

Village Life

Brian Beach

August 2015

Independence, Loneliness, and Quality of Life
in Retirement Villages with Extra Care



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ILC-UK

11 Tufton Street

London

SW1P 3QB

Tel: +44 (0) 20 7340 0440

www.ilcuk.org.uk

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Acknowledgements

This research would not have been possible without the funding from Audley Retirement and Bupa. While this report was produced courtesy of their funding, all views expressed within the report are those of the author and ILC-UK. We are grateful in particular for the support and feedback from Katherine Rose (Audley) and Graham Stokes (Bupa) throughout production of this report. Special thanks are also in order for Howard Nankivell and Priscilla Spurling at Anchor Trust for their help in distributing surveys at Denham Garden Village; to Ann Bowling (University of Southampton), Jill Manthorpe (King's College London), Anne Netten (University of Kent), and Jeremy Porteus (Housing LIN) for their advice and input in the design of the survey; and to George Holley-Moore and David Sinclair at ILC-UK for feedback on the drafted report.

This report uses data from the English Longitudinal Study of Ageing (ELSA). The data were made available through the UK Data Archive (UKDA). ELSA was developed by a team of researchers based at NatCen Social Research, University College London, and the Institute for Fiscal Studies. The data were collected by NatCen Social Research. Funding is provided by the National Institute of Aging in the United States and a consortium of UK government departments co-ordinated by the Office for National Statistics. The developers and funder of ELSA and the Archive do not bear any responsibility for the analyses or interpretations presented here.

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Executive Summary

As our society ages, we can expect to see greater numbers of people living into later life, with more people than ever before developing needs for care and support. Innovative and creative solutions are key to avoiding the increasing and unsustainable pressures to deliver this social care. One such solution – the focus of this report – is the idea of extra care housing, where care services are provided on an as-needed basis to residents within their own homes.

The underlying philosophy behind extra care as a concept when it comes to housing with care is that it offers an alternative to residential care, providing a home for life. This report surveyed residents in retirement villages that offer extra care support in order to explore three other objectives of extra care housing that have emerged:

- It can promote greater **independence** and provide greater **choice** in planning for later life than would otherwise be available.
- The communal environment has the potential to **reduce social isolation**, particularly for residents who move from more rural or remote homes.
- It can also promote residents' **quality of life**, enhancing it compared to what they would experience either in the general community or in another residential care setting.

We examined the motivations behind why people decided to move into their retirement villages, how they found them, and how their experiences might reflect the concepts of independence and control. We found that:

- **Friends and relatives** – particularly children – play an important role in helping respondents identify their new housing, with over a third (33.8%) giving this reason.
- Similar proportions reported **advertisements and living in the local area** as the main way they identified their housing. Marketing could therefore be an effective tool both in promoting the housing generally but also to inform locals about the opportunities and services on offer.
- **Independence and an active lifestyle** were the main reasons motivating a decision to move (52.8% and 53.3% respectively), though the desire to **downsize** was also prominent (48.2%).
- Very few respondents reported that care needs for oneself or a spouse/partner were the main motivating factor in moving (1.5% and 6.5%), although **expectation of future care** did feature (30.2%), suggesting proactive planning played a bigger role than 'leaving it too late'.

In addition to social isolation, loneliness can have a negative impact on people in later life, so our survey asked residents a number of questions used to assess feelings of isolation and loneliness.

- Overall, the findings suggest that a large proportion of respondents avoid the negative subjective experiences of both **isolation** and **loneliness**.
- Over 4 out of 5 (81.7%) respondents said they hardly ever or never feel **isolated**, and only 1.1% often feel isolated.
- Very small proportions of respondents report a high degree of **loneliness**, measured either using a single question or a three-item scale (3.6% and 3.8% respectively).
- Using the three-item scale, 64.2% of respondents can be classified as **not lonely** at all.

Quality of life can be measured a number of different ways, and previous research in this area around housing with care has used less well-developed or standardised measures. We adopted two sets of questions that examine quality of life among older people, which offer insights into particular aspects of people's experiences but also provide an overall score for quality of life.

- The vast majority of respondents have **high quality of life** as assessed using either measure of quality of life.
- Respondents also report a **high degree of control** over their lives as measured as a specific domain of quality of life.
- Nearly all of our respondents (97.0%) agreed or strongly agreed with the statement, '**I feel safe where I live**'.
- For both measures of quality of life, questions around **health concerns** showed the greatest variation, with relatively fewer positive statements than other items, demonstrating that health remains an important issue in how people think about quality of life.

Since our entire sample came from residents in retirement villages with extra care, the findings cannot tell us much about how their experiences might vary from those of others or if the residence might have an influence on this. We applied a statistical technique using additional data that allowed us to make a comparable sample of people living in private housing. We found that:

- The residents in our sample appear to have **higher quality of life** than a similar group living in the community, offering possible evidence that this housing arrangement can enhance residents' quality of life compared to if they had remained in their previous home.
- We also found strong evidence that our sample experiences a **higher sense of control** than those in community households, and that control appears to be the aspect of quality of life most positively associated with residence in housing with extra care.
- Our respondents reported lower loneliness than those in the community, giving some reason to believe that housing with extra care plays a role in **reducing loneliness** among its residents compared to what might be experienced if they stayed in the community.

Our findings have different implications for different groups. For example, since the results suggest that housing with extra care is delivering on its stated objectives – which are aligned with broad government policy priorities in this area – government should think about doing more to promote such alternative models of housing with care. For providers of such housing, our research provides evidence that residents are overall quite happy with their decision after their move. Moreover, we found that friends, family, locality, and advertising are all important reasons that people found out about such housing, while independence and an active lifestyle were important motivating reasons to move. Finally, for researchers in this field, this research provides some preliminary insights to the experiences in retirement villages, despite limitations in the data. Overall, the findings suggest that such extra care support is a good option for people, and further research is needed.

Introduction

New and innovative models for providing social care are crucial to address rising costs for care in an ageing society. The projected growth in the number of older people in the coming decades will put increasing and unsustainable pressure on existing services, and creative solutions to the emerging challenges have the potential to drastically mitigate these pressures, enhancing cost-effectiveness and improving on the quality of care and indeed the quality of life for those receiving care and support.

One approach to emerge in recent years has been alternative models to housing with care, in particular the concept of extra care housing. The idea behind extra care housing is that people can move into a new home where care services are available as needed, flexibly tailored to suit the individual circumstances of the resident. Part of the strategy behind extra care housing is to encourage people to make the move before care needs arise, so that as issues appear the services can intervene to deliver the needed support as well as mitigate any deterioration that might otherwise occur if they had remained in their previous home. Extra care housing also aims to provide a 'home for life'; the on-site care services are intended to prevent an unnecessary move into a more traditional care home, allowing residents to remain in their new home through their final years.

Other goals behind the development and design of extra care housing have been to provide people with greater independence and choice, reduce social isolation, and promote their quality of life. These concepts form the basis for the research included in this report. We distributed a survey questionnaire to residents in a number of retirement villages that are a form of extra care housing across England, collecting information on their decisions to move, their feelings related to their social connections, and standard measures of quality of life.

This report presents the findings of our survey along the following structure:

Section 1 presents some of the background information related to housing with care in general and extra care housing more specifically, which sets out the rationale for our approach here.

Section 2 outlines the research framework and the details related to the residences we surveyed.

Section 3 explores the concepts of independence and choice with respect to retirement villages with extra care housing by looking into the decision-making process and motivation of residents to move.

Section 4 offers insights into residents' experiences of loneliness, for which social isolation can be a risk factor.

Section 5 discusses different measures of quality of life and presents the findings from our survey using two such measures.

Section 6 compares our findings with those from a comparable sample in the general population to identify how living in retirement villages with extra care housing may have a beneficial impact on loneliness and quality of life.

Section 7 provides a short conclusion reflecting on the findings, the limitations to the research, and the implications for policy-makers and housing providers.

Housing with Care

The ageing of the population reflects huge advances in health and longevity. At the same time, with more people living longer, growing numbers of people will require care at some point in the future, as issues such as frailty or cognitive impairment become more prevalent among the population. Recognising this increase in the future need for care has led to a number of new developments and ideas around how to help people move into later life comfortably and with dignity.

A particular area that has evolved in recent years in response to the care needs of older people is in housing with care. A range of definitions cover what housing with care actually means, much of which reflects the way the concept has evolved in the UK.¹ In the end of the 20th century, housing providers – generally under the auspices of local authorities and housing associations – gradually began to respond to how residents in sheltered housing schemes had changing needs in terms of care.² Over time, interest from health and social care professionals grew as they viewed the changing approaches to housing with care as alternatives to the traditional models involving sheltered housing or residential care. Combined with the desire to enhance older people's independence, these models subsequently led to a number of other providers offering different schemes that draw appeal as alternatives to residential care, offer a new delivery of existing services, or even promote a completely new concept.³

The variety of schemes that have emerged – and the variation between them – contributes to the challenge of identifying clear definitions for different types of housing with care.⁴ Nonetheless, housing with care can generally be understood as a purpose-built, community-based alternative to residential care for older people that seeks to fill their housing, care, and support needs simultaneously while promoting their independence within private accommodation.⁵

Alongside the emergence of different models for housing with care, the market for retirement communities or villages has also been growing in recent years as greater numbers of people re-think their plans for later life. These arrangements take into consideration the housing and community needs for people as they age. Retirement villages are designed around a central hub, where amenities including a health club, swimming pool, GP surgery, restaurants and cafés are available. Since the first kind of retirement village was established in the UK over 25 years ago, more developments have emerged, with funding coming from local authorities, charitable schemes, and private organisations.

One particular approach to housing with care that has received growing attention is extra care housing, also sometimes called very sheltered housing or assisted living. However, rather than being seen as a specific type of housing, extra care is recognised as more of a concept.⁶ Indeed, much of the appeal of many retirement villages is in how they provide services for people as care needs evolve, and many retirement villages themselves can be called extra care housing.

At its core, extra care housing operates as housing first, providing private self-contained homes to people with the underlying legal rights inherent to such occupancy. In addition, extra care housing is generally also characterised as an arrangement for older people wherein care services are available in a flexible way, tailored to residents' particular and evolving needs, provided on-site, with staff available 24 hours a day.⁷ In providing personal housing alongside individualised care, extra care housing schemes are seen as a viable alternative to and possible replacement for residential care.⁸

¹ Croucher et al. (2006)

² Oldman (2000); Tinker et al. (1999)

³ Croucher et al. (2006)

⁴ Baker (2002)

⁵ Callaghan & Towers (2014); cf. Department of Health (2005), Riseborough & Fletcher (2008)

⁶ Riseborough & Fletcher (2008)

⁷ Laing and Buisson (2010)

⁸ Netten et al. (2011)

In this way, extra care housing is often promoted as providing a ‘home for life’, where the flexible delivery of care that is adapted to changing needs allows residents to remain living independently beyond the point where they would have had to leave their previous housing for services in a care home or other institutional setting.⁹ Previous research has explored the evidence around whether this is an accurate representation of extra care housing, with general consensus from the existing research up to 2007 suggesting that extra care housing could be considered as offering a home for life and an alternative to residential care.¹⁰ Limits exist however for those with unpredictable and continuous need, where a care home model is more appropriate, and the fact that some residents do transition into residential care has drawn criticism of this home for life claim.¹¹ Nonetheless, recent research has identified that extra care housing residents were far less likely to enter institutional accommodation than a comparable sample of people in the community receiving home care services, so even if some residents must inevitably transition into another institutional setting at some point, extra care housing does appear to be a promising option for helping older people remain living independently in their own homes for longer under these schemes.¹²

Part of the innovation inherent to extra care housing is how it offers a compromise or third way between residential care and staying in one’s previous home.¹³ This type of housing offers an alternative to traditional forms of institutional care settings, such as care homes, where concerns related to social care funding have also been increasing, and there is evidence that extra care housing is in fact more cost-effective than care homes, at least for some older people.¹⁴ At the same time, extra care housing serves as an alternative to remaining in one’s previous home – ‘staying put’ – which can be detrimental for people as they age when the housing is ill-suited to their needs (e.g. impaired mobility and several stairs), care service provision can be disjointed and inadequate, or the residence contributes to social isolation.¹⁵

Such arrangements in housing and care also harmonise with government policy aims in this area.¹⁶ These have chiefly been focussed on two areas. First is the desire to manage the financial implications of population ageing and offer new ways to deal with the growing demand for care through new innovations. In addition, policy is oriented around the goal of enhancing quality of life through independence and choice in housing and care. So far, the evidence supports the idea that extra care housing and retirement villages are well-positioned to support these policy goals.¹⁷ The nature of such housing options also aligns with the evolving emphasis on personalisation in care policy.¹⁸

As mentioned, there is a wide variety of definitions for housing with care and extra care housing specifically, made more complex by the fact that many of the schemes available have their own unique components. Despite this variation, the ideas that such housing can provide an alternative to residential or institutional models of care as well as offer a home for life are commonly reflected in discussions around the objectives of such housing provision.¹⁹ In recent years, there also appears to have been a gradual evolution in terms of the underlying philosophy around extra care housing. In addition to providing care services as needed, three other aims have emerged as common to how such schemes can enhance the lives of their residents:

- Fundamental to this new ethos is the idea that extra care housing can by its nature promote greater **independence** among older people by offering on-site amenities and care services, while also giving them greater **choice** in planning for later life than would otherwise be available.

⁹ Bäumker et al. (2012)

¹⁰ Institute of Public Care (2007)

¹¹ Croucher et al. (2006)

¹² Kneale (2011)

¹³ Callaghan & Towers (2014)

¹⁴ Bäumker et al. (2011)

¹⁵ Callaghan & Towers (2014)

¹⁶ Atkinson et al. (2014)

¹⁷ Atkinson et al. (2014)

¹⁸ Callaghan & Towers (2014); Atkinson et al. (2014)

¹⁹ Croucher et al. (2006)

- In addition, by bringing older people into a more communal living environment, extra care schemes have the potential to **reduce social isolation**, particularly for residents who move from more rural or remote homes.
- Extra care housing schemes also aim to promote residents' **quality of life**, enhancing it compared to what they would experience either in the general community or in another residential care setting.

These three objectives provide the basis for which extra care housing is argued as an attractive and innovative approach to managing the developing care needs of our older population. There have been some explorations in previous research into the degree to which extra care housing fulfils these objectives, and this research seeks to expand our understanding of how this particular type of housing with care succeeds in offering independence and choice, addressing social isolation, and improving quality of life. These three themes form the structure for the rest of this report.

Research Framework

This report draws on data gathered from survey questionnaires distributed to seven different residences run by two housing with care providers. The surveyed residences are all luxury retirement villages that operate as a form of extra care housing; in other words, they provide both the high quality amenities and flexible care services that characterise retirement villages and extra care housing. As such, we must keep in mind that the findings here reflect settings that are of a high standard, representing only this type of housing with care. Paper surveys were sent to all residents in each of the residences by post and returned via pre-paid envelopes to their respective administration teams who forwarded the surveys on to ILC-UK for coding and analysis. Out of the 743 total residents, we received at least partially completed surveys from 201, representing a response rate of 27.1%. As cohabiting residents were encouraged to respond individually, we can also identify that our respondents come from 158 households.

We must acknowledge that there is the possibility for bias in our sample from unit non-response. In other words, the residents who completed and returned the questionnaire are possibly quite different from those who did not. Various reasons could have played a role in influencing why non-respondents did not complete the survey. The most obvious example given the current research and sampling context could be that housing residents with a higher degree of care needs and limitations in mobility or functioning were less capable of or interested in going through the paper questionnaire and filling it out. Moreover, issues around cognitive impairment – in particular, dementia – may have hindered respondents' ability to complete the survey. Without information on the full population of the surveyed residents, we cannot know if our sample is representative or not, that is, if non-response is actually random.

The fact that unit non-response may not be completely random limits the ability for these results to be generalised, either to the full population of residents in these locations or to the broader group of people in the UK residing in extra care housing, which has been highlighted as an issue in other research.²⁰ As such, we must recognise that the findings represent only the subset of residents who responded and therefore form our sample, remaining aware of the potential for important differences to exist between the sample and the overall population of residents, although the variation in the characteristics of our sample may point to it being rather representative. Nonetheless, regardless of the degree to which our sample represents the full population of residents in these particular settings, the findings from the survey offer initial insights into the views of residents in retirement villages with extra care services.

Moreover, given previously identified differences between residents in villages with extra care like we study here and people in other extra care schemes, residents in extra care villages have been excluded from some of the previous research.²¹ This research thus provides some knowledge about this group and helps develop an understanding of the experiences of people in this type of housing with care.

The Residences

Six of the residences included in the survey are run by Audley Retirement. These residences represent luxury retirement villages, and their target market is composed of people from higher socio-economic and income profiles. Audley currently runs 10 properties across England, with two more in development. The residences included in the survey here reflect a geographical range from Yorkshire through the Midlands and down to Kent.

While some researchers have noted that there is a distinction between retirement villages and extra care housing, the noted difference is generally that retirement villages tend to be larger (e.g. with

²⁰ Bäumker et al. (2010)

²¹ e.g. Callaghan & Towers (2014)

100 or more units), generally provide a wider range of social activities, and may not in fact offer any extra care service provision.²² However, the industry has made no clear, standardised distinctions between such establishments, and communicating these products to consumers raises other questions and concerns. While the Audley developments are called luxury retirement villages, the residences also represent a form of extra care housing, as all residents have access to emergency care on a 24-hour basis, and the Audley Care programme provides personalised care services to residences.

The seventh residence included in the survey was Denham Garden Village, located in Buckinghamshire and run by Anchor Trust, a not-for-profit provider of housing and care for people aged 55+. Anchor offers rental and purchasing options at over 1,000 locations across England, including almost 100 care homes and three retirement villages. Like the Audley properties, Denham Garden Village is a luxury retirement village, and its on-site presence of a GP and 24-hour care and support confirm that the extra care concept is also in operation there.

Table 1 below lists the properties included in the survey, along with the number of respondents from each, the total number of residents in each location, and the subsequent response rate by location, which ranged from 18.6% to 55.6%. Despite some higher than average response rates at certain locations, the relatively small number of responses compared to the population size hinders our ability to draw definitive conclusions with strong confidence on a location-by-location basis. Still, although over-generalisation should be avoided, the similarity in the residences in terms of their underlying philosophy as luxury retirement villages provides us some scope in examining them as a group.²³

Table 1: Responses and Residents by Housing Location

Residence	Number of Respondents	Total Number of Residents	Residence Response Rate
Binswood	20	36	55.6%
Clevedon	22	70	31.4%
Denham Garden	90	413	21.8%
Inglewood	10	47	21.3%
Mote	30	68	44.1%
St Elphin's Park	18	50	36.0%
Willicombe Park	11	59	18.6%
Total	201	743	27.1%

The Sample of Respondents

The survey questionnaire distributed to residents had six pages of questions and included a unique identifying code to preserve the anonymity of the respondent. It began by collecting a number of basic socio-demographic details before moving on to ask residents about their decisions to move into their current housing and including standard batteries of questions used in other research to assess quality of life and feelings of loneliness. More details on the survey content will be featured in subsequent sections where relevant.

The socio-demographic characteristics that we gathered from the questionnaire included: self-reported general health, age group, gender, and marital status. While a few responses were missing on different surveys, the distribution of responses for each of these measures is listed in Table 2.

²² cf. Evans (2009); Netten et al. (2011)

²³ For example, the overall response rate here allows statistical estimates of 95% confidence with a margin of error of less than 6% if we were to ignore non-response bias.

Table 2: Socio-demographic Characteristics of Survey Respondents

Current Health	Number	%	Age Group	Number	%
Very good	33	16.67	<55	1	0.50
Good	87	43.94	55-59	2	1.01
Fair	67	33.84	60-64	10	5.03
Poor	10	5.05	65-69	16	8.04
Very poor	1	0.51	70-74	21	10.55
Total	198	100	75-79	47	23.62
			80-84	55	27.64
			85-89	30	15.08
			90+	17	8.54
			Total	199	100
Gender	Number	%	Health Over Time	Number	%
Male	73	37.24	Decline	55	27.92
Female	123	62.76	No Change	133	67.51
Total	196	100	Improvement	9	4.57
			Total	197	100
Marital Status	Number	%			
Single	7	3.52			
Married/Cohab	109	54.77			
Sep/Divorced	7	3.52			
Widowed	76	38.19			
Total	199	100			

In terms of these socio-demographic characteristics that we collected, we see that we do have survey respondents from a range of ages, with 3 respondents below 60 and 17 (8.5%) aged 90+, with over half of the sample aged 75-84 (51.3%). Nearly two-thirds (62.8%) are female, while over half (54.8%) are married or cohabiting. Among those without a partner, the vast majority (84.4%) report being widowed as opposed to single, separated, or divorced.

In addition to current self-reported health status, the survey questionnaire also asked people to report the state of their health prior to moving into their current residence, with the intent to examine the degree of any perceived improvements or declines in health following the move. Over two-thirds of respondents (67.5%) had no change in self-reported health, while over a quarter (27.5%) reported a decline in health after their move. The length of tenure for respondents was not available, however, so it is unclear the degree to which declines in health were associated with some sort of age-related decline over time. It is also worth noting that over half of the declines represented prior assessments of 'Good' health coupled with current reports of 'Fair' health; only around 1 in 10 respondents whose health declined ended up in 'Poor' or 'Very poor' health.

As for current self-reported health status, the vast majority of respondents in our sample reported 'Fair' or better health (94.4%), and over 6 in 10 reported 'Good' or 'Very good' health (60.6%). Although a particular appeal of these residences is in the availability of flexible care services, the respondents in our sample demonstrate relatively good health, possibly suggesting that they in fact

represent the kind of people who have elected to move into this kind of housing in advance of any health problems as part of a kind of preventive strategy; we look further into the reasons for moving in the next section.

At the same, however, this positive picture of health may point toward the caveat mentioned earlier around the representativeness of our sample. It could be that those residents who are in poorer health or with heavy care burdens were more likely not to return the survey. We do not have information on the overall prevalence of care receipt in the different residences, but we were provided information on individuals' receipt of care for most of those in the Audley properties – only four were receiving health-related care, and only 12 had ever received health-related care. Audley management have confirmed that only a small proportion of current residents are in receipt of health-related care services, so our sample may actually be representative in terms of health and care.

While there is tremendous interest in the context of this research to understand the experiences of residents in extra care housing who do receive the care services on offer, we must recognise that a limitation to the current research is the lack of information on care needs for Denham Garden Village and the extremely low proportion receiving care services where data are available. Although we cannot fully take into account the important relationship between receipt of care and the experiences of those in these retirement villages with extra care, the findings from our survey do offer some potential insights into what life is like in these settings. The next section offers the first look into our results, examining how residents make the choice of moving.

Independence & Choice: Moving into Housing with Care

Key Findings:

- **Friends and relatives** – particularly children – play an important role in helping respondents identify their new housing, with over a third (33.8%) giving this reason.
- Similar proportions reported **advertisements and living in the local area** as the main way they identified their housing. Marketing could therefore be an effective tool both in promoting the housing generally but also to inform locals about the opportunities and services on offer.
- **Independence and an active lifestyle** were the main reasons motivating a decision to move (52.8% and 53.3% respectively), though the desire to **downsize** was also prominent (48.2%).
- Very few respondents reported that care needs for oneself or a spouse/partner were the main motivating factor in moving (1.5% and 6.5%), although **expectation of future care** did feature (30.2%), suggesting proactive planning played a bigger role than ‘leaving it too late’.

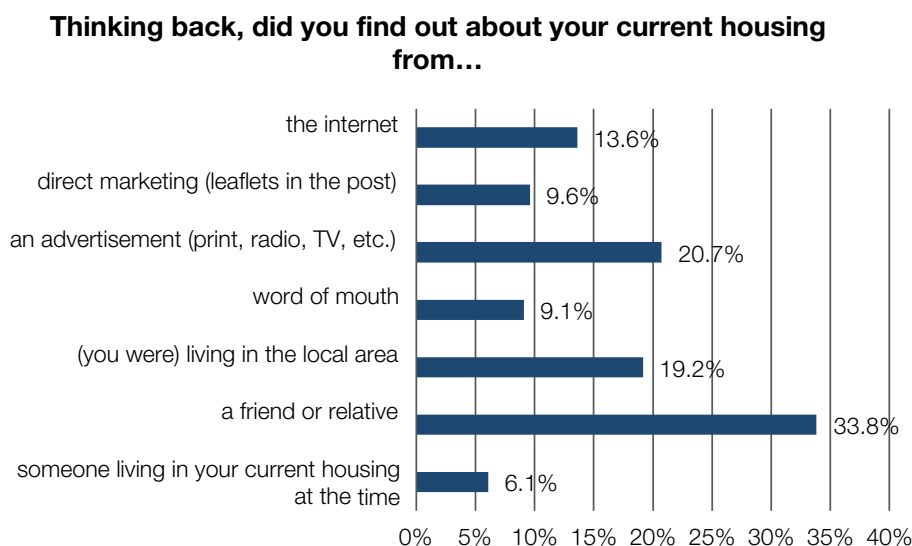
An objective of extra care housing is to provide older people with an alternative option to staying at home as their need for care and support increases as well as to avoid or at least delay for as long as possible moves into institutional or residential care settings. Part of the philosophy is to provide older people with greater independence as they age and greater choice over their options as care becomes a more important consideration.

As part of this research, we were interested in the decision-making process that residents undertook as they thought about this type of housing as an option for them. This interest was also motivated by the question of whether people are ‘leaving it too late’ to move into extra care housing. In other words, where moves are motivated by the sudden development of care needs, the comparative advantage that extra care housing can provide in terms of delaying or mitigating the onset of impairment may be diminished. This might increase the likelihood of needing to move into a more traditional setting like a care home, negating much of the appeal and overarching goals of extra care housing schemes. We were unable to find any empirical studies to date that have examined this question, and it remains an area ripe for new research.

Discovering These Housing Options

Of course, a fundamental element related to older people deciding to move into these alternative forms of housing with care is their awareness of their existence and what they offer. In our survey, we asked respondents to think back to how they learned about their current housing and to identify the sources through which they discovered it. Respondents were instructed to select all applicable answers, though few actually selected multiple options; 14 respondents did not select any of the available options. We also asked how they would describe what they thought about it as an option before they decided to move using an open-ended question. Figure 1 shows the different response options and the percentage of respondents identifying each.

Figure 1: Methods of Discovering these Housing Options



Over a third (33.8%) of respondents reported that a friend or relative played a role in helping them identify their housing. In the open-ended questions, many of the comments that were left referenced the importance of respondents' children in bringing this housing option to their attention, and this is supported by previous evidence.²⁴ This demonstrates the importance of word of mouth – an option on its own, with 9.1% of respondents noting it – and social networks in communicating the option of extra care retirement villages to prospective movers. One implication from this is that there may be a need for providers to put special consideration into how they reach and appeal to childless older people or those who might be socially isolated.

"I had been looking for a suitable flat for a long time as my husband was finding the stairs more and more difficult, and I was finding it more necessary to call for help. My grandson phoned on a Saturday afternoon and we drove straight down...and bought that afternoon."

Living in the local area and advertisements were the next most common responses, at 19.2% and 20.7% respectively. This highlights the importance of visibility for these housing options. Having a scheme nearby increases the chances that people will be aware of the residence's existence, but this will only encourage older people to consider moving into such an arrangement when they and other members of the community are also familiar with what the housing actually provides. People in the local area are also likely drawn by the fact that they will already be familiar with the surrounding environment and may have established social connections, including nearby family, which they would prefer to preserve.

"We lived down the valley...and so knew the building as a prep school. Then we heard of the plans for a retirement village and thought it would suit us - as it does!"

The percentage reporting advertisements as the way they discovered the housing shows that such marketing has had a certain degree of influence on drawing in residents. Advertisements may also provide an effective way for providers to reach more isolated older people and generate interest in retirement villages and housing with care among them. In addition, the relative prevalence of advertisements as the way people found out about the housing could serve as an effective tool to enhancing the degree to which older people – particularly those already living nearby – understand the purpose of the scheme and what it actually offers.

"I was very tempted by the promises...in the marketing literature. I looked forward to no longer being responsible for all the upkeep of my house...I have no intention of moving house again!... The fact that I could be completely independent in my own environment and with a small garden [was] important."

²⁴ cf. Gibler et al. (1998); Knight & Buys (2003)

Making the Decision to Move

Understanding the drivers for people to actually make the decision to move into retirement villages with extra care services is crucial for providers to ensure their accommodation appeals to people in an effective way. It also informs providers on what elements might enhance uptake and transitions into such housing.

Research has previously explored why people make the decision to move into housing with care. A recurrent theme that has been found is that such decisions appear primarily to be the result of proactive planning rather than a passive reaction to emergent care needs.²⁵ This seems particularly true for moves into retirement villages compared to smaller housing and care schemes – partly due to smaller schemes often being regulated by local authorities that target specific groups – but the evidence does also suggest that older people who move into smaller care schemes do make active decisions to move, taking their future needs into account.²⁶

There is also reason to look at differences between those people who do or do not have care needs when they move. People without care needs are more likely to be drawn to such housing by the social amenities and the accommodation itself than those who have care needs and thus have this weigh more heavily in their considerations to move.²⁷ Yet health concerns have been identified as an important motivation for people to move out of their previous homes, and this has been shown to be true for both groups, suggesting that future care needs are taken into consideration similarly to current needs.²⁸ The draw of flexible, on-site care support influences a planned decision-making process regarding moving into extra care housing. Overall, the evidence thus suggests that moves into extra care housing are related to a positive, proactive choice, distinct from the typically more stressful experience of moving into a care home.²⁹

To explore the motivations to move among our sample, our survey asked respondents to identify various reasons that influenced their decision. Our findings resonate with the conclusions drawn in previous studies that proactive decision-making plays a more important role than a response to the need for care. Figure 2 illustrates the prevalence of responses for the different reasons for moving.

Over half of the sample said that their decision was motivated by the independence of the housing (52.8%) and a desire to maintain an active lifestyle (53.3%). Nearly a half of respondents also highlighted the desire to downsize (48.2%), with many comments noting the appeal of the new residence in removing the responsibilities of homeownership such as maintenance of the physical structure and garden.

The high prevalence of these reasons as motivating people into moving into these retirement villages with extra care supports that idea that the objective of improving independence serves as a major draw for people to move. At the same time, however, the responses reflect the decision-making process rather than actual experiences of living in the village, so the question remains of whether such housing succeeds in fulfilling this objective, fostering active, independent living to manifest.

²⁵ Bäumker et al. (2012)

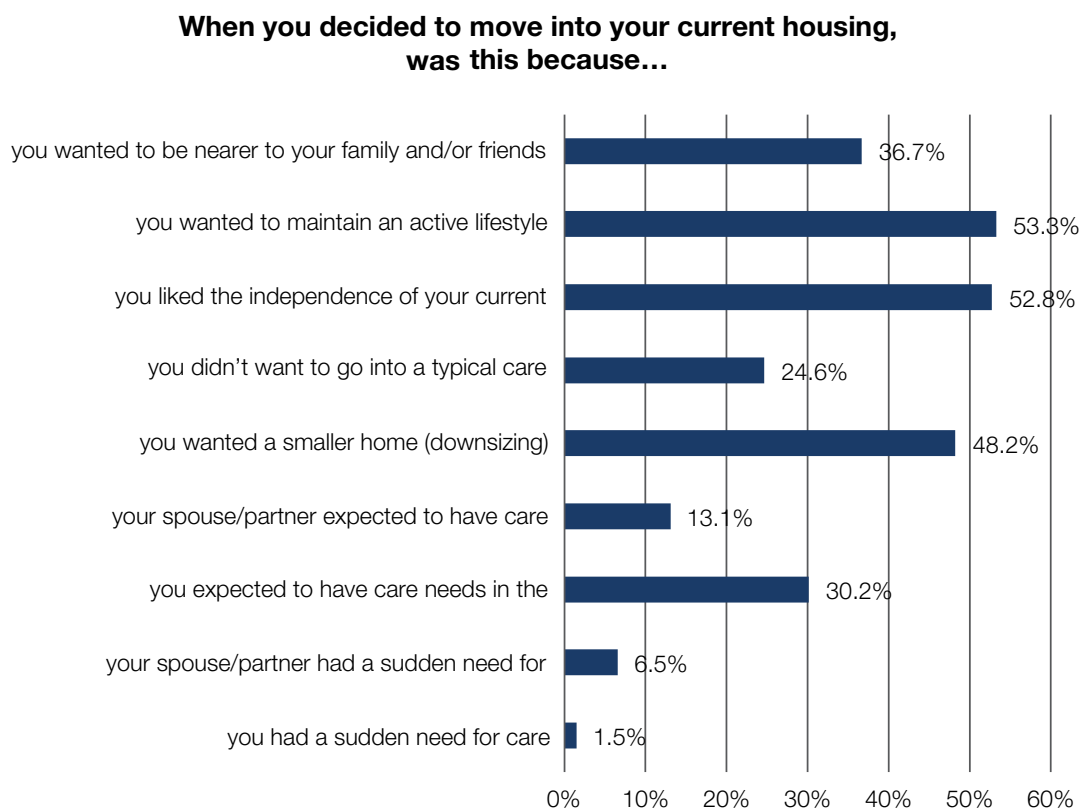
²⁶ Bäumker et al. (2012); see also, e.g. Dalley (2001) and Stillwell & Kerslake (2004)

²⁷ Bäumker et al. (2012)

²⁸ Bäumker et al. (2012)

²⁹ Netten et al. (2011)

Figure 2: *Reasons for Moving into this Housing*



In order to bridge this gap, we asked survey respondents to provide comments on whether their perceptions of their housing had changed since they moved in. Over half of the respondents (116 of 201) left responses to this question. The vast majority indicated that their perceptions had either not changed or improved after moving in.

“Even better than expected, a Shangri-La!”

“Better than anticipated. It provides a lot of feel good factor.”

“I am extremely pleased with this new home. Now I'm on my own, I feel secure among some delightful new friends.”

Many of the comparatively negative comments related to concerns around the building, such as fixtures or size, or issues with management. For example:

“When I first saw it, I thought that it was placed in a very good location within the development. Time has proved this to be true. However I am not a fan of the brick and zinc railings architecture nor do I suppose I shall ever be.”

“The flat is suitable for our needs, but I do miss the view (garden) and larger rooms.”

“The management leaves a lot to be desired.”

Despite the expression of particular criticisms in relation to how residents' views of the housing had changed after moving in, the comments provided by residents – and their overarching positive perceptions – suggest that these schemes do in fact provide the independence and active lifestyles that motivated the residents to move in the first place. While we must recognise that the overall characteristics of our sample may influence these residents' inherent ability to be independent and active, especially compared to residents that may have greater care and support needs, our findings provide tentative evidence that these retirement villages are succeeding in fulfilling the objective of extra care housing to provide independence to their residents.

Turning to the question of care needs, the least reported options were that the decision was based on a sudden need for care, either for the respondent (1.5%) or his/her spouse or partner (6.5%).³⁰ In contrast, expectations of future care needs influenced the decision of almost a third of the respondents (30.2 %). If we consider any of the reasons that mention care – including the desire to avoid a care home – 51.0% of respondents mentioned at least one of them. Taken together, this suggests that, at least among this sample, while the concept of care is taken into consideration by around half of respondents, proactive lifestyle planning appears to play a much bigger role in moving than thoughts solely around care needs. This may also be suggestive that people are not ‘leaving it too late’ to move into extra care housing.

One final insight from the responses around the decision to move is that nearly a quarter (24.6%) of the respondents highlighted these schemes as a way to avoid moving into a typical care home. This provides support to the idea that, at least among a proportion of residents, these retirement villages with extra care are in fact seen as offering an alternative choice to traditional care housing. In this respect, these villages with extra care do appear to achieve the goal of offering older people greater choice as they prepare for their future needs.

³⁰ It may be worth pointing out that relatively large proportions of widowed respondents reported care needs for a partner/spouse as a motivating factor in moving, suggesting the figures are not significantly distorted by lack of a partner/spouse.

Isolation & Loneliness

Key Findings:

- Overall, the findings suggest that a large proportion of respondents avoid the negative subjective experiences of both **isolation** and **loneliness**.
- Over 4 out of 5 (81.7%) respondents said they hardly ever or never feel **isolated**, and only 1.1% often feel isolated.
- Very small proportions of respondents report a high degree of **loneliness**, measured either using a single question or a three-item scale (3.6% and 3.8% respectively).
- Using the three-item scale, 64.2% of respondents can be classified as **not lonely** at all.

In addition to the idea of independence and choice, another important objective that extra care housing seeks to achieve is to reduce social isolation for people when they enter the accommodation. This offer of a community-based living arrangement for older people could also be seen as having an influence in reducing social isolation more broadly by offering social connections in such settings while encouraging older people to think about their future needs.

It is important to note, however, that discussions around people's interactions with other members of society often look at social isolation as well as two related but distinct concepts: social exclusion and loneliness. All three of these terms are conceptually similar but do encapsulate different ideas with some important distinctions:

- **Social exclusion** refers to several elements related to the marginalisation of a group and, in policy discourse in particular, is closely associated with the concept of social cohesion.³¹
- **Social isolation** broadly refers to the absence of contact with other people; in this way, it can contribute to social exclusion.
- **Loneliness** is generally understood as a subjective perception in which a person feels lonely. The absence of contact with others, i.e. social isolation, can contribute to feelings of loneliness, but loneliness is not necessarily related to the degree of contact one has with others.

Although social exclusion is an important topic in its own right, it is not the focus of our interest here. In other words, we are primarily concerned more with residents' social experiences than in the kinds of external barriers or broad social constructs that reduce social cohesion (or increase social exclusion).

Social isolation has generally been defined as the lack of meaningful communication or sustained contact with family or community.³² As a consequence, a key element at play here is the social network. It is important to note that many studies in the past have used the terms social exclusion or social inclusion to explore individuals' social networks and the degree of contact they have with others, i.e. social isolation as defined here.³³

In contrast, loneliness relates less directly to one's social network and more towards how a person feels about his/her overall social interaction and engagement with other individuals.³⁴ Loneliness differs from other related concepts of being alone, living alone, and social isolation, and while there is some overlap in these terms, they are not interchangeable.³⁵ Essentially, loneliness is the subjective counterpart to the objective measure of social isolation, representing how people feel about their social contacts.

³¹ cf. Scharf et al. (2005); Dwyer & Hardill (2011)

³² Victor et al. (2000)

³³ cf. Del Bono et al. (2007)

³⁴ Victor et al. (2006)

³⁵ cf. Victor et al. (2000)

Previous research has examined the way in which extra care housing may play a role in reducing social isolation, outlining different pathways through which this might manifest.³⁶ The community and activity elements of such housing feature in such evaluation. This framework also argues that loneliness may be reduced by decreasing social isolation, given the potential for social isolation to play a role in feelings of loneliness.

Because the nature of the housing explored in the current study includes a fundamental element of being community-based residential spaces, it is likely that residents will have ample opportunity to interact with others and engage in social contact. As a consequence, social isolation – considered in terms of objective measures of social relations – is unlikely to manifest as frequently compared to those living in other private housing. Indeed, a majority of those moving into extra care housing expect their social lives to improve.³⁷

However, while extra care housing may be specially positioned to have a positive impact on reducing social isolation, it is less clear that the nature of its arrangement would have any influence on loneliness – the reflection of how people feel about their social contacts. Given the emerging evidence that loneliness can have a significantly negative influence on health, it may be of greater interest to examine expressions of loneliness in housing with care settings.³⁸

In addition, a number of factors could negatively influence the potential for extra care housing to reduce social isolation. This could lead to particular manifestations of isolation, resulting from: negative dynamics in the form of bullying, gossip, or cliques; intergenerational segregation; discriminatory behaviour based on racist, sexist, homophobic, or even ageist attitudes.³⁹ As a consequence, the increased access to potential social contacts that such an environment as extra care housing can provide may not directly improve people's experiences around isolation. This supports the idea that understanding people's feelings with respect to isolation and loneliness may be more important in assessing the potential impact of such housing to play a role in the social lives of its residents.

Measuring Isolation & Loneliness

To examine the prevalence of isolation and loneliness in the retirement villages we surveyed, clear measures of these concepts are necessary. Previous research on the topics has measured social isolation and loneliness in different ways, but the most common approaches use indices made up from combining answers to multiple questions. With our interest in people's subjective experiences, as well as to avoid overburdening respondents with a lengthy questionnaire, we included five questions in our survey that generally appear in other large-scale surveys such as the English Longitudinal Study of Ageing (ELSA) that primarily address the issue of loneliness.

To begin with, there is the straight-forward question, "How often do you feel lonely?", which is sometimes used to assess loneliness. However, asking questions on how people feel in this way can lead to measurement error due to subjective bias, where some people may judge situations differently than others would or be reluctant to admit the same things. This kind of bias can be mitigated by constructing an index that uses responses to multiple questions to arrive at a general estimation.

We measured loneliness with an index called the Three-Item Loneliness Scale, which ranges from 3 to 9, with 3 representing the lowest level (or absence) of loneliness.⁴⁰ The scale is composed of responses to three questions:

³⁶ Kneale (2013)

³⁷ Bäumker et al. (2012)

³⁸ See e.g. Alspach (2013) or Burholt (2011)

³⁹ Kneale (2013)

⁴⁰ Hughes et al. (2004)

- How often do you feel a lack of companionship?
- How often do you feel left out?
- How often do you feel isolated from others?

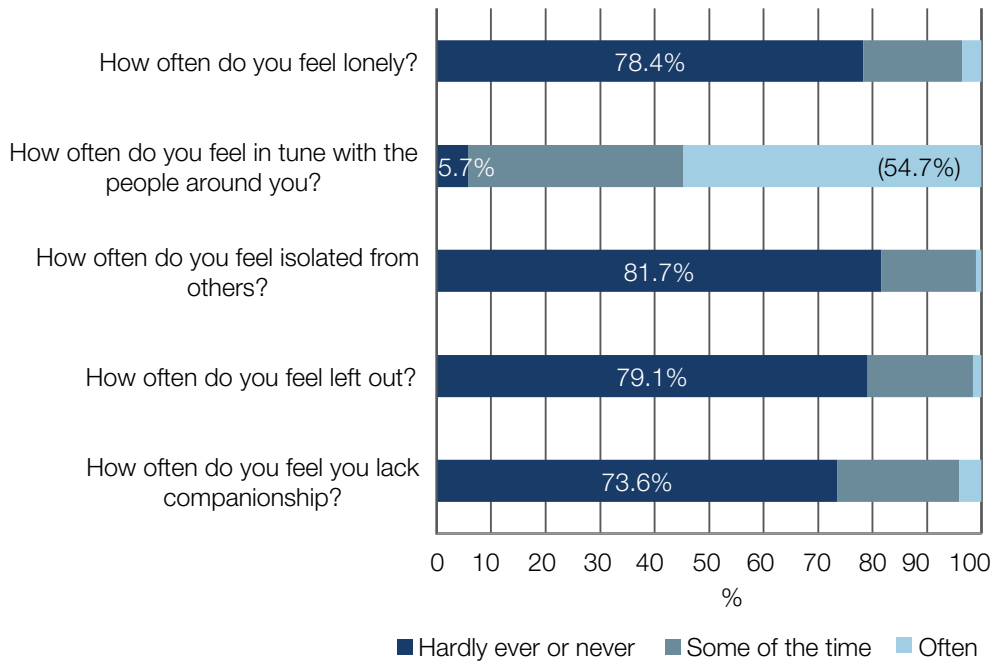
Responses include ‘hardly ever/never’, ‘some of the time’, and ‘often’, which score 1, 2, and 3 respectively. By adding up the scores for the three questions, an overall score for loneliness is given. It should be noted that one way to think about the scale of scores in relation to loneliness is that the lowest score (3) represents no or very little feelings of loneliness, while scores ranging from 7-9 can be thought of as representing the loneliest people, since scoring 7 requires a response of “often” to at least one of the three questions that make up the index.

While the survey items we included in the questionnaire relate more closely to established ways to assess loneliness, we should highlight that social isolation is generally measured by a composite index in other research. The elements contributing to this index include: partnership, frequency of contact with friends, children, and other family, and membership in an organisation. This objective way to measure social isolation is therefore not available in the current research, but it is worth noting that the index for loneliness includes a question asking about feeling isolated. The fact that this question asks about a feeling – therefore being subjective – distinguishes these responses from the standard way of measuring social isolation, but nonetheless gives information on respondents’ feelings of being isolated.

Experiences of Loneliness

Figure 3 shows the distribution of responses to the five questions included in the survey that relate to loneliness and feelings around social interaction. We see from the single-item question on loneliness as well as the three questions that make up the loneliness index that only very small proportions of our sample report often feeling the negative sensations. Just over 1% of the respondents often feel isolated, while 3.6% report often feeling lonely.

Figure 3: *Prevalence of Feelings Related to Loneliness*



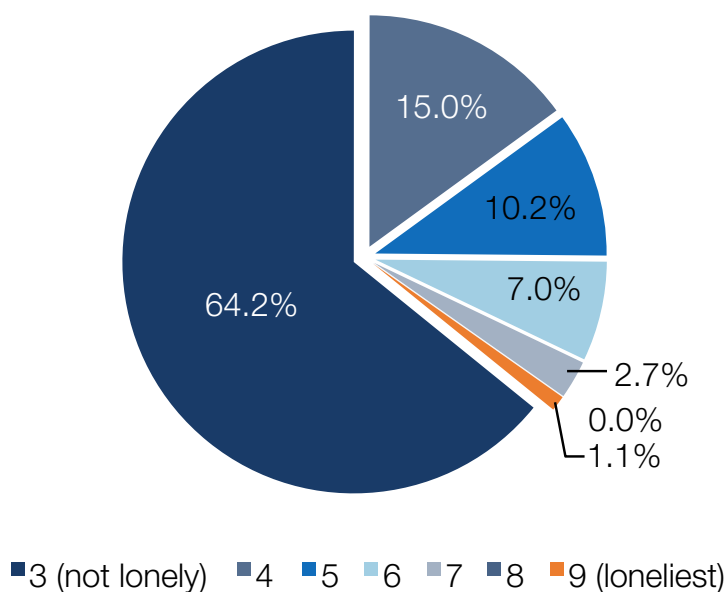
Looking at it from the other angle, the vast majority of respondents report hardly ever or never feeling lonely, isolated, left out, or lacking companionship. Over 4 out of 5 (81.7%) respondents say they hardly ever or never feel isolated, with 78.4% hardly ever or never feeling lonely. These findings together suggest – from the subjective point of view – that a large proportion of residents in

these retirement villages avoid the negative experiences of both isolation and loneliness. And while the lowest proportion responding hardly ever or never on these four questions was for a lack of companionship (73.6%), this may be moderated by the fact that widowed people comprise over a third of the sample.

The fifth question included in the survey related to this area asked about feeling in tune with the people around you. Over half of the respondents (54.7%) reported often feeling in tune with those around them, with only 5.7% saying they hardly ever or never felt in tune with others. The comparatively lower proportion giving the most positive response compared to the other questions in this section may indicate a degree of heterogeneity among respondents and their neighbours. This would have the potential to manifest as a source of increased isolation as interests and interpersonal harmony diverge. However, the low proportion rarely or never feeling in tune with others, combined with the low proportions feeling left out, isolated, lonely, or lacking companionship, suggests that the differences that might limit stronger personal connections may not in fact be leading to increased conflict or interpersonal dissonance.

As mentioned earlier, the subjective nature of these questions may lead to variation in reports due to bias, so looking at loneliness through the lens of an index combining multiple responses may serve to limit this kind of error. When we look at the scores on the three-item measure of loneliness, we find that nearly two-thirds of respondents (64.2%) can be classified as not lonely at all; they score 3 on the index, meaning they reported hardly ever or never for all three questions that comprise the index.

Figure 4: *Three-item Score for Loneliness*



This proportion is lower than that for those reporting hardly ever or never on the single-item question on feeling lonely. However, we should consider the fact that widowhood is likely to play a role in feeling a lack of companionship, part of the three-item index, but that these widowed respondents may not take this into consideration themselves when simply asked about feeling lonely. If we combine the proportion of those scoring 3 on the three-item index with the figure for the score of 4 – equivalent to scoring 2 on one of the items like lack of companionship – the total proportion equals 79.2%, just slightly higher than the proportion for the single-item index.

At the same time, the proportion scoring the highest levels of loneliness on the index – scores 7-9, reflecting at least one response of ‘often’ to one of the three questions – is roughly equivalent to the proportion reporting often feeling lonely on the single question (3.8% and 3.6% respectively). There is subsequently a high degree of concordance between the prevalence of the highest and lowest

levels of loneliness for both the single-item and three-item measures of loneliness. This suggests that, no matter how we measure it, loneliness is not highly prevalent among the respondents in our sample. However, despite the very low levels of respondents who often feel lonely or score high on the three-item index, we should recognise that around 1 in 5 respondents do feel lonely some of the time. So while persistent loneliness may be relatively rare in our sample, loneliness to some extent is experienced by around a quarter of our sample.

The expressed objective for extra care housing to reduce social isolation highlighted earlier thus appears to have some validation from the responses to our survey, although with certain caveats. First, it should be emphasised that our survey only captured feelings for people after their move, and thus the evidence cannot demonstrate any change or reduction. At the same time, our survey actually measured feelings around loneliness rather than the typical objective measures around networks generally used to assess social isolation. Nonetheless, especially given the potential link between social isolation and loneliness, it does appear that the residents in our sample are enjoying a high degree of social engagement in these retirement villages with extra care support.

Quality of Life in Extra Care Housing

Key Findings:

- The vast majority of respondents have **high quality of life** as assessed using two different measures of quality of life.
- Respondents also report a **high degree of control** over their lives as measured as a specific domain of quality of life.
- Nearly all of our respondents (97.0%) agreed or strongly agreed with the statement, '**I feel safe where I live**'.
- For both measures of quality of life, questions around **health concerns** showed the greatest variation, with relatively fewer positive statements than other items, demonstrating that health remains an important issue in how people think about quality of life.

An important shift in focus among ageing research literature in recent years has been to look beyond the simple fact of how demographic change has been driven by improvements in health and increasing life expectancy. Rather than simply identifying how people can expect to have more years of life, the idea of how these extra years will be experienced has risen in interest. Research has subsequently sought to ascertain the degree to which longer life expectancy is associated not only with being healthy for longer, but also how people's wellbeing and quality of life are affected.

In addition to the growing general interest in wellbeing and quality of life in ageing studies, the concepts are important when considering housing that offers extra care services. As highlighted earlier, one objective of extra care housing is to promote residents' quality of life, especially in comparison to what would be experienced in an alternative situation, such as staying in their previous home or moving into a more traditional residential care setting.

Overall, the general consensus from available research is that extra care housing does confer enhanced quality of life, with residents reporting generally positive outcomes.⁴¹ In particular, evidence also exists suggesting that such housing with care provides higher quality of life than what would be experienced in residential care.⁴² Other work has further identified that higher costs associated with a move to extra care housing are accompanied by improved care outcomes and quality of life.⁴³

The studies that have been conducted on quality of life in extra care housing have drawn on residents' views and experiences.⁴⁴ However, the research generally examines quality of life in terms of expressions of satisfaction and contentment rather than a more robust or detailed measure of quality of life.⁴⁵ This raises questions around whether these assessments are actually capturing the full range of elements that would impact individuals' quality of life and how they might report it. In other words, does the current body of literature looking at quality of life in extra care housing actually identify quality of life in a meaningful or comparable way?

Measuring Quality of Life

To address this concern from earlier research, our study sought to include more standardised measures for quality of life, rather than inferring an association from responses about general satisfaction. A variety of measures have emerged in recent years to assess quality of life, with

⁴¹ Croucher et al. (2006); Institute of Public Care (2007); Netten et al. (2011)

⁴² Fletcher et al. (1999)

⁴³ Bäumker et al. (2010)

⁴⁴ Atkinson et al. (2014)

⁴⁵ Croucher et al. (2006); Institute of Public Care (2007)

many designed to review quality of life specifically among older people. One of the first to emerge, CASP-19, uses responses to 19 questions to develop an overall score of quality of life from a strong theoretical basis.⁴⁶ Each item on the index has four possible responses, scored 0-3, and the full CASP-19 score ranges from 0 to 57, where higher scores indicate higher quality of life.

In addition to offering an overall score for quality of life, the items in the CASP-19 are classified into one of four dimensions that conceptually comprise quality of life in later life (and gives the CASP-19 its acronym): control, autonomy, self-realisation, and pleasure. These four domains contribute to the theoretical foundation of the measure, reflecting the areas of need that relate to experiences in later life. Six items go into measuring control, five make up autonomy, and four questions each contribute to self-realisation and pleasure.

An alternative measure of quality of life is the Older People's Quality of Life (OPQOL) questionnaire.⁴⁷ The development of this measure incorporated the views of older people alongside theoretical models to ensure it was representative and comprehensive. The original questionnaire featured 35 items and included questions that asked about: life overall; health; social relationships and participation; independence, control over life, and freedom; home and neighbourhood; psychological and emotional wellbeing; financial circumstances; and culture and religion. Further development of the questionnaire has led to a reliable and valid short form, composed of 13 items.⁴⁸

The full OPQOL-35 measure has demonstrated higher reliability and validity than other measures of quality of life in older age such as CASP-19, although the poorer performance of CASP-19 in one study may have resulted from the ethnic diversity of the sample.⁴⁹ However, the brief version of OPQOL also provides insights into domains not included in CASP-19, such as home and neighbourhood and psychological and emotional outlook.⁵⁰

Our survey included both CASP-19 and OPQOL for two main reasons. First, The CASP-19 schedule has been included in other large studies like the English Longitudinal Study of Ageing (ELSA), which provides the potential for comparative work to be conducted using our sample and another from the general population of older people in private households. At the same time, given the fact that our research relates to housing with care, including OPQOL with its elements related to home and neighbourhood seemed appropriate in order to allow any potential insights in this respect.

Quality of Life Using CASP-19

Given that the CASP-19 measure of quality of life is an index formed from responses to 19 items, we first discuss the results from our survey by looking at these different items. Figure 5 displays these responses and also identifies the different questions that make up the index, to which domain of CASP the item relates, and whether the question is reverse coded (where a 'negative' response of 'never' actually reflects higher quality of life).

⁴⁶ Hyde et al. (2003)

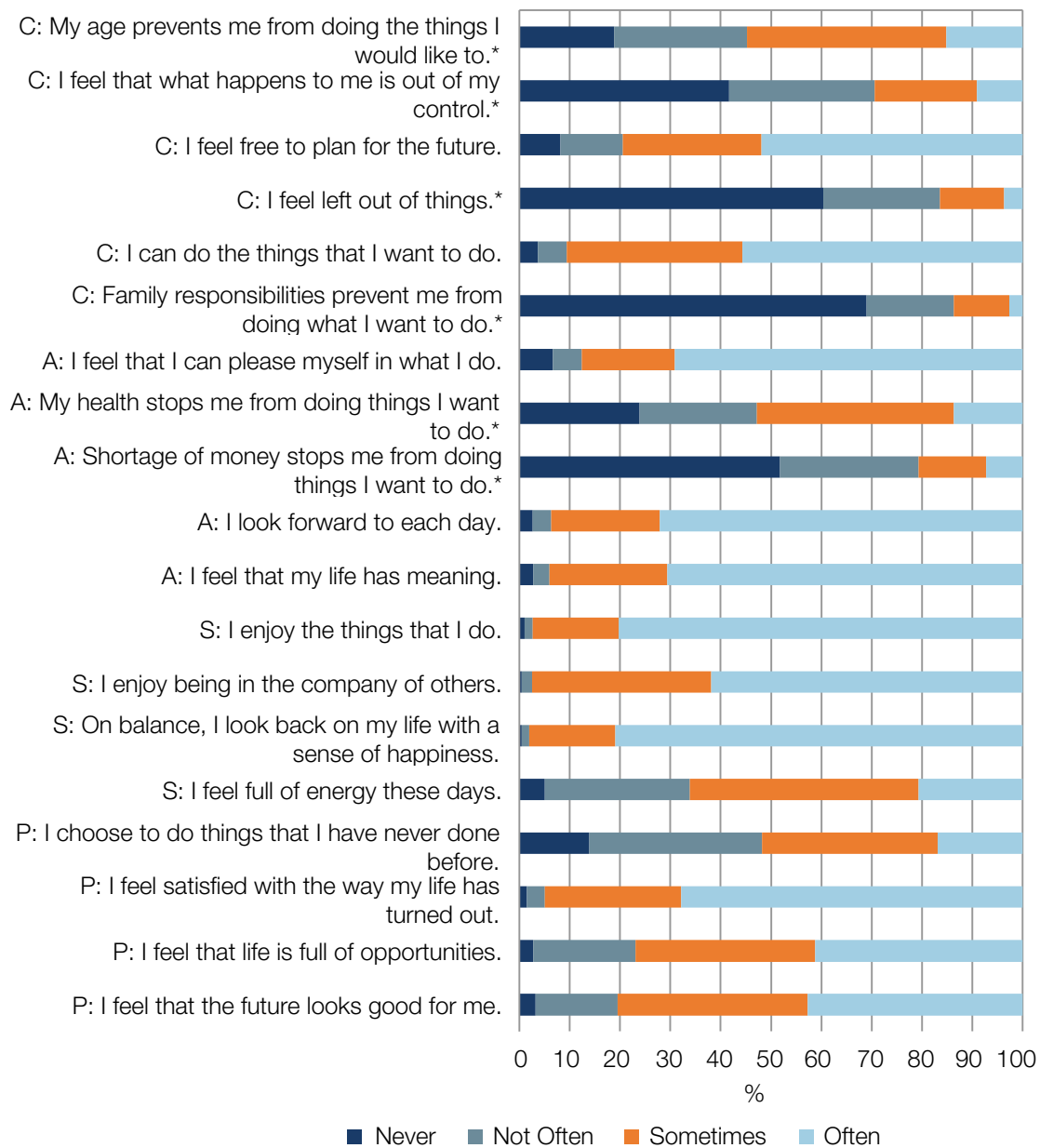
⁴⁷ Bowling & Stenner (2011)

⁴⁸ Bowling et al. (2013)

⁴⁹ Bowling (2009); Bowling & Stenner (2011)

⁵⁰ Bowling et al. (2013)

Figure 5: Responses to the Items of the CASP-19 Quality of Life Measure⁵¹



The first striking finding from looking at the range of responses across these items is that the vast majority of people in our sample give positive responses to almost all of the questions. For example, 94.9% of respondents say they often or sometimes feel satisfied with the way their life has turned out, while 83.6% say they never or not often feel left out of things.

There are three items where the range of responses is more evenly distributed: ‘My age prevents me from doing the things I would like to’; ‘My health stops me from doing things I want to do’; and ‘I choose to do things I have never done before’. The fact that responses to these questions are more equally positive and negative likely reflects the inherent subject of the items and the experiences of later life. Moreover, much of this could possibly be driven by health, with an implicit association on the part of the respondent that their age preventing them from doing things is a result of poorer health, or that their health mitigates them from doing new things.

While the different items of this measure of quality of life offer the ability to understand people’s experiences along the various themes that feature in them, a primary benefit of the CASP-19 is to provide the comprehensive assessment of quality of life by combining these responses. Figure 6

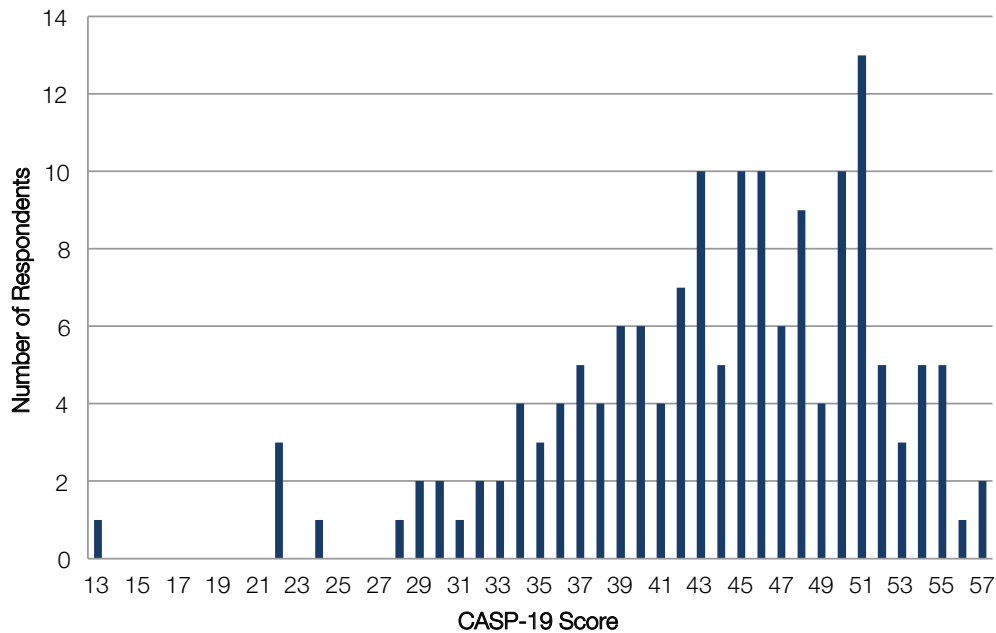
⁵¹ Letters ahead of the questions indicate the dimension of CASP to which the item belongs. Questions with an asterisk (*) are reverse coded, e.g. a response of ‘never’ would indicate higher quality of life.

illustrates the number of respondents for each score of the CASP-19 scale.

The first feature to note from Figure 6 is how nearly all respondents score 30+ on the 0-57 scale. This implies that the people who completed our survey do experience a high quality of life. In fact, the overall results on the CASP-19 scale include:

- The average score for quality of life is 43.73.
- The median score – the score where half of people are above and half below – is 45.
- The most frequent score is 51.

Figure 6: *Total Scores for CASP-19 Quality of Life*



The average score of 43.73 rests at the point on the 0-57 scale that reflects 76.7% of the scale. In other words, if you were to split the full scale into four parts, the average respondent in our sample would still be in the highest quartile of possible quality of life scores. With the median score higher than the average, this also means over half of our respondents are in this better part of the quality of life scale.

Overall, our results indicate that our sample experiences a rather high quality of life. It would be interesting to identify the factors that impact those who report lower quality of life, and there exists a range of research that has developed a more nuanced understanding of such determinants.⁵² The data gathered from our survey does not allow us to conduct a thorough investigation into how known factors are at play among our sample and influencing their reported quality of life. Nonetheless, a simple linear regression using the data that are available did demonstrate a significant association with one modelled variable, health, suggesting that people reporting fair or worse health score lower on quality of life than those saying their health is good or very good.⁵³ Taken as is, this reflects the idea that housing models with extra care support can offer some degree of enhancement to quality of life insofar as its availability of care services addresses issues as they manifest, allowing people to remain in better health than they otherwise would.

While the research here cannot go further into understanding the determinants of quality of life among our sample, we can look a bit closer into the different domains that comprise the CASP-19 measure. In fact, the first domain, control, is also an important principle featuring in the stated

⁵² See for example: Wiggins et al. (2004); Blane et al. (2007); Zaninotto et al. (2009); Webb et al. (2011)

⁵³ Full regression results are not reported given the fact that a full range of confounders was not available. Besides health, other variables in the model were gender, marital status, and age group.

objectives of extra care housing.⁵⁴ As a result, the concept of control has been explored in different pieces of research and presents a particular area of interest.

The CASP Domains: A Focus on Control

Government policy with respect to health and social care services has placed growing priority on how to promote choice and control for older people.⁵⁵ With respect to extra care housing, the fundamental component of flexible care packages that look at individuals' needs and preferences have been created with this objective in mind. In addition to offering greater control over the services and care that one receives, there is also an idea that the enabling environment of an extra care setting would have an overall impact in increasing residents' sense of control over their daily lives.

Previous research has identified that older people receiving care think about control more in terms of control over their care and support rather than about managing on one's own.⁵⁶ In this way, there is a strong emphasis from older people to think in terms of having control over their daily lives.⁵⁷ This may play a role in explaining research findings that have identified reports of increased control and quality of life among older people following a move into a residential care home, as well as the lowest levels of control for those receiving care services at home.⁵⁸ Having the sense that one can influence the delivery of care more directly in the residential care setting thus appears to enhance feelings of control and quality of life.

Indeed, it is important to understand how different care settings impact the degree of control older people experience. One challenge in developing a strong understanding of this is that many studies have measured control in different ways, with various scales and methods or asked about it in a way that is not easily quantifiable.⁵⁹ The scales for measuring quality of life that have emerged in recent years all have control as a fundamental component to their theoretical foundations, and future research should seek to make use of these standardised and robust measures.

One study conducted so far on control in different care settings used the measure from a new, alternative quality of life measure that looks explicitly at social care outcomes, the Social Care-Related Quality of Life (SCRQoL) measured through the Adult Social Care Outcomes Toolkit (ASCOT).⁶⁰ This research excluded residents in extra care villages, like our sample, but found that residents of other, smaller types of extra care schemes reported higher control over their daily lives than people receiving care at home. There was no significant difference between those in extra care and those in care homes, suggesting that people living at home receiving care are in the worst position when it comes to control over their daily lives. This should be kept in mind as policymakers think about how to improve people's lives and receipt of care, and caution should be exercised when considering the effectiveness of greater home-based care support.

Turning back to our survey responses, Figure 7 shows the distribution of scores for each of the four domains that make up the CASP-19 measure. We see a relatively high average score of 13.37 for control, measured on a 0-18 scale. Just like with the overall CASP-19 score, we find that just over half of the respondents fall into the top quartile of the scale for control. This finding suggests that, at least among the residents who make up our sample here, people in retirement villages with extra care services enjoy a high degree of control. As a consequence, this may add to other existing evidence that housing arrangements that offer extra care support are well-positioned to enhance the control that people feel in their lives.

⁵⁴ Croucher et al. (2006)

⁵⁵ Callaghan & Towers (2014); Atkinson et al. (2014)

⁵⁶ cf. Qureshi & Henwood (2000); Gabriel & Bowling (2004); Callaghan & Towers (2014)

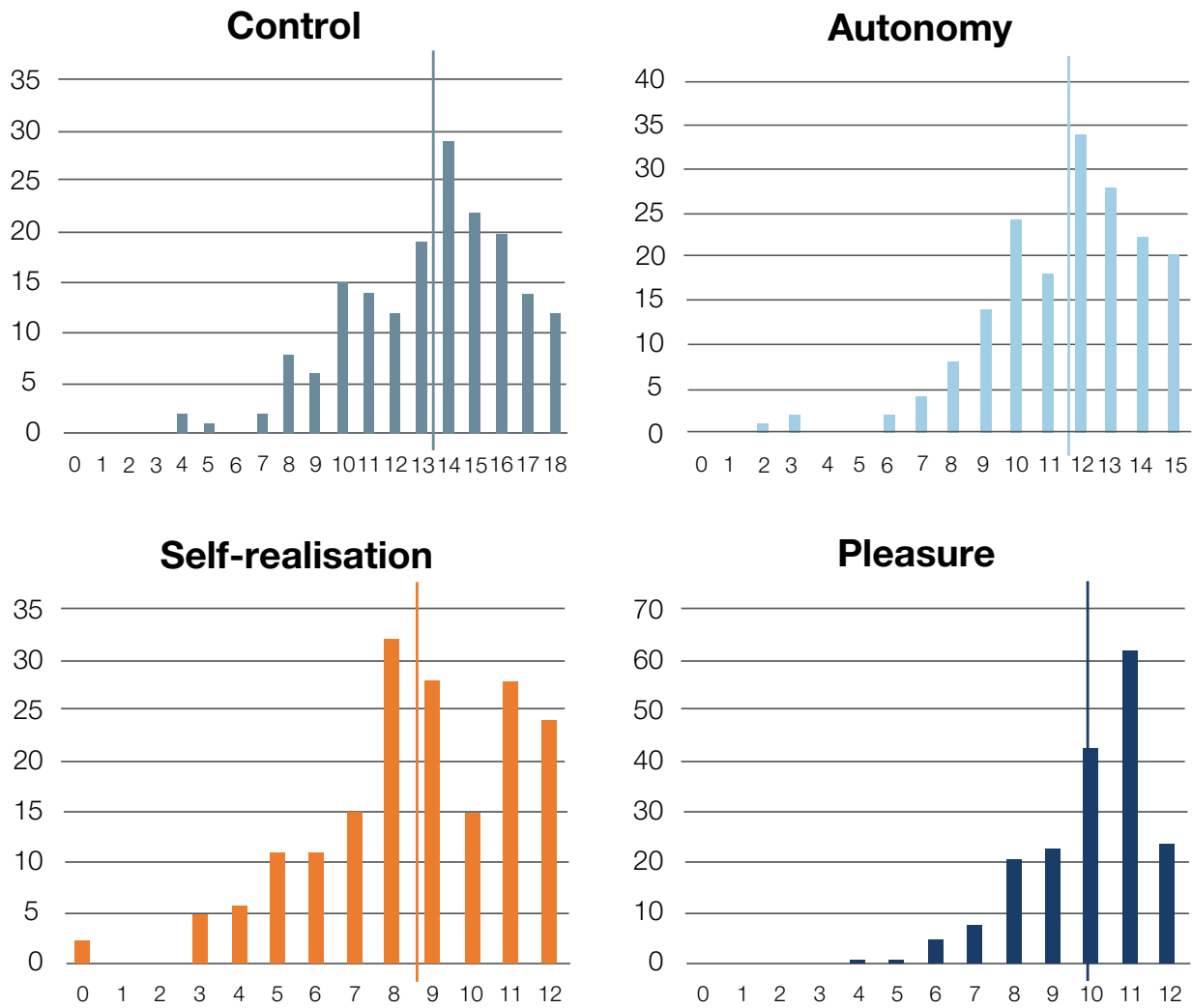
⁵⁷ e.g. Tester et al. (2004)

⁵⁸ Darton (2011); Boyle (2004)

⁵⁹ Callaghan & Towers (2014)

⁶⁰ Callaghan & Towers (2014); ASCOT was developed by researchers at Personal Social Services Research Unit (PSSRU) at the University of Kent. More information on this measure is available at www.pssru.ac.uk/ascot. We considered including ASCOT in our survey, but decided not to, based on its length and the desire to avoid making our questionnaire too cumbersome for respondents.

Figure 7: Scores for the Component Dimensions of the CASP-19 Quality of Life Measure⁶¹



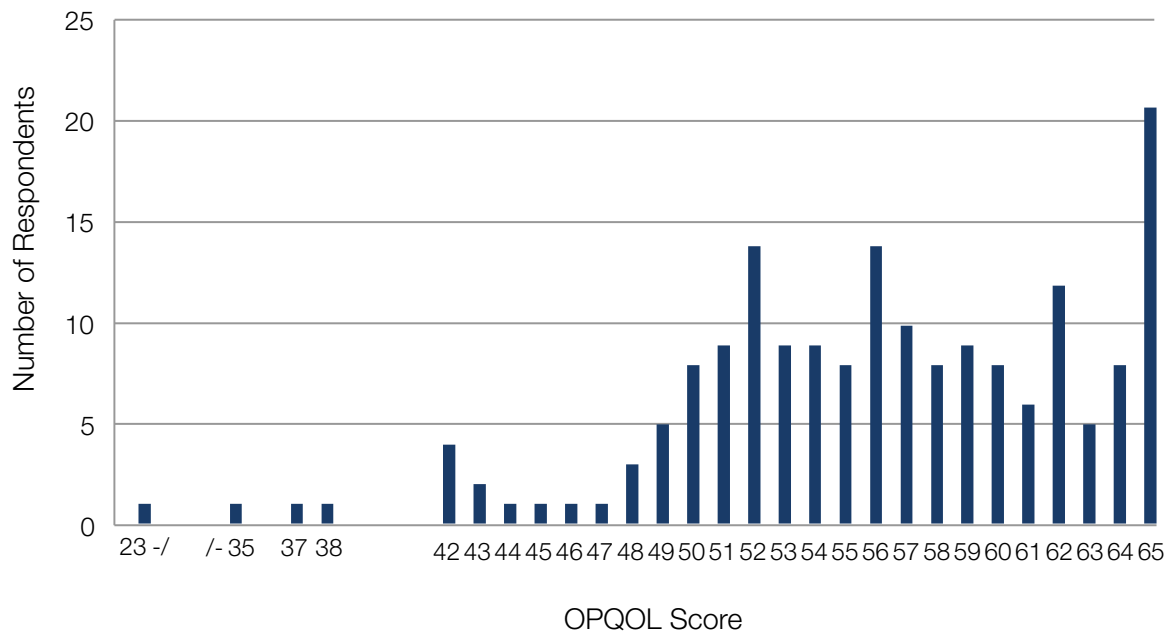
OPQOL: Older People’s Quality of Life

Like with the CASP-19 measure of quality of life, the other measure we included in our survey, OPQOL, is a score calculated from the combined responses to a range of questions. The original version of OPQOL had 35 items, but the shorter (validated) version that has also been developed was used here, comprised of 13 questions. This version is measured on a scale of 13 to 65, with higher scores reflecting greater quality of life.

Figure 8 shows the distribution of the overall OPQOL scores. Just like with the CASP-19 measure, the distribution is skewed to the left, with more respondents scoring highly on the scale. Another interesting feature to note is that the most frequent score in the sample is the highest possible score of 65. The average score for this measure is 55.92, and the median score is 56.

⁶¹ The thin vertical lines on the graphs represent the average score on each domain.

Figure 8: Scores on the OPQOL-brief



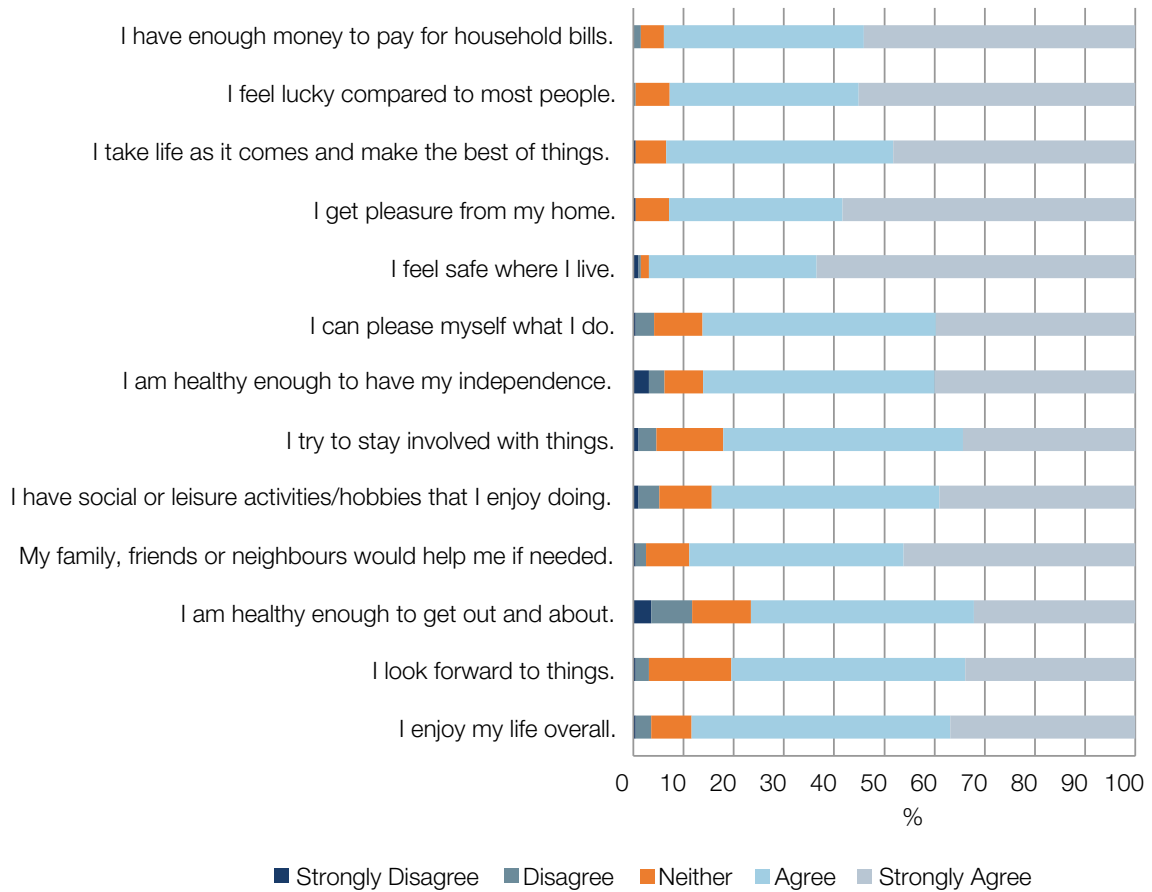
Framed in terms of the full scale, these scores demonstrate that just over half of the respondents have OPQOL scores that are in the top 16% of possible scores – the top sixth of the full scale. This contrasts to the finding for the CASP-19 measure, where half of the responding sample fell into the top quarter of the scale. Taken together, these findings suggest that the retirement village residents in our sample score more highly on quality of life as measured by OPQOL rather than the CASP-19.

This variation could be related to the higher number of questions included in the CASP-19 – and thus greater chance for scores to accumulate lower on the scale – and it could also be affected by the nature of the questions in both scales, the fact that the CASP-19 schedule includes reverse or ‘negatively’ worded questions while OPQOL questions are all phrased in a ‘positive’ direction, or the differences in the response options for each question. Understanding the reasons for this variation is beyond the scope of this research, and we are interested less in making direct comparisons between the two measures than in what each uniquely provides for experiences in housing with extra care. That said, we should note that these two measures had a degree of correlation of 0.781, which is quite strong and statistically significant.

As mentioned, we included OPQOL in our survey to explore an alternative measure of quality of life, motivated by the inclusion of questions around the home. Figure 9 illustrates the different items that go into the OPQOL measure. The first striking feature of this graph is that the question with the highest proportion agreeing or strongly agreeing is ‘I feel safe where I live’ (97.0%). This offers encouraging results to support the idea that the retirement villages with extra care in our sample provide a strong sense of security for their residents, another concept that has been occasionally mentioned as a benefit or goal of housing with extra care.

The area where respondents disagreed more was on the questions related to health: ‘I am healthy enough to have my independence’ and ‘I am healthy enough to get out and about’. In fact, these two questions had the largest proportions strongly disagreeing (3.1% and 3.6%), as well as the largest combined who either disagree or strongly disagree (6.2% and 11.7%). This highlights the important role of health in shaping a person’s experienced quality of life. At the same time, the vast majority of respondents for all questions gave agreeable responses, providing further evidence that, on these measures at least, this sample of residents in retirement villages with extra care enjoys high quality of life.

Figure 9: Responses to the 13 Items of the Older People's Quality of Life (OPQOL-brief) Measure



Comparison with Private Households

Key Findings:

- The residents in our sample appear to have **higher quality of life** than a similar group living in the community, offering possible evidence that this housing arrangement can enhance residents' quality of life compared to if they had remained in their previous home.
- We also found strong evidence that our sample experiences a **higher sense of control** than those in community households, and that control appears to be the aspect of quality of life most positively associated with residence in housing with extra care.
- Our respondents reported lower loneliness than those in the community, giving some reason to believe that housing with extra care plays a role in **reducing loneliness** among its residents compared to what might be experienced if they stayed in the community.

One of the main interests in research on the experiences of residents in housing with extra care is how this kind of housing arrangement might have an influence on its residents in comparison to what they would have encountered from staying in their previous home or moving into a residential setting. Our survey was distributed only to residents living in retirement villages that offer a form of extra care services. As a consequence, on its own, it cannot tell us anything about how these responses might be different from those that would be reported by people in other settings.

However, there is one possible way to explore how our survey results differ from those living in the community by drawing on data from the English Longitudinal Study of Ageing (ELSA). ELSA is a nationally-representative longitudinal survey of people aged 50+ living in private households in England. Since 2002, the survey has collected data every two years through personal interviews. The information gathered by ELSA covers a range of topics relevant to understanding the experiences of older people, including several items on health, wealth and income, and other aspects such as quality of life.

Important differences between our sample and the overall sample included in ELSA, however, mean that a direct comparison of the two would not be completely valid. In other words, we cannot directly look at the average score for CASP-19, for example, and subsequently determine that any observed variation from the average of our sample actually reflects the experience of living in housing with extra care. In a sense, it would be like comparing apples to oranges.

To overcome this limitation, we can apply a technique called propensity score matching. This method computes different scores for individuals based on observed characteristics common to both datasets. These scores can then be used to evaluate outcomes of interest by matching our sample (the 'treatment' group) to a subset of the ELSA sample (an 'untreated' or 'control' group). Essentially, the technique aims to create a comparable group of untreated people in such a way that both groups are adequately similar for valid comparison.

The available data restricts our ability to use an extensive and comprehensive set of characteristics to develop our propensity scores. Nonetheless, we can apply the technique using the data at hand, recognising that some indicators that would impact our outcomes of interest – quality of life measured with CASP-19 and the loneliness score – are absent. To calculate our propensity scores, we controlled for gender, age group, marital status, and self-reported health. Given that the residences included in our survey are luxury retirement villages, it is likely that our respondents also come from higher socio-economic class; to compensate for this, we used home value as an approximation, shaping the sample from ELSA to include only those with home values greater than or equal to £200,000, roughly similar to the values of homes in the housing locations we sampled.

Our results from applying this technique suggest that the residents in the retirement villages with extra care do report higher quality of life than those living in the community.⁶² Specifically, our survey respondents have an average score of 43.73, while the subset control group from ELSA averages 41.23, representing a difference of 2.5. This difference, however, is statistically significant only at the $p < 0.1$ level, so we can only have confidence that, 90% of the time, this higher value for our sampled residents is actually different from what might be observed just by chance. The somewhat small sample of respondents to our survey, and the slight reduction in numbers for those with completed items for all questions on CASP-19 – and thus a score for it – may play a role in obscuring a stronger statistical relationship. A more extensive study similar to this one would be needed to strengthen our confidence in whether this effect from living in retirement villages with extra care is truly valid. Nonetheless, this finding is encouraging for those engaged in providing housing with extra care, those living there, and those considering a move, as it does provide some evidence that this housing arrangement may in fact be fulfilling its objective to enhance residents' quality of life compared to if they had remained in their previous home.

In addition to the overall measure of quality of life, we explored whether there was an observable difference in the scores for the different domains that it covers. We found a much stronger statistical association for a difference on the control domain and no differences on the other three domains. Our sample's average score for control was 13.37, while that for the control group from ELSA was 11.59. This suggests that living in these retirement villages with extra care is associated with an increased sense of control, equivalent to 1.78 points higher on the measure derived from CASP-19. Despite given caveats related to the limitations in our data, this finding offers compelling evidence that accommodation in housing with extra care can play a role in encouraging residents to have greater control over their lives. Moreover, the lack of any identifiable differences for the other domains further suggests that the way in which residence in such housing influences quality of life is in how it enhances residents' sense of control.

Finally, in our comparison with respondents in ELSA, we examined whether the retirement villages with extra care services might play a role in reducing reports of loneliness compared to those living in the community. Again, we found a significant association suggesting that those in such housing tend to report less loneliness. More specifically, on the 3-9 scale of the loneliness measure, sampled residents on average reported a score 0.64 points lower than those in the sample derived from ELSA (3.73 versus 4.37). These average scores for both groups reflect the fact that high levels of loneliness are not extensively prevalent for either group, but they do indicate that there is some reason to believe that housing with extra care is playing a role in reducing loneliness among its residents compared to what would be experienced if they stayed in the community.

⁶² In terms of methodology, we applied nearest-neighbour matching with caliper equal to zero as well as using bootstrapping for re-sampling. Results from both approaches were identical for all outcomes explored.

Conclusion

This report has looked into a range of experiences among residents of certain retirement villages that offer extra care support in England. In particular, we examined three common aims that have emerged in the underlying philosophy around housing with extra care: providing independence and choice; reducing social isolation; and enhancing quality of life. These objectives are also structured around the notion that such housing with extra care can achieve them in comparison to what would be experienced in the general community or in another residential care setting. To assess this aspect, we also compared the results of our survey of residents with a comparable sample of people living in the community.

The analysis presented here indicates that our respondents are experiencing relatively low levels of loneliness and a high quality of life, using multiple options for measuring each of these ideas. Moreover, by applying a methodology to create a comparison group with those living in private housing in the community, our analysis provides some evidence that residents in retirement villages with extra care services are doing better than those in the community in terms of control, quality of life, and avoiding loneliness. Limitations in the data collected mean that strong conclusions should not be over-generalised to the broader population of extra care housing residents, and further research should be done to identify the degree to which our sample is representative of people living in other types of extra care settings.

Our findings have different implications for different groups.

For Government: Since these findings suggest that housing with extra care is delivering on its stated objectives – which are aligned with broad government policy priorities in this area – government should think about doing more to promote such alternative models of housing with care.

- Central and local government should identify ways of working with the private sector to stimulate the building of new good quality retirement housing. They should also ensure that no significant policy or regulatory barriers prevent the adaptation of existing structures into good quality retirement properties.
- Policy-makers should also encourage people in early older age to consider making such a move. Earlier moves into residences that accommodate evolving health needs may become an even greater issue in future decades given the low rates of homeownership among younger people.
- In light of the new pensions freedoms, policy-makers should consider offering information and advice on such housing opportunities to people who make enquiries into how to manage their retirement finances.

For Providers: Our research provides evidence that residents enjoy such housing and are overall quite happy with their decision after their move. Moreover, we found that friends, family, locality, and advertising are all important reasons that people found out about such housing, while independence and an active lifestyle were important motivating reasons to move.

- While the care element of extra care housing is a fundamental and inherent component, providers should consider the importance of ensuring that their marketing strategies include the aspects of independence, control, and activity.
- Providers should also think about how marketing to younger groups, i.e. potential residents' children, may be effective, perhaps along the lines of encouraging long-term strategic planning among extended families.
- Since living locally was relatively important in how residents' discovered their housing, providers may also find it a useful strategy to consider local demography in selecting sites for the development of any future residences or villages.

For Researchers: Despite the limitations in our data, the results offer some of the first insights into the experiences of residents in retirement villages that offer extra care support. Our analysis also uses established measures of quality of life rather than relying on respondents' reports of satisfaction. Overall, the findings suggest that extra care is a good option for people, but further research is needed.

- Future work should continue to apply standardised measures to assess concepts like quality of life and social isolation.
- Limitations in the data featured here should also be addressed by more extensive data collection on a larger scale, with a wider range of different types of residences that offer extra care. This would enhance our understanding of the broader population of extra care residents and could highlight how experiences in retirement villages vary from other settings.
- Greater attention should be taken by researchers to assess and address the concerns of people living in such care settings who suffer from dementia or other cognitive impairment, or who may suffer from multiple conditions.

Gathering more extensive data on the experiences of people in extra care housing would not only strengthen our confidence in what we know, but it would help guide providers on what does and does not work. In this area, providers and researchers may have an important scope for collaboration. Understanding residents in different models featuring extra care is most useful when their experiences can be compared to those in other types of settings, as a potential way to identify how housing with extra care itself plays a role in influencing characteristics such as wellbeing in contrast to other residential arrangements. Providers may be best suited to incorporate data collection within existing assessment tools of residents, for example, by also assessing quality of life upon entry into the new housing. Collected periodically, this could provide a strong evidence base for the value of such housing toward the quality of life of older people.

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ILC-UK

11 Tufton Street
London

SW1P 3QB

Tel : +44 (0) 20 7340 0440

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