Kent Older Pers.ons Housing Research

Working Paper 1: Older Persons Accommodation Trends

chris.cobbold@dtz.com

125 Old Broad Street
London
EC2N 2BQ

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Contents

1. Introduction

This working paper presents findings from a review of national literature and highlights key topics which are important to understand in assessing the accommodation needs of older persons, including:

- How best to define older people
- The categorisation of housing for older people
- Factors affecting demand and supply
- The inter-relationship of housing provision for older people with Central and Local Government strategy and resourcing of care for older people

2. Defining Older People and Accommodation Types

2.1 The Definition of Older People

For most purposes older people have been defined as those aged 65 or over, reflecting the historic retirement age for men. There is considerable logic in adopting this definition since clearly retirement represents a major life change, often associated with a significant change in household incomes. Data is readily available on the population of people aged 65 and over in five year age brackets.

However, it should also be acknowledged that many people retire before 65; and that accommodation aimed at older people is often opened up to those below 65. For example McCarthy and Stone target people over 50, though in practice the average age at which people move into their schemes is around 70. Likewise where demand for local authority sheltered accommodation is weak, it may be offered to those under the age of 65.

For the purposes of this research, DTZ propose to accept what has generally been accepted in national and local studies as the definition of older persons; that is, those aged 65 and over. However in considering demand for facilities targeted at older people it is worth considering how much demand may be generated from people aged 50-65.

The evidence is that, in practice, the demand to date from those aged 50-65 has been quite limited. This reflects the general position that in the UK people as they age wish to continue to live in the family home and maintain a fully independent lifestyle as long as they can.

It is worth noting, however, that the development of large scale retirement communities in the USA, while still dominated by those over retirement age, have attracted people from younger age groups as well. It is uncertain whether such large scale developments will occur in the UK, for cultural and planning reasons.

DTZ's view is that the large scale retirement developments to be found in southern USA, notably Florida, find their parallels in the UK/European context, in developments in the Mediterranean area with developments in Spain and Portugal being a key destination of retirement migrants from the UK.

How the change on the Euro/£ exchange rate will affect the pattern of outmigration from the UK to the European Sunbelt in the future is uncertain. National statistics indicate a very significant drop in out-migration from the UK since the downturn, and the development market in Spain and Portugal is highly stressed.

2.2 Classification of Housing for Older People

A very wide range of terms are used to describe different types of housing for older people (and younger people who require care). This can cause considerable confusion. The confusion arises because there are three principal ways that housing for older people can be categorised:

- By **the level of care** provided (which leads to terms like Care Homes, Extra Care Homes, Nursing Homes, Supported Living)
- By **the type of provider**. Providers include local authorities, housing associations, charities and private enterprises. Given different funding models and legacies each sector often uses a different description to describe its schemes.
- By **the nature of the occupancy.** The occupiers of local authority and most housing association schemes are generally tenants; occupiers of private sector schemes may be owners or tenants. Facilities providing high levels of care are charged on a bedspace or room basis, more akin to a hotel.

In examining the literature, DTZ have found the definition developed by Robson et al (1997) helpful since it is concise, and spans the range of types of accommodation older people may occupy. In the Robson model there are 7 levels in the 'housing and care' ladder, as follows:

- **Staying Put:** Assistance provided to help the older person stay in their existing home, with or without care support.
- **Retirement Housing:** Housing built specifically for occupation by fit and active older people, and adapted to the needs of this group.
- **Category 1 Sheltered Housing:** Purpose built self contained housing built to mobility standards with a scheme manager and minimal communal facilities.
- **Category 2 Sheltered Housing:** Purpose built, self contained housing for the physically frail (as above) but with access to wider communal facilities.
- **Category 2.5 or Extra Care Sheltered Housing:** similar to option 2 but with the option of purchasing personal care as required.
- **Category 3 Homes:** Residential care homes for older people who may be physically or mentally frail and in need of constant care.
- **Nursing Homes or Geriatric Units:** for older people who are very sick and require qualified nursing care.

Since this categorisation was developed more formats and different terminologies have developed. Generally these reflect changes that *'create a broader model of housing that maximises people's wellbeing, through their ability to maintain control and independence in old age.'* (Anchor, 2008:10).

The terms that are often now referred to are:

- **Housing with Care:** This is a generic term for models that combine independent housing with relatively high levels of care. While there are a range of definitions (including

assisted living, extra care, retirement housing, very sheltered housing, continuing care retirement communities), and a range of both public, not-for-profit and private sector provider organisations, such schemes have a shared conceptual base. They are intended to promote independence, reduce social isolation, provide an alternative to more institutional models of care, and offer a home for life.

- **Extra Care Housing (ECH):** This is an ill defined term that is used to describe '*Purpose built accommodation in which varying amounts of care and support can be offered and where some services are shared.'* (ECH Toolkit, 2006:8). There are rented and direct purchase schemes of extra care housing provided by the private sector, and there are also leasehold schemes provided by housing associations. Developments can take the form of flats, bungalows or houses.

- Frequent reference is now made to **Continuing Care and Retirement Communities** (CCRCs), the terminology used in the USA, which is now being introduced to the UK. These schemes mix independent living, where residents can buy the level of care support (if any) they want, with facilities that provide more intensive residential care facilities, often now including dementia units. These schemes are being developed by both the private and not-for-profit sectors. Sometimes in the UK they may be referred to solely as Retirement Communities – but this phrase could include developments without any specialist extra care facilities.

- Increasing use is also being made of the term **Dementia Units,** which are specialist care units for those suffering from dementia (Alzheimer's), which is a specialist extra care facility which seek to provide security, mental stimulation and community facilities to those who may be physically fit.

A matrix of different types of accommodation provided for older people developed by Wokingham Council and since used by many local authorities, and in Wales to analyse the supply of specialised housing for older people, is presented in Appendix 1. The framework has been used by Wokingham Council and others as the basis for discussion with existing and potential providers when matching the accommodation and care package they are offering against the aspirations of the authority's older persons' accommodation strategy. Some similar common basis of definition probably needs to be developed across Kent and Medway as a whole.

2.3 The Inter-Relationship of Housing and Care Strategies

The discussion presented above highlights how *specialist* provision of housing for older people is directly linked to the provision of different levels of care. The different forms of accommodation provided for older people lie at different points along a spectrum in terms of the intensity of care they are able to provide.

This study is not primarily about care of the elderly and infirm, and the scope of work does not entail significant engagement with Kent County Council's Older Persons Service or Primary Care Trusts, and the organisations that will supersede the PCTs. But policies for care of older people will have a direct impact on the demand and the supply of any of the forms of housing provision that are linked to the provision of care services.

For example, decisions made on the extent to which care can be delivered to older people in their own home will determine the level of demand/need for residential care. Decisions on this will be driven by a mix of what is best for the individual concerned, what is practicable, and the cost of delivery.

DTZ's working assumption is that the majority of individuals prefer to stay in their own home, and that this is generally more cost effective than residential care, so policy will encourage care in the individual's home until it ceases to be practicable. However what is deemed to be practicable may change over time, with advances in technology and available funding.

Another example of the relationship of care policy and funding is that the supply of homes that provide significant levels of care will depend on the fees they are able to charge for care. Where these are funded by the public sector, these fees are now under pressure, with many local authorities looking to reduce care charges by 10% and this will have an impact of profitability in the care homes sector.

Care homes are essentially service businesses, not property businesses. However property related costs are a significant business cost; and therefore the funding and financing of the property elements of the business have a major bearing on the viability of the core business; and have a major bearing on the ability to expand supply with private finance.

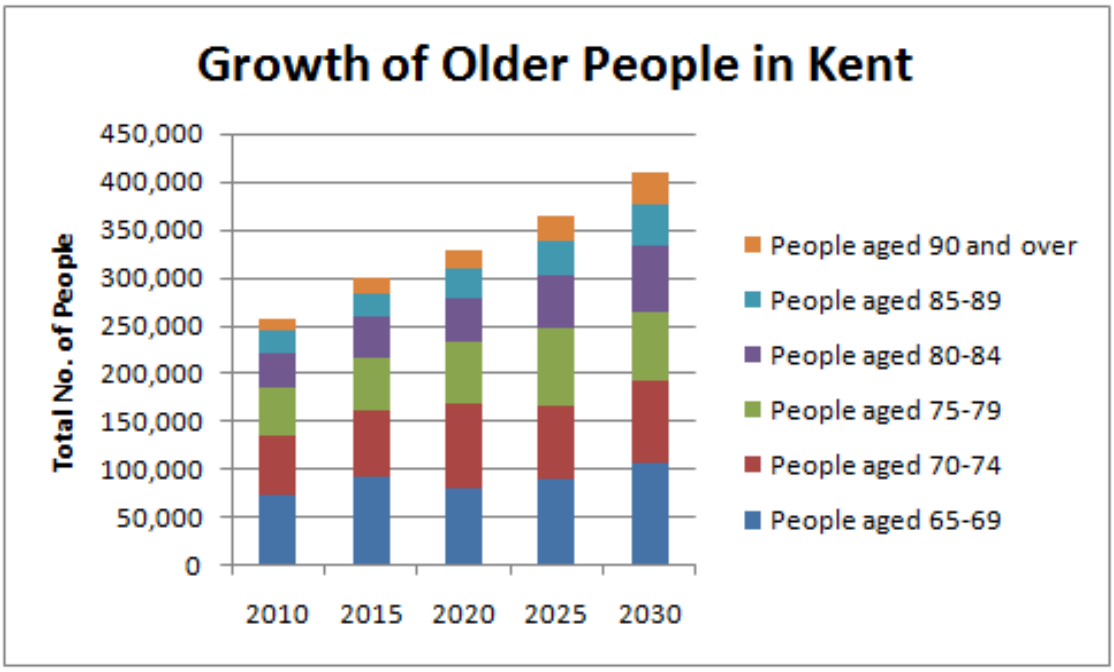
This sort of complexity potential is of considerable significance in how applications for development of new specialist housing facilities for older people are dealt with. Schemes with significant care elements are probably not best treated as housing developments, but as a healthcare business seeking to establish a new facility. This has implications for s106 policies. The position becomes more complex where an element of the overall scheme includes development of new homes for independent living.

3. Factors Affecting Demand and Supply of Housing for Older Adults in Kent

3.1 The Growth in the Population of Older Adults in Kent

The number of older adults (65 and over) in Kent is set to grow significantly over the next 20 years (see Figure 1). The growth in the numbers of older people is a direct result of the increases in life expectancy and the ageing of the post war baby boomer generation.

Figure 1: Growth in the Numbers of Older Adults in Kent 2010-30



Some of the key statistics relating to the growing number of older adults in Kent are as follows:

- The number of residents in Kent aged 65 and over will increase by 59% between 2010 and 2030. This is higher than the forecast increase in England (51%).
- In some Districts in Kent the increase in the population of older adults will be higher than the Kent average; in Dover District the forecast increase is 78% and in Tunbridge Wells District it is 76%.
- The numbers of Kent residents aged over 85 with a long term limiting illness and living alone is predicted to more than double (+ 112%) over the period 2010-30
- The number of those over 75 with a long term limiting illness and living alone is predicted to almost double (+84%)
- There will be a projected 86% increase in the numbers of people over 65 with dementia
- There will be a 62% increase in the number of over 65s living alone
- 80% of people between the ages of 65-74 are owner occupiers, so future provision will have to reflect the needs and aspirations of home owners in their later years
- There will be a projected 70% increase in the number of people aged 75 and over living alone

- Assuming that previous admission rates remain unchanged per '000 of population there will be a 59% increase in the number of local authority Residential and Nursing care beds required in Kent.

Some key findings from national studies indicate the nature of needs that arise as people get older:

- The General Household Survey identifies that a third of older people have difficulty undertaking one or more personal or domestic care tasks
- In 2001 research by Bebbington found that 51 per cent of people in care homes moved there after hospitalisation, because a return home was not practical
- Over half (56%) of retirees live in under occupied accommodation (Harding, 2007), which opens up a second avenue for housing policy of how to encourage less under-occupation of property.

3.2 The Provision of Older Adults Housing in Kent

The Elderly Accommodation Council (EAC) maintains comprehensive lists of providers of housing with support and housing with care by local authority. The EAC identify 1,050 housing and care homes for the elderly in Kent.

Figure 2 shows the number of units per '000 of population broken down by type of accommodation and District. Key points to note are:

- Kent & Medway on average have fewer housing units per '000 of population than the South East as a whole, and also less than England as a whole.
- However Kent & Medway have on average a higher number of care home beds per '000 of population than either the South East or England as whole.
- The greater provision of care home beds than the regional or national average is attributable entirely to the higher level of Residential Care beds.
- Kent has a lower level of provision of Nursing Home beds than in the South East or England as a whole
- In terms of housing units, (see Appendix 2), 66% of Kent & Medway's units are rented (and 34% owned), compared to 62% of units rented (and 38% sold) in the South East of England.

These statistics prompt two lines on investigation for partners in Kent & Medway:

- Residential Care is generally regarded as a higher cost option than Extra Care housing schemes. Is there a need to provide more Extra Care housing, and might there be scope to reduce the level of residential care provision? Perhaps this might be achieved by conversion or redevelopment of existing residential care schemes.
- Given that more of the provision for Kent is for rent (as distinct from sale) compared to the South East, is there more scope to lever in private funding by boosting the private sector for sale market for housing with support or care?

An additional question for consideration is the extent to which Kent provides specialist housing for older people who previously lived in London.

Figure 2: Provision of Older Persons Housing Units and Care Homes per '000 of population

Provision per 1,000 population aged 65+							
		Housing Units			Care Home Beds		
	Popn. (1000s)	Rent	Sale	All	RC	Nursing	All
Ashford	8	66	42	108	50	22	72
Canterbury	14	70	44	114	82	32	114
Dartford	6	99	38	137	65	73	138
Dover	10	89	20	110	94	27	121
Gravesham	6	103	46	149	42	34	76
Maidstone	10	109	50	159	69	36	104
Medway	14	102	33	135	50	41	91
Sevenoaks	9	131	30	160	50	31	81
Shepway	10	77	65	141	93	24	117
Swale	8	107	38	145	74	13	87
Thanet	15	46	65	110	99	30	128
Tonbridge and Malling	7	73	55	128	41	17	58
Tunbridge Wells	8	91	44	134	65	39	104
Kent & Medway	124	87	44	131	70	31	101
South East	640	92	55	146	59	38	96
England	3705	110	31	141	58	38	96

Note: RC = Residential Care
Source: Elderly Accommodation Council, Q1 2009

4. The National Policy Context

4.1 Key Drivers of Provision of Housing for Older People

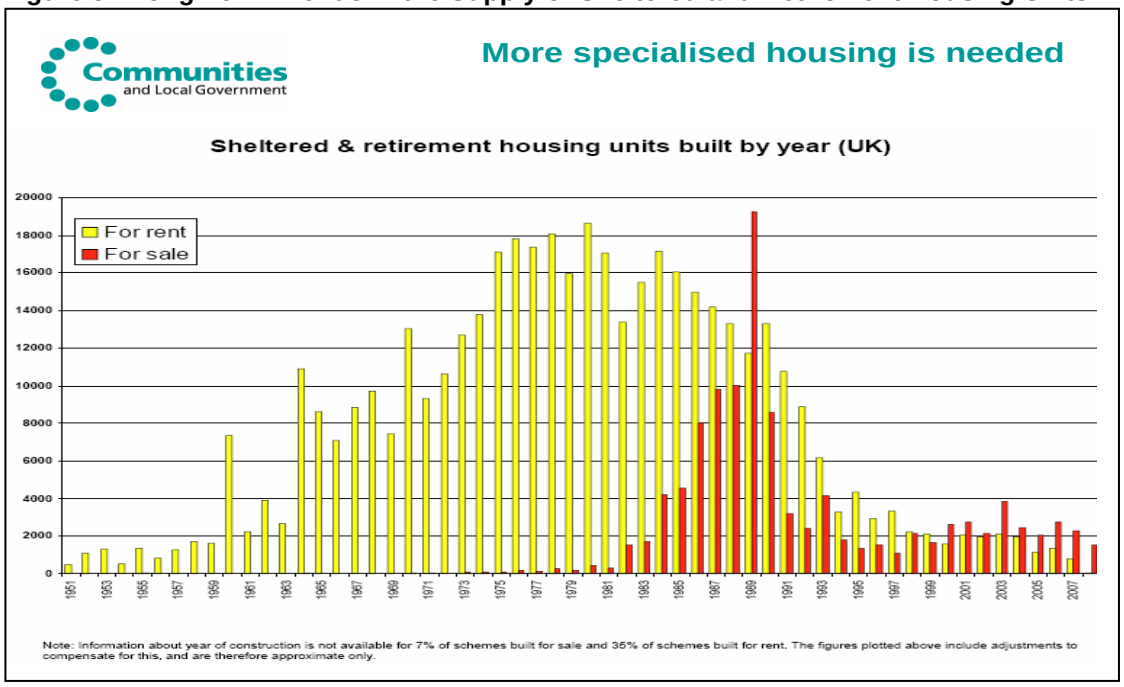
DTZ has undertaken a brief review of key literature as part of the preparation for the programme of research. Key documents that have been reviewed are referenced in Appendix 4. We would draw out four key themes that will shape future provision of specialist housing for older adults, particularly those which have some level of requirement for care assistance.

The Ageing Population: The trends regarding the ageing population in Kent are not significantly different to the national picture. The issue of the ageing population and the health of that population are national issues.

The Implications for Social Care Costs: The 2006 Wanless Social Care Review modelled the additional costs of an ageing population based on the existing configuration of care and estimated that social care expenditure would rise to $14 bn pa over the next period to 2030 if the Government were to maintain the existing system, an increase of 365% on current spending. Clearly this is unaffordable, especially in the current fiscal context; so new mechanisms will have to be found to fund care costs.

Declining Provision and Limited New Supply: Between 1996 and 2001, the number of care home places for older, ill and disabled people in all sectors fell by 50,000 (JRF, 2006). Figure 3 shows how the development of new sheltered and retirement housing units has fallen dramatically since the early 1990s. The reasons for the low level of new provision merit investigation. The decline in residential care and nursing homes is attributed by many to rising costs resulting from labour market regulation, wage inflation and new care standards. Greater emphasis has also been placed on home care.

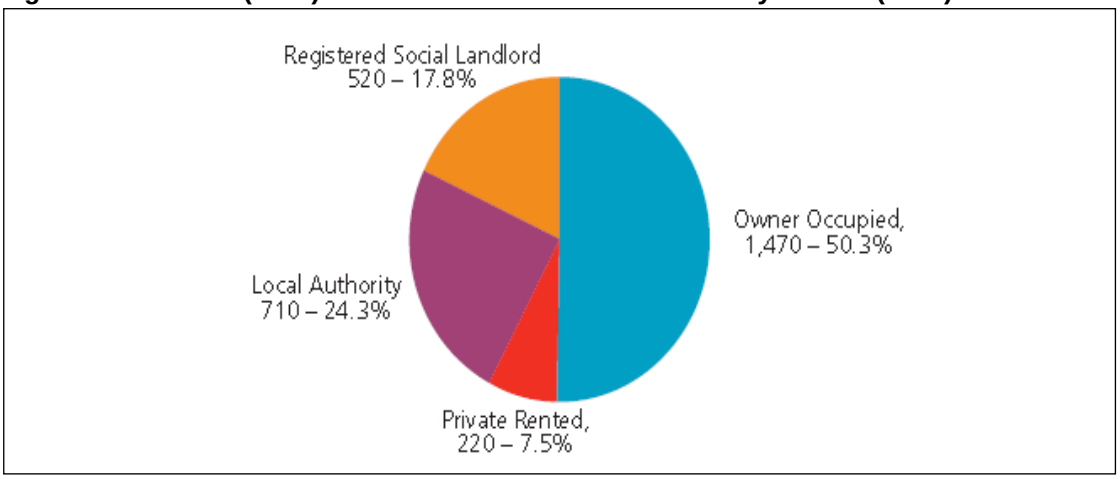
Figure 3: Long Term Trends in the Supply of Sheltered and Retirement Housing Units



Source: CLG, 2008

Changing Expectations: The generation that is now entering retirement contains a higher proportion of home owners, a very different position to that which was the case in the era of large scale building of sheltered and retirement housing units in the 1970s and 1980s. In 2005 around half of all *vulnerable* older households were owner occupiers. Historically the focus of public policy (and funding) was on providing housing for older local authority and housing association tenants. Policy now needs to reflect the fact that many older people will have significant housing equity.

Figure 4: Numbers (000s) of Vulnerable Older Households by Tenure (2005).



Source: CLG, 2008

The patterns of provision of housing for older people in recent years, with a fall in new provision despite a rising population of older people, is probably having the effect of reducing housing options available to older people. As long as home care is the appropriate option for older people, the need for additional specialist provision may not rise in line with the rising population. But there is the risk is that the complexities of bringing forward and funding new provision of specialist care may mean that there is under provision or a lack of choice in the market.

The risk of under provision has been highlighted in recent studies. The Wanless Review (2008) identified that there only around 35,000 extra-care housing units in England. A study by McCarthy & Stone a specialist private provider of older people's accommodation suggest that, if the rate of new provision remains unchanged, there will be a shortage of around 62,500 private sheltered housing units in the UK by 2020 given the demographic trends.

McCarthy & Stone clearly have a vested interest in making this point, but they are not alone in pointing to a potential shortfall in new provision of specialist housing that will meet the needs and aspirations of older people. Given funding constraints, much of the new supply will need to be delivered with private sector funding, by a diverse range of providers, including local authorities, housing associations and private providers.

The implications of the above trends means that there needs to be a new development and funding model that enables new investment in provision of housing, with associated care facilities to meet the needs of the growing population of older people. This needs to align the different funding streams that make specialist provision work – funding for care (whether paid for directly by clients or by the public sector); funding for development; and funding for the business operation (equity investment and loans).

The additional complexities that affect the establishment of new business models for the provision of older people's housing are the interaction between development of new facilities and the land use planning system, given that much new provision will entail new development; and the fraught issue of the share of responsibility between the state and individuals in funding their personal care and medical care costs, linked to the expectation that individuals should be expected to use accumulated wealth, including housing equity, to pay for the cost of their care in older age.

4.2 Staging Posts in the Development of Government Policy

It is beyond the scope of this study to present a comprehensive picture of the evolution of government policy around care and specialist older persons housing provision, but there are some key staging posts in the evolution of the debate about care and provision of residential care facilities, with many of those requiring such care being elderly.

A set of studies by the Audit Commission in the late 1990s highlighted the implications for the Health Service of inadequate provision of the right mix of residential care facilities.

Thus a 1997 Audit Commission's study into admissions to acute beds in hospitals found that 40% of admissions of people aged over 75s were 'avoidable'. The main reason for admission to an acute bed was that the patient required a lower level of care (eg, rehabilitation, community hospital). Half (50.5%) of all admissions could have been avoided had appropriate care facilities been available locally.

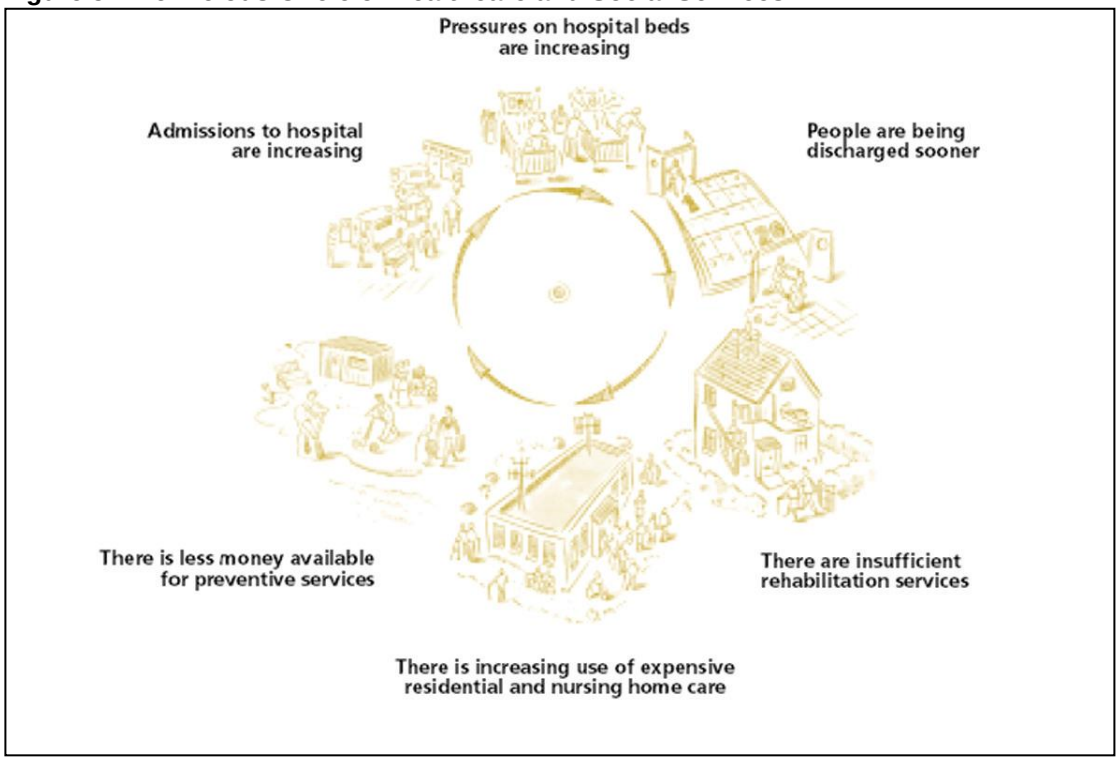
The Audit Commission concluded that *'action is required at a number of levels, and these actions should be prioritised to make them achievable. But local initiatives alone are unlikely to be sufficient. A clear statement of policy from government (is required), which might include answers to what is the correct balance between acute and preventative and rehabilitative services?'* (Audit Commission, 1997).

The Audit Commission continued to investigate this issue in its Home Alone report published in 1998 which identified a 'vicious cycle' of care. It claimed that too many people fall through the net because of poor collaboration between housing, health and social services, stating that *'a picture emerges of inadequate identification of needs, inflexible use of stock and insufficient early intervention to prevent vulnerable people reaching crisis point'.* Figure 5 shows the vicious circle identified in a subsequent Audit Commission report on this issue.

The Department of Health acknowledged the need for intermediate care as a means of encouraging independence for older people and a reducing in inappropriate admissions to the acute hospital sector (DoH, 2000). The DOH report called for an increase in multidisciplinary and inter-agency partnerships within intermediate care and access to rehabilitation services in a variety of settings to improve older people's quality of life (DoH, 2001; DoH, 2002).

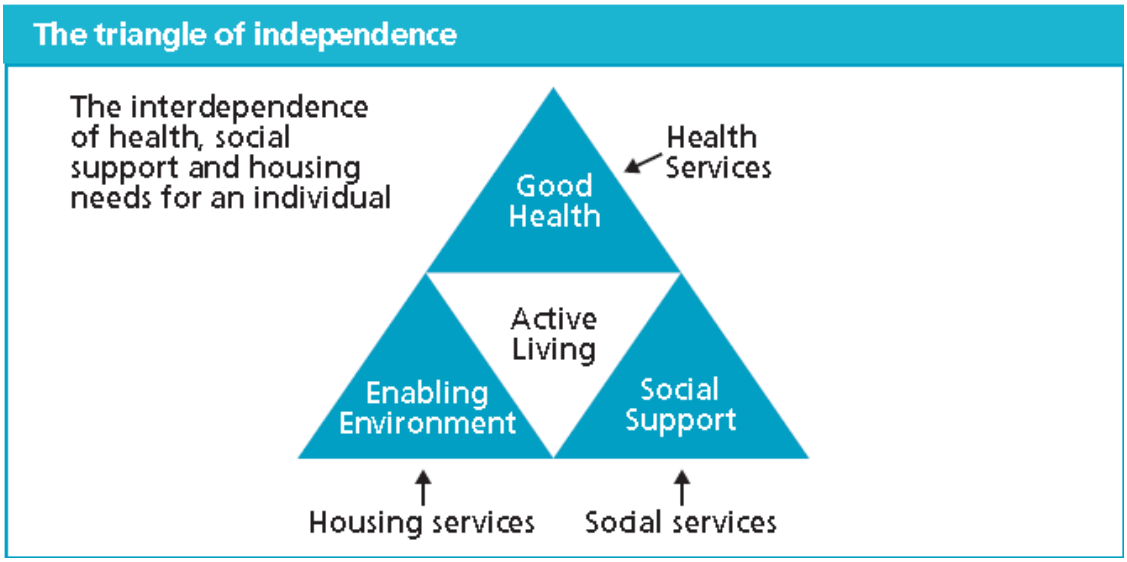
The focus on inter-agency co-ordination continued to be a focus throughout the decade to 2010. The former Labour administration attempted to overhaul the perceived failures of silo working by government departments and introduce the concept of 'whole systems working'. Figure 6 illustrates how different stakeholders need to interact within the 'whole system' of older people's housing and care strategies.

Figure 5. The Vicious Circle of Healthcare and Social Services



Source: Audit Commission, The Way to Go Home, 2000

Figure 6: The Whole System View of Meeting the Needs of Older People



Source DCLG, 2008: 80

Lifetime Homes and Lifetime Neighbourhoods (2008) was the government's response to Britain's ageing population and outlined the policy case for greater intervention and strategic planning of older people's services and housing. A multi agency approach is suggested to ensure better outcomes for older people (defined as those aged 65 and over) in the UK. The

report also identifies that more needs to be done to improve the housing options available to older people.

To assist the planning of provision of care facilities at the local level the DoH, CLG, the Housing Learning Improvement Network and the Care Services Improvement Network published the ‘More Choice, Greater Voice Toolkit’ (2008) alongside the 2008 policy document. This document recommends that local authorities deliver 55 places of health related support per 1,000 persons aged over 75. In addition to this there is also another toolkit, the Extra Care Housing Toolkit (2008) that can be used to predict and provide the requirement for older people’s housing and attempts to quantify a range of provision from dementia care housing through to retirement villages. More information is contained on these tool kits in Appendix 3.

Appendix 1: Wokingham Council Classification of Older People's Housing

The matrix below was adopted by Wokingham UA as the basis for discussion with existing and potential providers when matching the accommodation and care package they were offering against the aspirations of the authority's older persons' accommodation strategy. It has subsequently been used with a number of other authorities and in the analysis of the supply of specialised housing for older people across Wales.

Housing Type		Characteristics of population	Design and facility requirements	Services
Retirement accommodation	Essential	Independent population	Self contained accessible accommodation. A sustainable location in terms of access to local amenities and services	Community Alarm
	Desirable		Built to meet lifetime homes standards. Guest room with a range of facilities. Providing two rooms in each unit.	Visiting warden/scheme manager service on demand, floating support service and/or individual budget.
Conventional Sheltered Housing	Essential	Independent population	En suite private accommodation. Communal facilities. High standard of accessibility internal and external. Guest room with a range of facilities.	Facilitated access to care services. Dedicated warden/ scheme manager service.
	Desirable	Capacity to cope with occasional care needs.	Enhanced communal facilities: eg craft facilities, IT suite, etc. Infra-structure in place for assistive technology. Generous storage space in addition to that within the individual unit.	Facilitated social and recreational activity programme, floating support service and/or individual budget.
Enhanced Sheltered Housing	Essential	Mixed dependency population. Including up to 12 hrs per week care needs.	Assisted bathing facilities. Access to meals service. Recreational/Leisure facilities. Infra-structure in place for assistive technology. Guest accommodation with range of facilities.	Manager based on site to provide support and facilitate access to day opportunity services. Expedited access to care services. Facilitated social and recreational activity programme.
	Desirable	Aggregate care needs 150-200 hrs per week.	Restaurant. Fully equipped craft rooms. IT Suite. Exercise suite. Generous storage space in addition to that within the individual unit.	On site care and/or support.
Extra Care Sheltered	Essential	Mixed dependency	En-suite one bedroom &	Manager based on site to

Housing		population, around 1/3rd having care needs in excess of 18 hrs care per week. 1/3rd low care needs. 1/3rd no current care needs. Aggregate care needs at least 240 hrs per week.	accommodation - Restaurant - Fully equipped craft rooms - IT Suite - Exercise suite - Day opportunities Scheme design encourages orientation. Infra-structure in place for assistive technology Generous storage space in addition to that within the individual unit.	provide support and coordination 24/7 on site care. Facilitated recreation, social, cultural programme.
	Desirable	Existing residents supported in extreme frailty. Some residents with moderate levels of dementia.	Some utilisation of assistive technology Communal facilities available for older people in local community	Access to nursing/ wellbeing Services. Access to dementia services.
Registered Care Home	Essential	Minimum care needs 18 hrs per week up to highest level of personal care short of nursing.	In space and design standards meeting the requirements of the Commission for Social Care Inspection. Infra-structure for assistive technology.	In staffing levels and practice meeting the requirements of the Commission for Social Care Inspection.
	Desirable	Capacity to cope with highest levels of physical and mental frailty	Exceeding the minimum space standards and with additional facilities to enrich the life experience of residents. Guest accommodation with a range of facilities. Some utilisation of assistive technology.	Evidence of highest professional practice and staffing to support life enrichment for residents.

Appendix 2: Existing Supply of Older Persons Housing In Kent

EAC's *National Database of Housing for Older People* is the only national information source covering all forms of provision, all types of provider and all tenures. DTZ have therefore been able to use the information held on this database to identify the existing supply of accommodation for older people. Displayed below are comparison table for England, South East and Kent.

	Popn. 75+ (000)	*Housing with Support*			*Units per 1,000*	*Housing With Care*			*Units per 1,000*	*All Specialist Housing*			*Units per 1,000*
		Rent	Sale	All		Rent	Sale	All		Rent	Sale	All	
Ashford	8	526	293	819	103	0	43	43	5	526	336	862	109
Canterbury	14	814	598	1,412	104	137	0	137	10	951	598	1,549	114
Dartford	6	552	209	761	137	0	0	0	0	552	209	761	137
Dover	10	863	196	1,059	110	0	0	0	0	863	196	1,059	110
Gravesham	6	659	236	895	139	0	61	61	10	659	297	956	149
Maidstone	10	1,065	419	1,484	146	46	86	132	13	1,111	505	1,616	159
Sevenoaks	9	1,034	205	1,239	142	104	52	156	18	1,138	257	1,395	160
Shepway	10	758	612	1,370	138	0	12	12	1	758	624	1,382	140
Swale	8	895	322	1,217	145	0	0	0	0	895	322	1,217	145
Thanet	14	592	838	1,430	99	29	73	102	7	621	911	1,532	106
Tonbridge and Malling	7	487	311	798	112	66	79	145	20	553	390	943	133
Tunbridge Wells	8	801	294	1,095	132	17	67	84	10	818	361	1,179	142
Medway	14	1,402	463	1,865	132	0	0	0	0	1,402	463	1,865	132
Kent & Medway	124	10,448	4,996	15,444	126	399	473	872	7	10,847	5,469	16,316	133
South East	640	54,943	31,466	86,409	135	3,966	3,440	7,406	12	58,909	34,906	93,815	147
England	3,705	376,464	102,077	478,541	129	30,865	12,473	43,338	12	407,329	114,550	521,879	141

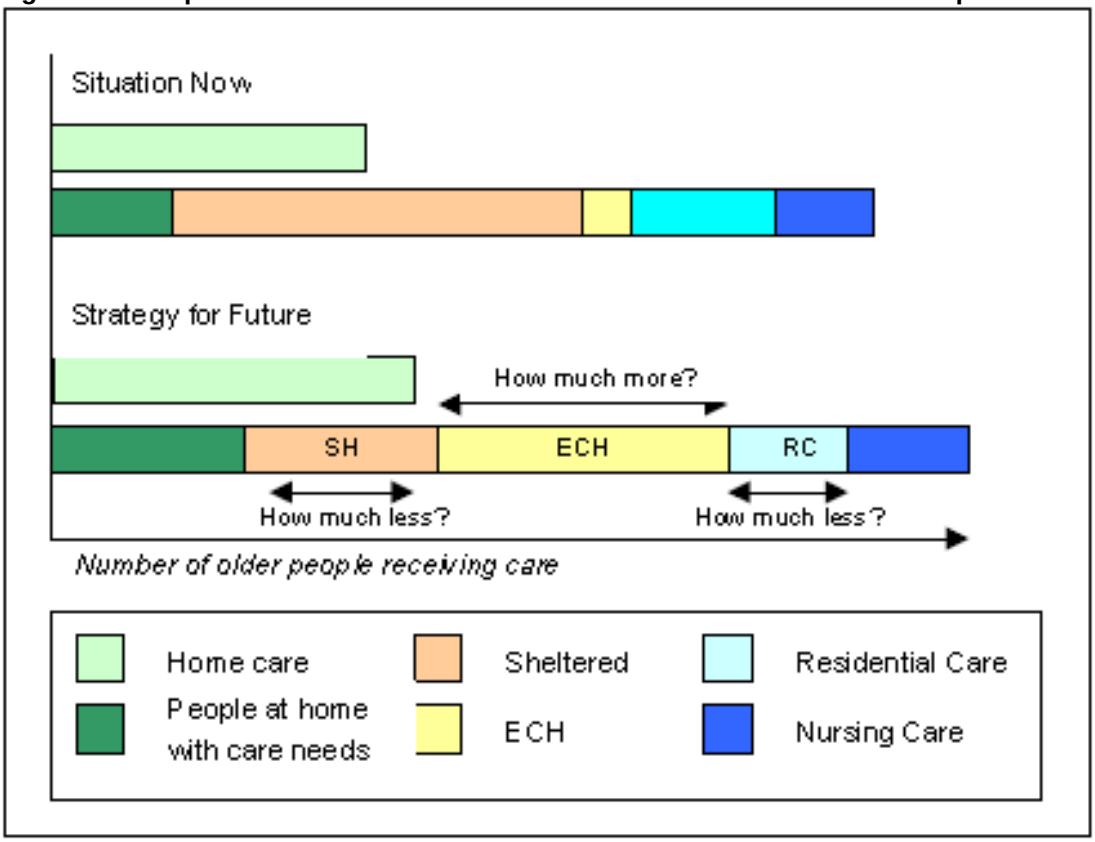
(Source: Elderly Accommodation Council, 2009 data)

Appendix 3: Review of Tools for Planning Older People's Housing Provision

Introduction

Government guidance stresses the importance of having enough of each type of accommodation to meet anticipated demand, in the right location and designed to meet people's needs and aspirations. This will generally require the delivery of new forms of accommodation. Figure A3.1 illustrates how the 'situation now' might compare with what is assessed to be required in future, reflecting the range of different forms of provision.

Figure A3.1: Spectrum of Care Services – Current Provision and Future Requirement



(Source: URS Corporation, 2005)

The two forms of formal care and housing that are most commonly received are home care and sheltered housing. These services overlap as about two thirds (66%) of people in sheltered housing receive some low to moderate level of home care (Audit Commission, 1997). The dynamics of assessing service provision and what a rebalanced care system might look like are complicated further by the impact of an ageing population.

Key questions that providers need to ask themselves are:

- What is the demand for ECH and how much ECH should be provided?
- What is the demand for Sheltered Housing and should it be decommissioned or remodelled.
- What is the demand for residential care, and how many people might be appropriately re-housed in ECH?

A number of predictive models are available to help to answer the above questions. In this report DTZ has examined the two models that are most frequently used:

- *The Extra Care Toolkit* (2006) *'Anyshire'* model developed by the Institute of Public Care (IPC) based at Oxford Brookes University and promoted by the Care Services Improvement Partnership (CSIP) which is a government agency aimed at promoting 'change management' in the delivery of care services in England.

- The *More Choice Greater Voice* (MCGV) developed in which has been endorsed by the government in the recent housing strategy for older people.

Both models are based on a number of assumptions about the prevalence rates of current impairment, the assumption that census trend data will continue in a linear pattern and that service user profiling has been conducted. Both models and their backers identify the following generic problems in the UK with regard to current provision:

- There is too much rented accommodation
- There is not enough leasehold accommodation
- There is inadequate provision of dementia care
- There are no mixed tenure schemes

The Anyshire Model

The Anyshire model is a tool for predicting demand for housing associated with an ageing population. The model forecasts an increase in the numbers of people over 65s of 30 percent by 2016. The highest growth is expected to be in the 65-69 and the 80 plus age ranges. Office of National Statistics projections show that by 2015 the over 65s are forecast to increase by 15 percent in Kent.

The Anyshire model makes the following assumptions;

- 30% of individuals currently in residential care would be better provided for in extra care schemes.
- ordinary sheltered housing does not delay admission into care homes.
- existing extra care schemes show a diminution in the demand for care services as compared to prior to admission to the scheme.
- there is demand for owner occupied accommodation.

Whilst small scale research and evidence suggests that these assumptions are correct they have yet to be proven by large scale studies. It is up to local authorities to decide what proportion of residential and sheltered housing should be replaced. The model advocates the complete abolition of sheltered housing.

In the Anyshire model, it is assumed that 3 out of 10 residential care and four out of ten sheltered housing units will be replaced, in order to facilitate the delivery of the strategy. It is suggested that the remaining six out of ten sheltered housing units are demolished and the land brought forward for both private and public provision of ECH. The Anyshire model anticipates that ECH will provide for older people with mixed dependency needs. These assumptions have been supported by a robust evidence base.

The Anyshire model indicates that 30% of older people that currently enter a care home will instead go into ECH and this pattern will continue with in the future. With respect to vulnerable older people, census data shows that 21% of older people have a limiting long-term illness. The model assumes that ECH will provide accommodation for 30% of these households.

The model assumes that 30% of the over 65 population will look to move to different accommodation of which 12 percent will look for accommodation with care.

The More Choice Greater Voice Model (MCGV)

The MCGV model takes a different approach to 'Anyshire' and makes normative assessments about existing provision and suggested ratios for future provision. Like the 'Anyshire' model, the MCGV model also identifies a rapidly changing tenure profile as a key issue to be addressed.

The MCGV model makes similar assumptions to the Anyshire model as follows;

- the demand for traditional sheltered housing will decline
- the older stock will become increasingly sub-standard and redundant
- the potential for leasehold retirement housing will grow

Unlike 'Anyshire' the MCGV model restricts its target population to the over 75s. This has been done to reflect the critical point when older people begin to enter health related 'crisis' points. MCGV anticipates an increased requirement for for registered care home places offering high intensity nursing care.

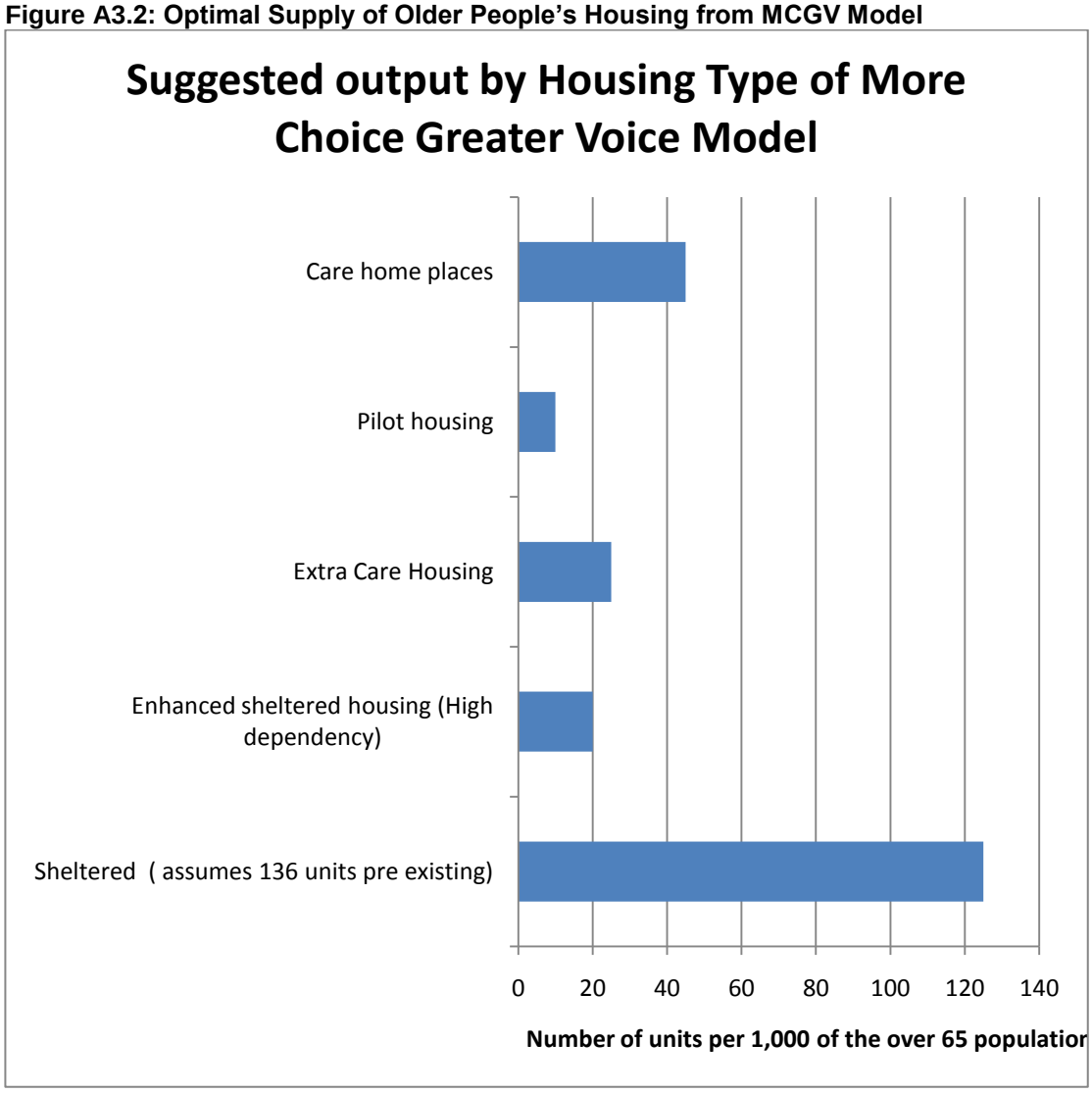
The Models Compared

The 'Anyshire' is a more ambitious model which looks not only to forecast demand for health related needs (likely to be 75 and over) but also those who are looking to downsize. Unlike 'More Choice Greater Voice' it produces outputs for private delivery whereas MCGV creates outputs and targets for public provision only – despite acknowledging the changing profile and likelihood of increasing demand for private accommodation. Ultimately MCGV is more conservative than 'Anyshire'.

In total the MCGV model suggests a total requirement of 225 places per 1,000 of the population. It assumes a dominant role for sheltered housing and seeks to retain the level of existing supply. This is surprising given that the literature highlights dissatisfaction with the quality of sheltered housing and its failings to slow down admission to nursing care.

In addition, the model also retains residential care provision (included within 'care home places' on Figure A3.2). ECH has a relatively small role and only a small role is given to new forms of housing such as CCRCs identified as pilot housing on this graph.

Figure A3.2: Optimal Supply of Older People's Housing from MCGV Model



In contrast the outputs generated by the 'Anyshire' model are more radical and in step with the Department of Health's preventative care agenda. For example, a clear emphasis on the introduction of mixed dependency care settings is made through the introduction of retirement villages and CCRCs (see Figure A3.3)

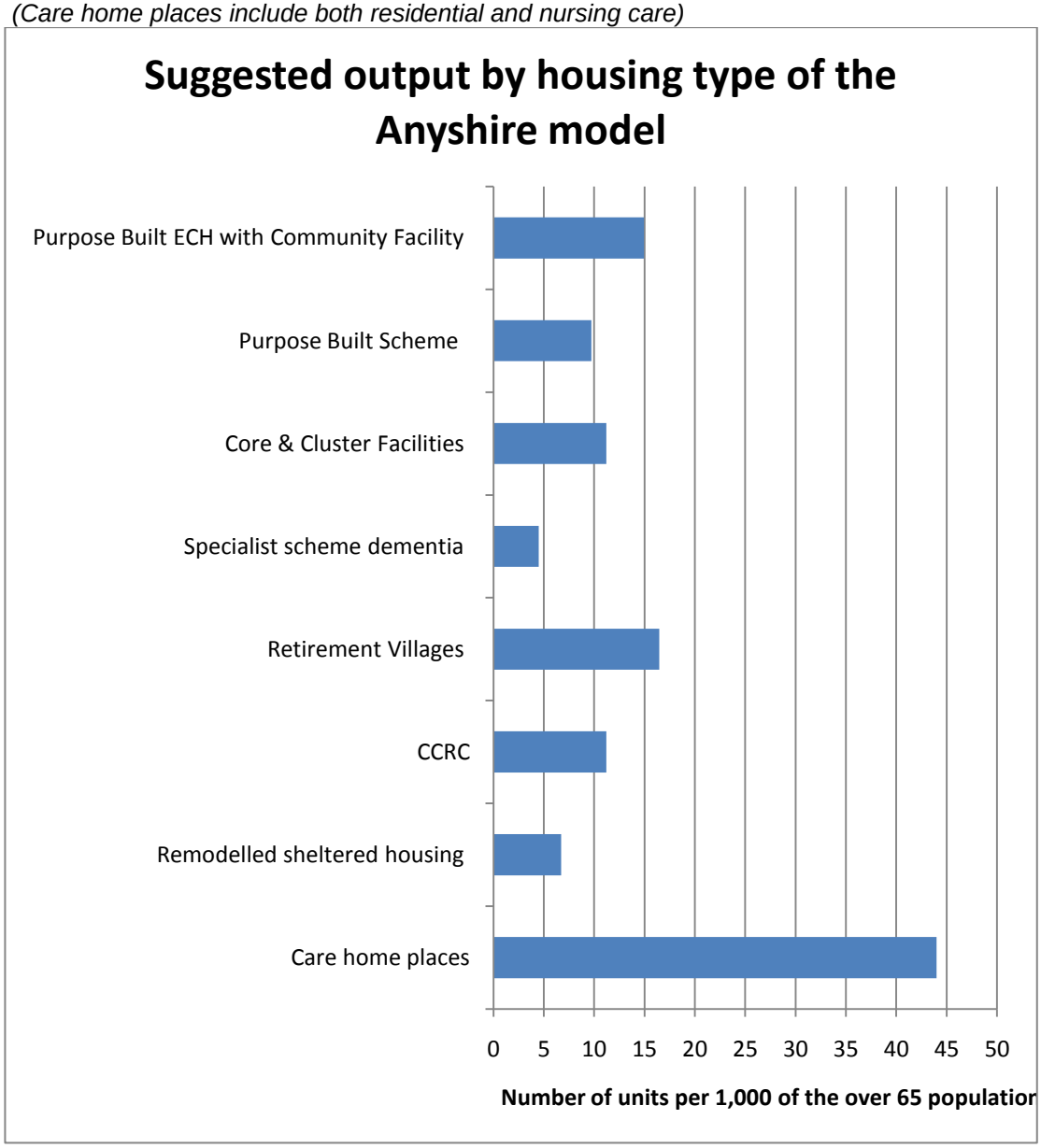
In contrast the MCGV model works within the existing system and advocates the remodelling of existing facilities and continued public sector delivery whereas the 'Anyshire' model emphasises mixed delivery and the reconfiguration of the existing care system.

The 'Anyshire' model recommends output at 74 newly delivered units per 1,000. This would run alongside a reconfigured residential care sector in which 30% of existing residential care

would be remodelled, and 30% of future placements would be redirected in ECH. A total of 118 places per 1,000 would be produced.

In total the Anyshire model has a new build requirement of 74 units per 1,000, in comparison with the more modest 55 units per 1,000 of MCGV. This will have a significant impact on the capital contribution required to implement the model.

Figure A3.3: Optimal Supply of Older People's Housing from Anyshire Model
(Care home places include both residential and nursing care)



Both the Anyshire Model and MCGV model recognise that there is likely to be an increased demand for owner occupation in the sector over the next 20 years. Currently 75%of all specialist housing provision is built for social rent. MCGV anticipates that the delivery partners for older people's housing will be housing associations. But the Anyshire model attempts to meet the anticipated rise in owner occupation and offers a fuller range of tenure options than MCGV model. This is reflected in the provider mix proposed for a typical county by the Anyshire model shown in Figure A3.4.

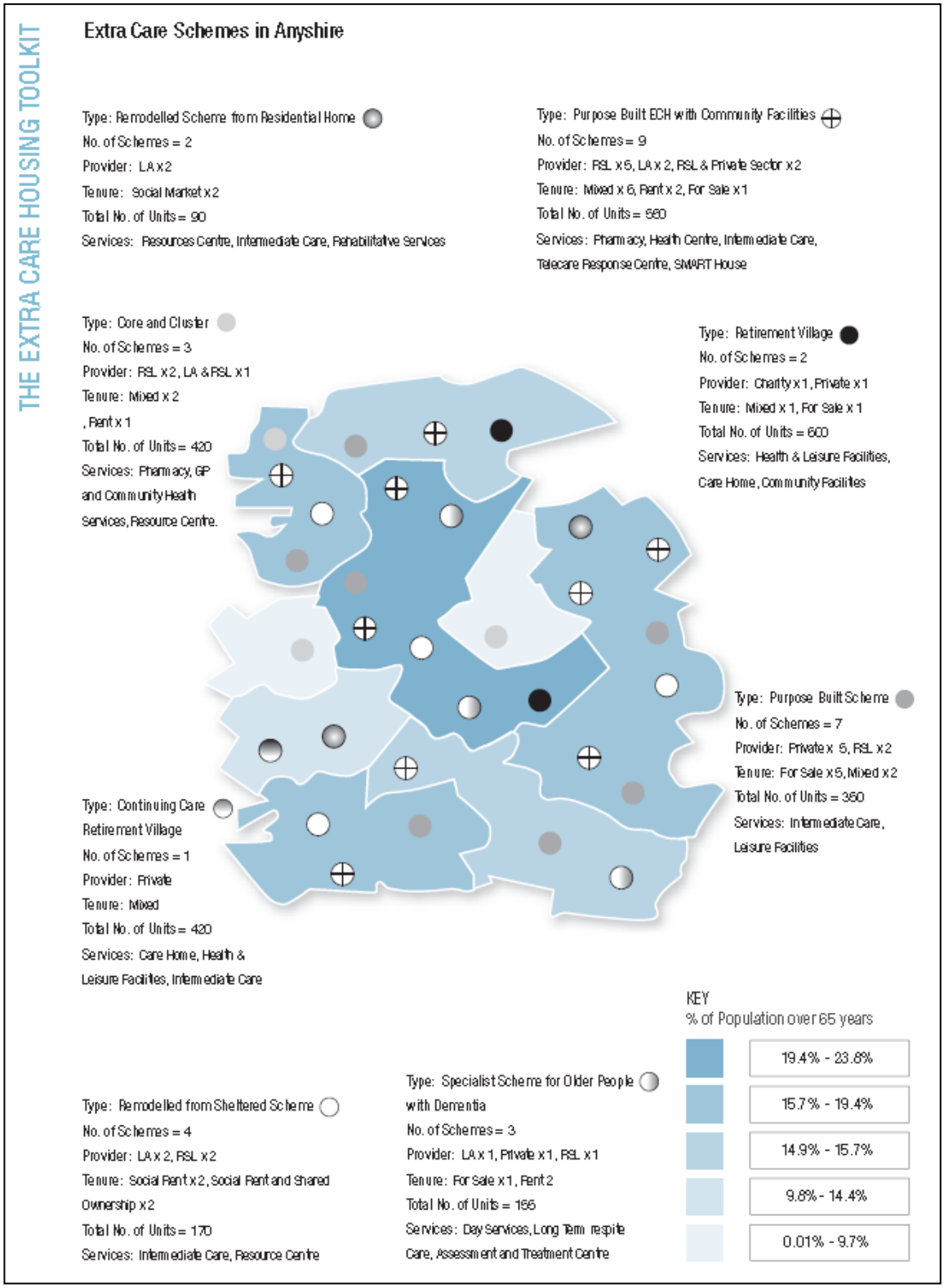
Figure A3.4: Indicative Provider Mix in the Anyshire Model

	Provider			
Accommodation type	Private developer	RSL	Local Authority	Charity
Continuing Care Retirement Villages	15%			
Specialist dementia care	2%	4%	2%	
Purpose Built Scheme	9%			
Retirement Villages	11%			11%
Purpose Built ECH with Community Facilities	2%	8%	4%	
RSL remodelled sheltered stock		6%		
Core Scheme		17%	3%	
Remodelled residential care housing			3%	
Remodelled sheltered housing			3%	
Total provision	39%	35%	15%	11%

Figure A3.5 pictures how the 'Anyshire' model envisages the pattern of provision might emerge over time across a county, in terms of a mixed economy of providers (independent and local authority), different forms of provision (retirement housing, purpose built ECH, dementia housing etc.), and in terms of the spatial pattern of provision, which would be linked to local demographic profiles.

The Anyshire model seeks to balance the changing demographic profile with the financial viability of scheme sizes. The model also takes into account the need for reconfiguration of care and factors in the remodelling of sheltered and residential care. Furthermore the Anyshire model attempts to cater for not just for social housing tenants, or those with physical impairment, but also for owner-occupiers. This is an important area of provision, which is not fully provided for at present. 'Anyshire' proposes bringing forward public sector land released by demolition of sheltered housing for both public and private development.

Figure A3.5: An Example of the full range of Provision provided by 'Anyshire' to a Hypothetical County



The Anyshire Model is also more sophisticated in DTZ's view than the MCGV model because it seeks to take into account current and future trends as follows:

- Care Trends
  - The proportion of residential care home residents who could have had their care needs met in extra care housing
  - implausibility of adult services care spending continuing in its current form
  - the extent to which Extra Care housing should replace a proportion of residential and all sheltered housing

- Demand Trends
  - A plausible forecast of the potential demand from owner occupiers for housing with care. This has been informed by the Lifeforce survey which is a study into the consumer preferences of over 1,500 older people
  - Makes an assessment about tenure and the mix of dependencies, which are financially viable
  - Demand assessment about the amount of Supported Housing and the number of units to be remodelled.

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Care Services Improvement Partnership (2008)
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Useful websites

Care Services Improvement Partnership
www.csip.org.uk/

Centre for Policy on Ageing
www.cpa.org.uk

Counsel and Care
www.counselandcare.org.uk/

Elderly Accommodation Counsel
www.housingcare.org/

Housing and Older People Development Group (HOPDEV)
www.communities.gov.uk/housing/housingmanagementcare/housingolder/abouthopdev/

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