Housing, Health & Social Care: Service Integration and Community Development in the Provision of Appropriate Residential Accommodation through Extra Care Housing.

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Contents

Preface

The research reported in this document is both important and timely.

It is important because it deals with a section of the population which is growing in number: the elderly. This group of people have particular housing and care requirements, and these requirements, if considered as part of an active stock management approach, can have positive consequences. These positive consequences in relation to the housing market include the release of larger properties, which can then be used to house families rather than elderly individuals or couples, and the provision of more appropriate housing for the elderly, which can be developed and maintained at lower cost. In addition, housing provision better matched to the needs of the individuals or couples, can also deliver benefits in terms of the reduced cost of social and health care. These and other dimensions of the provision of Extra Care Housing (ECH) are considered herein.

The report is also timely because the crisis in social care – especially the costs and staffing of conventional methods of delivering domiciliary social care – is growing in scale, intensity and political importance. This social care crisis is matched by the even greater problem of delayed transfer of care from hospitals; this problem is growing year-on-year and reflects the lack of conventional social care accommodation, restrictions in public funding and the increasing difficulty of providing domiciliary care.

This 'perfect storm' is the consequence, among other factors, of the absence of sufficient appropriate accommodation for the elderly and vulnerable. The response suggested by this report is to take action to promote ECH in order to provide mixed tenure accommodation – from short term social rented units, through shared ownership to owner occupation – with a range of social and health care services available to residents. As this report argues, this type of property offers a form of accommodation that better meets the requirements of the elderly and vulnerable, while also reducing the occupation of hospital beds by people who are fit to be transferred and cutting the cost to local authorities and other organisations of providing social and health care.

The benefits of ECH will not deliver themselves; they require careful planning and competent management. However, irrespective of the local situation, the available evidence

would appear to suggest that the provision of ECH can offer accommodation that extends the independence of the individual and allows for the more cost-effective delivery of health and social care.

The authors offer this report as a contribution to the wider debate on how best to accommodate elderly and other vulnerable people. It is offered in the spirit of open debate, and it provides suggestions as to how the necessary ECH accommodation can be built and managed.

Any report of this nature reflects not only the views of the authors, but also the experience and ideas of many others. We wish to thank all those who gave of their time during the research programme. We also wish to acknowledge the provision of funding to enable this research to be conducted; the Planning Exchange Foundation has been a generous sponsor.

As ever, this report could be subject to constant updating and amendment. Any suggestions for the further development of the work programme are most welcome, as are ideas for further case studies or the development of operational applications.

Executive Summary

This report considers the contribution of Extra Care Housing (ECH) to meeting the health and social care needs of elderly and other vulnerable people. It also considers how best ECH can be provided and offers case studies of such provision.

In examining the role of ECH, the report identifies and assesses the drivers of the increasing demand for suitable housing provision for older people – an element of the total UK population that is growing rapidly and, as a consequence, is placing significant demands on health and social care services. This increased demand is occurring at a time when public sector funding for social care has fallen in real terms and funding for the NHS struggles to meet the demand for services.

Through providing ECH, case studies indicate that the current number of hospital bed days utilised by older patients could be cut, both through avoiding admission (or re-admission) and through earlier discharges. These savings can also be seen as a way of freeing-up NHS beds that can then be used to treat other patients and thereby reduce the number of cancelled treatments and referrals to the private sector.

Extra Care Housing is best provided as part of an integrated package which brings together health, social care and housing solutions. Such an integrated package also allows for the release of under-occupied family housing and, as a consequence, contributes to reducing the shortage of family housing as part of an active stock management approach.

Most importantly, ECH as the keystone of an integrated service for older and vulnerable people would provide a foundation for better health and social care pathways, and it has the potential to provide more effective care in a more cost-efficient manner. Devolution arrangements in Greater Manchester and elsewhere offer important testbeds for an integrated approach.

Positive planning as a means of developing and implementing strategic initiatives aimed at the integration of services will require the development of partnership working; agreement on the desired actions and outcomes; the pooling of financial, human and other resources; and the sharing of roles and responsibilities.

By providing appropriate accommodation through the integration of housing, health and social care services, this report indicates how a substantial dividend can be delivered that will benefit the public purse, private budgets and, most importantly, the users of ECH.

Main Report

1. Introduction

Irrespective of which political party is in power, demography dictates that the provision of health and social care for the elderly and other vulnerable people is a problem that will not go away. Extra Care Housing (ECH) offers a positive contribution to solving this problem and deserves increased attention. This report examines the role ECH plays in the provision of care and accommodation for older and other vulnerable people and it considers how it may offer potential for service improvement alongside cost savings across the NHS and in social care. The discussion is set in the context of an ageing population that is placing more demand on NHS and social care services, but budget cuts within these services mean that more cost-effective and efficient means of provision must be identified and implemented.

Although much of the current debate on the topic is concerned with either the case for additional funding or the integration of the delivery of health and social care, the consideration of the potential of ECH as a means of meeting the needs of older and vulnerable people provides a more positive and potentially cost-effective perspective.

2. What is Extra Care Housing?

Extra Care Housing is housing accommodation for older and vulnerable people that allows the residents - individuals or couples - to maintain their independence by having their own front door, while also offering on-site health and social care and assistance. Extra Care Housing may be provided by a local authority, a housing association, a charity, a private company or some other form of competent organisation. As Independent Age (2015, p3) notes:

- *"Residents are usually aged 55 or over and are able to live safely on their own with some support.*
- *The accommodation consists of self-contained adapted flats or bungalows.*
- *Care and support staff are based on site and available up to 24 hours a day, providing personal care and domestic support such as cleaning and laundry services.*
- *Emergency alarms are placed throughout the scheme so residents can call for help, day or night.*

- *There are some communal facilities and shared services, such as a lounge, dining area and landscaped garden."*

In addition to the features noted above, it is important to recognise that ECH also offers wider benefits to both residents and the local community, including the better management of available housing stock, the provision of health, social care and other welfare facilities to non-residents, and the reduced call placed by ECH residents on public, private and voluntary services. As a consequence, ECH can help to reduce the overall level of inherent and actual demand for primary and secondary health services, local authority and other social services, and a range of welfare facilities.

3. Increasing Proportion of Older People in the Population

It is well documented that the proportion of older people in the UK population is increasing and will continue to increase.

> *"Our population is ageing by five hours a day[1]. The number of people in the UK over the age of 85 is set to double in the next 20 years and treble in the next 30[2]. As a consequence older populations will form a growing proportion of our society."*
> (Redding et al 2014, p4)

Between 2005 and 2015 the number of people aged over 65 increased by 21 per cent (Office for National Statistics (ONS) 2015) and is predicted to increase by the same proportion between 2015 and 2025, while the number of those younger than 65 will increase by just 4 per cent (ONS 2013).

In addition to the increase in the proportion of older people in the population, advances in medical care mean that some conditions that were previously life threatening have instead become long-term conditions. This means that the additional years that people are living are not necessarily healthy years.

[1] From: Kirkwood (2006) Too Fast By Mistake. Nature 444:1015-1016

[2] From: Office of National Statistics (2013) National Population 2012-based Statistical Bulletin. London: ONS.

> *"Around 15 million people in England have one or more long-term conditions, with the number of people with multiple long-term conditions predicted to rise by a third over the next ten years."*
>
> (London Health and Care Integration Collaborative, 2013, p11)

As a consequence of these and other factors, older people place greater demands on health and social care and so it follows that as the proportion of older people in the population increases, so will demand for these services. Furthermore, given the significant increase in the number of older people, coupled with a low rate of growth in conventional care home provision, the availability of conventional care has become problematic (Hurst, 2017) and the cost of accommodation has increased significantly (Brignall, 2017).

4. Reduction in Funding for Social care

Added to the increase in the proportion of older people in the population, is the decrease, in real terms, of public sector funding for social care. Between 2005 and 2015 it is estimated that spending on social care services fell by more than £2.5 billion (34 per cent) with cuts to community care services accounting for £0.6 billion of this (Age UK 2015). One consequence of this claimed reduction in expenditure has been the decrease, in some areas, of traditional local authority or supported care homes.

In addition, Brooks (2013, p1) notes,

> *"The total number of clients receiving care and support services aged 65 and over…declined from 1,148,000 in 2009/10 to 991,000 in 2011/12, a drop of 157,000 people or 13.7 per cent."*

This is reflected in the drop in the number of English local authorities providing support to low income pensioners assessed as having moderate needs, from 50 per cent in 2005 to just 11 per cent (17 councils) in 2013 (Brooks 2013).

The number of community nurses also dropped sharply between 2009 and 2014[3].

- *"district nurses plunged by 27.5 per cent (from 7,851 to 5,690)*

[3] From: Health and Social Care Information Centre (2015) *NHS Workforce Statistics – November 2014, Provisional statistics* http://www.hscic.gov.uk/searchcatalogue?productid=17324&topics=1 per cent2fWorkforce per cent2fStaff+numbers&sort=Relevance&size=10&page=1#top

- *community matrons dropped by 17.1 per cent (1,552 to 1,287)*
- *nurse consultants in the community fell by 40.4 per cent (from 235 to 140)"*

(Age UK 2015, p1)

Whilst these figures are telling in themselves they are also significant because these professionals play an important role in keeping older people out of hospital.

To compound the issue of reduced resources for social care, it has also been noted that the provision of unpaid care is likely to reduce in the future. Whereas today the majority of informal, unpaid care provided to older people is from family members, in the future this might not be the case as family members do not necessarily live close to those requiring care.

> *"with people born since the mid-1950s showing different patterns of family formation and dissolution, the longer-term prospects for the familial support of older people are likely to be less favourable."*
> (Healthwatch England 2015, p22)

This means that the need for formal care for older people will not only increase because of their greater numbers, but also because informal care from family members will be less prevalent. Such changes in circumstances and lifestyle are likely to have profound repercussions (Croucher et al 2017), including the need to consider now the mix of new build housing provision.

In partial mitigation of these trends, it is evident that ECH can help to deliver social and health care in a cost-effective manner. A study by East Sussex County Council (East Sussex County Council 2013) found that significant cost savings were made through developing ECH schemes. These savings were achieved through a combination of the effective placement of individuals in the appropriate care setting (i.e. ECH rather than, for example, more expensive private sector conventional residential care), good management of current health conditions, early intervention in new health conditions and accident prevention. There is also evidence to suggest that living in ECH can improve health (Kneale 2011). The East Sussex County Council study also notes:

"the cost of a placement in extra care housing is half that of the alternative placement or care package," and

"the return on capital investment is 1.5 years best case scenario and 3.3 years worst case scenario." [4]

(East Sussex County Council 2013, p8)

Similarly, savings are demonstrated by the Sunderland City Council case study (see Appendix 1), which notes that the cost of providing care through an ECH facility is 58 per cent less per annum than providing the same care through a conventional residential care home, and much less than maintaining a person in a hospital bed.

Both these statements are significant in putting the case for ECH[5]. The following section discusses the positive impact ECH can have on bed occupancy rates in hospitals and the resultant cost savings.

5. Reduction in Hospital Bed Occupancy Rates

One argument for the greater use of ECH is its ability to reduce hospital bed occupancy rates. Those aged over 65 account for 68 per cent of hospital emergency bed days per annum and use more than 51,000 acute beds at any one time (Imison et al, 2012). With more than 2 million unplanned admissions each year for people over 65, reducing admissions and creating a timely transition of care out of hospital for this group of people has a significant impact on bed use in hospitals. This direct and multiplier impact can be seen in the non-availability of beds and other facilities for planned treatments and consultations, thereby reducing the income of hospitals and other providers. These cumulative consequences exacerbate the financial difficulties faced by many NHS organisations. Moreover, delayed transfers of care can also have a detrimental effect on the longer term health of older people as, for example, it is *"estimated that 10 days of bed rest can equate to 10 years of muscle ageing with attendant loss of function" (Vernon, 2016)*

[4] This is based on capital contributions made by East Sussex County Council (ESCC) in 5 schemes and on the gross savings made. ESCC has invested £3.1m of a total £35.1m committed to the schemes, so the return on capital investment is based on this £3.1m figure. The gross savings have been made through services no longer being required by those entering ECH e.g. someone moving from residential care to ECH; these are actual cost savings. Savings are also made by residents of ECH avoiding admission to residential care, ESCC estimates this applies to 63 per cent of those living in ECH; these are avoided costs. (East Sussex County Council 2013).

[5] The figures upon which they are based are confidential so cannot be presented here.

It is also claimed that poor or inappropriate housing for older people (aged 55 or more) costs the NHS over £600 million per year (Adams 2016). This is due to older people living in accommodation that has not been adapted to prevent trips and falls, is cold and damp and is inappropriate in other ways.

> *"There is a well evidenced link between housing conditions and falling and also analysis of how poor or unsuitable housing conditions increases the risk of falls."*
> (Adams 2016, p8)

In addition, there is the issue of older people remaining in hospital longer than required. This is not a recent problem. In 2008, in a report on ECH for the Housing Learning and Information Network (LIN), Miller noted as one of the recommendations that the suppliers of ECH needed to,

> *"Develop links with PCT's e.g. health promotion; screening; health services linked to extra care housing; hospital discharge/intermediate care/respite care."*
>
> *(Miller 2008, p13)*

More recently the CQC (2016, p22) reviewed the integration of health and social care for older people and noted in its findings.

> *"Although we were made aware of initiatives to improve older people's transfer of care from hospital, in practice we saw delays in discharge from hospital, poor information for the receiving provider, and a lack of clarity of who was responsible for facilitating older people's hospital discharge."*

The review also notes that:

> *"Despite some improvements, care is still fragmented with unclear lines of referral and communication within and between organisations."*
> (CQC 2016, p8)

The review identified that delays to transfer of care were also caused by things as simple as lack of available transport or the inability of care homes to accept new people at weekends,

and not always by the failure of clinicians to refer or propose discharge at the correct time, or the inability of social workers to carry out timely assessments.

However, even when older patients are discharged, the transfer can occur without adequate assessments or care plans and without sufficient support arranged, which can lead to readmissions within a short period of time.

> *"In 2013 Age UK reported an estimated 830,000 older people in need of care were not receiving any formal support."*
> (Healthwatch England 2015, p28)

Furthermore, the report by Lord Carter (2016) for the Department of Health (DH) identified the potential for over £5bn of savings to be made annually by acute hospitals. As part of this, the review is explicit about the effect that delayed transfers of care have on the NHS and notes that 'nearly all' NHS trusts have an issue with moving people out of hospital and into more appropriate care settings. It notes:

> *"This failure results in sub-optimal use of high acuity clinical resources and delays to treatments for other patients.*
>
> *The resultant loss of income to trusts cannot be offset as costs are still incurred relating to clinicians, operating theatres and other overheads. Consequently, trusts are having to care for patients in the wrong clinical setting, find it more challenging to meet national standards for patient access, have poor clinical productivity, and incur operating losses."*
>
> *(Lord Carter 2016, p3-4)*

Since the initial Carter review was published, the situation regarding delayed transfers of care has deteriorated; alongside this is the continued erosion of local authority capacity to provide social care. The consequence is the exacerbation of an already serious situation, both in terms of the care provided and financially, for the NHS, local authorities and other public sector organisations.

Many of these problems have existed for some considerable time. For example, the work of Imison et al (2012, p15) revealed considerable differences between PCTs with high bed use

and those with low bed use for patients over 65 that had been admitted to hospital from home, but would be discharged to a care setting:

> *"Among PCTs with the highest use, the average length of stay for these patients was 36 days. The length of stay for similar patients in the other three PCT groups [with low bed use] was at least nine days shorter. This pattern is repeated for patients over 85."*

This variance reflects the provision of differing levels of support for over 65s making this transition. Where bed use is high, support is weak, but where support is strong, bed use is lower. Stronger support is often experienced in localities in which older people make up a larger proportion of the population; a greater proportion of older people in a local population can mean better developed policy and practice.

> *"Areas with higher proportions of older people have lower rates of emergency bed use. These areas may be more likely to have prioritised the needs of older people and to have developed integrated service models."*
> (Imison et al 2012, p1)

Carter (2016, p4) emphasises how important timely transfers of care are to financial efficiency stating that:

> *"a significant proportion of the £5bn [of savings identified in the Carter report] cannot be unlocked unless delays in transfer are managed more effectively."*

The delays in transfer of care have led to a high number of beds being occupied by patients that could be moved to settings more appropriate to their needs. For example, NHS England estimates that delays in transfer of care has led to around 5,500 patients per day occupying beds in acute trusts, but Carter argues this problem is much greater at around 8,500 beds per day (based on data provided by 96 acute trusts). Furthermore, recent figures show that in July 2016, 184,000 beds (across the whole month) were occupied by patients that should have been transferred. This was the highest monthly figure since this data started to be recorded in 2010 and compares with 147,000 in July 2015. Another report (Healthwatch

England 2015) estimated that 80 per cent of all delayed discharges or transfers of care are experienced by people over the age of 70[6].

In addition, Imison et al (2012, p4) adds a further perspective,

> *"…if length of stay for patients over 85 was reduced to the level achieved in the 10 urban PCTs with lowest bed use, about 3,200 beds would be released."*

Figures quoted by Carter suggest that the cost of delays in the transfer of care could be in the region of £900m/annum (based on £300/bed/day). If we assume that each episode of delayed discharge or transfer of care costs the NHS an equal amount, £720m (80 per cent) of this is attributable to those over the age of 70, including £350 million to those aged over 85. Applying this to the figures for July 2016 noted above, shows that the cost of delayed transfers of care in that month alone was an estimated £55.3m.

If these figures are also applied to the results of a study by Aston University (2015) it is estimated that for each ECH resident the savings made through the "*reduction in the duration of unplanned hospital stays from 8-14 days to 1-2 days*" is between £1,800 and £3,900 per unplanned stay.

Not only do these figures show that delayed transfer of care and increased length of stay issues are costly in themselves, as noted above, there is also a knock-on effect through the cancellation of operations in NHS hospitals with the result that operations are undertaken in the private sector and paid for by the NHS, the cost of which currently stands at £11bn per annum with acute care paying around £2bn of this (Carter 2016).

Through the provision of on-site care, and enabled by the design of homes that contain features to reduce the risk of injury, ECH can also help to prevent unplanned admissions to hospital through regular health and social care contact, which provides good management of current conditions, such as diabetes, and early intervention for new conditions. In addition, where minor injuries do occur to residents of ECH, they are more likely to be treated on an outpatient basis, whereas comparable injuries occurring to older people living in mainstream housing are more likely to be treated as an inpatient; this is mainly because immediate domiciliary care is not as available to the latter group. Furthermore, where

[6] From: Royal Voluntary Service Report 'Unhappy Returns' (2014)

inpatient care *is* required for residents of ECH, discharge is likely to be sooner than for those living in mainstream housing where again the absence of available domiciliary care is a key factor in delaying discharges (Kneale 2011).

It has also been noted that accident prevention within ECH comes not only in the form of the ergonomic design and adaptations that the residences contain to make them safer for older people compared with homes in the general housing stock, but also in the form of group exercise classes and other therapies which may improve mobility and thus reduce falls (Kneale 2011).

A study by the Aston Research Centre for Healthy Living analysed the health and social care usage and costs for 162 residents of ECH over the first 18 months of their residency. The key findings of the study noted:

- *"NHS costs were cut by 38 per cent over 12 months compared with when they first moved in.*
- *Extra Care residents experienced a significant reduction in the duration of unplanned hospital stays, from 8-14 days to 1-2 days.*
- *Routine GP appointments for Extra Care residents fell 46 per cent after a year.*
- *Numbers of people with clinical levels of depression fell by 64.3 per cent over 18 months.*
- *Of the residents who arrived at Extra Care in a 'pre-frail' condition, 19 per cent had returned to a 'resilient' state 18 months later."*

(Aston University, 2015)

It seems clear from the above study, and more recent evidence, including a detailed evaluation of ECH in Wales (Batty et al, 2017), that ECH can contribute to reducing bed occupancy rates in hospitals through prevention of the need for hospital stays due to better management of current conditions and, in some cases, through actually improving the health of residents. In addition, it can speed up the transfer of care process by providing a clear pathway to an appropriate and, hopefully, immediately available care setting for older people upon discharge from hospital.

6. Integrated Care

Effective integrated care has been a widespread national policy ambition and commitment for many years (CQC 2016). It is argued that the integration of all services that provide diagnosis, treatment and care can lead to a better experience and improve the outcomes and efficiency of care.

> *"Developing integrated care means overcoming barriers between primary and secondary care, physical and mental health, and health and social care to provide the right care at the right time in the right place."*
> (Ham & Walsh 2013, p1)

This is particularly relevant to older people, whose care needs are often more complex than the average member of the population and require the attention of more than one care service, and, in many cases, the providers of housing and other facilities. As Redding et al note:

> *"75 per cent of 75 year olds have more than one long-term condition, rising to 82 per cent of 85 year olds. The majority of older people may therefore have multiple physical and mental health needs which require input from across primary care, secondary care settings and social care."*
> (Redding et al 2014, p4)

Central government, as part of the National Collaboration for Integrated Care and Support[7], published a commitment to integrated care and support (2013, p1) in which it addressed the:

> *"need to create a culture of co-operation and co-ordination between health, social care, public health, other local services and the third sector."*

The news release for the report quotes Norman Lamb MP, the then Minister of State for Care and Support, who said:

[7] The partnership comprised: ADASS, ADCS, Care Quality Commission, Dept. of Health, Local Govt. Association, Monitor, NHS England, NHS Improving Quality, NHS Health Education England, NICE, Public Health England, SCIE and Think Local Act Personal.

> *"Unless we change the way we work, the NHS and care system is heading for a crisis. This national commitment to working together is an important moment in ensuring we have a system which is fit for the future."*

In 2015 the Comprehensive Spending Review repeated the desire of central government to promote greater integration between health and social care services (CQC 2016). It was anticipated this integration of services would lead to better pathways of care. As Carter (2016, p10) identifies, transfer of care processes are not always clear and the report makes an explicit recommendation for:

> *"DH, NHS England and NHS Improvement, working with local government representatives, to provide a strategy for trusts to ensure that patient care is focussed equally upon their recovery and how they can leave acute hospitals beds, or transfer to a suitable step down facility as soon as their clinical needs allow so they are cared for in the appropriate setting for themselves, their families and their carers."*

In addition to the integration of health and social care at local level, a third element – appropriate housing – needs to be added to the mix in order to provide an optimal solution. This third element, and especially housing provision through ECH, offers a means of developing health and social care that is both cost-efficient and, more importantly, tailored to the needs of the individual, irrespective of their prior circumstances.

Further to the above points, there is also an argument that better case management, including attention to the housing needs of individuals, would contribute to reduced bed use in hospitals. Redding et al (2014, p13) suggest that the key factors for achieving this include:

- *"Clarity about roles and responsibilities*
- *Accurate case-finding*
- *A single point of access and joint care plan*
- *Use of joint health care and social care teams*

- *Effective information systems and mechanisms for sharing information.[8]"*

The Care Act 2014 suggests 'integration' should go further and include wider infrastructure, with the intention that it:

> *"Drives integration of health and care services, including 'health related' services such as housing."*
> (Housing LIN 2014, p4)

An additional dimension in the search for integration is the link between poor or inappropriate housing and ill health (as discussed earlier in Section 5 on page 12). Work by the Housing Learning and Information Network and others has pointed to this link, which implies the need to provide appropriate housing, such as ECH, that better meets the needs of elderly and vulnerable people.

The Care Act 2014 also places a duty on local authorities to:

> *"Facilitate and shape their market for adult care and support as a whole…to influence and drive the pace of change for their whole market."*
> (Planning Advisory Service 2014, p11)

The place for ECH in this integration is not only in the provision of care to older people, but also in the prevention of conditions developing and deteriorating, and in the avoidance of accidents. It was noted earlier that ECH can help reduce admissions to hospital, reduce the length of stay for older people and also, significantly, can help to reduce the cost of care. However, there is considerable concern that the potential of ECH to deliver such contributions is not widely known. Miller (2008) noted that where ECH was provided, it was the view that there was a general lack of awareness of ECH. In addition, 58 per cent thought that there was a misconception about what ECH is and what it offers. However, it is clear from the case studies contained in the Appendix to this report that this lack of awareness has not affected the take up of ECH, indeed demand continues to outstrip supply (Idox, 2017). Within Knowsley there is a waiting list for ECH facilities, and both South Gloucestershire and Sunderland reportedly have no issues with demand. However, there is

[8] From: Ross S, Curry N, Goodwin N (2011). Case Management: What it is and how it can best be implemented. London: The King's Fund. Available at: www.kingsfund.org.uk/publications/case_management.html

an acknowledgement by Sunderland City Council that there is a need to explain very clearly what care packages are offered by ECH so that applications made for residency are eligible, i.e. potential residents are not in need of too much or too little care.

This desire to integrate health and social care, alongside wider public services and planning, has manifested itself as part of the 'deal' for devolution between central government and Greater Manchester Combined Authority (McKenna & Dunn 2015). This 'deal' resulted in the city-region taking control of its combined health and social care budget (£6 billion) on 1 April 2016 and has seen the unification of 38 different organisations (Greater Manchester Health and Social Care Partnership (GMHSCP) 2016). Two of GMHSCP's four key long-term aims are noted below and they indicate that health and social care will not operate independently of each other, nor will they operate independently of wider services:

- *"Creating a transformed health and social care system which helps many more people stay independent and well and takes better care of those who are ill.*
- *Aligning our health and social care system far more closely with the wider work around education, skills, work and housing."*

(GMHSCP 2016, online)

On the evidence available of the benefits that can be gained from the integration of services through the implementation of community planning in Scotland (Baczyk et al, 2016), it would appear that the aims of the Greater Manchester approach are well founded and will yield both service improvements and greater cost effectiveness.

7. Planning for Extra Care Housing

Many of the drivers to increase housing supply have resulted in a focus on enabling first time buyers to get on the housing ladder. By comparison there has been relatively less emphasis on the development and implementation of policy to increase the number of new homes for older people. However, given the ageing population, there is an increased and ever-growing need for bespoke housing for older people, and taking a strategic approach to this has a number of advantages, not least of which is that individuals can take up residence of bespoke housing in advance of the move being triggered by a health crisis. Adopting a strategic approach to development would also allow for integration of housing provision with new health and social care facilities and, importantly, could also enable the release of

more family homes onto the market through an active stock management approach (Housing LIN 2014).

> *"There is a generally accepted view..., driven by the knowledge of an increasing older population, that there is a large underdeveloped market for specialised housing offering a range of tenures including, leasehold, shared ownership, private rented as well as affordable/social housing."*
> (South Gloucestershire Council 2013, p5)

Whilst there is a general acknowledgement that housing for older people is required, the need to provide this housing has been described in Planning Practice Guidance as 'critical' (Planning Advisory Service 2014). The Select Committee on Public Service and Demographic Change (2013, p15) noted in its report 'Ready for Ageing?' that:

> *"The housing market is delivering much less specialist housing for older people than is needed."*

Research into planning for the housing needs of older people (Miller 2008) found that 64 per cent of 142 local authorities investigated had not produced a housing strategy specific to older people. Some 19 per cent of these had produced no strategy at all and 45 per cent had only recognised older people's housing needs as part of a wider housing or older people's strategy.

> *"Authorities with successful extra care programmes stressed the importance of a holistic approach that integrates accessible accommodation with care services across tenures and property types, linked also to improved neighbourhoods, information and advice."*
> (Miller 2008, p7)

More recently, initiatives have been developed that are aimed specifically at increasing the amount of housing built for older people. As noted above, the Care Act 2014 advocates considering housing as part of an integrated care approach, it also:

> *"Establishes the principle of wellbeing to shape assessments and delivery of services, including explicit mention of suitability of accommodation as part of that."*
> (Housing LIN 2014, p4)

In March 2015, under the Conservative and Liberal Democrat coalition government, the Department for Communities & Local Government issued a written statement to Parliament covering the provision of housing for older people. In this it stressed its expectation that local planning authorities produce clear and well-researched strategies for the provision of diverse housing types for older people. It notes:

> *"Local planning authorities need to be clear about the future level of both general and specialist accommodation that is needed for older people in their area."*
> (Department for Communities and Local Government 2015, online)

Prior to this the House of Lords Select Committee on Public Service and Demographic Change (2013, p15) had stressed:

> *"Central and local government, housing associations and house builders need urgently to plan how to ensure that the housing needs of the older population are better addressed and to give as much priority to promoting an adequate market and social housing for older people as is given to housing for younger people."*

There are also a number of business drivers for building accommodation for older people. For example, older householders have an estimated £250 billion of equity and as consumers they spend around £121 million a year, yet only 5 per cent of older people live in accommodation built to suit their needs (Housing LIN 2014).

Evidence from other sources indicates that the most severe under-provision of housing, when compared with similar countries in terms both of wealth and demographic characteristics, is in the field of ECH. In England, some 0.6 per cent of older people live in ECH, while in the US, Australia and New Zealand 5.3 per cent of older people are housed in ECH (Savills, 2015).

8. The Role of Positive Planning: Some Examples

In addition to the actions to secure enhanced integration between health and social care through the provision of ECH that have been discussed earlier in this report, it is also vital to consider such matters in the context of wider attempts to plan at local, regional and national level, including the role of land use plans and community plans (which currently operate in Scotland and Northern Ireland). Such an approach has been described as a 'whole of life and whole of community' model, and it offers best overall value through the integration of services and the most rational spatial alignment of facilities.

Work by the Town and Country Planning Association (2013) and its partners – including Public Health England, local authorities and a wide range of other organisations – has advocated the adoption of a place-based approach, and its model has also found favour at sub-regional level in many English Sustainability and Transformation Partnerships (STPs), which increasingly favour local place-based plans as a means of integrating the design and delivery of services. Further examples of such an approach can be seen in the various schemes now underway in the Greater Manchester city-region.

The remaining paragraphs in this section offer further information about the various approaches that have been adopted in order to enhance the planning and delivery of integrated health and social care through the provision of ECH.

South Gloucestershire Council is one local authority with a well-developed ECH strategy. It first developed an older people's housing strategy in 2006 and in 2012 it issued a briefing guide on ECH, which outlined the case for developing ECH in South Gloucestershire and provides details of the essential elements that ECH should contain. Importantly, and helpfully, the briefing also presents the council's planning policy position. The document is intended to provide a 'clarity of policy and approach' in order to encourage the development of ECH in the area and, as such, presents a proactive strategy for developing ECH and moving towards meeting the needs of an ageing population through active stock management.

In addition to this, the council also actively markets ECH in its area by publishing a magazine, 'Extra Care Housing' in which it promotes the benefits of ECH and the services offered, and provides details, including costs, of the ECH facilities available.

Interestingly, the Gloucestershire CCG area features as the locality with the biggest reduction – between 2006-07 and 2009-10 - in emergency hospital bed days per person for over 65's (Imison et al 2012).

Sunderland City Council has taken a similar approach to South Gloucestershire and has considered in detail the provision of housing for older people. This has been through consultation with all stakeholders. The conclusion is that older people do not want to live in traditional nursing care homes, and as a consequence the council is aiming to eliminate all of these in the City in favour of facilities offering different levels of care that meet the requirements of individuals (Planning Advisory Service 2014).

This is backed up by a recent change to Planning Practice Guidance which acknowledges that specialist accommodation or care is not necessarily what people desire.

> *"Planning for older people's housing is going through a period of evolution and change. The rapidly ageing population is making this more of a priority nationally, and housing preferences are diversifying to reflect changing aspirations and a better understanding of what works well for older people, within the budgets available."*
> (Planning Advisory Service 2014, p16)

9. Findings and Conclusions

Given the ageing population within the UK, the reduction in funding for social care, the ever increasing pressure on NHS resources and a stated requirement to reduce hospital bed occupancy rates, it is evident that ECH has an important role to play in providing an appropriate housing and care solution for older and vulnerable people. As has been outlined above, ECH can provide a more effective and less expensive care solution when compared with domiciliary and residential nursing care. Extra Care Housing can also reduce NHS costs by preventing hospital admissions and through offering a more explicit pathway to the transfer of care for older and vulnerable people.

However, a clear strategy at national and local authority level for developing ECH is required. This should be an integrated strategy that covers health, social care and local residential care providers. In order to ensure the most beneficial outcome, ECH should also be developed with direct links to the local CCG and healthcare professionals to ensure that

the role and provision of any ECH facility is known and can be utilised to best effect by all stakeholders. Forward planning and the active stock management of housing are also essential elements in the development of ECH. Appropriate accommodation will not deliver itself; neither can an individual organisation solve the problem.

Meeting the needs of the growing population of older and vulnerable people offers a classic instance of the importance of strategic thinking and action. No one organisation, be they in the public, private or third sectors, can undertake all of the necessary tasks. Rather, it is the case that partnership working, staff sharing, budget pooling and shared responsibility are the foundation stones for developing and delivering an effective and efficient solution. Continuing to ignore the problem or to work in isolation will not provide an appropriate and lasting solution. This report provides solid evidence that an integrated approach can deliver a substantial dividend to the public purse, private budgets and, most importantly, the users of ECH.

Appendix 1 – Case Studies

Bluebell Park (Knowsley MBC); South Gloucestershire County Council; and Sunderland City Council

1. Bluebell Park (Knowsley MBC)

Bluebell Park is situated in the Huyton area of Knowsley and is operated by Knowsley Housing Trust (KHT) part of the First Ark Group. There are 101 extra care apartments on site in a mixture of one and two bedroom units. The accommodation is modern and attractive and provides communal areas for socialising, relaxing and eating. The gardens provide opportunity for relaxation, exercise and gardening.

There are two operations on-site, the administrative and housing side run by KHT and the care side run by Community Integrated Care (CIC).

Strategy

Knowsley MBC published its Extra Care strategy at the end of 2016 used to plan and find sites for future ECH developments, identify potential partners for delivering these and find sources of appropriate funding. This is the first time that it has issued such a strategy with provision of housing for older people previously covered in its housing strategy.

Marketing

It has not been necessary to market Bluebell Park to potential residents because demand for it has been extremely high. Before the build was completed there was a waiting list of over 400 for 100 apartments and to demonstrate that demand remains high, 685 have applied for just 64 places at a new extra care facility being built in Knowsley.

There has been coverage by the local newspaper, principally concerning the opening of Bluebell Park and to report on awards won, but nothing wider than this.

Local integration

Health and social care

Bluebell Park, through First Ark, has excellent integration with local health and social care stakeholders.

Integration between KHT and CIC is seen as key to the successful provision of care to residents. The two organisations work closely and the site has been designed so that they share an open plan office to ensure that on-site teams do not work in isolation.

In addition, regular contact is made with the local authority and CCG through the Nominations Panel and CIC has strong relationships with local GPs and hospitals.

Referrals come from social services, care workers, GPs and access teams.

Community

Integration with the local community is seen as important. There is an on-site hairdresser and restaurant, both of which are open to, and used by, non-residents. In addition, the Bluebell Park residents group organises regular social nights that non-residents attend. Regular site visits are made by PCSO's and the local school choir has performed there.

Integration with local facilities is important and the location was chosen because of its proximity to Huyton town centre and accessible bus stops that go direct to Liverpool city centre.

Impact on local housing market

Around 50 per cent of residents at Bluebell Park have moved there from other parts of the local First Ark estate. This has freed up these residencies either for other tenants or for development to improve the facilities.

Admissions

The Knowsley Extra Care Nominations Panel recommends individuals for places in ECH in Knowsley. KHT has a place on this panel along with KMBC and the local CCG well as other providers of sheltered and extra care housing in the borough. This panel makes referrals to Bluebell Park where applications are assessed.

The provision of care at the facility is resourced to allow for a split between low, medium and high care needs of 30 per cent, 40 per cent and 30 per cent respectively; this is important so care needs are one of the considerations when applications for admission are assessed.

Local Financial Comparators

The housing package is funded through rental, service charge and fuel payments and the care package by Knowsley Metropolitan Borough Council (KMBC).

Costs charged at Bluebell Park in April 2016 are shown in Table 1.

Table 1 – Costs charged at Bluebell Park – April 2016 (£)

Beds	Net	Service Charge	Fuel	Lifeline	Total
1	91.39	36.92	22.76	1.50	152.57
1+	98.69	36.92	22.76	1.50	158.87
2	108.75	36.92	22.76	1.50	169.93

Non-clinical nursing care provision from KMBC costs £434/week or £456/week for the elderly or impaired; this is for home visits. CIC charges £12.50/hour or, if the care is commissioned by KMBC, £10/hour.

2. South Gloucestershire County Council

Strategy

The first strategic look at ECH by South Gloucestershire Council was in 2007. This was within the context of an Accommodation & Care Strategy that was produced in partnership with South Gloucestershire NHS. It involved auditing the current housing stock and care homes to gain an understanding of the lifespans of these buildings. The report identified three sites on which ECH units could be sited.

The main driver behind this is the increase in the number of older people living in the area in the future and a reduction in hospital admissions for older people was also a motivation. South Gloucestershire Council formally approved this document and it formed the basis for the future ECH strategy in the area.

South Gloucestershire's 'Health & Wellbeing Strategy 2013-2016', developed in partnership with the CCG is also explicit about the key role that ECH plays in helping older people to live healthy, active and independent lives for as long as possible.

The 'Better support for older people' project was developed and presented to the council in February 2010 and looked at future care and housing needs for older people in South

Gloucestershire and the results of consultation supporting the strategy of maintaining independence in a person's own home, the development of new care homes and supporting the Extra Care programme.

The stated aim of South Gloucestershire Council is to have in development 700 ECH units by 2016/17; 300 of these available for rent and 400 available to purchase, including shared ownership. Six sites have been utilised/identified in the public sector in addition to private sector providers developing two sites with a further two identified and at planning stage.

Marketing

South Gloucestershire Council produces a regular magazine that promotes its stock of ECH. In addition, social workers dealing with older people are also aware that it is offered and can recommend ECH where it would benefit the individual. Voluntary agencies, such as Age Concern, are also aware of the provision of ECH and are able to promote it. The operators of the sites actively market the sites to potential tenants and owners.

South Gloucestershire reports that there has been no significant issues regarding demand for the public sector ECH units.

Local integration & Community Setting

Sites for the development of ECH are distributed across the whole South Gloucestershire area. This is because potential customers generally do not want to move more than a few miles from their current residence.

Sites are chosen for their proximity to local amenities, health services and transport links and development follows the HAPPI design principles.

Impact on local housing market

The impact on the housing market of the provision of ECH has been 'very positive' allowing the release of larger homes to young families. The impact is evidenced by the fact that some 37 per cent of nominations to public sector ECH were previously home owners.

The increase in ECH provision has also led to a reduction in admissions to residential and nursing care homes. Accurate figures have yet to be determined; however, a project is shortly to be undertaken in partnership with Public Sector Health to determine the impact of ECH on reducing admissions to hospital, residential and nursing care.

Admissions

Applications for public sector ECH units are first considered by South Gloucestershire Council. Any that pass this stage are then put forward to the ECH providers for assessment and applicants are also interviewed should they wish to proceed. Assessed care needs are integral to the process with a mix of needs required to allow the units to operate successfully. The maximum care offered is 30-35 hours per week, the minimum could be one hour. The care packages are commissioned by the local authority and charges made to the service user according to care band and financial assessment although this can also be paid for privately if the individually wishes to and does not qualify for local authority funding.

Care Provision

The on-site 24 hour care and support component of the Extra Care service is tendered separately from the landlord functions of the service as each site is developed. This is to ensure a distinct service delivery of housing with care as opposed to residential provision.

Finance & Operation

To kick start the public sector Extra Care provision in South Gloucestershire the Council sought selected partners with expertise in the provision of Extra Care to bring forward identified sites. Ring fenced capital and Housing and Community Agency Grant funding secured to ensure an affordable and sustainable service.

Currently development is very different and future Extra Care provision is market driven through the planning process.

Local Financial Comparators

The average cost per week for ECH in South Gloucestershire is £176 for a single bed apartment and £192 per week for a two bed apartment; this includes utilities and service charge. The range of costs is £138 to £224 per week for a single bed and £150 to £225 per week for a two bed apartment. None of these costs include care. Care costs within ECH are broken down as shown in Table 2 below.

Table 2 – Cost of care South Gloucestershire ECH (2016/17)

Care Band	Hours per week	Charge per week	Cost/Hour (using mean of hours)
Entry	1.0 to 3.50	£31.15	£13.84
Low 1	3.75 to 7.00	£97.90	£18.21
Low 2	7.25 to 11.00	£160.20	£17.56
Medium1	11.25 to 14.00	£222.50	£17.62
Medium2	14.25 to 17.50	£280.35	£17.66
High1	17.75 to 25.00	£378.25	£17.70
High2	25.25 to 30.00	£493.95	£17.88

At the time of writing the average number of hours of care per week for residents in ECH is 8.75, which is in the Low 2 care band (173 residents, 1493 hours of care per week).

Comparative costs for domiciliary care are hard to calculate because the contracting of this service is on a case by case basis and is reflective of an individual's needs. However, it was noted by South Gloucestershire Council that care provided at ECH is certainly no more costly than domiciliary care and likely to be less per person.

3. Sunderland City Council

Strategy

Extra Care Housing is viewed as part of a suite of housing options for older people and is placed alongside sheltered housing and residential care in this context. The council's key strategy that directs the development of ECH is its 'Enabling Independence Strategy', incorporating its active ageing housing programme, the stated aim of which is to:

"Provide whole solutions for whole lifestyles, providing genuine options and real choice which deliver opportunities for individual growth, development and wellbeing."

Sunderland City Council (2013, cover page)

One of the features of this strategy is to reduce admissions to residential care homes and for this to cease to be the automatic choice for older people moving from their owned or rented private sector home to accommodation in a care environment. The strategy notes that a 2007 study showed that around 20 per cent of people moving into residential care

homes could have lived independently within ECH and the Council believes that this remained the case when writing the strategy.

This strategy is accompanied by the 'Enabling Independence Design Guide for Independent Living' and the 'Enabling Independence - Living well with Dementia' guide.

In addition, the council has a 'Housing Priorities Plan' covering 2010 to 2025, which includes reference to ECH. This notes that ECH is a priority of the plan and states the intention to deliver 'in excess of 1,350 units of mixed tenure extra care accommodation over the next five years' i.e. by 2015 (Sunderland City Council, 2010, p9).

This strategy has resulted in the successful delivery of 851 ECH units to date across 11 different sites, the first of which came on line in 2009. There are four different private sector operators of the ECH sites in the city: Housing & Care 21, Gentoo, Riverside and Abbeyfield.

At the time of writing Sunderland City Council is reviewing all of its relevant strategies to inform the production of its Local Plan.

Marketing

Marketing of the units has been through education of potential owners/tenants of the ECH and health care providers who can identify suitable candidates for ECH. In particular GPs have been targeted and referrals are being received from this source. The council learnt that the language used is very important in people having a clear understanding of what ECH provides and this was particularly relevant to health care provision. It is vital that the health care offering is clearly understood so that applications for units are received from eligible cases. In addition, the private sector operators of the ECH sites also market the units.

At the time of writing, occupancy levels at the longer standing sites are greater than 90 per cent and at the more recently developed sites is around 70 per cent. This is in line with expectations, the provision of 851 units in a short space of time means that there will be some lag before full occupancy is achieved.

Local integration & Community Setting

The ECH sites are located across the city and are close to local amenities and transport links. The sites are designed to form part of the local community and so are not closed off from the community in which they are situated. For example, the restaurants and shops on site are open to non-residents. Furthermore, the development of enterprises within the sites has considered social aspects with some of the restaurants employing those with learning difficulties and also homeless people.

Impact on local housing market

The introduction of ECH has coincided with an increase in Council Tax revenue of greater than £1m/annum. There has been greater churn in the local housing market and churn analysis is performed for each person that moves into an ECH unit (although no examples of this are available).

Admissions

Each ECH site is designed to provide care to residents with different levels of need and this needs to be considered for each application. The split is 40 per cent high needs, and 30 per cent each of medium and low needs. Initially, there were some individuals admitted that did not have care needs. This resulted in a new approach being adopted which is that any applicants for units must be over 55 and currently in receipt of a social care package. This, of course, leads to a slower take up of units but ensures that they are being occupied by the right people.

Care Provision

Housing & Care 21 provides its own care and the other operators use Sunderland Home Care Services.

The potential is being explored to use ECH sites as care hubs for serving the local community as well as providing care for residents. This is a longer term aim for the council and it is hoped will further reduce care costs. There are also plans to introduce an 'enhanced nursing' service which is designed to prevent hospital and GP visits by older people.

Finance & operation

The council's on the ground strategy for delivering ECH is to enable and encourage private investment in schemes. The council does not invest in sites itself, and has been clear that it

will not do so from the outset, but seeks private led financing with some further financial support from the Housing & Communities Agency and the Department of Health.

It encourages private investors by cutting through red tape, identifying council owned sites for the developments and making the investor's path through to construction as straightforward as possible within the confines of what it is legally able to do as the local authority. The success of this is demonstrated in the number of ECH units that have been developed since 2009 and in the example of a dementia care provider that approached Sunderland rather than other local authorities because it was attracted by this progressive attitude and action. Moreover, Sunderland is held up as an exemplar of an effective strategy for delivering ECH and has received visits from local authorities across England wanting to learn from its experience.

Sunderland does not play a role in inspecting the ECH sites and maintaining standards. It leaves this job to the Care Quality Commission and trusts in this system to effectively monitor the providers and sites.

Local financial comparators

For an individual in ECH requiring 14 hours social care per week the cost to the council for providing this care is approximately £10,000/annum. This represents a £14,000/annum saving per person when compared with the same individual in a residential care home. This does not take in to account the payment of housing benefit, should this be required to be paid for the ECH unit. If housing benefit is taken into account at £180 per week (which is the mid-range of the rental charged for ECH units in Sunderland by Housing & Care 21), the savings are £5,000 per person per annum (based on single occupancy).

The aim of the council is to reduce care costs by 4 per cent, which equates to £800,000/annum. If we take the mid-range saving of £9,500 per person entering ECH rather than residential care, 85 individuals will need to be housed in ECH instead of residential care to achieve this saving. Given there are currently over 100 hundred vacancies within ECH in Sunderland, the provision of ECH is enough to achieve these savings and more.

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