NIHR | Policy Research Unit Older People and Frailty

Briefing Report

Rapid scope of UK supported housing research

Alex Hall

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National Institute for Health Research (NIHR) Older People and Frailty Policy Research Unit, School of Health Sciences, Faculty of Biology, Medicine and Health, The University of Manchester, Manchester, M13 9PL, UK.

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Background

Supported housing is where accommodation is provided alongside support, supervision or care to help people live as independently as possible in the community.[1] The sector is diverse in terms of providers (e.g., housing associations, local authorities, charities and voluntary organisations) and in terms of size and scale. The way accommodation and support services are delivered is also variable, with some organisations providing both aspects and others separate aspects.

Some common terminology to refer to different concepts of supported housing includes:

- Retirement living/retirement villages, offering independent living in a village scheme where care can be arranged separately if needed[2]
- Sheltered housing, which usually offers support from a warden, 24-hour emergency support and communal areas[3]
- Assisted living or extra care housing, which offers more tailored 24-hour support[4]

Purpose and approach

This note presents findings of a light-touch, rapid scope of UK literature on supported housing. The scope was conducted to identify what is known in the literature about the characteristics of people who live in supported housing, and the evidence for outcomes for this group. The scope focused on work published in the last 10 years (2011-2021). As a very rapid scope, it is intended to give an overall impression of the evidence base and is not intended to be an exhaustive synthesis.

The websites of the following major groups involved in housing research were searched:

- Housing LIN (the Chief Executive was also contacted for guidance to recent major publications)[5]
- Cambridge Centre for Housing & Planning Research[6]
- Centre for Housing Policy, University of York[7]
- Joseph Rowntree Foundation[8]
- PSSRU, University of Kent[9]

A simple search of Web of Science and MEDLINE was conducted for quantitative peer-reviewed UK studies.

Key messages

The evidence regarding resident characteristics and outcomes appears very fragmented and of variable quality. It is mainly drawn from case studies and service-specific work conducted in partnership with providers, and there is a lack of robust, peer-reviewed academic

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[1] https://www.gov.uk/government/publications/supported-housing-national-statement-of-expectations/supported-housing-national-statement-of-expectations
[2] https://www.ageuk.org.uk/information-advice/care/housing-options/specialist-housing-options/
[3] https://www.ageuk.org.uk/information-advice/care/housing-options/sheltered-housing/
[4] https://www.ageuk.org.uk/information-advice/care/housing-options/assisted-living-and-extra-care-housing/
[5] https://www.housinglin.org.uk/
[6] https://www.cchpr.landecon.cam.ac.uk/
[7] https://www.york.ac.uk/chp/
[8] https://www.jrf.org.uk/
[9] https://www.pssru.ac.uk/

literature. Although several reviews and reports make claims for ‘good evidence for X’, overall, the strength and quality of evidence is unclear.

Main findings

A substantial, wide-ranging scoping review of the academic and grey literature around housing and adult social care published in 2015 gathered UK evidence published from 2003-2013.[10] A total of 119 articles, reports and other documents were included. The evidence includes housing and prevention of the need for adult social care; housing and delaying the need for adult social care; alignment of housing with the integration of health and adult social care; and cost and cost-effectiveness studies. The review revealed some ‘good evidence’ about several housing interventions, including housing with care for older people, aids and adaptations, and handyperson services in preventing and/or enabling people to live independently in their own homes. There were evidence gaps regarding prevention of the need for adult social care, enabling independent living, integration and cost-effectiveness.

The quality of the evidence base covered in this scoping review appears to be mixed at best. Many studies were not robustly designed or published in peer-reviewed journals, and much evidence came from bodies with an interest in the area and public sector organisations. The range of methodological approaches was limited, with very few randomised controlled trials, cross-sectional or longitudinal studies, and much evidence from evaluations of a small sample or a single case study. The review authors noted a methodological challenge in this area, that there may be little interest among providers in research comparing their approach with their competitors and a reluctance to share commercially confidential information.

This challenge was echoed in a more recent short scoping exercise that considered issues relating to a potential evaluation of the Care and Support Specialised Housing (CASSH) programme.[11] Desk-based research found ‘good evidence for the benefits of extra care housing for older people’, and cites evidence including savings to the NHS, reductions in social care spend and improvement in residents’ personal and mental health. However, the overall strength and quality of this body of evidence is not clear. In qualitative work, the researchers highlighted the significant difficulty they found in obtaining data about the operation of the CASSH programme and in speaking to providers, and suggested that this might hinder a formal evaluation.

The ECHO study [12,13] took a longitudinal qualitative approach (2015-2017) to explore how care is negotiated and delivered in extra care housing. It involved 51 residents from four schemes (one of which offered specialist dementia care), and managers and staff from each scheme. Residents appreciated the flexible nature of care provision that was able to respond to their changing needs, which may have been permanent or temporary. However, managers, staff and residents reflected on a changing profile of residents, seeing more residents entering services with higher support needs, which challenges the ability of services to function in the flexible manner intended by extra care housing. The research team also published a paper offering a critical consideration of the effectiveness of outcomes-based commissioning in adult social care within extra care housing.[14] The core

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[10] Bligh et al. 2015. https://www.sscr.nihr.ac.uk/wp-content/uploads/SSCR-scoping-review_SR008.pdf
[11] Bottery & Cooper 2020. https://www.york.ac.uk/media/healthsciences/images/research/prepare/reportsandtheircoverimages/CASSH%20report%20formatted.pdf
[12] Cameron et al. 2018. https://www.sscr.nihr.ac.uk/wp-content/uploads/SSCR-research-findings_RF073.pdf
[13] Cameron et al. 2020. J Integr Care https://doi.org/10.1108/JICA-09-2019-0040
[14] Smith et al. 2017. Housing, Care & Support. https://doi.org/10.1108/HCS-03-2017-0003

issue is that since both housing and adult social care are intimately interrelated in this kind of setting, care commissioners need to understand the worlds of housing commissioners and providers, and vice versa.

One peer-reviewed paper reported the findings of a health needs assessment of the population of a UK sheltered housing service.[15] It explored tenants' perceptions of health and well-being (n = 96 participants), analysis of the service's health and well-being database, and analysis of emergency and elective hospital admissions (n = 978 tenant data sets for the period January to December 2012). Tenants did not have a consensus understanding of the terms health and wellbeing and used them synonymously, but felt that the communal environment supported their personal responsibility to maintain their well-being, and supported their sense of safety and security. Barriers to sustaining wellbeing included population ageing, poor knowledge of services and how to access them. The most common reasons for emergency hospital admission were circulatory and respiratory diseases and ill-defined symptoms; neoplasms were most common for elective admission.

Another peer-reviewed study combined data from four separate studies where participants were older people either living in care homes or extra care housing or receiving care at home.[16] All of these studies asked participants to rate their control over daily life, using the Adult Social Care Outcomes Toolkit (ASCOT). After controlling for differences in age, ability to perform activities of daily living and self-rated health, the evidence showed that the setting had a significant effect on older people's sense of control. Residents in extra care housing reported similar levels of control over daily life but consistently report feeling more in control than older people receiving care at home.

Other peer-reviewed papers reported relevant findings regarding the demographic, health and socioeconomic characteristics of people living in supported housing settings, but used longitudinal data from the 1990s and early 2000s and hence were not included further in this brief summary note.[17] [18] [19]

One project[20] explored life expectancy in a case study of Whiteley Village, a charitable retirement community for around 500 older adults with limited financial means, consisting of three tiers of housing (cottages/almshouses, extra care flats and a nursing home). The study found that men and women have both benefited from moving into a cottage/almshouse, most notably women who have seen an increase in life expectancy of 1.3 - 4.9 years compared to the general female population.

A report from 2015 drew on data gathered from survey questionnaires distributed to seven different luxury retirement villages with extra care, run by two housing with care providers. [21] Out of 743 residents, 201 residents from 158 households returned partially completed surveys (response rate of 27.1%). The findings were generally very positive in terms of

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[15] Cook et al. 2017 https://doi.org/10.1111/hsc.12398
[16] Callaghan et al. 2014. Ageing Soc. https://doi.org/10.1017/S0144686X13000184
[17] Vlachantoni et al. 2016. J Epidemiol Community Health. https://dx.doi.org/10.1136%2Fjech-2015-205462
[18] Matthews et al. 2016. PLOS ONE. https://doi.org/10.1371/journal.pone.0161705
[19] Robards et al. 2014. J Epidemiol Community Health. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4033180/
[20] Mayhew et al. 2017. https://www.housinglin.org.uk/_assets/Resources/Housing/OtherOrganisation/ILC-UK_-_Does_Living_in_a_Retirement_Village_Extend_Life_Expectancy_-_Web_version.pdf
[21] Beach 2015. https://www.housinglin.org.uk/_assets/Resources/Housing/OtherOrganisation/ILC-UK_Village_Life_FINAL.pdf

quality of life, sense of control and feelings of loneliness. However, the sample consisted of largely affluent and healthy respondents.

Evidence including economic estimates

One briefing reviewed existing evidence regarding the impact of sheltered housing and made initial estimates as to the cost savings that could be achieve in a range of fields.[22] It included 52 academic papers and policy reports related to the social value of sheltered housing. Several papers reported benefits of specialist housing for older people, where improved physical and mental health has been quantified and compared with control/similar older populations or national averages. A much smaller number of studies went on to monetise these potential benefits in terms of cost savings to the NHS and/or social care. The estimates of the social value of sheltered housing totalled £483m per year, the majority of which was attributed to a reduction in inpatient stays (£300m) and health and care costs of hip fractures prevented (£156.3m). However, once again, the vast majority of this evidence is not from academic papers and its strength and quality is unclear.

Work with the ExtraCare charitable trust took a longitudinal approach (2012-2018) to explore the impact of 13 ExtraCare villages, with 162 residents and 39 controls at baseline. [23,24] Key findings were that there were improvements in personal health (e.g. increase in level of exercise, reduction in falls risk, delay in increase of frailty), psychological well-being (e.g. decrease in anxiety, improvements in memory and cognitive skills), social well-being (86.5% of residents were 'never or hardly ever' lonely). The study also found lower healthcare costs, e.g., reducing GP visits, fewer days per year in hospital, living in ExtraCare saves the NHS around £1,994 per person, on average, over five years.

Work in Southampton reviewed evidence on housing with care and constructed estimates of financial impact of housing with care, applied to the Southampton context to develop projected estimates for the locality.[25] The evidence review acknowledged the limited body of research available, but it suggests positive health impacts of housing with care coming through reductions in numbers of GP visits, community health nurse visits, non-elective admissions to hospital, length of stay and delayed discharges from hospital, and ambulance call outs, typically linked to reduced incidence of falls. The financial benefit to the NHS was estimated at £2,000 per person per year. This means that Southampton's current provision of housing with care (around 170 units) has been producing a cost benefit of over £334,000 per year, and is estimated to increase to £890,000 if the city realises its goal to supply 450 units of housing with care.

An evaluation of Extra Care Housing in Wales (2016-2017)[26] found that resident experiences were very positive, highlighting safety, security, social interaction, but there was some confusion over charges for services. Demand for local authority services was outstripping supply, but the report cautioned that this was based on waiting list evaluation and that little is

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[22] Wood 2017. https://www.demos.co.uk/wp-content/uploads/2017/06/Sheltered-Housing-paper-June-2017.pdf
[23] Holland et al. 2019. https://www.extracare.org.uk/media/1169231/full-report-final.pdf
[24] Holland et al. 2016. Ageing Soc. https://doi.org/10.1017/S0144686X16000477
[25] Strzelecka et al. 2019. https://www.housinglin.org.uk/_assets/Resources/Housing/Support_materials/Reports/HLIN_SouthamptonCC_HwC-Health-Care-System-Benefits_Report.pdf
[26] Batty et al. 2017. https://www4.shu.ac.uk/research/cresr/sites/shu.ac.uk/files/eval-extra-care-housing-wales.pdf

known about demand for full or shared ownership. The total cost of developing the extra care schemes developed by housing associations (n=45, data available from n=41) was around £350m, meaning the average cost was £8.5m and the cost per bedspace[27] was £120k (ranging from £50k - £200k).

Summary

This rapid scope was conducted to give an overall impression of the UK evidence base regarding supported housing since 2011, and is not an exhaustive synthesis. In general, there is evidence for positive benefits of supported housing, but the evidence regarding resident characteristics and outcomes is very fragmented and of variable quality.

[27] Bedspaces = the number of occupants a facility was designed to accommodate

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Email: pru-manager@manchester.ac.uk

Telephone: 0161 306 7797

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