

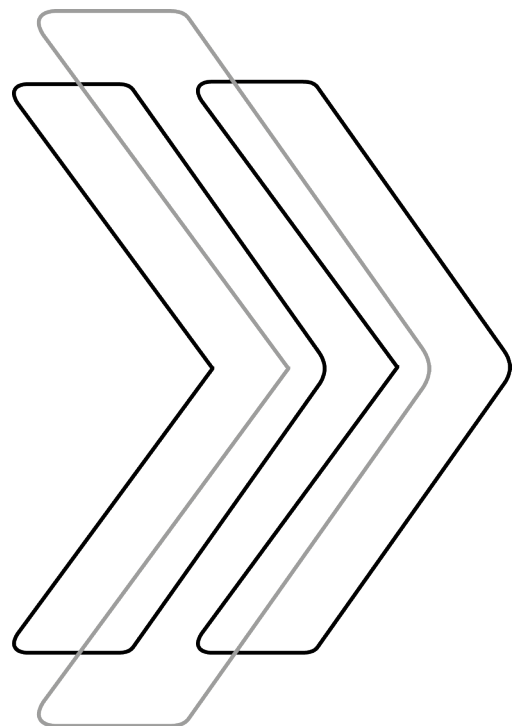
Evaluating the Care and Support Specialised Housing (CASSH) programme: results of a scoping exercise

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Contents

1	Background	4
2	Policy	8
3	Implementation	12
4	Summary and key point	19
	Appendix 1: Potential benefits of CASSH-type housing from literature review	20
	References	26

1 Background

The Care and Support Specialised Housing Fund

The Care and Support Specialised Housing Fund (CASSH) is a Department of Health and Social Care (DHSC) programme to 'support and accelerate the development of specialist affordable housing which meets the needs of older people and adults with disabilities or mental health problems'. The programme provides capital funding to build new specialised housing in England for older people and disabled adults with care and support needs¹. It is implemented by the Greater London Authority and Homes England (referred to in this report as 'implementation bodies') on behalf of DHSC.

Support provided by the CASSH scheme must offer:

- individual dwellings with their own front door
- flexibility to adapt or install equipment or assistive technology in the home
- varying levels of personal care and support to residents, including access to GP or other health services, provided either as part of the scheme or through locating the scheme near easily accessible and appropriate local facilities
- communal areas (for housing for older people).

Bidders are expected to focus on specialised housing models/features outlined in the Housing our ageing population panel for innovation (HAPPI) report (Housing LIN).

The programme has been split into several phases. Phase one (announced in July 2013) covered allocations outside London totalling £101 million to deliver over 3,000 affordable homes. Phase 2 (launched in February 2015) gave priority to housing for adults with mental health problems and to affordable housing provided as part of mixed tenure sites (Homes and Communities Agency 2015). This phase subsequently allocated around £84 million to develop up to 2,000 affordable homes. In 2018, the government announced £76 million a year of CASSH funding till 2020/21, with funding made available

through a continuous market engagement (CME) process (Homes England 2018).

Scope of this exercise

- The King's Fund was asked in 2019 by the Department of Health and Social Care to scope options for an evaluation of any future CASSH funding tranches that may be issued. The work was specifically not an evaluation, which would be commissioned by the department through the National Institute for Health Research. The scoping exercise was intended to explore areas including: the established benefits of CASSH-type housing generally
- any evidence already collected, eg by providers, for the benefits of the housing created under the CASSH scheme and any evidence it would be feasible to collect in future
- the wider health and care policy goals to which CASSH-type housing might be expected to contribute, and how these might be measured in a future evaluation
- what would need to be put in place in the roll out of future waves of CASSH funding to support an evaluation.

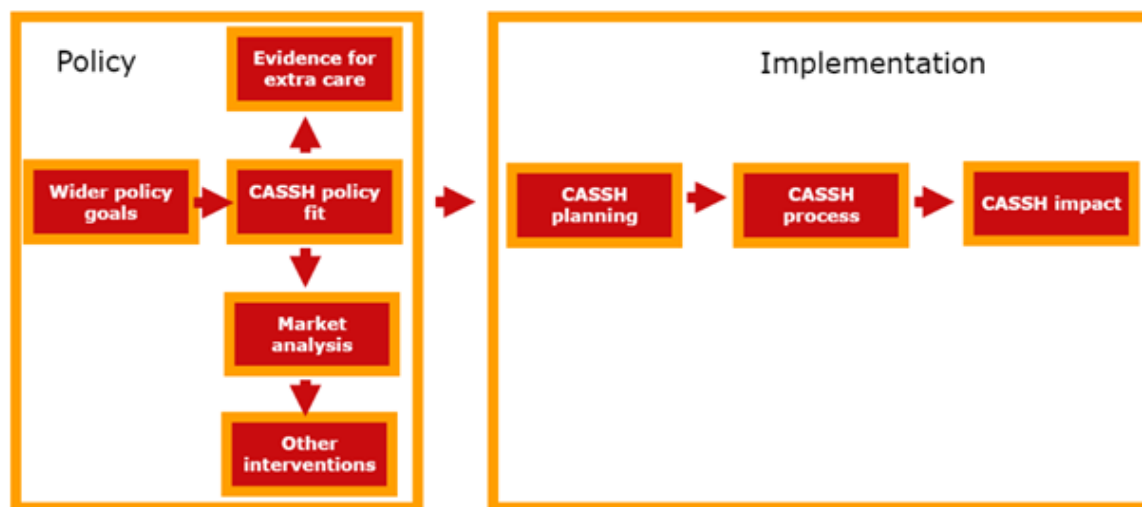
Methodology

The work involved two main strands:

- desk-based research to identify the expected benefits of supported housing with care and support for older and disabled people to which CASSH might reasonably be expected to contribute
- qualitative research with a small number of providers of CASSH housing and other stakeholders to: identify any quantitative evidence that might exist in the areas above; explore perceived benefits of CASSH-type housing from providers and residents etc; and explore the extent to which the benefits of extra care housing generally might reasonably be assumed for developments that are CASSH funded.

Logic model

In order to carry out the work, we created a logic model which divided the scoping exercise into two main areas: policy and implementation.



Policy

Within policy, we identified the following broad areas for a full evaluation.

- What are the wider policy goals underpinning CASSH and how well does CASSH appear to 'fit' them?
- What evidence is there that extra care housing will meet the policy goals?
- What does market analysis tell us about the specific goal of the CASSH programme (ie, to increase the supply of specialist housing for older and disabled people)?
- Are there additional or alternative initiatives that might help meet these policy goals?

Implementation

Within implementation, we identified the following broad areas for a full evaluation:

- How effective was CASSH planning in meeting policy goals?
- How effective was the application process for CASSH in supporting projects to meet policy goals?
- What was the impact of the funding delivered by CASSH? How is this impact measured?

Once again, our work was not an evaluation of these questions but rather a scoping exercise to help inform such an evaluation.

2 Policy

1. What are the wider policy goals underpinning CASSH and how well does CASSH appear to fit them?

The CASSH programme was first announced in Caring for our future: reforming care and support White Paper in 2012. It highlighted the critical role that people's housing can play in helping them to live as independently as possible, and in helping carers to support others more effectively.

In the CASSH phase 1 prospectus, the then Minister for Care Services set out the broad policy goals for CASSH (Homes and Communities Agency 2012). This was 'to shift the system from one that responds to crisis to one which focuses on wellbeing, and on an individual's ability to live independently for as long as possible'. He said, 'specialised housing is a key part of this new system' but that provision was 'not keeping pace with our ageing population' and 'that is why the government announced [the CASSH Fund]... to support development and stimulate the specialised housing market.'

Housing provided by the programme needed to see the following outcomes:

- improvement in individual's mental wellbeing through, eg, reduced loneliness
- usage as a 'community anchor' or wellbeing hub, eg, hosting activities such as physio practices, GP practices or NHS interventions
- generating greater efficiency in the housing market, eg through freeing up family homes.

Our scoping exercise identified a contemporary, large-scale UK study by Aston University/Lancaster University, which concluded:

In conclusion, over the five-year period since moving in, significant improvements can be found in extra care residents' health and well-being. Notably, residents are exercising more and have improved their memory and cognitive abilities. Importantly, in some critical health factors where a downward trend might normally be expected with age, for example in terms of functional abilities, independence or age-

related changes in cognitive function, specifically executive function, no such trends are emerging. This is very encouraging. Further, usual age-related changes in frailty status are delayed in extra care residents, which demonstrates that frailty is indeed malleable and that positive changes in physical, cognitive and social health can influence the progression of frailty. Levels of depression are low among residents while social well-being is high, with lower levels of loneliness than national averages. Further, extra care residents have changed the way in which they use health care resources and we note that there is a cost saving to the NHS of just under £2,000 per person, over five years. This is in contrast to the usual expected increase in NHS costs as people age.

(Holland *et al* 2019)

We explored these and other potential benefits during interviews with providers. Our summary of evidenced benefits (see appendix 1) was generally seen as correct and appropriate, however providers also suggested additional benefits not captured in the literature review. They included:

- the 'opening up' other care spaces for people with greater need – those who move to extra care may free up spaces in a care environment
- the cost equivalent of providing residential and nursing care
- the benefits of having care providers on site to identify health issues earlier
- 'softer' issues such as companionship and outdoor space and availability of activities such as reminiscing sessions
- local extra care housing means people need not move away from where they have lived and can retain social connection.

The literature review found few studies exploring the benefits of specialist housing for people with learning disabilities and mental health problems, rather than for older people. This was also commented upon by participants. Some felt that the benefits did not apply to some groups or that there were other benefits that were more specific to these groups:

Feels like the benefits listed are aimed towards frail elderly people and less for those with mental health issues or learning disability, eg, reduced visits to GP would be a good thing for an older person but would be a bad outcomes for people with [a] learning disability who are

underserved by primary care, same with examples around 'no change in independence'. For people with learning disability you would want improvement in independence.

(CASSH provider)

It was suggested that when thinking about the evaluation outcome measures for people with learning disabilities or mental health problems it is important to consider different sets of metrics and the different sorts of improvements that you would expect to see to those for people who are frail and elderly (and perhaps working age adults with disability).

See the benefits listed as being relevant to people who moved into care who had not been in care previously versus people who might have been in a more institutional environment who move into independent housing with the central office support on site.

(CASSH provider)

2. What does market analysis tell us about the goal of the CASSH programme?

The goal of the CASSH programme is to increase the supply of specialist housing for older and disabled people. We did not have access to any data or analysis in this area (see section 3 below). However our logic model suggests that a full evaluation would want to explore the size, shape and nature of the market of specialist housing for older and disabled people in England and attempt some analysis of the extent to which the CASSH programme had had an impact on this. That would involve questions such as the following:

- What are the long-term trends in the market of specialist housing for older and disabled people, ie, what was the state of the market at the time that the CASSH programme was launched, and what is it now?
- How many units or schemes have been built in each of the years for which CASSH has been operating?
- Is there any evidence that CASSH has had a significant impact on the market?

We understand that data about supply of extra care housing is available from external organisation such as Laing Buisson and the Elderly Accommodation Council. Other market data may be available from the Association of Retirement Community Operators.

3. Are there alternative or additional interventions to meet policy goals?

Again, our exercise did not attempt to explore this question and the exploration of wider policy interventions is outside its scope. However, in the course of interviews with providers, it became apparent that an important distinction existed between the build cost and the operating cost of extra care housing. Essentially, building extra care is only the first stage of successfully providing extra-care housing: it must also be operated profitably and successfully. An evaluation might therefore need to consider any implications of this distinction and explore the ongoing viability of the projects that CASSH has funded.

3 Implementation

Within this area, our logic model identified two broad areas for an evaluation to consider: process evaluation and impact evaluation.

Process evaluation included two sub areas:

- planning for implementation: for example, were the criteria for selecting proposals clear to all parties; to what extent were they applied consistently and fairly?
- the CASSH application process: for example, was the application and selection process efficient and effective in handling applications? were the schemes chosen for funding consistent with the intended results of the CASSH programme?

Impact evaluation covers scheme impact. Did the chosen programmes deliver the outcomes or impact the CASSH programme expected? How might these outcomes/impacts be measured?

To explore these areas further, we expected to rely on two main sources. Again, we did not intend to carry out an evaluation but rather to identify the range and sources of data that might be needed by an evaluation.

- Basic data about the number of applications, number and location of schemes, amount of funding provided.
- Interviews with a range of providers

However, our short scoping exercise found difficulties in both these areas which may have to be considered in planning a future evaluation.

The criteria used to choose applications are publicly available: Homes England (HE) and Greater London Authority (GLA) have published CASSH prospectuses and capital funding guides respectively to set out the criteria for CASSH schemes.

We did not have access to a set of data with detailed information at scheme level (eg, number of applications, number and location of schemes, amount of

funding, etc). Such information was not essential to this study as we did not intend to analyse the data, but that will be necessary for potential lines for enquiry for an evaluation in the future.

It was not clear to us who currently holds this data and whether it was unavailable to us because it was hard to compile or hard to provide due to e.g. GDPR concerns. This data would, however, be essential to full evaluation.

It also proved harder than expected to recruit provider participants for our interviews. In the end, we were only able to recruit 6 providers rather than the 12 we had originally planned. There appeared to be issues about confidentiality and adhering to the General Data Protection Regulation (GDPR) which made the process of recruitment more complex than we had anticipated: it was necessary for GLA and HE to approach and recruit interviewees for us instead of us doing it directly. This added time to the research. There was also a concern raised about research taking place during the pre-election 'purdah' period that limited recruitment. Overall, this suggests an evaluation may need to invest significantly in any qualitative research phase it plans.

The interviews we did carry out provided useful insights that an evaluation might want to explore further. Participants were able to answer questions relating to the CASSH process as they would in the evaluation itself, giving an idea of the type of information that might come out of a process evaluation. On questions around the impact of CASSH, participants were able to talk hypothetically about an impact evaluation including the challenges in measuring impact, the feasibility of data collection and what outcomes measures might be used.

However, the small sample size means that findings should not be generalised and should be considered only as potential lines of enquiry for an evaluation. For example, the small sample size means it is not possible to compare any differences in provider experience of the two funding bodies.

Process evaluation

Routes into funding

Existing relationships with the two funding bodies were a key way in which providers became aware of the CASSH funding. Having previously applied for other funding they were looking for opportunities or the funding body made

them aware (during ongoing discussions) or even advised that they apply. One had applied for other funding and was advised to 'switch' to CASSH.

Turnover and timescale issues: some participants in the research weren't in their organisations or roles when the original application was made. Others found it difficult to remember how they became aware of the funding or what the circumstances around their initial application for funding were. This suggests the importance of interview timing for a future evaluation.

Support during funding

Where participants could remember the support they received from the two implementation bodies, some found it to have been helpful in answering questions.

Where there was an existing relationship with a funding body, there was an ongoing dialogue. For example, there were discussions prior to the application about what criteria would need to be met in order to assess eligibility of a scheme for funding.

There were differences in the extent to which providers said funding bodies had been willing to give their opinion on the viability of a scheme and/or would engage in discussions prior to a scheme receiving planning permission.

Level of scheme planning required

Compared to other spending bids, where detailed project plans with milestones were required, one provider said that the initial conversations about the CASSH application was more about looking at different ideas. One provider said that while they didn't already have an 'oven ready' scheme in place, they had land and knew that they had the need in the area.

In some cases, funding bids and plans were already developed (for example, for other funding calls or projects they had been working on previously). However, in other cases the provider applied and received the CASSH funding a long time before they received planning permission.

Some providers said funding in advance made it easier for them to deliver schemes in line with the funding requirements.

The point about the timing of applying for the funding was highlighted by others. Providers said they do not always know the full costs of the scheme at

an early stage. If they bid too early (for example, without full planning permission) they might underestimate the funding required but if they bid too late they may not get the funding at all.

Providers found the following behaviours from implementation bodies helpful:

- transparency by the implementation body about bids – for example, the body calling the applicant if it needed further clarification. Some participants found questions asked during the application easy to answer: 'They are sensible questions which someone would expect to know the answers to if they are developing a project'
- clarity about how much funding was available
- speed of decision making from submitting the bid to finding out whether they were successful
- flexibility on delivery of schemes: some stated that often funding schemes have a backstop when a project needs to be completed by, however in reality things get delayed on the ground. They liked the fact that there was flexibility to the CASSH fund timeline.

These helpful behaviours were not universally reported.

Due to the lack of guidance and available information, one provider said the process 'felt very iterative which isn't very effective in terms of delivery, you had to keep submitting until you got it right'. Suggested solutions for this issue included being able to talk to those that had delivered CASSH funded schemes already to find out about costs and other considerations. Alternatively, a 'database of anonymised examples for people to look at was seen to be useful for getting this guidance on costs.

Some found the application process to be too long, with 'sticking points' that extended the bidding period. These included problems agreeing the appropriate level of subsidy grant, as what they had bid for was higher than they usually sought.

Views on feasibility

All felt the funding was very valuable but there were differing views as to the extent to which it was essential to schemes' progression.

Funding was important but not critical to progression

Some participants articulated that while they may have been able to go ahead with the scheme without the CASSH funding, they still found it valuable. It meant they were able to deliver what was needed and amend designs with any required changes.

For some, there was a feeling that although the funding wasn't always critical to a build's feasibility, the support of the funding body was crucial for delivering the scheme. For others, while the scheme may have still gone ahead (without funding), it might have cost them the ability to develop another project elsewhere.

Funding was critical

Some felt that without the funding they might have had to look at other build sites and sell the site they had. This would have presented challenges such as local objections that could delay the build.

One participant suggested that while the schemes 'pay for themselves' in terms of revenue it is important 'not to scrimp on capital at the beginning'.

There was a shared feeling that CASSH funding ensured quality in the build and enabled providers to produce an excellent 'all singing, all dancing' product.

Participants felt that the application process ensured the schemes 'hit all the metrics' and met the criteria, ensuring feasibility.

In general, where there are challenges and complexities to the building of a scheme, the funding helped with additional unforeseen costs. For example:

- having to align the build of the scheme with the service delivery needs (or the requirements of the local authority) meant that there were some changes to be made as the project went on – the funding was particularly helpful in these cases
- where there were objections about the build or changes to external factors such as possible limits on local planning allowances, the subsequent planning delay costs were mitigated by the funding.

On some occasions the money from the CASSH funding 'wore thin', for example when there were specific unforeseen problems such as contamination on the building site that created a construction challenge.

Impact evaluation

When considering the outcome measures two broader concerns were widely reported.

Some providers felt that they were not best placed to give an appraisal on the potential benefits of specialist housing for older and disabled people. They suggested it would be better to talk to those on the delivery side, who were responsible for care and support, as they (the providers) were involved in the build only. They thought there was a big challenge in 'detangling' the measurement of outcomes as result of people living in specialist housing/CASSH, from the output of the capital funding, ie the build itself.

Linked to the above point they felt it would instead be the revenue side and service delivery that determined the benefits however they also questioned how attribution of these benefits to the service provision might be quantifiably measured.

Currently data is collected in different ways by each provider. These include:

- external evaluations
- programme monitoring processes (including finances and progress reports)
- internal qualitative 'lessons learned' sessions
- surveys of occupants of newly build properties
- monitoring data from a management perspective.

For some, at the time of interview they did not yet have clients moved into the scheme so had not yet collected any data.

This suggests that an evaluation would have some provider-level data on which to draw but the type, consistency, extent, quality and value of that data is likely to be mixed. The evaluation might therefore need to consider primary data collection from providers and other sources.

We asked interviewees whether it would be possible to collect additional data to help judge the impact of schemes. Participants were broadly positive. Some stated it would certainly be possible, depending on the kind of data required, so long as there was a purpose and the requirements weren't too onerous. Others thought that continually evaluating the success of the schemes would be very helpful and part of a positive learning process. Some had already been talking about what data they could collect and by whom.

Timing was a factor in data collection.

- It would be important to know in advance what baseline they needed and what to collect and when.
- Participants also highlighted that it can take a long time to move people into specialist housing so asking for impact data might be too soon even after a year. This was corroborated by the participants who had not yet moved people into their scheme.
- Finally, one provider was very enthusiastic about collecting the lived experience of those living in the ECH schemes. They suggested using user led design throughout scheme development (not just in the evaluation) which would improve the appropriateness of the housing design ensuring it was matched to individuals' ways of living. This would then shape the evaluation and the outcome measures that might be used to evaluate success.

4 Summary and key points

- This was a short, scoping exercise to consider issues relating to a potential evaluation of the Care and Support Specialised Housing (CASSH) programme; it was not itself an evaluation.
- We found it helpful to adopt a logic model which divided our work into two areas: policy and implementation. This approach might be appropriate for the evaluation.
- We found good evidence for the benefits of extra care housing for older people. This might not need to be repeated in a full evaluation, though it might consider a systematic review of the evidence and might want to explore evidence for other groups.
- We found significant difficulty with obtaining data about the operation of the CASSH programme and speaking to providers. An evaluation commissioned by DHSC would need to tackle both these issues, and DHSC might need to play an important role in ensuring data was available. Good engagement and buy-in from the implementation organisations would be important. The evaluation would also need an understanding of wider trends in the market of specialised housing for older and disabled people.
- Our research was limited by the small number of interviewees, which meant findings were not generalisable. A larger sample might be able to identify these generalisable learnings from individual provider's experiences of the application and selection process.
- While there may be broad support among providers for improved data capture to aid evaluation, there will be a challenge to 'detangle' measurement of outcomes as result of people living in CASSH-funded housing, from the output of the capital funding itself

Appendix 1: Potential benefits of CASSH-type housing from literature review

Table 1 Savings to the NHS due to reduced elective and non-elective usage of NHS services, such as GP visits and accident and emergency attendances and from faster transit through the health system, eg, earlier discharge after a hospital stay

Benefit type	Data
Reduced visits to GPs (though increase visits to practice nurses)	There are now 0.96 fewer planned visits per year (Holland <i>et al</i> 2019).
Reduction in use of community nursing services	Costs of visits by nurses at home have more than halved (Bäumker <i>et al</i> 2008).
Reduction in length of hospital stays	Residents now spend an average of 3 days less per year in hospital over 5 years (Holland <i>et al</i> 2019)
NHS costs	No expected increase in NHS costs over time as extra care residents age, and a claimed saving of £,1991 per person over 5 years (Holland <i>et al</i> 2019).
Reduction in non-elective admissions to hospital	Residents now spend 4.8 nights per year compared to 5.8 those living in the community (Kneale 2011).
	There are 0.13 fewer admissions per residents per year (McCarthy and Stone 2014).
Reduction in length of stay/discharge	There has been a reduction in the duration of (unplanned) hospital stays, from an average of 8–14 days to 1–2 days (Holland <i>et al</i> 2019)

Evaluating the CASSH programme: results of a scoping exercise

Reduced ambulance callouts	Not stated (Copeman <i>et al</i> 2017).
Reduced emergency call outs	Fire emergency calls dropped by 61% and ambulance emergency calls dropped by 66% (Yates 2016).
Savings to NHS through return on investments	The estimated net financial return on investment to be £6.40 for every £1.00 spent on the project (Copeman <i>et al</i> 2017).
Hospital stays	Hospital stays are half the average length of time compared to general population of people aged 75 and over (Buck <i>et al</i> 2016).

Table 2 Reducing social care spending due to, eg, care packages reducing or a reduction in travel time for care workers

Benefit type	Data
Care package costs reduced	Care package costs 16% lower compared to the cost pre-admission. The saving to adult social care in home care costs was £2,400 per person per year (Lacey and Moody 2016).
Savings to Local Authorities/Health and Social Care services	An average net benefit of £444 per person per year, primarily driven by reducing reliance on health and social care services (Frontier Economics 2010).
Reduced usage of residential care and associated costs	An older person living in a specialist retirement housing unit is 0.75% as likely to move into residential care as someone in mainstream housing. Average expected lifetime cost of residential care for a person in specialist retirement housing is £15,500. This represents a saving of around £5,000 per person (Lloyd 2016).
Reduced usage of at home care and associated costs	A person living in a specialist retirement housing has a 0.15 probability of receiving home care in a given year. The cost saving of equipment and adaptations available through the retirement housing unit are worth £579 per year (Lloyd 2016).

Reduction in costs for home equipment and adaptations	Use of the emergency alarm call system on-site dropped by 42% (Yates 2016).
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Table 3 Improvement in individual’s personal health

Benefit type	Data
Increase in exercise	There has been a 75% increase in frequency over 5 years (Holland <i>et al</i> 2019).
Increased perceived health	Perceived health improves over time for residents, peaking at 24 months (Holland <i>et al</i> 2019)
Independence	No change (ie, decline) in independence over 5-year period (Holland <i>et al</i> 2019).
Increase in walking speed	Not stated (Holland <i>et al</i> 2019).
Reduction in risk of falls over 2 years	91,940 falls estimated to be prevented by people living in older people’s housing (Wood 2017).
Frailty	Increase in frailty delayed by up to 3 years (Holland <i>et al</i> 2019).
Increases life expectancy	Female residents, in particular, receive a substantial boost to their life expectancy when compared to the wider population – at one point in time reaching close to five years (Mayhew <i>et al</i> 2017).
Reduction in falls	Falls rates in extra care housing are measured at 31% compared to 49% in general housing (Kneale 2011).
Residents able to move more easily in home	Residents with physical disabilities spoke about being able to move more easily than before and about the advantages of having a shower (Burns 2014).

Table 4 Improvement in individual’s mental wellbeing, eg, through reduced loneliness

Benefit type	Data
Low levels of depression	Social relationships, physical health, and decisional control in the move to assisted living consistently yielded positive relationships with SOC (Sense of community) factors. (Plus and Qualls 2020).
23% decrease in anxiety	
Improvements in memory/ cognitive skills	
No decline in executive function	
Improved physical fitness (walking speed) benefits wellbeing	
Lower levels of loneliness than national average	
Sense of community and psychological wellbeing	
Improved cognitive functioning	Improvements in memory and cognitive skills: 24% increase in autobiographical memory and 17% increase in memory recall tests (Holland et al 2019).
Reduced cognitive decline	Delay in the onset of cognitive decline by up to 1.75 years (British Medical Association 2016).
Better or much better contact with family and friends.	Almost 45 per cent of residents reported having better or much better contact with family and friends (Hughes 2012).
Improved social contact	When living in their previous home, over half of respondents (58%) reported that they had little or not enough social contact with others. Since moving, 85% now have adequate or as much social

Evaluating the CASSH programme: results of a scoping exercise

	contact as they would like (Copeman et al 2017).
Improved confidence in self-managing health	91% feel more confident managing their health at home now, compared to 12 months ago (Copeman et al 2017).
Less unmet need on the social care related quality of life scores	Residents in housing with care had less unmet need than people receiving home care (Darton <i>et al</i> 2017).
Low reported feelings of isolation	81.7% respondents said they hardly ever or never feel isolated, and only 1.1% often feel isolated (Beach 2015).
Higher sense of control for residents	Respondents report a high degree of control over their lives as measured as a specific domain of quality of life. (Beach 2015).

Table 5 Usage as a 'community anchor' or wellbeing hub, e.g. hosting activities such as physio practices, GP practices, or NHS interventions

Benefit type	Data
Co-located GP practices	Not stated (St Monica Trust undated)

Table 6 Generating greater efficiency in the housing market though e.g. freeing up family homes

Benefit type	Data
Freeing up homes on housing ladder	'Reasonable assumption' that in four out of five cases, older people downsizing into new specialist retirement housing may enable first-time buyers to move on to the property ladder, whether through directly purchasing the home that is

	released or through the creation of a housing chain (Lloyd 2016).
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Table 7 Other benefits

Benefit type	Data
Decreased likelihood of entering longer term accommodation	After five years of residence, those living in extra care housing were less likely to enter long-term accommodation, compared to those living in the community in receipt of home care (Kneale 2011).
Delayed admission into a care home	Cites evidence that extra care housing can delay admission into a care home by providing alternative accommodation at the point where someone has to leave their original home and as a means of enabling them to live independently for longer (Bligh <i>et al</i> 2015).
Respite for carer/partner	Not stated (Livadeas 2016)
Reduction in housing benefit payments	A single new unit of retirement housing will on average reduce future public expenditure on Housing Benefit by around £38,200
Links built with wider community	Hazel Court in Swansea has become 'an integral resource' for the wider community (Housingn LIN wales 2015).

References

Bäumker T, Netten A, Darton R (2008). *Costs and outcomes of a housing with care scheme in Bradford*. London: Joseph Rowntree Foundation. Available at: www.jrf.org.uk/report/costs-and-outcomes-extra-care-housing-scheme-bradford (accessed on 14 September 2020).

Beach B (2015). *Village life: independence, loneliness, and quality of life in retirement villages with extra care*. London: The International Longevity Centre. Available at: www.housinglin.org.uk/Topics/type/Village-Life-Independence-Loneliness-and-Quality-of-Life-in-Retirement-Villages-with-Extra-Care (accessed on 5 October 2020).

Bligh J, Cairncross L, Porteus J (2015). *Housing and adult social care*. Oxford: Oxford Brookes University. Available at: https://ipc.brookes.ac.uk/publications/School_for_Social_Care_Research_-_Housing_and_Adult_Social_Care_2015.pdf (accessed on October 5 2020).

British Medical Association (2016), *Growing older in the UK: a series of expert authored briefing papers on ageing and health*. Briefing. London: the British Medical Association. Available at www.bma.org.uk/what-we-do/population-health/preventing-ill-health/growing-older-in-the-uk-a-series-of-briefings-on-ageing-and-health (accessed on 23 October 2020).

Buck D, Simpson M, Ross S (2016). *The economics of housing and health: the role of housing associations*. London: The Kings Fund and the New NHS Alliance. Available at <https://www.kingsfund.org.uk/publications/economics-housing-health> (accessed on 5 October 2020).

Burns, J., (2014). *The benefits of extra care housing on the quality of life of residents: the impact of living in Campbell Place, Fleet*. Case study. London: Housing, Learning and Improvement Network. Available at www.housinglin.org.uk/Topics/type/The-benefits-of-extra-care-housing-on-the-quality-of-life-of-residents-The-impact-of-living-in-Campbell-Place-Fleet (accessed on 5 October 2020).

Copeman I, Edwards M, Porteus J (2017). *Home from hospital: how housing services are relieving pressure on the NHS*. London: National Housing

Federation. Available at: www.housinglin.org.uk/Topics/type/Home-from-hospital-How-housing-services-are-relieving-pressure-on-the-NHS/ (accessed on 5 October 2020).

Frontier Economics (2010). *Financial benefits of investment in specialist housing for vulnerable and older people*. London: Frontier Economics. Available at: www.housinglin.org.uk/Topics/type/Financial-benefits-of-investment-in-specialist-housing-for-vulnerable-and-older-people (accessed on 5 October 2020).

Holland C, Garner I, O'Donnell JO, Gwyther H (2019). *Integrated homes, care and support: measurable outcomes for healthy ageing* [online]. Extra Care website. Available at www.extracare.org.uk/media/1169231/full-report-final.pdf (accessed on 14 September 2020)

Homes and Communities Agency (2012). *Care and Support Specialised Housing Fund: prospectus*. London: Homes and Communities Agency. Available at: www.gov.uk/government/publications/care-and-support-specialised-housing-fund-phase-1-prospectus (accessed on 18 November 2011).

Homes and Communities Agency (2015). *Care and Support Specialised Housing Fund: phase 2*. London: Homes and Communities Agency. Available at: www.gov.uk/government/publications/care-and-support-specialised-housing-fund-phase-2-prospectus (accessed on 18 November 2011).

Homes England (2018). 'Care and Support Specialised Housing Fund'. Gov.uk website. Available at: www.gov.uk/government/collections/care-and-support-specialised-housing-fund (accessed on 18 November 2011).

Housing LIN (2009). *Housing our ageing population: panel for innovation report*. London: the Homes and Communities Agency. Available at: <http://www.housingcare.org/information/detail-3056-happi-housing-our-ageing-population-panel-for-innovation.aspx> (accessed on 23 October 2020).

Housing LIN Wales (2015). *Extra care housing in Wales: a state of the nation report*. London: Housing, Learning and Improvement Network. Available at https://ipc.brookes.ac.uk/publications/HousingLIN_Wales_ECH_report_Dec15.pdd (accessed on 5 October 2020).

Hughes N (2012). *A better fit? Creating housing choices for an ageing population*. London: Shelter. Available at https://england.shelter.org.uk/professional_resources/policy_and_research/policy_library/policy_library_folder/a_better_fit_creating_housing_choices_for_an_ageing_population (accessed on 5 October 2020).

Kneale D (2011). *Establishing the extra in extra care: perspectives from three extra care housing providers*. London: The International Longevity Centre. Available at <https://ilcuk.org.uk/establishing-the-extra-in-extra-care-perspectives-from-three-extra-care-housing-providers> (accessed on 5 October 2020).

Kneale D (2011). *Establishing the extra in extra care: perspectives from three housing with care providers* [online]. International Longevity Centre UK website. Available at: <https://ilcuk.org.uk/establishing-the-extra-in-extra-care-perspectives-from-three-extra-care-housing-providers> (accessed on 22 October 2020).

Lacey P and Moody S (2016). *Evaluating extra care – valuing what really matters. The case for taking relationships seriously*. London: Housing, Learning and Improvement Network. Available at www.housinglin.org.uk/Topics/browse/HousingExtraCare/Evaluation (accessed on 5 October 2020).

Livadeas S (2016), *In sickness and in health, extra care housing works especially well for couples*. Case study. London: Housing, Learning and Improvement Network. Available at www.housinglin.org.uk/Topics/type/In-sickness-and-in-health-Extra-Care-Housing-works-especially-well-for-couples (accessed on 5 October 2020).

Lloyd J (2016). *Valuing retirement housing: exploring the economic effects of specialist housing for older people*. London: Strategic Society Centre. Available at www.housinglin.org.uk/Topics/type/Valuing-Retirement-Housing-Exploring-the-economic-effects-of-specialist-housing-for-older-people (accessed on 5 October 2020).

Mayhew L, Rickayzen B, Smith D (2017). *Does living in a retirement village increase life expectancy? The case on whitely village*. London: Cass Business School. Available at www.housinglin.org.uk/Topics/type/Does-living-in-a-retirement-village-extend-life-expectancy-The-case-of-Whiteley-Village (accessed on 5 October 2020).

McCarthy and Stone (2014). Local area economic impact assessment [online]. Institute of Public Care website. Available at: https://ipc.brookes.ac.uk/publications/Final_McCarthy_and_Stone_EIA_report_-_March_2014.pdf (accessed on 23 October 2020).

Plys E and Qualls S (2020). 'Sense of community and its relationship with psychological well-being in assisted living'. *Aging and Mental Health*, vol 24 issue 10, pp 1645–53. Available at www.tandfonline.com/doi/abs/10.1080/13607863.2019.1647133 (accessed on 5 October 2020).

St Monica Trust (undated). 'Charterhouse at The Chocolate Quarter'. St Monica Trust website. Available at: www.stmonicastrust.org.uk/care/care-homes/charterhouse (accessed on 5 October 2020).

Wood C (2017). *The social value of sheltered housing*. Briefing paper. London: Demos. Available at: <https://demos.co.uk/project/sheltered-housing> (accessed on 5 October 2020).

Yates, K (2016). *A fresh outlook on wellbeing: delivering person-centred care across the West Midlands* [online]. Case study. London: Housing, Learning and Improvement Network. Available at: www.housinglin.org.uk/Topics/type/A-fresh-outlook-on-wellbeing-delivering-person-centred-care-across-the-West-Midlands (accessed on 5th October 2020)