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Older people's housing, care and support needs in Greater Cambridge 2017-2036

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Executive Summary

Background

This report presents the findings of research into the housing, care and support needs of older people in Greater Cambridge. Commissioned by South Cambridgeshire District Council (SCDC), in collaboration with a range of local partners, and with funding from the NHS's Healthy New Towns initiative, the study combines modelling of future demand and supply of older people's housing with assessments of current policy and practice aimed at meeting the requirements of this population. Through these two research components the report provides a comprehensive, independent assessment which can form the basis of local policy making.

Addressing the needs of a rapidly ageing population in both SCDC and Cambridge City will require decisive action. It is acknowledged in recent policy and research documents that to meet this challenge, a system of provision is required which includes and connects together the following five components.

1. **Housing-related support and assistance services** helping to ensure that older people are living in safe, appropriate housing that is fit for purpose and promotes health and well-being.
2. **New housing** which promotes independent living and provides opportunities for older people to move to more appropriate accommodation (on the basis of size, design, site and situation) as their needs change in later life.
3. **Specialist housing** which assists older people with their housing and support needs in later life and delays or reduces the need for more intensive care.
4. **Integrated housing, health and social care** services which help meet the on-going health needs of older people.
5. **Information and advice** which promotes informed choices and planned moves and supports independent living in later life.

To inform such efforts in Greater Cambridge, the report sets out the development of, and recommendations from, a new model for estimating the required supply of housing for older people. On the basis of this, and acknowledging that future supply is subject to a range of possible policy interventions and external factors, the report explores the efficacy and interdependencies between housing and other components in this system of provision.

Methods

The research was conducted through four strands of activity, which can be summarised as follows:

a. Reviewing a variety of national research reports and good practice documents, alongside local policy documents, strategies and secondary data.

b. Modelling the demand and supply of older people's housing, using national datasets to develop a new model of required supply grounded in the realities of local authorities with high levels of supply.

c. Interviews with a range of local stakeholders, including those within public bodies, voluntary organisations and private developers.

d. Focus groups with residents in various locations, with people of different ages and from different ethnic groups, to explore their needs, preferences, perceptions and decision-making processes.

Older people's housing, care and support in Greater Cambridge

Greater Cambridge is set to experience a rapidly ageing local population, with the number of people aged 75 and over set to nearly double between 2016 and 2036. As the population ages, the prevalence of long term health conditions is likely to increase, creating complex geographies of need and demand on various services. The number of older people in Cambridgeshire living with dementia, for instance, is expected to rise from 6,600 in 2006 to 10,200 by 2021, placing significant pressure on housing, support and care provision. Incidences of trips and falls already constitute a large percentage of emergency hospital admissions, raising questions about the role that suitable housing can play in mitigating these.

There are signs that general needs housing may present problems for older people, with 37 per cent of private sector stock (across Cambridgeshire) failing to meet Decent Homes Standards, and containing hazards which increase the chance of trips and falls. Analysis suggests that investment in aids and adaptations provides clear cost savings, and assistive technologies can help people remain independent in their home. Future general needs housing can also help by being sympathetic to the needs of an ageing population.

Specialist housing plays a critical function in helping those unable to remain in general needs housing. With a large sheltered housing stock - much of it retained by the local authorities - and with recent increases in the number of extra care schemes, such supply is performing an important function, though the provision of private sector housing for older people remains at a low level. Added to this, Cambridgeshire County currently has the lowest level of care home provision per capita in the region.

Responding to these challenges, a dedicated Older People's Accommodation Strategy is guiding local policy-making, prioritising short-term management of demand in the health, social care and housing systems, increasing choice and affordability of specialist provision, and enhancing the choice of accommodation options (across a range of types). These objectives are being operationalised, at

least partially, through local policies and services in such areas as planning, housing, and health and social care.

Modelling the supply of Older People's Housing

This research develops a new model to estimate supply and demand for older people's housing. Acknowledging the shortcomings of other tools for this purpose, the CRESR model is purposefully grounded in the realities of those local authorities that have high levels of existing supply. The first stage of our modelling assessed the level and composition of supply of specialist housing, age-exclusive housing and care beds across the 100 English local authorities with the highest overall provision per 1,000 older people (aged 75 years or older). Based on these 100 authorities a recommended level of provision for specialist housing was identified and broken down by accommodation type. The second stage used statistical modelling to identify factors that are predictors of the variation in provision between those 100 authorities.

By modelling on the basis of existing provision in areas with higher levels of supply, we address the criticisms of other models which use pre-set prevalence rates for demand among older people. This means that the CRESR model is grounded in what is possible at a local level, but this means it is both retrospective and based purely on quantitative measures of supply in other local authorities (and not on the suitability or quality of that supply).

The CRESR model identifies a requirement for 3,422 units of specialist housing in Greater Cambridge in 2016, against actual supply of 3,280 units. Other models, such as SHOP@, suggest there is a current supply requirement of 3,554 specialist units in Greater Cambridge.

The CRESR model identifies current deficits in the supply of age-exclusive housing and residential and nursing care. The boundaries between age-exclusive and sheltered housing are blurred, but given the current undersupply of both of these housing types, it is suggested that there is a gap in provision which is a step below extra care in terms of the care and support offered. This 'space' may be filled by a range of products that provide a more modern alternative to traditional sheltered housing.

There are significant differences between our modelling and SHOP@ in terms of the forms of supply required. SHOP@ suggests enhanced sheltered and extra care units should make up approximately one in five specialist units. Whereas our model suggests that one in 10 of the recommended supply of specialist units in Greater Cambridge are either enhanced sheltered or extra care. The CRESR model suggests that extra care housing is approximately supplied at the right level at present in Greater Cambridge. However, if it is decided that extra care can meet a greater proportion of needs (currently met in other areas of the system), then this could significantly change how many units of extra care are required. The CRESR model suggests sheltered housing is likely to be under-supplied, or perhaps more precisely, there is an under-supply of housing that meets the demands of those who require lower levels of support, but nonetheless age-appropriate housing.

The CRESR model recommends that by 2035, the supply of specialist housing will need to be 80 per cent higher than present, at 6,163 units. This equates to an annualised rate of development of 142 new units through that period, before any additional units are required to account for reductions in the stock. This bears similarities with SHOP@ which recommends aggregate supply of specialist housing in Cambridge and SCDC of 6,632 by 2035. Similar increases are recommended for age-exclusive housing and care beds, as we suggest that both forms of accommodation need to increase by 80 per cent by 2035.

Understanding future provision in these accommodation types enables us to give approximate estimates for the number of older people in general needs housing. This raises important questions about the proportion that is suitable for people with mobility problems and wheelchair users, and the standards to which new general needs housing should be developed.

Existing models such as SHOP@ recommend a focus on ownership options when developing future older people's housing. However our model shows rental forms of supply are predominant in the selected authorities. Hence, whilst our model recommends large percentage increase in ownership forms of specialist and age-exclusive housing, nearly 3,000 additional rental units will be required by 2035 in the form of age-exclusive and sheltered housing.

Rather than accepting the projected supply figures as static, we argue that policy-makers should see them as the basis for more informed policy making. Demand may be met through a vast array of different interventions within the sphere of housing, but also via other means which involves understanding the wider system of provision for older people.

Informing policy and practice: Stakeholder insights and resident perceptions

Our qualitative research has revealed a range of lessons relating to local policies and practices. Drawing on the interview testimony from public officials, voluntary sector organisations, master developers, housing associations and large retirement housebuilders, as well as insights from over 60 residents, we set out a number of opportunities to maximise action on the five areas of provision. These are detailed throughout Chapter 5, and summarised in section 5.7.

Our resident focus groups revealed how many residents have a desire to remain living at home, and are reluctant to move. Most also do not have a full knowledge about their housing choices and the benefits that could be gained from moving, and many still have a binary view of their housing pathway - from current house to care home (if absolutely necessary).

However, residents expressed what qualities they valued in housing terms, and how these should be translated into future provision. In particular, integrated communities were valued highly - providing choice to live within mixed communities rather than housing that concentrates older people. For some, this idea of community was associated with maintaining their association with friends, family, neighbours and

familiar places; but for others it was associated with being active, having access to social and cultural assets, and living within an age-diverse community.

Allied with evidence from our stakeholder interviews, this enables us to recommend certain areas of focus to improve older people's housing, care and support. This includes:

- Providing an improved advice and information service to help older people make informed choices. This would build on the evolving HOOP initiative, ensuring this is adequately resourced and its impacts are understood.
- Establishing, in a robust way, the impact of home modifications and adaptations on mitigating demand for other services. This is in addition to streamlining the way such work is allocated and managed. Assistive technologies could, in some cases, replace large scale and expensive home modifications.
- Using local authority assets to build and/or commission housing to meet gaps in provision for older people, capitalising on the interest among developers who are willing to build age-exclusive or age-tailored housing.
- Creating opportunities for private providers to develop low support age-designated housing, removing identified barriers where possible. Maximising demand for extra care by utilising a new tool for appraising potential sites.
- Using emerging policy agendas and associated funding to integrate housing, health and care, potentially targeting pinch points such as delayed hospital discharges or accommodation for those living with dementia. Stakeholders identified opportunities to develop better multi-agency approaches to working with older people.

1

Introduction

1.1. The purpose of the study

This research was commissioned by South Cambridgeshire District Council (SCDC), in collaboration with a range of local partners, with funding from the NHS's Healthy New Towns initiative. The research assesses how, in the context of a rapidly ageing population, the housing, care and support needs of older people can be met. Acknowledging the close working relationship between the local authorities, along with the fact that housing, care and support needs transcend administrative boundaries, the study focuses on SCDC and Cambridge City, defined throughout this report as Greater Cambridge.

This study aims to build on existing models for estimating the supply and demand for older people's housing. An alternative model is developed which is more firmly grounded in what is possible, and what is currently provided in local authorities with high levels of supply. In addition to this, and to inform local policy and practice, we assess the strengths and weaknesses of the current policy framework, and explore the views, behaviours and preferences of residents in terms of their housing, care and support needs.

1.2. Methods summary

The research was structured around four key activities:

a. **Reviewing national policy and research, local policies and strategies and secondary data.** In addition to capturing learning from recent research and national policy documents, we have reviewed key local strategies, such as the Cambridgeshire Older People's Accommodation Strategy (OPAS), and the Commissioning Strategy for Extra Care. We have also reviewed a wide range of other documents related to local planning policy, housing strategies, and health and social care provision. This was supplemented with analysis of varied secondary data relating to Greater Cambridge.

b. **Modelling the demand and supply of specialist housing.** This entailed drawing on national datasets of specialist housing, and a wide range of other secondary data to explore factors affecting the supply of specialist housing in other local authorities. This enabled us to assess the adequacy of supply in Greater Cambridge, and estimate the requirements for future supply.

c. **Exploring the views of local stakeholders.** Exploring the current policies and practices related to older people's housing, care and support, we conducted thirteen interviews with stakeholders from a wide range of organisations from local authorities and health organisations, through to master developers, homebuilders and home improvement agencies. All interviews were recorded and transcribed in full.

d. **Understanding residents' needs, preferences and decision-making processes.** Exploring residents' views in six focus groups, we spoke to 63 residents in total. Two sessions were undertaken in central Cambridge with residents of Cambridge City, and three sessions were conducted in South Cambridgeshire (with residents of Histon and Impington, Harston and Lolworth). A final group was conducted with resident board members of a local forum representing different ethnic communities. The vast majority of focus group participants were aged 65 or over, with the exception of those in one group which sought to capture the views of people in a younger age bracket. All participants in this group were aged 45-65. All focus groups were audio recorded and transcribed in full, with the exception of one, where attendees requested only written notes were taken.

A detailed methodology statement is provided in Appendix 2.

1.3. Defining older people's housing, care and support

The research seeks to build a deeper understanding of the interdependencies between older people's housing and the other key interventions needed to support older people. The research did not presume that older people will inevitably follow a pathway through the various options presented in Figure 1.1, from ordinary, general needs housing through to a care home with nursing. Many people will continue to live independently in general needs housing and never move into specialist housing or a nursing home. It is also important to recognise that two people with similar needs can be living in different housing situations and draw on different packages of support and assistance as a result of personal preference and circumstance; and still be suitably housed.

Figure 1.1: Types of housing for older people and associated support and assistance

General Needs Housing			Specialist Housing		Care Homes	
'Ordinary' Housing	Lifetime Homes	Age Designated Housing	Sheltered Housing	Extra Care	Without Nursing	With Nursing
Housing Support • repair schemes • home improvements • equipment and adaptations			• independent • self-contained • emergency alarm service • can have a manager or warden • communal facilities	• independent • self-contained • communal facilities • on-site staff • domestic support • personal care	• shared • single rooms • on-site care • can meet specific needs (e.g. dementia)	• shared • personal care • qualified nurse on duty • can meet specific needs (e.g. dementia)
Social Care and Support • smart technology • floating support • intensive home care • day care services						

Such are the varying forms of provision for older people that there is no shortage of concepts and phrases used to describe these. Precise definitions are therefore required and below we define some of the key terms used in the report. We have applied the definitions used by the Elderly Accommodation Counsel (EAC), since their data - and the fields and categories this uses - underpins the modelling work we have undertaken. Where possible we have aligned these definitions with those used locally, as set out in Cambridgeshire Older People's Accommodation Strategy (henceforth OPAS). :

- An **older person** is someone aged 65 years old or over. This definition may vary in some instances, for example, in housing exclusively for older people which may accept people younger than 65.
- **Care** refers to direct help that an older person receives from a carer. This might include help and assistance going to bed, getting out of bed, washing and dressing, and help with medical matters that do not require a trained medical professional.
- **Support** refers to practical assistance with a range of tasks and activities, which can include cleaning and tidying, shopping, preparing food and paying bills. Support does not include direct help with personal care, but can include reminders or advice that helps an older person manage their personal care.
- **Housing-related support/assistance** refers to practical help that is required to maintain an appropriate, safe and healthy living environment. Such support can include basic repairs and maintenance, renewal work to address more substantial issues (a new boiler, double glazing, repairing a leaking roof) and

adaptations in response to health or disability related needs. Housing-related support and assistance also covers a range of other services which enable people to remain independent in their home.

- Mainstream or **general needs housing** refers to 'ordinary' housing and includes accommodation (flats, apartments, bungalows and houses) owned outright or on a mortgage and accommodation rented from a social or private landlord. General needs housing also includes housing that might be more suitable for older people, by virtue of location, type, design and adaptations. This includes housing that conforms to the former lifetime homes standard, Buildings Regulations Part M4 (1, 2 or 3) and standards for age designated housing. This housing might be available to households of any age or might be designated for people over a particular age (age designated/exclusive).
- **Specialist housing** is restricted to older people, often through conditions in the tenancy agreement or long-lease. While these housing options take many different forms, they have common features such as individual dwellings with a private front door; some communal living areas such as lounges and gardens, and sometimes restaurants, hair salons and even post offices and shops; and some form of support service such as a scheme manager or another type of service, and varying levels of personal care and support. In addition, specialist housing can be different forms of tenure – private or social rented, owned and shared ownership. Specialist housing can be usefully reduced down to two essential types: sheltered housing and extra care housing:
    - **Sheltered housing.** Traditionally, and when first commissioned, sheltered housing schemes would typically have a full or part-time manager whose job included providing support and advice to residents. However, in Greater Cambridge, as in most other areas of England, sheltered housing has been re-modelled. Rather than on-site support, residents have access to a tenure-neutral service which supports people to live more independently. Properties in sheltered schemes may be purchased or rented. Many sheltered schemes have a social dimension. Residents and/or staff may organise regular activities such as coffee mornings, bingo, whist drives, entertainments, religious services or outings. The EAC data also refers to a sub-category: Enhanced sheltered housing. This is defined as accommodation which provides 'residents with the independence of having their own front door and self-contained flat whilst also having access to some on-site support service. Most developments will have a scheme manager and alarm system in the property, there may also be some personal care and home help services that can be arranged by the management'. In some instances, this may be a kind of specialist housing that sits between sheltered and extra care. However, these will be mainly private sector schemes, where the leasehold is purchased by the residents. It is important to note that enhanced sheltered housing is not referred to in Cambridgeshire's OPAS document. Future remodelling of specialist provision in Greater Cambridge may include a spectrum of specialist housing catering for a wide range of needs.

- **Extra care housing**. 'Extra care' housing refers to a concept, rather than a housing type. It is used to describe developments that comprise self-contained homes with design features and support services available to enable self-care and independent living. It comes in a huge variety of forms and may be described in different ways, for example 'very sheltered housing', 'housing with care', 'retirement communities' or 'villages'. Occupants may be owners, part owners or tenants and all have legal rights to occupy underpinned by housing law (in contrast to residents in care homes).

- **Residential care home.** Accommodation and personal care for people who may not be able to live independently. A residential care home provides personal care to ensure these needs are met. A care home providing personal care only can assist you with meals, bathing, going to the toilet and taking medication.
- **Nursing care home.** As distinct from a residential care home, such accommodation has to provide the kind of care which requires the specific skills of a qualified nurse or the supervision of a qualified nurse.

1.4. Structure of the report

The report sets out the key findings and learning from this study in the following chapters:

- Chapter 2 - presents a framework for structuring responses to older people's housing, care and support needs.
- Chapter 3 - draws on the policy reviews and administrative and secondary data to set the context for this study. It outlines the 'state of play' in terms of current policy frameworks and what is known in terms of factors affecting the supply and demand of older people’s housing, care and support.
- Chapter 4 - sets out the development of, and findings from, the modelling exercise. This provides estimates of the future demand and supply of older people's housing
- Chapter 5 - synthesises findings from our stakeholder interviews and resident focus groups to present a series of lessons for policy, and further issues to explore.
- The final chapter summarises the key insights to emerge from the research, setting out the implications for local policy and strategy.

2

A framework for meeting the needs and demands of older people

In recent years, there has been growing interest in whether the housing options of older people in England are relevant and appropriate. This interest has been driven by rising concerns about the health and social care needs associated with an ageing population and the shifting aspirations of older people, which appear to be at odds with the traditional choice that has confronted older people between staying put or moving into sheltered housing or some form of residential care. Inquiries into the challenges posed by population ageing (such as the All Party Parliamentary Group inquiries[1]) have foregrounded housing issues. Charities and campaign groups seeking to raise awareness of the situations faced by older people have called for targeted action to meet the housing needs of older people, and government policy documents setting out proposals for legislation in the fields of health and housing have also spotlighted older people's housing as a strategic priority.

These discussions have been informed by a large body of research detailing the housing preferences and situations of older people and exploring good practice in delivering different forms of provision. Key messages that can be distilled from this evidence base include:

- That the majority of older people in England prefer to stay put or move to more appropriate general needs housing in mixed aged communities.
- Specialist housing is playing an important role in meeting the needs of older people, but demand outstrips supply and the sector is only ever likely to accommodate a small minority of older people.
- Adequate housing is critical to meeting the health needs of older people and creating a health and care system focused on prevention, early diagnosis and intervention.

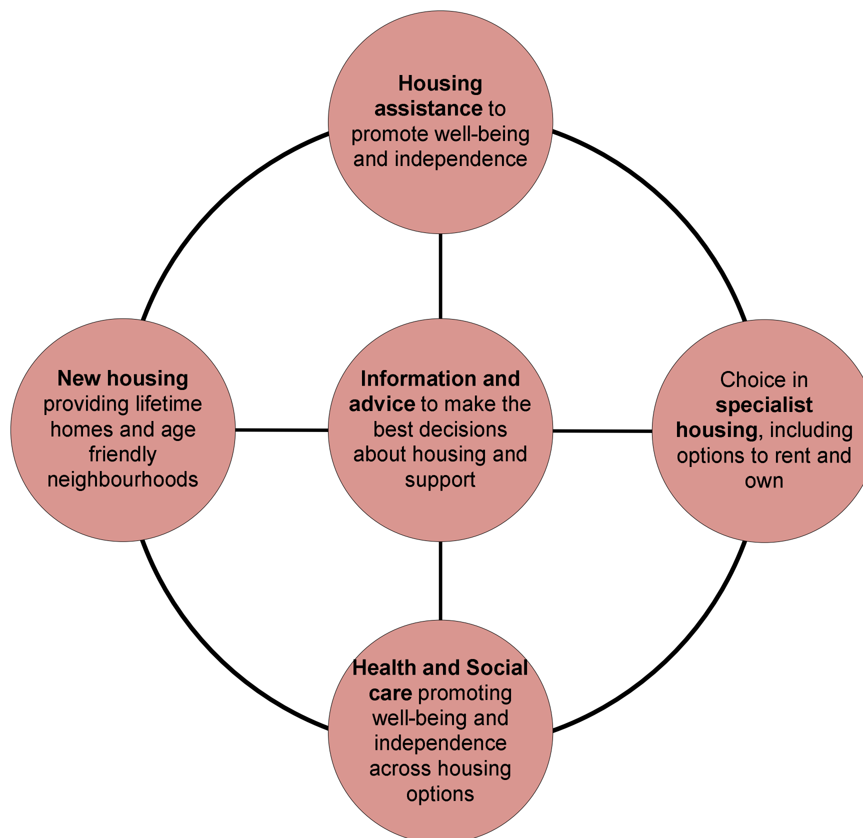
The outcome of this debate is the emergence of an apparent consensus across policy, practice and research about housing options for older people. The emphasis is on promoting independent living and attention is focused on five components within a system of provision:

[1] See https://www.ageuk.org.uk/our-impact/politics-and-government/all-party-parliamentary-group/previous-meetings/

1. Housing support and assistance services are vital in helping to ensure that older people are living in safe, appropriate housing that is fit for purpose and promotes health and well-being.
2. New and existing housing should promote independent living by providing opportunities for older people to move to more appropriate accommodation (on the basis of size, design, site and situation) as their needs change in later life.
3. Specialist housing can assist older people with their housing and support needs in later life, and delay or reduce the need for more intensive forms of care.
4. Strategic and operational links between housing, health and social care will also be critical to local solutions to meet the on-going health needs of older people.
5. Information and advice promotes informed choices and planned moves and supports independent living in later life.

These five priorities were integrated into the national strategy for housing in an ageing society published by the government in 2008[2] and were central to the 'new deal' for older people's housing outlined in the government's housing strategy for England.[3] This system of provision is depicted below, emphasising the central role of advice and information to the other functions.

Figure 2.1: Five components in a system of housing provision for later life



[2] DCLG (2008) *Delivering Lifetime Homes, Lifetime Neighbourhoods A National Strategy for Housing in an Ageing Society*. December 2008 Department for Communities and Local Government.
[3] DCLG (2011) *Laying the Foundations: a Housing Strategy for England.* London: Department of Communities and Local Government.

This model is used throughout the research to structure our analysis, and also to understand the role that different forms of housing play within a wider system and set of interventions.

3

Older people's housing, care and support in Greater Cambridge; the current state of play

3.1. Introduction

To set the context for this research, the following chapter outlines some of the key factors affecting demand for, and supply of, housing, care and support in Greater Cambridge, and how policies in various spheres are guiding stakeholders' efforts. This provides a basis for our analyses in Chapters 4 and 5. Such is the complexity of this subject that this context is brief and stylised, trying to identify key factors, interventions and policies that have informed our quantitative and qualitative work.

The chapter has been split into three sections, starting first with a discussion of factors shaping demand for housing, care and support, followed by a brief outline of how those demands are being met through various accommodation-related activities. The final section briefly summarises key elements of the local policy framework guiding efforts in this field.

3.2. Factors shaping demand for housing, care and support

Population and the ageing demographic

Local research and policy documents reveal how Greater Cambridge is set to experience most acutely, the national phenomenon of an ageing population. Across this area the number of people aged 75 and over is set to nearly double between 2016 and 2036,[4] when over 65s will constitute nearly 1 in 5 of the population[5]. In the wider county, growth is projected to be highest among the over 90s age group, which is set to grow by 181 per cent from 6,148 to 17,292 between 2016 and 2036[6]. The impact of this demographic change is likely to be felt most strongly in rural districts: South Cambridgeshire is expecting the largest increase in its over 75s at 98 per cent by 2036, with Cambridge City seeing a rise of 77 per cent over the same time period[7].

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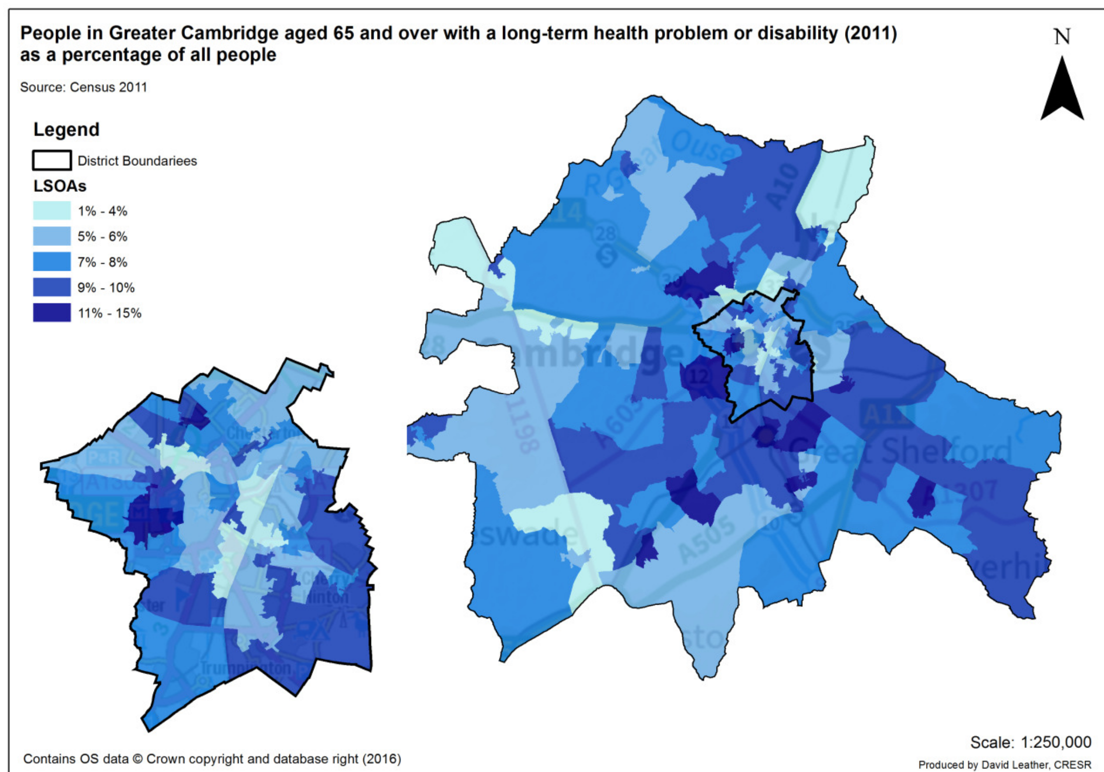
[4] Cambridgeshire County Council - Research Group (2017) *2015-based population forecast.*
[5] CambridgeshireInsight (2017) *2015-Based Population and Dwelling Stock Forecasts.*
[6] Cambridgeshire County Council - Research Group (2017) *2015-based population forecast.*
[7] CambridgeshireInsight (2017) *2015-Based Population and Dwelling Stock Forecasts.*

At the sub-district levels, ward population projections suggest some areas will see triple digit percentage increases in the number of over 75 year olds by 2036. This is likely to be pronounced in areas to the fringe of Cambridge, but also in wards such as Bourn (SCDC) and Castle (Cambridge)[8]. Here, the geographic differences between SCDC and Cambridge City come to the fore, with key differences in how densely concentrated their populations are. By 2036, SCDC may have twice as many people aged 75+ as Cambridge City, but spread across 22 times the area.

Health and wellbeing

This growth is partly explained by an increase in life expectancy in the sub-region, which has also brought increased incidences of long-term illness and disability. Cambridgeshire's increasing older demographic presents a number of challenges for authorities in the county. In 2011, approximately 13,900 older people in Cambridgeshire were experiencing physical frailty, mental frailty or a combination of both[9]. The number of older people in Cambridgeshire living with dementia is expected to rise from 6,600 in 2006 to 10,200 by 2021[10]. At the ward level there are significant disparities in levels of long term health conditions and disabilities, with wards peripheral to Cambridge City showing some of the highest levels.

Figure 3.1: People in Greater Cambridge aged over 65 and over with a long-term health problem or disability (2011)



[8] ibid.

[9] Extra Care Group (2012) Commissioning Strategy for Extra Care Sheltered Housing in Cambridgeshire

[10] Ibid.

The Projecting Older People Population Information System (POPPI)[11], offers various projections on the prevalence of health issues in older people. Whilst these estimates can be problematic, as they often apply national prevalence rates at a local level, they can at least be a starting point for deeper analysis. It is significant that POPPI estimates major increases in the number of over 65 year olds in Cambridgeshire who are unable to manage domestic tasks.

Table 3.1: Total population aged 65 and over unable to manage at least one domestic task on their own

	2017	2020	2025	2030	2035
Cambridgeshire	49,294	53,568	61,706	71,183	80,737

Source: POPPI

The frequency of falls among older people, the majority of which happen in the home, is a particular challenge locally. On the various falls related indicators, Cambridge City scored significantly worse than the England average. In Greater Cambridge, there were 1,055 emergency admissions in 2015/16 for injuries due to falls in the over 65s[12]. Estimates in 2013 suggested that such incidents accounted for 7.7 per cent of all emergency admissions for the over 65s[13]. This links to demand for emergency bed space in hospitals. In 2011/12, nearly 70 per cent of all emergency occupied bed days were for people aged 65 or over.

Various local policy documents highlight the strain on public services as result of an ageing population, with evidence of multiplying and intensifying health needs. Forecasts suggest that demand for health and social care services is already rising faster than there are resources – and capacity in the system – to pay and provide for.[14]

Assets and incomes

Evidence suggests that in 2011 across Greater Cambridge there were 66,000 homeowners, 19,000 of which were categorised as having a household reference person aged 65 or over, with 90 per cent of these owning outright (17,000)[15]. With average house prices in SCDC exceeding £390,000[16], and in Cambridge City exceeding £500,000[17], clearly there are major asset holdings among significant numbers of older people locally. Private rents in Cambridge are among the highest

[11] See http://www.poppi.org.uk/

[12] Public Health England (2017) Public Health Outcomes Framework. Accessed at: https://fingertips.phe.org.uk/profile/public-health-outcomes-framework/data#page/4/gid/1000042/pat/6/par/E12000006/ati/102/are/E07000012/iid/22401/age/27/sex/4

[13] C&PCCG and Cambridge County Council (2013). Joint Strategic Needs Assessment: Prevention of Ill Health in Older People

[14] Cambridgeshire Older People's Accommodation Programme Board (2016 updated). Older People's Accommodation Strategy (OPAS)

[15] NOMIS (2017) Tenure by ethnic group by age (2011) - Household Reference Persons

[16] SCDC (2017) Interim Housing Strategy Statement. pp.8

[17] Cambridge City Council (2017) Interim Housing Strategy Statement. pp.6

in the country, with the average two bedroom home in Cambridge being £265 per week, which is over 40 per cent of the median weekly income for a full time worker[18].

Significant numbers of older people are living alone, estimated to be 11 per cent of over 65 year olds in 2011[19]. This brings various considerations in terms of how they might receive various forms of support and interaction. The 2013 Strategic Housing Market Assessment (SHMA) notes that there are around 12 per cent of households in the housing sub-region of Cambridge with an income of less than £10,000, and that this is likely to include a number of older owner-occupiers with a low level of income but a higher level of savings and capital tied up in their home[20]. When we look at the levels of people aged 70 and over in receipt of Disability Living Allowance (at a lower super output area), clear concentrations emerge to the east and eastern fringes of Cambridge City, and in the North West of SCDC[21]. Variations in wealth, income and assets are an important demand-side factor, as they constrain or enable certain choices. However, categorising older people's demand for housing, care and support simply on the basis of tenure distinctions, or indicators of their financial position, are likely to be flawed.

Whilst the above provides only an indication of demand-side factors affecting future housing, care and support provision, it does suggest the need to plan for a set of demands that are likely to become more diverse, more intensive and complex, and playing out in changing geographical ways.

3.3. Current responses to meet older people needs

As noted in Chapter 2, meeting some of the above demands requires a coordinated effort across a range of activities and functions. Looking specifically at the accommodation for older people, excellent work has been done locally to quantify the range of accommodation utilised by older people, and the flows of individuals through various forms of provision. The following diagram is taken from the Cambridgeshire Older People's Accommodation Strategy (OPAS).

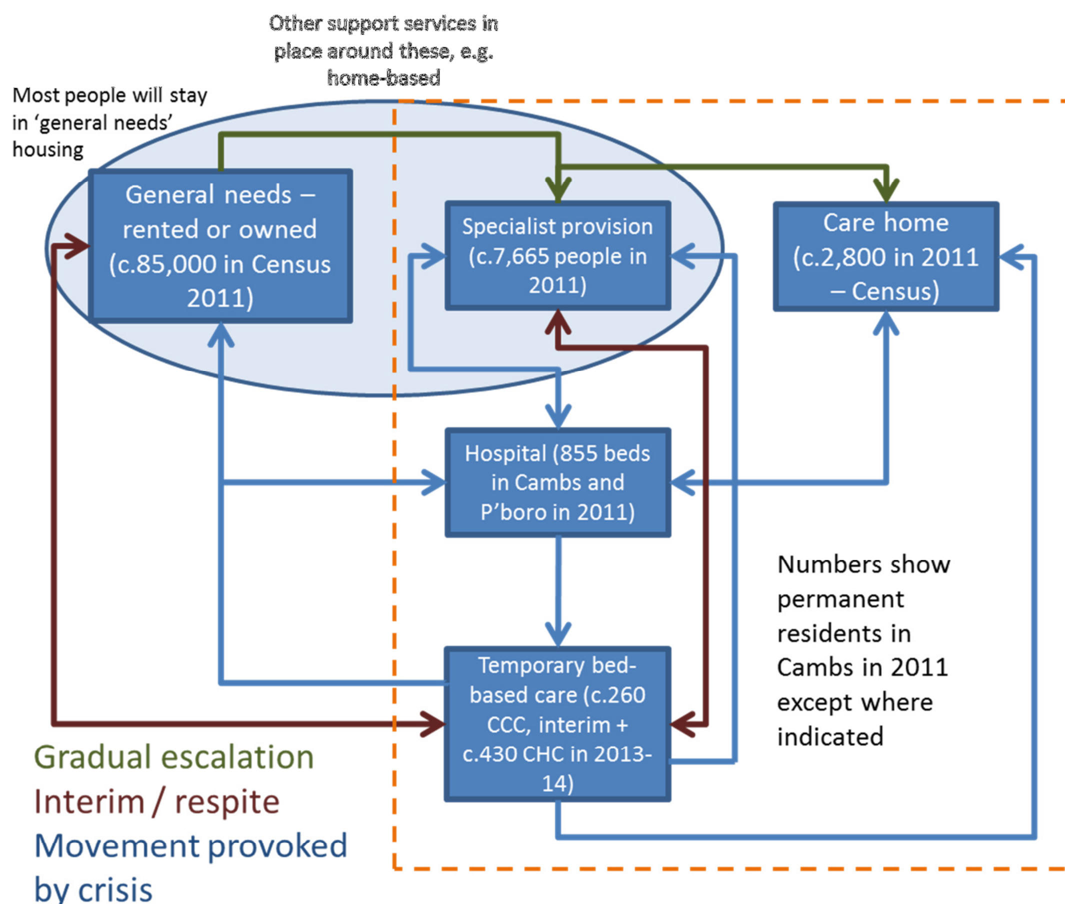
[18] Ibid. pp.7

[19] NOMIS (2017) Household composition by age by sex (2011)

[20] Cambridge sub-region SHMA (2013).

[21] NOMIS (2017) Benefit claimants - disability living allowance for small areas

Figure 3.2: Where older people currently live and how they move around between different forms of accommodation



Source: Cambridgeshire Older People's Accommodation Strategy (2016)

Local strategies assert the need to meet as many of the demands of older people as possible at home; either in their current home or in another suitable general needs property. This, it is suggested, is both a general preference among residents and a more cost effective approach to meeting their needs. A range of local policies and interventions are trying to achieve this.

General needs housing

The above diagram highlights the central function that general needs accommodation plays in this system. With 85,000+ residents in general needs housing, it is critical that this stock is suitable and adaptable to their needs, not least because transitions out of general needs is likely to place added pressure on other forms of accommodation. With this in mind, it is significant that 37 per cent of private sector stock (across Cambridgeshire) does not meet Decent Homes Standards, and around 2,000 dwellings contain Category 1 hazards (under the Housing Health and Safety Rating system) which increases the likelihood of trips and falls[22].

[22] C&PCCG and Cambridgeshire County Council (2013) Joint Strategic Needs Assessment: Housing and Health.

Efforts to mitigate these issues centre on the use of Disabled Facilities Grants. In 2016, SCDC and Cambridge City received grants of over £1.1m to provide a range of services, aids and adaptations to people's homes to help them live independent, safe and more dignified lives[23]. The local Home Improvement Agency is responsible for much of this work and efforts have been made to quantify the potential financial benefits from such work[24], which includes:

- postponing entry into residential care by a year saves on average £28,080 per person;
- preventing a fall leading to a hip fracture saves the state £28,665 per person on average;
- housing adaptations reduce the costs of home care (saving £1,200 to £29,000 a year); and
- hospital discharge services speed up patient release, saving at least £120 a day.

Linked to the above is reference to potential of assistive technology[25] to help people maintain their independence and quality, and also a range of other housing-related support[26].

The development of new general needs housing presents an opportunity, and has been the subject of another JSNA. The significant amount of development taking place in Greater Cambridge, particularly on large schemes and growth sites, has placed increasing pressures on health care services, such as GP practices.

There are significant numbers of households in social housing, in both SCDC and Cambridge City - 8,546 and 11,023 respectively[27]. With the majority of this stock retained by the district authorities, they play a large role in meeting the needs of older people, particularly lower income households. The movement of older people through this stock becomes a key consideration that can help identify hotspots in geographic demand. For the purposes of this research, we have analysed the lettings in Greater Cambridge to those aged over 65, through the local Choice Based Lettings system. Using data from June 2016 to August 2017, we mapped 125 lettings at ward level (see Appendix 3). Perhaps the most significant insight from this relates to the overall number of lettings to people over 65 years of age. With large projections of newly arising demand (discussed in Chapter 4), such a small number of lettings suggest local authority and housing association stock is only meeting a very small proportion of newly arising demand. This has implications for future planning, particularly the role of private providers of housing tailored to older people.

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[23] Foundations UK (2016). The Disabled Facilities Grant: Before and after the introduction of the Better Care Fund

[24] C&PCCG and Cambridge County Council (2013). Joint Strategic Needs Assessment: Prevention of Ill Health in Older People

[25] Cambridgeshire County Council (2012). Shaping our Future: Assistive Technology Strategy 2012 - 2014

[26] C&PCCG and Cambridge County Council (2013). Joint Strategic Needs Assessment: Prevention of Ill Health in Older People

[27] Cambridgeshire Insight (2013) Strategic Housing Market Assessment. Accessed at: www.cambridgeshireinsight.org.uk/file/2094/download

Specialist housing

Given the insights above about the adequacy of general needs housing, provision of specialist housing for older people becomes a critical issue. Table 3.2 below outlines the current type and location of specialist housing in Greater Cambridge, and is based on data obtained from the Elderly Accommodation Counsel (EAC).

Table 3.2: Specialist housing schemes by type and location in Greater Cambridge

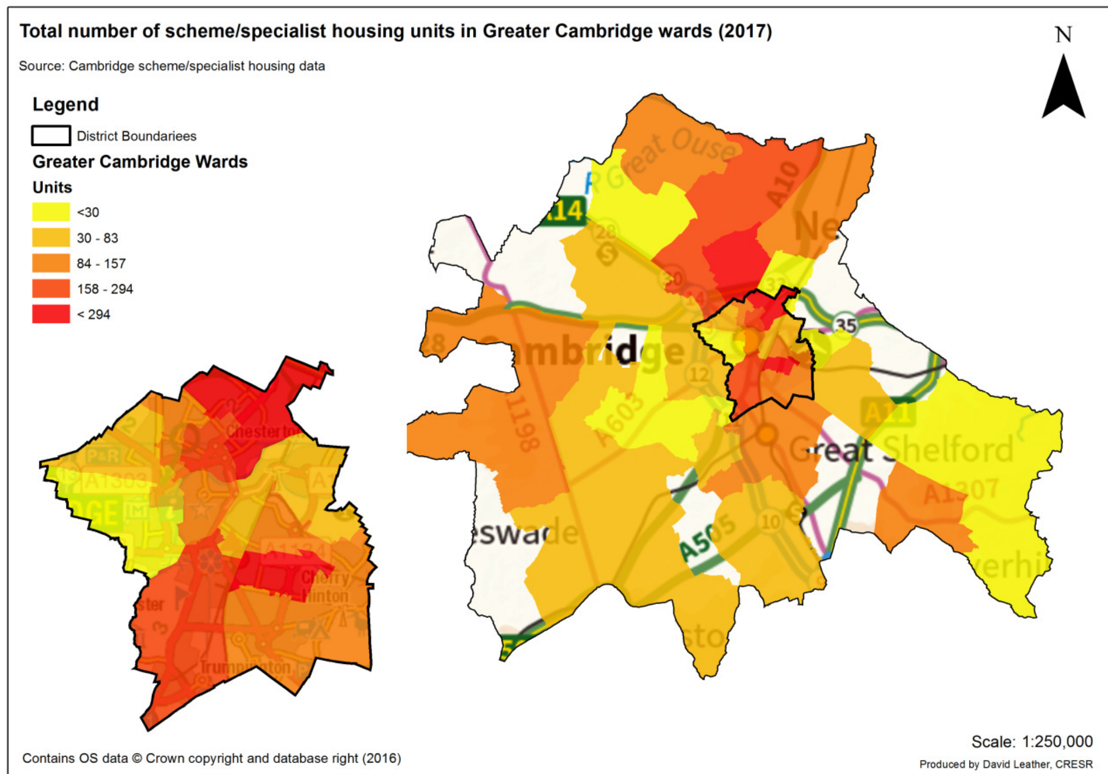
	SCDC		**Cambridge City**		**Greater Cambridge**	
	Schemes	Units	Schemes	Units	Schemes	Units
Sheltered	56	1669	39	1276	95	2945
Enhanced sheltered	1	48	0	0	1	48
Extra care	4	181	3	106	7	247

Source: EAC data (2017)

Local scheme data, provided for the purposes of this research, uses a different typology to categorise the schemes and units of housing, but shows a very similar picture to the EAC data. Local scheme data captures a number of private schemes targeted at older people. Across Greater Cambridge, private providers are managing 11 schemes, containing over 400 units. It is unclear whether this captures the entirety of the private retirement housing market. The analysis above does not include schemes in the pipeline that are yet to be completed. This notably includes an extra care scheme currently being developed in Hauxton, which will provide 70 extra care units, and other potential schemes in the pre-application stage of planning, such as that at the Fulbourn hospital site or on various growth sites/new towns.

The nature of the local geography makes the distribution of such provision a key issue. Mapping the local schemes, at ward level, reveals some obvious geographical disparities. As might be expected, concentrations of schemes are found in Cambridge City and the peripheral areas. Nonetheless, it is revealing that certain wards seem to have no provision at all, though how significant an issue this is depends on local demand factors.

Figure 3.3: The location and number of specialist housing units by ward



Within Cambridge City, the disparities between wards may be less relevant than they are in South Cambridgeshire, where travel times and distances to specialist housing may be more pronounced. A deeper analysis of this provision is provided by the new model developed for this study in Chapter 4, along with projections for future supply.

Care provision

Local policy documents highlight the important and pressing demands on residential and nursing care in the county. Cambridgeshire currently has the lowest level of care home provision per capita in the eastern region[28]. Challenges are apparent in the extent of provision, its affordability, and the knock-on effects of these issues of resources in other service areas. Local scheme data suggests that there are some 40 residential and nursing care schemes across Greater Cambridge, providing a total of over 1,600 units or bed spaces.

[28] Cambridgeshire Older People's Accommodation Programme Board (2016 updated). Older People's Accommodation Strategy (OPAS)

Table 3.4: Schemes and units of residential and nursing care

	SCDC		Cambridge City		Greater Cambridge	
	Schemes	Units	Schemes	Units	Schemes	Units
Care home	2	61	2	200	4	261
Care home: nursing care	8	380	7	487	15	867
Care home: personal care	13	283	8	237	21	520

Source: Cambridgeshire scheme data

Comparisons of expenditure on residential and nursing care in Cambridge, compared to a comparator group of 15 other local authorities, suggests less is being paid than the average for this group for over 65s care[29]. Despite this data concerning historic demand for residential care, and projected demand, it suggests that increasing pressures will be placed on provision. It is recognised that recent interventions for securing the access and price of such provision (e.g. through block purchasing) will be *'no longer adequate to ensure the sufficient supply of affordable care provision'*[30].

A key part of this jigsaw of provision, but somewhat beyond the scope of this study, is the provision of care at home, or in the community. Local JSNAs[31][32] highlight the central role that carers (including family carers) play in supporting older people, and also the challenges of integrating this provision with other services and provision.

3.4. The local policy framework

Dedicated Older People's Strategies

The dedicated Older People's Accommodation Strategy (OPAS) represents an acknowledgement of, and concerted effort to tackle, future challenges posed by an ageing population. The OPAS performs an important function as it provides a more detailed evidence base, filling in the gaps in other documents such as Local Plans and the Strategic Housing Market Assessment, and also articulating the need for concerted action on this specific issue given national policy pressures related to housing delivery and potential caps in supported housing.

Against this backdrop of complex demands and systems for supply, a policy framework has emerged from various sources, setting out various commitments across different public service areas. The Care Act 2014 provides the framework for partner agencies to work together to provide a more holistic approach in terms of both care and the suitability of housing. In their *Interim Housing Strategy Statement*

[29] NHS Digital (2017) *ASC-FR 2015-16: Comparator report.*
[30] Cambridgeshire Older People's Accommodation Programme Board (2016 updated). *Older People's Accommodation Strategy* (OPAS) pp.25.
[31] C&PCCG & Cambridge CC (2013). *Joint Strategic Needs Assessment: Prevention of Ill Health in Older People.*
[32] C&PCCG and Cambridgeshire County Council (2013) *Joint Strategic Needs Assessment: Housing and Health.*

2017,[33] Cambridge City Council identifies a number of actions to support the delivery of specialist housing, in addition to working with others on hospital discharge issues, and continuing to provide visiting support services for older people across all tenures.

As Cambridge City and SCDC move towards a joint strategy, SCDC's Interim Housing Statement is aligning with this, focusing on the need to help people live independently in their own homes, as long as they desire, to reduce the need for entry into hospital or other care settings. It identifies Northstowe, as a Healthy New Town, as a key opportunity to test innovations in this sphere.

The OPAS sets out a framework to move away from the need for 'high acuity' bed-based care (as much as possible), towards encouraging independent living and reducing the frequency and/or severity of people's needs. The difficulties of achieving this balance are acknowledged: a silo-ed commissioning and decision-making process across the housing and care sectors means that capacity to influence how well they factor in future needs is limited. Likewise, the Strategy notes the added complications of the housing market, and the difficulties of accurately predicting housing needs into the future. In essence, the OPAS sets out three objectives to meet future goals, outlined in Table 3.4 below.

Table 3.4: OPAS objectives and interventions

Objective	Interventions
Address current issues to help manage demand in the health, social care and housing systems in the short term	• Target improvements in the suitability of accommodation and addressing the gaps in provision regarding maintenance and access to adaptation and assistive technology to maintain independence. • Use Disabled Facilities Grant capital and revenue funding from statutory partners to support the adaptation of homes for vulnerable households and the work of home improvement agencies, exploring further opportunities to use the funding more effectively to encourage people to seek their own housing solutions.
Increase choice and affordability for those requiring specialist care	• Increase the range and volume of affordable care homes in Cambridgeshire; as well as re-developing the existing Hinchingbrooke Hospital site to create a multi-faceted health and social care campus with 'various residential elements and older people's care'.
Influence and develop a choice of good accommodation options for older people (general needs and	• Use the Healthy New Towns initiative to test approaches to creating a healthy built environment for all ages. • Assess the need for Extra Care provision, identifying the number of schemes that can be financially supported over a five year period, geographical distributions, and getting commitments to the schemes by providers. • Assessing the amount of sheltered housing required in the county, identify a model of delivery that best utilises

[33] Cambridge City Council (2017) *Interim Housing Strategy Statement.*

specialist support)	the existing schemes and meets demands; and provide clarity on the required role of sheltered housing and strategic fit with other services for older people. • Increase understanding by service users and their families about housing options and choices. Provide better information for professionals so they can better signpost service users and their families and assist them with making the best choices.

Alongside the OPAS, strategies have been developed to guide the commissioning of Extra Care[34]. The strategy also outlines a number of 'housing and community outcomes' for extra care schemes (based on the Sub Regional Housing Strategy, 2008), stated as:

- Good quality, cost effective and accessible affordable housing in areas of housing need, either through remodelling of existing or provision of new schemes.
- Flexible design to meet current and potential future needs of older people, and the diverse needs of communities.
- Homes developed in the most environmentally sustainable way possible, to minimise impact of use in relation to CO^2 emissions and fuel costs.
- Responsive, flexible and person-centred housing related support and care.

The targets for the development of extra care housing come from the Best Value Review in 2004, which set an increase of 1,079 additional extra care units in Cambridgeshire. Analysis of data from a mapping exercise carried out since the Best Value Review established priority geographical areas for new schemes to be located based on high demand yet low supply of extra care housing. These areas were found to be mainly in Huntingdonshire, South Cambridgeshire, and Fenland. The high priority locations included a number in SCDC: Histon and Impington; Over, Willingham or Cottenham; and Fulbourn. Other potential locations were identified within growth sites or Cambridge City.

An exercise to calculate capacity to develop new schemes found that one new scheme (of approximately 40 units) could be developed each year for the next ten years to 2020. These 400 units would replace the need for additional residential care places that were forecast to be required.

Local planning policy

The emerging Local Plans, yet to be adopted, provide the framework for guiding how new general needs housing might address the needs of older people, and also the form, location and affordability of specialist housing. Various policies contained within these documents will impact on the development of such housing, but there

[34] Extra Care Group (2012) *Commissioning Strategy for Extra Care Sheltered Housing in Cambridgeshire 2011-15.*

are specific policies in both relating to the provision of specialist housing, and the design of properties to ensure future suitability for older people.

In South Cambridgeshire, the emerging Local Plan proposes that all affordable homes and one in every 20 market homes will be built to meet the former Lifetime Homes Standard. To meet the needs of wheelchair users, the Plan targets only the affordable housing element of developments and specifically in response to identified need[35]. The Plan highlights a number of specialist housing forms that it would encourage, from a range of providers, without committing to any specific forms, quantities or spatial distributions of them.

In Cambridge City, subtly different policies have been proposed. Certain requirements for specialist housing are set out, demanding developers can demonstrate need, suitability, proximity to amenities and facilities, and awareness of other localised supply - to 'help to enable people moving into such accommodation to remain in their local area and to create and maintain balanced communities'[36]. It is suggested that developers have the support of commissioners, on whom future support and care funding may depend. In terms of general needs housing, the emerging Local Plan suggests that all new housing development 'enable' the Lifetime Homes Standard to be met, without committing to any specific percentages actually built to that standard. As these plans are consulted upon and modified they will reflect changes to building regulations and design standards and replace references to 'Lifetime Homes'. Recent research into accessible housing requirements in Cambridge City recommends that all new homes meet Part M4(2) requirements, and that five per cent of affordable units built on schemes of 20 units or more are built to Part M4(3)[37].

Various other policies are likely to emerge which affect decisions about both specialist and general needs housing. These take the form of supplementary planning documents or future Community Infrastructure Levy (CIL) schemes. Furthermore, as master-planning processes shape the development of new towns and growth sites, this may well give rise to differential accommodation for older people. For instance, in Northstowe, there is focus on building homes 'fit for the future', and to secure Lifetime Homes Standards for all affordable housing, and a proportion of market housing. There are, as yet, no commitments to specialist provision however.

Health and social care commissioning priorities

The £48 million *2016/17 Cambridgeshire Better Care Fund Plan*[38] sets out a joint strategy to help health and social care services[39] work more closely together to deliver:

[35] SCDC (2014) *Local Plan.*
[36] Cambridge City Council (2013) Local Plan
[37] Cambridge City Council (2017) Accessible Housing in Cambridge: A study into accessible housing requirements in Cambridge for the emerging Local Plan.
[38] C&PCCG (2016) Cambridgeshire Better Care Fund 2016/17 Narrative Plan

- Services built around the needs of the most vulnerable older people within the community in order to provide care closer to home wherever possible.
- Better support for carers (those who look after and care for loved ones).
- More efficient services through closer joint working between, health, local authorities and the voluntary sector.
- A system that is better equipped to meet the needs of the growing older population.

The vision over the next five years focuses on a health and social care system that 'can help people to help themselves':

> *Over the next five years in Cambridgeshire we want to move to a system in which health and social care help people to help themselves, and the majority of people's needs are met through family and community support where appropriate. This support will focus on returning people to independence as far as possible with more intensive and longer term support available to those that need it'.*

As noted in the Cambridgeshire OPAS, the focus is on moving money away from acute health services, 'typically provided in hospital', and from ongoing social care support. Given that these services are funded on a demand-led basis, however, reducing spending is only possible if fewer people have crises - 'this is required if services are to be sustainable in the medium and long term'. The Better Care Fund is being used to invest in key transformation projects to support the shift away from long-term and acute care towards care that is increasingly personalised and provided to people in their homes and communities. The transformation projects for 2016/17 include several projects relevant to older people's housing, care and support; healthy ageing and prevention, intermediate care, older people's accommodation and care home support. Various JSNAs, discussed above, are shaping the focus service development, budgeting and approaches to integration of housing, health and social care. A newly emerging driver for the integration of services is the devolution agreement between Cambridgeshire and Peterborough and the UK Government, in which a commitment is made to:

> *'moving progressively towards integration of health and social care, bringing together local health and social care resources to improve outcomes for residents and reduce pressure on Accident and Emergency and avoidable hospital admissions'.*[40]

[39] Organisations including the County Council, Cambridgeshire and Peterborough Clinical Commissioning Group, Acute Trusts, Community Trusts, Mental Health Trusts, Peterborough City Council, District Councils and the Voluntary Sector.
[40] HM Government (2017) *Cambridgeshire and Peterborough Devolution Deal*. pp.18.

Modelling the demand and supply of older people's housing

4

4.1. Introduction

In the following section we estimate future demand for housing for older people (age-exclusive, specialist housing and care beds), and the likely supply of housing needed to meet this demand. The section also explores how this provision relates to general needs housing for older people. As noted in Chapter 1, the term specialist housing relates to such forms as sheltered housing and extra care, but excludes both age-exclusive housing with no dedicated support, and forms of residential and nursing care. It is important that the outputs of this modelling are seen as the *basis for informed policy making*, rather than a replacement for this process. Demand can be met in various ways, and through various interventions, as discussed throughout, so the following estimates act as a departure point to consider how various activities and interventions can be aligned to best meet future needs and demands. We return to this issue in the conclusion of this chapter.

Measuring demand for older people's housing is an imprecise science. Demand is likely to vary depending upon a range of variables that are difficult to quantify. Despite this, a number of approaches have been drawn on by local authorities to provide an indication of demand now and in the future, and what that entails in terms of supply. This chapter starts by considering these different approaches, then presents an alternative model based on patterns found in 100 local authorities with the greatest level of supply. The chapter then presents the estimates generated by this model, at various geographies, and over various points in time. We conclude with a discussion about the policy implications for this modelling and the questions this poses for policy-makers.

4.2. Projections based on current supply and demographic change

The most basic attempts to understand demand for older people's housing simply draw on waiting lists or lettings data in relation to affordable housing. However, in itself this is insufficient given that such data is shaped by levels of supply, expectation of access and allocation rules. Alternative approaches have emerged which seek to measure changes in demand based on a series of assumptions - for instance, about the proportion of older people who are likely to need specialist housing - and then relate this to projected growth in the population of older people.

If we apply these approaches to Greater Cambridge, using its own 2015-based population projections, we see that the number of people aged 75 years and over is expected to increase by 48 per cent to 31,307 in 2026 and by 68 per cent to 35,482 in 2031. In order to maintain the current balance between demand (as expressed by the size of the population of older people) and current supply of, for instance, specialist housing, then supply would need to grow by 68 per cent over the next 15 years. Table 4.1 shows the number of additional specialist housing units that this simple modelling would recommend.

Table 4.1: Estimates for the required supply of specialist housing based on simple population projections

	Current supply	Projected demand based on current levels of supply			
	2016	2021	2026	2031	2036
Age-exclusive	**239**	**287**	**355**	**402**	**454**
Specialist housing	**3,280**	**3,943**	**4,867**	**5,516**	**6,234**
Sheltered	2,945	3,541	4,370	4,953	5,597
Enhanced sheltered	48	58	71	81	91
Extra care	287	345	426	483	545
Care beds	**1826**	**2,195**	**2,710**	**3,071**	**3,470**

Looking back at recent trends in population growth reveals Greater Cambridge has seen population increases at a higher level than was anticipated back in 2005 by the ONS (four per cent higher). If the actual population growth in 2031 was to be a similar proportion above the current projection, then some additional 274 specialist housing units would be needed above the estimate for 2031 outlined in the table. In addition, Greater Cambridge would require an additional 20 age-exclusive units and a further 152 care beds. This highlights how fluctuations in projections can dramatically affect such calculations.

Similar approaches have been used in the work of Three Dragons consultancy[41], with the additional component of assessing how demand manifests in terms of tenure (at least in a London context)[42]. It is crucial to note that the Three Dragons approach uses household projection data (rather than population estimates) to forecast the number of households that will seek specialist housing. It therefore expresses new demand and the supply required to meet this. This model applies the assumptions that 15 per cent of over 75s and 2.5 per cent of over 65s will seek specialist housing at any one time. When applied to Greater Cambridge, this modelling suggests that in 2016 there were 2,776 households with a household member over 65 years old seeking specialist housing. The extent to which this demand was met in specialist housing is clearly a function of the stock that became

[41] Cambridge Centre for Housing and Planning Research, Three Dragons, Land Use Consultants and Heriot Watt University (2012). T*he role of the planning system in delivering housing choices for older Londoners*, London: GLA.

[42] Given the tenure assumptions in the Three Dragons model are developed from analysis of London specific data, we have not applied these.

available (new stock and turnover), and each household's capacity to access that housing.

These simple projections merely indicate what new provision will be required to maintain the levels of provision in line with the numbers of older people (or households with an older representative). Such models do not factor in the possibility that demand might currently outstrip supply (or vice versa). Neither does it recognise the possibility that an increasing proportion of older people might be in need of the support provided by specialist housing, as people live for longer with health and mobility problems. In essence, it fails to account for a range of factors which could significantly affect demand, and therefore has an effect on any policies seeking to meet that demand with appropriate supply.

4.3. Established prevalence models

More nuanced models have been developed such as SHOP@. This model seeks to estimate demand based on prevalence rates that are guided by informed assumptions (for example, about the health, social care and support needs of the older person population) to estimate the current and future needs of older people.

The SHOP@ model is not without its problems. For example, it was reported that only seven local authority areas in England have reached the prevalence rate employed in the model and only 12.5 per cent are within 50 per cent of the target. Recognising that SHOP@ was developed in a different financial and development era, when there was optimism and planning for growth in the extra care market, Housing LIN is in the process of reviewing the methodology, parameters and prevalence rates used[43]. SHOP@ estimates demand based predominantly on the size of the projected population, with given levels of health and support needs.

Table 4.2 provides SHOP@'s estimates of demand for, and required supply of, specialist housing and care beds in Greater Cambridge now and in the future. These figures suggest that there are currently 273 fewer specialist units of housing supplied, compared to the estimated demand. Whilst the supply of sheltered accommodation is higher than the estimated demand, both enhanced sheltered and extra care are under supplied, by 370 units and 236 units respectively. Current provision of care beds is 473 beds short of the estimated demand calculated using SHOP@.

[43] Housing LIN and Elderly Accommodation Counsel SHOP@ Analysis Tool Review, July 2016

Table 4.2: SHOP@'s estimates for demand and supply of specialist housing and care beds in Greater Cambridge, 2016

	Demand	Supply	Difference
Specialist housing	**3,554**	**3,280**	**(274)**
Sheltered	2,613	2,945	333
Enhanced sheltered	418	48	(370)
Extra care	523	287	(236)
Care beds	**2,299**	**1,826**	**(473)**

The extent to which demand needs to be met by specific forms of older person housing remains to be seen. There are doubtless people whom SHOP@ declares as needing sheltered or extra care housing who might be suitably housed - and prefer to be housed - in age-designated or general needs housing with relevant adaptations, housing support and access to floating care services.

Evidence from the National Survey for Wales (2015), for example, shows that most older people view their current home as suitable for their needs, even if they have health and social care requirements. The survey found that 13 per cent of Wales' population aged 65 years or older used or needed help with everyday living, 24-hour care or help with equipment or adaptions to their home. Despite this, less than one per cent reported that their home was not suitable for their needs. This suggests that despite the high level of 'suitability' (or latent demand) for different forms of specialist housing, there are few older people who see their home as unsuitable for their needs and are, therefore, unlikely to seek out (reveal demand for) specialist housing. However, we should note that there are other studies that refute this. For example, research by Demos in 2013, suggests that half of 60 year olds would move house as they get older, and that one in four people aged over 60 would consider purchasing a retirement property[44].

The level of demand for different specialist housing will be influenced by strategic decisions made by local and national government about how to accommodate the population of older people, as well as the decisions of older people themselves. For example, the decision may be taken to support greater numbers of older people to live longer in general needs accommodation, through a programme of adaptations, maintenance and repairs and the provision of relevant domiciliary care and support. Clearly, it is important that older people are able to make an active, informed choice to live independently, rather than being required to do so because of a lack of alternatives in specialist housing.

4.4. Developing the CRESR model

In response to these challenges associated with estimating future demand, and doing so in a manner that is sensitive to local context, this study develops an alternative approach. Our model has been developed through a series of stages.

[44] Demos (2013) *The Top of the Ladder* [online]. Accessed at: https://www.demos.co.uk/files/TopoftheLadder-web.pdf?1378922386

The first stage assessed the level and composition of supply of age-exclusive housing, specialist housing, and care beds across the 100 English local authorities with the highest overall provision of each broad type of older person housing per 1,000 older people (aged 75 years or older). This drew on the national data set of such schemes provided by the EAC. The full list of these 100 local authorities is provided in Appendix 4. It is assumed that these areas are more likely to have achieved a better balance between demand and supply (but not necessarily achieving a perfect state, and not necessarily of a quality and form that meets the needs of their populations). This exercise does, however, reveal which authorities are supplying units at high levels given the measure of older people locally, and provides a sufficiently large sample on which to explore the factors associated with higher provision. This provision may vary between local authorities, particularly in reference to sheltered housing which may describe a range of forms with some, for instance, providing high levels of support through resident staff, and others offering ad hoc visiting support. Through our analysis of information about the staffing of sheltered schemes across the 100 local authorities, it appears the majority do not have permanently resident staff. This is important given the move in Greater Cambridge away from resident wardens to visiting support, and does suggest that schemes in SCDC and Cambridge City are not isolated examples in this regard.

The analysis reveals that in the 100 local authorities with the highest levels of supply of age-exclusive housing, 55.0 units per 1,000 people aged 75 years and older are provided.

In the 100 local authorities with the highest level of specialist housing, these provide 172.6 units per 1,000 people aged 75 years and older. This was made up of:

- 153.2 units of sheltered per 1,000 people aged 75 years and older
- 4.4 units of enhanced sheltered per 1,000 people aged 75 years and older, and
- 15.1 units of extra care per 1,000 people aged 75 years and older.

In the 100 local authorities with the highest level of care beds, these provide 110.8 beds per 1,000 people aged 75 years and older.

The second stage used statistical modelling to identify factors that are predictors of the variation in provision between the 100 local authorities with the highest overall level of supply of age-exclusive, specialist and care beds respectively. This used repeated cycles of analysis, adding and removing variables, to identify the combination that best explain the variation[45]. This analysis revealed a number of relationships within local authorities, including:

- The supply of age-exclusive housing being positively associated with the level of people aged 75 years and older who report their day-to-day activities are 'limited

[45] The variables included were: the percentage of persons aged 75 years and older who are in owner occupation, the percentage of persons aged 75 years and older living with dementia, the usage of Home and Day care per 1,000 persons aged 65 years and older, expenditure on home and day care per 1,000 persons aged 65 years and older, the proportion of persons aged 85 years and older, the proportion of persons aged 75 years and older whose day-to-day activities were limited a lot, and whether the area is urban or rural.

a lot by a long-term health condition or disability' (henceforth LTHCD) and negatively associated with whether the local authority was classified as urban.

- The supply of specialist housing being positively associated with the level of people aged 75 years and older limited by a LTHCD.
- Sheltered housing is positively associated with the level of people aged 75 years and over limited by a LTHCD. Furthermore, the level of sheltered housing was negatively associated with supply of extra care per 1,000 people aged 75 years and over.
- Extra care accommodation was positively associated with the level of people aged 75 years and older limited by a LTHCD. As above, this form of provision was negatively associated with supply of sheltered housing per 1,000 people aged 75 years and over.
- Enhanced sheltered was not associated with any of the variables considered.
- The supply of care beds being positively associated with the proportion of people aged 75 years with dementia and negatively associated with whether the local authority was classified as urban and the supply of extra care units per 1000 people aged 75 years and over.

The CRESR model uses the above findings to recommend a level of supply at the aggregate rate for the 100 local authorities with the highest level of provision, but crucially it adjusts this with localised data - for example, the proportion of people aged 75 years and older with a limiting LTHCD in the case of specialist housing. In addition, the model allows adjustments based on the current balance between the provision of sheltered and extra care housing.

This model has a number of strengths and weaknesses. Its strengths are that it is based on the realities of supply and demand in other local authorities and it provides a distinctly grounded and realistic estimate of what supply is possible. One criticism of models based purely on future projected demand is that they can be viewed as somewhat idealistic, and therefore susceptible to challenge on this basis. One might argue that a weakness of employing quantitative estimates based on other local authority provision is that it makes the model merely reactive to what is happening in those other areas, rather than responding to underlying or changing needs. To counter this, the model should be re-run regularly to take account of changing provision which reflects changes to the determinants of demand and supply of specialist housing.

Any model cannot negate the need for policy decisions about how best to meet demand. Demand might be met in various ways, with different interventions affecting the need for different levels of supply in specialist housing. With this in mind, the next chapter considers the current policy framework for meeting older people's needs, and key questions and decisions to inform how the demand outlined above might be met. Before that however, we present the supply estimates based on our modelling.

4.5. The CRESR model: Estimating supply requirements

Table 4.3 provides estimates for the supply of older people's housing in Greater Cambridge, based on our modelling work. This recommends a current supply of:

- **1,145 age-exclusive units**, 906 more than is currently provided (239 units)
- **3,422 units of specialist housing.** As current supply in Greater Cambridge stands at 3,280 units, there is then a shortfall of some 142 units. Breaking this down, the model suggests the need for 112 additional sheltered units to increase supply to 3,057 units, an additional 42 units of enhanced sheltered to increase supply to 90 units, and a reduction in extra care housing by around 12 units.
- **2,152 care beds.** This is 327 beds more than is currently provided (1,825 care beds).

Table 4.3: Recommended supply of older people's housing in Greater Cambridge from the CRESR model

	Recommended supply	Current supply	Difference
Age-exclusive	**1,145**	**239**	**(906)**
Specialist housing	**3,422**	**3,280**	**(142)**
Sheltered	3,057	2,945	(112)
Enhanced sheltered	90	48	(42)
Extra care	275	287	12
Care beds	**2,152**	**1,825**	**(327)**

Comparing our model's estimates against those from SHOP@ reveals a very similar estimate of current 'demand' for specialist housing (3,422 in our model versus SHOP@'s 3,554) and care beds (2,152 beds in our model versus SHOP@'s 2,299). However, there is a distinct difference between the two models in term of the forms of specialist housing supply required. SHOP@ suggests enhanced sheltered and extra care units should make up approximately one in five specialist units. Hence it identifies significant deficits in the current supply of extra care and enhanced sheltered accommodation in Greater Cambridge. On the other hand, our model suggests only one in 10 of the recommended supply of specialist units in Greater Cambridge are either enhanced sheltered or extra care. This reflects the fact that our modelling is premised on existing provision in authorities with a high level of overall supply, and where extra care provision may vary in scale. As discussed in Chapter 5, if it is decided that extra care can meet a greater proportion of needs that are currently met in other areas of the system (e.g. in residential care), then this could dramatically change how many units of extra care are required. In addition, future changes in the health of the local population may affect projections for extra care in significant ways.

4.6. The geography of supply and demand

Another important consideration is where the recommended supply is needed within the Greater Cambridge area. Such attempts at assessing the geography of supply and demand are difficult, as moves into older people's housing will not conform to administrative boundaries. Clearly there will be demand originating in Greater Cambridge being met outside of the area, and vice versa.

Nonetheless, we have assessed the differences in demand and supply for Cambridge City and South Cambridgeshire[46], to inform joint and individual policy decisions.

Table 4.4 recommends a supply of 474 units of age-exclusive housing in Cambridge City. This is 296 more than is currently provided. Current supply of specialist housing in Cambridge is marginally above the recommended 1,313 units from the model. Within this, the model recommends a provision of: 1,171 sheltered units which is 105 units fewer than is actually supplied at present; 33 units of enhanced sheltered housing where there is currently none; and 108 units of extra care which is similar to current supply (106 units). Finally, the table recommends an additional supply of 365 care beds (recommended supply is for 803 care beds).

Table 4.4: Recommended supply of older people's housing in Cambridge City from the CRESR model

	Recommended supply	Current supply	Difference
Age-exclusive	**474**	**178**	**(296)**
Specialist housing	**1,313**	**1,382**	**69**
Sheltered	1,171	1,276	105
Enhanced sheltered	33	0	(33)
Extra care	108	106	(2)
Care beds	**803**	**1,168**	**365**

Certain similarities and differences can be seen when looking at the model's outputs for SCDC. Table 4.5 recommends a supply of 960 units of age-exclusive housing in South Cambridgeshire. This is 899 more than the 61 units that are currently provided.

The current supply of specialist housing is some 208 units below the recommended provision (Table 4.5). The model suggests there are currently 214 fewer units of sheltered housing than the 1,883 units that are recommended. The provision of enhanced sheltered and extra care housing is similar to their recommended levels - 57 units and 166 units respectively. Current provision of care beds (657 beds) is also below the recommended supply (1,233 beds).

[46] Note small differences may emerge due to rounding and the estimation procedure.

Table 4.5: Recommended supply of older people's housing in SCDC from the CRESR model

	Recommended supply	Current supply	Difference
Age-exclusive	**960**	**61**	**(899)**
Specialist housing	**2,106**	**1,898**	**(208)**
Sheltered	1,883	1,669	(214)
Enhanced sheltered	57	48	(9)
Extra care	166	181	15
Care beds	**1,233**	**657**	**(576)**

The EAC, who produce the data used for this analysis, acknowledge the challenges in delineating age-exclusive housing from, for instance, sheltered housing without a scheme manager or warden. Given the changes to how sheltered housing in Greater Cambridge is now provided by the local authorities (largely without resident managers or warden), this is all the more relevant. That both of these categories are deemed to be under-supplied in Greater Cambridge should confirm that this type of low-or-no support housing is very much needed.

To provide deeper insights into the geography of demand, we have applied the model at a ward level, to identify hot and cold spots in the demand and supply in 2016 (see appendix A1). However, working at such a low geography creates some challenges. Clearly, not all demand manifested from within a ward will be met in that ward. Hence, to refine the picture of demand, it is suggested that broad sub-district areas are devised, upon which the model calculations can be run.

One of the challenges for local planners and policy-makers, as described in Chapter 5, is estimating whether there will be demand for new schemes such as extra care. To estimate demand for future extra care schemes on specific sites, we have developed a draft set of calculations using the outputs of our model. Our modelling suggests that for every 1,000 people aged 75 years and older, 15.1 units of extra care are required. Data gathered from three extra care schemes in Greater Cambridge suggests that 80 per cent of their residents move from within a 9 mile travel zone (see section 5.5). Furthermore, recent guidance recommends that extra care schemes should be at least 40 units in size to be economically viable[47]. Using the above information, we can create a draft demand equation, which highlights how many over 75s need to reside within a 9 mile travel zone to support demand for 80 per cent of the 40 units in that scheme.

$$\left[40 + \text{the existing supply of equivalent units in travel zone}\right] \times \left[\frac{1000}{15.1}\right] = A \times 80\% = \text{Number of over 75s required to live in 9 mile travel zone to support demand for 80\% of units}$$

47 https://www.housinglin.org.uk/_assets/Resources/Housing/Support_materials/Reports/CostModel_ECH_April15.pdf

The equation has a number of limitations which can only be refined with more data. Information from more existing extra care residents, in terms of their past location, is needed. Furthermore, some refinement is needed to sensitise the model to local population densities and differences in urban and rural contexts. This could simply mean adjusting the travel zone at the end of the equation depending on the urban/rural status of the site being assessed, using evidence from other studies which give indicative travel distances for rural, semi-rural and urban schemes[48]. As more data is gathered, and this tool is refined, there is an opportunity to test it against existing schemes, to see if it matches actual levels of demand.

4.7. Projecting future recommended supply

The model provides recommendations for future supply, using projections of the future size of the population aged 75 and assumptions about other factors identified in the modelling which affect local variation in provision. These include the percentage of people limited by a LTHCD, the percentage of people aged 75 years and over living with dementia and the supply of extra care units per 1,000 people aged 75 years and older.

As noted above, different assumptions can be applied to make further refinements for a given locality, in light of local constraints and support, be they political, economic, social etc. This is discussed more fully in the next chapter. This is critical as SHOP@ and other models are rooted in fixed propensities in terms of demand for specialist housing. These models use the size of the population as the major determinant of the level of demand for each type of specialist housing. They also suggest analysis of POPPI indicators to assess projections of health and social care need. However, many of the POPPI indicators are based on historic national level prevalence rates. Therefore, variation over time (and between local authorities) is only variable by the size of the projected population.

The CRESR model projects significant shortfalls in supply of housing for older people in the future, without major increases to the current levels of provision. Table 4.6 provides estimates from our model, using the ONS' 2014 based population projections for 2020, 2025, 2030 and 2035. This assumes that the proportion of people who have a LTHCD, the percentage of people aged 75 years and over with dementia, and the supply of extra care units per 1,000 people aged 75 years and older are fixed at the current level.

By 2035, the recommended supply for specialist housing is 80 per cent higher than at present (6,163 units compared to 3,422 units). Age-exclusive housing and care beds will need to increase by similar percentages.

[48]Cartwood (2014) *Focus: Extra care housing: Where do residents come from?* Accessed at: http://arcouk.org/wp-content/uploads/2013/01/Moving-distances-analysis-extra-care.pdf

Table 4.6: Projections of future recommended supply in Greater Cambridge

	Recommended supply				
	2016	**2020**	**2025**	**2030**	**2035**
Age-exclusive	**1,145**	**1,321**	**1,619**	**1,835**	**2,062**
Specialist housing	**3,422**	**3,950**	**4,839**	**5,485**	**6,163**
Sheltered	3,057	3,529	4,323	4,901	5,506
Enhanced sheltered	90	103	127	144	161
Extra care	275	318	389	441	496
Care beds	**2,152**	**2,484**	**3,043**	**3,449**	**3,876**

Comparing these figures with SHOP@ reveals only a marginally lower recommended level of supply. The recommended supply of specialist housing in Cambridge and SCDC within SHOP@ is 6,632 units of specialist housing by 2035.

4.8. General needs housing

The number of older people living in general needs housing, and the number of units they occupy, can be difficult to establish. As census data does not segment the older populations by housing type (e.g. general needs, sheltered housing etc.), various informed assumptions need to be made.

Our approach has been to first estimate the number of older people in all housing types other than general needs, making informed assumptions about household size and void rates. This then leaves a residual figure, which we assume to be the number of older people in general needs housing. Applying assumptions about household sizes and the number of older people concealed in multi-generational households, enables us to make rough estimates regarding:

- the estimated proportion of people aged 65 years or older in Greater Cambridge in different forms of older person housing (Figure 4.1)
- the estimated number of units accommodating older person households in Greater Cambridge (Figure 4.2)

Figure 4.1: Estimated proportion of people aged 65 years or older in Greater Cambridge in different forms of older person housing; 2016

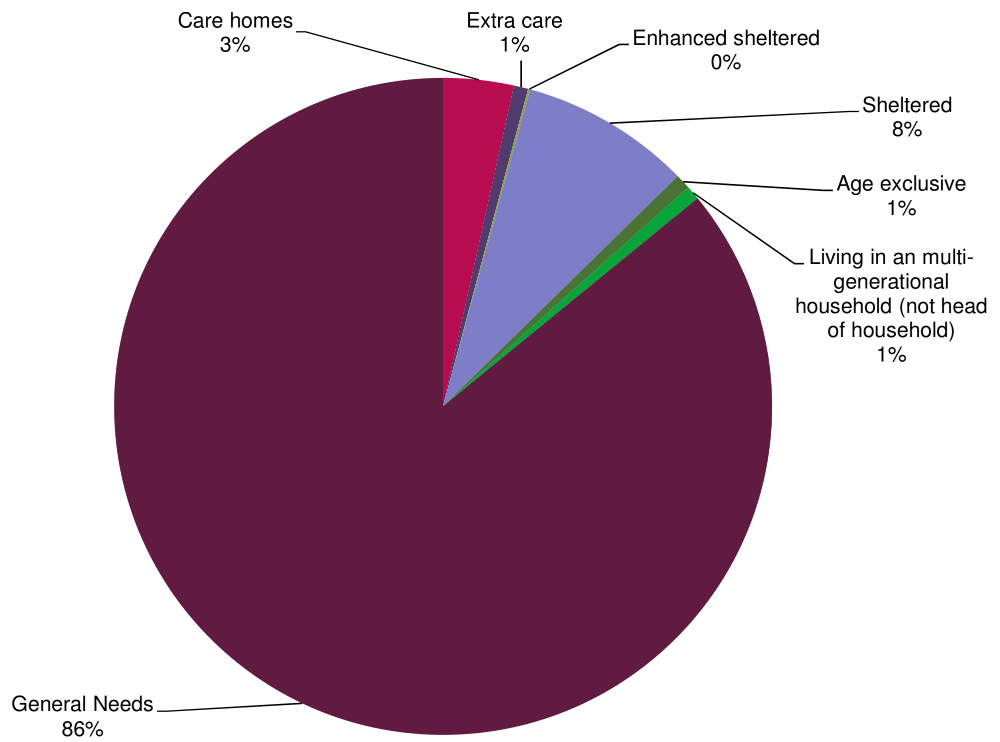
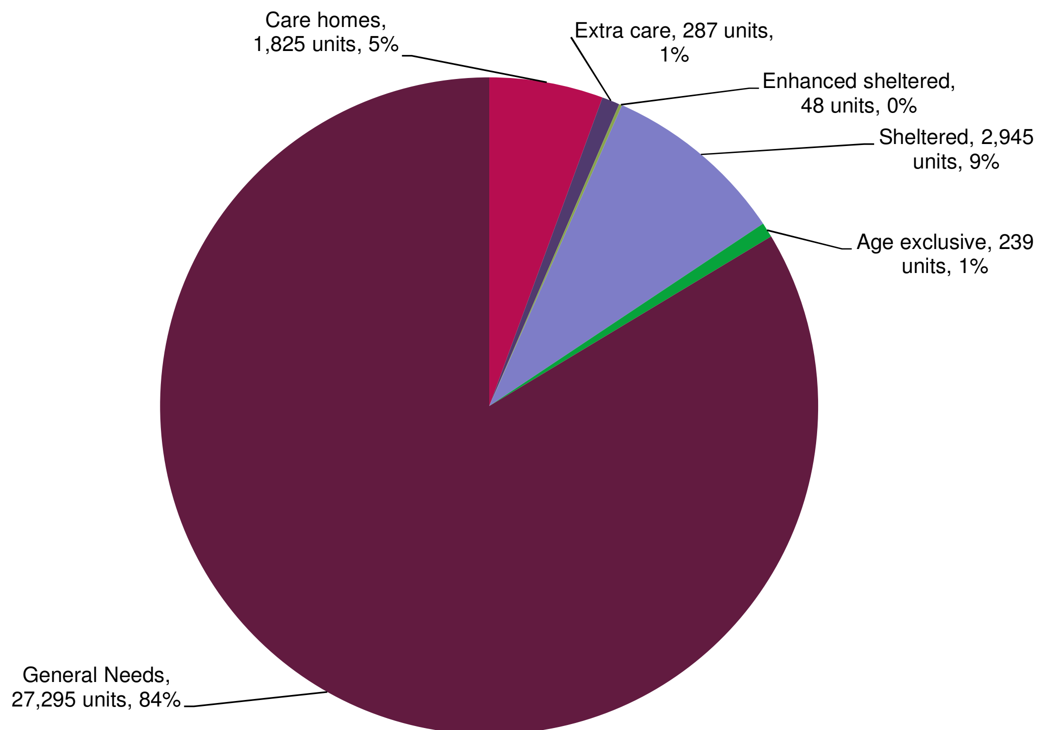


Figure 4.2: Estimated number of units accommodating older person households in Greater Cambridge; 2016



Using this framework it is possible to make projections of the future population of older people in general needs. Applying ONS 2014 based population projections[49] for 2035, it is estimated that if the current distribution across older people's housing options is maintained:

- just under 59,800 people aged 65 years or over (86 per cent) will live in general needs accommodation, and
- older people will occupy just over 41,700 general needs units, meaning that 84 per cent of older people will be in this housing type. This is some 14,400 more units than are currently occupied by this population in Greater Cambridge.

However, if the recommended supply of age-exclusive, specialist housing and care beds is achieved, and we assume similar levels of occupancy, we estimate:

- just under 56,000 people aged 65 years or over (80 per cent) will live in general needs accommodation, and
- people aged 65 years or over will require just over 39,100 general needs units, meaning that 78 per cent of older people would be in this housing type. This is fully 11,800 units more than are currently occupied by this population in Greater Cambridge.

Under both scenarios general needs accommodation, and in particular owner occupier accommodation, will remain the dominant housing option for older people. This has implications for the provision of health, social care and housing adaptions discussed in Chapter 5. It is also important to acknowledge that decisions and actions, including the promotion of more specialist housing options such as extra care, may influence the precise number of older people in general needs housing.

Such large numbers of older people in general needs housing has important implications for local planning policies, particularly relating to the design and accessibility of such housing. If the existing stock in Greater Cambridge has the same proportion of fully 'visit-able dwellings'[50] as was found nationally in the English Housing Survey (seven per cent), then there is likely to be a significant shortfall in the housing which meets the access and use needs of disabled people, and particularly wheelchair users and those with mobility problems. In Cambridge City it has been estimated there is a need for over 6,000 more 'fully visit-able' homes if the objective is to house all over 65s in such dwellings[51]. This research also highlights a current

[49] Note adopting Cambridgeshire's own 2015 based projections increases both the predicted number of older people living in general needs and number of units of general need accommodation required for older people. Under the first scenario presented - assuming the same distribution - approximately 44,500 units will be required. Similarly, under the second scenario - assuming the recommended supply is achieved - just over 42,000 units of general needs accommodation will be required for older people aged 65 years and over.

[50] Department for Communities and Local Government (2016). English Housing Survey: Adaptations and Accessibility Report, 2014-15. Accessed at: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/539541/Adaptations_and_Accessibility_Report.pdf

[51] Cambridge City Council (2017) Accessible Housing in Cambridge: A study into accessible housing requirements in Cambridge for the emerging Local Plan.

need for 84 more dwellings built to Part M4(3) standards relating to wheelchair accessibility standards. This perhaps explains Cambridge City Council's decision, in light of the nature of the existing housing stock, to apply Part M4(2) standards to *all* new housing, and to require five per cent of all affordable housing to be developed to Part M4(3) specifications.

It is beyond the scope of this research to estimate and recommend how many units should meet the various Part M standards, as this demands detailed and dedicated work, ideally using local health data to better estimate levels of need. Nonetheless this is a key issue which merits further research, and our estimates of older people in general needs units will help refine these calculations.

4.9. Estimating the future tenure of supply

This section considers the current and future tenure split of housing for older people in Greater Cambridge. To provide guidance on future tenure splits we assessed separately the top 100 local authorities in terms the level of supply of age-exclusive and specialist housing. The respective 100 local authorities were then split into two groups, depending on whether the proportion of people aged 75 years and over living in owner occupation was above, or below, the median across all English local authorities (79 per cent). The aggregate proportion of units that are rented or owned was then calculated.

Table 4.7 uses the above analysis to set out prevailing tenure splits for the different forms of older people's housing across the local authorities studied. Such tenure proportions are informed by whether an area has an above, or below, median proportion of over 75 year olds who live in owner occupation.

Table 4.7: Tenure splits within the 100 local authorities studied, by the proportion of older people in owner occupation

		Proportion of 75 years and over in owner occupation	
		Above median	Below median
Age-exclusive	Rented	84	92
	Owner	16	8
Sheltered	Rented	69	84
	Owner	31	16
Enhanced sheltered	Rented	47	55
	Owner	53	45
Extra care	Rented	71	87
	Owner	29	13

These tenure splits reflect current provision, which is significantly skewed towards social rented provision. If there is a desire to expand the provision of older people's housing beyond current levels, this is likely to require disproportionate increases in ownership forms of supply. This is in part due to demand being focused on these

ownership forms, particularly in areas with high levels of existing older homeowners. Research and modelling by the Three Dragons Consultancy to assess future supply in London, suggests that of those current owners moving into retirement housing, 85 per cent will move into a purchased property.

Data for Greater Cambridge suggests that across all specialist, age-exclusive and retirement housing currently being provided in Greater Cambridge, less than 20 per cent of schemes have *some* ownership options. Acknowledging that Greater Cambridge has a below median proportion of over 75s in owner occupation, age-exclusive and sheltered housing, it is currently providing sufficient ownership options, according to the CRESR modelling. However, with no extra care schemes offering ownership options, this is a clear area of under-supply.

Table 4.8 applies the tenure patterns in Table 4.7 to our projections for future recommended supply of specialist and age-exclusive housing in Greater Cambridge.

Table 4.8: Recommended supply of housing units in Greater Cambridge by tenure, from the CRESR model

		Recommended supply				
		2016	**2020**	**2025**	**2030**	**2035**
Age-exclusive	Rented	1055	1218	1493	1692	1901
	Owner	89	103	126	143	161
Sheltered	Rented	2564	2960	3627	4111	4619
	Owner	492	569	697	790	887
Enhanced sheltered	Rented	49	57	69	79	88
	Owner	41	47	57	65	73
Extra care	Rented	240	277	339	384	432
	Owner	35	41	50	57	64

These recommendations show marked differences to those proposed by SHOP@ (presented in Table 4.9 below). The latter suggests that in 'affluent' and 'the most affluent' areas, ownership models for specialist housing should constitute at least 50 per cent of units, and up to as much as 80 per cent in the most affluent locations. This contrasts starkly with our analysis. In the CRESR model, it is only enhanced sheltered that gets close to this level of ownership. For all other specialist housing types, rented options are much more prevalent, suggesting that a move to 50 - 80 per cent ownership models will require a major paradigm shift.

Table 4.9: SHOP@'s suggested percentage tenure split by affluence / deprivation

	Most Deprived		Deprived		Affluent		Most Affluent	
	Rent	Leasehold	Rent	Leasehold	Rent	Leasehold	Rent	Leasehold
Sheltered	75	25	50	50	33	67	20	80
Enhanced sheltered	80	20	67	33	50	50	20	80
Extra care	75	25	50	50	33	67	20	80

SHOP@ suggests that in affluent areas such as Greater Cambridge, 67 per cent of sheltered housing should be for ownership, and similarly for extra care. This is significantly at odds with current provision in the area. Our model suggests that ownership forms of specialist housing and age-exclusive will need to increase significantly in percentage terms, but that rental options will remain predominant.

4.10. Summary and implications

Both the CRESR model and the SHOP@ model suggest there is a current under-supply of specialist housing for older people in Greater Cambridge. The CRESR model recommends a current supply of specialist housing in the order of 3,422 units (142 more than current supply). SHOP@ recommends a current supply of 3,554 units (274 more than current supply). Just as importantly, increasing future demands are likely to place major pressures on existing provision in the area. Both models highlight a likely need for at least 2,700 more units of specialist housing by 2035, an 80 per cent increase in the 19 years from 2016. This equates to 144 new units being developed each year, before any additional units are required to account for reductions to the stock.

There are important implications from the CRESR model in terms of the recommended supply of 'sheltered' housing. This is a consequence of the model using as its basis the 100 local authorities with the highest level of specialist supply. In such authorities sheltered housing is a prominent feature of provision. The supply of sheltered housing does not necessarily confirm its adequacy or how well it represents the underlying demand. Instead, the supply of sheltered housing should be seen as imperfectly meeting a more varied and complex set of demands. As noted above, deficits in the recommended supply of *both* age-exclusive and sheltered housing suggests there is a significant requirement for housing with low or no support, but which is nonetheless age appropriate. This is an issue explored in greater depth in the next chapter, drawing on the direct testimony of residents and stakeholders.

Existing models suggest much higher levels of ownership than our model recommends, reflecting a difference in methodology. As evidence from recent studies suggests, there is a significant latent demand for ownership options in specialist housing. Hence, the outputs of our model in terms of ownership should be seen as a minimum. As our model is re-run at future points, it is likely that an increase in such supply will be seen, and this could affect supply recommendations.

The above modelling supplies a set of estimates, on the basis of which more informed policy-making can take place. Demand can and will be met in various ways, shaped by various interventions by public bodies, but also voluntary and private providers. Important questions therefore arise from the above analysis, which situate older people's housing in a broader set of interventions to meet people's needs: how many units of specialist housing are no longer required if a certain amount of aids and adaptations enable people to remain in their current housing? How many specialist units are needed if there is a drive to reduce residential care provision, or at least mitigate increasing costs? And what would be the impact of robust housing options services on demand for specialist housing, as it identifies and helps people who are unsuitably housed? Whilst we can project demand for specialist housing based on prevalence rates or proven demand-side factors, how much supply is created is also shaped by policy objectives and choices, as well as economic realities.

To explore some of the interdependencies between interventions requires engaging with the *quality* of those interventions; their delivery, the processes through which they interlink and their perceived value. Through this it is possible to describe, and start to quantify, how one intervention might off-set, multiply or trade off against another.

The above modelling, therefore, poses a number of deeper questions:

- How will demand for older people's housing be shaped by interventions geared toward enabling people to live in their existing home for longer?
- How will such demand be informed by changes in the provision of care and support services, and the availability of related resources?
- How will demand be influenced by changing approaches to the provision of advice and information, as it seeks to help people make informed choices?
- How will demand be informed by changes in the design and supply of suitable new general needs housing?
- And finally, given the difficulties (and potential inaccuracies) when defining demand at low level geographies, how should decisions about the location of older people's housing be made?

To explore these issues further, and unpick the relationships between different interventions, the next chapter turns to our qualitative data from stakeholder interviews and resident focus groups.

5

Meeting future needs: Stakeholder insights and resident perceptions

5.1. Introduction

This chapter synthesises material from our stakeholder interviews and resident focus groups to present a series of lessons for policy-makers. Detailed notes on our qualitative methods are presented in Appendix 2, but this analysis draws on data from 13 semi-structured interviews and five focus groups with over 50 local residents. The section uses the framework presented in Chapter 2 to structure the presentation of findings, targeting five components in a system of provision for older people:

a. Advice and information to support informed housing choices

b. Housing-related support and assistance

c. New mainstream housing

d. Specialist housing

e. Integrated housing, health and social care

This analysis builds on the modelling above, using local testimony and insights to explore how this integrated system of provision might be improved. It highlights some of the policy decisions inherent in deciding how best to meet the demands outlined in Chapter 4.

5.2. Advice and information

Helping people assess their housing options

The provision of advice and information, which helps people make informed choices about their housing, is a critical part of a well-designed system to meet older people's

needs[52]. Informed choices are more likely to result in better outcomes for older people, which can be contrasted with those made at points of crisis. Advice and information encourages people to engage with questions about their housing, care and support needs before a crisis point, so they consider the range of options they have available. This includes considering alternative housing, as well as modifications and adaptations to their existing home. Hence there are knock-on effects from improvements in advice and information which need to be considered (as discussed below).

Residents participating in our focus groups had a limited knowledge of their future housing choices, and where to go for information. While residents were able to identify a number of information and advice sources - including care navigators, organisations such as Age UK and social care and GP surgeries - their knowledge of housing options and types of housing related support was limited.

There was also concern that housing advice and support was provided in ad hoc ways, varying considerably across the Greater Cambridge area. For example, one resident explained:

> *'We've got an older person coordinator in […] that's funded, I know she is almost like a go to; if you don't know about her that could be tricky. If you know the right people then there is support'. (Resident)*

Another resident who had received some advice admitted that her knowledge of housing options, even within her village, was very limited:

> *'I'm thinking - do I even know what the options are in […] and I'm not sure I do. You can get the generic information from Age UK or somewhere like that but if I wanted to know what my [housing] options were in this community, I'm not sure'. (Resident)*

One particular challenge is that advice and information is often targeted at those most in need, for example, those at risk of or experiencing homelessness. Such systems carry the risk of missing a large number of older people in unsuitable accommodation but who are not yet interfacing with public or other services. Local authorities and partners in Greater Cambridge are piloting progressive approaches on this issue. Interviewees highlighted the application of the Housing Options for Older People (HOOP) model: a formal process for assessing the suitability of individual's current housing that is integrated within existing services. This is being designed to ensure pathways are provided to support people with possible adaptations to their existing home, providing guidance and help on finding alternative housing, and/or signposting to other wellbeing related support. This approach is currently being trialled in SCDC, with one member of staff delivering support (based in the Early Adult Help team), and connecting service users to other services such as peer support networks, handyperson services and visiting support provided by the

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[52] The Care Act 2014 and its accompanying guidance outline how housing can support a more integrated approach. One of these guidelines is that Local authorities must: 'establish and maintain a service for providing people in its area with information and advice relating to care and support for adults and support for carers' and this should include housing options. (https://www.gov.uk/government/publications/care-act-statutory-guidance/care-and-support-statutory-guidance#chapter-3)

local authority. There are plans to extend this model across SCDC later in 2017 and to a county level by April 2018.

This is an important development as our stakeholder interviews and focus groups revealed how residents often have a poor understanding of their housing options:

> *'…at the moment we don't have a central point or a structured conversation that we all have, that partners going in would have, there isn't the information I think available…[the project will start]…training up some older volunteers to do some of that…getting a person who's been through it themselves to have that conversation'. (Stakeholder)*

Traditional approaches to HOOP have tended to filter people through some initial gateway, providing advice services, before then undertaking more detailed casework. The effectiveness of this new approach in the pilot areas is yet to be established. One client group for whom the benefits could be significant is older people in private sector housing. Whilst visiting support services operate across tenures, it was acknowledged that those residents in the private sector are least likely to interface with professionals and consider their housing choices. The HOOP process may provide a means to engage this group in deeper thought about the suitability of their current housing and future options.

Stakeholders highlighted how conditions in privately owned or rented housing may be worse than that in social housing. For these households there is a need to:

> *'…sit down quite intensively with somebody and say let's go and have a look round, contact the estate agents, build rapport with the estate agents, how can we target housing waiting lists, in the city I knew there was however many people sitting there in a low priority band that were over 65, never going to get moved but clearly their housing's inadequate for them'. (Stakeholder)*

Focus groups with residents also suggested that, in general, owner occupiers had little contact with local authority services, and were unlikely to draw on them for housing advice. For many owner occupiers word of mouth and personal research were their main sources of information. It was suggested by residents that information and advice was better tailored to the needs of those seeking social housing sector options. One resident explained the dilemma she faced;

> *I think there's two issues. One is even with the internet. People can't find out where everything is. For example I know that [a housing association] put an extra care scheme on [a site in Cambridge]. I live in Cambridge and I didn't even know it was there, I only found out by accident yesterday and it's an extra care scheme which has got these sort for sale on there and it's got for rent. I think the other problem with rented accommodation, if you're doing it through the not for profit sector or doing it through a housing association it's means tested, so if you've got a house, even if it's only half a house, you're not likely to qualify for rent and I think that's a major disadvantage cos a lot of people are asset rich and cash poor and I think they should be able to sell family houses and move into rented accommodation and have a good quality of life and be able to afford their own care and be able to afford to go out to tennis courts and have the holidays and do all those things that keep you healthy and I think it's*

completely wrong that a lot of it is means tested, so for most people like us who've got our own property or part share of property can't qualify for it.' (Resident)

This testimony reveals how concerns relating to affordability and price might well be navigated in a stronger housing options service.

There was evidence from the focus groups that a lack of housing advice and information was responsible for the development of partial, and at times erroneous, perceptions. Residents held some clear views on specialist housing, which reflected both an awareness of recent changes to provision, but also inaccurate understandings about the availability and access to such housing:

'Sheltered housing no longer has wardens, so what's the point of it'.

'Sheltered housing is really poor quality'.

'Extra care housing is OK, but it's only for those who've been renting from housing associations'.

'If living at home becomes impossible, the only option will be a care home'.

What these quotes show is an awareness of some changes to provision (e.g. the removal of wardens), but perhaps not others (e.g. that extra care may be open to those not currently in social housing or affordable tenures). In thinking about the wider application of the HOOP process after the pilot, thought might be given to the knock-on effects on such work on other areas provision. For instance, other HOOP initiatives have resulted in relatively high rates of moves after advice is given. For instance in year one of the North Manchester HOOP service, 25 per cent of cases to whom advice was provided moved into alternative accommodation, 60 per cent of which was either sheltered or extra care. There are differences in demand and supply of specialist housing in Greater Cambridge, but such an impact should be noted. HOOP and related services might therefore add to demand pressures and policy-makers should anticipate and plan for this. Nonetheless, evaluations of HOOP projects, like the one in North Manchester, suggest that significant annual savings to the public purse can be generated, which were in the order of £800k to £1.4m (in 2015/16)[53]. These savings relate to a range of deferred costs, for instance, in delaying the need for residential care or lower care packages, and avoiding falls and hospital admissions.

For the HOOP approach to work effectively demands a level of integrated services and shared knowledge of housing options and systems. The ability of housing options advisors to refer into other services, and conversely the ability of other service providers to refer into HOOP, would seem critical. Occupational therapist assessments provide a unique opportunity to present people with a range of housing options, advice and information, not least about the potential for specialist housing to better meet their needs. For this opportunity to be seized will require non-housing

[53] Northwards Housing (2016). Housing Options for Older People service. (HOOP): An Evaluation of First Stop Manchester

professionals to be upskilled and trained, so they can correctly advise individuals about their choices.

Furthermore, a range of other professionals who work with the public could refer people into the formal HOOP process. Repairs service providers, builders, removal companies, estate agents etc, could all refer people to HOOP if they knew how to do so.

Questions for policy and practice:

- What will be the knock-on effects of HOOP on existing specialist housing (especially given already high levels of demand for these types of housing)? Is the HOOP assessment process formally linked to allocation/panel processes for sheltered housing and extra care? Will HOOP and related services, target those outside of waiting lists and those not interacting with health or other public services?
- Is the HOOP pilot being fully evaluated to understand what works and what outcomes it is securing for people with different needs? Are cost savings to statutory services being captured?
- Is the HOOP process and related services being adequately resourced? Will those supporting this service be able to meet an increase in demand, especially as the project expands? How would any expansion be funded? As in the North Manchester example, can health funding be mobilised to support the expansion of the service?
- How well-informed on housing-related issues are the various professionals who work with the public? Can they be trained to refer people into the HOOP process?

Wider information and dissemination activity

Beyond systems for providing detailed advice there is a need for wider dissemination of information about different housing types. This includes improving perceptions of certain forms of housing provision.

Local information campaigns and initiatives - targeted at older people and those approaching older age - could help to spread awareness of various options for housing in later life. This could actively encourage people to begin their planning at an early stage. As one interviewee noted:

> *'…a massive marketing campaign that promotes younger people thinking positively about moving, thinking about the future, putting that in a very positive way'. (Stakeholder)*

Lessons can be learned from large retirement housebuilders about how to frame messages about older people's housing, and help trigger planned housing moves if desired. As a representative from one such organisation suggested:

> *'…we actually have two customers, one is the older person and the other one is their sons and daughters, so our marketing material, it's quite a challenge really to make sure that we're addressing those two different customers…It is difficult,*

cos if you focus too much on those needs-based triggers, it presents the perception that this is an old person's home…A big challenge for us is how can we get across to people that this is just a really good thing for them to do'. (Stakeholder)

This stresses the importance of communicating with people on the basis of life-style considerations and aspirations, rather than solely on future care and support needs.

One housing option where there is a need to shift public perception is extra care. As one local authority commissioner noted:

'…why would somebody move into extra care, again it's a bit of a hidden resource, people don't know about it, they can visualise what care homes look like, this thing called extra care people don't understand'. (Stakeholder)

During focus groups, residents revealed a mixed knowledge of extra care - both in terms of where it was and what it was. Of those who knew most about extra care, there was still a degree of uncertainty the nature of the care and support on offer. One resident offered his thoughts on a new development:

'Well the big development in […], the only facility for older people is they're building extra care - a block of 70 apartments, but they're a block of flats and not everybody wants to live in a block of flats and as I understand it you've got to look after yourself but there is going to be care provided, but it's not 24 hour care.' (Resident)

Clearly there is scope to improve residents' understanding of different forms of specialist housing. Wide reaching communications work alongside tailored housing options advice (from HOOP) is likely to improve the quality of people's decision making. This will promote planned moves into specialist housing, which may have knock-on benefits in reduced demand on other services.

Questions for policy and practice:

- How can communications work be targeted at, and reach, the intended audience? Can consumer segmentation profiles, such as that provided by Experian[54], be used to target such communication campaigns?
- Does the perception of specialist housing need to be shifted? Can the extra care offer be conveyed more succinctly and accurately to potential residents?

5.3. Housing assistance and support

Agencies in Greater Cambridge have prioritised helping older people remain independent within their community, wherever possible. Interventions are required that ensure people's current housing is suitable for their needs, and that mitigate or delay the requirement for more intensive care. Housing assistance and support helps residents to undertake repairs, maintenance and adaptations alongside other

[54] See Clark (2017) *Retirement Living Explained: A guide for planning and design professionals* [online]. Accessed at: https://www.housinglin.org.uk/Topics/type/Retirement-Living-Explained-A-Guide-for-Design-Planning-Professionals/

forms of support which go beyond advice or information. These services aim to ensure that accommodation is safe, warm and appropriate to the changing needs of households in order to promote independent living and well-being. Interviewees spoke extensively about this challenge, focusing heavily on grants made through DFG, and other options for modifying people's homes.

The effectiveness of home modifications

Interviews revealed that there is uncertainty around the outcomes achieved through aids and adaptations and related support. This was highlighted in our interviews with officers at the local Homes Improvement Agency, who identified difficulties in assessing the impact of their work, and its effect on helping people remain in their home. Establishing the impacts of home modifications, for instance in delaying entry to residential care, is complex. However, without such evidence it is difficult to decide how best to use the resources available to help people live independently in their own home. Past research has provided some quantification of savings from home modifications. For example, Heywood and Turner's (2007) study suggested that modifications to a home can prevent or deter entry of older people into residential care[55]. The study suggested that interventions with an average cost of £6,000 brought a saving of £26,000 for every year that residential care was delayed. Similar cost-saving projections were outlined in a local JSNA (see Chapter 3). It is important to develop the evidence base on the impacts and associated cost savings of adaptations and modifications so that more informed local policy making about such interventions can take place.

Questions for policy and practice:

- How can the impact of different adaptations and modifications be assessed? The evidence from which can improve investment decisions. What additional information needs to be collected to inform this understanding?
- To what extent can investment in housing adaptations and modifications be used to reduce demand/need for specialist housing?

Making best use of resources for modifications

A theme repeated in a number of interviews was how expenditure on home modifications could be better targeted. For example, the Home Improvement Agency reported that adaptations may not represent the ideal path for some households, and that in parallel with any health-based assessment should be a housing options assessment. This would include discussing future needs with individuals prior to installing adaptations to make sure they are fully aware of their options and, where appropriate, help them make planned moves into more suitable accommodation.

Those developing local housing policies highlighted efforts to improve this process:

[55] Heywood, F. and Turner, L. (2007) *Better outcomes, lower costs: Implications for health and social care budgets of investment in housing adaptations, improvements and equipment: a review of the evidence*. Accessed at:
http://webarchive.nationalarchives.gov.uk/+/http:/www.officefordisability.gov.uk/docs/better_outcomes_summary.pdf

'…what we want to try and do is do some more upfront work with people to understand, get them to think about what their housing options are, if this doesn't look like the best option can we help you with support to move to something more appropriate'. (Stakeholder)

A commissioner shared an example of a single person household which had been referred for a through-floor lift and downstairs toilet. This made them consider if alternative accommodation might have been preferable for the resident and more cost effective.

Added to these dilemmas is a need to streamline the process of assessing and completing home modifications, creating a joined-up approach across the county. Various interviewees highlighted issues in the process of conducting work funded through DFG, with a number focusing on the long delays between assessment and completion of works. As one commissioner noted:

'…some organisations are managing to get a fast track system where they get it done in 30 days from referral to completion, we're taking six months to a year. So we've been looking at the whole pathway. We've also been looking at…the housing related support services…to make sure they're also part of that pathway, cos some of this work doesn't necessarily need to wait for a specialist OT assessment'. (Stakeholder)

Efforts to streamline this process are ongoing. Interviewees identified issues such as the absence of framework agreements with contractors and not applying strict time limits for making a decision to proceed with the work. Questions also arose about the extent to which funding and support for home modifications were advertised and sufficiently utilised, with Home Improvement Agency staff noting:

'…I don't think the service is marketed well enough, so I think there's probably untapped demand out there that we're not aware of at the moment'. (Stakeholder)

This chimes with evidence from the resident focus groups. While there were residents who knew about schemes to fit aids and adaptations at home, the majority were unaware how to access them. Questions arose about the availability of such assistance to self-funders. Owner occupier residents in our focus groups doubted that they would be eligible for financial assistance for such work, or that they could access advice and support from the Home Improvement Agency.

In discussion, residents often talked about the usefulness of stair lifts, but many were put off by the cost of installation, and the difficulty fitting them, particularly to older properties. Other modifications that respondents identified as enabling them to live more independently included grab rails, ramps, walk-in showers, hoists, wet rooms and relocation of bedrooms and bathrooms to the ground floor. Despite these benefits some identified a perceived negative impact on property values as a limiting factor to installing aids and adaptations.

In addition to the larger home modifications, residents identified problems with general maintenance issues, such as changing lightbulbs, fixing taps etc. Some

residents found these tasks very difficult and, in the absence of help from friends and family members, would be unsure of where to turn:

> *'People would be stuck if they didn't have people to help fix things and install things'. (Resident)*

There is a need to improve local knowledge about such services, tying in with the findings outlined in our 'Advice and information' section. However, this is likely to lead to increased demand and cost. Policy-makers and commissioners will need to consider how to meet these additional pressures. A key concern reported by those managing such budgets was the different approaches being taken by local authorities in terms of their funding for the local Home Improvement Agency, and the certainty around future funding.

Questions for policy and practice:

- Could assessments for home modifications be provided alongside housing options advice?
- Where are the blockages in the process from referral through to completion of home modifications? Is there scope to improve marketing and levels of service for self-funders?
- If better advice and streamlined processes increase demand, from where might additional funding come to expand services? This again reveals the interdependencies between different interventions, and how this might be modelled to take account of the impact of one intervention on the need for another.

Housing-related support

Across Greater Cambridge there is a floating support service for residents helping people deal with landlords, undertake household budgeting, find rent deposits, move into alternative accommodation etc[56]. The shift to providing this across all tenures is an important change and provides a mechanism to reach those in private accommodation.

The introduction of a community alarm system, again across tenures, was highlighted as a positive development by interviewees. This prompted further reflection on the speed at which new technologies are being integrated, particularly those which connect people socially, and to key support services. Such technologies were seen as important to maintaining people's quality of life in their home.

There are signs that the voluntary sector plays an important role in helping older people manage in their existing home, with the value of transport schemes and Community Navigators highlighted in particular. Interestingly there is a sense that key functions played by the voluntary sector may be stretched, with one housing services manager noting;

[56] Cambridgeshire County Council (2017) Housing related support services. Accessed at: http://isthisyou.co.uk/yourlifeyourchoice/i-need-help-with/living-at-home/housing-related-support-services.html

'…[people] might need help with hospital transport or someone to go with them to an appointment or shopping or seemingly quite small things but they make a huge difference and there's the voluntary sector who do their best but it doesn't seem to be enough'. (Stakeholder)

This begs important questions about whether more ad hoc, generic forms of support, such as those outlined above, might play a critical role in enabling more people to remain in their current housing.

***Questions for policy and practice**:*

- How can local authorities build on their cross-tenure support service to reach more households, not currently working with them, in owner occupation and private rents?
- What assistive technologies would make the biggest impact in helping people remain in their home, if they desire? And how can newly built properties be designed to make the integration of such technologies easier?
- Are their critical 'events' in older people's lives for which support is not available? Are existing support services doing 'the small things…that make a huge difference'?

5.4. New mainstream and general needs housing

Designing housing for future needs

Given the future pressures on specialist housing suggested by our model, it is revealing that evidence from our focus groups suggests that many people wish to remain living in their existing home. The design of new housing therefore becomes a critical issue, and how this might support both policy objectives and resident preferences. Building suitable housing for older people, connected to the required services, amenities and infrastructure, was a challenge frequently referenced in our interviews. One officer from SCDC summed up the dilemma when noting:

'…there's a huge danger that [new sites will] provide almost nothing that's appropriate for older people's needs'. (Stakeholder)

As more people live in general needs accommodation for longer, particularly into old age where they might have to manage multiple health conditions, the impacts on health and other related services are likely to be significant. Interviewees highlighted one type of health-related incident, trips and falls in the home, as placing a significant burden on secondary care services, and notably being the main factor in a significant proportion of ambulance visits. Clearly the design of new houses, and the adaptation of existing properties, could reduce this level of demand on health services.

The development of new housing to improved specifications will not, however, mitigate problems in the existing stock. As our focus groups revealed there is a cohort of people determined not to move. One resident spoke about the difficulties she was experiencing with her parents:

‘My mum used to work in the care industry in care homes and I think that’s a lot of it. My mother is very disabled, it’s incredible how they manage. My father due to the stroke is developing vascular type dementia I believe, they’re very in denial. I have lots of down to earth conversations with them about various scenarios that might occur cos my dad had a very serious heart attack a couple of months ago and nearly died and my mother would have been in a really critical situation, she depends on him a lot to do the physical tasks, he depends on her to remind him to take his tablets and one thing and another. But they’ve lived in that house for so long now that I don’t think they can envisage themselves leaving, in fact I think it would impact on their health so severely. I tried when they were in their 70s cos for me that was the best time for them to consider the future and several of my aunts and uncles in their 70s moved to a bungalow or a flat, downsized into something that was on one level, but my parents are just head in the sand, they just refused to consider any possible scenarios and they just say they’ll manage. There’s nothing I can do’. (Resident)

Accepting these challenges, it is still prudent that local authorities try to future-proof new housing against the needs of older people. This justifies ambitious targets for units which meet certain visitability and accessibility standards. A key challenge will be in ensuring those private properties developed to Part M4(2 & 3) standards actually house those that need them. This suggests that enforcing these standards in developments of new affordable housing, where there is some control over allocation, would be wise.

Incentivising private developers to build to these standards is clearly a challenge. Whilst interviewees highlighted positive responses from registered providers (RPs) on this issue, such as with BPHA at Trumpington Meadows, evidence from planners suggests that private developers, through the processes of financial viability assessments, are stepping back from these design standards. One area of particular contention related to lifts in multi-storey developments. During an interview with a local planning officer we asked whether housing on growth sites would meet the accessibility and design standards set out in Local Plans. They noted:

'…on the back of Brexit quite a few of the house builders who already had reserved matters…[have] substituted four and five bed houses with two and three bed houses or apartment blocks and when we’ve tried to secure improvements in terms of accessibility they say we’ve got viability issues with delivering any housing on this site'. (Stakeholder)

The pressure to deliver a large number of new homes, along with other imperatives such as securing sufficient affordable housing and improving opportunities for first time buyers, means that these specific concerns about design and accessibility could be lost.

On growth sites and new towns the role of the master developer becomes fundamental in setting the terms of future development, ensuring that bigger questions of sustainability and older people's needs are answered. Interviews with master developers revealed both the positive role, and potential shortcomings of their efforts:

'…it's outline stage that we're at at the moment with [development site]…thinking about the overall provision of what would need to be there like care home provision…you need this amount of square footage of care homes…but then start to think through sustainability…where does that need to be in relation to core facilities and transport links'. (Stakeholder)

Whilst master developers may be alive to some of the bigger issues of sustainability and futureproofing any development, questions might be asked about how strategic they are able to be. For instance, at Waterbeach there are proposals for a 600 unit care home. It is unclear whether this is a reflection of need or demand, and on what evidential basis this has been proposed. There are opportunities in large developments to use masterplanning processes to explore specialist housing models, which may place a lower level of demand on the public purse than residential care, but which might also better meet people's needs, binding developers to this provision through the planning process.

With regard to Northstowe there are worries that this unique opportunity to focus on residents' health and wellbeing may be lost, with a failure to ensure high levels of accessibility and flexibility within any dwellings. As one commissioner noted:

'Northstowe is going to be an interesting one in that regard, where I think a lot of money was paid for the land originally and as times have moved on and the economy's got tougher I think questions of viability have come up'. (Stakeholder)

It appears that new dwellings in Northstowe (in Phase 2 at least) will be built to standards set out in the Local Plan, with all affordable housing meeting the former Lifetime Home Standard, and five per cent of market housing. Northstowe provides an important test case for meeting high design and accessibility standards, and an opportunity to build-in the right infrastructure, which would otherwise be costly to retrofit in later years.

On other sites there is potential for more direct intervention by the local authorities. A senior officer in the county council reflected on this fact, and particularly the potential of any intervention which could reduce other public costs:

'…there's a bit of an appetite in the council to be bold, a bit more commercial, the council is willing to invest capital, to loan, to borrow money, to develop anything it thinks will have a positive impact on revenue and I suppose the only game in town really is around prevention, early intervention, anything that we think will reduce long term cost'. (Stakeholder)

There appears to be potential for local authorities to use their various development vehicles and joint venture partnerships to target the development of new housing that specifically meets older people's needs, justified on the basis of future cost savings.

Questions for policy and practice:

- What are the range of mechanisms that might be used, and aligned, to ensure maximum delivery of homes which will be suitable for older people now and in the future? How might future CIL schemes be used to support such delivery? How can future devolution deals, related to health and social care, be aligned to these

goals to future-proof new housing? How can public bodies steer the housebuilding market, incentivising builders to develop to higher accessibility standards?

- Can the two local housing companies, and the Housing Development Agency for Greater Cambridge, align resources to increase the development of general needs accommodation designed specifically for older people? Could the case for this be made on a costed model which itemises future savings in the form of residential care, hospitalisations etc?

Housing form

Beyond meeting specified design standards, there are questions about the form that new mainstream housing might take. A consistent theme in the interviews related to the demand for 'downsizer' or 'rightsizer' properties. Traditional forms of older people's housing remain firmly in demand, as one representative from a master developer noted:

> *'…in Huntingdon we are delivering some bungalows and even though we haven't even started the infrastructure yet we've already got interest in those cos there's such big demand for that…the reason why we've got bungalows coming forward at Huntingdon is cos we're building them ourselves'. (Stakeholder)*

Ironically, officers managing local authority sheltered stock, largely in the form of bungalows, suggested this is being 'over-relied' upon. Focus groups with residents also suggested that bungalows were favoured more than apartments; however, they were apparently very difficult to come by (particularly for sale):

> *'The traditional thing would have been a bungalow but they are, well I know this year, there's one planning application in [SCDC village] for a bungalow to be knocked down and four houses built in its place. There's another house…which has been knocked down and turned into two houses….why would a developer really want to build a bungalow, which means there will be a lack of bungalows. When we get older it'll be harder to find a bungalow if that is our choice'. (Resident)*

A shortage of larger properties is also affecting housing options for certain groups. Residents highlighted how, for some BAME groups, multi-generational homes are the solution to older people's housing needs, making the supply of larger properties essential. Others urged caution however in assuming that younger BAME households will continue to co-habit with their older relatives. As one interviewee noted;

> *'In particular cultures your family will support you…[younger people are] pulled between the tradition and the demands of wider society. So you can become very isolated if you're from somewhere else, and your children don't feel that same obligation any more'. (Resident)*

The growth in multi-generational households[57] may create demand for larger properties, raising questions about whether the market will respond. Focus group participants in Cambridge City highlighted this issue, and how high prices diminish access to larger properties, within which multiple generations of a family could be housed.

Large retirement housebuilders interviewed in the course of this research, who see Cambridge and surrounding settlements as target areas for their development, see opportunities in building housing which is age-exclusive. One particular area of focus is providing accommodation with low or no support, geared toward active older people but which would not be identified as 'specialist housing'. As an interviewee from a large retirement housebuilder revealed:

> *'Lifestyle Living, that's aimed at, well it was initially aimed at a younger, downsizer but the first few schemes that we brought to the market we were attracting someone who was a little bit younger than our retirement living customer but not someone in their mid-60s, so what we're doing is attracting the older person who just doesn't want to move into traditional retirement housing with the communal facilities. We see a big opportunity for that as a product'. (Stakeholder)*

Retirement housebuilders themselves note how national policy is doing little to incentivise volume housebuilders to enter this space, and how their focus lies on other products with potentially higher profit margins. There are likely to be opportunities for public and voluntary providers to focus on mixed equity products, and here protections against worsening affordability may be found. This opportunity is already being explored as one planning officer noted:

> *'…we're looking at an equity model there so we're looking at an element of bungalows where owner occupiers can buy a share in the property. So we are starting to think about how are we going to provide for the older generation but now with the, the support is always going to be a huge issue I think'. (Stakeholder)*

All of this evidence highlights again the need to rethink traditional boundaries between general needs, age-exclusive and sheltered housing. The interest from a range of providers to develop housing in this space highlights the potential to address the shortfall in such supply identified by our model. Ensuring these interests align with the underlying needs and demand of residents, and that they cover all ranges of affordability, will be the challenge.

Questions for policy and practice:

- What incentives might be offered to encourage the development of downsizer accommodation? How can the planning system support the development of homes for multi-generational households?
- Evidence suggests a shortage of housing which bridges the traditional types of 'older people's housing'. How can this 'space' be redefined to encourage more

[57] NHBC (2017)

developers to bring forward such development?

Rural locations and wider community building

Evidence from our focus groups suggests residents are generally unwilling to move large distances to access alternative housing. This reticence will place added pressure on general needs accommodation which may not be suitable for older people's needs. In the more isolated rural settlements this is a particular issue. Here planning policies, for instance related to rural exception sites, may be used to create suitable housing for older people. SCDC is well versed in using such instruments, and local planners highlighted the potential here, making connections with self-build/custom build approaches:

> *'We're very good at providing exception sites in the district…and we're now starting to think about we can have an element of market on there, if there's a need in that village how about building some bespoke bungalow accommodation, maybe through our self-build vanguard…we're looking at community-led development quite a lot now in our villages…if we can identify the need cos it's got to be for local people that wish to downsize…not self-build but custom build and we almost build specific bungalow, flat, whatever for people to downsize into'. (Stakeholder)*

With both District Councils being recipients of money through the Community Housing Fund, and with grant funding likely to be made available in subsequent funding rounds, there are opportunities to activate community-led responses to older people's housing needs.

Another issue relates to transport and wider connectivity. In several of the focus groups in rural areas, transport was a key factor in residents' thinking about where they would like to live in future. Poor transport links was seen as a problem likely to manifest to a greater degree in later life, and act as a barrier to remaining at home: *'I don't think isolating people is helpful' (Resident)*. This issue was well understood by a number of stakeholders interviewed. As one planner noted:

> *'…older people will obviously have the potential to have quite a few mobility issues so making sure that they're close to services that they can potentially get to without assistance if they have enough mobility, it's important to make sure that they're part of the community'. (Stakeholder)*

And residents shared this sentiment by recognising the importance of transport links and maintaining links to a community:

> *'So it's about how accessible [older people] are to the activities and structures and things people can do. It's important that enhanced transport is integrated within housing, if you build something on the outskirts of town it might be lovely and great accessibility in the house but you can't go to the library or wherever'. (Resident)*

These are important lessons when planning new housing. To counter the potential for isolation among older people, stakeholders suggested that section 106 agreements might be used, on larger sites, to fund community development work

and services for people with various vulnerabilities, connecting them with the wider community.

Beyond issues of transport and community development, is the need to design spaces with varying age groups in mind. Residents in our focus group seemed alive to the need to design for private and public spaces, with the latter tailored for those living with, for instance, dementia. Useful guidance and good practice is emerging on how to develop 'age friendly neighbourhoods[58]. Such lessons from this might be applied in places like Northstowe.

Questions for policy and practice:

- Can interest in self-build and community-led housing be channelled to support the development of older people's housing? What incentives and support systems are required to encourage custom-build, and community-led housing in its many forms?
- How can various planning instruments, like s.106, be used to encourage housing development for older people?
- How can the transport needs of older residents in rural locations be met? This could be a key factor in helping people remain independent in their current home.

5.5. Specialist housing

The quantum and type of housing required

The difference in forecasts generated by SHOP@ and the modelling undertaken in this study raises some important questions. Perhaps the most significant of these relates to the quantity of extra care and sheltered housing. Is the current supply of extra care either significantly below what is needed (as SHOP@ suggests) or is provision roughly sufficient (as our modelling suggests)? Similarly, should we accept suggestions that sheltered housing is either over supplied or under-supplied in Greater Cambridge, and at a district level?

One of the challenges in modelling provision based on patterns in the 100 local authorities identified is that this assumes the adequacy of supply in those areas. It may also hide differences in the nature of provision, e.g. 'sheltered housing' may look very different in diverse administrative areas with differing resources, operational structures etc. Our model prescribes increased levels of sheltered housing (in SCDC), but demand for this is dependent on that supply being of a certain quality, delivered in a certain form, with certain facilities, and allocated in certain ways etc.

To help nuance our understanding of demand for different types of specialist housing, we explored this with interviewees from a range of public bodies. Despite concerns among some interviewees that sheltered housing was now an 'outdated' model, and that some are badly designed with poor accessibility, it was suggested by others that demand for such properties has been relatively high in both SCDC and Cambridge City. Other interviewees urged us not to lose sight of these 'old models'. One reason

[58] See http://www.ageuk.org.uk/Documents/EN-GB/For-professionals/Communities-and-inclusion/Policy%20Review%20Age%20Friendly%20Neighbourhoods.pdf?dtrk=true

for continuing demand may relate to the fact that sheltered lets are not restricted on the basis of existing equity or income, and hence this provision meets needs across a broad socio-economic range. As one local care commissioner noted:

> *'…there is a demand in that people want bungalows and there is a lot of that type of accommodation…what you have got is a relatively high proportion of older people living in semi-supported communities'. (Stakeholder)*

So, there may well be demand for bungalow, age-tailored housing with some support and communal aspects. However, questions remain about whether in its current form this will meet future needs and aspirations. We might understand the demand for sheltered housing as an imperfectly expressed demand, i.e. people are willing to live in this accommodation but actually they aspire to something slightly different.

Resident perceptions and preferences

Insights from the resident focus groups suggested that there is some negativity around sheltered housing. It was perceived to be 'old-fashioned', of poor quality, and not always available in a suitable location. There was also a perception that a move to sheltered accommodation represented 'a surrender of independence'.

> *'My mum-in-law lives in sheltered accommodation and the only exciting thing that happens to her for days on end sometimes is a carer comes to someone else and she's up at the window like something's happened. I don't want to live somewhere which is so sheltered as to be like in a bubble'. (Resident)*

Conversely, other residents perceived that onsite warden and care services were no longer associated with sheltered, and therefore, it was a poor housing choice. One resident explained her perspective on sheltered housing in South Cambridgeshire:

> *'I think there's quite a lot of sheltered accommodation around this area of varying quality I understand. I've always thought that sheltered accommodation is the first step where you might have a warden on site and get some support but you've still got quite a bit of independence but my own experience of it with family members…it might be me being prejudiced and not knowing, but it always seems to be quite inferior, like the architects haven't really thought about what people really need, it's just a flat but it's not of good quality or good design. Maybe I'm wrong, maybe people who live in them feel it's ok for them'. (Resident)*

The resident focus groups provided some insights into the type of specialist housing that residents held preferences for. It is important to note that it was difficult to reach a consensus, but we noted some important themes that emerged from the discussion. The majority of people do wish to remain living at home as long as possible. However, for some older people this is partly driven by either a lack of other palatable housing options, or a lack of understanding about the options available *and* the value and benefit that might be derived from a move. Residents highlighted barriers experienced by BAME residents in accessing specialist housing and residential care. Worries about language, food, and the observance of certain customs were deemed the most significant barriers. Recent efforts to develop culturally sensitive accommodation had not adequately consulted with that community and hence, '*when it was built it didn't suit what that community wanted*

because it was single rooms' (Resident). What was seen to be required was community leadership in minority groups to 'agitate' for, or self-fund, culturally sensitive provision. This in part demands building knowledge about housing options and models, and it was felt this could be done through sessions between local authority officers and BAME residents:

> *'Actually having some sessions where they get information, but also where communities are informed about ways they can find solutions. It doesn't have to be about housing, but providing culturally sensitive support to older people to live in their homes for longer'.* (Resident)

On the face of it, the focus groups revealed that most people were reluctant to move much beyond their current location to access specialist housing. People's preferences were for very localised provision. This was particularly true in South Cambridgeshire's rural communities. Some people had a pragmatic view, that it would be unrealistic to build specialist housing in every community. For some, the shear practicalities of moving were a limiting factor:

> *Researcher: '… so it sounds like a lot of you want to stay in your own home although some other options might be attractive, are there problems you could see if you did reach that stage where you wanted to move?'*
>
> *Resident: 'Hassle'.*
>
> *Resident: 'Moving at any stage in life, it takes so long, it can fall through at any moment, it's not like Scotland where once you've made the bid that's it'.*
>
> *Resident: 'If you're on your own…'*
>
> *Resident: 'It's a huge amount of stress moving, and the paperwork.'*
>
> *Resident: 'Costs £10,000 the average move.'*
>
> *Resident: 'More than that.'*
>
> *[talking together]*
>
> *Resident: 'Again this plan ahead, you don't want to make a move before you feel you really need to, but so many moves are made at a point of crisis which is a very difficult time to make decisions.'*

The practicalities of moving seem to prevent consideration of different housing options. However, the focus groups also suggested that the perceived nature of specialist housing, and its potential compromises were strong limiting factors. While there was some enthusiasm for 'retirement village' type developments, in three focus groups residents strongly voiced their concerns about new developments that were exclusively occupied by older people. Instead, their preference was for mixed age developments, citing the importance of remaining part of a wider community; as one resident put it:

> *'…not corralling older people into isolated, out of the way places'. (Resident)*

This was particularly the case for residents living in Cambridge City.

> *'We don't want to create communities of just older people, that's not the way to go'. (Resident)*

In a similar vein, residents frequently stressed the importance of 'community' - building strong communities and maintaining links with 'their' communities through later life. There were fears that existing and planned specialist housing provision would break these community links, isolating people from their established lives.

> *'Community can make a village and we've got a thriving community. Some people have lived in the village 30, 40 years, why in their later years should they have to move home or move away from people that they know, areas that they know. Some older people it can get very confusing to have to move, it can be very stressful'. (Resident)*

Residents discussed what they meant by 'community'. There were three distinctive narratives:

- For many, it was about maintaining the association with friends, family, neighbours and familiar places - and this was indicative of a reluctance to move any distance to live in more suitable accommodation.
- But for others, the desire for 'community' was associated with being active, having access to social and cultural assets, and living within an age-diverse community. So, for some residents, it was apparent that they were less constrained by the desire to hold onto familiar surroundings, provided that such valued 'community' aspects were associated with new accommodation options.
- Many residents still had a very binary view of their housing pathway - stay at home and then (if necessary) move to a care home. To a large degree, this is reinforced by a lack of knowledge (and lack of provision in some areas) of alternative housing options. To a smaller degree, there were some suggestions that when someone reached a crisis situation, a move to a care home was a more likely outcome than identifying a more independence-based solution. When asked about future housing options, one resident explained:

> *'Thought about it, very much so, but there's so little in this area, this is the whole problem, this area there is so little for older people over 55s who don't want a care home, that in-between bit. This is one of my big things with South Cambs'. (Resident)*

Focus group discussions revealed surprisingly little evidence on the affordability of specialist housing. While a small number of participants expressed concerns about affordability, most had not appraised future housing options, and had little knowledge of costs. Individuals living in shared ownership accommodation were particularly attuned to the future constraints on their choices in light of existing equity holdings.

The built form of their future housing was an important consideration for residents. As we discussed earlier, there remains a strong desire for bungalows as a later life option. Focus group discussions attempted to unpick why this was the case. A bungalow offers accessibility, privacy, space, and a garden - all important

considerations for many. Some residents accepted that bungalows might be difficult for developers to provide, but nevertheless, bungalows were an attractive option because they provided the comforts and assets that people desired, but in a more manageable form that assisted with mobility decline in older age.

Specialist accommodation was often viewed as the antithesis of this ideal - usually flats, usually 'too small', lacking privacy and without private gardens. To some extent, this is a perceptual issue. For example, well-designed extra care schemes often provide similar levels of privacy, space and a private garden, but in an alternative built form. As with many aspects of specialist housing, there would appear to be opportunities to stimulate increased interest and demand for alternative housing options - by changing perceptions through improvements to information and advice.

As noted above, in future significant demand for 'sheltered housing' could be met by a variety of providers, offering products which bridge the definitions of 'sheltered' and 'age-exclusive'. Indeed, this is what a number of private providers are trying to do, under the label 'retirement housing'. Interviewees from the County Council seemed to concur with this noting, with a degree of caution, that:

> *'…retirement villages could be very useful…let's have some serious investment now and encourage the private sector too to start building different types of housing that will meet the needs of this population for the next 20, 30 years. I think that could be some way off'. (Stakeholder).*

On the subject of extra care, interviewees from both planning and social care highlighted examples of extra care facilities being under-used or *'half-empty'*, whilst others identified schemes in high demand, being closed to new applications. To explain this, one interviewee noted that it was not about the type of provision per se. Rather demand is a function of getting the right accommodation for the local area, and ensuring you *'get the services right going in'* (Stakeholder). Localised demand factors then become the predominant concern.

What our modelling highlights, in contrast to SHOP@, is the continuing need for a form of age-appropriate housing with low or no support, perhaps performing a comparative function to sheltered housing, but updated to meet the aspirations and expectations of the current and future generation of older people.

Questions for policy and practice:

- What are the core demands of those housed within sheltered and age-exclusive housing? How can specialist housing be configured to address some of the current and future demands highlighted here; the need for private space, good transport links and other connectivity, feeling part of a wider community that is not age-exclusive etc?
- Can the local authorities engage with BAME communities (as suggested) through advice sessions? This will help spread information about different housing and care options, and learn about specific demands and needs.
- How might residents be encouraged to consider specialist housing further afield? What type of housing form, community, or additional services might affect residents' willingness to move?

Geography and distribution

The geographical distribution of specialist provision becomes a central concern, not least in SCDC where it is acknowledged that issues of rurality and connectivity will make the location of future specialist accommodation a key concern. A senior county council officer noted:

> *'..if you want a specialist service like extra care sheltered housing for instance, you're not going to have* [it] *in every village area around South Cambs and it's a pretty spread out area, Linton is a long way…you're talking about a distance of 30 miles. I think South Cambs is a particularly tricky area so in a way I think you have to see it linked by Cambridge'. (Stakeholder)*

Unique analysis undertaken within this study provides important corroborative evidence. Working with an RP active in Greater Cambridge we have analysed the distances each current resident moved to take residence in their three extra care schemes. What was revealed was that 80 per cent of current residents had moved from within a 9 mile travel zone, 70 per cent from within a 4 mile zone. Differences were seen in travel distances dependent on the schemes' proximity to major settlements. In the two schemes close to Cambridge City, 80 per cent of residents travelled from less than 7 and 5 miles respectively. For the scheme in South Cambridgeshire, travel distances for 80 per cent of residents were 14 miles or less. Similar travel patterns to extra care facilities have been presented by Carterwood[59], on the basis of research with 12 members of the Associated Retirement Community Operators (ARCO). This revealed that 60% of residents travelled from within five miles, with average distances being three miles, noting large variations between urban and rural schemes, and also depending on tenure. Taken together, this evidence reasserts the suggestion that the vast majority of residents of such specialist housing are drawn from a very close proximity.

Developing better sub-district models for assessing demand for older people's housing are needed. Lessons can be learned from private retirement builders who have created models to assess demand for (and the financial viability of) developments on specific sites. In the course of this research we interviewed a representative from McCarthy and Stone, who are the UK's largest retirement housebuilder. Cambridgeshire was identified as a '*hotspot*' for them. Recent land acquisitions attest to this, with sites in Cambridgeshire being acquired in 2016, though not in Greater Cambridge[60]. What is clear is that small schemes are becoming more viable for such private sector developers, with their equivalent of sheltered housing 'following the public sector' and replacing resident house managers with day managers. Now organisations like McCarthy and Stone '*can do schemes that are smaller…often in smaller market towns…that are in the low 20s…up to roughly 60 units*'. The equivalent of extra care is deemed to require a minimum of 40 units to be viable, in light of the more extensive communal facilities.

It is apparent from our interviews with developers and master developers that they are attuned to the opportunities to meet demand for older people's housing, but

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[59] Carterwood (2014) *Focus: Extra care housing: Where do residents come from?* Accessed at: http://arcouk.org/wp-content/uploads/2013/01/Moving-distances-analysis-extra-care.pdf

[60] McCarthy and Stone (2017). Buying land, Building Homes.

approach this issue with strong models for assessing financial returns. Developers like McCarthy and Stone focus heavily on brownfield sites, with a clear model for assessing potential demand within a close proximity to that site:

> *'…The first thing we would do is carefully define what we think is the primary catchment area, often that will be a four, five mile radius of the site cos we know the majority of customers will come from there…then we'll look at how many of our best prospects, socio-economic characteristics, so the sort of people who buy our properties live within that catchment area and then we'll look at their existing property values to see how many of those best prospects could afford one of our properties…in very crude terms, if we've got around 100 best prospects who can afford every one property that we're bringing forward, we're pretty comfortable going with that'. (Stakeholder)*

Taking similar approaches to assessing sites may enhance the spatial planning of all specialist housing, including that which provides social rents. This would in fact address a key concern of planners to build a better evidence base to inform negotiations with developers, and to be more proactive in identifying future sites for such provision:

> *'…where we can evidence requirement in negotiations with developers and have requirements identified at the earliest stage of development cos then it's much easier to secure those and you can build in time to be able to work through that process'. (Stakeholder)*

Using our modelling work, and what we have learned about travel distances for extra care, we can develop site appraisal tools such as those set out in Chapter 4, which can be refined over time with more data from local schemes. In time this will provide a tested site appraisal model tailored to the unique geography of Greater Cambridge, and account for the disparities in rural/urban locations and also differing tenure types.

Careful thought is required as to how planning levers can be utilised to incentivise certain forms of development. Section 106 agreements are clearly a key lever in creating new older people's housing, but more could be done to incentivise such developments. This could mean applying flexibilities with retirement housebuilders who are competing with commercial retailers in land markets, but where the latter often have no requirement to make affordable housing contributions. Interviewees highlighted other opportunities, for instance, to use new flexibilities associated with CIL when this has been agreed. Other opportunities may arise from targeted use of public land holdings to prioritise older people's housing, and funding opportunities arising from devolution agreements and additional money being made available through the Improved Better Care Fund, likely to be targeted at housing.

Questions for policy and practice:

- Could better models for identifying suitable areas for older people's housing be developed, and for appraising individual schemes? Initial models may be instructive, but there are also opportunities to build on the models used by commercial builders, making them more sensitive to issues of affordability and health/support needs.

- How might the barriers to development which might impinge on different providers of older people's housing be removed?
- Can planning powers be combined with new funding streams and land assets to develop the types of provision the market may not deliver?

Price and affordability

Such is the nature of the local housing market that questions of affordability came to the fore in our interviews with stakeholders. It was noted that a resident in an extra care facility, required to self-fund their 20 hours of care, may be paying close to £700 per week after rent, service charges and care costs. Clearly there is significant evidence to suggest extra care brings important benefits for residents, but interviewees raised questions about whether extra care is any cheaper (to both the public purse and the individual) when compared to domiciliary care. The inability to answer this question suggests that such a comparison may be valuable, and may help inform decisions about the nature of future extra care provision. In the more exclusive retirement accommodation service charges may be very high, putting this beyond the reach of many. Other interviewees highlighted examples of new age-exclusive housing being made available through shared ownership. This required purchasers to:

> *'…come up with nearly £400,000, and there's a service charge element which takes the weekly rent to £50 above the local housing allowance, so this effectively prohibits anybody that would claim housing benefit.' (Stakeholder)*

Interviewees also noted how forthcoming schemes being developed by RPs are intending to offer equity sale options, mixed with rental units. This is likely to be an important feature of future schemes, and will enable the cross-subsidy of schemes.

There are some current challenges to developing more extra care provision. Multiple interviewees, including a representative of a RP currently running extra care schemes in the area, talked through these difficulties. In particular, uncertainties about supported housing funding, and procurement rules which create uncertainty about future care contracts, have diminished interest among such providers.

Questions for policy and practice:

- Can demand for equity models be more closely assessed, including whether mixed tenure schemes can address providers' worries about financing such developments?
- If there is identified demand for extra care schemes in an area, how can procurement processes provide certainty around contracts for future care provision, particularly for those providers combining housing and care services?

Processes and practices

The speed and efficiency of allocating units of specialist housing came under scrutiny in our interviews, particularly in extra care schemes. Those tasked with

commissioning care services lamented the differences in the speed of placing discharged patients in residential care compared to extra care:

> *'…the ability of the housing provider, and I suppose ourselves as part of an allocation panel, to make a quick decision on whether that person could move in, in the timescale the hospital needs which is a few days, it's just not there'. (Stakeholder)*

Further improvements might also be made to maximising the role of extra care in an era when, as the population ages, more people are likely to have long term conditions and multiple needs. As a representative from the CCG noted:

> *'I think it isn't just about demand for specialist, I think we've got to go further in terms of what under the regulators we could manage within that setting'. (Stakeholder)*

This issue clearly raises a number of questions about the provision of support and care that can and should be offered in these settings. Interviewees currently managing extra care schemes noted the additional pressures being placed on them in light of ever more acute care needs. This was only manageable because (for foreseen reasons) their scheme was temporarily running under full occupancy. Other interviewees noted the phenomena of providers being very selective about who they would take into their scheme, preferring those with low support needs. These issues are unlikely to go away, and may even become more pronounced. Furthermore, many of the above themes relating to extra care, both regarding the important role it plays and the challenges faced, are recurrent themes in other research on this topic, including some of CRESR's work in Doncaster[61] and Wales[62].

Other concerns were raised about the marketing, and understanding of, different forms of specialist housing. As noted in section 5.1. there is clearly potential to improve the advice and information available to help people considering their housing options.

Questions for policy and practice:

- How might the processes for allocating specialist housing be speeded up?
- What are the implications of meeting more intensive needs within extra care settings, both in terms of regulation and appropriate staffing? How are the care and support needs within such settings changing, and how can this be planned for?
- Can a stronger approach to housing options increase awareness of, and demand for, specialist housing? How can this effort be co-ordinated across various professionals?

[61] CRESR (2015). The Housing Options of Older People in Doncaster. Sheffield, CRESR
[62] CRESR (forthcoming). Evaluation of Extra Care Housing in Wales. Sheffield, CRESR

5.6. Integrated housing, health and social care

Aligning and integrating services for better outcomes

The integration of housing, health and social care is not a choice but a statutory responsibility, having recently been reinforced by the Care Act 2014. This placed a requirement on local authorities to join up services with those provided by the NHS when carrying out their care and support responsibilities, and underlined the need for local authorities to consider the suitability of accommodation when fulfilling their general duty to promote an individual's well-being. Also in 2014, a Memorandum of Understanding (MoU) to support joint action on improving health through the home was signed by health, social care and housing representatives from across national and local government, the NHS and the voluntary and community sector[63]. The memorandum committed organisations and agencies across government, housing, health and social care sectors to work together to enable people to live in home environments that are beneficial to health and well-being throughout life.

Despite this drive, integration is fraught with challenges. As a symbol of how housing, health and care are not sufficiently integrated, the Cambridgeshire OPAS notes that 'in 2015-16 an average of 2,442 bed days per month were lost as a result of someone being fit to leave hospital but unable to'[64]. The financial consequences of this are significant, and ensuring that fewer bed days are lost, whilst also not overloading residential care, will demand solutions in the wider housing system. In an interview with a senior local authority officer the difficulties in developing sufficient accommodation to keep pace with needs were acknowledged, and that in time *'everyone's going to need high needs costly residential care*'. Interventions are likely to demand innovation in housing provision, alongside similar developments in health and care services, to prevent (or at least delay) the need for more intensive forms of care.

Interviewees suggested that part of the challenge of integrating services lay in the differing working cultures and planning horizons of different agencies. Those interviewees in local authorities acknowledged how health professionals were driven to meet short term pressures which hindered longer term planning, and also bemoaned frequent structural and staffing changes. Nonetheless, partnerships have formed in Greater Cambridge, at both strategic and operational levels. Whilst the Older People's Accommodation Programme Board offers a structure to align policy and funding, other interviewees managing specialist housing schemes noted their excellent relations with certain district nursing teams. What became apparent during the interviews were geographic disparities in the joining up of services, seemingly based on individual relationships and shared goals.

Changing the processes and systems to integrate housing, health and care may demand more multi-skilling of professionals and operational structures which

[63] Chartered Institute of Housing (2014). A Memorandum of Understanding (MoU) to support joint action on improving health through the home. Accessed at: http://www.cih.org/resources/PDF/Policy%20free%20download%20pdfs/MOU%20project%20final%20Dec%2014.pdf

[64] Cambridgeshire Older People's Accommodation Programme Board (2016). Older People's Accommodation Strategy.

maximise the relationships that certain professionals might have with individual residents. One service manager interviewed in this study pointed to the approach used in children's services whereby:

> *'…If you can get the person closest to the individual to have those difficult conversations with them whether that's a district nurse that goes to see them or a GP that sees them, I don't think it can just be one agency that has responsibility for doing that'. (Stakeholder)*

This would clearly demand each professional working with an older person to be fully versed in housing, health and care options, or at least be able to refer into different services. Interviewees provided examples of professionals being some way from this. Occupational Therapists were seen to be undertaking an important function, but perhaps not having the wider knowledge of housing options and related services. This hinders their capacity to help residents make more informed decisions about their future housing and care.

This is particularly pertinent in reference to minority groups where there are significant barriers to accessing suitable housing, care and support. Highlighting challenges around care for older BAME residents, focus group participants noted:

> *'There are a lot of hidden issues. Problems with language means that when they needed to go to a care home they didn't want to, but also things around diet or food…the observance of certain customs. It resulted in older ethnic minority people in substandard care'. (Resident)*

> *'…you have someone looking after someone with dementia, so this is an issue as there are more and more BME people getting older...so these issues of care not reaching communities are going to be more and more'. (Resident)*

Our focus groups found that many older people often sought housing advice and information from services and organisations which were proficient at providing advice on care, but less versant in housing options and choices for later life. Reasserting the need to upskill professionals, and ensure housing advice and support is integrated with other services.

Smarter and more efficient use of emergency health services was proposed by some stakeholders. One health commissioner noted how specialist housing providers might look again at their decision-making processes to do this *'in a more resourceful way'*, placing less stress on emergency provision.

An issue regularly raised in the interviews was the importance of respite or step-down accommodation for those leaving hospital. This is reiterated in recent JSNAs[65]. Here, whilst it was suggested that too few units of such accommodation were available, good practices are emerging:

> *'We're building links with the discharge planning team at the hospitals so we get more and more referrals from them, people that have perhaps gone home and we pick up some support for following that. We do marketing days up at the*

[65] https://www.jsna.info/sites/default/files/LBHF per cent20Housing per cent20Support per cent20and per cent20Care per cent20JSNA per cent20Sept per cent2016.pdf

hospital and different events, community days on our housing estates, lots of different things, stakeholder events that the county council organise, so it's quite well promoted'. (Stakeholder)

The implications of this are significant. Over 5,500 people over 65 were admitted to hospitals due to falls in Greater Cambridge in 2012/13. It is unclear how many of these people were delayed leaving hospital or had to enter residential care before they could return home. However, with only 700 beds of 'temporary bed-based care' across the county[66], this raises questions about whether this constitutes sufficient step-down provision. This issue is receiving increasing attention, with various documents highlighting good practice[67][68].

Assisting the drive for integrated services is the local devolution deal which has prioritised the task of '…bringing together local health and social care resources to improve outcomes for residents'[69]. This could provide the impetus to tackle some of the missing links between components in this system of provision for older people.

Questions for policy and practice:

- How are different professionals assessing the suitability of individuals' housing, and how does this link into the emerging housing options service?
- How can various perceptional and operational barriers be bridged, to ensure those from minority groups can access appropriate housing, care and support?
- Can the potential for increased multi-skilling be explored? Is there merit in models which allow individuals from different professions to lead casework with older people?
- Is the current supply of respite/step-down accommodation sufficient? How can good practices and relationships between housing providers and health professionals be built upon?

Use of resources

Meeting the challenges above will require, at the very least, better use of existing resources. Interviews with housing officers highlighted a lack of additional resources in the commissioning processes, noting *'…the way commissioning groups have been set up, we haven't got any extra money to spend on anything'*. Improving outcomes for older people may demand changes to processes, for instance, by looking at the needs of individuals in the round and making more informed decisions about what will help them maintain independence. As one health commissioner noted in our interviews:

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[66] OPAS

[67] NICE (2017). Moving between hospital and home, including care homes. https://www.nice.org.uk/about/nice-communities/social-care/quick-guides/moving-between-hospital-and-home-including-care-homes

[68] HousingLIN (2017). Home from hospital: How housing services are relieving pressure on the NHS https://www.housinglin.org.uk/_assets/Resources/Housing/Support_materials/Home_from_hospital_-_executive_summary.pdf

[69] Cambridgeshire and Peterborough Combined Authority (2016). Devolution Deal

'…what we want to get to is a process whereby we're considering everything rather than just consider assistive technology cos you've been referred for assistive technology, you just get equipment cos you've been referred for equipment. It's how do we get to the optimum options?' (Stakeholder)

Finding the optimum option for an individual demands a knowledge of the range of housing, health and care provision that is available. This demands multi-skilling, and sector specific professionals learning about interventions beyond their sphere of expertise.

Supporting people living with dementia is clearly a pressing concern. As 70-80 per cent of people living with dementia continue to live in their existing home, interviewees saw solutions beyond health and care services, reflecting on the suitability of the current housing stock. As one interviewee from housing strategy noted:

'But dementia is a gap, I think unless we get to grips with this fairly soon and we try and get some, even if they're just standard homes that we adapt and people can live in at an older age I think we're going to be in real trouble'. (Stakeholder)

This raises questions about whether any mainstream or general needs housing is being designed for people living with dementia, and if so, in sufficient numbers. There is an increasing range of design advice and learning to be drawn upon in this regard[70].

Several resident focus groups touched on this issue. Some residents were very knowledgeable about the challenges of living with dementia, particularly those who had supported their relatives. One resident relayed their experiences in helping their mother:

'I live in a semi-detached three bedroomed house, my son still lives at home. I'm here cos my mother has dementia, she lives 10 minutes' walk from me, she lives in a two bedroomed house. When she was first diagnosed a couple of years ago I had looked into care homes. I'm not happy about putting her anywhere, I know people who've had their parents in various care homes and have had unhappy experiences and I just look after my mum myself with the help of a paid care agency, who I trust very well, I've just had a week's holiday for the first time in two years and I was happy to go away knowing that this care agency was going to look after her. If I put her in a care home I would have had no contact with her, these people I feel I know, they are friendly towards my mother and we know each other well. My house is not big enough to have her with me, we have a fairly good system as it is, she's still able to go out to day centres so she has a fairly good life but she just doesn't remember anything, she does need care'. (Resident)

Such testimony is, if only anecdotally, a sign that domiciliary care can be an important intervention for those living with dementia.

[70] For instance https://www.bre.co.uk/dementia and http://www.hlpdesign.com/images/case_studies/Vol1.pdf

Linked to concerns about increasing levels of dementia are worries about future pressure on residential care, and the attendant impact on budgets. It is significant that the County Council is keen to intervene in the residential care market. Interviewees noted how the organisation could use its land assets acting as:

> *'…the commissioner, the facilitators who would make it happen…you get into all sorts of discussions about do we sell land, do we rent the land, do we lease the land etc. So there's lots of commercial discussions going on around how we make use of those assets'. (Stakeholder)*

Such willingness to use existing assets and intervene in the care market presents an opportunity to innovate around this provision. This might involve developing more residential care in combination with less intensive models to target certain types of need and demand. This could build on seemingly good work within local extra care schemes, which have provided short term care for people discharged from hospital before they moved back home. Alternatively, land assets could be leveraged to bring forward developments which innovate around accommodation for those living with dementia.

Questions for policy and practice:

- Are current funding and grant making processes making best use of resources? How can assessments of an individual's needs be developed to consider the full range of housing, health, support and care options?
- If local authorities are to use land assets to address older people's needs, what needs should this target? Can these assets be used to steer the market towards developing lower cost residential care, or dementia-friendly design?
- How many units have (or are) being built specifically for those living with dementia? How might the required supply of such accommodation be estimated?

Staffing and workforce issues

Further challenges lie in the human resources required to provide appropriate health and care services. This is a particularly pertinent issue in specialist housing schemes where, as noted in the section above, staff are dealing with more acute needs. As one scheme manager noted:

> *'…training the staff is also an important factor in that, cos they're dealing with things now that they just wouldn't have dealt with ten years ago, end of life care, a lot more around dementia, they've maybe had a two hour dementia awareness course but now they're coming face to face with a lot more people with dementia, more complex and challenging behaviour'. (Stakeholder)*

One might ask whether the business model to finance support in such schemes will continue to be fit for purpose.

To make the best use of physical assets such as accommodation, recruitment and workforce issues will need to be addressed. Interviewees highlighted particular challenges in rural locations, notably in terms of recruiting well skilled domiciliary care staff. Health commissioners noted a growing concern that:

'…actually having people with the right skills to enable people to remain in their own home is particularly difficult. Part of that's linked with the amount that's paid for care versus the skill level that you need to keep somebody safe in the community'. (Stakeholder)

If it is a strategic objective to enable people to remain in their home for as long as they desire, and/or to defer their entry into residential care where possible, then having the right workforce to deliver care in people's homes will be critical.

Questions for policy and practice:

- Does Greater Cambridge have the workforce to deliver the care needed, across a variety of settings, now and in the future? Are particular schemes at risk of skills shortages?
- How might existing staff in specialist housing be upskilled to meet changing demands?
- What plans are in place to ensure care in rural locations is sustainable, particularly domiciliary care, given the significance of these services to the core objective of maintaining independence?

5.7. Summary and implications

This chapter has presented a range of insights about current efforts to address older people's housing, care and support needs. Building on the framework set out in Chapter 2, it reveals a series of lessons and opportunities to improve the various interventions being made. A number of these are highlighted below:

- **Advice and information**. The provision of advice and information, to help people make informed choices about their housing, is a critical part of a well-designed system to meet older people's needs. The current HOOP project provides a means to improve the advice and information people receive, and to track the effects of this on other parts of the system. Improvements could also focus on the upskilling and educating of a range of professionals working with the public on housing related issues. This would ensure older people are receiving better advice, but could also generate casework for any future housing options service. Beyond systems for providing detailed advice there is arguably a need for wider dissemination of information, or 'campaigns' to shift perceptions about specialist housing.

- **Housing assistance and support**. Repairs, adaptations and maintenance services, alongside cross-tenure visiting support, help ensure people's current housing is suitable for their needs. There is evidence these services are helping mitigate or defer the requirement for more intensive care. The extent to which home modifications are a cost effective way of helping people remain in their home is unclear. This demands closer evaluation, with the potential to target interventions more precisely. The assessments for home modifications present an opportunity to inform people of their housing options, and to support moves if required. Assistive technologies can, in some cases, replace large scale and expensive home modifications. The processes for

managing this work are under review, targeting delays in the system. Stakeholders and residents highlighted the scope for more ad hoc support around key events and appointments, which may be critical to people remaining in their existing home.

- **New mainstream and general needs housing.** Ensuring new housing is built to standards which will enable older people to remain healthy and independent in their homes, is a key local objective. Delivering this objective is difficult however, even on sites like Northstowe where health objectives are prominent. Opportunities are emerging for local authorities to use a range of existing assets, new funding streams and planning powers to leverage more future-proofed general needs housing. This may involve acting directly to build and commission housing, but also in 'steering the market'. Retirement housebuilders interviewed in this study argue that, as they compete with retail developers in land markets, the requirement to provide affordable housing contributions puts them at a disadvantage. There is evidence of demand for age-exclusive or age-appropriate housing, and various private providers highlight this potential, with evidence that some are able to build bungalow accommodation in certain areas within the county. Rural areas in Greater Cambridge present a specific challenge. Rural exception sites and community-led housing could target the development of older people's housing in such locations.

- **Specialist housing.** Sheltered housing addresses a varied set of demands, although it can be perceived negatively and as an outdated model. The boundaries between general needs, age-exclusive and specialist housing are blurred, and residents expressed an appetite for a range of different forms of housing and support in this 'space'. Commissioners recognise the opportunity to put in '*some serious investment now and encourage the private sector too to start building different types of housing*'. The challenge ahead is to properly define the underlying demands of residents and shape future provision accordingly. Residents' knowledge of different forms of specialist housing was limited, with a prominent view that they will not move until a crisis point is reached. BAME residents perceive particular barriers in making moves into specialist housing and residential care, notably relating to language, food and observance of customs. One factor affecting residents' desire to move was their attachment to place, as they expressed a desire for specific forms of provision within their existing community. Stakeholders recognise the challenge this poses, particularly in locating extra care schemes. Using information about the distances residents had moved to live in several extra care schemes, and the outputs of our modelling work, we have developed a formula to appraise demand for potential extra care schemes on a given site (see Chapter 4). Extra care schemes are supporting people with ever intensifying needs, requiring careful consideration about the role this form of specialist housing plays in relation to other care accommodation.

- **Integrated housing, health and social care**. The integration of housing, health and social care has become a key responsibility, and other local drivers such as the devolution deal are creating opportunities to deepen

integration. This could support a transformation in terms of how multi-agency teams work with older people, connecting up with various other interventions such as housing options services and assessments for home modifications. Hospital discharges were a key issue highlighted in our interviews, with opportunities for local bodies to increase the scale of step-down accommodation and improve the processes involved, building on existing good practice where possible. Developing an integrated approach to housing, health and care for those living with dementia was cited as a priority by both residents and stakeholders. Using existing council assets to commission or develop tailored accommodation for people living with dementia was suggested.

This qualitative data reveals the significant interdependencies between interventions being made locally. The final chapter of this report sets these out in a more structured form, and in reference to the demand and supply estimates produced by our model.

Conclusion

6

6.1. Introduction

This research has explored how the housing, care and support needs of older people in Greater Cambridge can be met, now and in the future. On the basis of a new model, we have estimated the future demand for, and required supply of, specialist housing, age-exclusive housing and care beds. We have also highlighted key issues in terms of how the general needs stock accommodates older people. Rather than presenting the supply estimates as a static figure to aim for, we urge that the modelling is used as the basis for more informed policy making. Our qualitative work presents intricate relationships between different interventions, showing how demand for specialist housing will depend on interventions in four other areas of provision for older people; information and advice which promotes informed choices and planned moves; housing support and assistance to ensure that older people are living in safe, appropriate housing which promotes health and well-being; new housing which is built to maximise accessibility and future adaptability; and integrated housing, health and social care services.

This chapter summarises the key findings from the research, before concluding with a recommendation about how to align interventions and resources in a more strategic way.

6.2. Key findings

Through this research a new model has been developed to estimate supply and demand for various forms of older people's housing. This model is purposefully grounded in the realities of those local authorities where supply and demand seem most closely aligned. Using statistical modelling, predictors of the variation between these local authorities were identified. From this the scale of provision in those authorities has been calculated, adjusted to local data. This provides the means to estimate how many units of age-exclusive housing, specialist housing and care beds are required across Greater Cambridge.

The CRESR model identifies a requirement for 3,422 units of specialist housing in Greater Cambridge in 2016, against an actual supply of 3,280 units. Comparisons with other models such as SHOP@ reveals certain similarities, with the latter identifying a supply requirement of 3,554 units. Our model also identifies significant shortfalls in the supply of age-exclusive housing and residential and nursing care.

There are differences between our modelling and SHOP@ in term of the forms of supply required. SHOP@ suggests enhanced sheltered and extra care units should make up approximately one in five specialist units. Our model however suggests only one in 10 of the recommended supply of specialist units in Greater Cambridge are either enhanced sheltered or extra care. Our model suggests that extra care housing is approximately supplied at the right level at present. However, if it is decided that extra care should meet a greater proportion of needs (e.g. a proportion that would otherwise be met in residential care), then this could significantly change how many units of extra care are required.

Our model suggests that sheltered housing is currently under-supplied, or perhaps more precisely, under-supplied to meet the demand which this represents. Of course, this is not to suggest that 'more of the same' sheltered housing is required in Greater Cambridge. Rather, it suggests there is a gap in provision which is a step below extra care in terms of the care and support offered. This 'space' may be filled by a range of products that provide a more modern alternative to traditional sheltered housing. When taken with the outputs of our modelling, which suggests clear shortfalls in the provision of age-exclusive housing, there is an opportunity to configure future supply to meet needs in this combined space.

The CRESR model recommends that by 2035, the supply of specialist housing will need to be 80 per cent higher than present, at 6,163. This equates to an annualised rate of development of approximately 140 new units through that period, before any additional units are required to account for reductions to the stock. Similar percentage increases are recommended for age-exclusive housing and care beds. Such recommendations bear similarities with SHOP@ which suggests, for example, that aggregate supply of specialist housing in Cambridge and SCDC is 6,632 by 2035.

Existing models such as SHOP@ recommend high proportions of future housing for older people are provided in the form of ownership rather than rent. However, our models show rental forms of supply to be predominant. Hence, whilst our model recommends a large percentage increase in ownership forms of specialist and age-exclusive housing, nearly 3,000 additional rental units will be required in the form of age-exclusive and sheltered housing. This reasserts the importance of planning any new provision in this space to ensure it meets modern needs and demands.

Rather than accepting these projected supply figures as static, we argue that policy-makers should see them as the basis for more informed policy making. This requires understanding how the demand and supply of housing for older people is affected by various other interventions outside the housing realm. Over time, and as the model is re-run, new patterns and trends will emerge to which policy-makers will need to respond.

Our qualitative research has revealed a wide range of lessons relating to local policies and practices. Drawing on the testimony of residents, as well as those within public bodies, voluntary sector organisations, master developers, housing associations and large retirement housebuilders, we set out a number of opportunities to maximise action in the five areas of provision. These are detailed

throughout Chapter 5, and summarised in section 5.7. Key opportunities have been identified in relation to:

- Providing an improved advice and information service to help older people make informed choices. This would build on the evolving HOOP project, ensuring this is adequately resourced and its impact understood.
- Establishing, in a robust way, the impact of home modifications and adaptations in mitigating demand on other services. This is in addition to streamlining the way such work is allocated and managed. Assistive technologies could, in some cases, replace large scale and expensive home modifications.
- Using local authority assets to build and/or commission housing to meet gaps in provision for older people, capitalising on the interest among developers to build age-exclusive or age-tailored housing.
- Creating opportunities for providers to develop housing which is a step below extra care in terms of care and support, removing barriers to greater engagement by private providers where possible. Future extra care provision can be targeted using new tools developed in this research for appraising potential sites (set out in Chapter 4).
- Using emerging policy agendas and associated funding to integrate housing, health and care, potentially targeting pinch points such as delayed hospital discharges or accommodation for those living with dementia. Stakeholders identified opportunities to develop better multi-agency approaches to working with older people.

6.3. Assessing the effects of different interventions on supply

The recommended supply of older people's housing by 2035, as suggested by our model, may be higher or lower depending on the other interventions which will be made. A key decision emerges as to whether to reduce the demands on specialist housing through other interventions, or to let such housing absorb more demand, for instance, from those inappropriately housed in general needs stock.

It is possible to hypothesise how different interventions might interact and trade-off one another. For instance, if specialist housing could be made suitable to those who would otherwise enter residential care homes, then just 140 such units of specialist housing could reduce demand on residential care by five per cent[71]. A small increase in demand for specialist housing from an estimated 39,000 older people in general needs accommodation could have a major effect. If an additional one per cent of this population demanded specialist housing this would create new demand from 390 more people. If these people formed individual households, that would create a requirement for 11 per cent more specialist housing than our model recommends. Project forward to 2036 and any fluctuations in demand from older people in general needs housing could significantly affect the amount of specialist housing required.

[71] These calculations are based on the figures in the Cambridgeshire Older People's Accommodation Strategy

It is important therefore to estimate how other interventions might influence such fluctuations. For instance, what would be the effect of a more robust system of advice and information, such as a comprehensive housing options service for older people? If this delivered similar outcomes to schemes in North Manchester[72], then this could create demand for over 50 specialist or age-designated units per annum, or a cumulative total of 900 units by 2035. Clearly there are differences between Greater Cambridge and North Manchester in terms of the populations and supply of older people's housing. However, if similar patterns of demand did emerge in Greater Cambridge this would require 15 per cent more units than our model predicts for 2035, though likely less than this given natural churn in the stock. Clearly some of these moves into specialist housing could have materialised anyway, so understanding the net effects of any such service would be key. Despite the demands created by such services on specialist housing, this might divert demand from other interventions, for instance, by delaying the need for residential care, ensuring lower care packages and avoiding falls and hospital admissions. This could bring some substantial cost savings[73].

Informed hypotheses could also be generated about the impact of effective housing assistance and support. If home adaptations, as has been suggested[74], can delay entry into residential care by four years, then the impact of this on the flow of residents into such specialist housing and residential settings may be significant. Add to this the potential to build new homes to the Part M4 specifications, and this may diminish demand for specialist housing, with potential secondary impacts on domiciliary care.

All of the above highlights the need to; 1) improve local evidence about the interactions between different interventions for older people, and 2) develop the means to calculate how each intervention reduces or increases demands on other areas of provision. Building these calculations is beyond the scope of this study, however this research does provide a basis on which a more systematic approach to older people's housing, care and support needs can be developed.

[72] Northwards Housing (2016) *Housing Options for Older People service. (HOOP): An Evaluation of First Stop Manchester*
[73] Ibid
[74] See https://www.hsj.co.uk/finance-and-efficiency/tracking-the-care-journey-holds-the-key-to-a-better-life/7013587.article

Appendix 1: Ward level modelling

A1

	Recommended supply 2016			
	Specialist	Sheltered	Enhanced sheltered	Extra care
Cambridge City wards				
Abbey	92	82	2	8
Arbury	121	108	3	10
Castle	64	58	2	5
Cherry Hinton	119	106	3	10
Coleridge	107	95	3	9
East Chesterton	120	107	3	10
King's Hedges	111	99	3	9
Market	45	40	1	4
Newnham	65	58	2	5
Petersfield	53	47	1	5
Queen Edith's	131	117	4	10
Romsey	74	66	2	7
Trumpington	107	96	3	9
West Chesterton	102	91	3	8
South Cambridgeshire wards				
Balsham	70	62	2	6
Bar Hill	59	52	2	4
Barton	54	48	1	5
Bassingbourn	49	44	2	3
Bourn	63	57	2	5
Caldecote	27	24	1	2
Comberton	37	33	1	3
Cottenham	129	115	3	10
Duxford	35	31	1	3
Fowlmere and Foxton	35	32	1	3
Fulbourn	92	82	2	7
Gamlingay	78	70	2	6
Girton	87	78	2	7
Hardwick	22	19	1	2
Harston and Hauxton	35	31	1	3
Haslingfield and The Eversdens	46	41	1	4
Histon and Impington	155	139	4	12
Linton	86	77	2	7
Longstanton	28	25	1	2
Melbourn	85	76	2	7
Meldreth	40	35	1	3
Milton	51	46	1	4
Orwell and Barrington	40	36	1	3

Papworth and Elsworth	56	50	1	5
Sawston	123	109	3	10
Swavesey	28	25	1	2
Teversham	21	19	1	2
The Abingtons	33	30	1	2
The Mordens	30	27	1	2
The Shelfords and Stapleford	155	138	4	12
The Wilbrahams	37	33	1	3
Waterbeach	82	73	2	7
Whittlesford	34	31	1	3
Willingham and Over	84	75	2	7

Appendix 2: Detailed methodology statement

A2

Below we provide a more detailed description of the work undertaken in the four strands of the methodology:

a. Reviewing research, policies, strategies and local data

A review of existing research evidence and good practice was conducted to ensure that the research approach was rooted in a comprehensive appreciation of existing knowledge and understanding about housing options of older people. This involved:

- Revisiting previous literature reviews, undertaken by CRESR on behalf of SCDC, identifying new academic and grey literature.
- Using various sources, such as Housing LIN, to identify emerging research of relevance to the issues of older people's housing, care and support.
- Drawing on research into different models for assessing the supply and demand of housing for older people.
- Assessing emerging policy proposals and consultations which may affect the future funding for, and delivery of, older people's housing care and support.

Supplementing the above was a more specific and dedicated review of local policies and strategies. This entailed reviews of the Older People's Accommodation Strategy, Extra Care Strategies, along with a targeted review of, for instance, local planning documents, housing strategies, and JSNAs. At this stage we also reviewed and analysed various secondary data, including local Choice Based Lettings data.

b. Modelling supply and demand for specialist housing

In developing the model of future demand and supply for older people's housing we reviewed documentation relating to other models, notably SHOP@ and that developed by Three Dragons. The dominant approach adopted by Local Authorities has been to use the SHOP@ model – a free to use online tool developed by HousingLin. However, it is reported that only seven local authority areas in England have reached the prevalence rate employed in the model and only 12.5 per cent are within 50 per cent of the target. Recognising the potential deficiencies in this model, we sought to develop a new model which is able to provide a more robust estimate of required supply.

The first stage assessed the level and composition of supply of specialist housing, age-exclusive housing and care beds across the 100 English local authorities with the highest overall provision per 1,000 older people (aged 75 years or older). It was assumed that these areas are more likely to have achieved a balance between demand and supply. Based on these 100 authorities a recommended level of provision was identified, and broken down by type; age-exclusive, sheltered, enhanced sheltered, extra care and care beds.

The second stage used statistical modelling to identify factors that are predictors of the variation in provision between the 100 local authorities with the highest overall level of supply. A stepwise selection procedure was used to repeatedly run multiple regression models, adding and removing variables, to identify the combination that best explain the variation. The variables considered were: percentage of people aged 75 years and older who are in owner occupation, percentage of people aged 75 years and older living with dementia, usage of Home and Day care per 1,000 people aged 65 years and older olds, expenditure on home and day care per 1,000 people aged 65 years and older, proportion of people aged 85 years and older, proportion of people aged 75 years and older whose day-to-day activities limited a lot, and whether the area is urban or rural.

This analysis revealed a variety of relationships within local authorities, relating to the prevalence of long-term health conditions and disabilities, between levels of provision of different accommodation types and urban/rural classifications. Quantitative estimates of recommended supply (demand) for specialist housing, age-exclusive housing and care beds were calculated from the analysis of aggregate supply and the statistical models. The model recommends a level of supply at the aggregate rate for the 100 local authorities with the highest level of provision, adjusted for the underlying level of people aged 75 years and older with a long-term health condition or disability that limits their day-to-day activities a lot. In addition the model allows adjustments based on the balance between the provision of different accommodation.

To sense check our model we have replicated a model used by the Three Dragons consultancy in work with the Greater London Authority, drawing on other applications of this as applied by Sheffield University, in addition to the information provided by SHOP@.

c. Understand the local context and systems for policy-making and implementation

This strand of work centred on engaging with key stakeholders to explore current understandings of supply and demand factors relating to older people's housing, care and support, and to explore the adequacy of current policy, practice and partnerships. Key stakeholders from various public bodies were interviewed, including those managing adult social care, strategic housing functions, older people's housing management, planning policy and development control, home improvement agencies, social and private housing developers and land agents, and relevant voluntary and community sector organisations working with older people in Greater Cambridge. In total, 13 stakeholder interviews were conducted. All interviews were digitally recorded, with the participants' consent, and transcribed in full. Data analysis was undertaken in NVivo, through a process of structured coding.

d. Understanding residents' needs, preferences and decision-making processes

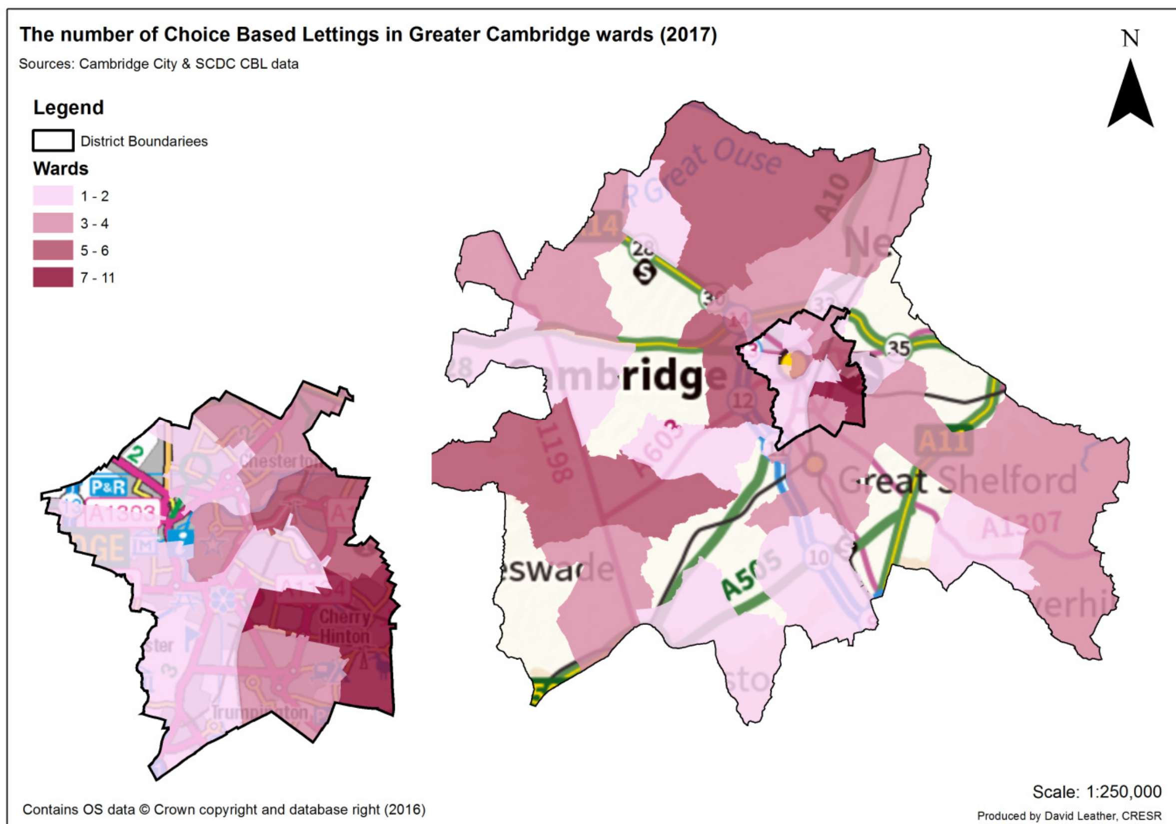
There is a wealth of national evidence detailing what older people want and a high degree of consistency in the findings that have emerged. This includes information regarding attitudes

and preferences in relation to dwelling types, tenure, specialist provision (and associated forms of support and care) and moving in older age. The focus groups sought to explore the perceptions, preferences, behaviours and decision-making of older people around their future housing, care and support.

Sampling sought to ensure that the focus groups included a cross section of older people of different ages, household situations, and living in different parts of Greater Cambridge. In total, five focus groups were conducted, involving over 50 older people. One of those groups was specifically with people aged 45-65, to explore the preferences and options considered by younger residents; the next generation of older people. Another group was conducted with a group of residents from different ethnic backgrounds, to explore the preferences and perceived housing options among non-white British residents. All focus group participants were recruited through existing groups or fora (classes, clubs, groups, associations), or recruited individually, with the focus group being promoted through online sources beforehand. All focus groups were digitally recorded, with participants' consent, and transcribed in full. Data analysis was undertaken in NVivo, through a process of structured coding.

Appendix 3: Choice Based Lettings in Greater Cambridge (June 2016 - August 2017)

A3



Appendix 4: The local authorities with the highest levels of supply

The tables below list the 100 local authorities with the highest levels of age-exclusive housing, specialist housing and care beds per 1,000 people aged 75 years or older.

Age-exclusive housing:

Local Authority (A-F)	Local Authority (G-Roc)	Local Authority (Ros-W)
Allerdale	Gateshead	Rossendale
Ashfield	Greenwich	Rotherham
Barnsley	Guildford	Runnymede
Bassetlaw	Haringey	Rutland
Birmingham	Harrogate	Salford
Blaby	Hastings	Scarborough
Blackburn with Darwen	Herefordshire, County of	Selby
Bolton	Horsham	Sevenoaks
Bradford	Kensington and Chelsea	Shropshire
Breckland	Kingston upon Hull, City of	Solihull
Brent	Kirklees	South Derbyshire
Bristol, City of	Lancaster	South Hams
Bury	Leeds	South Kesteven
Calderdale	Lewisham	South Somerset
Carlisle	Lichfield	South Tyneside
Cheshire East	Malvern Hills	Southampton
Chesterfield	Manchester	Staffordshire Moorlands
Christchurch	Melton	Stockport
Copeland	Mid Devon	Tameside
Corby	Middlesbrough	Taunton Deane
Cornwall	Newcastle upon Tyne	Tendring
Cotswold	North East Lincolnshire	Three Rivers
County Durham	North Kesteven	Torridge
Craven	North Lincolnshire	Waverley
Dacorum	North Warwickshire	West Dorset
Darlington	North West Leicestershire	West Lancashire
Doncaster	Northampton	West Lindsey
Dudley	Northumberland	West Oxfordshire
East Northamptonshire	Norwich	Winchester
East Staffordshire	Nottingham	Wirral
Epsom and Ewell	Oldham	Wolverhampton
Exeter	Redcar and Cleveland	Worcester
Fareham	Rochdale	Wyre
Forest of Dean		

Specialist housing:

Local Authority (A-Hac)	Local Authority (Ham-Ri)	Local Authority (Ru-W)
Amber Valley	Hammersmith and Fulham	Rugby
Basildon	Haringey	Runnymede
Bath and North East Somerset	Hartlepool	Rushmoor
Birmingham	Hertsmere	Ryedale
Blackburn with Darwen	Horsham	Salford
Bolton	Hyndburn	South Cambridgeshire
Bournemouth	Ipswich	South Tyneside
Brighton and Hove	Kensington and Chelsea	Southampton
Bristol, City of	Kingston upon Thames	Southend-on-Sea
Bromsgrove	Lambeth	Stevenage
Broxtowe	Leeds	Sutton
Burnley	Maldon	Swindon
Cambridge	Manchester	Tandridge
Camden	Mansfield	Taunton Deane
Chelmsford	Mendip	Telford and Wrekin
Cheltenham	Middlesbrough	Thurrock
Cherwell	Milton Keynes	Wandsworth
Cotswold	Newark and Sherwood	Warwick
Crawley	Newcastle upon Tyne	Watford
Dacorum	North Dorset	Welwyn Hatfield
Darlington	North Hertfordshire	West Berkshire
Derby	North Tyneside	West Dorset
East Cambridgeshire	Northampton	West Lancashire
East Devon	Norwich	West Somerset
East Hertfordshire	Nottingham	Westminster
Eastbourne	Oxford	Weymouth and Portland
Elmbridge	Pendle	Winchester
Erewash	Peterborough	Wirral
Exeter	Poole	Woking
Gateshead	Portsmouth	Worcester
Gloucester	Preston	Worthing
Gosport	Reading	Wycombe
Greenwich	Ribble Valley	Wyre Forest
Hackney		

Care beds:

Local Authority (A-Ga)	Local Authority (Gl-P)	Local Authority (R-W)
Amber Valley	Gloucester	Reigate and Banstead
Arun	Harrogate	Richmondshire
Ashfield	Hastings	Rossendale
Aylesbury Vale	Hertsmere	Rother
Babergh	Hyndburn	Rugby
Bassetlaw	Ipswich	Scarborough
Blackburn with Darwen	Isle of Wight	Sefton
Blackpool	Kettering	Shropshire
Boston	Kingston upon Hull, City of	South Derbyshire
Bournemouth	Lancaster	Southampton
Bradford	Leicester	Southend-on-Sea
Braintree	Lincoln	Stockton-on-Tees
Breckland	Liverpool	Stoke-on-Trent
Brentwood	Malvern Hills	Sunderland
Bromsgrove	Manchester	Surrey Heath
Burnley	Mansfield	Tameside
Cambridge	Mendip	Tandridge
Cheltenham	Mid Sussex	Taunton Deane
Cherwell	Middlesbrough	Teignbridge
Chesterfield	Newark and Sherwood	Tendring
Chichester	Newcastle upon Tyne	Test Valley
Colchester	North East Lincolnshire	Torbay
County Durham	North Hertfordshire	Warrington
Darlington	North Lincolnshire	Watford
Dartford	North Somerset	Waverley
Derby	North Warwickshire	West Lancashire
Dover	Northampton	West Lindsey
East Hampshire	Norwich	West Oxfordshire
East Northamptonshire	Nottingham	Weymouth and Portland
East Riding of Yorkshire	Oldham	Windsor and Maidenhead
Eastbourne	Oxford	Woking
Elmbridge	Plymouth	Wolverhampton
Fylde	Preston	Worthing
Gateshead		