UNIVERSITY OF BIRMINGHAM

Housing and Communities Research Group

EVIDENCE REVIEW 1

EXTRA-CARE HOUSING: IMPACTS ON INDIVIDUAL WELL-BEING

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Abstract

Extra Case Housing (ECH) is a growing part of the housing and care landscape for an ageing population. It's recent growth has been driven by a number of factors, notably the potential of cost savings compared to residential care provision for social care commissioners and the emergence of an 'assisted living' market for self-funded older people. Alongside these financial drivers claims are often made about advantages for individual well-being. This Evidence Review builds on earlier state of the art reviews and a search of recent UK sources (mainly peer reviewed academic papers but also professional practice literature). Focusing on 18 key publications it identifies nine advantages claimed for individual well-being and critically reviews the current evidence. It ends by identifying evidence gaps and proposing further research.

Contents

Preamble

This paper was drafted as part of a wider project by the School of Social Policy[1] on the evidence on the costs, impacts and effectiveness of extra-care housing. It considers the housing/living environments provided by extra-care and impacts on individual wellbeing. Individual well-being may be assessed in several ways: the ability to live independently, to age in place, to avoid social isolation, to feel secure (tenure rights and personal safety) and supported, to exercise choice and to enjoy improved health outcomes.

On all of these measures extra-care cannot be considered in isolation but requires a comparator. Most commonly extra-care housing is compared with residential care (or indeed hospitalisation), but it is equally important to consider the comparison with independent living in separate dwellings that are not part of a 'scheme' and with ordinary sheltered housing.

One problem is the absence of an agreed official definition of extra-care. The best estimates of the size of the sector from Elderly Accommodation Counsel[2] are based in self-reported definition by providers. There are a number of different models including adapted and remodelled sheltered housing schemes, apartment blocks, and bungalows with a central resource hub, retirement villages, leisure complexes and hotels. They range from 6 to over 300 dwellings. Key ingredients found in various combinations[3]:

- An accessible building design that supports ageing in place
- Self-contained dwellings: mainly flats/apartments, but also in some cases bungalows
- A level of communal facilities (including restaurants, social and leisure)
- Facilities for staff to provide a service on a 24/7 basis (+ care packages and contracts)

[1] The review '*Extra-care housing: what do we know and where should research go next?* was commissioned by Housing and Care 21 and undertaken by Robin Miller, Steve Appleton and David Mullins of the School of Public Policy at the University of Birmingham. This paper by David Mullins is published by the Housing and Communities Research Group **with acknowledgement and thanks to the wider project team and the support provided by Housing and Care 21 for their kind permission to publish as an HCRG Evidence Paper.**

[2] EAC (2013) survey shows a total of 518,125 properties in 15,999 schemes in England that conform to their definition of sheltered housing as *'a group of dwellings intended for older people and served by a resident or non-resident warden/scheme manager with specific responsibility for the group*". It notes that *'extra care, assisted living and other forms of housing with care are included". The EAC further estimated that there were about 55,000 housing with care (ECH) dwellings in England a total overshadowed by more than 450,000 housing with support (sheltered housing) dwellings and nearly 600,000 residential and nursing home beds.* (www.housingcare.org),

[3] Riseborough M. and Fletcher, P. (2008, 2015) Extra care Housing. What is it? Housing LIN, Care services Improvement Partnership. **Many thanks to Moyra Riseborough for helpful comments on drafts of this Evidence Paper.**

There are a number of important differentiators between extra-care and residential care

- Tenure rights
- Ability to choose providers of care and support services
- Planning use class distinction between independent housing and care home

There are several distinct market segments with different aspirations and resources. The DoH ECH new build programme, remodelled sheltered schemes and private assisted living retirement housing market are geared to very different market segments and may differ in their well-being impacts. This affects research findings.

In this review we draw on scholarly articles and practice publications that make reference to the outcomes of extra care housing in the UK, published in the last 5 years. We build on earlier reviews (Evans et al (2010) and Atkinson et al (2014)) and an expert librarian search of academic and grey literature by the Health Services Management Centre which generated over 100 in scope publications, later narrowed down to 18 key sources for detailed review. For the selected sources this Evidence paper critically reviews evidence on outcomes for individual well-being.

Current evidence base: breadth, depth and robustness of research to date

The review indicates that work in this field is at a relatively early stage and is often focusing on specific ECH models and research questions. The studies reviewed were clustered around two main types of extra-care housing; new build under the DoH Extra Care Housing Fund capital grant programme (DoH ECH P) and remodelled sheltered housing schemes in the local authority and housing association sectors. Other types including retirement villages and private assisted living schemes were underrepresented. There was some representation of mutualist, co-housing approaches but this was more evident in the policy/practice outputs than the primary research approaches.

There was a considerable clustering of researchers who have undertaken much of this work (especially around PSSRU at University of Kent), and of research funders/publishers (DoH, JRF and Housing LIN) and datasets (particularly of the (DoH ECH P). Different paradigms and approaches were found within the research and three different kinds of output were included in the review:

peer reviewed research based academic journal papers, literature reviews and practice orientated dissemination reports and viewpoints. The usual debates between positivist data driven approaches and more interpretivist qualitative approaches were apparent; "*findings from longitudinal studies on housing with care in England have usually been based on administrative sources (such as assessments) rather than the primary focus being on the voice of residents and frontline staff. It is therefore suggested that further studies are required to reflect the views of everyday life in housing with care settings"* (Smith 2015 p.1).

All of these differences mean that the findings presented provide impressions and indications rather than definitive statements of evidence that apply to all of the types and market niches of ECH noted in the pre-amble.

In relation to residents' quality of life the following substantive issues were to some extent illuminated by the review (these themes structure the next section on evidence of impacts):

- What aspects of well-being do individual residents most value?
- What aspects of well-being are found in ECH schemes – where is the 'extra'?
- How does ECH compare to residential care and living in the community in the achievement of individual well-being?
- How does scheme design contribute to individual well-being?
- How do connections with neighbourhood and community outside the scheme contribute to individual well-being?
- Does ECH overcome social isolation?
- Does ECH enable choice and ageing in place?
- What evidence is there on mutual and self-help approaches for ECH residents?
- What is the role of the ECH workforce in co-producing ECH solutions?

What do we know about the impact of ECH on individual well-being?

This section summarises the main evidence to emerge from the literature review in relation to the 9 sub-themes identified above.

What aspects of well-being do individual residents most value?

Standard research tools such as ASCOT have been developed to operationalise well-being into a set of indicators that can be used for comparative studies of different residential settings for care. Such tools have been used by several of the studies reviewed here as a basis for quite sophisticated statistical analyses of outcomes (Baumker at al 2010, Callaghan and Towers 2014). However, other studies have been critical of data driven approaches particularly where these are "*based on administrative sources (such as assessments) rather than the primary focus being on the voice of residents and frontline staff"* (Smith, 2015). Papers reviewed varied considerably in the extent to which user voice was directly reported, with Wright et al (2010) providing more direct reporting than most. Thus it is not always clear that what is being measured is what users most value in relation to individual well-being. Statistical indicators often tell us more about what administrative data is maintained than about the lived experience of residents.

There is a reasonable consensus on what residents value and are looking for when they move in to ECH. Atkinson et al 2014 reference work suggesting that residents value security, privacy, flexible care and support, independence and control, access to amenities and social activities, lack of responsibility for property maintenance and low levels of crime. Evans and Vallelly (2007) in a widely cited study highlight six key factors that can maximise social well-being as *'opportunities for social interaction; connecting with the wider community; good design and location; the involvement of family carers; staff training and cultures of care; and the provision of appropriate facilities'* (Evans and Vallelly 2007 as summarised by Atkinson et al 2014 p.20). These factors have therefore been given considerable weight in choosing the themes for the remainder of this review.

However there are individual variations around these desired elements and not everyone is looking for the same thing. A degree of sophistication is therefore required to unpack the aspirations and intentions that underpin individual well-being. *'A move to a supported living environment may be driven by preference for this type of housing or a particular strategy to avoid difficulties in private housing that may be encountered in the future; however, relocation may also be reluctant or passive.'* (Burholt et al 2013 p.129).

What aspects of well-being are found in ECH schemes – where is the 'extra'?

The absence of an official definition for ECH and the presence of products and services responding to very different market segments can make it hard for residents and potential residents to pin down exactly how ECH can affect their individual well-being. However, most of the studies cited offered further definitions of ECH building on that of Elderly Housing Counsel for example Smith (2015) proposed 9 criteria including security of tenure, an issue that was surprisingly rarely discussed in the research literature, despite its importance for individual control (compared to the insecurity of care home accommodation) [4].

Croucher and Bevan (2012) identified the importance of an ethos of respect and tolerance in providing the foundation for inclusion of high support need residents. This must be nurtured rather than imposed. However, turnover in the workforce and the use of agency staff who may not be aware of the ethos underpinning ECH can be a major barrier in practice (Wright et al, Smith 2015). Wright et al 2010 were also critical of the failure of schemes to encapsulate the 'extra' value of enabling independence by *'staff working with, rather than for, tenants'* (p. 2253). They also noted the absence of core elements of ECH models amongst the 10 remodelled schemes that they audited; e.g. six of these schemes failed to provide a communal cooked lunch for residents each day.

This leads to a need for clear communication with potential residents to ensure that there is a congruence between the elements they value and those that are actually present in specific schemes.

'if a move is based on the need for care, information is required on the quality and quantity of care that can be provided in the facility. Likewise, if a move is based on the desire for increased social interaction in the belief that this will contribute to changes in feelings of loneliness, then evidence

[4] it is primarily for older people;
- the accommodation is almost always self-contained;
- care can be delivered flexibly, usually by staff based on the premises;
- support staff are available on the premises for 24 hours a day;
- domestic care is available;
- communal facilities and services are available;
- meals are usually available and charged for when taken;
- it aims to be a home for life; and
- it offers security of tenure

is required on which to base the judgment to relocate. In order to address the current gap in knowledge regarding the social benefits of extracare housing, this paper has described the relationships between social resources, loneliness, marital status and living environment'. (Burholt et al 2013 129)

It is sometimes suggested that a differentiator between the private assisted living market and the DoH/LA funded care market is the level of need at which people move in to ECH. Access to local authority contract funded places relates to existing care costs and the studies frequently reported high support needs at the point of admission. There is a comparative absence of studies on the private retirement living market. There it is understood that people purchase at a younger age and with fewer care needs, seeing the assisted living facilities as an insurance against future deterioration enabling them to age in place. These differences reduce the ability to generalise across niches from existing evidence.

How does ECH compare to residential care and living in the community in the achievement of individual well-being?

On the question of the added value of ECH in comparison to residential care there have been some attempts to move forward from Croucher et al's 2006 view that *'The evidence available to date does not yet demonstrate that housing with care offers a cost-effective alternative to residential care or to care in the home '*.

Several of the more empirically oriented studies attempt direct comparisons between care provided in different residential settings using tools such as ASCOT (discussed above). Baumker (2010, p.155) claimed to have 'comprehensive data' on outcomes. "*The outcome measures used in the study included a single quality of life question using a seven-point scale (Bowling, 1995), the Adult Social Care Outcome Toolkit (ASCOT) (Netten, Forder, & Shapiro, 2006), the CASP-19 scale (Hyde,Wiggins, Higgs, & Blane, 2003), and an indicator of self-perceived health as well as interviews with staff and relatives."* This data was applied to a single ECH scheme in Bradford to compare outcomes for those rehoused there to their experience in previous accommodation.

Previous quality of life measures were based on interviews at admission (potentially leading to confirmation bias); ECH QOL then measures on same scale after 6 months in ECH. Results show

improved QOL and reduced unmet needs. The biggest change was in improved social participation and involvement. *"Approximately two-thirds of residents reported that they had a good social life after moving to the scheme, and half of the residents had said that they had felt lonely and socially isolated in their previous homes."* (p.160). But there was no difference in self-perceived health before and after ECH. The main limitation is the single case study of a specific ECH model which is not well described. The methodology could be applied to a larger study to look at different ECH models and alternative living and service delivery configurations relating outcomes to costs and other enablers.

A more ambitious study by Callaghan and Towers (2014) assembled a large data set from four research studies of DoH ECH Programme, residential care homes and independent living settings to compare well-being outcomes across these residential settings. Resident experience was captured by ASCOT multiple dimension toolkit and outcomes were compared using logistic regression analysis. They found that *'after controlling for the independent effects of dependency, self-rated health and age group, setting had a significant effect on older people's sense of control. Residents in care homes and ECH reported similar levels of control over daily life but consistently reported feeling more in control than older people living at home and receiving home care.'* (1443). Thus while the study does evidence an improvement in well-being from living in ECH it fails to conclude that ECH has overall superior outcomes to residential care when directly compared. This is despite an earlier finding that '*people living in extra care schemes were 3.68 times more likely to feel in control than those receiving care at home, while people living in care homes 2.13 were times more likely to feel in control than those receiving care at home.'* (p.1441).

There remains some doubt about the adequacy of design of such studies with Smith who in 2015 still notes the "*paucity of past investigations on the contribution of social care to the quality of life of elderly residents in extra care housing."*(p.1). He argues for a more sophisticated longitudinal design in which "t*he same people are regularly revisited over a period of time'* with more direct voices of residents. He concluded that *'the importance of longitudinal studies lies in the very purpose of this kind of development and is more suited to a qualitative than a quantitative approach' (p,4).*

How does scheme design contribute to individual well-being?

Much of the research reviewed here payed very little attention to the built environment and the physical design of schemes. However, Atkinson et als (2014) meta-literature review did highlight the importance of built environment encapsulated by Utton (2009) "*an impairment becomes a disability only when the built environment does not compensate for impairments*" (p. 380). The design emphasis should be on promoting activity not safety and health - '*giving people control of their environment and affording good links with the community have a positive association with well-being.'* (p.19).

Wright et als study of 10 remodelled sheltered schemes was unusual including design audits by a built environment expert. They argue that "*more attention should be paid to design within an extra care scheme. The quality of some people's lives within several of the schemes was spoilt by inappropriate design for those with mobility and sight problems and, like many older people, declining strength."* (p.2252).

Atkinson et al also highlight the importance of access to outdoor space for resident well-being; and this can often be prevented by fortress type designs. Single main entrances can be *"intimidating because they shut too quickly and had poorly designed entry systems"* (Wright 2253). The HAPPI programme (HCA 2009), cited by Atkinson, had identified principles for housing and neighbourhood design, space, light and accessibility and connections with the wider community and disseminated these across providers who signed up to them.

One interesting debate in the literature is over the importance of communal spaces. within ECH schemes. Baumker et al 2011 analysed the DoH ECH programme and found that communal space accounted for 40% floor area. This could be interpreted as an unnecessary cost - '*Communal space increases the initial capital investment, which in effect has to be spread across the costs of the apartments rented or sold, and the cost of maintaining, cleaning and heating these areas impacts residents' service charges.*' (p.417). There were reports that HCA and some HAs were cutting down on communal space to 30%. However it could also be seen as a benefit "*some schemes have creatively used space and location advantages to try to offset the amount of capital investment on communal space such as restaurants, gyms and lounges by generating income from outside users or commissioned health and/or social care services."* (p.417). Moreover citing Evans

and Vallelly and others it is suggested that there is *"clear evidence that communal facilities, in particular restaurants and shops, are important in facilitating residents' social well-being* (Evans and Vallelly, 2007; Callaghan et al., 2009); furthermore commercial providers see these as important for scheme marketing. (P.417).

The need for careful interpretation of evidence on communal spaces is evident from the following tweet from a recent cohousing for elders seminar - *'you can create wonderful sharing spaces but that alone doesn't mean anything will happen in the space.*' (ESRC Collaborative Housing and Community Resilience Seminar, Nottingham, September14 2015).

How do connections with neighbourhood and community outside the scheme contribute to individual well-being?

Some of the design points discussed above touch on the important question of whether ECH is to be regarded as a facility within the community or as an institution closed off from the community in a similar style to a residential care home. The presence of forbidding controlled entrances and high levels of communal facilities could place ECH closer to Residential Care than independent housing in containing residents within an enclosed community. The emphasis on space for activities (support, social, leisure) within the institution rather than the wider community might be seen to reduce involvement of residents in the wider neighbourhood community. However, Baumker et al 2011 suggest the converse that these communal spaces may bring the community in to the institution by providing high grade facilities that others want to use.

Evidence on building wider community links and their contribution to well-being is found mainly in the more practice based contributions to the literature reviewed. An excellent example of community use of facilities an ECH scheme in Swansea in integrating ECH into the wider community is provided by Riseborough and Fletcher (2015) but the need for careful preparation and consultation with residents is highlighted.

Does ECH overcome social isolation?

The evidence on the role of ECH in overcoming social isolation is broadly positive. Moving from individual homes into a communal setting with some shared activities clearly has the potential for

increased social interaction (Netten 2011) and reduced isolation was often seen as one of the more successful outcomes for individual well-being. Baumker at al's (2010) study of people who had moved in to an ECH in Bradford found that the biggest change was in improved social participation and involvement and reduced isolation and loneliness. *"Approximately two-thirds of residents reported that they had a good social life after moving to the scheme, and half of the residents had said that they had felt lonely and socially isolated in their previous homes."* (p.160). But there was no difference in self-perceived health before and after ECH.

However, Callaghan et al's (2009) more nuanced finding was that '*those who continue to experience social isolation tend to be those with the highest support needs'.* This led to work such as Croucher and Bevan's (2012) on overcoming isolation by promoting positive and supportive relationships between residents with higher and lower support needs within ECH. (JRF Living Together Getting Along programme). This may be initiated by the organisation, resident-led or involve outside enablers. It can include building links between the scheme and the neighbourhood and community.

Nevertheless there is a difference between social interaction and the absence of loneliness. *Burholt et al (2013)* used 'mediation analysis' in a stratified sample of 183 older people aged 60–98 years split equally between three living environments: residential care, extracare sheltered housing and in the community. They found greater social interaction in ECH (using the Luben Social Network scale) but no difference in loneliness between the three settings. They further found that quality and emotionally satisfying social relationships were generally limited to those outside of the scheme. This led to an important conclusion that maintaining long-term friendships outside the scheme is very important to reducing loneliness. This further builds the case for ECH with strong external community links rather than as a self-contained institution.

Does ECH enable choice and ageing in place?

Overall despite the limitations of evidence and the relatively short period in which to assess the longer term role of enabling people to age in place, the studies seem to be remarkably positive about ECH outcomes in this respect. Atkinson et al found very limited evidence on how social care is delivered in these settings but nevertheless found housing with care in 'strong position to deliver' on Government aspirations. They cite Riseborough and Fletcher (2008) who suggest three

key features: being primarily housing and not an institution; supporting ageing in place and promoting independent living.

The strongest evidence on this topic in the review comes from Kneale (2011) cited by Smith (2015) as "a longitudinal retrospective analysis of the quality of life of nearly 4,000 residents *living in extra care housing schemes operated by three providers. The focus was on the social profiles of the residents, length of stay and whether extra care housing can be seen as a "home for life", together with changing health characteristics. A key feature of the study was to compare the information from the extra care housing providers with matched data from two national sources (the British Household Panel Survey and the English Longitudinal Study of Ageing) to compare the pattern of life over time between extra care housing residents and older people living in their own home "in the community"* (Smith 2015 p.6). Kneale (2011) concluded that extra care housing does support *"some of the oldest and frailest members of society" and with relatively small numbers moving to "institutional accommodation" can be seen as a "home for life" for the majority of residents (p. 124).*

Smith sums up the evidence to date '*In summary, most residents were enjoying a good social life, using the activities available and making new friends.'* Smith 2015 P.6.

What evidence is there on mutual and self-help approaches with ECH residents?

Blood and Panell (2012) ask *'how do those living in communities exclusively designed for older people support each other and contribute and connect to the wider community living in retirement housing'* (p.1). They attempt to answer this question in a LIN Viewpoint piece informed by literature review and case studies.

They found a lot of good practice at local level on mutual, co-production approaches involving residents and volunteers, for example time-banks, hact's up2us pilots (2011), older residents of an extra care housing scheme in Barking and Dagenham, have been supported to set up a formal association. Although they do not receive individual budgets, they instead contribute from their own money to collectively purchase activities and have opened a collective bank account in order to do this (p.15). There is reference to co-housing models (Brenton 2008) but are there no 'ageing

better together' case studies of the type developed by Glass for US elders co-housing schemes (Glass 2013).

Blood and Pannell (2012) argue that these initiatives have not become mainstream in the retirement housing sector. They concur with Wright et al (2010) that there is not a strong tradition of *'staff working with, rather than for, tenants'* (Wright et al *p.* 2253). Yet this is not seen as a problem by the Commission for Social care inspection process. Furthermore Blood and Pannell identify some additional barriers in ECH schemes. '*Co-production of extra care housing is a daunting task because of the scale, timeframe and financial risks, but the Abbeyfield Society can offer support to local communities'*(p,15).

Furthermore '*High support needs – especially in extra care housing, where there tends to be increasing levels of disability, frailty and dementia, there can be a number of cognitive, practical and communication barriers to involvement'* (p.16). Residents with higher care needs are also thought to be less able to finance self-help approaches because their "*money is tied up in buying the support that they need to live in their accommodation" (p.16).*

What is the role of the ECH workforce in co-producing ECH solutions?

A key issue for the promotion of individual well-being in ECH highlighted by two of the publications reviewed is the role of the workforce, particularly front-line staff. Smith (2015) argues powerfully that *"An important knowledge gap is on working conditions of staff in ECH. We need research on everyday lives of residents and their interaction with staff."* Blood (2010) concurs using a resident quote to confirm *"It's the staff that make this such a good place to live."* (p.1).

The role of staff in the development of the scheme and in building relationships with residents to impact on their well-being is also something that requires study over time. Smith (2015) argues that *In housing with care, residents do over time for one reason or another, change the pattern of their everyday life, The experiences of frontline staff and their managers can also change over time* (p.4).

Blood et al 2010 also consider the role of ECH in building links between professional staff in three distinct fields: housing, care and support services. This JRF programme report was geared to

disseminating findings to a practice audience. It nicely unpacks findings from 2 research studies of 21 Housing with care (HWC) schemes, including 98 tenant and leaseholder interviews. Findings on workforce and management and partnerships help to understand drivers of individual well-being They distil research findings into practical tools such as checklists of staff roles divided between care, support and housing.

The importance of staff in co-producing well-being outcomes with residents has probably been underplayed in the literature to date. Smith (2015) argues that ' t*here has been a dearth of qualitative longitudinal studies focusing on care workers and care managers in extra care housing.'* SITRA (2014) ask whether the development of extra care housing has helped to break down barriers and has led to roles that "cross-over" between care and housing professionals.

What are the key gaps in our knowledge?

The review indicates that work in this field is at a relatively early stage and is often focusing on different ECH models and research questions. There is a particular focus on specific programmes: namely the DOH Extra Care Housing Fund capital grant programme and to a lesser extent on remodelling of existing local authority and housing association sheltered housing schemes into ECH. There is a surprising neglect of the growing private sector assisted living market and the increasing role this is playing in later life transitions.

Attempts to track the impact of moves into ECH for individual well-being are often hampered by the absence of longitudinal data before the move and by an over-reliance on administrative data rather than personal perspectives of residents.

There is an emerging literature on the claimed benefits of cohousing, mutual and self-help approaches but this now needs to be bolstered by more primary research. Whilst a key advantage for residents of ECH over care homes is their occupancy based on tenure rights this has been given surprisingly little attention in the literature reviewed which focuses more on costs, care services and overcoming isolation. There is also little attention to the Planning system and how use classification affects ECH as opposed to residential homes.

Another theme that is surprisingly mute in the literature reviewed is the availability of choices of care and support providers for residents living in ECH, with the default assumption appearing to be provision by the landlord or the selected care and support partners. Finally there is a neglect of the key role played by front line workers and the co-production of services with residents.

Summary of Gaps

- Qualitative longitudinal studies reliance on administrative data and recall at the point of admission.
- Cohousing, mutual and self-help approaches (need to move from think pieces to primary research).
- Tenure rights and how these affect well-being compared to insecure status of residential care.
- Choice of care and support services and providers by ECH residents (to what extent is accommodation unbundled from services?)
- The Planning system and how use classification affects ECH v residential homes.
- Workforce issues and role of co-production of services between staff and residents.

What further research would we therefore recommend?

We would therefore recommend the following areas as worthy of further research to begin to fill in some of the gaps in knowledge on the impact of ECH on individual well-being.

- Closer exploration of different models of ECH, differences between the social care contract market and the assisted living retirement market, differences between tenures to separate out the drivers of impacts on well-being.
- Qualitative longitudinal studies focused on users' perceived wellbeing before, after and for a longer period after the move into ECH.
- Primary research on cohousing approaches and impact on loneliness, control and well-being.
- Linked consideration of the significance of individual control through secure tenure and choice of service providers in driving individual well-being.
- Action research exploring co-production of well-being between front-line staff and residents – how are choices articulated and realised?

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About Housing and Communities Research Group

The Housing and Communities Research Group, led by Professor David Mullins, is part of the School of Social Policy at the University of Birmingham. With a team of professors, research fellows, lecturers and PhD candidates, the group draws on a wide range of skills and expertise. In addition to large scale research, the group also work with practitioners and industry on short-term consultancy projects (1 to 4 month projects) on our core themes and fields of interest including:

- Housing solutions for low and middle income communities
- Social housing, Community led housing, Self- help housing and Cooperatives
- Role of Private Rented Sector in housing low and middle income households
- Social Lettings Agencies
- Choice based Lettings – conditionality and need in social housing allocations
- Homelessness, young peoples' housing options, youth homelessness
- Generation rent – the expanding role of private renting for younger households
- Older people's housing: extra care housing, co-housing and 'growing older together'
- Community led engagement, Community investment and financial inclusion
- Renewing older housing and empty homes
- Role of organisational design, governance and partnerships
- Governance and leadership of housing organisations
- Non-profit sector housing, social enterprises in housing, Civil society and housing

About the Evidence Review Series

This new series will publish short but well-informed and critical state of the art reviews of key topics in housing policy and practice drawing on evidence from peer reviewed academic work and the professional practice literature. If you would like us to undertake a review like this of a topic of importance to your organisation please contact David Mullins to discuss your requirements d.w.mullins@bham.ac.uk

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