JRF JOSEPH ROWNTREE FOUNDATION

REPORT

SUPPORTED HOUSING FOR OLDER PEOPLE IN THE UK
AN EVIDENCE REVIEW

Jenny Pannell and Imogen Blood

This UK-wide review examines the quality of life that sheltered and retirement housing offers older tenants and owner-occupiers, especially those with high support needs.

Forthcoming changes to funding and welfare benefits for housing and support services should be underpinned by robust evidence: from statistical data, and research on costs, quality of accommodation/services and resident views. Yet supported housing (sheltered and retirement) has received little recent attention from policy-makers or researchers, despite significant changes to sheltered housing over the past decade. This report draws on original analysis of official data and literature.

The report:

- identifies significant gaps in the evidence base;
- considers the impact of a broader mix (of age and support needs) among incoming and existing residents in sheltered housing;
- discusses the effect of reduced on-site staffing on quality of life;
- examines concerns about costs, funding and affordability; and
- contrasts changes to resident mix and on-site staff in social rented and owner-occupied retirement housing.

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EXECUTIVE SUMMARY

This UK-wide review considers recent evidence on supported housing and what it offers older people in terms of quality of life.

Most supported housing for older people is 'sheltered' housing (for social rent) and owner-occupied retirement housing (mainly for sale). Across the UK there are nearly 18,000 developments and around 550,000 dwellings (480,000 in England) housing around 5% of the older population. Developments are built and managed by both not-for-profit and private providers. Around three-quarters of dwellings are for social rent, and one-quarter for sale, with a small but growing market for private rent. There are significant variations by region and country, with much less retirement housing for sale in Scotland and the north of England, and hardly any in Northern Ireland.

This review excludes housing with care (also known as extra-care or very sheltered housing) because this is covered in three other studies in the Joseph Rowntree Foundation (JRF) A Better Life Programme.

Overview of the evidence base

The evidence review took place from June to August 2012.

Research and practitioner publications

We carried out a detailed search for material published since 2000, and examined around 80 publications with material on housing with support and further background publications. We carried out more detailed analysis of 24 academic and resident-led research reports; however, most were pre-2005. In recent years, the main emphasis has been on housing with care – other supported housing for older people has been largely ignored.

Most research evidence on sheltered housing for social rent describes a relatively homogeneous model with a dedicated warden/scheme manager service, because older research pre-dates more recent changes and reductions in services. We found much less evidence on owner-occupied retirement housing (OORH), and none on private rented retirement housing.

Quantitative data sources

We commissioned detailed analysis of CORE (COntinuous REcording) and Supporting People (SP) data, which provides anonymised details on individual residents (England, social rent only). However, they record different information for different purposes (CORE: new social rent tenancies; SP: housing-related support). Information on health and disability is limited, with no information on care needs/provision, so it is difficult to make an informed judgement on the number of supported housing residents with high support needs (as defined by JRF), or on their quality of life. There is no similar data available for the other three nations, nor for owner-occupied or private rented retirement housing.

Gaps in the evidence base

We identified the following gaps in UK-wide statistical data that was publicly available:

- comprehensive data on specialist housing, support and care (models, services, needs, provision);
- holistic data on resident profiles (across age, health, support/care needs, ethnic origin and sexual identity).

We also identified the following gaps, suggesting the need to:

- explore what effect changes to warden/scheme manager/support services in social rented sheltered housing are having on residents (especially those with high support needs);
- confirm or challenge anecdotal evidence on the impact of changes to the resident 'mix' of tenant profiles in sheltered housing (including residents under pension age; residents with a wider range of support needs; residents who are very old/frail/with high care needs);
- explore the role of owner-occupied retirement housing and the views of residents, across different developers and managers from both the not-for-profit and private sectors;
- examine the growth of retirement housing for private rent and use of the Right to Manage (RTM) by private retirement leaseholders;
- discuss and clarify the current 'offer' of different models, costs and tenures.

Questions and answers

Here we set out the research topics, answers from the evidence, and relevant chapters: each topic focused especially on people with high or increasing support needs.

Residents' age and health profiles and care and support needs (Chapter 3)

We found evidence of a widening age range of people both moving into, and living in, social rented sheltered housing in England:

- an increasing proportion of younger tenants (below pension age);
- a significant number of very old tenants (aged 85+);

- new residents with a wider range of support needs and reasons for moving, including homelessness.

Around 60% of those moving in reported a 'disability-related requirement' (higher percentages among older movers); 15–18% moved for reasons connected to homelessness (higher percentages among younger movers).

Existing residents reported a wide range of impairments/ill-health: mobility (43%), physical health (40%), sensory impairment (12% visual, 15% hearing), chronic disability/illness (13%), mental health (9%). Four years' data on the need for support to manage health issues showed no change in most categories but a slight (statistically significant) increase in the need for support to manage mental health or substance use. This may confirm anecdotal evidence from existing residents in some studies.

Over a quarter of existing residents are aged 85+, many probably having care packages, indicated by evidence of joint working between health and/or social services (18%) plus some limited evidence from research literature.

We found no evidence of a similar shift in the age/health profile in OORH. The average age has been around 80 for the past two decades. In his study of OORH recent residents, Ball, *et al*., (2011) found that most were still over pension age and from similar backgrounds to those in earlier studies; significant numbers had health and care needs.

Quality of life for residents with high support needs (Chapter 5)

Much older evidence on the positive impact of sheltered housing is based on a traditional model with an on-site warden/scheme manager. There is still a high degree of satisfaction with *some* sheltered housing, evidenced, for example, by the Elderly Accommodation Counsel annual awards (EAC, 2012b), which record resident views across a number of 'quality of life' indicators (e.g. social interaction, environment). However, there is also evidence of residents' concerns.

Little evidence relates specifically to older people with high support needs. Qualitative evidence suggests traditional models can promote self-determination (especially compared to care homes), safety/security, privacy to conduct personal relationships and opportunities for wider social interaction.

Factors that may improve or reduce quality of life include:

- personal factors (e.g. regular contact with family, ongoing community involvement , longer-term disabilities versus those acquired later in life);
- accommodation (e.g. space standards, location);
- on-site service provision (e.g. scheme manager/support model, quality of staff);
- availability of additional care/support (including specialist support; e.g. for people with a learning difficulty).

Views on quality of life may also be influenced by what residents expect, especially if they feel they have not been consulted or involved in changes (e.g. to scheme-based services, cost increases).

For OORH, the EAC annual awards also confirm that residents from some schemes enjoy a good quality of life. However, the three main research studies have been conducted with only two providers.

Home-for-life? (Chapter 4)

Studies have consistently found that most residents hope to remain living in their supported housing for the rest of their lives. A majority will 'age in

place' in supported housing or move to institutional settings rather than into housing with care. Estimates of moves from supported housing to institutional settings vary between 13% and 21%.

Diversity (Chapter 6)

People from minority groups can be at risk of isolation or discrimination in mainstream provision, yet specialist provision faces challenges around insularity and funding. However, older people from these groups can benefit from supported housing in the same ways as others, and there are examples of good practice.

English national data indicates that 8.2% of existing social tenants and 6.6% of new tenants are from black and minority ethnic backgrounds. We found no data on ethnicity for the other UK nations nor for OORH.

No CORE or SP data is available on sexual identity. There is some evidence of concerns from the lesbian, gay and bisexual population around discrimination in supported housing for older people, and a few good practice examples.

Type and quality of accommodation and services (Chapters 2, 5 and 7)

There is a very wide range of type and quality of accommodation and models of support provided. There are some patterns by sector and country but also considerable variation.

Contact with personal networks, participation in the life of the scheme, engagement with the wider local community (Chapter 5)

Residents with high support needs can experience practical and attitudinal barriers to accessing the social life of the housing scheme, and to retaining or building a social life outside. Evidence suggests that supported housing is most successful for those with support from family members and/or local services. Warden/scheme manager support, location, transport and proximity to family or other networks can all help.

Limited evidence suggests that where support from scheme-based staff in sheltered housing has been reduced or removed, residents with high support needs may be especially affected. A combination of reduced staffing and a wide range of ages and support needs can affect community cohesion and may reduce the possibility of informal support from other residents within the scheme.

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Workforce and partnerships (Chapter 7)

Lack of clarity and unrealistic expectations about the role of scheme-based staff by relatives, professionals and residents was a key finding. This sometimes hampered communications with partner agencies (especially hospital discharge). Several studies identified concerns from staff and residents about whether there was sufficient support for these diverse and challenging roles. More recent studies questioned whether staff still had the time and skills to build relationships where their roles had changed.

Cost and affordability (Chapter 8)

There is good evidence on affordability issues from the recent New Policy Institute study (Aldridge, *et al*., 2012) and supporting evidence from other research on both rented and owner-occupied housing. Affordability links to entitlement to state help and benefits; forthcoming changes are likely to affect affordability for many residents, especially those under the

state pension age (and including couples where one person is under the pension age).

There is significant variation in initial and ongoing costs of living in supported housing. Self-funders, especially former owner-occupiers with no mortgage, are likely to find rents/charges very high compared to previous housing costs. Some private leasehold retirement schemes have taken control of costs by using their Right to Manage.

1 INTRODUCTION

The Joseph Rowntree Foundation (JRF) has commissioned this UK-wide review of recent evidence on supported housing, with a particular focus on the quality of life that this setting offers to older people who have high support needs.

The programme A Better Life defines older people with high or increasing support needs as:

> Older people of any age who need a lot of support associated with physical frailty, chronic conditions and/or multiple impairments (including dementia). Most will be over 85 years old. A minority will be younger, perhaps reflecting the impact of other factors linked to poverty, disadvantage, nationality, ethnicity, lifestyle, etc. Some of the very oldest people may never come into this category.

Most supported housing for older people is 'sheltered' (usually social rented) and a smaller amount is private retirement housing (mainly owner-occupied). JRF asked for this review to give more attention to housing for social rent. Because of changes to the traditional sheltered housing model over recent decades, definitions are no longer clear-cut, as discussed in Chapter 2.

Across the UK, there are just over 550,000 dwellings in nearly 18,000 schemes with some on-site scheme manager/warden presence, however limited (Aldridge, *et al.*, 2012), the most recent estimates being:

- **England:** 480,000 dwellings, 15,000 schemes (EAC, 2012a);
- **Scotland:** 32–35,000 dwellings (Scottish Government, 2012a), around 1,200 schemes (Croucher, *et al.*, 2008);
- **Wales:** 27, 000 dwellings, approx. 860 schemes (calculation by NPI for unpublished draft, Aldridge, *et al.*, 2012);
- **Northern Ireland:** 10,000 dwellings, approx. 280 schemes (ERoSH NI, 2006).

Our evidence review seeks to answer the following questions concerning supported housing for older people (*excluding housing with care*), with chapters addressing each question in brackets:

1. What do we know about the age and health profiles and care and support needs of residents? (Chapter 3)
2. What do we know about quality of life for residents with high support needs? (Chapter 5)
3. To what extent do these settings provide a home-for-life for older people with high support needs? (Chapter 4)
4. What can and does supported housing offer to older people from diverse groups? (Chapter 6)
5. What do we know about the type and quality of accommodation and services? (Chapters 2, 5 and 7)
6. (How) do residents (especially those with high support needs) retain and build contact with their personal networks, participate in the life of the scheme, and engage with the wider local community? (Chapter 5)
7. What do we know about staff working in supported housing and their relationships and partnership working with staff from other agencies? (Chapter 7)
8. What do we know about the cost of sheltered and private retirement schemes, especially their affordability for people with high or increasing support needs who are paying or may need to pay for care? (Chapter 8).

Our approach

This was a short, time-limited study, undertaken between June and August 2012. It is not a systematic literature review, nor did we interview key players because this is covered in evidence they gave to the Age UK (2012) inquiry into sheltered and retirement housing.

We conducted internet-based searches using search engines including Social Care Online, Ingenta Connect and Google/Google Scholar to identify and prioritise relevant literature. We also undertook a manual search of the Housing Learning and Improvement Network (LIN), Elderly Accommodation Counsel (EAC) and CARDI (Northern Ireland) publication libraries and of specialist bibliographies (e.g. Centre for Policy on Ageing Information Service, 2010; Housing LIN/ADASS, 2011; NHF, 2011).

We were already aware of a lack of attention to sheltered/retirement housing in recent research and policy, with most focus having been on housing with care. Initially, we searched for documents published from 2000 onwards, intending to prioritise studies from 2005 to date; however, much relevant literature was pre-2005, with certain key texts being from the 1990s. Recently there has been more interest (for example, Age UK, 2012; Institute of Public Care, 2012, forthcoming).

Much relevant literature was pre-2005, with certain key texts being from the 1990s.

We recorded the key features, strengths and weaknesses of evidence identified and/or reviewed. We identified around 80 publications of direct relevance (see References: evidence review) of which 24 were primary research studies (see Table 1). Further publications were used and referenced for general background and context.

Table 1: Primary research evidence reviewed

Author	Date	Country	Methodology	Comments
Allwood	2008	England London	26 qualitative interviews with Jamaican residents of specialist Brixton SH scheme	Research explores questions of identity, belonging, adjustment; reflects on pros and cons of specialist scheme
Ball	2011	GB	Phone/face-to-face survey of 345 owners of 44 McCarthy & Stone OORH schemes; also info from 5,000+ sales records	Only sampled recent purchasers (av. 1.8 years residence) so better health, also housing standards better than older OORH
Branfield, *et al.*	2009	England Cumbria	73 older people. (9 of whom were resident in SH/ HWC) participated through a variety of means – groups, interviews, questionnaires	Broader study on housing and support provision/needs in Cumbria but some useful qualitative data on experiences and perceptions of sheltered accommodation
Bristol Older People's Forum	2010	England Bristol	198 resident questionnaires about impact of removal of warden services	Response rate: 39%; Good representation of older people with high support needs: 44% were >80 years; 37% had serious and 48% had minor health problems. Sample may not be representative
Croucher, *et al.*	2008	Scotland	Quant. analysis (of EAC data); 641 responses to resident postal questionnaire; provider and LA questionnaire/6 case studies	Response rate good for resident postal survey (>50%) but those with high support needs may be under-represented
EAC	2012b	UK	3 years of EAC awards (card game)	UK wide; includes many providers (large, small, private sector, leasehold), but findings are very broad
Eastleigh SP OP forum	2007	England South	Survey of 722 older people in community; 27 interviews and focus groups – some of whom were in sheltered/retirement housing	Peer researchers; sample were self-selecting older people's forum members – may not be representative; many with limited understanding of supported housing
Field, *et al.*	2005	England	138 residents from 6 schemes in inner city and new town areas interviewed	Uses a standardised needs assessment tool for older people to compare unmet needs in the two locations; high response rate (92%)
Field, *et al.*	2002	England	Interviewed 87 residents at 3 sheltered schemes	High response rate; combined standard instruments and qualitative/ quantitative (ranking type) questions
Fleming, *et al.*	2010	England East	Survey in last year of life and death certificate details for 321 people aged >85 years over the previous decade in Cambridgeshire	Timings of transitions cannot be known with accuracy. Also, presumably depends on the supply and practice of SH in Cambridgeshire over a decade
Foord, *et al.*	2002 & 2004	England North	6 focus groups (3 with SH residents) then piloted tool in 10 schemes in N. England	Focused on the development of a satisfaction measurement tool

(*continued overleaf*)

Table 1 (*continued*)

Author	Date	Country	Methodology	Comments
Ford and Rhodes	2008	England	Postal survey 2,000 (sampled from 5,000 new Hanover residents): 46% response rate	High response rate; no distinction in data between tenants/ leaseholders, sheltered/housing with care
Frew	2006	England London	One case study: spoke to 5 residents and commissioners/ providers	About switch to floating support but research conducted *before* the switch
Hill, *et al.*	2010	England	17 sheltered tenants as part of more general study; qualitative interviews, longitudinal	No data on age, health, etc. of these interviewed
HSP	2011	England London	9 focus groups: 7 with 108 LA sheltered tenants (approx. 10%) from 22 schemes; one with 12 wardens; one with 15 relatives	
King, *et al.*	2008	England	5 focus groups, 64 tenants aged 55–97, 25 schemes, 6 providers. Survey of 100 Supporting People Administering Authorities	*'Nobody's Listening':* plans, perception, consultation, impact of change from scheme-based to floating support
Manthorpe and Moriarty	2010	England	81 interviews with practitioners, commissioners and BME older people and their carers at 4 sites.	Broader study on promoting mental health and well-being among older BME people but contains useful case studies and qualitative data on diverse groups in sheltered housing
McLaren and Hakim	2003	GB	Postal survey of 1,000 McCarthy & Stone resident responses (3,500 sample), survey of prospective residents, focus groups	One of few surveys of private retirement OORH
Percival	2001	England London	50+ resident interviews, 8 focus groups and observations at 3 schemes	Ethnographic approach, exploring social interactions and well-being; all schemes social rented, of similar size, London
Phillips and Knocker	2010	England London	Feedback from 58 service users in groups; 1:1 interviews with 13; review of data	Broader evaluation of LGB initiative for older people: some survey findings, case studies and quotes on SH
Sheltered Housing UK	2012	England South West	Focus groups with 18 residents at two sheltered schemes, and report on a third scheme	Peer researchers providing information for Age UK inquiry; graphic examples of resident experiences of problems
Smith-Bowers	2004	England London	Interviewed/ surveyed 245 sheltered residents	
Rolfe, *et al.*	1995	England	Postal survey 1,000/1500 70%+ response rate), 25 resident interviews	No equality and diversity profile data on sample
Taylor, *et al.*	2009	N. Ireland	10 tenant focus groups; 16 scheme manager questionnaires	

BME: black and minority ethnic; EAC: Elderly Accommodation Counsel; HWC: housing with care; LA: local authority; LGB: lesbian, gay, bisexual; OORH: owner-occupied retirement housing; SH: sheltered housing

Statistical sources

We commissioned detailed analysis of two publicly available databases and consulted some key individuals and organisations to seek access to data and reports.

This report draws on the following sources:

- CORE (COntinuous REcording) data: information on all new social rent lettings in schemes defined as 'housing for older people' over two years (2010, 2011), in England only (25,000 with low support; 77,000 with medium support, i.e. sheltered housing; 9,000 with high support, i.e. housing with care), with data on residents aged 45+; analysis by New Policy Institute;
- Supporting People (SP) data 2007–2011 on SP clients aged 45+, England only, from 10% annual sample of existing SP clients living in 'sheltered housing with warden' (over 20,000 SP clients in 2010/11) and some additional data on 'very sheltered housing' (i.e. housing with care) and other (all-age) supported housing for older residents aged 45+; analysis from the Centre for Housing Research, University of St Andrews;
- data from research in Scotland, including the private sector (Croucher, *et al*., 2008);
- detailed information from one large national housing association (new and existing tenants and leaseholders, 2001–2010);[1]
- relevant statistics in other research publications about sheltered and retirement housing; e.g. changes to scheme-based services, social rented housing (King, *et al*., 2008), characteristics of people moving into owner-occupied housing (Ball, *et al*., 2011).

Report structure

This report includes:

- an introduction to supported housing for older people;
- chapters exploring the eight questions outlined above, including (as appropriate):
  - statistics;
  - findings from qualitative evidence;
  - discussion of differences between countries, sectors, diverse groups, etc.;
  - comments on strengths, weaknesses and gaps in the evidence base;
- final reflections on:
  - what surprised us, what was confirmed or challenged, and what was not covered (at all, recently or in sufficient detail);
  - whether or not supported housing does offer a suitable setting for older people with a range of high support needs.

2 WHAT IS 'SUPPORTED HOUSING' AND WHAT DOES IT OFFER?

This chapter discusses definitions and describes key changes in supply, demand, role and funding over recent decades. We begin to consider how these developments have affected the type and quality of services on offer and the age and health profile of residents.

Around 5% of the older population live in retirement housing (NHF, 2011). There is a range of different models and tenures of supported housing for older people, including:

- Owner-occupied retirement housing: available to buy outright or through shared ownership, usually leasehold, mostly housing with support. 'Owner-occupied retirement housing' (OORH) is the term used by Ball, *et al.* (2011) for owner-occupied apartments with a scheme/house manager but no other services; it is provided by both private companies and housing associations.
- Sheltered housing: for social rent, usually with some support, mainly provided by housing associations and local authorities.
- Retirement villages: large developments of retirement housing, across tenures and support/care types.
- Almshouse charity provision: spans across support/care types.
- Abbeyfields: mostly shared supported housing for social rent (not designed for older people with high support needs) or housing with care models, so excluded from this review.

Additionally, older people live in all-age supported housing (especially specialist schemes for people with learning difficulties, disabilities or mental

health problems). Such provision is excluded, except for comments where relevant (e.g. disability section, Chapter 3).

Definitions

A key finding from this evidence review is the complexity around definitions relating to housing with support. Croucher (2008) points out that 'two broad dimensions ... can be included in a definition:

- physical attributes of the property (e.g. meeting disability standards, etc.);
- service provision associated with the property (e.g. community alarm, warden).'

Sheltered/retirement housing used to be defined by the built form, and nearly always provided a scheme-based warden/manager on site. Because of the changes discussed below, it is now more often defined by service provision.

Definitions by support

The Elderly Accommodation Counsel (EAC, 2012a) identifies three categories of housing for older people according to the support provided:

- **Housing without support:** schemes without an on-site scheme manager service, including those with only an on-call/emergency visiting service.
- **Housing with support:** schemes with some form of regular on-site 'warden' or scheme manager service, however limited.
- **Housing with care:** schemes that offer support and the facilitation of care services described by their landlord/manager as extra-care, assisted living, very sheltered, close care or continuing care.

Note that as in Table 2, EAC's category 'housing without support' may have a very limited visiting support service: see also CORE's definition of 'low support'.

Our focus is primarily on EAC's 'Housing with support' category (i.e. at least some on-site presence); our brief excludes housing with care (although where relevant we make comparisons). Designated housing for older people 'without support' can also provide suitable housing for older people with high support needs.

Definitions by built form

The Housing Corporation (2004, 2008) definitions took into consideration both support availability/provision and built form/design features (e.g. whether there was a lift, wheelchair/mobility access, a common room). These were based on research (see, for example, Riseborough, 2001; Riseborough and Fletcher, 2008) to improve and update definitions, taking account of issues including outdated 'difficult to let' housing stock, and changes to support with the introduction of 'Supporting People' funding (discussed below). Older people's housing is designated as:

- **'All special design features'** (i.e. mainly new-build housing with care);
- **'Some special design features'** (i.e. recent or upgraded sheltered housing);
- **'Designated supported housing for older people'** (i.e. much other sheltered housing).

Table 2: Definitions of housing for older people based on support provision

	Indicative levels of support			
	No support	**Low support**	**Some support**	**High support/care**
Also known as		Sheltered housing	Sheltered housing Retirement housing	Housing with care Very sheltered housing Assisted living Close care
Source				
EAC, 2012a	Housing without support	Housing without support	Housing with support	Housing with care
CORE Housing with support: Housing for older people		Low support	Medium support	High support
Supporting People Long-term outcomes monitoring (accommodation based services)			Sheltered housing with warden	Very sheltered housing

CORE definitions of support provision in housing with support
Low levels of support (visiting staff weekly/fortnightly or less).
Medium levels of support (staff on site during the day/or frequent visits; some out of hours cover).
High levels of care and support (24-hour cover), i.e. housing with care.

CORE definitions of housing for older people
Housing intended for older people (regardless of the age/characteristics of each tenant) incorporating basic facilities and special design features, or specially designated housing for older people matching the Housing Corporation definitions below.

Many schemes could not be modernised to include certain features that were essential under the new classification (especially lifts) because of either their configuration or lack of finance. Many have been re-classified as all-age/'low support' housing.

What is striking about these definitions is the *range* of both built form and support provision, and the minimal support required for inclusion in some categories. Except for 'designated supported housing for older people', there is no requirement for support to be provided: it is sufficient to have a process to assist in accessing or signposting tenants to support services.

The changing role of sheltered housing

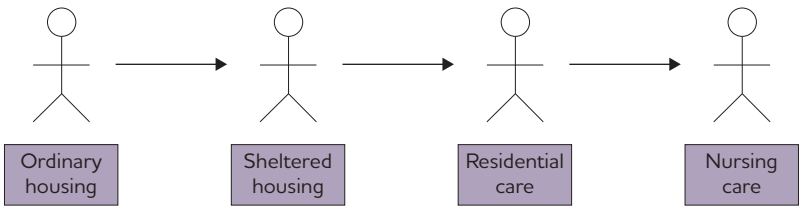
Smith-Bowers (2004) gives a useful summary of changes to social rented sheltered housing between 1950 and 2000:

- **1950s:** sheltered housing built for relatively fit, healthy older people who required limited support;
- **1960s and 1970s:** rapid expansion with emphasis changing from provision of 'general needs' to 'special needs' housing;
- **1979–89:** 69% increase in sheltered housing units in England (Peace, *et al.*, 2001);
- **late 1980s–90s:** concern about overprovision and difficult-to-let sheltered stock – in 1994, 8% of local authorities and 13% of housing associations had over half of their sheltered housing stock designated as difficult-to-let (Tinker, *et al.*, 1995).

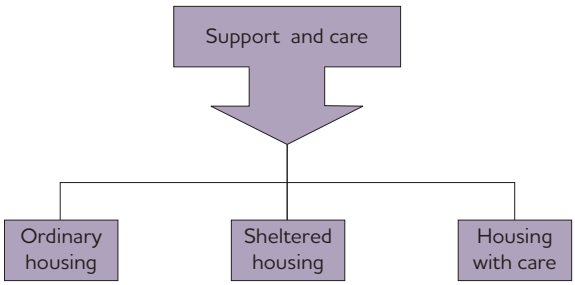
The 1990 NHS and Community Care Act 'represented a radical break from the concept of a literal continuum of care whereby at some given level of dependency older people moved on to a more intensive form of provision [and had] considerable implications for sheltered housing providers' as tenants became frailer and access to residential care much more restricted (England, *et al.*, 2000, p. 53). We capture this shift in Figure 1.

Figure 1: Changes to social care and the role of sheltered housing

PRE-1990: Older person moves through a range of services and specialist provision as needs increase, from housing solutions to institutional care.



POST-1990: Housing solutions: Support and care are provided as needed to individuals in their own homes, as an alternative to entering institutional care. This is aimed especially at those receiving public funding; however, institutional care still remains an important part of overall provision.



A major government review of housing for older people (McCafferty, 1994) concluded that:

- two out of three older households did not need subsidised housing;
- there was an oversupply of sheltered housing for rent;
- there was a need for sheltered housing with additional care (i.e. 'very sheltered' or 'extra-care' housing); alongside
- an increased emphasis on adaptations and delivery of care services to older people remaining in mainstream housing.

Many studies reflect on implications for sheltered housing, including residents' needs and the balance between fit and frail. For example:

- Percival (2001) reflects on tenants' frustration/intolerance with more disabled or dependent neighbours who 'should not be health or social care clients ... but should be people capable of taking responsibility for a tenancy and their own well-being';
- Foord, *et al.* (2004, p.128) point out that 'sheltered housing has increasingly come to be regarded as a "home for life" rather than a step to residential care';
- Lloyd (2006) argues that sheltered housing has a key role to play in preventative care for older people.

Changes to warden/scheme manager services and Supporting People

Originally, most sheltered and retirement housing had an on-site (frequently resident) warden or manager linked to flats by alarm systems and paid for through the rent or service charge. The role usually included daily contact and individual support for residents, facilitating social activities and some housing management.

Over time (and prompted by the European Working Time Directive, which restricted on-call arrangements and resident staff hours of work), some providers moved towards non-resident managers alongside community alarm services monitored from an off-site call centre. So by 2000, warden/scheme manager services were already changing (Parry and Thompson, 2005; Anchor/ILC-UK, 2008; King, *et al.*, 2008; Scottish Government, 2010).

In 2003, sheltered/retirement housing was included in the UK-wide Supporting People (SP) framework. Housing Benefit and Pension Credit still covered housing costs (including 'housing management') but not 'housing-related support' (e.g. part of the warden/scheme manager service; community alarm), which transferred to a new, cash-limited, locally administered SP 'pot'.

The warden/scheme manager role is a combination of housing management and support. Providers have had to separate costs and contract with their local SP authority for support provision. Budget and other pressures have increasingly led local authorities to re-tender support contracts. Some housing providers have lost SP funding for scheme managers; many replacing them with peripatetic, shared or 'floating' support services. In parallel, 'housing-related support' has been increasingly targeted to individuals based on a needs assessment. By 2012, except in Wales, SP funding was no longer ring-fenced; in many localities it ceased to be a separate funding stream. It has also been subject to severe cuts, especially in

Budget and other pressures have increasingly led local authorities to re-tender support contracts. Some housing providers have lost SP funding for scheme managers; many replacing them with peripatetic, shared or 'floating' support services.

England (ADASS, 2012; Inside Housing, 2012), and there are cuts to come in Scotland (e.g. SCSWIS, 2012) and Wales (SSIA, 2011).

Evaluating a pilot project to replace wardens with floating support, Frew (2006) comments that such changes could be 'viewed negatively' by residents; Croucher, *et al*. (2008), King, *et al*. (2008), Hill and Sutton (2010) and Age UK (2012) found similar resistance in schemes which had lost their on-site service. Chapter 5 discusses evidence of the impact of these changes on quality of life.

Scale and impact of the Supporting People funding cuts

Inside Housing and Capita's Supporting People UK-wide survey in May/June 2012 found SP budgets had been slashed by up to 50% during the past year:

In Shropshire, **Severnside Housing**'s sheltered schemes used to have a dedicated manager who visited three or four times a week but now, since budgets for older people's services have been halved, they get just one visit a week.

Coastline Housing in Cornwall has had to revisit the support plan of each of its individual sheltered resident in response to 40% cuts to the county's SP budget. This has meant 'in some cases, downgrading the level of intervention they receive. Daily visits ... have been swapped with daily phone calls and two visits a week'.

Extracts from Inside Housing 'Keeping afloat', 13 July 2012

Owner-occupied retirement housing

Retirement housing for sale dates from the 1980s, pioneered by housing associations and private providers (e.g. McCarthy & Stone). Unlike social housing (allocated according to need), private retirement housing is bought by older people who can afford it (usually by selling their existing property). Developments typically include one- or two-bedroom apartments or bungalows plus some communal facilities. More upmarket developments include larger properties and (especially in retirement villages) more facilities: some villages also offer care and so fall into the 'housing with care' category.

Guardian (now Anchor) built the first schemes: they expected purchasers to be 'in their early retirement years and able to live independently' (Rolfe, *et al*., 1995). The profile changed over time as existing residents aged and as entry criteria changed to reflect difficulties in the housing market. The study found evidence that warranted a cautious interpretation of future demand and stated that providers would need:

> to look carefully at the details of design and management to meet the demands of an increasingly discriminating consumer. ... This might not augur well for the resale of existing units built to lower standards ... [nor] demand for new units if ... potential customers were to perceive the risk of loss on resale ... Increasing public awareness of rising service charges, and of the need to retain capital to meet health and care needs in the context of reduced welfare state provision in the 1990s and beyond will also make potential purchasers more cautious. – pp. 67–68

This prediction from the 1990s still resonates today: Ball, *et al.*, (2011) described the difficulties faced by retirement housing providers in the recent housing market downturn; Age UK (2010) and Pannell, *et al.* (2012) reported continuing problems with some providers over service charges, exit fees and re-sales, confirmed by Channel 4's *Dispatches* (24 September 2012).

What do we know about the types of services?

There are now huge variations across nations, regions, sectors and schemes in service provision and delivery.

We found no central records to show the extent of services and on-site/floating support staff. The Scottish survey (Croucher, *et al.*, 2008) found that 97% of housing associations and 68% of councils still had a warden at every scheme, though with considerable diversity in the type and amount of warden support provided.

King, *et al.* (2008) surveyed English local authorities: when SP was introduced in 2003, 95% of sheltered housing had an on-site warden/scheme manager. In 2007, 88% still had on-site provision and 11% had floating support. Local authorities estimated that by 2010/11, this would have changed to 61% with on-site provision and 38% with floating support. In 2012, EAC estimated that 25% of sheltered housing schemes now have no 'dedicated' scheme manager (EAC 2012b).

'Floating support' covers a very wide range of services (see King, *et al.*, 2008):

- In some schemes, all residents will still have regular face-to-face contact with support staff (unless they deliberately opt out).
- Contact may be with different members of a large team or a named worker attached to their scheme (or two schemes).
- Elsewhere, contact is mainly by phone or from community alarm staff.
- In many schemes, only a minority (those with an assessed support need) will receive any contact from support staff.

As services have reduced, some self-funders have chosen to opt out rather than pay for reduced service (especially if their scheme has no dedicated staff member; King, *et al.*, 2008; Age UK, 2012).

Following the introduction of SP, there was a contrast between how different local authorities contracted for SP-funded services (see King, *et al.*, 2008 for detailed discussion) and how providers responded:

- Large national specialist housing associations (e.g. Anchor, Hanover, Housing 21) have largely kept scheme-based managers to provide a housing management presence on-site, though even low-income residents may have to pay (King, *et al.*, 2008).
- Many local authorities and smaller or regional housing associations have probably changed to floating support models, although we found no data to confirm this.
- Anecdotal evidence suggests that some smaller/specialist providers for older people (e.g. almshouse charities; Pannell, *et al.*, 2013, forthcoming) have kept scheme-based staff.
- A scheme-based manager (even if now non-resident) remains the predominant model in owner-occupied retirement housing (OORH), confirmed by Ball, *et al.* (2011) and our own observations.

- In Scotland, Pleace (2011) pointed out that when SP was ring-fenced, this limited expenditure to lower-intensity support services. Now, floating services can combine housing-related floating support, personal care and health services (e.g. Bield Housing Association's 'housing support service' in Glasgow, and (particularly in rural areas) sheltered housing as a 'hub' for floating support services extending to older people living locally).

Examples elsewhere include rural/urban hub and spoke models and changes to support services in Somerset and the Midlands (Housing LIN/CSIP, 2008; King, *et al*., 2008; NHF, 2011), and an integrated service including extensive telecare in Sunderland (Appleton and Porteus, 2012).

What do we know about the type and quality of accommodation?

Some social rent providers have reviewed their sheltered stock: some has been demolished, sold, re-designated to general needs, or upgraded to housing with care (e.g. Wright, 2009). Our findings suggest a range from poor quality, poorly located bedsits to brand-new housing.

We were limited by the lack of data and recent research, but found the following:

- Most Scottish schemes had a laundry, communal lounge, social activities, a guest room and car parking; most units were 1-bedroom flats, with 7–10% bedsits/studios (Croucher, *et al*., 2008).
- Paris (2010) found the need for refurbishment contributed to lack of demand for some sheltered schemes in Northern Ireland.
- In Wales, a review of support services identified that much local authority sheltered housing 'now needs modernisation but [councils] have not been able to make the investments required. As a result, this form of housing has become less popular.' (SSIA, 2011, p40)
- In England, in 2008 Anchor had over 9,000 bedsits (40% of 23,000 units; Anchor/ILC-UK, 2008). Anchor commented (personal communication, August 2012):

  > At Anchor we are investing in our stock, including studios, where it is in a location with sufficient potential demand, and are finding that these units can still be popular. Size of accommodation is just one of the factors which influence decision-making. Geography, quality of the service, community links and price are all also significant factors.

- There are very few bedsits in OORH and more two-bedroom units, though most (from the largest provider) are still one-bedroom (Ball, *et al*., 2011).

3 AGE AND HEALTH PROFILE OF RESIDENTS

This chapter explores the available evidence on characteristics of residents in supported housing, pointing out the gaps in data. It asks three broad questions, comparing models with different tenures and levels of support or care.

The questions examined were:

- What do we know about the age and health profiles and care and support needs of people living in supported housing for older people?
- Roughly what proportion of residents might fit JRF's definition of 'older people with high support needs' (as defined in Chapter 1)?
- Does evidence suggest that this varies between tenants/leaseholders, social rented/private providers, region/country, or other factors linked to service provision models?

There is limited data available to answer these questions. National data on older people (age, health, care/support needs) is not available specifically for residents in supported housing. There is no national data source on owner-occupied retirement housing (OORH). Sources for social rented housing (England only) provide limited data on health and support/care needs. Most detailed research took place some years ago (1990s–2006) and statistics are too out-of date to be worth including.

A lack of centrally collected statistics relating to supported housing residents has been highlighted in Scotland (Scottish Government, 2010) and Northern Ireland (Paris, 2010). Of the datasets available openly online, CORE allow in-depth analysis and cross-comparison, the Welsh equivalent does not allow bespoke analysis.

Statistical sources

This chapter draws on the following sources:

- CORE data;
- Supporting People (SP) data;
- data from research in Scotland (including the private sector): the 'Review of Sheltered Housing in Scotland' (Croucher, *et al*., 2008), referred to as the *Scottish Review*;
- detailed information from one large national housing association;
- relevant statistics in research reports (e.g. Ford and Rhodes, 2008; Ball, *et al*., 2011).

Key points from quantitative data

Our main focus is on housing with low and medium support, using data on housing with care only for comparison. Note that SP and most research report data is about existing (and perhaps long-standing) residents. CORE and some research report data (e.g. Ball, *et al*., 2011) is about new/recent residents.

We know that there have been recent increases in the number of private rentals. Girlings Retirement Rentals is the largest provider, with around 2,500 properties in 500 retirement developments in England, Scotland and Wales: tenant numbers have increased threefold in the past five years (www.girlings.co.uk). We were unable to find any further data on this growing market.

Age: social tenants

Older research reports are consistent in confirming the average age of existing residents at around 80 years.

In Table 3, SP data on existing residents (10% annual sample) shows a small but steady increase in the number of younger residents in the 45–65 age-band, from 11.6% in 2007/8 to 14.6% in 2010/11, which links to the CORE data below. Data in Table 4 also shows an increasing trend, but the difference is that in housing with care they would have high care/support needs (including, for example, people with learning difficulties or progressive conditions). The increase of three percentage points over four years is significant.[2] It confirms anecdotal information discussed in Chapters 5 and 9.

Table 3: Ages of existing residents in 'sheltered housing with warden'

Age range	2007/8 (%)	2008/9 (%)	2009/10 (%)	2010/11 (%)
45–64	11.6	12.7	13.6	14.6
65–74	25.0	25.4	25.5	25.9
75–84	35.8	34.7	34.3	33.9
85+	27.6	27.3	26.7	25.6
Total	100	100	100	100

Source: SP data collected by The Centre for Housing Research (CHR), University of St Andrews, on behalf of the Department for Communities and Local Government; data analysis by the CHR, University of St Andrews

Over a quarter of sheltered housing residents are aged 85 years and over, which is, as expected, lower than the *proportion* aged 85+ in housing with

care (36%). However, the *number* of very old people in sheltered housing is much higher, because around 90% of all retirement housing is 'with support' and only around 10% 'with care' (Pannell, *et al*., 2012).

Table 4: Ages of existing residents in housing with care

Age range	2007/8 (%)	2008/9 (%)	2009/10 (%)	2010/11 (%)
45–64	5.3	7.1	8.1	10.8
65–74	20.1	17.6	18.5	19.5
75–84	35.9	37.1	33.3	33.3
85+	38.7	38.2	40.1	36.4
Total	100	100	100	100

Source: Centre for Housing Research, University of St Andrews, as for Table 1

In Table 5, CORE data shows that in 2010 and 11 a high proportion of younger people (under 65 years) moved into housing with support (less so into housing with care, and this would again be for the reasons outlined above for the SP data).

Table 5: Ages of new residents moving into housing for older people 2010 and 2011

	Low support		Medium support		High support	
Age range	**Number**	**%**	**Number**	**%**	**Number**	**%**
under 45	1,100	4	1,300	2	300	3
45–54	2,000	8	3,400	5	200	3
55–64	7,900	33	21,000	29	1,100	12
65–74	6,700	28	20,300	28	1,600	18
75–84	4,400	18	17,200	24	2,700	30
85+	2,100	9	9,800	13	3,200	35
Total	24,100	100	72,900	100	9,200	100

Source: CORE data for two years, analysis by New Policy Institute (NPI): age is of the 'household reference person' (in a joint tenancy this is the person who is more economically active or older)

Not surprisingly, a *higher proportion* of new lettings in housing with care were to very old people (over a third of new lettings were to those aged 85+) and a lower proportion in medium-support housing (13%). However, there were greater *numbers* moving into medium-support housing because of the much larger amount of such provision. Of new lettings to people moving into housing with low support, 9% were to households aged 85+.

Looking in more detail at the under-65s, nearly half of all new lettings for housing with low support were to this age-group (12% under 55, 25% under 60, 45% under 65), as were over a third for housing with medium support (7% under 55, 15% under 60, 36% under 65).

This trend is confirmed by data from the large housing association and the Local Government Group (2010) case study of Bolton Metropolitan Borough Council: 20% of Bolton's total housing stock was sheltered housing; 14% of sheltered properties were let to people under the age of 60 because of low demand.

The increase in lettings to younger people (under state pension age) is in contrast to earlier comments on the *rising* age of sheltered housing residents (e.g. Parry and Thompson, 2005).

Age: owner-occupiers

Ball (2011) and the large housing association data show that new and recent moves into private retirement housing are still mostly older people, with an average age of around 80, in contrast to the younger people now moving into social rented housing.

This shows little change over nearly twenty years (1994–2011), being similar to the survey of Guardian leaseholders (Rolfe, *et al*., 1996). The McCarthy & Stone research (McClaren and Hakim, 2003; Ball, *et al*., 2011) and the much older Guardian research show an average age of 79, and the same proportion of residents aged 85+ at 20%.

New and recent moves into private retirement housing are still mostly older people, with an average age of around 80, in contrast to the younger people now moving into social rented housing

Health and disability, care and support needs

There is limited data on health, disability, care and support needs, except for the comprehensive information from the *Scottish Review* survey of over 600 residents in social rented and private housing (Croucher, *et al*., 2008), and a survey of Hanover residents (Ford and Rhodes, 2008).

The Hanover survey (46% response, survey of 2,000 recent residents) covers tenants and leaseholders in sheltered/retirement housing and housing with care. Overall, across single and couple respondents, around 60% could not climb stairs; around a third had sensory impairment; over 40% had memory problems; and 20–30% could not walk short distances. Two-thirds of single respondents needed help with cleaning, and a third of two-person households (where both were in poor health) needed help with cooking and cleaning.

Health and disability: social tenants

The main quantitative evidence on health and disability is presented here, with further discussion in Chapters 5 and 9:

- The *Scottish Review* survey of residents found housing association schemes had more very old residents compared to local authority and private sector schemes; local authority residents reported slightly worse health; less than half of respondents said they were in good health (Croucher, *et al*., 2008, Table 6.2, p.57).
- Bristol Older People's Forum (2010) surveyed over 500 local authority sheltered housing tenants: 44% of 198 respondents were aged over 80, 37% had serious and 48% minor health problems.
- Nearly a quarter of the large housing association's sheltered tenants reported limiting health or disability problems; 11% of residents used a wheelchair, mobility scooter or buggy.

CORE has limited data on health and disability (of the 'household reference person') from questions on the primary reason for moving and whether there is a 'disability-related housing design or adaptation requirement'.

The most frequent primary reason is either 'to move to accommodation with support' or '[previous] property unsuitable because of ill health/ disability', and these two reasons account for nearly half the moves into housing with support (and nearly three-quarters into housing with care). Overall, 60% of movers have a disability-related requirement: slightly fewer for low-support housing (55%); slightly more for housing with care (72%). This suggests some disability, but not necessarily JRF's 'high support needs'.

Table 6 (from SP data) shows whether existing residents have one or more self-reported disabilities. SP clients aged 45+ in all-age supported housing and housing with care are included for comparison. The disability categories are those used for SP data collection.

Table 6: Disabilities in different types of supported housing 2010/11

Disability	Sheltered housing with warden *n*=20,453		Housing with care *n*=1,315		All-age supported housing (aged 45+ only) *n*=6,694	
Mobility	8,855	43%	748	57%	1,880	28%
Visual impairment	2,489	12%	319	24%	615	9%
Hearing impairment	2,993	15%	280	21%	557	8%
Progressive illness/chronic disability, e.g. MS, cancer	2,728	13%	157	12%	475	7%
Mental health	1,837	9%	225	17%	2,225	33%
Learning disability/autistic spectrum condition	471	2%	57	4%	2,660	40%
Other disability	1,048	5%	64	5%	259	4%

Note: Sheltered housing and housing with care based on 10% sample; all-age supported housing based on 50% sample; individuals may have more than one disability.
Source: Centre for Housing Research, University of St Andrews, details as for Table 1.

There are high levels of self-reported disability in sheltered housing, although not as high as in housing with care, which has an older population. There are very different patterns of disability among residents (45+) in all-age supported housing.

Care and support: social tenants

SP outcomes monitoring data shows type of support given to each client. Categories apply across all SP client groups: we selected the most relevant for sheltered residents. SP monitoring data does not indicate whether the person is also receiving care (from the local authority, a private agency or relatives). However, since 2009/10 it monitors for support provided in partnership with a range of other agencies, including health and/or social services.

Parry and Thompson (2005) discussed the increase in care packages and joint working across housing, health and social care for older/disabled sheltered residents in 2005. In 2010/11, SP data suggested joint working between health and/or social services for 18% of SP clients.

Residents with a range of needs can be receiving SP housing-related support, assisting them to:

- participate in leisure, cultural, faith-related and informal learning activities;
- establish contact with 'external services/groups' (including the wider community);
- better manage physical health;
- better manage mental health;
- better manage substance misuse;
- manage independence better through use of assistive technology/aids and adaptations;

- minimise harm/risk of harm from others;
- develop confidence and ability to have greater choice, control, and involvement.

Table 7 indicates the proportion of SP-client residents receiving support with one or more of these aspects. Over 40% need help to better manage their physical health, which links to Table 6 above (over 40% with mobility problems; between 10% and 15% with sensory impairments and progressive illness/chronic disability).

Table 7: SP support for clients in 'sheltered housing with warden'

Type of support	2007/8		2008/9		2009/10		2010/11		Overall %
	Number	(%)	Number	(%)	Number	(%)	Number	(%)	
Informal learning activities	4,775	25.4	5,960	25.2	5,433	22.4	4,933	24.1	24
External contacts	5,488	29.2	7,312	30.9	6,755	27.9	5,861	28.7	29
Physical health	7,941	42.2	10,299	43.5	10,464	43.2	8,915	43.6	43
Mental health	2,056	10.9	2,911	12.3	2,958	12.2	2,685	13.1	12
Substance misuse	300	1.6	426	1.8	459	1.9	399	2.0	2
Assistive technology	11,194	59.5	15,240	64.3	16,302	67.4	14,120	69.0	66
Harm from others	911	4.8	1,348	5.7	1,301	5.4	992	4.9	5
Choice and control	4,674	24.8	6,027	25.4	5,482	22.7	5,061	24.7	25

Note: Sheltered housing and housing with care based on 10% sample; all-age supported housing based on 50% sample; individuals may have more than one support need.
Source: Centre for Housing Research, University of St Andrews, details as for Table 1

Three items show increases over four years. Assistive technology could reflect availability and/or use of a wider range of assistive technology (see Appleton and Porteus, 2012) or (perhaps more likely in view of changes to support/warden services) an increased use of remote monitoring by telephone or community alarm compared with face-to-face contact. Mental health and substance misuse are discussed below.

The *Scottish Review* survey found that, in social rented schemes, one in four residents received home care; one in ten regular nursing input; and 40% help with housework and shopping. All these figures were much lower for private sector residents, i.e. owner-occupiers (Croucher, *et al*., 2008, Table 6.2, p. 57).

Mental health, learning difficulties, other disabilities/complex needs and vulnerabilities

There is limited quantitative information on mental health, learning and other disabilities and needs. The SP 'mental health' category includes dementia; we found no other data on people with dementia in supported/sheltered housing.

SP data (see Table 7, above) shows that, overall, one in eight SP client residents received support to 'better manage' their mental health, 2% to manage their substance misuse and 5% to minimise harm or risk of harm

from others. There are few changes across four years' of data (2007/8–2010/11), except for a slight but statistically significant increase in two areas, which could support anecdotal information discussed in Chapters 5 and 9:

- support for managing mental health (10.9% increasing to 13.1% of clients);
- managing substance misuse (1.6% increasing to 2%).[3]

Around 60% of people (aged 45+) in all-age specialist supported housing have a 'primary client group' defined as 'mental health problems', 'learning disability' or 'physical and sensory disability', so are likely to be growing older in specialist accommodation, although the numbers and proportions reduce as we move up the age-scale.

Health and disability: owner-occupiers

Ball, *et al*., (2011) surveyed recent residents in McCarthy & Stone retirement housing and reported that many had moved because of mobility or other health problems (e.g. stroke or heart attack).

Nearly half (45%) of the large housing association's leaseholders reported health or disability problems; half use a stick or Zimmer frame, and 15% use a wheelchair, mobility scooter or buggy.

Care and support: owner-occupiers

Over a quarter (29%) of the large housing association's leaseholders received some support and/or care, mostly from private providers or relatives.

We have found no information on the extent of mental health problems, dementia, learning difficulty or other disabilities.

Social tenants: why did they move?

CORE analysis indicates the self-reported primary reason for moving into housing with low or medium support, and also sheds some light on the increase in younger residents. Key points include:

- The proportion of households moving to housing for older people from owner-occupation increased with age: 6% for 45–54 year olds, 18% for those aged 75+.
- Aggregating reasons linked to potential homelessness suggest that overall this accounts for 18% of moves into low-support housing and 15% into medium-support housing. Sheltered housing is often the only available option for middle-aged or older single people and couples, whether or not they have any other support needs; the large housing association also reports an increase in homeless applicants.
- Very small numbers/percentages moved straight from a hospital or care home into housing with support (under 2%) compared to housing with care (8%).

The impact of widening age ranges of new and existing residents is discussed in Chapters 5 and 9.

4 MOVING ON FROM SUPPORTED HOUSING

This chapter considers available data on how long older people stay in supported housing, why they leave and where they go. Does supported housing offer people with high support needs the 'home for life' that they hoped for? Do we know how many have to move on to care homes or housing with care?

To summarise, studies and Supporting People (SP) data confirm that residents want supported housing to provide a home for life; estimates of moves to institutional settings range from 13% to 21%, with few moves into housing with care (from CORE data). *Average* lengths of stay data is not very useful because the length of stay varies so greatly (large provider data).

Chapter 2 described the policy shift towards bringing individualised support and care to people's own homes (whether ordinary or sheltered housing) to reduce the need to move to residential care. Here we discover that to some extent this has been borne out in practice – both in terms of moves out of supported housing and because of resident expectations that it will be a 'home-for-life'.

Quantitative data on moves out of supported accommodation/end-of-life

Fleming, *et al*. (2010) studied 321 people who had died at age 85+ during the previous decade in Cambridgeshire. In the year before their death, 53 people were living in sheltered housing. Seven (13%) moved permanently during their final year of life: six to residential/nursing care, one to long-stay hospital. Nine died within the scheme; others were transferred and died in institutional settings, although the address on the death certificate was sheltered housing.

CORE data shows that 760 moves into housing with care (two years: 2010, 2011) were from 'housing for older people' (8% of moves): most were

probably from sheltered housing. At around 380 per year (from around 450,000 units of housing with support in England), this suggests that most tenants 'age in place', or move to institutional settings rather than to housing with care.

Provider data from the large housing provider

In the year 2009/10, 1,834 sheltered housing tenancies ended: a turnover rate of 15.8% of the housing stock, increasing by roughly 1% each year over the previous three years.

The average length of residence has fluctuated between seven and eight years, but with great variation: nearly a quarter of sheltered tenancies last for ten years or more; 18% of sheltered tenancies ended within the first year of occupation.

Why did these tenancies end?

- 27% on death;
- 21% moved to institutional care;
- 20% were internal transfers;
- 14% transferred to other housing associations;
- 5% moved in with relatives.

Any differences by type of accommodation?

Bedsits
Average length of stay was lower (5.8 years); tenants in bedsits were slightly more likely to be evicted or move on due to mental health reasons (1.8% compared to 1% for flats).

Leasehold properties
Turnover was much lower (around 7%) than in rented units; leases were more likely than tenancies to end with death (37% in 2009/10; 52% in 2008/9). Over half (55%) of the leaseholders had been living in their homes for five years or more.

Comparison with housing with care
Around half of HWC tenancies ended with the death of the tenant and around a third ended because the tenant moved to residential, nursing or specialist dementia care.

Older people's hopes and expectations

SP data shows that over four years, 97% to 98% of tenants agreed that they intended their sheltered housing to provide a 'home for life'. There is very little variation between years or regions, except for a larger number (up to 10%) of residents who thought it would not (two different northern regions, two different years); we speculate that this was probably linked to changes in support provision/demolition/re-designation of specific schemes.

A study of sheltered housing tenants in Northern Ireland also found the same:

> Tenants expressed concerns about any suggestion of moving on from their supported housing that was now 'home' ... Tenants felt they had

made a major life change by moving into supported housing. They felt that at their time of life they would not like to undertake another big move again.
– Taylor, *et al*., 2009, p. 24

Both England, *et al*. (2000) and Percival (2001) highlight paradoxical views: residents with lower support needs often felt strongly that they would not want to have to move out of retirement housing, *yet al*so felt that residents with higher support needs should move on to institutional care.

Although most residents would prefer not to move, some accept it may become necessary. Ball (2011) asked leaseholders how long their current retirement housing would suit their needs: 66%of respondents answered "for many years to come", 27% answered "until I need greater assistance" and 3% replied "only for a few years". Tenure may be a factor here, though our major provider's data suggests that leases were more likely than tenancies to end at the death of the resident. The current economic climate may have an impact here: private providers in Blood, Pannell and Copeman (2012) explained there were difficulties selling leasehold properties in some areas, so older people had moved to nursing homes but were unable to sell.

Some older studies found evidence of people choosing to move out of sheltered/retirement housing due to dissatisfaction with accommodation or services (e.g. Rolfe, *et al*., 1995). Others may choose to make another move preventatively – perhaps to live nearer to family: a third of our provider's sheltered tenancies ended because tenants were transferring to other housing association properties.

What helps?

Security of tenure can, as Age UK (2012) argues, confer important rights here. Yet the following example demonstrates how certain factors can also help older people remain in supported housing when they might otherwise be forced to move:

- mediation and advocacy;
- flexibility – particularly of the housing provider;
- supportive family;
- social workers and health professionals who understand what supported housing can (and cannot) provide and can work in a person-centred way.

Creative use of mediation

A social worker had been arranging a client's discharge from hospital, but the almshouse charity where her client lived said it planned to evict the resident, as she had care needs they could not meet, and her challenging behaviour upset other residents. It was, said the charity, in the best interests of all concerned that she should move into a care home rather than return.

The social worker contacted Age Concern's Advice, Information and Mediation Service after a meeting with the almshouse ended in an argument. AIMS advised that the client had no security of tenure but suggested mediation. All parties agreed and the resident's grandson attended as an advocate.

The mediation resulted in a better understanding of the repercussions of eviction by the charity, and also an acknowledgement by the resident and her family of the problems she was causing other residents. There was a constructive discussion about possibilities, which led to the idea of reopening an external door to the property, which had previously been blocked up, so that the resident did not need to use the internal facilities.

This led to a creative solution that allowed the resident to remain in her home while protecting the rights of other residents. The almshouse charity should be commended for its willingness to look beyond its 'rights' to find solutions that work for all concerned, and at a significant financial cost to itself.

Adapted from AIMS newsletter, in Pannell, *et al*., 2013 (forthcoming)

5 QUALITY OF LIFE

This chapter considers how far different types of supported housing can promote physical, psychological and social well-being. Evidence is analysed using a framework developed with older people with high support needs to reflect what they value in their lives.

The Joseph Rowntree Foundation commissioned Katz, *et al.* (2011) to develop a framework of things that older people with high support needs value in their lives to inform the A Better Life programme (see figure 2). We have used their model to conceptualise quality of life and organise our evidence under three broad headings: physical, psychological and social well-being (including evidence on relationships, networks and participation), with Katz subheadings in bold alongside related evidence.

Figure 2: What older people with high support needs value

Most research on sheltered housing for social rent is pre-2005, so pre-dates changes to the warden/scheme manager services outlined in Chapter2. Some later evidence (e.g. EAC, 2012b) is drawn mainly from sheltered housing with a scheme manager. So we have to be very careful when interpreting data on whether/how the model promotes quality of life, especially since the presence or absence of a scheme manager may be a key variable. We therefore refer to older evidence as relating to 'traditional sheltered housing' (TSH) i.e. with a dedicated scheme manager/warden, the likelihood of social activities, and daily contact with residents. Most owner-occupied retirement housing still has some scheme manager presence; research on this provision is identified as OORH.

Recent research by resident and older people organisations

Bristol Older People's Forum (2010) surveyed local authority sheltered housing residents to explore the impact of changes to warden services, which are now provided only in response to specific need.

The results showed that 83% thought the service was worse; 54% said it was 'much worse'. Older people with high support needs may be more affected: 85% of over-80s and 91% of those in poor health said things were worse than before, and 79% of those with poor health (compared to 68% overall) said the change had had a direct negative impact on their quality of life.

Specifically, of those in poorer health: 76% said social and community life had worsened; 66% didn't feel as safe; 49% found their immediate environment wasn't as clean and tidy; 60% found it harder to cope in severe cold weather; and 79% felt more lonely/isolated.

Sheltered Housing UK resident research findings (authors' summary from Age UK, 2012, p. 53) included:

- ongoing loss or dilution of warden services;
- inappropriate allocation of younger people with high support needs to schemes designed for older people;
- residents having to provide concierge/support/care themselves to other vulnerable residents;
- older people with dementia being allocated to sheltered schemes without appropriate support, with negative effects on the quality of life of both the residents with dementia and existing residents.

Details of case studies can be found at:
http://worldofdifference.vodafone.co.uk/blogs/anne-ludlow

Despite other studies exploring quality of life of people living in TSH and OORH, none has focused specifically on those with high support needs. Some reports have broken down survey findings by health status and/or age group; others have highlighted qualitative findings relevant to different support needs.

When assessing the impact of living in supported housing on quality of life, Lloyd (2006) reminds us of likely risks and benefits of alternatives – usually either remaining at home or moving into institutional care. There may be losses and gains across the Katz categories:

- moving from inaccessible/substandard housing; or
- downsizing from large, comfortable family homes;
- leaving situations with risks of crime, harassment or abuse; or
- moving away from good neighbours and friends.

Psychological well-being

We found some evidence that TSH and OORH may promote **self-determination** for those with high support needs, particularly when compared to care homes. Recurring themes include:

- having your own front door, so enjoying privacy, controlling entry, inviting guests (e.g. Taylor, *et al.*, 2009);
- increasing independence: residents with high support needs may be able to do more for themselves (see *Physical well-being*); for those with substantial care packages, life can be less 'routinised' than in a residential care home (Abbott, *et al.*, 2000);
- questions about how far residents (especially with high support needs) can participate meaningfully in decision-making about how a scheme is run (e.g. Foord, *et al.*, 2002; King, *et al.*, 2008; EAC, 2012b).

Disruptions to **continuity** and the need to **adjust to change** when moving into supported housing may be the price of extending independence as long as possible (Percival, 2001; Scottish Government, 2010).

Percival (2001) observed how living alongside/comparing yourself to other older people can both threaten and reinforce **self-esteem**. However, residents can gain increased confidence in TSH, usually when staff have time, skills and willingness to provide support.

Support from on-site staff to rebuild confidence

Ms B, in her fifties and diabetic, moved into sheltered housing after a relationship breakdown. She had no family and had completely lost confidence. She would not leave her new flat until the warden encouraged her to take part in coffee mornings and social activities. The warden also took her shopping a few times and taught her to knit. Ms B has now regained her confidence and is an active participant in tenants meetings and committees. She said she had been suicidal and "*would not be here today*" if it were not for the skilled and sensitive help from the warden who was there for her when she needed help.

King, *et al.*, 2008, p. 31

There is also evidence of TSH promoting general **mental well-being** for older people, including those with high support needs. Even where people raise concerns or describe trade-offs, most research participants say they are happy and pleased that they moved in (e.g. England, 2000; Eastleigh, 2007; Hill and Sutton, 2010). However, most studies identify a minority who are unhappy (e.g. Field, *et al.*, 2002) for a range of reasons including smaller accommodation, bereavement, ill-health and loss of friends/neighbours.

The evidence about more serious **mental health** problems/cognitive impairments is also mixed. Field, *et al.* (2005) identified higher levels of

unmet social and psychological needs for sheltered residents with dementia and/or depression. Earlier research (Field, *et al*., 2002) highlighted limited access to mental health professionals, likely to be part of a broader, well-evidenced gap for this age group (Mental Health Foundation, 2009), also discussed in Sussex Gerontology Network (2005).

> Another very worrying problem for the residents is that an ever-increasing number of people with Alzheimers and dementia are being housed among them – with no on-site warden ... Abandoned simply to fend for themselves as best they can, these residents pose a serious danger, both to themselves and to the other residents. Not only do they pose a very real threat of fire by forgetting that they have turned on a cooking unit, but they are also only too apt to open the automatic doors to the building without the remotest understanding of what they are doing.
> – Peer researcher's report of resident focus group by Sheltered Housing UK (for Age UK), 2012

Physical well-being

Safety and security are frequently cited by residents in older studies of TSH as the most important benefits of living in sheltered housing (e.g. Smith-Bowers, 2004; Eastleigh, 2007; Sussex Gerontology Network, 2008b), as well as in studies of prospective residents (e.g. McClaren and Hakim, 2003; Burholt and Windle, 2007; Croucher, 2008). This compares favourably with high levels of fear of crime experienced by older/disabled people living alone in the community (Paris, 2010). Losing this feeling of safety/security is evidenced in more recent studies where scheme manager/warden services have been withdrawn, diminished or replaced with floating support (King, *et al*., 2008; Bristol Older People's Forum, 2010; HSP, 2011; Age UK, 2012).

Safety and security are frequently cited by residents in older studies as the most important benefits of living in sheltered housing.

The changing resident mix has also affected some residents' sense of security: Bristol Older People's Forum survey respondents described problems with noise and other anti-social behaviour from younger residents/guests with support needs linked to mental health and/or alcohol use. Frailer and older people may feel more vulnerable, like the resident in a Sheltered Housing UK blog:

> This morning, I missed my morning call and overslept: Because the man next door, who is under the mental health act, makes noise at night to keep me awake, I sleep in the kitchen with the door closed and ear plugs in ... The Scheme Manageress tells me they were banging on my flat door and she phoned the Police and head office. The suggestion from head office was to get somebody to take my flat door off. As I feel unsafe at night, when I am sleeping with ear plugs in, I barricade my flat door, so it cannot be forced.
> – (http://worldofdifference.vodafone.co.uk/blogs/anne-ludlow [dated 20 April 2012]:

A **good living environment** is highly valued by older people with high support needs (Katz, *et al*., 2011). Having a home which is accessible, with storage space for equipment and medical supplies, and space for relatives to stay or partners sleeping separately makes a big difference to quality of life (Thomas Pocklington Trust, 2002). Those with high support needs may have few

opportunities to get out, so pleasant surroundings (e.g. windows with views, light, airy rooms, balconies) are important.

Space, garden views and birdsong

Mrs Burrows is 79, and has Parkinson's disease and has suffered two strokes, which resulted in falls and broken bones ... Her flat is accessible and she can keep it clean herself. It is adapted for easy movement with a walk-in shower plus equipment, such as an electric chair lifter which helps her get out of her own armchair, tap adjustments and wheeled trolley, supplied by social services. As a countrywoman, waking up in this light and airy flat with views of the garden and the sound of birds is very important to Mrs Burrows. "I have all I need here."

From Parkinson, P. and Pierpoint, D., 2000, p. 73

However, evidence suggests great variation in how far sheltered housing delivers these valued features. For example:

- Age UK (2012) raised concerns at the number of schemes which are badly designed or lack basic accessibility features.
- Croucher, *et al.* (2008) identified issues with lack of sufficient storage/ circulation space; few schemes had visual or tactile signage to help those with visual or cognitive impairments.
- The Elderly Accommodation Counsel (EAC, 2012b) found that 15% of respondents had inadequate natural light in their flats; only 62% had a good view.
- Dissatisfaction with repairs and maintenance, highlighted in a number of studies (e.g. Eastleigh, 2007; Croucher, *et al.*, 2008; Sussex Gerontology Network, 2008a), impacts more on disabled residents, who may need more help.

  The accommodation is much too small. ... They say, "When you're old you don't need so much space". I think older people need more space. It's what you've collected over the years and if you don't get around so well, you need the space.
  – Sheltered Housing tenant in Eastleigh, 2007, p. 35

We know that people with high support needs place considerable value on being able to **get out and about** (Katz, *et al.*, 2011). The position of the flat within the scheme, and the location in relation to shops, public transport and other facilities, makes a big difference (Taylor, *et al.*, 2009; EAC, 2012b).

Social well-being

In contrast to residential care, supported housing can afford older people with high support needs the privacy to conduct **personal relationships**. CORE data identified 14% of new lettings (medium support) being to two older adults living together; our major provider reports around one in five new lettings to couples in recent years. We found no research evidence on quality of life of partner carers in sheltered/retirement housing and what helps or hinders them.

There is more evidence on maintaining links with family and long-standing friends. Ball, *et al.* (2011) found many people had moved – sometimes long distances – to live in OORH near to family, friends and/or an area with a previous connection. Nearly half the sample felt contact with family and friends had improved since moving.

For those with high support needs, active relationships with family and friends tend to involve some degree of care and support, though England, *et al.* (2000) found considerable variation in the amount and type of support sheltered residents received from their relatives. Field, *et al.* (2005) concluded that sheltered housing tends to be most successful in promoting quality of life where residents 'can gain access to help from family members and/or access local services, and to some extent this will depend on the area in which they live and the reasons for the move' (p.116).

Sheltered housing can, as Percival (2001) points out 'raise social expectations'. There is evidence to suggest that, for most TSH and OORH residents, these expectations around **social interaction** with neighbours are met or even exceeded. In the EAC sample, 75% of residents agreed that their retirement housing scheme was a 'good place to make new friends'. An ERoSH survey (quoted in Anchor/ILC-UK, 2008) found that 90% of respondents reported a good network of friends within sheltered housing. England, *et al.* (2000) highlighted the benefits of simply meeting and greeting others and feeling part of a 'village' community.

However, there can be significant barriers for those with high support needs. A study of three schemes (Field, *et al.*, 2002) found that residents who were oldest (83+), depressed or with serious activity limitation were least likely to have made new friends since moving into sheltered housing. Barriers to participating in the life of the scheme and **cultural activities** in or nearby may include: fear of falling or being too far away from a toilet (England, *et al.*, 2000); mobility problems making it difficult to leave the flat and move around the scheme, especially where space standards and/or accessibility are poor (King, *et al.*, 2008). Ill health may mean frequent hospital appointments and limited availability, or simply days where residents do not 'feel up' to getting involved (Riseborough, 1996; TPAS, 2010).

Percival (2001) concluded that, although sheltered housing can help develop friendships and a sense of community, interactions with neighbours can have a mixed impact on well-being. The presence of older or less capable neighbours can 'offer the opportunity for favourable contrasts and comparisons' so people with high support needs (especially dementia) may be more at risk of experiencing discrimination from neighbours.

Improving integration for residents with high support needs

Awareness-raising initiatives may promote better understanding and integration. Moore (2009) describes a partnership approach between a sheltered scheme and the Alzheimer's Society. They found that 'Increasing the awareness of those who do not have dementia has released the voluntary capacity on schemes which often in the past had not generally been directed towards people with dementia' (p. 248).

Cliques, empty communal spaces and the lack of younger people may intensify the experience of loss and bereavement. A sheltered tenant interviewed in Thomas Pocklington Trust (2002) used a wheelchair: she could not get out very often to escape the eerily quiet atmosphere:

> "I sometimes feel that I'm going crazy, simply from the stillness of the place, do you know what I mean?"
> – p. 12

Katz, *et al*. (2011) identified how important **making a contribution** can be to older people with high support needs. In Blood and Pannell (2012) we found examples of residents who participated in inter-generational activities, timebanks, fundraising activities and mutual befriending projects.

Despite these initiatives, many schemes offer few structured opportunities to engage with the wider community; those with high support needs may find it harder to do this independently. Less than half the EAC (2012b) respondents felt they had lots of opportunities to go on outings, or 'felt part of the wider community'. Reductions in SP funding, support staff and funding for activities co-ordinators probably had an impact: HSP (2011) and King, *et al*. (2008) found some schemes with resident-run committees, but without staff support there is a risk that they peter out.

Overall, SP monitoring found that around a quarter of sheltered tenants received support to access informal learning opportunities, external groups and more general community links. Northern Ireland scheme managers interviewed by Taylor, *et al*. (2009) felt that their tenants' lives would be most enhanced by more social activities, better links with the wider community and better transport (particularly in rural areas).

Scheme location seems to make a difference: EAC found residents of rural schemes were more likely than those in cities to agree that they felt part of the wider community, though proximity to a bus stop and the frequency of services were also key factors (also found in Runnicles, 2006; Taylor, *et al*., 2009). There will be a greater impact for residents with high support needs, without their own transport and encountering barriers walking to and accessing public transport.

There may also be differences in type of urban location: Field, *et al*. (2005) found inner-city sheltered residents were more likely to rely on support from the community (due to the relative ease of accessing community-based groups and other resources); those in new town areas drew more on family support.

Interviews with residents in traditional sheltered housing found:

> a sense of being part of a community with reciprocal networks of help. These were often low level, fetching small amounts of shopping or 'popping in' but they were important to both parties. They helped maintain the appearance of still being able to manage ...
> – Parkinson and Pierpoint, 2000, p. 66

For those receiving domiciliary care, having a **good relationship with carers** is a significant determinant of quality of life (Katz, *et al*., 2011). We did not find much recent evidence on whether or how living in sheltered accommodation affects this relationship. England, *et al*. (2000) found that, although tenants, relatives and wardens were mostly positive about the care services available, '[i]ndividual carers varied in quality and changed a lot – tenants often did not know which individual would be coming' (p. 49). Wardens were monitoring standards of formal care, liaising with care agencies and working to obtain suitable care packages for tenants. They struggled with assumptions that they would fill in gaps if carers did not turn up or complete a task; and that sheltered tenants being discharged from hospital needed less formal care than others living independently.

Evidence from a number of sources (e.g. Branfield and Willis 2009; HSP, 2011; Age UK, 2012; Sheltered Housing UK research and blogs) suggested that, where warden services have been reduced or removed, gaps may be filled by no one, leaving those with high support needs without food or stranded in stairwells following hospital discharge.

6 DIVERSITY

This chapter explores the available evidence on diversity issues in supported housing for older people: numbers, experiences and good practice. The main sections cover black and minority ethnic older people, and lesbian gay and bisexual older people. The final section addresses other diversity issues.

Ethnicity

Quantitative findings

Overall, the ethnic mix in sheltered housing appears to broadly match that of the overall population. There are some specialist schemes.

Based on a 10% annual sample of Supporting People (SP) clients living in sheltered housing with a warden, 8.2% are from black and minority ethnic backgrounds, including minority ethnic white people ('White Irish' and 'White Other') and people of mixed background, but excluding the 'other/unknown' category.

Table 8: Ethnic breakdown of those living in 'sheltered housing with warden'

Ethnic category	2007/8 (%)	2008/9 (%)	2009/10 (%)	2010/11 (%)	Mean for 2007/11 (%)
White British	89.9	90.0	91.5	91.5	90.73
White Irish	2.5	2.6	2.4	2.4	2.49
White Other	2.0	1.8	1.6	1.7	1.78
Mixed	0.4	0.5	0.4	0.5	0.47
Asian/Asian British	1.9	1.7	1.6	1.5	1.66
Black/Black British	1.9	1.9	1.6	1.7	1.77
Other/unknown	1.5	1.5	0.9	0.6	1.10
Total BME (exc. Other)	8.7	8.5	7.6	7.8	8.18

Source: SP data collected by The Centre for Housing Research (CHR), University of St Andrews, on behalf of the Department for Communities and Local Government; data analysis by the CHR, University of St Andrews

There are some differences by age: BME people account for around 9% of 45–64 and 65–84 year olds, but just 5% of those aged 85 and over (excluding 2008/9: 9.7%). This reflects differences in the national population: the Office of National Statistics estimated that, in 2010, 8.3% of 65–84 year olds in England and Wales were from BME backgrounds, compared to 4.6% of those aged 85+ (our calculations, based on Falkingham, *et al*., 2010).

CORE data suggests that people from BME backgrounds (using the SP definitions above) made up 6.6% of those starting medium-support tenancies and 5.6% of low-support tenancies in 2010 and 2011. Compared with SP data, new tenants in sheltered or medium-support housing are less likely to be White Irish or Asian/Asian British, giving a lower average overall for BME residents.

Our large provider reports that 2.4% of existing sheltered tenants are known to be from Black and Asian backgrounds (although ethnicity is not known for 22% of tenants). There is evidence suggesting an increasing trend because 3.5% of new sheltered lettings were to BME people (in line with CORE data).

Given the concentration of BME populations in the major English conurbations (Lievesley, 2010), we were not surprised to find significant regional differences in the numbers of BME sheltered residents in the CORE data, although detailed breakdowns of non-white British categories were unavailable. OORH studies had no ethnicity profile data.

Table 9: Ethnic breakdown of those moving into housing with low/medium support 2010 and 2011

Ethnic category	Low support % of total	Medium support % of total
White British	92.4	92.2
White Irish	1.1	1.5
White Other	1.3	1.6
Mixed	0.4	0.5
Asian/Asian British	1.2	1.3
Black/Black British	1.5	1.7
Other/unknown	2.1	1.4
Total BME (exc. Other)	5.6	6.6

Source: CORE data, analysis by NPI and authors

Qualitative findings

BME populations in Northern Ireland and Scotland are relatively small (Lievesley, 2010). We found no evidence of the experience of older BME people living in supported housing in these countries, though professionals in the *Scottish Review* (Croucher, *et al*., 2008) highlighted the lack of services and information for these groups in Scotland.

BME older people can benefit from supported housing just like other older people can. Mainstream sheltered housing does not always recognise or cater for different cultural needs (Jones, 2008; Metcalfe, 2008), such as accessing places of worship, foods and dietary requirements, hairdressing, and social and cultural activities. However, there is advice and good practice, for example:

- scheme staff facilitating communication with family around the world;
- landlords granting permission for satellite dishes to access TV from country of origin;
- social activities such as dominoes and mah-jong as well as bingo (Parry and Thompson, 2005; Manthorpe, *et al*., 2010; Jones, 2012).

Where only small numbers of BME people live in a scheme, there is a risk of isolation or discrimination from other residents.

Where only small numbers of BME people live in a scheme, there is a risk of isolation or discrimination from other residents. Careful monitoring, sensitive management and good communication with family can help to prevent this (Manthorpe, *et al*., 2010).

> I think, with give and take, we seem to have reached a place where everybody is reasonably happy. It took us quite a while but we got there ... We have been through a whole series of issues of the fact that nobody here is used to living with Asian people. I think the place obviously suits her. She is happy here and it is home. It's the lack of all things Indian around her that she really misses.
> – Mrs Patel – daughter of a sheltered tenant interviewed by Manthorpe, *et al*., 2010, p. 36

In a diverse scheme, tensions can also arise *between* people from different equality groups: examples include a BME male resident who offended female staff and residents with his cultural beliefs about gender (Manthorpe, *et al*., 2010) and LGB sheltered tenants who felt uncomfortable with religious information on display in their scheme because they had experienced very negative reactions to their sexual orientation from some religious people (Phillips and Knocker, 2010).

Specialist provision for minority groups avoids these problems (Allwood, 2008) but may bring other challenges:

- The risks of insularity and isolation from the local community (Allwood, 2008) might make the scheme a target for racist/homophobic attack (a fear of respondents in Croucher, 2008).
- Specialist schemes are generally only viable in urban areas where there is a larger community of BME/LGB people: those outside of these areas would need to move, often considerable distances, to benefit from them (Manthorpe, *et al*., 2010).
- There can be challenges for the managers of specialist schemes within their home organisations or in dealings with partner organisations, as in the example on p. 46 (Allwood, 2008).
- It is difficult to set up specialist schemes using government funding, given the financial climate, political steer towards 'cohesion' and restrictions on SP funding for social/cultural activities (Jones, 2012).

EAC's HousingCare.org website identifies 'housing with support' schemes in England and Wales aiming to attract older people from a particular minority ethnic group: some are exclusively designated for that group but most are mixed; some may appear in more than one category. Table 10 shows how many schemes cater for particular ethnic groups.

Sexual orientation

There is no reliable data on sexual orientation. This has been collected for SP monitoring from April 2012 but numbers are extremely low and, as in other

settings (Creegan, *et al*., 2010), there are likely to be issues affecting data quality (e.g. staff not feeling confident to ask, or making assumptions; older people not understanding the question, or refusing to answer).

Table 10: Number of 'housing with support' schemes catering for specific ethnic groups

Ethnic group	Number of schemes
Asian	55
Jewish	36
African Caribbean	26
Chinese	19
Irish	8
Polish	5
Cypriot	4
Vietnamese	3
Somali	2

Source: EAC website, author analysis, August 2012

A number of studies (e.g. Hubbard and Rossington, 1995; ODS/Communities Scotland, 2005; Phillips and Knocker, 2010) have explored middle-aged and 'younger-old' LGB people's *perceptions* of supported housing. Recurring concerns include:

- homophobia from staff and neighbours: not feeling safe enough to be 'out';
- losing control of lifestyles and privacy: whether there will be sufficient support to continue accessing LGB social and cultural life;
- whether relationships will be accepted;
- whether the surviving partner will retain the tenancy if the other dies.

The literature includes a few case studies and quotes from LGB people living in sheltered housing. For example, Phillips and Knocker (2010) describe two cases of residents who experienced homophobic harassment within their schemes and struggled to elicit support from their housing providers to tackle this. Others talk about having to hide their sexual orientation and the impact on their quality of life:

> I'm not out where I live. [Someone] on the committee said "I don't care if they're blue, black ... as long as they are not homosexual." If I said I was gay, they'd be shocked and probably never talk to me again. There is still so much homophobia. I keep my mouth shut.
> – Angela, Sheltered housing tenant interviewed in Phillips and Knocker, 2010, p. 58

> There are a lot of people going back into the closet when they move into sheltered accommodation, because they don't feel able to tell people about who they choose to have as life partners. People take pictures off the wall, move books around, so that they don't have to out themselves.
> – Tina Wathern, Stonewall Housing: expert witness in Age UK, 2012, p. 41

There is, however, some evidence of advice and good practice (e.g. Parry and Thompson, 2005). A lesbian resident on Croucher's (2008) New Horizons focus group explained that the welcoming attitude of the scheme manager ("although she's straight, I knew she'd got lesbian friends") had been a key factor in her decision to move into the scheme. Anchor has taken a significant step towards, as Age Concern (2006) suggests, 'coming out' as a 'gay or lesbian friendly' organisation.

Support and guidance for tenants and staff

Anchor's LGBT group provides support and guidance to tenants and staff and acts as a sounding board on LGBT issues for the organisation.

It has 50 members, around two fifths of whom are staff who have received considerable personal support from older tenant members. The group has made its mark by helping develop specialist training for Anchor employees, which includes tutoring new recruits in the kind of language they should use to encourage tenants to open up about their sexuality.

Rowena McCarthy (a 68-year old lesbian sheltered tenant who chairs the group) said:

"For me, the most important thing is knowing that if I have a problem here, where I live, it will be dealt with," she says. "It feels safer now. But there's still a long way to go [in transforming residents' attitudes]."

Extracted from Rogers 'Out of the shadows', 24 February 2012

Gender and household formation

CORE data shows the sex of the 'household reference person (HRP)' (with similar numbers of male and female HRPs in low- and medium-supported housing). The large housing association has a ratio of around 60:40 women to men in sheltered housing.

Other diversity issues

This section briefly considers other diversity issues. Background papers for JRF's A Better Life programme are as relevant to supported housing as to housing with care, especially Blood (2010), Blood and Bamford (2010), Samsi and Manthorpe (2010) and King and Pannell (2010), all summarised in Garwood (2010).

Disability quantitative data was addressed in Chapters 3 and 5. We have found very little on good practice or the role of sheltered/retirement housing for people with other needs, except in Parry and Thompson (2005), which has sections on sensory impairment, dementia/mental illness, learning disability, older homeless people and alcohol/drug dependency (their terminologies).

There is also relevant literature on older homeless people (e.g. Blood, 2002). For example, in a longitudinal study of resettling older people who had been homeless, sheltered housing produced more successful outcomes (length of stay, quality of life) than other settings, though with a need for some additional support (Crane and Warnes, 2002).

7 WORKFORCE

This chapter explores specific questions on staff working with older people in supported housing, with a particular focus on residents with high (or increasing) support needs: partnership working, management and supervision, training and staff time.

Most older research concerns dedicated wardens/scheme managers in local authority and housing association sheltered schemes, although there is some old evidence on leasehold schemes (Rolfe, *et al.*, 1995). More recent research studies examine the reduction/withdrawal of scheme-based staff and moves to floating support staff, but there is limited evidence of what staff themselves felt. However, some studies have collected staff views (including England, *et al.*, 2000; Parkinson and Pierpoint, 2000; King, *et al.*, 2008; HSP, 2011), as do some conference and training reports (e.g. Thompson, 2001a,b).

There is also extensive training and good practice material, and organisations which promote good practice in the sector (including ERoSH and the Centre for Housing and Support). Some key publications are now rather old, so may not reflect recent changes in support services (e.g. Parry and Thompson, 2005).

What do we know about staff relationships and partnership working with other agencies?

Lack of clarity and unrealistic expectations about the role of scheme-based staff by relatives, professionals and residents emerges as a key finding over the past two decades. For example, Field, *et al.* (2002) found that wardens commented that expectations placed on them by those outside were often beyond their job description. In reports of two workshops with scheme staff and some residents (Thompson, 2001b, 2002) there are a number of 'grey areas' identified, especially around personal care tasks (similar to those identified in our parallel study Whose responsibility? for housing with care: Blood, *et al.*, 2012).

Foord, *et al.* (2004) highlights the 'vagueness of this pivotal relationship [i.e. between scheme manager and tenants]' (p. 129). England, *et al.* (2000)

found that few residents, relatives or professionals understood the care co-ordination role of Anchor's wardens:

> Most [wardens] enjoyed their care co-ordination role but they felt they lacked time, resources or authority ... Wardens thus had an uneasy relationship with formal carers, compounded by the tendency of hospitals and other official agencies to assume that part of a warden's role was to provide support when tenants were discharged from hospital.
> – pp. 36, 49

As discussed in Chapter 5, this can leave residents at risk but can also leave wardens overstretched.

The study by England, *et al*. was conducted more than twelve years ago. Age UK's inquiry (2012) suggests that things have not improved: resident panel members and expert witnesses also expressed concern about poor communication between housing managers, social services and health care providers, leading to problems, particularly around hospital discharge.

Is there evidence of support from managers for front-line staff?

We found little reference in research reports to the management of scheme-based or floating support staff, although good practice publications have much more on this topic (especially Parry and Thompson, 2005, also Thompson, 2001a,b and others).

Staff in a London borough wanted greater flexibility in managing their roles and their time (HSP, 2011). They felt that their managers liked them to deal with problems out of hours but would not take responsibility for giving formal permission to do so.

Allwood (2008) highlighted tensions between the manager of the specialist scheme for BME older people, and generic housing officers and managers who did not understand the rationale for separate provision and needed more training. The specialist scheme manager felt unsupported, explaining that: "The lack of understanding of the cultural things by others does make the job harder than it is and the job is hard enough" (p. 37).

The clearest recent information came from a sample Scottish inspection report. In Scotland, housing support services (including wardens/scheme managers) are regulated under the National Care Standards for Housing Support and inspected regularly by SCSWIS (Social Care and Social Work Inspection Scotland): these reports provide a rich seam of evidence which would repay further study.

A web search produced an example report (SCSWIS, 2012) which provides comprehensive information on staff management, recruitment, training and leadership at one provider. For example, managers are qualified to SVQ4, and some of the wardens and cleaners to SVQ2. Three tenant volunteers had received training to take part in future staff recruitment.

The quality and thoroughness of the inspection and the report can be gauged by the level of detail (for example, detailed checks on recruitment practice and induction training for recent staff appointments) and the following extract:

> One Warden we spoke to had a particular interest in trying to develop bereavement counselling for residents and staff. The discussion was in the context of the impact on other residents and staff when a long term resident dies. The service manager supported the staff member researching material and potential training organizations who might assist in helping the service develop appropriate responses to bereavement. The Warden told us their residents were like a little family and community and a death of a resident often had an impact on everyone one who lived and worked there.
> – p. 30 in section on leadership values

Is there sufficient opportunity for staff to acquire and maintain the skills they need?

Percival (2000) discusses the pivotal role of the scheme manager in influencing the social atmosphere and managing discord between tenants. Staff need to be both assertive and tactful (Garwood, 2008) and have adequate training and support so as to manage group dynamics (Bernard, *et al*., 2004).

Some evidence suggests differences between the skills providers are looking for and those valued by older people. One focus group of residents (HSP, 2011) thought their provider seemed to be recruiting 'a different kind of person – we're looking for caring people, now they are looking for a manager' and suggested the following attributes:

- empathy, good listener;
- 'prepared to go the extra mile';
- dedicated – not just 'doing a job';
- a 'people person';
- prepared to help.

However, we found no evidence of resident involvement in staff recruitment in our literature review and this echoes the findings in our *Whose responsibility?* study for housing with care. The exception is the Scottish report example below: user involvement is a requirement in Scotland. Yet service-user involvement in staff recruitment (especially frontline staff) has been common practice in all-age supported housing (e.g. for people with learning difficulties this dates back to the 1990s; see for example Townsley and Macadam, 1996).

Resident panel members on Age UK's inquiry into sheltered and retirement housing expressed concern about:

> the welfare, training, pay and conditions that many support workers face ... all support staff should have broad training to deal with situations that require an immediate care response ... staff are currently not allowed to carry out certain tasks as the result of health and safety requirements.
> – Age UK, 2012, p. 46

Gorton (2005, p. 5) comments on the need for training if sheltered housing is going to house:

> a less traditional client group [and] a need for developing training and awareness raising within the workforce. ... Scheme managers are not

> resettlement workers and if it is to work settling people with more complex needs into sheltered schemes then the support element does need to be taken seriously and specialist workers employed to do that.

Reports on skills and training for housing with care staff are relevant (and have some reference) to sheltered/supported/retirement housing scheme managers.

Samsi and Manthorpe (2010) discuss communication, decision-making and the need for training and support for staff working with people with communication support needs (e.g. because of stroke, sensory impairment or learning difficulty).

Manthorpe and Moriarty (2010) focus primarily on the social care workforce. They point out the difficulties in separating out housing-related support staff from other care and support staff, and identify an emerging 'housing support workforce' and the role they have in 'promoting independence' rather than providing personal care.

Do staff have the time and opportunity to support and build good relationships with residents?

Most older research studies comment on the best staff working beyond their job description and contracted hours.

A recurring theme with the change from the 'good neighbour' to the more professionalised 'manager' is that more time is spent on administration. King, *et al.* (2008, p. 49) quote the explanation given at a tenant consultation meeting by their scheme manager:

A recurring theme with the change from the 'good neighbour' to the more professionalised 'manager' is that more time is spent on administration.

> When we were wardens, we did have a lot more to do with tenants and were more of a good neighbour as such, but now as managers we are having to spend a lot more time in the office and less time out on the [scheme]. 80% of our working life is now administration, we are still here as a support for tenants and will help with things such as filling out forms, getting in touch with external agencies if your care needs change and we will still call you every morning.

The Scottish study (Croucher, *et al.*, 2008) found that wardens (especially in larger schemes) felt stretched, particularly when significant numbers of residents were frail or unwell. Frew's (2006) pilot evaluation of changing to floating support questions whether the new floating support worker would have sufficient time for sheltered scheme residents with an assessed support need as well as visiting/supporting older people in the neighbourhood.

These concerns have been picked up by Age UK's resident panel, who were 'worried by the practical barriers placed on support workers ... such as a lack of parking space and insufficient time allotted to residents' (Age UK, 2012, p. 46). The panel were also concerned that 'assistive technology is being used as an excuse to reduce human contact with housing support and care workers'; this was also picked up by expert witness Domini Gunn from the Chartered Institute of Housing: 'There is increasing interest in the contribution of telecare and telehealth ... but there is a balance to be struck. We need to ensure that we also provide human contact and prevent social isolation' (Age UK, 2012, p. 49).

In a staff focus group (HSP, 2011), most staff expressed frustration about insufficient time to support tenants effectively. Covering up to five different sheltered schemes in a day, they felt the service was stretched, and they had to 'knock and run' when checking on residents.

8 AFFORDABILITY

This chapter outlines what we know about the cost of sheltered and private retirement housing for older people, especially affordability for people with high or increasing support needs, who may need to fund their own care.

We draw especially on two sources:

- a recent study by the New Policy Institute (NPI) for JRF and Age UK (Aldridge, *et al* , 2012 , which analyses the affordability of retirement housing for people of state pension age in the UK, referred to as the *NPI Affordability study*;
- the comprehensive review of sheltered/older people's housing in Scotland (Croucher, *et al*., 2008) referred to as the *Scottish Review*.

The chapter is arranged under the following headings:

- definitions of costs;
- costs in social rented housing;
- costs of private retirement housing;
- state help with costs;
- resident/self-funder views on housing-related costs;
- issues concerning care costs.

We draw together the implications (especially for older people with high or increasing care needs) in our final chapter.

Definitions of costs

Retirement housing has a wider range of costs than much mainstream housing. The *NPI Affordability study* identifies these as purchase costs (owner-occupiers) and three categories of ongoing costs:

- housing costs (including rent, service charge, sometimes ground rent for leaseholders);

- housing-related support costs (as discussed in Chapter 2 on Supporting People, e.g. scheme manager, community alarm service);
- care costs for those who need personal care.

Even in social rented housing, tenants may need to spend their own money on the property: for example, the *Scottish Review* found tenants had spent up to £7,000 to bring their sheltered housing flats up to a decent standard.

Costs in social rented housing

The *Scottish Review* found it impossible to provide a 'definitive' cost for sheltered housing because of the great variation by area, provider and scheme.

The *NPI Affordability* study analysed CORE data for new lettings: average weekly total costs for housing with support were £97 (rent £65, service charge £22, support charge £10). The lower quartile average figures were £75 total (£60/£10/£5), and the higher quartile £120 total (£75/£30/£15).

Costs of leasehold/private retirement housing

The *NPI Affordability* study's online survey (RightMove and EAC housing directory) found typical prices for resale retirement dwellings in England between £80,000 (North) and £110,000 (South East); Scotland and Wales averaged £85,000, but with large variations within regions/countries. New developments and more upmarket schemes can be (much) more expensive; there is very little retirement housing for sale in Northern Ireland (Aldridge, *et al*., 2012).

For ongoing charges, there is no equivalent to CORE data: the *NPI Affordability study* estimated service/support charges at the upper CORE ranges above (£32–£45 per week or £140–£200 per month). A major private provider contacted for this study quoted typical service/support charges of £30–£40 per week and ground rents (where applicable) of £8–£9 a week (i.e. total costs £30–£49 per week or £130–£212 per month).

Owner-occupiers in retirement housing may also have to pay into a major repairs fund (in the service charge, and/or as an 'exit fee' when the property is sold). This is not eligible for state help through the housing cost element of Pension Credit (see below).

We found evidence of resident concerns about increasing service charges (e.g. SERFA, 2010; Age UK, 2010, 2012; Pannell, Aldridge and Kenway, 2012) also reflected in Channel 4 *Dispatches* (24 September 2012).

The Association of Retirement Housing Managers expert witness Debbie Matusevicius told the Age UK resident-led inquiry:

> "From a management point of view ... [the charge] has got to cover the cost of the services. They can't always control the external costs – for instance, gardening, window cleaning. They might go up at a different rate to pensions. So there needs to be a careful balancing act to get it right. I would like to see absolute transparency, when someone is purchasing a leasehold property. Does the sales literature give all the information in the purchaser's information pack? Is it absolutely transparent so you can see what the service charge is? What might I pay to the sinking fund, when I move out of the property?"
> – Age UK, 2012, p. 25

Retirement leaseholders have the right to change managing agents (or self-manage): in 2005, Parry and Thompson found that none had yet done so, but Blood and Pannell (2012) spoke to one agent who had ten Right to Manage (RTM) schemes. We found no data on the number of private leasehold schemes which had exercised their right to manage.

Age UK's inquiry panel members included leaseholders who had used the RTM. The inquiry recommended more promotion, advice and support for residents interested in using RTM, because it can help tackle problems with overcharging by poor managing agents and result in substantial savings. However, RTM is easier where there are residents with managerial or financial experience (Age UK, 2012).

We conclude that residents with high support needs (because of age/disability/ill health) are unlikely to be able to follow the RTM route, unless there are younger and/or fitter residents to take on this role.

Both the *NPI Affordability study* and the *Scottish Review* point out that self-funders, especially former owner-occupiers with no mortgage, are likely to find charges for sheltered/retirement housing very high compared to previous housing costs.

State help with costs

The *NPI Affordability study* provides a detailed examination of state help for pensioners (summarised in Table 11 below), because this is crucial when discussing affordability.

Table 11: Benefit entitlement and conditions for housing, care and support costs

Tenure	Aspect	Mortgage interest/ ground rent/ rent	Service charges	Housing-related support costs	Care costs[i]
Owner-occupier	Policy/ benefit	Guarantee credit	Guarantee credit	Supporting People	Fairer charging (England)
	Conditions	Means-tested, tapered	Means-tested, tapered	Means and 'tenure' tested, capital limit	Means-tested, capital limit
	Scope	For mortgage interest/ ground rent	Partial coverage[ii]	No help (mostly)[iii]	Variable
Social renting	Policy/ benefit	Housing benefit	Housing benefit	Supporting People	Fairer charging (England)
	Conditions	Means-tested, tapered	Means-tested, tapered	Means and 'tenure' tested, capital limit	Means-tested, capital limit
	Scope	For rent	Partial/full coverage	Some/full help	Variable

[i] Care costs refer to England and Northern Ireland (variation by UK country is discussed in the NPI full report). All other costs in principle apply across the UK. State help with care costs is limited to the cost of meeting local authority assessed level of need, which varies by LA, severity of need and services required.

[ii] There is a wide variation in what aspects of service charge are covered by guarantee credit.

[iii] In practice, few leaseholders get any financial help through the local authority (Supporting People) and increasingly social renters are having to contribute.

Source: NPI

The study concludes that:

- The guarantee element of pension credit and other state help provides a minimum income for pensioners after housing costs – creating an income floor. As such, pensioners should be able to live in retirement housing with a remaining income at or above this floor.
- Middle income pensioners not entitled to state help are liable to spend the most on retirement housing as a proportion of their income. But the nature of state help ensures that their remaining income is not lower than pensioners receiving means-tested benefits.
- Pensioners may find that some of the costs in retirement housing are not eligible for state help, typically because of their level of savings, their tenure or the way that the cost is classified.
- Pensioners with more than £23,250 in savings will have to pay their care cost in full regardless of their income. If care costs are high enough, even the wealthiest pensioners would have to spend their savings to meet them.
- Owner-occupiers and private tenants often do not get help with the small but numerous costs incurred in retirement housing that that are covered for most social tenants.

Resident and self-funder views on housing-related costs

In the *Scottish Review* survey, only 7.5% of respondents felt their scheme was *not* good value for money (usually because of high charges, reduced warden service, size of flats). While 60% of council tenants felt the rent was reasonable, less than half of private sector residents thought their service charges were reasonable.

> "Last year, our amenity charge, which is supposed to pay for all these facilities, went up from £27 a week to £45 a week, on top of our rent of £54. Now when we complained they said the rent's reasonable, we're not talking about the rent we're talking about the amenity charge. Now for that to go up by that amount in one year when you're on a fixed income is just devastating. ... It's supposed to pay for the secure system on the external door, for the alarm system, which is a cord that you pull in any of the rooms. If you have a fall and you can't reach your cord, tough."
> – Branfield and Willis, 2009, quote from sheltered housing tenant, pp. 48–9

Research for Hanover (2010, p. 3) found 'increasing concerns about the lack of control [sheltered housing] residents have over services and costs (which are typically decided by the provider).'

Research for Hanover found 'increasing concerns about the lack of control residents have over services and costs'.

Issues concerning care costs

Pleace (2011) includes discussion and detailed estimates of the cost to the state in Scotland of providing personal care to residents in sheltered housing compared with other settings (own home, extra care housing and residential care). As elsewhere in the UK, he points out that:

> poorer people in Scotland will tend to experience debilitating physical illness earlier on in their retirement than more affluent people and are likely to live shorter lives. However, all people generally experience an ongoing deterioration in physical health as they age, i.e. any group of people are likely to be less well at 75 than they were at 65.
> – p. 3

A study of the role of relatives in supporting tenants in Anchor sheltered housing found that 'both tenants and relatives did not always understand formal care arrangements: how the costs of care had been arrived at; whether or not payment was means-tested; how formal care was obtained; who was eligible and what criteria had to be fulfilled to qualify for it.' It suggests that at least some of the tenants described as 'very resistant to receiving care and where the relations themselves were finding it very difficult to manage' either couldn't afford to pay or were reluctant to pay (England, *et al*., 2000, p. 50). This is likely to remain true today: it is echoed in recent research on self-funders of care in the wider community (Henwood and Hudson, 2009; ILC-UK, 2011; EHRC, 2011; NAO, 2011).

9 REFLECTIONS AND CONCLUSIONS

Here we present our final reflections on the evidence base: what interested, surprised or disappointed us; what was confirmed or challenged; and what was not covered at all, recently or in sufficient detail – the gaps. We conclude with ideas on whether or not 'housing with support for older people' provides a good quality of life for those with high support needs.

Changes to residents in sheltered housing

We were aware of concerns about a perceived change to resident characteristics. We were surprised at the strength of the evidence from CORE data which confirmed the number of people under pension age moving into social rented housing, including for reasons other than needing support. We were also aware of concerns from some existing residents about the range of needs, including mental health and substance misuse. The suggestion that overall there are lots of new residents with such support needs was not confirmed, although there is some evidence of an increase in people receiving support, which may reflect improvements in the identification and response to these types of support needs rather than necessarily an increase in the size of this group.

The lack of comprehensive data

Quantitative data

We were disappointed that we could not find better quantitative data that covered housing, care and support holistically: the data reflects the silos that affect the sector. Some providers do have data but it was difficult to access this in the time available and there can be sensitivities about sharing some data.

Unfortunately, some of the best published data is now too old (e.g. from the Housing Corporation on the quality of the sheltered housing stock). Although we know that some providers and local authorities have reviewed their sheltered housing and taken strategic decisions to re-designate, upgrade or demolish, reports are not always available. The same applies to changes to warden/scheme manager services: although many reviews have taken place, it would need a longer research project to gather such evidence together.

We found less statistical data from Wales, Northern Ireland and the private owner-occupied sector; and a lack in some areas (CORE, Supporting People) for Scotland; again, a longer project would have enabled more investigation.

Qualitative data

There was better qualitative data in some areas than others (e.g. the Scottish SCSWIS inspection reports; the Age UK, 2012 inquiry) but, overall, the most thorough research was very old.

Comparisons between residents living in sheltered/ retirement housing and housing with care

We were interested to see how these groups of residents compared, especially in terms of age/ disability/support needs, not least because of the much greater staffing presence in housing with care. There is scope for more in-depth analysis, but our initial trawl through Supporting People (SP) data suggests higher *numbers* of very old residents in sheltered housing, with relatively high levels of disability, although lower *percentages* than in housing with care.

Contrasts between owner-occupied and social rented housing

We were interested that owner-occupied retirement housing (OORH) has remained relatively similar since the 1990s (e.g. resident ages and support needs, scheme-based staff) whereas social rented housing has changed greatly. This is an area that would repay further investigation: is there greater satisfaction and better quality of life if the community is relatively similar? What does this say about equality and diversity – and the role of staff in building community cohesion?

Changes to the warden/scheme manager service

We were of course already aware that this has been a major issue in social rented housing, not least from conducting focus groups with residents for '*Nobody's Listening*' and attending the recent Age UK inquiry, and this was confirmed by some evidence. We were surprised at the different definitions, and lack of commitment to an on-site service, where 'access' to support can be as little as signposting.

Originally the warden role was described as being a 'good neighbour'. By the 1980s/90s, this was developing into a multi-faceted role (Parry and Thompson, 2005), although some of the evidence for the importance of this to residents only comes from schemes where this has been lost! Here

we reflect on how aspects of the role might be particularly important for residents with high support needs:

- individualised support to residents as needed (perhaps especially important to those with high support needs, ideally in partnership with other support/care if needed);
- 'enabler' – including (as discussed in England, *et al*., 2000) a care management role for residents with high support/care needs, similar to the 'ringmaster' discussion (in *Whose responsibility?* for housing with care);
- facilitator of social activities (the lead may come from a resident committee or the warden/scheme manager); scheme-based social activities are likely to be more important to residents with high support needs who find it more difficult to access outside facilities (e.g. because of mobility problems, sensory impairment, dementia);
- community development, including welcoming and involving new residents (especially those with higher support needs because of factors such as disability, sensory impairment and diversity factors, as described in examples in earlier chapters);
- mediation and managing minor disputes (e.g. use of laundry room, interpersonal tensions, challenging racist, homophobic and 'disablist' attitudes), which may be more likely with a wider resident mix;
- housing management, especially valued by residents because of acting as a 'go-between' for minor but annoying problems (e.g. delays in getting repairs done by landlord). This can be especially helpful to residents with high support needs (especially if they have no involved relative to support them), or those with communication difficulties (e.g. visual or hearing impairment, English as a second language, illiteracy); however, housing management duties may mean more time on office administration and less time with residents;
- monitoring performance and allowing access to outside contractors, especially cleaners (communal areas), gardeners and maintenance contractors.

The introduction of SP in 2003 changed this because the focus was on the support needs of *individual residents*, and not the needs of the *resident community*.

Gaps in the evidence base

We identified the following gaps, suggesting the need for research to:

- explore what effect changes to warden/scheme manager/support services in social rented sheltered housing are having on residents (especially those with high support needs);
- confirm or challenge anecdotal evidence on the impact of changes to the resident 'mix' of tenant profiles in sheltered housing (including residents under pension age; residents with a wider range of support needs; residents who are very old, frail or with high care needs);
- explore the role of owner-occupied retirement housing and resident views, to include a number of different developers and managers from both private and not-for-profit sectors;
- examine the growth of retirement housing for private rent, and private leaseholders' use of the Right to Manage;

- discuss and clarify the current 'offer' of different models, costs and tenures.

Who is sheltered/retirement housing for? Does this include people with high support needs?

There is a real issue here – as the Age UK inquiry (2012) says, with no staff presence, it's just 'housing where older people happen to live'.

Where people with high support needs around mental health problems or alcohol are moving in, that raises different issues from those of very frail old people (such as the example in Chapter 5, where someone had been discharged from hospital at a weekend with no food).

In sheltered and retirement housing (as in housing with care) there is an idea of residents getting and giving mutual support – but what needs to happen for that to work?

Is even the term 'supported housing' misleading? It isn't the *housing* that is supported any more, but (with floating support) just some of the residents who have an individual assessed support need.

There is significant evidence in earlier research on the importance of a scheme-based staff presence, largely retained in OORH. Even if not important before moving in, it became so later, for residents and also for relatives (England, *et al.*, 2000; and HSP, 2011 interviews with family members).

In conclusion, sheltered or retirement housing is likely to be suitable for older people with a wide range of high support needs as long as:

- the scheme as a whole (individual dwelling and communal areas) meets their needs in terms of location, accessibility, facilities, design and space standards (depending on the disability or support need);
- there is sufficient scheme-based staff presence to support not only individual residents but also the resident community, as discussed above;
- there is an appropriate level of individualised support/care to meet individual needs, from scheme-based and/or floating support staff and (as needed) specialist support/care (e.g. personal, mental health, substance misuse).

And we end with the Age UK inquiry which summarises the key issues:

> ... there is no clear national vision or leadership on the future of sheltered and retirement housing. This is exacerbated by uncertainty around funding for preventive care and support services ... During the inquiry it became apparent that there is a great deal of confusion over what sheltered and retirement housing is meant to offer. This lack of clarity is important, as a partial understanding of sheltered and retirement housing by policy makers will continue to result in poor policy decisions.
> – Age UK, 2012, p. 4

NOTES

1 Other major providers were unable to supply information within our timeframe.

2 The increase of 3 percentage points over four years is significant, with a confidence interval of 2.3 to 3.7. Confidence intervals are calculated on data samples to show the accuracy of the results. Wider intervals indicate less certainty.

3 The increases of 2.3 and 0.4 percentage points over four years are significant, with confidence intervals of 1.6 to 2.8, and 0.1 to 0.6.

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ABOUT THE AUTHORS

Jenny Pannell is an independent researcher working with Imogen Blood, Housing & Support Partnership and New Policy Institute. Her research interests focus on older people's housing, care and support, and especially on resident perspectives and choice. Jenny was previously a senior housing manager and Visiting Research Fellow at the University of the West of England, Bristol.

Imogen Blood is a freelance consultant working across the public and not-for-profit sectors to improve effectiveness and promote equality, with a particular interest in older people. Her background is in social work, research and evaluation, and equality and diversity training and consultancy.

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