

insights

evidence summaries to support
social services in Scotland

extending the housing options for older people: focus on extra care

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May 2014

written by

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Key points

- Extra care housing offers an additional housing option for older people which is particularly relevant to the Scottish policy agenda of Reshaping Care for Older People.
- Extra care provision is diverse: key elements are self-contained accommodation, support accessible 24 hours, some collective meal provision and a range of leisure and other facilities on site. A range of tenure options can be offered.
- Most of the research evidence to date derives from schemes in England where government funding has promoted greater development of extra care.
- People are motivated to move to extra care housing for physical and emotional security, availability of support and an accessible environment and social contact. These requirements all tend to be met – ‘autonomy with security’. People valued the opportunities for friendship and social interaction.
- Inclusive design and sensitive management are essential for supporting people with dementia within extra care.
- In terms of affordability of extra care for the individual, there is a complex interaction across factors such as prior equity, tenure, benefit eligibility, support costs and savings.
- Good partnership working embracing health, housing and social care across statutory and independent agencies is critical to the planning and funding of developments.

“It could be argued that extra care housing is the embodiment of many of the core principles of current social care policy ... prevention, personalisation, partnership, plurality and protection” (Bäumker et al, 2011:524)

Introduction

Ideally, as promoted by *Reshaping Care for Older People*, older people should be supported to remain in their existing home with the provision of care and support as required; but for some this is not possible and others may wish to choose an alternative. This *Insight* seeks to explore the evidence base in respect of housing with care and support, in particular extra care provision, and the extent to which the range of models embraced by this term provide an effective alternative to residential and nursing care. The aim is to offer a greater range of housing options for older people and to promote a continuum of provision between home and care home. Some will welcome this model; for others it would not be their choice; and yet others may wish to explore alternatives such as cohousing (Brenton, 2013).

IRISS *Insights* aim to provide accessible summaries of the available evidence on a range of policy and practice issues. It should be noted that much of the published research for extra care housing has been based on work in England; it is hoped that the detail provided here will contribute to the ongoing debate and practice development that is taking place in Scotland.

Defining the scope

Given the multiplicity of definitions, it is important to clarify the focus of this *Insight*. ‘Extra care’ is being used to refer to housing developments that offer self-contained accommodation units, support accessible 24 hours, some collective meal provision and a range of leisure and other facilities on site. The focus is on maintaining independence, privacy and choice, with the provision as appropriate of person-centred care and support (Garwood, 2010). A distinction is often made between larger extra care developments over 100 units, often referred to as retirement villages, and smaller schemes, typically around 40 units. Retirement villages tend to seek a spread of ages and dependencies, encouraging people to move in before any specific need for support. Developments are not necessarily new-build; Whitebeck Court in Manchester is an example of refurbishment of a high-rise block to provide 91 rented apartments with support, access if required to a linked day centre – and a residents’ lounge on the roof.

Extra care housing can offer a range of tenure options: rented accommodation, owner occupation and shared ownership. Tenants and owners have security of tenure and the associated legal rights. Early developments tended to be single tenure; more recently mixed tenures have featured. Financial models and the contributions of different partners are an essential element of the configuration. Westbury Fields, developed by the St Monica Trust in Bristol in 2003 (Evans and Means, 2007), was one of the first mixed tenure developments, although planning restrictions led to physical separation of different components within the site which led to characterisation of ‘that lot up there and us down here’ (Evans, 2009). Subsequent developments by the Trust (eg Monica Wills House, Bedminster) have been more integrated, while the Hartfields scheme in Hartlepool (Croucher and Bevan, 2010) epitomises an integrated mixed tenure village of 242 units. Developed by the Joseph Rowntree Housing Trust, it is the product of close partnership working with the local authority and health trusts and involvement of older people’s organisations. No distinction is made between direct care and housing related support in the provision of services and service contracts focus on outcomes for the individual.

Scotland has seen fewer developments of extra care options than south of the Border. Exceptions include Cowan Court, Penicuik developed by Midlothian Council, Dovecot Court provided by Eildon Housing in the Borders and Elizabeth Maginnis Court developed by Dunedin Canmore HA in Edinburgh. For a number of providers the interest — and challenge — is in the transformation from earlier models of sheltered housing (Croucher et al, 2008). Developments in Scotland tend to be smaller in scale. Only Auchlochan and Inchmarlo would be cited as examples of the retirement village model, the latter solely for owner occupation.

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Policy context

There has been less policy emphasis in Scotland on extra care provision to date, although there have been moves to provide for increasing needs in more traditional supported housing (CIH and JIT, 2013). The Older People's Housing Strategy, *Age, Home and Community* (Scottish Government, 2011) offers encouragement (although little detail).

7.18 We are keen to encourage the development of new and innovative models of housing that enable older people to maintain their independence in the community ... New build housing with care and support often offers services to the wider community, expanding the provision of preventative support and building social networks ... Retirement villages can also provide another option for older people, who wish to live in a community setting with support and care available on site.

In England extra care development has been stimulated through the Department of Health's Extra Care Housing Fund which between 2004 and 2010 provided £227m capital funding to local authorities and housing associations to encourage innovative schemes and partnerships. Several evaluations outlined below feature developments under this funding; a detailed evaluation of the overall initiative has been completed by PSSRU (Darton et al, 2011; Netten et al, 2011).

The recent report from the Task Force on the Future of Residential Care in Scotland (Scottish Government, 2014) offers an enhanced profile for extra care. Three types of accommodation are prioritised: 'an evolution and expansion of the extra-care housing sector; a residential sector focused on rehabilitation and prevention (step-down/step-up care); and a smaller, more specialised sector focused on delivering high quality 24-hour care for people with substantial care needs' (p16). A further suggestion is that 'in some areas, single facilities or hubs might provide all of these service types' (p80). A range of associated recommendations address a number of key issues including: the need for a more integrated planning framework; maximum involvement of families and communities through co-production and co-location; recognition of the diverse preferences amongst older people; future proofing of new initiatives; imaginative joint commissioning strategies; and integration of regulatory frameworks.

Underpinning many recent policy initiatives is a focus on the individual, on their exercise of choice and the promotion of their independence. The implementation of self-directed support gives particular resonance to expanding the ways in which older people access support; indeed the Task Force acknowledges that housing-based models are likely to offer the greatest opportunities for personalisation.

The contribution of housing to the achievement of health and well-being also requires greater emphasis, for example in the delivery of the 2010 Healthcare Quality Strategy for NHS Scotland through the 2020 Vision for Health and Social Care.

Location

The physical location of extra care schemes is important, with good access to local facilities and transport links both for residents and visitors. Some larger developments enhance interaction with their local community by offering facilities such as café, beauty spa, shop, pub or meeting place. A number of schemes offer in effect a ‘village street’, a particular feature of developments of the ExtraCare Charitable Trust. There can be mixed responses from residents to local people coming into their scheme; a number of providers have adopted a progressive privacy model, communal areas open to the public but restricted access to areas of living accommodation. Although fences or security barriers may enhance feelings of safety, they can also be perceived as a barrier to wider interaction, a tension expressed by residents at Westbury Fields (Evans and Means, 2007).

Community engagement can be enhanced through provision on site of support facilities such as a health centre. Rowanberries, a purpose built 46 unit mixed tenure scheme in Bradford developed

by Adult Services and the Methodist Homes Housing Association incorporates a day centre, while a domiciliary care team provides outreach, including reablement and rehabilitation, to the local community. At Hartfields a GP surgery has been included, staff from the local authority and the health trust have been co-located on the site, promoting a health and well-being agenda across the neighbourhood, and a day centre has been relocated to the development and reconfigured as an intermediate care service. Intergenerational contact can be nurtured through for example a nursery on site, while the ‘Abundant Life’ proposal for Dartington (<http://www.dartington.org/abundant-life>) seeks to reinstate a range of small businesses as part of the development.

Support arrangements

Access to on-site support on a 24 hour basis is one of the defining elements of extra care housing. The configuration and provision of this support can vary. In some developments there is a single provider of housing and support, in others distinct housing and support providers, and in some the option for individuals to arrange their own provider for routine support. Moreover catering, leisure facilities and other options such as transport may involve additional providers. A range of other professionals, for example health, social services and welfare benefits, also play a role.

The support arrangements in larger extra care ‘villages’ are often based on assumptions about the dependency mix. The ExtraCare Charitable Trust development at Berryhill evaluated by Bernard and colleagues (2007) identified four levels of support, ranging from minimal support of two or three calls a week (Level 1) to intensive support every three of four hours (Level 4).

Blood, Pannell and Copeman (2012) have explored in detail some of the complexities of commissioning in housing with support and the issues that arise in respect of boundaries of roles and responsibilities. They cite the importance of clarity for all parties and stress the importance of strong and detailed partnership agreements. Examples are highlighted of the difficulties that can develop in their absence: these range from key decisions such as pressure to move on at the end of life, through isolation of minority groups (including males) and the need to manage nomination rights to ensure resident mix, to more local concerns such as disputes over parking spaces. Drawing on these and other examples, the authors highlight four cross-cutting themes: regulation, complaints and user consultation and involvement; rights, mediation and advocacy; equality and diversity; and costs and affordability.

The development of Hartfields as traced by Croucher and Bevan (2010) highlights the importance of the Hartlepool Extra Care Partnership Committee. It details the arrangements at a number

of critical stages: design and site procurement; designing for a wider community; care and support services; financial models; allocation policy; marketing; and management arrangements.

‘It’s just the idea of a place for the rest of your life. When you are getting on a bit, this can adapt. So there’s care. But if you don’t need it, then you don’t need it.’ (Hartfields resident)

Quality of life

A number of studies have explored the experiences of those living in extra care housing and the triggers for their move (Croucher et al, 2003; Bernard et al, 2004; 2007; Evans and Means, 2007). Callaghan and colleagues (2009) describe what they term ‘the development of social well-being’ over the initial twelve months in 15 new-build schemes, 13 smaller (35–64 units) and two village-style (258 and 270 units). Their term embraced social relationships, social participation, social networks and social support. Residents valued the combination of independence, security and opportunities for social interaction. Two-thirds indicated they had a good quality of life; 90% had made friends since moving; 85% did not feel lonely; 75% felt fully occupied with activities of their choice; and 70% took part in an activity at least once or twice a week. The small minority who felt more isolated or lonely tended also to be in receipt of care services, to rate their

health as worse, were less likely to be married and more likely to be living in a smaller scheme.

Across these studies a number of recurring aspects are particularly valued:

- The independence and choice afforded by the model of provision
- The feeling of safety and security, both physical security and the knowledge that help is at hand
- The opportunity for social interaction around communal facilities such as restaurants and shops
- The friendship and stimulation provided by social activities and events; in some schemes these were developed by an activities coordinator or scheme manager, in others the preference was for these to be organised and led by residents

Successive surveys of residents of extra care schemes record high levels of satisfaction. Initial motivations for moving – physical and emotional security, availability of support and an accessible environment, social contact – all tend to be satisfied. In a nutshell extra care offers ‘autonomy with security’. Nonetheless, a minority report disappointment at finding the community ‘less vibrant’ than they hoped (Blood, 2013) or report difficulty in fitting in; moreover individual

preferences for wider engagement vary and some prefer to ‘keep to themselves’. Matching expectations to the nature of the provision is important.

The mix of residents with differing support needs can impact on the atmosphere and sense of community of extra care provision. More active residents may resent those who need higher levels of support or are perceived as ‘difficult’; those experiencing particular challenges, for example incontinence, may start to withdraw. Percival (in Garwood, 2010) characterises this as the challenge of the ‘fit and frail’. King and Pannell (2010) highlight a range of groups where there needs to be particular attention to provide for specific needs and to promote integration. These include older people with learning disabilities, people of different ethnicities, and people with capacity or communication limitations. Bernard and colleagues (2007) suggest that large schemes may be challenging for those with complex conditions or affective mental health issues such as anxiety or depression. Carr and Ross (2013) highlight hostility experienced by LGBT individuals and couples in extra care housing.

Provision for dementia

The extent to which extra care housing can support those with dementia as it progresses is a critical test. The distillation of the key findings from the literature of the previous decade by Dutton (2009) suggests a number of factors impacting on whether the concept of a 'home for life' can be sustained. These include the ability to work with and minimise 'challenging behaviours' and to provide enhanced and flexible support; the availability of community nursing services; the dependency mix; the willingness of funders to pay for increasing levels of support; and the choices and preferences of individuals and their families. Evidence suggests that common features such as incontinence, anger and distress can be effectively managed; more complex can be disruptive or disconcerting behaviours.

The support of other residents can be a critical factor. Evidence from Hartrigg Oaks (JRF, 2006) suggests greater tolerance for those who have 'aged in place' rather than moved in with their dementia already developed. There is evidence and agreement that people whose dementia is already advanced should not move to extra care housing. Darton and Callaghan (2009) confirm from the findings specific to dementia in the PSSRU evaluation that the preference is for individuals to move in when they can become familiar with

their new accommodation before any cognitive impairment has become more severe.

Positive quality of life outcomes for people with dementia are particularly associated with attention to dignity and engagement; individualised activities and experiences (witness the Enriched Opportunities Programme described by Brooker et al, 2009); effective communication (for example using Talking Mats); meaningful relationships and interactions; freedom from pain and discomfort; and access as required to health care and palliative care. The availability of specialist dementia expertise and staff training, simple and robust assistive technology, strong management and leadership and empowered staff, procedures to address specific behaviours, and strong partnership working and integrated health, housing and social care strategies are all shown to contribute to achieving these outcomes.

“There is evidence and agreement that people whose dementia is already advanced should not move to extra care housing.”

A three-year longitudinal study tracked 103 people with dementia in six extra care housing schemes through in-depth interviews (Vallely et al, 2006; Evans et al, 2007). People spoke of the aspects of independence they valued:

- The freedom to come and go within and beyond the housing schemes
- Maximising opportunities to 'do things' for themselves
- Having choices about how to spend time

Family and friends often provided invaluable support; 60% of those still resident at the end of the study had received this additional support in the previous month. This study highlighted the fine balance between maintaining the privacy afforded by independent units and experiencing isolation.

A range of initiatives has been developed to enable those with dementia to be supported within extra care housing. 'Locksmiths' are key workers dedicated to people with dementia or other significant mental health issues; they work with the individual to identify their interests and enable them to enjoy them within the development and the wider area (Croucher and Bevan, 2012). Other schemes have provided activity coordinators; some may have day care provision on site.

An important consideration is support for the small proportion of individuals for whom remaining in their self-contained accommodation may no longer be practical. One solution is the provision of a small specialist dementia unit within a development. This offers major advantages when the person with dementia lives with a partner; rather than moving to a care home off site they remain within the same complex and in a familiar environment.

Design

Consideration of provision for individuals with dementia often focuses on aspects of design, but dementia-friendly design should be common to all extra care provision, ideally all provision. More generally a range of features enhance the quality of design in extra care schemes. These include imaginative use of light and space, for example through atriums; provision of access to outside space, ideally through balconies but certainly through communal garden areas; adequate individual cupboard space and perhaps access to communal storage for larger items; varying the width and curve of corridor space and breaking it up with glazed openings; and use of colour to promote both variety and signposting. Incorporating activity space within the design, for example a craft room or a greenhouse, is also a strength. Seating areas should be varied but need to have a sense of purpose to be used. Design can also be critical

to privacy and noise, ensuring for example that noise from a bar or visitors to integrated facilities do not intrude on individual comfort. The Dementia Services Development Centre signposts a wide range of design resources (<http://dementia.stir.ac.uk/information/design-resource-centre>).

Design that particularly assists individuals with dementia ensures spaces clearly conveying their purpose, routes that support wayfinding and offer landmarks, and distinguishing features for the doors of individual apartments (Torrington, 2009; Van Hoof and Kort, 2009). Detailed guidance in line with the eight core principles for designing for people with dementia is offered by Utton (2009), while Burns and colleagues (2009) provide details of Rowan Court, a specialist extra care dementia scheme providing 21 self-contained one-bedroom flats with a communal lounge and dining room. A range of assistive technology devices are fitted including flood alarms, pressure alarms, fall detectors and door alarms.

The Thomas Pocklington Trust, focusing on housing and support for people with sight loss, has addressed lighting and design issues in extra care and developed a series of checklists, Evolve-for-vision. This was part of a wider EVOLVE programme considering how well extra care buildings provide for different needs.

End of life

Extra care housing should be well placed to enable a greater proportion of people who wish to die at home to do so. Easterbrook with Vallely (2008) report on a pilot project promoted in three extra care schemes by Housing21 and the National End of Life Care programme. Involvement of a range of health, housing and social care professionals highlighted four key issues: promoting dignity and choice for older people and family carers; staff support and skills development –providing bite-sized elements of training; extra care and its links to wider health and specialist resources; and commissioning and funding. A Learning Resource Pack has been distilled from this work and published by the Housing LIN (2012). It is designed to ensure that dying at home is a realistic option in extra care housing and builds on the Core Steps of the End of Life Strategy. It includes a number of case studies equally valuable in the context of *Living and Dying Well*, the Scottish action plan for palliative and end of life care.

Costs

The affordability of extra care housing, both for potential residents and for partners involved in the development of initiatives, is of course key. The context and affordability of housing options for older people was explored in two reports from the

New Policy Institute (Pannell, Aldridge and Kenway, 2012; Aldridge et al, 2012).

The first of these reports focused primarily on England, but core elements such as choice, availability, affordability and quality of life are common. In terms of affordability, the second report highlights the complexity of interaction across factors such as prior equity, tenure, benefit eligibility, support costs and savings. The concept of an 'income floor' and of 'trapdoors' in that floor is introduced; for social renting tenants it is suggested the floor is more solid than for owner-occupiers and private tenants. Equity considerations in Scotland for older homeowners with investment capacity have been specifically addressed in a report from Newhaven Research et al (2011). This concludes that 'housing with care owner occupation looks set to remain a niche product' (p4). It is important, however to recognise that older people may no longer place the highest priority on equity maximisation. In their study of affordability, choices and quality of life across 21 housing with care schemes, Pannell, Blood and Copeman (2012) found that one third of their 78 respondents were former home-owners who were now happily renting – 'tenure swappers'.

An examination of costs was a key component of the PSSRU evaluation highlighted above (Netten et al, 2011). This provided comprehensive costing in respect of 67 individuals in two village

development and 398 living in 16 smaller schemes. At 2008 prices this indicated a mean weekly cost per resident per week of £416 (SD £180, range £175–£1,240). These costs are distributed 25% on the annuitised capital cost; 25% social care; 16% health care; 15% housing management and support; and 19% living expenses.

A comparative analysis of costs for extra care and residential care in England suggested that costs were lower compared to equivalent people moving into publicly-funded residential care in 1995, and similar to the more dependent people moving into care homes in 2005 (Bäumker et al, 2011). Moreover outcomes were more favourable. Cost effectiveness was also examined in a 'before and after' study of Rowanberries (Bäumker et al, 2010; IRISS Money Matters, 2011). At six months, weekly costs at an average of £470 per resident were higher than before moving in (£380), mainly the result of increased social care and accommodation costs (the local authority covered all care costs regardless of income). Overall health costs fell by £68, while take-up of benefit and allowances increased. In terms of outcomes, residents reported significant improvement in their quality of life, particularly social participation: two thirds reported a good social life whereas before moving in half had felt lonely and socially isolated. They also reported a decrease in the level of unmet need across seven areas. Caution should be exercised in drawing conclusions from a single site and at an

early stage. Bäumker et al (2011) highlight a number of factors that may influence development costs: the range of communal facilities, site complications, planning difficulties, economies of scale, target rent levels and the institutional capacity of the housing associations.

In Scotland, three of the major housing associations involved in developing what they term 'very sheltered housing' conducted a social return on investment (SROI) study (Bield et al, 2012). This argues that investment in very sheltered housing results in levels of autonomy, well-being, independence and social contact that are significantly higher than care home alternatives, and that a housing unit saves an estimated £19,000 a year in care home costs. This reflects a return on investment of £1.50 to £2.00 for every £1 invested. For the three housing associations involved this equates to a return of £33.7 million on an investment of £18.3m.

Implications for policy and practice

Extra care housing offers a potential development area for Scotland that appears ideally suited to accelerate the implementation of Reshaping Care for Older People and to provide an effective alternative to care home provision. A number of factors appear to constrain current provision,

including a lack of awareness of the model, a reluctance to embark on nurturing and sustaining the partnerships which underpin many of the most effective developments, and the absence in Scotland of the capital funding carrot offered in England. Radical change of this type, however, is required if we are to achieve more than tinkering with existing models.

It is suggested that in the wake of the profile accorded to extra care housing by the Task Force on the Future of Residential Care, there should be a clear policy directive on the need to foster provision, supported by associated funding. This should target in particular the extended partnership working exemplified by the development of Hartfields (Croucher and Bevan, 2010), with a vision for the contribution of extra care provision shared across housing, health and social care. In parallel the potential of the model needs to be promoted much more widely through widespread information and awareness raising, embracing older people, providers and commissioners.

NB The Housing LIN (www.housinglin.org.uk) produces a range of excellent factsheets covering a wide range of aspects related to extra care provision. A recent publication for example provides a technical briefing on aspects of mixed tenure (Housing LIN, 2014).

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Acknowledgements

This *Insight* was reviewed by Amanda Britain (Craigforth), Yvette Burgess (CCPS), Alistair Welsh (Key Community Supports), Neil Macleod (SSSC), Helen Allbutt (NES) and Brian McAteer (North Lanarkshire). IRISS would like to thank the reviewers for taking the time to read and comment on this *Insight*.

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