

Futurecare@home

*A collection of papers for
the Housing Learning &
Improvement Network*

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February 2005

Housing Learning & Improvement Network

A Department of Health resource to enhance learning and support across health, social services and housing.

- Facilitating development work of extra care housing and new technologies, including adaptation of good practice to local settings
- Promoting the development of a whole system and joined-up approach to other housing with care services for older people and for disabled people
- Supporting a local plan, including implementation and follow-up to achieve improvements
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Published by:

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135-155 Waterloo Road
London SE1 8UG

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FOREWORD

Where do you want to live as you grow older?

The answers shift and change as time passes, and we need to look at this as not just an academic exercise, but as part of a process. 2025 may seem a long way off, but with most housing built to last several generations, it makes sense to think about futureproofing in its widest sense.

The landscape of health, housing and social care is rapidly changing but inextricably linked. The projected growth in the older population in the next 20 years will have a major impact on where and how we live, whatever generation we're from.

There are many initiatives under way, across the sectors, which will make the transition easier, as long as we can learn from the mistakes of the past and cater for the choice agenda of the future. Standing on the sidelines with the doom mongers is an easy option; the challenge is to respond to the changing wants and needs of older people now and in the future, through innovation and partnership.

And that process has begun. The growth of extra care schemes, healthy eating, better tailored design and construction, mixed tenure, telecare, the use of technology, increased consultation and user involvement, the development of community services and better joint working between housing, health and social care providers – these are just some of the initiatives which are making a real difference to the way older people are living in our communities.

As we look to the future, we need to acknowledge people are going to want new, and more, choices. As the baby boomers start heading for retirement, their attitudes and desires will be the driving force for the provision of housing and care.

This report pulls together some of the thoughts, ideas and experience of people with a broad range of expertise across the sectors which can be used as a springboard for discussion. Thanks go to all those who have taken the time to contribute stimulating and interesting views.

We hope it's a useful tool in the debate about how, and where, we want to live as we get older.

Jeremy Porteus
Housing Learning and Improvement Network

One Community's Vision

Georgina and John Truscott, Esk Moors Action for the Elderly, Abbeyfield Esk Moors, North Yorkshire.

INTRODUCTION

This paper describes a unique project designed to help older people to remain within their community in a remote area of the North York Moors, as they find increasing difficulty in coping in their own homes.

The project is three pronged – sheltered residential accommodation for up to 18 people in double and single flats, a community care centre to cater for up to sixty clients a week, and outreach help to enable people to continue living in their own homes if they so wish. The driving force for the project over the past seven years has derived almost entirely from within the community. This has been a tremendous source of strength to the project, and is being widely seen as a very attractive model for other similar projects, but it has also presented great difficulties in identifying and securing the resources and support to convert the community vision into reality.

The project has now secured around £2m of the approximately £2.75m needed for completion. Building should start in mid 2005, and a project worker is already in place developing the services to be operated from the centre.

The paper is in three distinct sections:

- A story, as told by a family, illustrating their hopes and fears for the care and comfort of the parents in their old age. This is based upon a series of recorded interviews of older people in one small village.
- Explanation of how a group of local people came to recognise the needs of older people to help to remain within the community as they became more frail and less able to stay in their own homes, and an account of the progress to date.
- A personal view of the problems faced in progressing the project from the “grass roots”, and of the lessons for the future.

THE STORY OF A FAMILY

1999 Tom

“My name is Tom. I am 84 years old, and me and my wife Annie live in our two bedroom terraced cottage in a small village on the moors. It’s been my wife’s home since she was two years old, and mine since we were married in 1951, when I moved in with her and her father. She moved into it with her parents from the village mill in 1921.

I was born in the village but when we were courting I was shepherding in the next valley, and had to walk a fair way back over the moor to see Annie. As a fit young man it wasn’t much trouble to me to build a stone footbridge over a beck on the

way over, so I didn't get my feet so wet! Then I got a horse. Then a bicycle. We've had good times and bad. We haven't been away from home. We don't have holidays – mind you, as children we did have little holidays with our grandparents on the valley side. I didn't go away to war because farming was a reserved occupation. Very few around here did because of that.

Farms don't pay now – the young chaps can't make a living at it any more. I'm getting worried now about the future. I've not been too good these past few months. Annie's not been walking well for years now. If anything was to happen to me, who would help her get her shoes on and get her safely down the stairs? They're steep in our cottage. We get bad winters up here. It's cold without a fire. She wouldn't be able to empty the ashes or bring the coals in for the fire, so how would she keep warm?

Mrs next door gave up running the post office in 1994 – well they let her go on until she was 74, but she'd had enough, and there isn't a post office now. It's a job getting our pensions. We don't drive or have a car – not many our age do around here. I get a lift from a neighbour most weeks to the post office in the next village, two and a bit miles away. That's where the nearest shop is, and the pub.

Annie doesn't get out. What would happen to Annie if I was to die? What if she fell down? She's done that a few times. It's better since we got a telephone installed, a couple of years ago, but Annie can't get the hang of using it.

People have to go to the town, eighteen miles away, to live in a home. She wouldn't like that. She's never spent a night away from home. Friends can't get there to visit. If I get put in the hospital there she won't be able to visit me. There isn't a bus comes near. I wouldn't be able to visit her if she had to go to hospital, either, unless somebody gave me a lift. Our son lives away – there's no work around here for him, so there's not much he can do for us. And we don't want to leave home. As long as we can manage...”

2004 Annie

“My husband Tom died in 2000. The Millennium. I have to get by without him. I get worried.

My next-door neighbour looks after me when she can. She can't be here all the time, but she sees me safe downstairs in the mornings and back up to bed. And lights my fire and brings the coal in. Oh, and she brings me a bit of dinner or supper on the five days we don't get meals on wheels. Of course she's 84, like me, but she's a bit fitter, though she does have trouble with her eyes.

The trouble is she can't help me with a bath, and it costs me six pounds every time I do, because it's miles from the town for the carer people to come. I don't ask for help more than I have to. But things are getting difficult. If it weren't for my neighbour I would be even more lonely now Tom's gone, and I wouldn't feel safe, falling and so on.

People round here depend on their neighbours. My son can't get here often because he's working. I'm getting a bit much for my neighbour. I don't want to leave my home, go away from the people and place I know, and live in a town. I don't know how long I can manage at home. What will I do?”

2004 Their son

"I've seen so many older folk from the villages on the moors have to be moved to Whitby when they can't cope on their own – they don't last there. It's so different, and they've never had any experience of living away from the moors and valleys and the people they know. People don't visit, it's too far and the roads are bad, so they lose touch. They don't adapt. They just fade away pretty quickly, they're so miserable.

I don't want my mother to go through that. She wouldn't manage here in my flat in the city. I shall have to give up my job and go to live with her to look after her. There's not much work to be had there, though, and even if I could find a job there's no day care centre for her to go to, or anything like that. Mobile phones don't work in some parts. My mother isn't managing in her cottage. I'll have to think what to do..."

The names have been changed, but these are real people. The experiences described are exactly those of many families in this moorland area of 'Rural Isolation'.

Now A neighbour (an incomer)

"Ever since we came here fourteen years ago we've felt welcomed – though incomers are everyone whose grandparents are not natives of the area! We were welcomed as 'new blood' in a quiet rural community where jobs were disappearing and young people were leaving with them. Now, as incomers have re-invigorated society and re-established facilities, sons and daughters with their young families have been returning.

Incomers are still relatively few here but soon the balance will tip and a way of life little changed for generations will have vanished. As demand increases from outside the area for holiday and retirement cottages on the moors, property values are escalating.

Local people are kind, proud, private and straight speaking. I was gladly included in village life, helping to organise the church fete and the Mell Supper. I joined the wives and mothers at the Mothers' Union and the Yorkshire Countrywomen's Association in the next village, and was blessed by warm friendship from the older women.

In the year 2000 I was honoured to be allowed to record several life stories, including one from which the above stories are taken. Each life story took hours to assimilate on audiotape and even longer to set down. I gave these back to the families so that they would have a record of a way of life that is gone. The stories gave me some understanding and a great respect for my friends. My older neighbours have helped me through hard times, and I have sorrowed for them in theirs.

Then my husband and I heard of a group of people –volunteers who, in their own kitchens, cooked the 'Meals on Wheels' and then distributed them through the villages and farms at this upper end of the Esk Valley to the older people. They,

too, were distressed when their 'customers' disappeared to be taken care of in Whitby, knowing very often that they would never return.

They also were concerned when elderly friends had to be taken by ambulance uncomfortable miles over twisty, narrow, steep roads for physio treatment, occupational therapy, chiropody, anything to do with outpatient care (though we do have two excellent GP practices in the 60 square miles of this end of the valley). Day care is too far away, so some of the 'Meals on Wheels' volunteers and other people from the valley set up weekly social clubs for the old people in a few village halls.

It isn't enough. Friends are being lost. Friends who have been the pattern, the very being of tradition and culture in this remote moor land landscape. So the community is doing something about it! Something HAS to be done. So a voluntary committee was formed which has been named 'Esk Moors Action for the Elderly'. We wanted to help, joined them, and... here we are!"

The Story of the Project

Early Thinking and Research

The story of Tom and Annie is an example of the situation which in 1997 prompted concerned local people in the Upper Esk Valley to form "Esk Moors Action for the Elderly" (EMAE). The group included lifelong residents of the valley with a deep understanding of the community, working alongside other long-term residents who brought a range of skills from their professional careers. They met simply to think about the problems they saw of older people becoming unable to remain in the community. Their first task was to carry out a household survey asking older people whether they thought a care home was needed in the area. There was a 55% response, and 90% of the respondents thought there was such a need, although the precise need was ill defined. At this point, the project had its first injection of expertise from the outside world, in the form of the local Help the Aged, who recognised the need to undertake more rigorous research of the needs of the population. Help the Aged also helped to find the funding for this work, as EMAE at this point had little money, and was just beginning to organise social events, both to raise some funds and to attract further interest in the valley.

This action research project, funded by Help the Aged, NYCC and Yorkshire Forward, collected information about the circumstances, needs, hopes and aspirations of older people in the valley. Of all those aged over sixty, 77% were interviewed individually in their homes and a key element of this work was to advise individuals on benefits and services available to them. This work resulted in the document: "Sixty Years Plus in Moor land Yorkshire – Report of the Survey of Older People in the Upper Esk Valley." Most of the older people interviewed said that they would like, with help, to remain in their homes for as long as possible, but that if they had to leave their homes they would like to stay in their local area.

This research took a year to complete, and was undertaken on behalf of EMAE by Whitby Disablement Action Group. In commissioning this work, EMAE realised that it did not have the resources available to administer and payroll such a project, and that there were very distinct advantages in placing the contract with an organisation rather than with individuals – this thinking was also reflected in subsequent decisions, such as the employment of a Development Agent.

The publication of the report, in mid 2000, was marked by the holding of a half-day workshop in Danby village hall, to which all the potential partners in the emerging project were invited. These included the Scarborough Borough Council Housing Department, North Yorkshire Social Services, the National Park Authority and the local Primary Care Trust as well as local GPs and councillors. Most of these bodies had already been involved in informal discussions, but this was a key event in the formation of the partnerships which were to become so crucial to the progress of the project.

Professional Support

In the course of the Action Research programme it became clear that the project was now taking a more permanent shape, and had transformed itself from a wish to a commitment. The EMAE committee realised that they needed to enlist more professional support for the project.

Once it became clear that a significant building construction project was necessary, they approached Bradford and Northern Housing Association (now known as Accent Homes) who agreed to become managing agents for the construction aspects. Bradford and Northern HA undertook these responsibilities on an “at risk” basis, and continued to do so for an extended period, for which EMAE is extremely grateful. It was also recognised that the undertaking to operate a residential house as an independent voluntary committee was not feasible in the long term, and EMAE applied to form the Abbeyfield Esk Moors Society, as an independent charity affiliated to The Abbeyfield Society. The national Abbeyfield Society then gave strong support to the development proposals, and together, Bradford and Northern HA, Abbeyfield and the local committee began to prepare a bid for a Social Housing Grant to the Housing Corporation.

The Care Plan

One major outcome from the Danby Workshop in July 2000 was the suggestion of the Social Services Community Care Manager for North Yorkshire that a care Plan should be prepared to set out in some detail the needs of the older population and how they could be met. One member of the EMAE committee had professional experience with community projects, and undertook to prepare such a plan, which was published in early 2002 under the title “A Care Plan for Older People in the Upper Esk Valley.” This document identified 42 key issues, many of which need to be resolved through partnership agencies, to provide an integrated care service.

As a result of the Care Plan study, the project now incorporated a Community Care Centre in addition to the twelve flats already envisaged in the residential house. This Centre was both to provide day care facilities and to offer a range of outreach services to help people remain in their own homes as long as possible. This development was encouraged by Abbeyfield as fitting their recent thinking on offering “integrated care.”

Two significant moves were seen as crucial to starting the whole programme – Housing Corporation approval for the Abbeyfield residential housing project, and funding for a Project Officer to lead the Care Plan partnership. The application process for the former was already in hand. An application to the North Yorkshire Single Regeneration Budget for three years’ funding for the Project Officer was successful, and the post was filled in late 2003.

Finding a Site – Planning Approval

In the early stages of the project, EMAE became aware that the 5-Year Plan for The North York Moors National Park Authority was at the public consultation stage, that it contained no provision for sheltered housing, and appeared to accept that older people in need of such accommodation would have to leave the area. Successful representations were made to include a provision in the long-term plans – a vital preparatory step to a subsequent planning application to the National Parks Planning Authority.

The search for a suitable site took some considerable time. EMAE invited offers of potential sites to be purchased from local landowners, and a number of suggestions were received from which a short-list was drawn up based on assessment against an agreed set of criteria, such as access, proximity to services, aspect, etc. The planning authority was also asked to comment informally on each site, as the planning application for such a large new building in the National Park would inevitably be a significant event. The site eventually selected, following a geological survey, was one of the very rare “brown field” sites in the area, near the railway at Castleton, the largest village in the upper end of the valley. As a result of the Care Plan study, the building was now to include day care facilities in addition to the twelve residential flats. The development agent at Bradford and Northern HA engaged an architect, Burns Architects, who have also worked “at risk” for the project, to prepare plans which were discussed with Abbeyfield Esk Moors. Planning approval was granted with the full backing of the planning authority, subject to the expected restrictions such as using local stone.

Bid for Social Housing Grant

The first bid for Social Housing Grant, made to the Housing Corporation in the autumn of 2002, provided the project with its first major setback. It was thought that all the work had been done, all necessary boxes ticked and conditions met in completion of the application. The bid apparently had the requisite level of support

from Scarborough Borough Council. In early 2003 it was learned that not only had the bid not been successful – it had apparently barely warranted serious consideration.

It was agreed that there was no alternative to submitting another bid in October 2003, as without a Social Housing Grant there was no realistic chance of being able to raise the necessary funds for the project, which now stood at about £2.2m.

Preliminary discussions with the Housing Corporation, including a visit to the site by the Investment Manager, proved helpful and encouraging, as well as throwing up some additional problems. The site visit was arranged to demonstrate the rural isolation of the project, as the initial reaction had been that the unit costs of the residential element of the building, which the Housing Corporation could support, were extremely high. The explanation of these unit costs lies in a combination of environmental factors arising from being within the National Park, remoteness of the site from sources of construction labour and materials, and the small number of units required. Nonetheless, the Housing Corporation also required that the floor area of the flats, and hence the cost, should be further increased to provide added flexibility in possible future use of the building. It also became clear in these discussions that the Abbeyfield Esk Moors Society would no longer be able to achieve Registered Social Landlord status under new guidelines, nor could the bid be submitted by proxy, using Bradford and Northern status. This resulted in an inevitable decision by Abbeyfield Esk Moors to apply to join Abbeyfield UK, the newly formed society within The Abbeyfield Society. This move removed the option previously taken by the Esk Moors Society to retain its legal independent entity until the reality of Abbeyfield UK became clearer.

A group of local committee members had been invited to contribute a presentation on the project at a Help the Aged “Village Voice” conference in the late summer of 2003. In the course of that conference a great deal of helpful advice was offered by delegates from the Countryside Agency, Housing Association Charitable Trust, Help the Aged and others, on the need to find advocates and supporters for the next bid to the Housing Corporation. This led to a major effort in lobbying all the relevant local authorities and agencies, at both elected representative and officer levels in support of the bid.

No sooner had this campaign been started than a further major problem presented itself. It became apparent that the Housing Corporation would not accept a bid from the project unless it was guaranteed support from the North Yorkshire Supporting People team. Abbeyfield Esk Moors Society had previously registered as a “pipeline” application, but as there was no operating house in place, that application could not be translated into a fully substantive bid. The Supporting People team was unable to offer any support, and so the whole project was in jeopardy.

It was decided that the only effective response to this impasse was for a delegation to go down to Westminster to meet the local MP who already knew of and supported the project. The MP responded splendidly and within quite a short

time a deal was reached in which North Yorkshire Social Services underwrote any Supporting People funding for the project. In the meantime, all the appropriate letters being prepared in the lobbying campaign had been revised to include the details of the further problems over Supporting People funding. The responses received from these letters were overall very encouraging and supportive, with politely guarded replies coming only from those who could not afford to express more open support. More leisurely retrospective feedback on the lobbying campaign indicates that the inevitable irritation caused in some sectors was probably not unhelpful, and that it was certainly outweighed by the more positive responses. What is quite clear is that the relationships developed over the years with key figures in local government have been extremely helpful.

In early 2004, the Housing Corporation confirmed an allocation of slightly over £1m to the project.

The Cost of Rural Isolation

This issue has bedevilled the project from the time of the earliest estimates of cost. The initial reaction of almost all the “professionals” approached, whether from County or Borough Council Departments, the Housing Corporation, Abbeyfield UK or potential funding bodies, to the unit costs of the flats, was one of either disbelief or horror. The project team had to work very hard and patiently to explain the background and reasons which justified these levels of cost, and this usually could only be achieved if the explanation of the figures could be supplemented by personal exposure to the remote rural landscape in which the project is set. There are at least three reasons for the high unit costs of the flats (approximately £160K) which are directly attributable to the particular rural situation:

- a) the remote situation adds to costs of both construction labour and materials
- b) the environmental factors introduced by situation in the National Park
- c) the sparse population in the catchment area results in the number of flats which can be justified being well below the economic optimum for capital.

These three factors result in a 20% increase in cost.

Although most people will accept the logic of this explanation, there remains a reluctance to fund the extra cost. This reluctance tends to over-ride any Government policy preferences in favour of redressing rural deprivation.

Fundraising

In the early stages of the project, the fundraising efforts of the project team were low key, and aimed as much at raising awareness of the project in the valley. Funds were raised through social events and activities to cover the administrative costs involved, while North Yorkshire Social Services, Yorkshire Forward and Help

the Aged provided funds for the research. When the Abbeyfield Esk Moors Society was formed support was offered from the Abbeyfield fundraising team and a local sub-group began to map out the fundraising opportunities and available contacts.

Alongside these efforts members of the team had, from the early days of EMAE, developed strong relationships with key individuals in Social Services and Housing Departments and in the local Primary Care Trust. These contacts came to recognise the potential of the project to help them deliver services which they found difficult to provide in the rural areas, and they themselves came to champion the project. This proved vital when, on securing the Housing Corporation allocation, the project became viable and serious fundraising started. At this juncture Abbeyfield UK provided the services of a fundraising consultant Consulting to guide the process with a small team from the local committee. The project quickly began to locate potential sources of funding from the public sector through the local authority channels. This process was further boosted by the recent lobbying campaign in support of the Social Housing Grant bid which had sensitised local politicians and council officers to the aims and needs of the project. At the time of writing, all except £300K of the funding secured so far has come from the public sector.

The interest shown in the project from local authorities has generated an unexpected spin-off. The project has appealed to people in local government largely because it is so firmly rooted in the community, and it is seen as a model which could be used elsewhere. The project has been particularly both inspired and supported by senior managers at the North Yorkshire Social Services Directorate. As a result, the fundraising team has been asked to talk about the project at events designed to share good practice following on from this to the present conference. A number of articles have also been written about the project. This has provided the project with a high profile, both locally and nationally, from which the campaign for funding from trusts and the private sector is now in full swing.

Learning and Lessons: A Personal View from the 'Grass Roots'

This project has been generated entirely from within the community – from the “grass roots”. In country areas such as ours there seems to be no blue print for provision of care in their own locality for older people who need it. Low population figures in difficult geographical areas mean that there is no care provision from within that neighbourhood - travel is necessary to access it.

Consequently, the project has aroused considerable interest as an exemplar of a new way of meeting the needs of local communities, and it seems appropriate to end this paper by attempting to draw together the main lessons we have learned, and to suggest how some of the difficulties we have encountered could be eased in future.

- The fact that the project is community-based is crucial. We have nurtured our links with the community on the social level, and this has been reinforced by the research we have commissioned. The research base has, in turn, given the project a very firm grounding and credibility with the outside world.
- We have acknowledged our limitations as a local volunteer group. At times the group loyalty may have tempted us to believe we could do everything ourselves, but we have always been reminded in time that we should avoid entering into commitments, such as directly employing staff, which we could either not be confident of sustaining in the long term, or which would be better undertaken by professionals.
- It is clear, in retrospect, that we have been very effective in fund-raising – a very necessary preliminary to the securing of funds. In talking to both elected representatives and officers from local authorities about the project we have infected some key decision makers with our enthusiasm and commitment, as well with the virtues of the project. In turn they have then helped us to understand the workings of government and to recognise opportunities that we may well have missed. It is this learning which we are now bringing to the task of fund-raising in the private sector – raise funds first.
- In the earlier stages of the project we probably relied too heavily on the local mechanisms and realise the need for more active advocacy of the project, and we can now see that this is particularly necessary for grass roots working. Where projects are driven from within government departments or agencies, their managers are much more aware of the organisational culture in which decisions are taken, and can make the appropriate adjustments to content and emphasis. If grass roots processes are to be encouraged, there is a need to help community groups to recognise, understand and react to the internal mechanisms and culture of government. Perhaps the current move towards the appointment of Rural Housing Enablers is a recognition of this need in the housing sector, which could usefully be built upon to cover social services and health.
- An apparent mismatch between stated government policy and application of the rules has been a source of some irritation. For example, clear policy support for the housing needs of older people in rural isolation was not matched by acceptance of the inevitable extra costs of meeting those needs. This is understandable in terms of pressures and politics within government, but nonetheless very frustrating for those on the outside. Such issues can probably only be addressed by matching performance criteria to non-financial objectives in addition to value-for-money. We trusted that filling in the forms well and ticking all the boxes would bring us the due rewards for an excellent project. This failed on a few occasions, most notably with the Social Housing bid. A number of friends among the professionals within the voluntary sector helped us.

Recognising and acting upon these lessons should improve the processes whereby future community groups can pursue their aims and implement their projects.

These aims must always be based upon the real needs of the community – in our case our vision for our older people, based on their expression of need.

Our vision of the future for an ageing population

There are two underlying principles to our vision for the year 2025:

- that older people experience total support and encouragement to remain fully active within the community, to remain living in their own homes for as long as they wish, and to know that supported accommodation will be available locally if needed.
- that older people have acquired the confidence that the necessary utilities, services and care are both reliably available and affordable. This principle presents particular difficulties in an isolated rural community such as ours.

The establishment of these principles over the next twenty years represents a very considerable challenge, particularly when bearing in mind that it has taken us over seven years to progress to our current position. There are a number of key themes which need to be developed, and among these are:

- **Housing.** We need to develop alternative models to encourage flexibility both in mixed tenure arrangements for supported housing, and in recycling of property within the community. We are examining, for example, the feasibility of retaining houses released by older people moving into supported accommodation as affordable housing, rather than being sold as second or holiday homes.
- **Technology.** While we understand the current thinking directed towards technological monitoring of individuals within their homes, we have concerns that this may lead to rather de-personalised services. We prefer to see technology in an assistive, rather than supervisory role, with more help available from friends within the community. With an ageing population, we see greater availability of fit and active 60s and 70s able to support the 80s and 90s.
- **Finances.** In the present climate very many older people have great fear about their future care and their ability both to pay the bills and retain their dignity. They do not understand the rules and regulations, and in many cases prefer not to enquire. This situation can only sap the confidence which we seek to encourage, and there is a need both for government to develop greater long-term vision and clarity about financing of care, and for the community,

particularly the younger retired, to become more active in helping older people to understand their situation.

- Volunteering. With the increasing span of the “third age” there is scope for more fit and active younger retired people to become more involved in community issues, and to apply their very considerable skills and experience to these tasks. This will have the effect not only of helping to establish the principles we support, but also will prepare those involved to cope better with their own old age. The further development of voluntary work would have huge potential benefits both nationally and within communities, and we believe it would be worth exploring options to encourage such growth, for example, by recognising such work through extra credits in the pension scheme to help volunteers who may themselves be feeling the effects of the demographic squeeze on pensions. We recognise the danger of diluting the voluntary principle but believe that, provided some distance is maintained between effort and reward, then there could be enormous overall benefit.

An Update – January 2005

As I write this in January 2005, here on the moors as in other parts of Britain both urban and rural, there is no electricity. So far for 37 hours.

It happens most years. Many older people have been left cold and alone in the dark. Friends have been taking around aid to different isolated cottages. Sources of warmth and food.

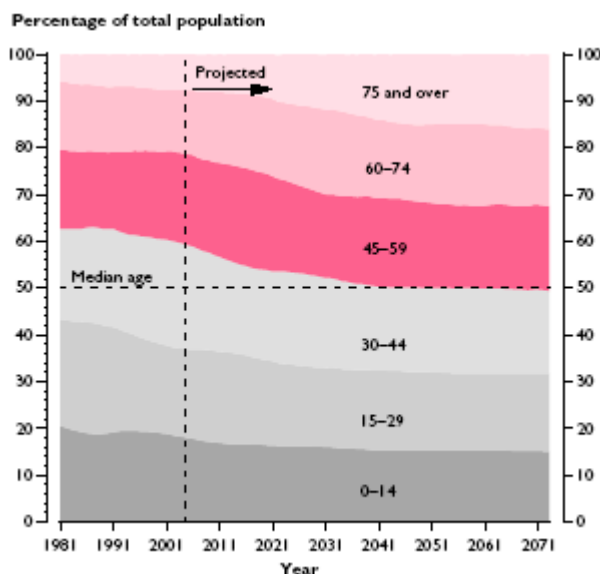
Oh, and since I wrote before, Annie has had another fall...

We are going to make warmth to gather them into – a centre from which they can be cared for...

Are we ageing older, or just for longer?

Dr Ian Donald, Consultant Geriatrician, Gloucester Royal Infirmary

We are all familiar with the startling statistics which tell us we are an ageing society. The percentage of the population over the age of 65 increased rapidly during the late nineteenth and twentieth centuries from less than 1% of the population in 1850 to 10% in 1950, and 16% in 2000. There will be a continuing rise in this proportion during the first half of the twenty-first century, perhaps then levelling out at a peak of a little over 25%. The rise in the population over the age of 80 and 90 has been even more dramatic, with the proportion of the UK population over 85 changing from 0.4% of the population in 1950 to an estimated 5% in 2050. The number of centenarians will probably increase 10 fold over that period.



These extraordinary figures might suggest that health and social care will shortly be swamped by the rise in demand, yet there remains considerable uncertainty about the implications for the future. This is because we lack confidence in predicting the health of the older population. There are trends within different diseases which are moving in opposite directions, and no consensus has yet emerged. In this article I will describe some of these trends in a rather general and descriptive manner, rather than with a sea of figures and statistics. I will then attempt to gaze into the crystal ball to describe the elderly population we might predict in fifty years' time. I will then add a personal view on the consequences of these trends on housing needs in the future.

The fundamental question is whether an eighty-year old today is fitter than an eighty-year old was, say, 20 years ago. Observation and intuition might suggest that this must be the case. Yet the proliferation of clubs and sporting activities for older people may just reflect the larger number of older people from which to draw. One characteristic of ageing is an increase in diversity dependent upon the extent of the ageing process in individuals. While ageing occurs throughout life, it may be

easiest to recognise ageing as the onset of disability and loss of function. There then begins a period of greater vulnerability, adaptation to changing physiology, increased medical care, and dependence on others. This is generally referred to as functional decline. If functional decline begins at a constant age, yet longevity is increasing, there will be a prolonged duration of disability. If functional decline begins at a later age, and longevity is constant, then a shorter period of disability would be experienced. The duration of functional decline is measured as the difference between disability-free life expectancy and total life expectancy.

Unfortunately robust surveys capable of defining the age of onset, and the duration, of functional decline were not in place in the UK during the twentieth century. Cross-sectional surveys, such as the General Household Surveys and the national population Census, are limited in their health data relying on self-reporting and interpretation of the questions asked. Neither one asks detailed health questions. However, they provide some valuable insights and are the source of much of the information presented here.

Obesity

Being overweight does not necessarily equate to poor health or disability but is certainly a severe risk factor for many diseases such as arthritis, diabetes and circulatory diseases. These long-term conditions are far more common in older people, with more dramatic consequences on their health. Obesity is therefore a strong marker and indeed predictor of health service use. Women aged between 65 and 74 have the highest prevalence of obesity (a body mass index above 30) in the UK at around 30%. This was only 22% 10 years ago. It is somewhat lower in the over 75s at present, but almost as high in 55-64 age group – those who will be the over 65s in a few years. This rapid increase in obesity has occurred in spite of health promotion focus on the benefits of exercise and the concerns about cholesterol.

Smoking

Smoking has fallen slowly but steadily through the twentieth century. Older people have much lower smoking rates than younger people, probably because they have experienced smoking-related health events. Smoking in men over 65 years has fallen far more in the last decade than in any other age group – from 23% to 13%. It is likely that these rates will continue to decline during the twenty-first century with toughening policies on smoking in public places. This should have a positive impact on the prevalence of chronic obstructive airways disease, the most common respiratory cause of disability. This is already declining in prevalence.

Exercise

Physical activity has probably fallen dramatically for older people over the last century related to improved affluence and access to transport, although this is difficult to quantify. Recent trends in lifestyle and physical activity are uncertain but some information is available from the Health Survey of England. Participation in exercise declines markedly with age, from 54% of adults aged 40 to 14% of those over 65, and only 4% of women over the age of 75. The Health Survey has shown a slight drop in exercise levels over the last decade. Therefore the growth of

walking and fitness clubs for older people has so far not impacted on the general population.

Circulatory diseases

In spite of the rise in obesity and diabetes, and the stable smoking rates, the incidence of circulatory events such as stroke and heart attack is falling, and has done so for at least 20 years. Mortality rates from circulatory diseases have halved over the last 10 years alone for most age groups. There has been a 40% drop in stroke age-specific incidence in Oxfordshire over the last 20 years. This is hardly noticed in clinical practice because of the large rise in the number of older people, which has resulted in a small rise in the overall number of new strokes each year. In heart disease, the threshold for specialist intervention has been falling, combined with an increasing readiness to intervene on older people. The marked decline in mortality from vascular disease can probably be explained by preventive medical care such as the widespread use of aspirin, antihypertensives and cholesterol-lowering drugs to a high proportion of the general population.

Osteoporosis and Fractured Hip

The twentieth century witnessed an epidemic rise in the incidence of hip fracture, the most dramatic manifestation of osteoporosis. There may have been a ten-fold rise in the age-specific hip fracture rates in very elderly women through the century, and records certainly show a three-fold rise in women over 80 over the last 50 years. The reasons for this dramatic increase have been attributed to weaker bone (osteoporosis), weaker muscle, less exposure to vitamin D, and less active lifestyles. The relative immobility and loss of fitness further increases the risk of injurious falls. However, there is now evidence that the epidemic has levelled off, as many countries have reported no further increase in age-specific fracture rates over the last 10 years. There is some belief that the cause for this levelling is through campaigns and services aimed at reducing falls. It is also possible that this is part of a cohort effect (see below).

Of course, this is of little comfort to orthopaedic services because of the increase in the absolute number of fractures. For instance, in Australia the number of fractures has increased by 40% in the last 10 years, although the age-specific rates have been constant. The continuing rise in the number of over 80s during the coming fifty years will mean potentially a fourfold increase in fractures, unless the age-specific rates start falling. Worldwide there were an estimated one million hip fractures in 1990, and a prediction of around 20 million in 2050.

Dementia

Dementia is potentially the most important disease for an ageing society, partly because of the potential burden of care either at home or within nursing homes and also because of the devastating effect on quality of life for the sufferer and for their close family. Unfortunately, there is very little information about whether dementia incidence is changing. The causation of dementia in general, and Alzheimer's disease in particular, is multifactorial. It is related to some extent to circulatory disease, and so the fall in other circulatory diseases could also lead to

a fall in dementia. However, current evidence has not shown any decline in the age-specific prevalence of dementia.

Dementia may well be age-dependent – that is, every individual may develop dementia if they live long enough. Certainly the prevalence increases from around 6% at the age of 75 to over 40% at 95. Measuring the prevalence of diseases in those over 90 is problematic because of the high mortality rates; individuals may develop the disease and then die from other causes before the disease is recognised. When the mortality rates are adjusted for, it does appear that dementia increases steadily – perhaps to 65 or 70% - by the age of 105. There is some encouraging evidence that healthy lifestyles, including social and mental engagement, may postpone the onset of dementia.

Arthritis

Arthritis is the largest single cause of disability in older people. This is to some degree an age-dependent process as well, becoming increasingly common in extreme old age. Around 80% of people over 75 experience some degree of joint pain. Joint replacement surgery has had a huge impact on improving pain and disability for older people, and is now carried out safely with good results into extreme old age, and with remarkably short stays in hospital. Waiting lists for these procedures has rapidly fallen, and will continue to fall further in the coming years. However, there are limits to the potential coverage of surgery, and it seems likely that osteoarthritis will remain the major cause of disability for older people in the future. Increasing obesity combined with a sedentary lifestyle predicts that age-specific prevalence of disabling arthritis is likely to increase rather than decrease in the coming years.

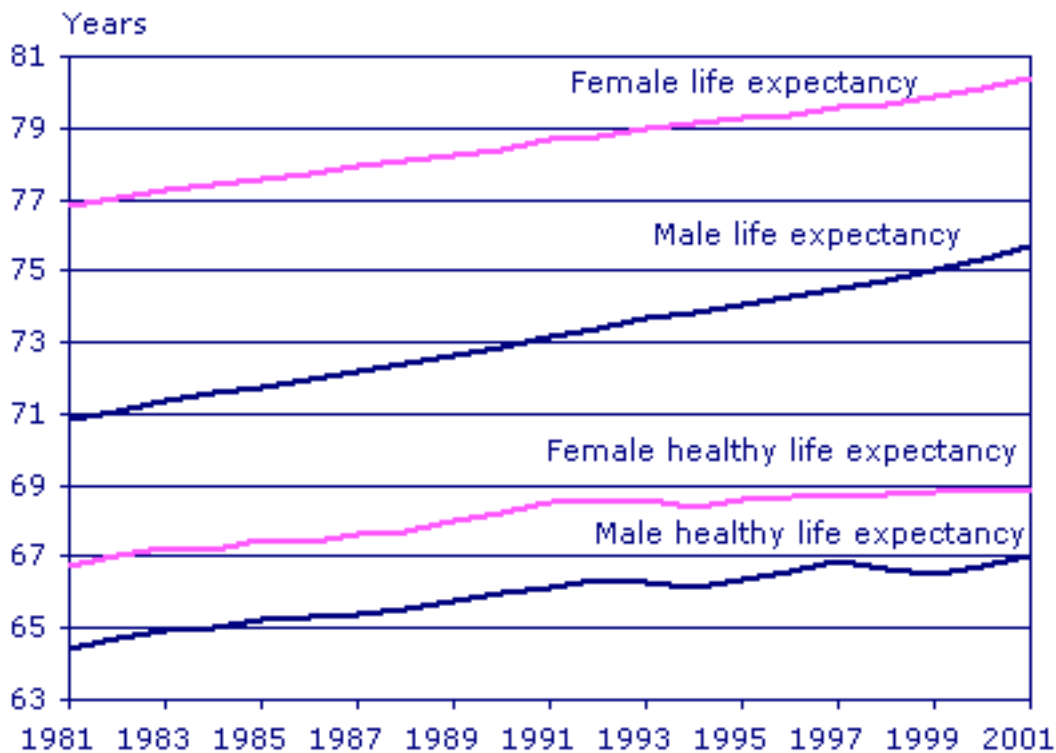
The problem with cohort effects

There are many difficulties with making predictions, and one of these is the cohort effect. This may be very important when making predictions relating to older people. One generation of older people may be quite unlike the succeeding generation because of totally different experiences. Examples from the twentieth century include the effects of world wars, changing diets, including the changes related to rationing, and the availability of public and private transport. It is quite possible that these cohort factors will have played a major part in shaping the health and disease structure of the current elderly population. One consequence is that trends observed over a time period could easily be reversed in a subsequent time period.

Healthy life expectancy

A somewhat artificial definition of healthy life is freedom from any major functional disability, although this in no way is meant to imply that life with one such disability is inevitably of lower quality. There is no international agreement about exactly which disability characterises the start of functional decline and the loss of healthy life – one disability in isolation may be quite unrelated to the ageing process. This concept also tends to ignore the importance of recovery and rehabilitation, where a disability is endured only for a season. Old people can and do recover from their illnesses and disabilities.

In the UK, life expectancy for men at the age of 65 has increased by about three years over the last 20 years, from 13 years to almost 16 years. At the same time, healthy life expectancy at 65 has increased also, but by only two years, now reaching 12 years. For women who have reached 65, life expectancy has increased by about two years, from 17 to 19 years, and healthy life expectancy has increased by only 1.5 years to 13.5 years. This means that on average the last four years of life for men, and the last 5.5 years for women are lived with significant disability. The changes in life expectancy from birth are even more striking and suggest that added years may in part be unhealthy years.



Unfortunately, but perhaps unsurprisingly, social class is also related to changes in life expectancy: Social class V has experienced very little extension of life expectancy in the last 20 years.

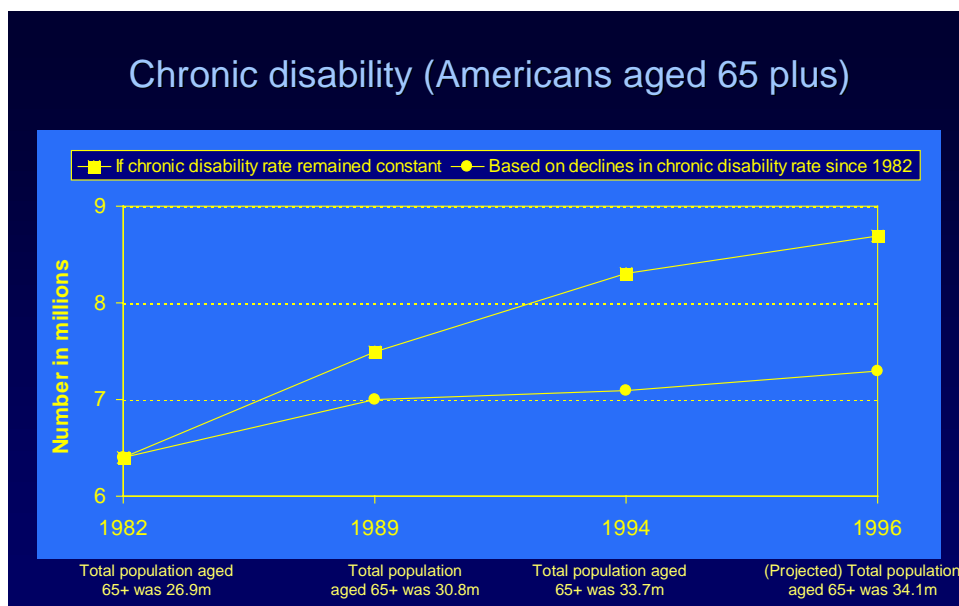
A rather fascinating part of the English Longitudinal Survey of Ageing, a large longitudinal study of ageing which commenced in 2002, was the inclusion of a question about people's expectation for the future. Men and women both underestimate their chance of reaching the age of 75 or 85. Women report their chances only slightly higher than men, and as a result underestimate their longevity chances considerably more than men.

Observations from the US

By contrast to the rather gloomy picture of added unhealthy years in the UK, evidence from the US is far more encouraging. Life expectancy from the age of 65 has increased by only 1.2 years over the last 20 years, reaching 82.7 years. This is now the same life expectancy as in the UK, but the rise in the last 20 years is

less than seen in the UK, and indeed is a smaller rise than in previous decades in the US. The US therefore predicts rather modest further increases in life expectancy. Some will argue that a decline in the rate of increase in life expectancy is inevitable if the maximum age of humans is finite.

Longitudinal studies of disability have been far more numerous in the US over the last 25 years than in any other country. Americans, like the British, have seen falling smoking, rising obesity, and more sedentary lifestyles. However, in spite of this, there is good evidence that a reduction in age-specific disability rates is occurring. The fall is between 1 and 2% each year. The magnitude of this effect is illustrated in the graph, which shows that 1.6 million less elderly Americans were disabled in 1996 than would have been predicted from disability prevalence in 1982. The reasons for this decline are unknown, and are probably multifactorial, but could be related to improved healthcare, for example, joint replacements, reduced smoking, and substantial improvement in education levels in the US elderly over the last 20 years. There is a strong rise in expectation for healthy ageing in America and far stronger public campaigns such as “the grey vote” by comparison with the UK. This may in some way be self-fulfilling in leading to better health.



Studies in the US have also shown the potentially dramatic effect of healthy lifestyles on the age of onset of disability with disability postponed by as much as 10 years, which far exceeds the prolongation of life expectancy. The results are rather more modest from programmes promoting healthy lifestyles, but still there are very measurable benefits. Trials measuring this and exploring the most effective ways of changing behaviour are also underway in the UK.

Social trends

The average income of pensioners has grown 60% in real terms over the last 20 years, and there has been an average annual growth rate of almost 3%. This has outpaced the growth in earnings. The growth has been due both to an increase in occupational pensions, and a rise in state benefits. The young old are more wealthy, mainly because they are far more likely to have an occupational pension which only became commonplace in the 1950s.

There has been a steady rise in owner-occupation of housing for all age groups in the last 50 years. Already 70% of retired people are homeowners, and further increases will be seen in the coming 20 years, but less so in younger age groups. Interestingly, older people living in non-decent homes are much more likely to be living in their own home than in social sector housing as presumably they fail to invest in adequate maintenance and house improvement.

Living alone has shown little change in recent years, but affects around 45% of people over the age of 75. This increases dramatically with age for women, who have a longer life expectancy than men so that three-quarters of women over 90 live alone. It is, however, encouraging that life expectancy is increasing faster for men than women at present, so perhaps in the future there may be reduction in women living alone

What are these statistics telling us?

There is some evidence that modern health care is improving the health and disability of older people, with reduced circulatory diseases and at least a levelling of fracture rates, perhaps through reduced falling. For the individual sufferer from arthritis, joint replacement surgery has a dramatic effect on quality of life, and growth in this surgery is likely. However, the picture with dementia and arthritis as age-dependent processes is more worrying, arguing against the potential for simply postponing the ageing process by a few years without any adverse effect on years in ill health.

The present picture in the UK is that added years of life expectancy are also adding to the years spent in disability. However the opposite is now occurring in the US. It is often said that the UK follows trends established earlier in the US. If this might also be true of health and ageing, then positive changes may be just round the corner.

Regarding lifestyle, early retirement and comparative affluence in the young elderly have probably contributed in recent years to a more sedentary lifestyle combined with good eating. Messages about the importance of regular exercise have been taken seriously by only a few, as the prevailing societal attitude is to "put your feet up in retirement." Improving affluence has traditionally been associated with better nutrition, improved access to health care and hence better health. However, in older people this may depend on whether at the same time people access their new opportunities, and adopt healthy lifestyles.

Image of ageing

Perhaps a fundamental change in attitude is taking place in America and has not yet occurred in the UK – that older people have growing self-respect and positive personal image and greater expectations for health and wealth. This has been supported by the political realisation that older people are an important part of the electorate. In addition, large national state-sponsored campaigns promoting healthy ageing are well established throughout the US, and in Canada and Australia.

For some reason, such campaigns are only just beginning to gather pace in the UK. As the ELSA survey revealed, older people in the UK have not fully grasped their improving life expectancy. Political parties seem more likely to campaign on increasing the value of the state pension than any other issue affecting older people – yet opportunities for social, leisure and intellectual pursuits should perhaps be pre-eminent. Health promotion campaigns seem more likely to stress keeping warm and wrapped up rather than taking exercise and meeting friends. Is this really a positive image of ageing? And then there are those “Over Fifties” clubs – as if ageing began at 50? Television and the media play an important part in shaping our image of ageing; comedy programmes such as “One Foot in the Grave” inevitably dwell on negative stereotypes.

A positive image for both the older person and society at large may be dependent on whether older people enter the workplace in the future. There has been considerable discrimination in the UK against older people at work, but the tide is now changing. There is a much wider appreciation of the value of employing older people, combined with the realisation that people in their sixties can reasonably be expected to remain quite healthy and reliable employees. With wider employment would probably come wider respect from the public and an appreciation of their contribution to society. The largest contribution of older people to the economy is as carers for their spouse, or indeed parents, or as child-minders for their grandchildren. Sadly these roles are generally unpaid and undervalued.

It is also unclear whether older people themselves are ready to grasp a more positive image. A minority have done so, making use of their health and freedom to live varied lives, taking up new employments or exploring the world. Many are self-sacrificing and ready to spend their life caring for a very elderly family member. Most look forward to early retirement, seem fearful of government proposals to raise the retirement age, and have little clear idea of how they intend to spend the remaining 25 years of their life. The future therefore depends in large measure on whether the stereotype of being “ready to retire and put my feet up in front of the telly” soon after 60 is to be jettisoned once and for all. Planning the last third of your life will probably require far more support from the government and business if it is to change wholesale attitudes in society.

What might we expect from healthcare improvements in the future?

This is impossible to judge, other than describing the trends for current diseases. The two conditions most likely to dominate disability and dependence in those aged over 80 for the coming decades are arthritis and dementia. We might

reasonably anticipate a fall in the incidence of stroke and respiratory disease consequent upon the improved management of vascular risk factors and reduced smoking. An increase in the number of people receiving joint replacement surgery is likely, and will be an important cost pressure on delivering health care to older people. However, sedentary lifestyles and obesity will increase the prevalence and severity of arthritis. There are currently no prospects of major breakthrough in the prevention or treatment of dementia, but this must be the most important area to watch.

What implications does this have for housing in the future?

Older people have always valued staying in their own homes in preference to moving into alternative and perhaps more suitable housing. With improved wealth, and a longer retirement, there may be greater impetus to invest in home improvements. Work by King's College London has found that adaptations to homes to support living with disability are easier in ground floor flats and large bungalows; interestingly, sheltered bungalows may be too small for easy adaptation for the disabled. From the economic point of view, the improving life expectancy makes it more cost-effective to carry out expensive adaptations. Using the King's College models, even expensive adaptations, if resulting in a reduction in the amount of domiciliary care, seem to break even after about six years, and most adaptations become cost-neutral after 2.5 years.

The main alternative to this approach is the development of communities for older people incorporating purpose-built accommodation suitable for disabled people. This may include a social centre, integration with the local community, and resident care staff who can meet the needs of residents in a much more flexible manner than traditionally possible by staff visiting disparate homes. To this can be combined a degree of "Telecare" which can further promote independence, enabling a more person-centred approach to calling for assistance when required. The largest experiment of this sort is being conducted in West Lothian, but it is too early at present to measure its impact or identify the residents most likely to avoid admission to a care home through the scheme. It is clear from their early reports that success depends not just on building and staffing the units, but also changing a whole culture. This is the culture of caring for people at set times for set tasks; the culture of minimising risk by taking away freedom; and the culture of being cared for because of being old.

The rise in the number of people over 80 and the consequent rise in the number of disabled people will inevitably lead to a significant demand for both types of home. Both approaches should be able to meet the needs of a physically disabled person who remains free of dementia and has the psychological health to remain confident and independent. If people at the age of 65 can expect to remain healthy for a further 10-12 years on average, then decisions about suitability of their current housing should be made between the age of 70 and 75, while still healthy. Individuals should anticipate that arthritis, or possibly a fracture, will cause limitations on functional abilities in the near future. If their home could not be adapted easily to accommodate this, then people would be wise to consider

moving to accommodation designed for older people. For many owner-occupiers, this will often mean moving to retirement schemes.

Housing that can support physical disability should provide a growing alternative to long-term care. However, common reasons for requiring long-term care relate to dementia and a loss of confidence: about 60% of residents in UK care homes suffer from a degree of dementia. Adaptations to the home cannot provide the supervision and reassurance such people require, and the shortage of domiciliary care staff will make it harder to provide this supervision in a person's own home. Therefore a key question in predicting future housing needs is whether Telecare will be able to provide appropriate supervision in the context of dementia and whether this will be acceptable to patients and family alike. Currently this is quite unknown but is being explored by pilot projects such as the West Lothian work. In their early evaluation they have noted that residents who have not managed to remain within the scheme have included people with dementia and some who clearly wished for more hands-on support and care. In other words those people psychologically wanted to be, or needed to be, dependent on others.

The future

The future therefore depends on the interplay of all these factors. We may be optimistic that the American reduction in age-specific disability will be seen in the UK but this probably depends on societal changes towards more positive attitudes to healthy ageing. The campaigns from charities such as Help the Aged and Age Concern, and the University of the Third Age are all excellent initiatives impacting thousands of older people but have not yet gained a national momentum to shape societal perceptions. Meanwhile, the sheer scale of the growing number of older people with significant physical and mental disabilities, combined with the lack of available personnel to provide individualised care at home, will clearly place enormous strains on all sectors of the health and social care services for older people. The priority for research should include finding effective ways of changing lifestyles towards healthy ageing and a productive retirement. Only through a better-informed older population, making full use of their retirement, may we expect a new culture of independence and a positive experience of ageing to replace the culture of negativism and dependency.

Concept before construction

Nigel Appleton, Contact Consulting

Making form follow purpose

The basic thesis of this paper is that not a cubic metre of concrete should be poured, nor even a pencil sharpened to set about designing an extra care housing development, until some fundamental questions have been addressed about its purpose. While that may seem so obvious as not to be worth saying, past experience suggests otherwise. When a development is no more than a gleam in the eye of a commissioner or developer two questions need convincing answers: Who do we think will live here? What will their life be like?

The primary purpose of an extra-care housing development is not to keep design and development teams in business, not to add units to the stock of the provider, nor even to give the local authority a flagship development that can be named in honour of the leader of the council! The purpose should be the enrichment of the lives of older people through the provision of an appropriate context for a chosen lifestyle.

Unless we have sought to understand the lifestyle aspirations of a rising generation of older people and have understood the facilities and services that will support that lifestyle through changing personal circumstances and requirements for support, we are doomed to provide a mighty herd of white elephants.

Too often in the past the built form has been provided without sufficient thought being given to the characteristics of those who will live in a development; what their aspirations and needs will be in the present, let alone the future. Like a growing adolescent in a second-hand suit, the lack of fit has become increasingly obvious. What model of communal living informed the design of traditional sheltered housing? Designed by middle-class officialdom for the deserving elderly poor, sheltered housing combines something of the ethos of the Workhouse with a sentimentalised vision of the communal life of the tenement.

How have we handled that in the past?

We have inherited a dislocated pattern of provision that lurches from housing-based forms, principally the variants of sheltered housing, to institutional care in its various forms. On neither side of that divide was form dictated by a clear view of purpose and although there was a presumption of continuum this was largely illusory. As the Audit Commission pointed out in 1998 the current pattern of provision is “entirely historic and not related to any identifiable levels of need or demand”.¹

¹ Audit Commission 1998 Home Alone - the role of housing in community Care, Audit Commission, London

What the various elements in this range of provision do have in common is that their design was heavily influenced by expectations of dependency. Because all grew out of a “welfare” perspective there has been a major concern with qualification through need, generally defined in terms of current or future loss of functional capacity. Accommodation has been designed to facilitate the delivery of services to meet the identified need. In the case of sheltered housing this means small easily managed accommodation with support from a warden to respond to a very low level of need, and in residential and nursing care services are delivered through shared accommodation in which supervision and care could be more easily provided.

Within each category there tended to be a “one size fits all” approach that linked the accommodation context to a fixed menu of provision. Qualification for residential care, for example, through inability to perform two or more tasks of daily living, triggered a move into a setting in which assistance was provided for all personal care and domestic tasks.

Figure One sets out the linkage between each accommodation context and a “blanket” pattern of care in the traditional pattern of provision.

Figure One The traditional configuration of accommodation and care for older people

Accommodation Context	Characteristics
General Housing	Community personal social care. Community medical, nursing and para-medical services. Meals on wheels. Provision on demand according to need.
Sheltered Housing	As above but with support from a warden, generally in the past resident on site. Provision on demand according to need.
Residential Care	Higher inputs of personal social care. Community medical and para-medical services. All meals provided. “Blanket” provision.
Nursing Homes	Frequent nursing and higher levels of personal social care. Special arrangements for medical and para-medical services. All meals provided. “Blanket” provision.

(Source: Contact Consulting, 2004)

The major watershed has been from housing-based provision, in either general or specialised housing, to residential or nursing care. Failing capacity to perform essential tasks in one area has precipitated a move that made all other surviving

capacity redundant. The consequence has been accelerated dependency and deterioration in personal capacity, autonomy and quality of life.

Jef Smith, in his foreword to Joanna Bartholomeou's 1999 study of Hanover extraCare, identifies a further underlying problem:

“Forms of residential provision for older people based on health and social welfare models – residential care and nursing homes, long stay units, almost all facilities offering grouped care – cannot avoid referring back to the hospital and the workhouse in the way they operate. Both these institutions, however benignly they were managed, defined people as essentially problematic; their inmates were – in the case of hospitals still are – reluctant guests on someone else's territory.”²

Can we move from a position that sees older people as problematic and dependent to one that acknowledges their right to live a full life in old age? How can we express that changed perspective in the accommodation designed for them to occupy?

Can we disaggregate our assumptions about old age?

If we are looking to accommodate “older people,” whom are we actually talking about? It is not as simple as it once was to agree upon a threshold for old age. In the past it was generally accepted that exit from economic activity and entitlement to state pension marked the beginning of old age. Over the past three or four decades, while average life expectancy has increased, the average age of exit from the labour market has continued to fall³. For those who leave the labour market in their early fifties old age may, on this definition, stretch from the early fifties into the eighties and beyond.

We may take instead declining functional capacity as the defining threshold of old age: losing the ability move around freely and to live independently. By this measure old age might commonly start somewhere in the mid-to-late seventies.

What is absolutely certain is that a simple threshold, such as that for entitlement to state pension at 65, is inadequate. We have argued elsewhere⁴ for the recognition in relation to accommodation and care needs of three phases of old age in which 55-70 might be regarded as early or pre-old age, 70-85 as mid-old age and 85+ as advanced old age.

The circumstances of individuals within each of these cohorts are enormously varied. The factors that will influence individual circumstances are well known:

² Smith in Bartholomeou J 1999A view of the future – the experience of living in extraCare, Hanover Housing Group

³ Campbell N (1999) The decline of employment among older people in Britain, Centre for the Analysis of Social Exclusion, London ISSN 1460-5023

⁴ Appleton N 2002 Planning for the majority - the needs and aspiration of older people in general housing, YPS for Joseph Rowntree Foundation, York

health, income, gender, social integration, work history, child-rearing and caring history, location and housing conditions, among others.

The old age of some will be characterised by good health and high levels of independence before an acute health episode leads to sudden decline and death. Others will suffer the steady attrition of chronic health problems that diminish the quality of their life for much of their old age but will continue in this state for many years.

In coping with these circumstances some will deploy their savings; others will have to rely upon publicly funded services. Thus any general statements must be hedged around with a clear understanding that one size will not fit all.

In the current population of older people there is a predominance of women over men. The imbalance becomes more pronounced in advanced old age so that some commentators speak of the “feminisation” of old age. The experience of women in old age has been shown to be markedly different from that of men. In income, access to health and social care services, and housing options they are seen to be disadvantaged.⁵ The different health experience of men and women in old age is marked with many women suffering chronic health problems through many years of their old age, problems which could be addressed in part by appropriate housing. In future cohorts the survival rate of men is expected to improve and the gender balance may become more even.

What do we know about the rising cohorts of older people?

The media erupts every so often with apocalyptic scenarios for an ageing society. Poor, frail and draining the economic lifeblood of society, it would appear that, as a South Australian “Minister for the Elderly” once remarked to me, the declining effectiveness of antibiotics seems to offer the only hope for a sustainable future.

The notion that the whole older population represents an unsustainable burden on health and social care services is hard to substantiate. Most of us look after ourselves or each other with limited recourse to formal services.

Certainly in early or pre-old age the overwhelming majority of people will continue to live in much the same way as they before. Those fortunate enough to have the resources to retire from the labour market will have more time for leisure, travel and family. Most will continue to live in general housing, very few will use formal care services although their demands on health services may begin to increase.

In the middle period of old age the benefits of accessible, low maintenance housing may be more apparent as problems with mobility begin to become more common. Demands upon health services may increase but demand for formal care services will continue to from a minority.

⁵ Dooghe G & Appleton N (Eds) (1995) *Elderly Women in Europe – choices and challenges*, Population and Family Studies Centre, Leuven ISBN 90 75544 01 4

Even advanced old age is not a uniform picture of decrepitude and high service usage. If we take some of the numbers that are normally presented negatively and invert them we begin to see a rather different picture. Even in advanced old age most of us retain the capacity to maintain our independence and to be largely active and able:

- 78% of those 85+ have no cognitive impairment⁶,
- 79% of those 85+ are able to bathe themselves⁷,
- 98% of those 85+ can get around their home successfully if it is on a single level⁸.

Although we cannot ignore the effects of failing physical, and for some, mental function it is all too easy to get the challenge they represent out of proportion. It is right that we prepare to tackle them, as not to do so is to condemn those who experience them to an existence that is socially impoverished, physically uncomfortable and limited in a whole range of other ways. For the majority, throughout their old age the quality of their life will depend much upon the opportunity of living independently, enjoying leisure and recreational pursuits, and having an active social life with a high degree of personal autonomy.

What are the aspirations of older people in relation to life in old age?

The key aspiration that older people have, whatever their circumstances, is the one they will have pursued throughout their lives from childhood and adolescence, through adulthood and into old age: the desire to have control over their own lives. It is the desire to remain in control that motivates people to struggle on against enormous odds when their existing housing situation becomes difficult. That desire for control covers all the most basic aspects of our lives: with whom, if anyone, we choose to share our living space, what time we get up and go to bed, what we eat and drink, when, where, and how we fill our free time, with whom we will socialise, and on and on. These are the basic decisions of our lives. Traditional forms of accommodation and care for older people have tended to compromise this autonomy.

That desire for some degree of control over their own lives leads to concern for the future: what will happen if the capacity to care for oneself is diminished, if savings are exhausted and income is inadequate, if other circumstances change? Whilst recognising that change for themselves and in the world around them is inevitable, older people look for some degree of predictability in the matters that will affect them and their ability to live as they would wish. So will the place they move to

⁶ By inversion of prevalence calculated in Ely M, Melzer D, Opit L & Brayne C 1996 Estimating the Numbers and Characteristics of Elderly People with Cognitive Disability in Local Populations, Research Policy and Planning Vol 14 No2

⁷ By inversion of prevalence of difficulty reported in Report on the General Household Survey 2001, ONS, London

⁸ Ditto

continue to accommodate and care for them if mental, physical, financial circumstances change? What can they expect and what are their rights?

The autonomy that older people aspire to includes the freedom to choose their own life style. Traditional forms of accommodation and care have implied a degree of conformity: to fit in, to live conventionally, to join in with communal activities. No loud parties and an assumption of celibacy for the single. Older people increasingly wish to assert their distinctiveness: in the decoration and furnishing of their living space, in their choice of relationships, in the ways in which they spend their leisure time, and so on. Shared activities are more likely to include collective internet browsing and rock and roll appreciation evenings than Bingo and sing-alongs to the songs of the Second World War.

There is too a concern about eventual access to care; that the accommodation they occupy may be suitably designed and equipped so that when the need for care arises it does not necessarily precipitate a move. There is also a concern that the care they require can be provided without a complete surrender of privacy, autonomy and lifestyle.

Closely linked with all these aspirations are concerns about financial autonomy; that older people should maintain control of the resources they have built up through their working life and have a degree of control over how those resources are used. Older people may also want to maintain their status as home owners, if that is their choice, not to see their capital drained through the narrow accommodation options available to meet their care needs when they arise.

For that minority of older people who enter old age as tenants and have limited other financial resources, exercising the same degree of choice will be difficult. Unless providers are willing to offer genuinely mixed tenure schemes in which social renters and home owners live side by side they will contribute to rather than dilute the emergence of a two-class old age.

Accommodating the “good old age”

If older people are to have their aspirations met we shall need to provide accommodation and care options for them that will:

- Give them a choice of tenure
- Offer them value for money in the accommodation and services we provide
- Ensure that their accommodation meets, and preferably exceeds, Decent Homes standards whatever their tenure⁹

⁹ ODPM Quality and Choice: A Decent Home for All, April 2000 & ODPM: Decent Homes Target Implementation Plan, 2003.

- Provide adequate private space to accommodate their private life and chosen lifestyle
- Recognise their desire to find opportunities for leisure, recreation and personal growth
- Give them opportunities to participate in the shaping of the communities in which they live
- Share with them our expectations about what will happen if their circumstances change.
- Have systems in place to respond to care and health needs in ways that are tailored to individual circumstances and to change over time.

Exploring the link between our vision of the good old age and the built context in Extra Care.

The decision to move to an Extra Care development is in some senses no different from housing decisions made at any other time of life: when setting up home, when looking to accommodate a growing family, when increasing prosperity offers the possibility of choice. A range of both “push” and “pull” factors will influence the decision. The decision to move to specialised accommodation in old age has generally in the past been seen as a reluctant accommodation to approaching infirmity. At best this will have been a pre-emptive decision to move to accessible accommodation. At worst it will have been a hurried acceptance of a seemingly inevitable move following some sort of crisis such as bereavement, illness or accident, or some confidence-eroding event such as a burglary.

This is not the way it ought to be. As Hanson rightly reminds us:

“Where people do consider an alternative to mainstream housing, this should spring from a positive lifestyle choice to live that way, rather than from a decision forced by present home circumstances being (or being deemed) insufficiently supportive and enabling”¹⁰

What is that “positive lifestyle choice”? It surely does not include a private living space so small that the inclusion of furniture of standard dimensions brings on claustrophobia. Nor an assisted bathing suite white tiled from floor to ceiling with a bath that looks like a fairground ride located in the centre of it. Still less a common room of small prairie size surrounded by upright chairs with leakage resistant covering.

¹⁰ Hanson J 2001 From “special needs” to “lifestyle choices”: articulating the demand for “third age” housing in Peace S & Holland C (eds) Inclusive Housing in and ageing society, Policy Press, Bristol

Might it not rather include sufficient space in the private accommodation to house a reasonable amount of furniture and personal belongings? Might it not, by its space and design, make it possible to accommodate some social life in private? Might not the normal functions of domestic living be accommodated within the private space, whether by a kitchen large enough to include a washer drier or a bathroom designed to facilitate the provision of assistance when required without recourse to an “assisted bathing” facility?

How is the good old age to be financed?

There are, of course, major challenges in funding the aspirations of a rising generation of older people. Having embraced, individually and corporately, a “live for today” culture we are understandably nervous that tomorrow approaches. Whether through the short-term perspective of companies that gave themselves “pension holidays” when funds appeared to be in surplus, or the failure of individuals to recognise that investments can go down as well as up whilst their aspirations moved only in one direction, it is clearly an issue.

The range of financial products that will help us maximise the benefit to be gained from resources built up during our working lives is only now emerging. Equity Release products have some way to go before what they offer matches what people require¹¹. Currently they are seen as inflexible, with high thresholds for the value of property and the level of borrowing that will be considered, with high administrative costs. The rising generation of older people may be more than willing to use the equity they have built up in their home to finance a wide range of elements to facilitate a good old age, from a new car or caravan to exotic holidays and even the more worthy (in the eyes of government at least) home repairs and personal care. Before that becomes an established pattern, the financial institutions will need to provide means through which older people can draw down the funds in relatively small packages with a minimum of bureaucracy and at a reasonable cost.

The possibility that providers may offer those buying into their Extra Care development the opportunity to buy not only accommodation but an explicit undertaking to provide care in return for an initial investment, may prove more attractive than the purchase of a care bond from a financial institution unconnected to the ability to remain where you choose to live.

Although we are enjoying the positive effects of funding through the Department of Health Extra Care programme, with support from housing funding from other agencies of government, we may assume that the general level of statutory funding to provide accommodation for a good old age will be limited. The majority of funding will need to come from individuals contributing to capital costs through purchase. Some will certainly come from public funds, but much of this will be found by the re-cycling of existing resources.

¹¹ Appleton N 2002 Ready, Steady but not quite Go - older home owners and Equity Release, Joseph Rowntree Foundation, York

What are the other obstacles?

Who will do the caring?

In a society whose ageing is accelerated by the addition of a falling birth rate to the effects of increased life expectancy, one of the greatest challenges will be to recruit people to provide support and care to those among the older population who need it. Some would see labour market limitations as the greatest obstacle to providing a pattern of facilities management, stimulation and care to enable a good old age. Some European countries see the issue as so acute that they are taking steps to arrest the decline in birth rate. Sweden, for example, is providing very generous benefits to parents in an attempt to encourage a rise in birth rate. Labour migration, particularly from the new accession states of Eastern Europe to Britain, may help in the short-term to fill the gap.

Making use of technology?

Technology will make some contribution but to avoid an Orwellian scenario in which surveillance has been substituted for care we need to be clear about the best application of emerging technology. Technology can help in managing risk by providing security and offer alerting capacity well beyond that provided by human supervision. What it cannot do is deliver care. Care delivery requires a combination of functional and emotional inputs best provided by a human carer. What technology can do, by dealing with those monitoring, alerting and measuring functions, is to free human carers to make better quality interventions. Instead of entering the room of someone with severe dementia at hourly intervals through the night to check that they are still in bed and asleep, the care staff can entrust the equivalent function (through bed occupancy and movement detectors) to the technology, and spend time with the person who is wandering or has fallen. The evidence is that if enhancing quality of care is the priority rather than finding lowest cost solutions, the use of technology may not reduce the number of human carers needed. It may however enrich the quality of their work and therefore of the life experience of those they care for.

Making better use of sheltered housing?

The sheer volume of existing sheltered housing is another obstacle to be overcome in re-shaping the range of provision. There is just so much of it: around half a million units, overwhelmingly for rent to a dwindling number of older people who move into the target age group as tenants. Quite apart from those schemes whose location has become less desirable with the closure of shops and surgeries, the removal of bus routes and general decline, and that large proportion that offer bed sitting room accommodation, there are others that have fundamental design flaws present since they were built. (Last sentence is not pretty.) There are schemes without lifts, schemes with flights of steps in internal corridors, schemes with poor internal arrangements within flats, narrow corridors with low ceilings and ill thought out communal areas. We may confidently predict that demand for this accommodation will decline to the point where an increasing proportion of it cannot be let. If we re-define its purpose so that we stop letting sheltered housing to people who have no reasonable cause to sacrifice their housing quality by moving in their early sixties, or even earlier, into a bed sitting room flat and paying a

service charge for a service they do not need, the pace of decline will be even greater.

Yet we cannot simply bulldoze it all. People live there and some will wish to continue to do so. For some it will provide manageable accommodation in a setting in which they feel safe and secure and among people with whom they share a sense of community.

Rather we need to stand back from what we have and appraise it realistically. With levels of owner-occupation among older people moving inexorably upward (in some parts of the country, for people over 85, it is already reaching three-quarters of all households and for the succeeding cohorts is more than 80%) tenure diversification cannot be resisted.

Housing design and procurement

Looking back at the short-sightedness of so many of our policy decisions over the past forty years we might hope that we could do better. But the evidence is that we continue to put up buildings that will stand for a hundred years or more, finance them over twenty or thirty years but work with models that have no more than ten or at most fifteen years' future proofing in their design. It remains as difficult as ever to secure funding for future proofed design. Who in 2025 will want a one-bedroom retirement flat? Yet they are being built because our funding and land use constraints push providers toward them.

Accommodation for older people is not immune from the general trend by which we have achieved only a very low rate for the building of new dwellings. Most older people in the future will continue to live in property that already exists. In this event these properties will need a significant level of investment in re-modelling and adaptation. Adaptation services continue to be neglected and under-funded, stifling opportunities to make pro-active adaptations that will provide long-term advantage to individuals and to the community as a whole.

A lack of vision

Perhaps the greatest obstacle will arise through a lack of imagination and information to fuel it. People cannot easily choose what they do not know about. So much of the debate around the future provision of accommodation and care at a local level revolves around rearguard actions to defend what is already in place, however outmoded. Generally, this is because no vision has been shared with older people, their carers and advocates, of what they might aspire to, the benefit to them of new forms of provision and the opportunities for a better old age.

If Extra Care housing can be the flagship, what will make up the rest of the fleet?

General Housing

Upon the assumption that we do manage to avoid the fatal error of allowing Extra Care housing to become the new panacea, it will only ever accommodate a minority of older people. Most will continue to live in general housing to the end of

their days. For them we need to be developing a range of services that address both the needs of the housing itself (in maintenance, repairs, security and adaptations) and of the occupant (in information and advice, access to leisure and recreation, care and health services).

Retirement Housing

For that portion of the current stock of conventional housing that will meet Decent Homes standards but is not needed for older people who require active support or care services, there may be a future as compact and serviced accommodation for those who require it.

Conventional Sheltered Housing

Conventional sheltered housing needs re-definition in a way that matches the aspirations and needs of those who live in it to the facilities and services that are provided. To be credible this will need to be driven by the occupants rather than the accountants!

Enhanced Sheltered Housing

A good deal of the best of the current stock of sheltered housing will lend itself to enhancement through the maximisation of accessibility and the provision of additional facilities to provide independent living for those with moderate care needs.¹²

Extra Care Housing

Extra Care housing will increasingly become a pivotal part of the economy of accommodation and care for older people, providing a mix of private space, and imaginative facilities to support an enriching life style and care when required. All this in the context of a diverse community, offering the possibility of peer support and high levels of participation in the direction of the community's life.

Housing models for people with dementia

Just emerging are new patterns of housing-based provision for people with dementia and their carers. Drawing on the design principles enunciated by the Dementia Services Development Centre Unit at Stirling University and exemplified by such developments as the Seven Oaks scheme operated by Fold Housing Association in Londonderry, new forms are beginning to emerge. Traditionally we have relied upon a caring spouse to support a person with dementia in their existing housing situation for as long as possible. When that arrangement has broken down we have transferred both into residential or nursing care, commonly in different locations. We need some flexible forms between those two ends of the scale. Schemes like Seven Oaks provide bungalows on site in which carer and cared-for may continue to live together, and in which individual flats and an empowering regime emphasise remaining capacity rather than incapacity. These will be an increasing part of a variegated range of provision in the future.

Tenure and choice

All of this, of course, should be offered on the basis of a variety of tenures. Specialised accommodation for older people has been dominated by rented sheltered housing and institutional provision, occupied on the basis of licence. The

¹² For an argument for the need to differentiate between Enhanced Sheltered and Extra Care Housing see Extra care housing for older people - a guide for Commissioners, DoH 2004

levels of home ownership now being seen among older people will drive a shift in this pattern. Some will wish to maintain their status of home ownership, buying accommodation within a complex that will support their lifestyle requirements and their existing or eventual care needs. Some will transfer from other forms of rented accommodation. Some owners will choose to transfer to renting, using the capital released to fund their lifestyle choices or care needs. Others, through choice, or necessity driven by the relatively low value of their existing property, will look for forms of shared equity purchase. Diversity of tenure with older people using their housing equity to exercise choice will re-shape the pattern of provision.

A Portmanteau Future

What is certain is that future patterns will be much more diverse with choice of lifestyle being exercised by a much larger proportion of older people. Already close to mainstream is the choice to live part of the year in a warmer climate. In addition to those choosing to move permanently to warmer climates, increasing numbers of older people are spending between one and two months of the winter in Mediterranean holiday resorts. Mainly these are older owner-occupiers living in general housing and setting the renting costs of out of season holiday accommodation against their winter heating bills, but it is a trend that will not exclude older tenants. Landlords may need to reconsider their tenancy terms for those who may choose to be away for two months in the winter. Some organisations may even decide to facilitate the pattern.

The Bulletin of the American Association of Retired Persons (AARP) in its December 2004 issue reports on the relative benefits of living in “Assisted Living” and living permanently on a cruise ship:

Figure Two Comparison of Assisted Living and Cruise Ship Living

Services Provided	Assisted Living	Cruise ships
Meals provided	OPTIONAL EXTRA	INCLUDED
Housekeeping	OPTIONAL EXTRA	INCLUDED
24/7 medical care	NO	YES
Escorts to meals	OPTIONAL EXTRA	YES
Staff-to-client ratio	1 TO 10-40	1 TO 2-3
Average cost per month	\$3,000	\$3,000

(Source: Bulletin of the AARP, December 2004, quoting Lindquist & Golub in Journal of the American Geriatrics Society, no date referenced.)

When accommodation is seen to serve a lifestyle rather than determining it, the permutations increase. 25 years ago Charles Handy was promoting the notion of the “Portmanteau” career¹³: a pattern in which rather than have one settled full-time employment, one might have a part-time job, some consultancy and an element of unpaid work, with the mix changing as we progressed through our working life. Perhaps we are beginning to see the emergence of the portmanteau retirement in which some months are spent in a fairly conventional housing setting,

¹³ Charles Handy 1989 *The Age of Unreason*, Business Books, London & Charles Handy 1994 *The Empty Raincoat: making sense of the future*, Hutchinson, London

others are spent abroad, and others still in a setting that provides for our leisure interests or pursuits, whether as participant, student, volunteer or staff member. The mix may alter as we advance through old age and our needs and capabilities change.

The accommodation we are providing now will need to have the flexibility in its design and its management arrangements to fit within this emerging pattern, enhancing rather than restricting lifestyle choices. However you answer the first of my prime questions: "Who will live here?" The answer you provide to the second: "What will their life be like?" will need to be capable to infinite variation.

Beyond Welfare. Who Pays for the Baby Boomers?

Moyra Riseborough, Lecturer at the Centre for Urban and Regional Studies, University of Birmingham

Financial security in older age depends, as we know, on a range of factors, not least life opportunities to create and amass wealth and assets and the decisions people make to save or spend if they are able to. Life chances are never equal and safety nets are needed, but what form should these safety nets take? The old post-Second World War consensus on welfare, its universal relevance and the certainties it provided society, has gone. We live in a less certain world where social attitudes and policy commitment by Government towards welfare are fragmented. There are indications that each successive generation is less disposed towards contributing towards welfare. This could arguably create fissures between generations and damage the principle of responsibility towards one another. Evidence from opinion polls certainly suggests that different generations have different attitudes. For example, young people aged between 18 and 34 years old are least likely to see the relevance of welfare. They are less likely than the rest of the adult population to agree that income redistribution to tackle poverty or raising taxes to provide better welfare is worthwhile. In contrast, the older generation is more strongly disposed towards welfare and maintaining state involvement in pensions (British Social Attitudes Survey 2004).

There are occasions where the welfare help we do have penalises people who have made efforts to help themselves. This acts as a disincentive for people to save. Despite the Government's efforts to encourage more saving for retirement through new pensions arrangements, the system is too complex for most of us to understand and there are no guarantees. In addition, public trust has been undermined by market failures affecting savings plans and the collapse of some employer-led pension schemes. The lack of a clear steer by Government on the best course of action to take doesn't help matters.

This paper considers the social and political change that brought us to the present situation. It describes the uncertainties that the more prudent or fortunate of my cohort (the Baby Boomers) are trying to deal with or, alternatively, how we intend to hedonistically ignore them (Martin, 2003). It also tries to assess the possible impacts on our financial security and options in older age if the state's role in welfare continues to decline.

Tracing welfare change

The welfare state in the United Kingdom was never truly universal and always relied to some extent on a mix of market as well as state arrangements. Private health, education and pensions have worked alongside the state. However, the UK has moved increasingly towards a residual welfare state market economy. Of the three¹⁴ main models for welfare states described by Esping-Anderson (1990) the

¹⁴ Esping Anderson presents these as ideal types that are rarely present in pure forms anywhere. The other two models are the corporatist state which involves social rights, some of which are met

UK is closest to the liberal welfare state, which involves a residual means-tested welfare system with strict eligibility rules and strong state support for market provision. The residual nature of welfare also spreads into other areas, particularly housing. We are a nation of owner-occupiers and council or social rented housing is often described as a residual tenure. The rise of home ownership has had a profound effect, not least on the assets and wealth we may accumulate in our lifetimes. Combined with the drive by successive governments to encourage the population to make individual provision for older age through private and occupational pensions, we could say that we are now beginning to reap the fruits of welfare change.

Changes in welfare have not occurred without public knowledge. They were accompanied and affected by changes in social and political attitudes. Changes during the Thatcher (1979-1990) and Major (1990-1997) years, characterised by a determination to reduce the power of organised labour, privatisation policies, reductions in welfare, attacks on municipalism and strong beliefs in individualism and the power of the market, left their mark. Most importantly, policies under Thatcher helped break down the bonds between individuals and the notion that everyone has some sort of role in working together for collective social good which was arguably at the heart of the consensus on welfare from the 1940s. The experiences of many people in my generation of 'flexible' employment practices and uncertainty in the job market during the 1980s and 1990s (see Ford 1998) had an impact on creating changes in attitudes. Some people did well out of being able to job-hop but others have fared badly. The pursuit of personal wealth, combined with the experience of being exposed to a riskier labour market, helped create an ethos of selfishness and self-interest. It also sharpened instincts for survival and made us unsentimental about being loyal to employers. As a result, people change their jobs more frequently and have few illusions about employer interests in retaining or motivating staff (see, for example, Penna 2003).

Not surprisingly then, by the time New Labour came to power in 1997, welfare had been eroded but social and political attitudes had also changed dramatically. People had responded to government exhortations by taking out private pensions and contributing to occupational pensions including Additional Voluntary Contributions (AVCs) to top up occupational pensions. But at the same time it was abundantly clear that for many people the state pension continued to be the main or only source of income in later life. Its importance was certainly understood by policy analysts and government advisers (see Burchardt et al 1999). Pensions and the need for reform attracted considerable debate in the 1997 general election campaign.

During the run up to the general election, New Labour used the concept of the 'Third Way' to explain why reforms were needed and what they were intended to do. Giddens (1998) describes the 'Third Way' as a distinctively different way of thinking for New Labour compared to the thinking that characterised the old left

by the state but with important subsidiary roles played by church and family, and the social democratic state based on universal de-commodified welfare services with access that does not depend on the church, family or market.

social democracy or new right neo-liberalism. The 1998 Green Paper *A New Contract for Welfare: Partnership in Pensions* outlined how the 'Third Way' was going to be applied in a settlement for pensions that would be relevant to the 21st Century (see King, 2002 for a discussion). Since the Green Paper a number of complicated changes in pensions have been introduced. They include credits via tax as well as increases in more traditional welfare benefits and state pensions and a Minimum Income Guarantee aimed at improving the income of the poorest people eligible to receive state retirement pensions.

The Minimum Income Guarantee and plans to increase the basic pension above the inflation rate were generally welcomed (see responses to the Pension Credit Consultation Document DSS 2000). However, there was a lukewarm response to the proposals overall. This was largely because of the failure to increase basic pensions through restoring the link to average earnings. Other proposals in the Green Paper for stakeholder pensions and a second state retirement pension (to replace SERPS) introduced complicated tiers of arrangements. There were fears from the start that the measures were too complicated and hard to explain.

Since the Green Paper, a series of steps was introduced over a relatively short period to keep the basic pension down bringing in methods to encourage more people to provide for their own retirement. Pension Credit replaced the Minimum Income Guarantee and there are plans to encourage more people to stay in the labour force through offering them incentives to defer retirement and through their eligibility to receive state pensions.

The illustration below is based on a table produced by Falkingham (2004), which expresses the changes that have occurred.

	Pre 1998	Post 1998
<i>First tier state provision</i>	Basic State Pension Income Support	Basic State Pension Minimum Income Guarantee Pension Credit
<i>Second tier compulsory option</i>	SERPS Occupational pensions Personal Pensions	SERPS State Second Pension Occupational Pensions Stakeholder Pensions Personal Pensions
<i>Third Tier Voluntary option</i>	AVCs	AVCs

It is now clear that the above measures are being used to reverse the balance from the previous public/private mix of 40:60 to 60:40 (Falkingham 2004).

The changes have been criticised for failing to bring pensions up to decent levels and relying on other elements of *first tier provision* to make up the difference, whilst also penalising those people who don't qualify for a full pension. Women in particular are less likely to receive full state pensions or, if they do have other pensions, to have as much in their private or occupational pension funds as men.

Then there are all the so-called 'older workers' who are forced to leave the labour market through ill health or redundancy and cannot find employment because younger workers still tend to be preferred by employers. Their chances of obtaining full basic retirement pensions or access to other sources of income are obviously reduced.

There are not enough incentives either for people who have savings and occupational pensions and there are perverse effects on people who may be interested in deferring retirement income and staying in the labour force.

Most importantly, as was feared as far back as 1998, most people still do not understand the changes. Take-up of stakeholder pensions has been low and means-tested top ups on basic pensions are undersubscribed.

The Uncertainties for Baby Boomers

The biggest uncertainty facing all of us is trying to forecast the future while the present keeps on changing. We can speculate about some things, based on evidence about people who are retired now and guess at others, based on information about the assets they have and the intentions people say they have when they retire.

A couple of things are certain. The age at which women will be eligible to receive the state pension will rise to 65 by 2020 and everyone will be encouraged to stay in paid work for longer. Baby Boomers are facing the knowledge that we may not be able to afford to retire when we plan or hope to (Pensions Commission Report, November 2004; DWP 2003). Being able to work beyond retirement age is, of course, something many people want to do but there is a difference between choosing and having to work. There is also a difference between choosing to do some paid or voluntary work that brings satisfaction and continuing in work that makes us ill or unhappy. The final salary scheme could prove to be a noose around people's necks if they are grimly hanging on in order to get the income they need. Things could get worse or better depending on one's point of view. The CBI recently floated the idea that the state retirement pension age should be raised to 70 by 2030 (BBC News, 30 Nov 2004). This isn't purely in the interests of reducing the burden on society of paying for pensions. It is also a response to falling birth rates and a lack of younger workers in the labour market to do essential and skilled jobs. Are we to conclude that Baby Boomers may have no choice other than to continue to be self-reliant? It seems that more self-reliance will be required while migrant labour may also have to increase to make up the shortfall.

Looking at people who are retired now, one of the clearest trends is that people tend to get poorer as they get older because they erode the assets they have accumulated or their incomes are worth less. Women, particularly single women, amass less wealth, assets and pensions in their working years, which affects them in later life. However, women born in the 1960s are participating more in the labour force compared to previous generations and we might expect the outlook for

women to be better (Evandrou and Falkingham 2004). Unfortunately women still tend to accumulate less. Research by Rowlinson et al (1999) showed that in 1995/6, working age women had saved an average of £2,000 compared with men's £13,000. Women also had slightly more assets in state rather than in occupational pensions.

Older people from Black and Minority Ethnic groups feature strongly in the poorest groups, while people who never participated in the paid labour force, had broken job histories and poor health or lost their place in the labour market also tend to have very low incomes in older age. Current trends suggest that men in particular tend to leave the labour market before retirement. The New Deal has been extended to include 'older' workers as a result. One of the theories put forward by the Government and some economists is that if the right conditions are in place to encourage people to work for longer, people would not only be able to add to their retirement income but some low-income problems could be overcome as well (DWP 2004). Proposals along these lines include more private sector-style arrangements such as protected annuity schemes that could pay out a lump sum to another beneficiary if the holder dies before the annuity matures. In addition, there are proposals to make membership of occupational pensions compulsory.

In the 1980s and 1990s, older people's share of income and wealth improved but it is unclear if the general trend will continue in the same way. Some of the cohort immediately in front of us Baby Boomers did very well out of SERPS, occupational and private pensions, property investments and savings schemes, largely because of stable employment and a thriving economy, including an overheated housing market. Current trends for Baby Boomers suggest that more people have assets to draw on largely as a result of home ownership. However, our lives and futures are less stable and there are many demands on incomes including maintaining children in further and higher education. If we look at home ownership, it increased rapidly in the 1980s and then grew more slowly between the 1990s and the first two years of this century (68% of all households in 1991 to 71% in 2002-2003). Estimates on the value of property vary. For example, research by the Council of Mortgage Lenders (2001) suggested that older homeowners have more than £400 billion worth of equity in property while research by the Institute of Actuaries in 2004 (cited by Harrison 2005) estimated that the figure is more than double this amount. Older homeowners currently draw on little more than one per cent of equity. Will Baby Boomers be any different?

Reports from MORI aimed at forecasting the future are part of a growing number of consumer reports that focus on Baby Boomers. Interest in our spending and buying patterns is of course motivated by the desire to sell us new products, not least financial services and schemes to make it easier for us to release the equity in our homes. In this, the market is also responding to a demand for easy and trustworthy equity release products. The lack of trusted products or lack of awareness of such products is thought to be part of the reason why current older homeowners have been unwilling to use equity release to buy the services they want or to fund essential repairs and adaptations. Other reasons are linked to a

strong belief that they should not have to draw on an asset they worked hard for and a desire to pass on the benefits to kin.

All the indications are that we intend to be very different from people who are older now. Baby Boomers report that they intend to be less cautious than previous generations. MORI calls us the SKIN - Spend the Kids' Inheritance Now - generation. The general thrust of the argument is that we Baby Boomers seem to be accumulating assets in order to *enjoy* them at a later date rather than mainly provide for later age. Far from expecting to have to accumulate more in order to provide for a longer period in retirement because we are living longer the idea seems to be to retire early if possible and spend the money on activities we want to do. For example, travel to remote places, sail around the world, pursue a leisure interest, learn a new skill and keep in touch with networks of friends and family around the globe (Martin 2003).

In the unstable and uncertain times we live in there is greater reluctance to trust the occupational or private retirement fund or the market to perform and give people the returns they are seeking. There are often valid reasons for lack of trust. Consumer distress over the collapse of some occupational and private schemes, and the risks that these failures have exposed, have forced Government to intervene and establish schemes to protect pensions when businesses go bust or schemes fail to make their target. What this tells us is that the market and shareholders/employers cannot be trusted to act in our interests or, at least, not all of the time. Possibly in order to win back some control there is evidence that people are spreading the risks. For example, by buying second homes and ISAs or investing in home improvements to increase the value of their homes.

Second home ownership is on the increase. Housing statistics for England in 2002-3 show that 175,000 households had a second home (excluding those held solely as an investment) and 144,000 of them had second homes outside Great Britain. The most common reasons for a second home were holiday or retirement home (51%) or working away from home (19%) (National Statistics 2002). Investing in housing to let is also growing in popularity and one of the reasons is to provide properties for student sons and daughters, partly as an asset that can be made to yield an income through student sons and daughters who flat share with other students, and partly to protect their children from the worst experiences of student lets (Guardian September 21, 2002). Baby Boomers are doing all of these things.

Friends and family members who were pestered for information on their plans for this paper said they were variously doing nothing at all for later life or they were planning furiously, but there was a general intention to spend and enjoy what they had rather than conserve it. They intend to use the equity in their homes or second homes to do some of the things they wanted and did not expect to pass money on through inheritance. These intentions seem to be different compared to previous cohorts, especially using equity in the home. None of the people I asked expected that there would be much for them from the State. Almost all of them have had to make provision for themselves because they didn't have traditional occupations, or

they started out on careers and job pathways that were affected by redundancy, or because they didn't want to work for someone else.

Consumer research across Europe suggests that this kind of hedonism is on the rise amongst other Baby Boomers. Worcester (2000) characterises the changes as the move from saving to *savouring* time. Baby Boomers are said to have less respect for authority, traditional institutions or organisations. We tend to be more articulate and are quick to voice our dissent or dissatisfaction. We have highly developed networks, enjoy a variety of different leisure and cultural activities, consume more and travel further afield than previous generations. Above all some of us can't see the point in saving for the future if it involves not being able to enjoy it when we get there because ill health or death overtook us. This is one of those things that all cohorts have to grow used to but perhaps Baby Boomers are taking it to heart.

On the other hand, lack of certainty doesn't necessarily mean that everyone wants more of it. Some of us have grown used to uncertainty and accept that change is the name of the game so stability in itself or at any cost to our lifestyle isn't likely to be attractive. Social attitudes studies suggest that it isn't only the younger generation that have little interest in contributing to welfare or who see its relevance; Baby Boomer attitudes on supporting welfare have hardened as well (British Social Attitudes Survey 2004). Yet I think it's unlikely that my cohort has been totally turned off the principle of being responsible for each other as a society. Baby Boomers have at least an understanding, if not always a clearly expressed desire, for the collective good rather than naked self-interest. This is in contrast to the cohort behind us who grew up under Thatcher and whose attitudes and opinions have been formed without any understanding or experience of what went before. One could argue then that Baby Boomers want the state to continue to have some role in welfare and for welfare as a social good to continue. The problem is New Labour has fallen short of expectations and failed to catch our imagination with its reforms.

We have also grown more selfish and neither New Labour nor any other political party has given us any of the things that might make us want to behave less selfishly. For example, we have grown used to hearing about employers that have 'closed the door' on new entrants to final salary pension schemes. The inference is clear – there won't be enough to go around if younger or newer entrants to the work place join in. This opens up divisions between workers and creates new tensions and levels of uncertainty. There is also potentially less protection for younger workers and even fewer reasons why they might have any interest in contributing to our welfare. The example set for them is, after all, not very good.

Some people argue that New Labour has failed to be sufficiently radical. Falkingham (2002) says that the "pensions policy is the oil tanker of social policy". It takes a great deal to turn it around and so far there has been a lack of fundamental rethinking and a lot of changes around the edges. We need something that is more far-reaching and simple instead of the complicated system of separate elements that don't work together. Different 'tiers' of provision, some

compulsory and some voluntary, seem to make matters worse for those people with the least opportunities and the lowest incomes. Meanwhile, plans to introduce changes to benefit the better-off even more through tax breaks are emerging. They include tax breaks on opportunities to invest in a wide range of goods and services that can be used to spread the risk for individuals in control of their own pension funds or savings plans. Opportunities include 'fun' investments such as wine. The aim is to encourage more of us who have the money and the opportunity to take out more interesting products and private pensions.

Some marginal gains have been made through welfare reforms under New Labour (particularly through improving basic state retirement pensions on a redistributive basis) but there are fears that Government intentions to continue raising basic retirement pensions and achieve better basic incomes is both too little too late and unsustainable in the long term. Sustainability is a vexed issue. It is naturally informed by discussions on public willingness to pay given levels of tax and other contributions. Unfortunately both right and left leaning economists agree that sustaining what we have or improving things radically means making far more radical changes. However, none of the major political parties seems to have the appetite or confidence to begin.

The sting in the tail is that although we Baby Boomers may have less respect for welfare and don't want to admit that it's important, we still use it a lot in practice. During the 1980s and 1990s, consumption of private education, health and pensions grew apace but we still tend to use private welfare alongside, rather than as a replacement for, state welfare (see, Burchardt et al (1999) for a discussion). We also need state welfare since most of us could not afford to purchase most of our health care or other services currently provided through state welfare.

Conclusions – the future

The paper has looked at how welfare and what we mean by it has changed. It has looked at how we got to where we are now and considered the impact on, and the contribution to, change, by my generation the Baby Boomers. The paper has suggested that we are affected by increased opportunities to earn more and accumulate wealth, while the role of the state is to provide less direct financial security and promote more self-reliance. As a cohort group our experiences are divided. The majority seem to be continuing to prosper and aspire to enjoy later life despite high levels of uncertainty over the future and the experience of job insecurity. A minority are doing badly and the outlook for those people when they do retire is that they will receive a low basic pension which will be topped up by other means-tested benefits or funds from small occupational or private pensions. There have been some improvements through Minimum Income Guarantees but the value of the state retirement pension continues to be low and there has been a shift from relying on the state for welfare with some market provision to a larger reliance on the market and less welfare provision. There are changes in political and social attitudes and it seems that fissures are opening up between generations.

Perhaps we get the political leadership and the courage for change that we deserve? New Labour reforms have not dealt with the fundamental issues and it is unclear if the market and state can deliver effectively for the future, but did we take any interest in making sure that they did? There seems to be little doubt that radical change is needed. However, the big question is, will we, the Baby Boomers, seek to influence any change? Welfare and pensions tend not to interest us. Baby Boomers have lost touch or interest in how society will fare and our experiences have taught us to become selfish. We may take more steps to look after our own families and complain about university tuition fees and hefty parental contributions but otherwise those of us who can, go on making provision to deal with it. We don't as a rule engage in political protest or debate about the need for fundamental reforms.

There is some hope that we will turn our attention back to matters that affect us all. There is still a vestige of memory left in our consciousness of the principle of collective or social good and if that fails there is a chance that self-interest could make us face the reasons why the present situation has come to pass and what might be done about it. For example, interest in pensions was stimulated recently by proposals to raise the retirement age. This was widely reported in the media. Protests by civil servants and public sector trade unions such as Unison over proposals to raise the retirement age and their effects on eligibility to final salary pension funds have also received extensive coverage. It seems likely that protests will continue as more people realise that pension change affects them – the middle class Baby Boomers for the most part.

We also have to acknowledge that market mechanisms can have adverse effects. The state has been forced to intervene on more than one occasion, for example, to regulate the market after pensions mis-selling in the 1980s and to control the activities of shareholders following Robert Maxwell's thefts from the Mirror pension fund. The market/public mix we have arrived at is really an uneasy one and does not function very well. The inequity of the present arrangements is also very stark. Some of us Baby Boomers may be facing uncertainty but we will still probably have enough assets and funds to have more than a basic income when we are older. Our complaints are really about not having as much as we want, but the dice are loaded against people in our cohort who have no spare income to put aside and who have not benefited from a system that helps those of us who have more.

I don't think we can afford to ignore the role that welfare plays in our lives or continue to be selfish. For these reasons I have some hope that we baby Boomers might finally get our heads out of the sand and get to grips with the implications on our lives of changes in pension arrangements, working longer, and the relationship to welfare and tax arrangements, savings and assets. After all, despite what we say, we actually use a lot of welfare and depend on it. We need fundamental, rather than piecemeal, reforms and it is something we need to take an active interest in to benefit everyone.

Note: As this paper was being finalised the Department of Work and Pensions announced further details of welfare and pensions reform, including arrangements to be introduced in April this year for people reaching the age at which they could be eligible for state retirement pensions to receive a one off payment after a period of years as a reward for deferring their state pensions. (See DWP 2nd February Press Release Flexible retirement.)

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Mainstreaming the Caring Home

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1. The Basic Proposition – Time to Bring the Caring Home into Mainstream Housing

The critical link between health and housing has been well understood for many years. As Florence Nightingale put it in 1865 “the connection between health and the dwellings of the population is one of the most important that exists”.

Recent studies by Shelter Cymru¹⁵ based upon the 1998 Welsh House Condition Survey and a more detailed analysis as part of the 2002 Scottish House Condition Survey¹⁶ clearly indicate a coincidence between respiratory illness and housing conditions. The two reports differ in some aspects. The Scottish report is careful not to attribute causality and finds that the level of disrepair to homes is not a significant factor in health prediction, although dwelling type, level of use of the heating system and tenure are. The less detailed Welsh report attributes the high incidence of childhood asthma in Wales to the poor quality of much of Welsh housing and, in particular, to dampness within homes. In either case, health and housing appear to be closely linked.

Many initiatives have been taken over the past twenty-five years, both here in the UK and in other countries, to demonstrate that housing can be designed to significantly improve levels of care and wellbeing, especially through the installation of more intelligent care systems within homes. However, the impact of these demonstrations has to date been limited, and they have certainly had little or no influence upon the design of mainstream housing.

Our basic proposition is that the time is right for this to change. Through a unique combination of factors, which are described below, we contend that the opportunity and the need now exist to break out from the specialist niche that has been created for healthcare in housing, and to deliver the fundamentals of care and wellbeing as part of the basic value proposition of mainstream housing.

The dynamics of moving from a niche market into the mainstream are not easy, but they are now understood. Lessons can readily be learned and transferred from the INTEGER action-research programme, which over the past seven years has succeeded in developing and transferring the specialist concepts of *intelligent* and *green* housing into the mainstream of UK housing programmes. The way in which

¹⁵ Shelter Cymru (2004) *Housing and the asthma epidemic in Wales*
www.sheltercymru.org.uk/images/Housing%20and%20Asthma.pdf

¹⁶ Scottish House Condition Survey (2004) *Housing and Health in Scotland*
http://www.shcs.gov.uk/.%5Cpdfs%5CSHCS_HealthHousingReport.pdf (sic)

we believe an equivalent breakthrough can be achieved for the *caring home* and illustrated below.

2. Why now?

Four key factors can be identified as to why now is the time to take the caring home into the mainstream of housing in the UK.

2.1 A time of innovation in housing

We are currently experiencing a period when fundamental questions are being asked, and answered, about the design, performance and value of mainstream housing in the UK. After a lengthy gestation period, this debate has been focussed into action by global environmental and energy issues which the Government is committed to addressing. We are thus seeing a period when standards and methods of housing design are being radically reassessed for the first time in many years. Over a relatively short period of time, building regulations and practices are being upgraded to meet the emerging demands of the twenty-first century. A real opportunity therefore currently exists for health and care factors to be systematically incorporated into revised building regulations and practices. However, this will not happen unless those working in the specialist fields recognise the need to move their ideas and aspirations into the mainstream debate.

2.2 A time of opportunity

Extensive activity is currently underway to tackle problems of housing in the UK, led by a blitz of governmental initiatives. The £10 billion Decent Homes programme is driving the refurbishment of kitchens and bathrooms, the repair of heating systems and the treatment of damp in social housing across the UK. The Housing Market Renewal programme is tackling the problems of unwanted housing in poor repair and consequent low market values in much of the north of England whilst the Sustainable Communities programme is gearing up to deliver up to 50,000 homes per annum; much of this in the South-East of England. The Barker Report¹⁷ suggests that, in England alone, the private sector build rate needs to increase to some 255,000 from a current value of some 125,000 completions in 2002-03. Perhaps more importantly, in the context of this paper, the supply of new social housing needs to increase to as much as 38,000 from the level of 21,000 in 2002-03. To put this in perspective, the level of social housing completions was some 42,700 in 1994/5.

Housing built and refurbished today will form the core of housing available in the UK in 2025. It is clearly crucial that we seize these major opportunities to improve the design and performance of mainstream housing in terms of health and care provision. We may well not see their like again.

¹⁷ HM Treasury (2004) *Review of Housing Supply* www.hm-treasury.gov.uk/media/0F2/D4/barker_review_report_494.pdf

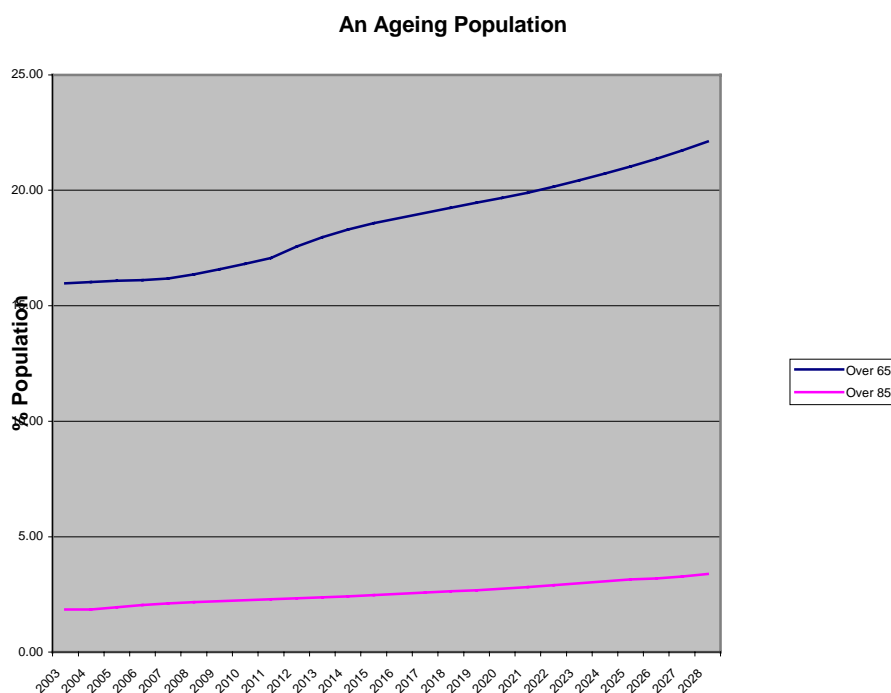
2.3 A time of changing demographic demands

Much of the demand for the 50,000 homes per annum identified by the Sustainable Communities programme comes from fundamental changes in the demographics of the UK and the overall growth of the population. The steady decrease in average household size, previously a significant factor in the demand for homes, seems to have slowed and the significant factors are:

- Increasing longevity
- Net migration to the south-east of England from Scotland and northern England
- Immigration, both legal and illegal

It is the first of these factors that we consider in some detail in this paper. The elderly are significant consumers of health services both in their own homes and in health service facilities.

Over the time frame of this paper, which is up to 2025, the number of centenarians is expected to rise from a current figure of some 9,000 to some 34,000 with some 25,000 of these being female.¹⁸ Similarly, and as illustrated below, the current government population projections show a steady increase in the percentage of the population over-65 and over-85. The over-65s rise from a current level of 16% to 21% of the population whilst the over-85s almost double from just 1.8% to 3.15%. In absolute terms this is an additional 4.0m over-65s and 929,000 over-85s.



¹⁸ Government Actuary's Department (2004) *Projected populations at mid-years by age last birthday in five-year age groups* www.gad.gov.uk/Population/2003/uk/wuk035y.xls

One critical point that has to be tackled is that this increase in population is unlikely to be evenly distributed. Previous studies comparing 2001 and 1991 data¹⁹ have shown that the percentage of over-65s in some areas, such as inner London boroughs, has dropped by over 10% whilst in other areas it has increased by over 10%. Twenty-one local authority districts showed increases of over 20% topped by Wokingham with a 29% increase in the percentage of residents over the age of 65 in that 10 year period.

These changes may be understood as the result of two migrations in opposite directions: the migration of those of working age into cities and those of retirement age away from cities to pleasant places to spend their retirement. This may be expected to increase since, for many, the value of their home is a significant part of their financial provision for retirement. This effect is less likely to be significant for those in social housing who may largely be expected to “age in place”.

The overall thrust of these demographic trends is that mainstream housing demand will shift significantly over the coming 25 years, moving towards a more elderly and therefore more demanding population in terms of health and care provision in the home. What has been a marginal demand is becoming mainstream, and we must respond accordingly with actions to provide the caring home.

2.4 A time of digital convergence

There are fundamental technology shifts currently underway which offer major new opportunities to enhance health and care within the home.

Telecare has been defined, by the Association of Social Alarms Providers, as “the use of a combination of communications technology and sensing technologies to provide a means of manually or automatically signalling a local need to a remote service centre, which can then deliver or arrange an appropriate care response to the telecare service user”. There are alternative definitions used, for example, within the Housing Learning and Improvement Network but the general thrust is the same.

Members of the association provide services for some 1.5m people in the UK but few of the installations include sensors other than, perhaps, fire detection. The systems are therefore not generally capable of detecting the onset of chronic conditions and are usually only of use in acute conditions. Whilst this is important in saving lives and minimising the consequences of falls, etc., the opportunity for early intervention is lost.

Whilst much of the basic care provision for the elderly is currently based on the traditional analogue telephone line, it appears that there are new opportunities emerging with the much wider availability of broadband and the falling costs associated with that. A related change in the core telephone networks is planned with BT’s announcement of a switch to Voice over IP (VoIP) technologies and the

¹⁹ Office for National Statistics (2004) *Demographic data needs for an ageing population*

availability of self-provisioned broadband by the end of the decade, i.e. broadband will be available on the vast majority of lines as soon as a subscriber signs up for it.

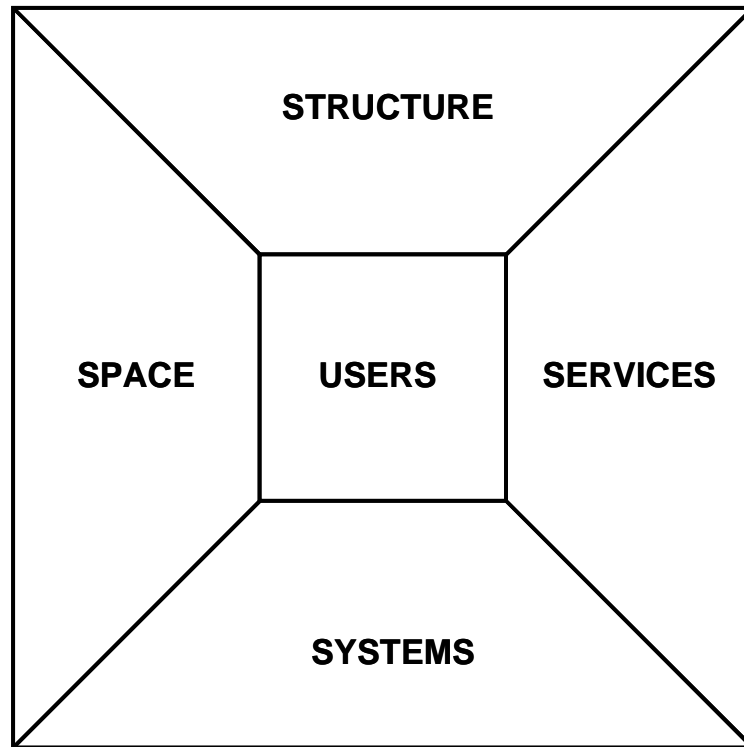
This switch to a wholly digital environment offers a number of important enhancements when dealing with emergency alarms, home care monitoring and the like. The existing analogue telephone-based systems provide only a single channel and, when that is occupied by a voice call, no other information can be sent. The digital broadband-based systems should allow two-way speech as before but offer additional channels allowing for data from, or about, the resident to be sent simultaneously and, potentially, for a video image of the carer to be available to the resident. Such an image improves communication substantially. Equally, if the home has smart home features, the carer may make adjustments or effect control of the home to assist the resident; tasks that would previously require a home visit.

3. What do we mean by The Caring Home?

In order to move a concept into the mainstream, two key elements are required: a broad value proposition which has recognition and appeal for a wide range of people, and a unique selling proposition (usp) which differentiates this concept from that which has gone before.

In the case of the caring home, the broad value proposition relates to the improved provision of safety, security, care and wellbeing through the design and operation of the home. This is a value proposition that connects to people of all ages, not just to older and disabled people. Children, young people, wives and families can all relate to this proposition in their own way. The precise way in which each perceives and captures the value will vary, and the home must be sufficiently flexible and adaptable to respond to these different needs. This can be achieved through the provision of infrastructures which can be used to support different applications over time, much in the way that we use the electrical infrastructure within the home.

This general value proposition must be applied to the different components of the home in a co-ordinated and consistent manner in order to achieve radical improvement in its performance and value. This integration can be considered in terms of the different elements of the home, from different viewpoints, as illustrated in the caring home pyramid below.



The Caring Home Pyramid - Viewed from Above

The unique selling proposition of the caring home relates to the integration and the performance of the systems and the services within the home.

In this regard, Nigel King proposes in Factsheet 5 of the Housing Learning & Improvement Network²⁰, the specification of a platform of basic property-based technology that can be built on as the resident's needs change. He also provides a checklist of levels of provision of assistive technologies for extra care.

We agree with that checklist but with one difference: it appears to us that many of the items on that checklist are either essential or at least highly desirable in mainstream housing whether that housing is single units or multiple dwelling units. We have therefore re-ordered the checklist and indicated those which should be universally applicable in housing (All Units), those that are applicable in multiple unit developments (Multiple Units) and those which are perhaps more closely connected with supported, sheltered and extra care schemes.

²⁰ Housing Learning & Improvement Network (2004) *Assistive Technology in Extra Care Housing*
www.changeagentteam.org.uk/_library/docs/Housing/Factsheet05rev02.pdf

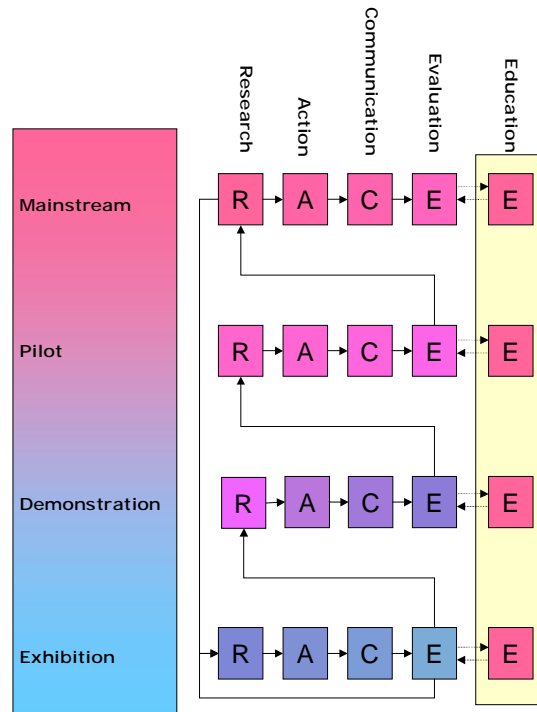
Item	Essential	Desirable	
Property-based sensors	Smoke Gas Flood Burglar alarm	Electronic shut off valves for water and gas	All Units
Smart Home	Strategic location of power points. Internet points and telephone sockets	One or two fully equipped units provided up-front for identified clients	
Internet	Narrowband Choice of Internet Service Provider	Broadband	
Care	Supporting structure for hoists		
Telephone	External supplier choice for residents	Free internal call system resident to resident	Multiple Units
CCTV	Cross site installation linked to monitoring facility or web cams in strategic locations		
Access	Keyless lock to communal doors	Extended to all doors	
Television	Develop and own infrastructure Terrestrial and cable or satellite Terrestrial to be at no extra cost to residents	A Scheme intranet	
Fire system	addressable system in main buildings to assist in fast identification of site of fire	Extend to all properties	
Billing for services	Menu of services and charges, cashless system as much as practicable	Access to bill data	
Building management	Heating, lighting, lifts, ventilation	Receive fault alarms Remotely interrogate devices Remotely rectify faults	
Emergency alarm	Radio sensors Resident cancelling facility Local management and remote site back up	Facility to alert relatives in parallel	Extra Care
Personal sensors	Movement detection Fall monitors Bed sensors	Tele-medicine facilities	
Environmental controls in dwellings		Building management package for lighting, music, heating etc (perhaps an option for sale properties)	Option

4. Models for Moving into the Mainstream

Over the past seven years the INTEGER action-research programme has worked successfully to bring the concepts of *intelligent & green* buildings into the UK mainstream. Emerging from this work are a number of change models which we believe can be beneficially applied to the mainstreaming of the caring home.

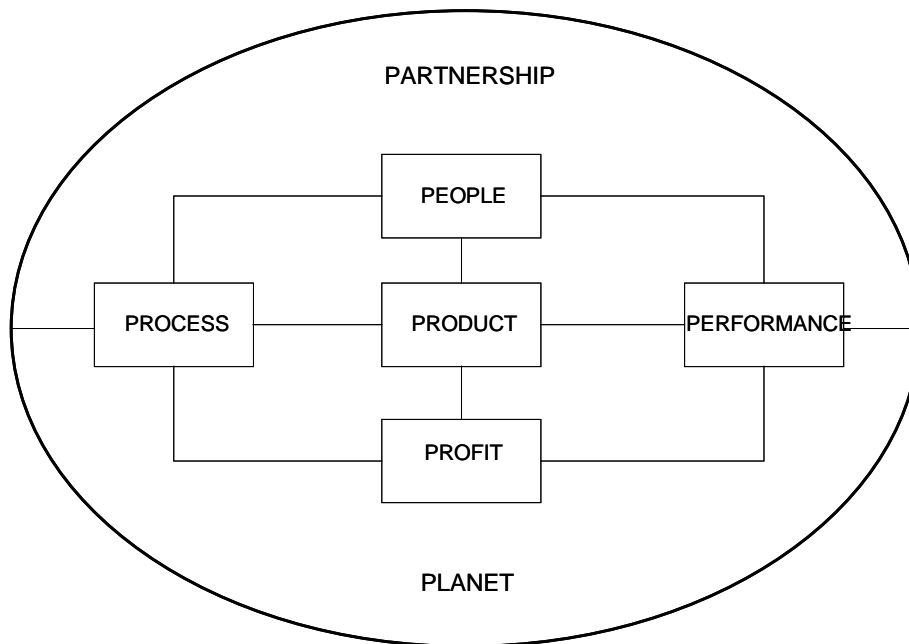
The first of these is the four-stage innovation model shown below. In our experience, it is quite impossible to establish a radical new concept in an established, conservative industry such as housing in a single step-change of innovation. What is required is a change management process which recognises and addresses this fact. The four-stage INTEGER innovation model achieves change through the four stages of Exhibition, Demonstration Projects, Pilot Projects and Mainstreaming. At each of these stages a systematic methodology is applied of Research, Action, Communications, and Evaluation. Each stage feeds

into an Education “ladder”, which raises the understanding and the aspirations of the general public.



This step-change innovation model has to be applied within the framework of a programme management integration model which engages all of the key stakeholders in the process. The INTEGER 7P Programme Integration Model, illustrated below, provides such a framework.

This model take a holistic view of the process of designing, constructing and using buildings, seeking to identify opportunities for applying innovative principles in an extensive and integrated way. The INTEGER partnership turns these ideas into action by involving stakeholders from all parts of industry and the community, thereby demonstrating the extensive benefits of innovation to all concerned. Underpinning this approach is the 7P Programme Integration Model, which demonstrates how innovation and benefits can be delivered simultaneously at the levels of Process, Product, Performance, Profit, People, Planet and the Partnership. The fundamental aims of this model are to develop and deliver an extended, integrated value proposition for the innovation which is shared by all the stakeholders, and to provide a mechanism which maintains a focus upon this value proposition. This model shifts the fundamental management aims from cost management to value delivery.



The 7P Programme Integration Model

5. Demonstrating What's Possible

The principle of taking the caring home into the mainstream is currently being put into practice by the INTEGER partnership, working in particular with Westminster City Council and the ALMO CityWest Homes. The project on which these principles have been demonstrated, and are now being extensively piloted, is the refurbishment and regeneration of Glastonbury House, a 1960's twenty-storey tower block located in Pimlico.

The overall value proposition for this programme was developed through a series of inter-active workshops with management, residents, and other stakeholders. An integrating model was used as a basis for these workshops, to produce the necessary integrated value proposition. Health and care facilities are being incorporated into the block at the level of the individual homes, through the provision of additional tenant and neighbourhood services, and through the incorporation of extra-care units.

The success of this project may be judged from the following evaluation, provided by the Deputy Prime Minister following his visit in October 2003:

This morning I visited Glastonbury House refurbishment project only a few minutes away from here. It is a 22-storey tower block in Pimlico which was built over 30 years ago and is a flagship project for innovative practices in four areas: the environment, the social innovation, construction innovation and technology. Once this project is completed, Glastonbury House will be the UK's first intelligent and green residential tower, clearly a truer, better building. The building is eco-friendly, designed with low energy from district heating and with a four-metre high wind turbine on the roof, which apparently caused problems for the planning body.

Water use is kept low with rainwater harvesting, spray taps and showers - you know most of those. Moreover, residents will be able to stay in the block during the construction, which is quite unique, and this shows that eco-friendly developments can be built into refurbishment programmes and even these old tower blocks. It was exciting, well liked by the residents, a sustainable community in a tower block, and I congratulate all those involved and recommend that you visit it.

6. Next Steps into the Mainstream

The INTEGER action-research partnership has now been commissioned to work on a series of major housing projects around the country. These provide an opportunity to bring the proposition of the caring home further into the mainstream, by delivering it as part of an integrating innovation agenda and composite value proposition. These projects include tower-block refurbishments in Newcastle, new-build social housing in Wolverhampton and new-build housing developments in Hertfordshire. INTEGER welcomes the opportunity to work with the DoH, and other partners working in the field of health and care in housing, to develop and deliver the caring home as a fundamental aim of these projects.

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BIOGRAPHIES

Nigel J W Appleton

Nigel Appleton leads Contact Consulting, a small research and consultancy practice specialising in the accommodation and care needs of older people and operating at the interface of health, housing and social care.

Nigel has undertaken various assignments for the Change Agent Team at the Department of Health

He led the team that carried out the research and preparatory work for the recent joint ODPM/DH & DES guidance on housing adaptations. He has written for the Joseph Rowntree Foundation and has recently published work on assistive technology.

Peter Colebrook BSc, MIEE

After a wide range of roles in the world of engineering, in the mid-1990's Peter founded his own consultancy advising on technology strategy for the home, building and utility control industries. In 1998 merged with other market leaders to form i&i limited, where he is Director of Technology.

He was responsible for a number of projects including Carol Vorderman's "Dream House" for BBC TV, and consults for companies in the construction industry on related intelligent systems opportunities.

Peter has written and lectured widely on intelligent controls for buildings and specialises in the cost and performance benefits of integration. He chairs the British Standards Institution committee on Home and Building Electronic Systems.

Dr Ian Donald

Dr Ian Donald has been a consultant geriatrician in Gloucester since 1988, having qualified from Cambridge and Edinburgh, and trained in Nottingham. His long-standing interest in the organisation of services for older people in the community probably stems from his family background of general practice. His MD, carried out as a consultant, was based on a longitudinal study of older people in the county. He is now Clinical Director for Rehabilitation services across the county, and also PEC member of West Gloucestershire PCT.

Alan Kell MSc, BSc

Alan is a consultant on innovation and change management between information technology and the built environment. He specialises in creating the vision, understanding and partnerships to deliver buildings that meet the changing needs of the 21st century.

In 1998 he established i&i limited, in partnership with Allan McHale and Peter Colebrook. Together they provide a unique range of professional services in market research, strategic technology consultancy, and market development. He is an international speaker on intelligent buildings and has held a series of

leading industry positions, including convenor of Intelligent Buildings 2004 and chair of the MSc in Intelligent Buildings at the University of Reading.

Jeremy Porteus

Jeremy is the Housing Network Lead in the Health and Social Care Change Agent Team at the Department of Health. He has particular responsibility for developing the Housing Learning and Improvement Network and working across health, housing and social services to promote and facilitate the development of housing with care choices for older people.

Prior to his present post, Jeremy was Head of Corporate Policy at Anchor.

He is the joint author of 'Using Telecare: Exploring Technologies for Independent Living for Older People' (Anchor Trust/Housing Corporation, 2000) and co-wrote 'Having our say: A housing action kit for older people' (Care & Repair England, 2003).

Moyra Riseborough

Moyra Riseborough is an academic and freelance researcher, consultant and writer. She is a Lecturer at the Centre for Urban and Regional Studies School of Public Policy at the University of Birmingham and heads RRCA, a small consultancy organisation based in Northumberland.

Moyra contributes regularly to the Housing LIN as a speaker and as a researcher and writer.

Georgina Truscott

Georgina Truscott was a marionette maker and performer working in schools and with young people in the community. Gradually, since the late 1980s, increasing physical limitations because of multiple sclerosis have diverted her energies towards her interest in people, and concern for their well-being. She works with Whitby Disablement Action Group, helping disabled people to lead more independent and fulfilled lives, and is deeply involved in finding ways to help the older people in her community.

John Truscott

John Truscott trained as a metallurgist and spent most of his working life as an engineering manager in the process industry, latterly concentrating on recruitment and development of young engineers.

In retirement his main interest is now in the Abbeyfield Esk Moors project, and he also spends one day each week as a voluntary advisor in a local Citizens Advice Bureau.