the Personal Social Services Research Unit (PSSRU) in 2005 identified that within the sample participating only 2,500 dwellings could be classified as extra care housing across all 13 Local authorities (Dawson et al, 2006). The National Housing Federation (2010) estimate that there are already over 70,000 people aged over 60 on a waiting list for suitable housing and related support services; a figure which is set to rise to at least 300,000 by 2019. Whilst the majority of older adults are home owners, the majority of specialist housing provision is available for rent rather than purchase. Despite aspirations for wider choice of rented or purchased property for older adults with different designs, tenures and pricing, this is still a long way from achieving reality (Housing LIN & ADASS, 2011).

This raises concerns for the choices which are available to older adults in relation to where they would choose to live as they grow older; 'Older people want housing that is attractive, in a safe, well-connected neighbourhood. They typically value homes that are well insulated, have some outdoor space, and have a spare bedroom' (Shelter, 2012, p6). If housing is to provide the conduit to delivering cost effective,

personalised care services such houses must be places where older adults want to live and provide the types of accommodation they need; the housing market must meet the demands and aspirations of a changing population.

Age UK (2006) identified three key factors in preparing for the future:

- If we wish to enable older people to remain living independently in their own homes for as long as possible we must build housing that is suitable for people at all stages of their lives
- All new housing should be made more readily adaptable to meet our changing needs as we get older
- All new homes need to meet the Lifetime Homes Standard promoted by the Joseph Rowntree Foundation and Habinteg Housing Association (Goodman, 2011).

In planning for provision of extra care housing, the aforementioned Strategic Housing for Older People toolkit (SHOP) (Bligh and Kerlake, 2011) identifies three key decisions:

1. WHO – Whose needs are you aiming to meet? What is the target client group for this development? What is the evidence that this will provide a viable population for any scheme?
2. WHAT – What type, shape, size of scheme? What is the impact of land availability and design on scheme configuration? What is the relationship between cost, design and viability and the impact of this on size and configuration to maximise public subsidy and/or private investment?
3. HOW – What are the timescales and processes that need to be agreed? What are the funding mechanisms for the scheme? Who are the partners that need to be involved and at which stages?

In response to these questions, they identify three basic options for extra care housing:

- (i) Retirement Village where apartments can be purchased and entry is by free choice;
- (ii) Large schemes which have mixed tenure consisting usually of 1-2 bedroom apartments with selective entry banded into different levels of need to create a 'balanced' community;
- (iii) And small schemes with properties for rent, which act primarily as an alternative to residential care aimed at people with existing care and support needs.

However, it is clear that more extra care housing is needed which must be more appealing to residents. Without further capital investment and development of marketing strategies there may be a danger of extra care losing its distinctiveness and becoming more like residential care (Darton et al. 2011).

Where housing with care can provide a 'home for life' there is an expectation that continuity of care can provide seamless provision of services as individual needs change. However, this is sometimes not the experience of residents in retirement villages or extra care schemes where a 'significant minority of residents do move on to other care settings' (Vallely & Kaur, 2008). Whilst housing with care can provide an 'alternative to residential care, the evidence suggests that it is not always a substitute for these settings (Croucher, Hicks & Jackson, 2006). This report also found that residents moved to residential or nursing home care for a number of reasons including increased care needs. With older adults experiencing an escalation of their care needs and schemes providing for day care, respite and intermediate care the transition needs of older adults must to be addressed if a move to a different type of care environment is

envisaged, whether in the short term or long term; 'despite the widespread aim to create mixed communities within schemes, none was known to have a policy in place on when people are moved on as their physical frailty or dementia level increases' (Dawson et al, 2006). A project currently being undertaken by The University of Birmingham (due to report in September 2012) is considering older people's experiences of transition between different services and agencies in health and social care on the basis that evidence shows that older adults experience many problems before, during and after transitions.

Housing must also respond to the wider needs of a diverse community. It is noted by Garwood (2010b) that 'very little work has been done in relation to the housing and support needs of LGBT older people, and also those with multiple or complex needs who are at risk of being homeless, so work in these areas would be timely' (p6). Furthermore, she suggests 'the growing number of older people with a learning disability, and the likelihood that they will have experienced a life of disadvantage makes work in this area a high priority' (ibid). Whilst some schemes make separate provision for black minority ethnic groups (BME) such as day centre provision other schemes operate inclusively to create a rich diverse community (Hanover, 2009). Hanover (2009) note that 'one size does not fit all' and have noted the following points in relation to providing for inclusive and diverse communities which:

- Meet particular cultural aspirations and preferences
- Provide services in an appropriate language
- Provide a programme of activities and services that meet particular community needs
- Provide catering that meets cultural dietary requirements
- Enable the development to be located close to the wider community and become a focal point for additional outreach services that can benefit others in the area
- Enable older people from all communities to live together, through the promotion of a culture of tolerance, respect and understanding of the individual

4.4.8 Planning

As the new Coalition Government strives to address the needs of older adults, its National Planning Policy Framework (2012) places an onus on local authorities' Strategic Housing Market Assessment (SHMA) to determine the trajectory of the scale, range and tenure mix in their areas. However, in line with the lack of a standard definition of extra care housing a grey area still exists around classification. In terms of the current planning system it currently sits somewhere between C2 (residential institutions) and C3 (dwelling houses), which has implications for funding streams, scheme viability and ownership (public or private).

4.4.9 Evaluations of Housing with Care

Housing with Care, particularly extra care housing, has no firm definition. Housing with care has differing typologies, differing tenures, differing models of care provision, differing capital funding streams, differing management structures, differing populations and differing ways of individuals funding their needs. Within this rich mix there is evidence to suggest housing with care works. However, how it works, for whom it works and at what cost may yet need to be determined.

A literature review by Croucher, Hicks and Jackson (2006) noted that there was a relatively limited evidence base for housing with care with evaluations focusing either on a single scheme or on the provision of one provider organization. Making comparisons between schemes can also be complex and difficult to achieve;

Croucher, Hicks, Bevan & Sanderson (2007) noted that it was difficult to make judgments about the comparative effectiveness of schemes as each is quite distinctive based on the size of schemes, their location and design, eligibility criteria, provider organisations and the partnerships that were in place. This led them to the conclusion that there is 'currently there is no single dominant model that works best' (ibid, p59). Darton, Bäumker, Callaghan, Holder, Netten & Towers (2012) make a similar point noting that information collected has usually been specific to a particular study or collected for specific purposes, again making comparisons difficult.

In contrast to evaluations which consider only housing with care options, others focus on a comparison between residential care, community care and care within housing with care environments such as extra care housing. A report by Burholt, Nash, Doheny, Dobbs and Phillips (2011) considered the integration and management of complex care in these three types of settings specifically exploring quality of life, the extent to which complex integrated social and health care can be delivered and the cost effectiveness of extra care compared to residential and home care. They made the following observations:

- Care services within extra care facilities lack both breadth and depth
- Residents recognize that complex care needs are not likely to be catered for within extra care facilities
- Community and residential care managers focus on providing the older person with care whilst extra care managers provide a purpose to the provision of care – to enable older people to participate in the community.
- None of the extra care facilities had registered as domiciliary care providers so the availability of '24'hour care is open to debate
- Extra care managers were unwilling to admit or continue to support people suffering with cognitive deterioration so the menu of services is structurally restricted from the outset
- Despite the increase in social interactions facilitated in extra care environments there were no reported differences in levels of loneliness between the three types of living environments.
- Information for residents is likely to make a difference to how access to services is experienced. Extra care residents were the least satisfied with access to personal services but had not been adequately informed.

In response to these challenges, the report identifies the following amongst their list of recommendations:

- There should be a gold standard to clarify what older people can demand/expect from extra care facilities either in the public or private sector
- There is a need for standard criteria regarding admission to extra care accommodation. Managers currently have the right to refuse applicants based on future care needs and their capacity for social activity in the community.
- Explanations should be given to potential extra care clients identifying what is available, how this differs from living in the community and what upper limits are placed on care provision which may necessitate a move to a different type of facility.

Interestingly, these observations are made in relation to the Welsh Assembly Government and it will be important as part of this project to see if the same ethos around purpose of provision of care in extra care housing (i.e. to be socially active in the community) holds true.

Croucher and Bevan (2010) make a salient point in their evaluation of a large retirement community noting that 'residents are at a certain point in the life course, and this has influenced their decision to move to such environments, and must shape their expectations and experiences of living in such developments' and that living in such schemes is perceived as a 'different way of life' (p. 7). Learning points from this evaluation included:

- The importance of marketing the scheme from the outset, not just to prospective residents, but to the whole community
- Balancing the expectations and needs of diverse groups of residents, and how best to enable and empower residents to take a positive and active role in developing and shaping their communities.
- Mechanisms to engage with residents should be in place before residents move in.
- Understanding the local community in which schemes are located, and how local cultures will shape the new communities that evolve.

Whilst some evaluations offer a perspective *within* the housing with care community and others offer perspectives *between* housing with care, community and residential care, it is important to note Croucher's point above that even comparisons within housing with care settings may prove challenging when the settings themselves are so diverse. For example, within different models of extra care housing, services may be sourced externally or in-house. Where services are the responsibility of the client and sourced externally it is incumbent upon providers to remain aware of decisions taken by clients. Although this type of 'decision ownership' is a positive move towards personalisation, it needs to be well managed in order for providers to be aware of client decisions and address any unmet needs. Croucher et al (2007) note that 'care services and the community alarm services for the residents were sourced from the local council with residents directly responsible for organising these themselvesin this respect there was potential for high levels of care and support being received without awareness from the scheme itself, and conversely for needs to remain unmet' (p. 45).

5. Discussion

This review has identified and reported on an emerging body of peer reviewed and grey literature of relevance to housing with care settings. The scope and depth of this reflects a growing recognition of the importance of housing, care and support to increasing numbers of people who are living longer and aspire to enjoy an active retirement. Home is an extension of who we are; it is central in supporting us to be who we want to be. It is a place where we feel safe, where we entertain our friends or take time to be alone. Home should always be the place where we have control of our own environment and where we make the choices that affect how we live. These ideals, which are so firmly embedded in the notion of 'home', are crucial to our independence, dignity, health and well-being. These ideals do not change as we age but they are impacted upon by our ability to take care of ourselves, to provide financially when we are no longer of working age and to address challenges to our health. It should come as no surprise that in preparing for growing old society must look to housing as being the key to delivering quality of life for older adults.

This review has explored how adult social care can be delivered in ways that meet the needs of older people, treat them with dignity and respect, enhance their quality of life and support social interaction. Housing with care is a growing sector which aims to address these needs.

The peer reviewed literature has relatively little of direct relevance to say in this respect. A small number of papers have focused on the delivery of care and support

A strong theme emerging from these is the variety of models that exist within the broad 'housing with care' and 'extra care' labels. This can make it difficult for older people, their relatives and professionals to be sure exactly what is being offered in terms of care and support. Several papers address the ability of housing with care settings to support residents with dementia and other mental health needs. The overall conclusion is that a good quality of life can be supported but that a proactive approach is required that addresses all aspects of a scheme, including staff training, leadership, the built environment and the provision of appropriate activities. The international literature adds evidence for the importance of family members in providing support to residents and the lack of direct social work input.

The rest of the peer reviewed literature focuses on other aspects of housing with care, including the role of the built environment, workforce issues, and resident perspectives on living in such settings. There is also a substantial literature describing the characteristics of housing with care schemes and the people who live in them. This includes some interesting and useful descriptions of different types of scheme, leading to the emergence of criteria that could contribute towards a typology. The main criteria discussed are:

- the housing and care provider relationship;
- building type, layout and location;
- facilities and activities
- tenure and letting policy
- structure – the capacity of the facility to provide care
- process – how the facility delivers care
- resident case mix – the proportion of residents who are functionally dependent

Our review of the grey literature has in some ways been more fruitful in providing a narrative of policy and practice in relation to the commissioning and delivery of care and support in housing with care settings. The 2012 Adult Social Care White Paper indicates growing recognition of the aspirations of older adults to maintain active, independent lifestyles. The government is also looking for ways to manage the increased

financial burden of a growing population of older adults and envisages this may be through more innovative housing initiatives that support the aspirations of older adults, restore the sense of community and provide more financially viable alternatives to traditional models of care.

Whilst it is relatively simple to identify the direction of past and current policy and the outcomes which this aims to achieve, it is less straightforward to understand and appreciate the most effective system for delivering these aspirations. As a relative newcomer to the housing market, housing with care, under the auspices of extra care housing and retirement villages, has a multitude of models under one umbrella with seemingly no single mode of delivery. With such unique interpretations of flexible care, how are commissioners and providers to know which is the most beneficial to the individual and the most cost effective? However, taking into account what government policy aims to achieve and evidence from evaluations and explorations of housing with care documents about the complex interplay of factors required to support older adults to lead healthy and fulfilling lives, we can begin to identify the implications of current models of adult social care delivery.

Cultural change at a specific population level (old age), at a wider population level (whole community) and at an organisational level (institutions, providers) will be required in order for policies to be fully implemented and operationalized. A paradigm shift will be required for older adults to conceive that they can be agents of change at a macro level rather than a micro level and this will take time to be fully understood; commonly held beliefs about institutionalised care and ageist discriminatory processes take time to overcome; it will take time to convince those who are cynical about personalised budgets operating as anything more than a cost cutting exercise. As the saying goes, "Rome was not built in a day" and whilst reform is certainly taking place at a political level, in practice the impact of this at the individual level may be far more complex with inherent social barriers to reform obscuring and frustrating the process.

While the policy literature presents housing with care as an important option for older people, the provision of which is likely to continue to grow, the practice literature bears strong witnesses to its popularity among those who live in it, despite the reservations of some academics and professionals about inequality and age-segregation (e.g. Kuhn, 1977; Phillipson, 2007). This literature also allows us to observe the development of housing with care in response to a range of drivers, including an ageing population, consumer aspirations and changes in capital and revenue funding. In terms of social care, the focus of this review, the literature suggests that housing with care has the potential to deliver in relation to multiple current priorities, including prevention, early intervention, personalisation and independence. While some of the literature reviewed provides details of specific elements of the provision of care and support in housing with care settings, there is a lack of evidence for how these elements combine into broader models, the impact of those models on quality of life for residents and their relative cost-effectiveness.

6. Appendices

6.1 Full list of Peer Reviewed Papers

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6.3 Search Terms

- 1 Aged/
- 2 (elder\$ or aged or older or retire\$).tw.
- 3 1 or 2
- 4 extra care.tw.
- 5 housing with care.tw.
- 6 (sheltered housing or sheltered accomodation).tw.
- 7 assisted living.tw.
- 8 (retirement housing or retirement village\$ or retirement communit\$).tw.
- 9 care housing.tw.
- 10 (supported housing or service housing).tw.
- 11 Assisted Living Facilities/
- 12 Housing for the Elderly/
- 13 or/4-12
- 14 personal care.tw.
- 15 social care.tw.
- 16 social support.tw.
- 17 person centred care.tw.
- 18 care plan\$.tw.
- 19 practical support service\$.tw.
- 20 home help\$.tw.
- 21 (home care service\$ or home care support).tw.
- 22 community-based care.tw.
- 23 health care support.tw.
- 24 independ\$.tw.
- 25 Independent Living/
- 26 Social Support/
- 27 "Quality of Life"/

6.4 Evidence Assessment Template

Author (s)	Article Title and Journal details	Model of Housing ⁱ and Country	Service/care type	Purpose, Aims, Methodology & Participants (State Qualitative or Quantitative)	Main findings & Summary	Main Categories ⁱⁱ

ⁱ Model of Housing = E= extra care RV= retirement village S= sheltered CH= care homes AL= assisted living GH= general housing

ⁱⁱ Main Categories: Resident Focused = 1 (e.g. health, care and support, attitudes); System Focused = 2 (e.g. policy, costs, commissioning); Schemes = 3 (e.g. built environment, workforce, technology)