

Marketing Extra Care Housing

This objective of this report is to:

- explore the techniques deployed by Extra Care Housing (ECH) developers/providers in the marketing of ECH across all sectors
- establish what providers view as 'successful' marketing and how they gauge this and assess and review performance
- determine which factors/criteria/conditions make for effective marketing
- describe the tools/resources/knowledge/assets/personnel/training deployed
- identify good ideas and best practice and set out a strategy for wider dissemination and education to ease/lower barriers to market entry
- isolate examples of failed marketing and assess what has been learned or could be done to transform this
- discern areas of 'Marketing Deficit' where the case for ECH has not been made or needs to be promoted more effectively and set out how marketing can adapt to recession

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MARKETING EXTRA CARE HOUSING

INTRODUCTION

Background

This report was commissioned by the Housing Learning and Improvement Network (LIN) at the Department of Health to:

- explore the techniques deployed by Extra Care Housing (ECH) developers/providers in the marketing of ECH across all sectors
- establish what providers view as 'successful' marketing and how they gauge this and assess and review performance
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- describe the tools/resources/knowledge/assets/personnel/training deployed
- identify good ideas and best practice and set out a strategy for wider dissemination and education to ease/lower barriers to market entry
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- discern areas of 'Marketing Deficit' where the case for ECH has not been made or needs to be promoted more effectively and set out how marketing can adapt to recession

Introduction to the Report

In early 2009, information was gathered through a questionnaire to Housing LIN members; through e-mails; telephone contact; and through direct interview. It is supported by reviews of marketing material and strategies provided by respondents and by reference to the internet and to publications relating to extra care housing (ECH).

Our essential concern here is with *marketing* and, as far as possible, we have sought to confine attention to this. However, we have suggested that marketing embraces a far larger span than simply providing promotional and sales literature to potential customers of extra care housing.

Our brief was to explore the wider marketing process and to identify constituencies, some perhaps not conventionally seen as marketing targets who, nevertheless, need to be more aware of what extra care housing means and the part they do or can play in increasing awareness.

Most contributors preferred to be anonymous and we have applied this as a general principle to their responses to both the questionnaire and to related dialogue. We are very grateful for the information they have provided and for the time they have invested variously in writing and talking to us or meeting with us directly. We do refer to the names of providers where we have drawn on information provided in the *public domain* in brochures to illustrate variations in the 'description' of ECH.

Terminology can be confusing, particularly in a sector where there are a number of distinct players from different sectors and where there are multiple interpretations of

extra care housing. We have chosen to keep it simple. We refer to all those (regardless of sector) who provide extra care housing as 'providers' rather than as developers or operators although very occasionally we have resorted to these terms to illuminate a specific point. We relax this rule in the section on planning where it is helpful to use the terms 'developer' and 'applicant'.

Elsewhere, we generally refer to the sectors as:

- *public*: local authorities, RSLs (or housing associations)
- *private*, and
- *not for profit*: the latter embracing charities and trusts.

Finally, we abbreviate extra care housing to ECH and apologise if this proves an irritation to some. Most importantly, we do interchange ECH with 'housing with care' and as the descriptions go on to show we treat both terms as encompassing assisted living, very sheltered housing, close care and other variants, which share considerable common ground.

The matter of 'description' is central to the report. Overall, our concern has been to provide a reasonable glimpse of awareness, terminology, marketing tools and techniques; how in some instances these could be improved; and to set out what providers themselves thought were the most effective means of marketing; and how good practice and successful experience could be transferred to others. Virtually all those who participated in this study were keen to improve the means by which we could all come to be aware of extra care housing and to put in place measures to expand and develop provision.

1. THE MARKET: BREAKING AND ENTERING

Is there a Market? (1)

Some general facts and figures:

- England has a population aged 65 and over of 7.8 Million
- One third of all social tenants in England are over 60
- The population of over 85s is projected to increase by 2.3 Million by 2036
- The number of older disabled people in England is likely to double to 4.6 Million 2041
- Unless we increase current housing with care provision occupied places in hospitals and - care homes could increase by 150% by 2051
- Currently over 300 providers claim to deliver extra care housing – two thirds have less than 3 developments
- Some 227,000 people with dementia are registered with the NHS and Social Services –an estimated 450,000 are not
- England has over 3 Million carers – many are over 50 years of age, some much older
- At February 2009 only circa 42,000 units of ECH are either developed or are under construction
- Valued at £100K each, these would have an estimated stock value in excess of £4billion
- Investment by the Dept of Health 2004-2010 is now of an order of £227million
- The demographics are favourable but market penetration remains low

Extra Care Housing as a Market: The Importance of Marketing –Why, Who, How, Where

A recent report by Deloitte for the Resolution Foundation described extra care as a 'mixed market for social good' and 'not the traditional public service many citizens perceive it to be'. **(2)** There are three material points here – *market*, *public service* and *perception*. Each has a bearing on the way in which extra care is distributed and all are relevant to any assessment of how extra care housing is marketed. Thus, long term care is defined as a *market* precisely because the distribution, allocation and take-up of care is influenced by characteristics to be found in markets generally, namely:

- the reconciling of supply and demand;
- the allocation of care as a commercial transaction and
- the incidence of profit, or social capital in the case of not-for-profit organisations, for the successful marketer.

In this market consumers *compete* for the goods and services available (care and support) primarily because they are effectively rationed by:

- an overall dysfunction between supply and demand (lack of volume);
- an uneven distribution of the care available (geographical coverage);
- affordability (put out of reach by cost of delivery and resulting price);

- varying degrees of awareness and knowledge of what goods and services are available and where (market intelligence); and
- what may be described as difficulties of access (more idiosyncratic barriers to entry which may include lack of connections with the supplier, lack of a 'champion' to press the interests of the (frail) consumer, inefficiencies/ charging criteria of the suppliers that escalate costs, admissions/engagement criteria of the supplier).

There are other factors but these will suffice to make the general point that what we are dealing with in the extra care market – like virtually all others - is *imperfection*. Sometimes the value framework and social imperatives that adorn this market hide the fact that, contrary to perception, it is quite flawed. What we mean is explained below.

In practical and simple terms this means that some consumers will lose out and this underscores the down side of 'competition' – *failing to win*. The experience of failing to win, and this could be defined as not securing a home with a suitable package of care perhaps in the desired location or at a preferred price or not securing any at all in the time frame required, is compounded further by the frailty and needs of the consumer group. It manifests typically in the lack of provision where and when it is needed. This issue of 'coverage' is an important feature of marketing. What appears to be a 'national' distribution of supply is nothing of the sort. There are still many localities in England that do not have any form of ECH (source: EAC database).

These imperfections occur in *markets* and are compounded at the present time in ECH by the effects of both the housing downturn and wider economic recession. Commentators suggest that this situation could endure for some time and the ECH sector faces the risk of existing disadvantages experienced by consumers and barriers to entry for new developers becoming entrenched. This creates uncertainty for investment on two levels:

- 1) the ability of individual customers to transact (make a financial commitment) and
- 2) of corporate stakeholders to support, fund and deliver development programmes, whether in the public, private or not for profit sectors.

But there are two other factors which aggravate matters in this market. These are, first, consideration that the market is a *social good* which implies that there is an ethical element to distribution when in fact it is a commercial business driven by investment and profit on the one hand and a combination of social philosophy and the need for public resource efficiencies on the other. Commissioners need to ensure that ECH is value for money, more cost-effective in the long term than residential care. Private providers need to make a profit and not-for-profit organisations need to achieve a 'surplus' that enable them to continue to expand provision. And, second, the perception that extra care is a public service when in fact many providers and large parts of the ECH 'infrastructure' such as land, labour, investment, construction and the provision of services and care are not.

It may be oversimplifying the situation but it is reasonable to say that this perception and some of the disadvantages that consumers experience lie not only with the scale and distribution of provision but also with the way extra care is marketed, in the means of raising awareness and in the degree of resulting education for planning, housing, health care and social care professionals and consumers. The latter include older people, relatives and carers.

We know that there are inefficiencies, inadequacies and inequities in the care market for the reasons described above. There is no single care market governed by a set of unifying principles and/or by constants in supplier and consumer behaviour. Rather, it is a quite disparate collection of providers bound informally by certain regulatory, policy

and financial imperatives and is only 'national' in the superficial sense that it is really a rather loose (and as yet only partially developed) aggregation of *local* markets operating for the large part *locally*, or sometimes *regionally* or *sub-regionally*, on a site by site basis. This narrowness of focus applies as much to investment as it does to marketing and management. Relatively few providers (the exceptions being private sector and charitable trust developers of larger 'care village' models) have a degree of 'scale' in their planning and delivery of developments. Lead times range usually from 1-3 years and are sometimes 4 or more for larger village-type projects. **The result is that marketing itself tends to be site by site.**

Marketing in a Confined Space

Most forms of housing with care are defined from the outset by a degree of exclusivity. Access to the product and services is structured and filtered by certain qualifying criteria. These include in their most general and universal form an age-qualification imposed for both needs, allocation and management reasons but, unusually in the housing sector, these can also be embedded and enforced by a planning condition, such as a Section 106 Agreement. These are entrenched further by policy objectives and funding programmes.

Other criteria also apply and may vary according to:

- local planning conditions;
- with the aims and values of the provider strongly to the fore in the not for profit sector
- the design and size of the development
- the scope of services available
- regulatory requirements; and
- in the case of public and not-for-profit providers a requirement to meet the needs of specific vulnerable groups or particular localities.

The consequence is that extra care housing may be perceived as a closely defined and structured market. In turn, the planning conditions, eligibility criteria and the service and management imperatives which govern it influence the way providers market their offer to the consumer and also (earlier in the marketing process) to the secondary stakeholders in whose altogether different interests extra care housing is built.

This means that we cannot, and neither can most providers, market extra care housing as if it were a monolith. It simply is not and, at the moment, there is little evidence that it is likely to be or that we would wish it to be. Existing patterns of provision reflect the desire for choice and diversity. The disparate origins, values, aims and objectives, coverage and catchment, development requirements and funding and income models evidenced in the activity of providers across all three sectors - private, public, and not for profit - suggest the contrary is the case. Indeed, the information provided by respondents to this study suggest that recession may result in *greater* choice of tenure and payment arrangements *within* developments in all sectors

In fact, there is a highly diverse and sometimes quite idiosyncratic supply model. Nor is it static. It is characterised by its heterogeneity and by its mutability and it has moved a long way from the first wave of both private retirement housing and local authority Category 2 sheltered housing that emerged just over thirty and fifty years ago respectively. As we shall see, this diversity is reflected also in the marketing strategies, *positioning* and *tools*, of providers.

Barriers to Entry

A number of barriers to entry to the ECH market were identified in the course of our research. We refer to these throughout the course of the paper. They include:

- Knowledge of the market and of needs
- Expertise and experience
- Access to development finance
- Requiring a track record –profitability
- Availability of private capital to secure institutional match funding
- Access to Commissioner funds
- Viability of local partnerships
- Ability/capacity to scale activity
- Land ie suitable sites capable of winning consent
- The planning process
- Brand awareness –individual providers
- Permeability of the concept of extra care housing

Awareness of Extra Care Housing

Our survey suggests that despite a significant effort to promote it, awareness of ECH is still significantly lacking, in some areas notably so. Rural provision, special needs and BME extra care housing solutions are some examples. Providers from all three sectors, public, private and not for profit, indicated that not only was the concept entirely unfamiliar to many older people and their families, but where it was known the proliferation of different descriptions and models of ‘housing with care’ was a source of confusion. Some marketing may have *complicated* rather than illuminated the basics of the ECH offer.

This is not an uncommon charge where housing for older people is being promoted and ‘sold’. The recent history of retirement housing offers some perspective and suggests that we may need to be more patient with ‘legibility’ (people actually understanding what ECH is) and ‘permeability’ (it then reaching a level of awareness and currency where informed and sustained demand starts to emerge).

A brief glance backwards at the permeation of ‘private retirement housing’ is instructive. It took the best part of 15-20 years for a concept with unfamiliar tenure and legal structures, varying levels of service provision, relatively untried sales and re-sales arrangements and an uncertainty about what happened next when the provider could provide for a resident’s needs no longer, to establish itself as a legitimate and attractive housing choice for many older people. It did not happen overnight. It took a further period of 10 years or more for the sheltered sector to settle into the more familiar, ‘professionalised’ model we see today. **(3)**

Private retirement housing for sale has had over three decades to refine and establish its marketing pitch. Looking forward, perhaps its primary challenge will lie in ensuring its distinction from the new kid on the block - and the latter from it. There have been some fundamental challenges to legibility, relevance and durability along the way. It is now 32 years since the market leader effectively pioneered the private model; it took a further 5-6 years before a step change in volume was triggered by the large-scale entry of major house builders and by speculative investors encouraged in part by the Business Expansion Scheme. **(4)** There was almost a reversal of this influx less than a

decade later, when the early 1990s housing recession and a shift towards a more accountable and service-based culture exposed the underlying frailty of the sector. This saw a withdrawal by many leading house-builders for whom the enterprise had not succeeded as a 'core' house building business and the failure of a number of dedicated developers who had simply overstretched. **(5)**

Arguably, time and experience is on the side of the latest variant, extra care housing. A number of the leading players and/or their senior management have their origins in this formative period and have learned from it. Overwhelmingly, these are highly professional and engaged providers who view ECH as a long-term business rather than as a *venture*. But the proliferation of typically local and regional rather than large-scale national players means that marketing is most concentrated and most effective in the confined space of their target catchments. After all, this is where the sales and commissions are. There may be a superficial nod to cultivating wider awareness in the form of the odd article or feature in a national daily or weekend property supplement, but the material evidence - *investment, coverage* and the current programme of *completed development*, which has only so far yielded circa 42,000 units **(6)** suggests that the greatest awareness of ECH lies, as we might expect, close to the location of these developments. It either does not manifest elsewhere or simply dissipates beyond these parameters. Moreover, as we show later, this may also be a direct outcome of a preference for 'localism' in the provision and marketing strategies of providers, even in the case of those who operate regionally, sub-regionally and quasi-nationally.

It is an interesting conundrum that if awareness was increased exponentially by government, local authorities, by providers and through the media on a national and sustained basis, the sector might simply *not be able to cope* given high latent demand, low supply, the need to find suitable sites, secure planning consents and to commission and fund development followed by long lead times to deliver the new stock. Are we therefore inadvertently depressing demand and rationing supply to a 'manageable level' by *not* being more zealous in promoting awareness?

Respondents told us that sometimes the most surprising lack of awareness is within local authorities. Promoting and understanding ECH and differentiating it from other forms of housing and other housing objectives is seen as an issue with planning officers and in some instances with housing colleagues focused on delivering mainstream affordable housing targets. Some private developers compound this confusion by 'tinkering' with conventional retirement housing models, sometimes in planning applications, presenting it as extra care housing when it is clearly not. If officers and committees are not clear what *does* constitute ECH then its treatment and regard will suffer. Local authorities have a clear and influential role to play in raising awareness of ECH and developing strategic approaches to help shape local markets. **(7)**

Raising awareness is not the sole responsibility of providers or the media or for that matter of the DH. Local authorities have a vital part to play in explaining, promoting, supporting and funding ECH. Yet a Housing LIN Report in July 2008, *Whose Market?*, found in an on-line survey that nearly two thirds of the local authorities who responded had not produced a housing strategy specific to older people; nearly a fifth had produced no strategy and 45% said they addressed the specialist housing needs of older people within a wider housing or older people's strategy. **(8)**

Submerging specialist needs in this way cannot be good for conscious raising and it is certainly no good for business. Indeed, *Whose Market?* noted that "*almost all respondents thought the lack of public awareness of extra care housing limits demand; the majority thought that perceptions of extra care were also a limitation on demand.*" **(9)**

One area of weakness is the very limited involvement of private providers in the development of local authority extra care housing strategies. While there has been in a number of authorities effective engagement and partnership with housing associations and charitable trusts that with the private sector has been scarce and circumscribed. *Whose Market?* reports that only 5% of local authorities said they had involved the private sector in Local Area Agreements as part of their extra care strategy. This is a poor response and there is an urgent need for capacity building between public commissioners and private providers.

We are moving towards a 'mixed economy' of extra care housing that is increasingly likely to be characterised by a choice of tenure and affordability *within* the same development, regardless of provider. It won't happen on every development clearly, but *it is* clear that it will happen far more often. Not for profit providers and RSLs have led the way in setting out a market economy for ECH by extending choice to shared and full ownership *alongside* rented and affordable housing with care (for further details see the Housing LIN Technical Brief, No.3, on Mixed Tenure). Some private providers are now edging towards the principle of mixed income communities. A more flexible stance on partnership and diversification is the way forward. Recession will accelerate this as 'temporary' devices such as 'try before you buy' 'rent to buy' and graduated 'shared ownership' prove their worth, attract a market and embed as permanent ECH options. A number of private and not for profit providers acknowledged this in their responses. It is conceivable that in the near future this may influence a redefining of commissioning arrangements, procurement and partnership.

The increasing scale of extra care housing projects, many now numbering in excess of 100 units and in the case of some providers typically exceeding 200 and with land-takes in excess of 5-6 acres, has raised barriers to entry in two obvious ways. First, for these larger developers (in all sectors) the combination of scale, recession and inactivity in the housing market increases both the difficulty of institutional borrowing in the foreseeable future (placing pressure on other forms of fund raising) and increases their financial exposure on developments not fully sold or let or on commitments to work in progress.

Secondly and conversely, the tendency to larger development while often producing an admirable range of housing, care, service and leisure/lifestyle choices can price smaller entrants out of the market and limit by dint of comparison *their* bids for institutional funding. The recession may come to demonstrate by exclusion what many believe already that, despite the risks and the levels of exposure, the most likely survivors in the private and not-for-profit sectors will be the larger players with a solid record of financial provenance, demonstrable expertise, a wealth of experience in development, sales and management and a 'risk contained' game plan for the next 5 -10 years. This was underscored by a number of institutional lenders at a recent Savills seminar on the state of the healthcare market. **(10)**

If we look at the healthcare sector, experience there suggests that those who operate as and are perceived to be 'specialists' with a clear game plan and who are committed to the long term are those most likely to draw consumer confidence and win institutional support. They are attractive to lenders and to professional networks and commissioners who are increasingly influential in site location and who play a decisive role in funding, partnership development and delivery of valuable referrals. As private providers reflect on the rising merits of private-public initiatives and on the creation of mixed income/mixed tenure communities the value of continuing dialogue with housing, health and care professionals will rise. Ultimately, barriers to entry, varying degrees of awareness and confusion over terms will affect the coverage achieved by the sector. In turn, the failure both to expand the volume and to disperse the pattern of coverage is almost certain to reinforce these problems. This results in a vicious circle.

Coverage and Market Penetration

By 'coverage' we mean the distribution of ECH throughout the country. *More Choice: Greater Voice* (CSIP/CLG, 2008) suggests that there should be 25 units per 1,000 of the population over 75. However, there are numerous reasons why provision is at best patchy and at worst scarce or even non-existent in some areas. These include:

- geography and demography;
- housing densities and property values;
- availability of suitable sites;
- local planning conditions;
- cultural, community and ethnic considerations;
- the quality and availability of housing needs information;
- whether the local authority has a dedicated ECH strategy;
- the influence of key professionals in promoting and implementing it;
- the drive and political will of commissioning and partnering organisations;
- the incidence locally of private developers, housing associations and not for profit organisations interested in ECH;
- the attitude of lenders and access to development finance and grants;
- the strength of community interest; and
- ultimately 'awareness' of extra care housing and the proximity of useful comparators to draw support from in making the case.

Market penetration can be described in two main ways. It can refer to the extent to which a product secures share within an *existing* market or to the success gained in promoting a *new* product, in this case extra care housing. Second, it is used as a term to measure the extent of a particular product's sales volume relative to that within a wider market of competing products. In this instance, we might translate this as ECH penetrating the overall retirement housing market or the success of its promotion as an alternative to residential and care provision. In each case, its penetration to date has been limited. Part of the reason may lie in the way it is marketed.

The table below demonstrates just a fraction of this unevenness in coverage at January 2008. It also points up the relatively low volume of provision overall which may lead some to suggest that, despite encouragement and investment from government, the growth of ECH has been really rather slow and may now arrest and even falter, at least for a time, as a result of recession. The manner in which recession has affected ECH, *and what providers are doing about it*, is therefore a central consideration of this report (also see the recent Housing LIN Factsheet No.30. Extra Care Housing and the Credit Crunch: Impact and Opportunities). The table has been adapted from the EAC publication *Statistics on Housing With Care in England, 2008*. EAC estimates that there were just over 39,000 housing with care units distributed among 935 schemes built or under construction at January 2008. At January 2009, EAC estimates the numbers of units as approaching 42,000. The units are shown per 1000 of population aged 65 and over.

Estimated Coverage at January 2008

| Region | Pop 65+ | Units per 1000 | Variations in Coverage By County | Variations By District | Sales as % of all Units |
|-----------------|------------------|----------------|---|---|-------------------------|
| East Midlands | 670,600 | 3.9 | Derbyshire has 1.4 units per 1000 people 65yrs and over Lincs – just 2.3 per 1000 Northants –home to a number of large ECH schemes –9.5 | Bolsover 0 Derby 0 (but projects now in pipeline) Erewash 0 S Derbyshire 0 Ashfield, Notts 0 Mansfield 0 rural Leics districts poorly provided for. | 18.7% |
| East of England | 886,600 | 5.4 | | | 14.9% |
| Greater London | 891,600 | 5.1 | | | 11.4% |
| North East | 396,200 | 4.0 | Very low provision in Northumberland –1.7 units –but now set to rise with 200 new units imminent | Berwick 1.4 Morpeth 0 Easington 0 | 6.75% |
| North West | 1,076,000 | 4.3 | Cumbria –2.3 per 1000 Gtr Manchester –2.4 | In Cumbria, Allerdale 0 Barrow 0 Burnley 0 Bury 0 Pendle 0 Rochdale 0.8 | 25.6% |
| South East | 1,309,000 | 5.8 | Oxfordshire – 3.4 Kent –3.5 | Chiltern (Bucks) 0.3 Wycombe 1.1 Dover 0 Shepway 0.6 Aylesbury Vale 1.1 | 40% |
| South West | 918,000 | 4.2 | High levels of coverage in Bristol -13.4 per 1000 - which has a strong ECH strategy supported by some key providers distorts regional figs – some areas are very low Cornwall – 0.8per 1000 Devon 2.2 per 1000 | 5 of Cornwall's 6 Districts had no provision East Dorset 0 Exeter 0 – projects now under way N Cornwall 0 Mid Devon 0 | 36% |
| West Midlands | 840,000 | 7.5 | Shropshire –3.5 units | Bridgnorth 0 N Shrops 0 | 24% |
| Yorks & Humber | 818,800 | 3.9 | Lincs 0.6 per 1000 | Boston 0 Craven 0 – though two projects now under way S Holland 0 | 21% |
| England | 7,808,000 | 5.0 | | | 25% |

As a percentage of overall units, those developed *for sale* (outright and shared ownership) vary sharply by region (2008) from just 6.75% in the North East (with none at all in some areas of N Yorks) to 40% in the South East. There were circa 6,200 local authority housing with care properties developed for rent at January 2008; circa 24,400 for rent provided by RSLs; and just 9,600 properties developed for sale. The table illustrates a key area of deficit (we develop others in Part 3) showing that rural counties and rural districts were the least well provided for. In some areas, there is simply no provision. This compounds the general disadvantages associated with 'rurality' and effectively excludes some older people from reasonable geographical access to housing with care facilities. This is a key area for government and providers to address (for further details see Housing LIN Factsheet No.12. An Introduction to Extra Care Housing in Rural Areas).

While coverage is compounded by the geographical and commercial criteria employed by some private providers they are the 'junior partner' in housing with care provision. It is affected far more by the influences of planning conditions on residency, by care commissioning arrangements and by the policy objectives of the local authority. The Housing LIN Factsheet No 25. Nomination Agreements in Extra Care notes...*"Nomination arrangements are a key element in creating a successful extra care housing scheme...They can influence the choices available to individuals, the impact that the scheme has on reducing residential care admissions, the balance of the community that is created, the risks faced by commissioner and provider and even the outcomes for residents."* (11)

Stand and Deliver : Emerging Providers

Contributors to this study included local authorities, housing associations, private developers and charitable trusts. There were three interesting joint venture operations combining the construction/sales expertise of a developer/contractor with the operational expertise of a care provider. Though modest, together with other known co-ventures, this may point to an emerging trend in which as a response to the costs, risks and complexities of larger scale ECH projects we may see an increasing pattern of 'duality'. This would see development and operational skills provided by *specialists working in tandem* rather than by a single player dealing with everything in-house.

This marks a distinction between the traditional developer/operator who hitherto may have conceived, financed, developed and operated the project but who hived off the build contract (and some of the risk) to a third party contractor via a competitive tender for 'Design and Build' and the emerging model where a 'known' (sought/recruited) contractor with a clear interest in the sector (possibly in the form of equity in the 'provider' or the project) forms a formal (ongoing) alliance with a care provider predicated on a division of risk, reward and function.

There is a likelihood that this type of partnership will increase during recession and that we will see new and innovative joint ventures arise both from necessity and from forward thinking. Three respondents told us that they already had this model in place and were more comfortable with the division of labour and attenuation of risk. Another foresaw and was actively working towards a very clear division of labour in which the investor, contractor and operator functions were entirely separate and provided by individual specialists. A fourth player, the 'broker' or 'enabler', was responsible for spotting opportunities, identifying the partners and bringing the 'mix' to the table. Then taking overall responsibility for realising the project before, on completion, moving on to the next and leaving it to be run by the housing with care provider.

Describing ECH: One Size Fits All?

Prevailing descriptions

We asked providers how they described ECH and whether they were familiar with those employed by the Department of Health and by Elderly Accommodation Counsel. Overwhelmingly respondents were familiar with these descriptions and with the two primary ECH websites www.extracarehousing.org and www.housingcare.org. Two care home operators we spoke to who provided a ECH facility on their care developments were not familiar with the definitions or the websites.

Department of Health:

The DH describes extra care housing as

“a type of specialised housing that provides independence and choice to adults with varying care needs and enables them to remain in their own home. Extra Care Housing should be able to provide most residents’ if they so desire, with a home for the remainder of their life regardless of changes in their care needs. Services are provided in a purpose-built, housing environment with care and support delivered to meet the individual resident’s needs. This type of housing provide 24 hour support, meals, domestic help, leisure and recreation facilities and a genuinely safe environment to its residents. It can provide a base for out of doors outreach services to the local community. Intermediate care facilities, to prevent avoidable admission to hospital or to help people return from hospital to their own home more quickly, can also be based at Extra Care Housing Schemes.” (12)

Elderly Accommodation Counsel:

The housing advice charity EAC widens the compass by embracing Extra Care Housing as one among a number of forms of ‘Housing with Care’.

“ We mean all forms of specialist housing for older people where care services are provided or facilitated. This includes extra care housing, assisted living, very sheltered housing, close care and continuing care environments and care villages.”

Taking this broader view EAC notes that housing with care had by early 2008 spawned many different models *“developed by over 300 providers across the public, voluntary and private sectors and innovation continues.” (13)* This view of innovation is supported by the evidence presented by contributors to this study.

How Providers Market Descriptions of ECH

Most of the sales brochures or promotional literature we reviewed do employ a description of ‘extra care housing’ *though frequently using an alternative term.* Appendix 1 lists samples of descriptions from a range of providers. We have selected these to illustrate variations in terminology and the range of values and services that one would expect ECH providers typically to convey ie. independence, trust, dignity, security, choice of tenure, flexible care, rights, partnership, professionalism, skills.

We asked providers directly how they described extra care housing. Some simply do not like the term ECH, seeing it as too generic or as ‘institutional’. One described it as ‘clumsy, unattractive and meaningless’. It does not reflect the key elements of the

product. This organisation, a regional RSL, is currently considering abandoning the term. Another said it burdened the sector with a term that did not convey inherently that the model could have a strong emphasis on activity, independence or on the graduated nature of the care element. Those moving in to ECH do not always engage with care programmes immediately on entry. A number affirmed what we know from experience of retirement housing generally that some will enter developments as a means of 'insurance' before the onset of infirmity or frailty. In the case of married couples, they will often do so because the husband wishes to ensure that his wife's new life is comfortable and assured in the event that he falls ill or dies before her. **(14)**

For the most part, alternative terminology is the means by which providers, especially private and voluntary sector developers, 'differentiate' their offer to the customer. This may raise brand awareness and increase sales but there is no doubt that it also contributes to some of the bafflement about what is and what is not ECH. Accordingly (though perhaps perversely), a number of questionnaire respondents suggested that there should be greater clarity, implicitly from government, rather than looking at their own marketing.

However, the fact that there *is* a working description offered by the Department of Health, which is subscribed to by a large number of organisations and which enjoys significant currency, does suggest that the issue lies *not* in the absence of an acceptable generic term *but rather* in the marketing behaviour of businesses which, plain and simple, need to secure a commercial edge or fulfil occupancy and care funding objectives.

The descriptions provided in response to the questionnaire included the following explanations of or variants on ECH:

- Housing with care
- Housing for people requiring assistance with day to day living
- The help you need in a home of your own
- Living independently for as long as you possibly can
- Supported living
- A 'home for life' with round the clock professional help
- Care Suites with right of tenure –rent or lease
- Sheltered housing with a dedicated care team, providing flexible support around the clock
- Independent living with care
- Independence with added peace of mind
- Apartments for mature purchasers with 24 hour on site care
- Bespoke care
- Assisted Living
- Close Care and Extra Care
- Serviced apartments
- Very sheltered housing
- Community healthcare hub

Characteristics Affecting the Marketing Offer: Convergence/Divergence

| Factor | Public | Not For Profit | Private |
|-----------------------------------|--|---|---|
| Housing and Need | Pressures for integration of housing, health and care services. Meeting key needs and other policy objectives. RSLs and LAs are strong partners in funding and delivery frameworks. | Substantially needs driven but also the key provider of 'mixed income communities'. Emphasis on mixed tenure. Capital programmes are part 'enabled' through sales of leasehold properties | Primarily lifestyle – driven. But recession now forcing rethink on including an element of mixed tenure/income. Likely to see more private players seek partnerships and referrals. |
| Funding | Primary recipients of DoH funding HCA finance Topped up with bank loans Assured of future | Some DoH funding Bank finance Private charitable funding Sales receipts from leases Some community and business fund-raising Relatively assured future | Reliant on sales receipts Bank finance Shareholder funds May seek now to explore DoH funds Most at risk financially if sales falter and loans called in |
| Assessment and Eligibility | Driven by <i>assessed</i> housing/care needs by Social Services, PCT and Adult Care Teams. Also nominations from housing waiting lists. Wider community goals also play a part. Formal gate-keeping via nomination process. | Similar scenario. Also in-house assessment. May impose health/ability thresholds for eligibility to schemes. Charities also have strong social, moral, community objectives. | In house care assessment. GP and other referrals. But financial worth is the key to entry. Housing equity of prime importance. Financial support often provided by family also. Unlikely to have community obligations to fore unless through a Section 106. |
| Affordability | Fundamental aim and likely to embed further if the HCA takes a stronger interest in ECH. RSLs and LAs meet needs of people on low incomes and benefits. | Similar scenario. But not for profit providers also favouring mixed income approach to fund development. Attracts a mix of both renters and home owners. | Ability to purchase or to rent at high levels is the prime 'gate keeper'. Almost exclusively home owners without mortgages Open-market –first come first served. |

| | | | |
|--------------------------|---|--|---|
| Outreach Services | May be integrated because of local policy (LA and PCT) objectives / partnerships. Also to secure Value for Money in use of public resources. | Similar scenario but also use outreach to make capital development and service provision more financially and operationally efficient. And to increase awareness of developments. | Relatively rare but likely to increase for similar reasons to not for profit sector. Economies of scale. Brand awareness Leads and Sales generation. |
| Values | Rights to the fore. Self determination. Support. Community cohesion. | Choice. Independence. Support. | Independence. Lifestyle. Choice. |
| Other Aims | Community cohesion. Social capital. Best value. Meeting HCA, RSS and LDF requirements. | May have related charitable, community and faith objectives. | May act as the 'social arm' of a mainstream housing contractor. |

Type of Provider

Those who operated on or saw themselves in future delivering on a national basis viewed coverage as a function of economies of scale or in some instances as the result of having been approached to form a local partnership which opened up a wider area of activity. Typically, the partners were local authority commissioners who were attracted by the model and/or track record of the provider. It is worth noting that only 6 providers (all sectors) currently have 20 or more housing with care developments. These range in scale from 20 to 63. Some of these providers would not necessarily describe their models as 'extra care housing'. Some of the more prominent identify their schemes as 'Very Sheltered Housing', 'Independent Living' and 'Assisted Living'. Last year, EAC estimated that of the largest 60 providers (all sectors) delivering variants of housing with care, 46 had less than 10 developments. **(15)**

Most of those who responded to the current study were small to medium operators, typically 3-15 developments, but the breadth of response ranged from single scheme provider to some in excess of 30. Some clearly on their way up and in for the long haul. There was positive evidence of continuing investment. It may have slowed in some instances but no respondent (questionnaire, calls, e-mails) betrayed an intention to withdraw from the sector at this stage. Indeed, conversations with some of the larger private providers suggested that when the market 'settled' again *it* and *they* would be stronger for it. A handful of local authorities stated that they were embarking on ECH for the first time and were committed long term. Others had well thought through development strategies which envisaged a significant commitment to ECH in partnership with local trusts. One joint venture between a private developer and a charitable trust is embarking on ECH for the first time and has one project underway, 8 more earmarked and one retirement village planned. A new local authority/local trust partnership in the North East expects to deliver 200 units from scratch in the next 2 years.

Working Independently or in Partnership

There is generally increasing evidence of partnership, even traditional private sector providers are now looking at this. A number of providers promote to both the rental and purchase sectors. Some do so because they are approached by referral agencies and commissioners; others as a defence against recession. Other private sector providers see *a market in transition* where future developments may characteristically, rather than randomly, be mixed income/mixed tenure communities. We also had responses from a number of smaller providers (1-3 schemes) who favoured independent working, preferring not to be “encumbered” by relationships or partnerships. One provident society had been particularly innovative in establishing a range of health, special needs, ECH and community outreach partnerships and in integrating the various staff and facilities, including the ECH provision, within a single site ‘hub’.

Where local authorities responded, they described their ‘partnerships’ as with RSLs, with Supporting People Teams, with social workers and with health teams in the PCT. One East Midlands’ housing association said it operates two different models of ECH. In the first it provides the specialist housing and support but the care is commissioned separately and provided by a partner independent agency which delivers integrated care and support services. In the second, *it* provides the housing, support and care for a wider range of needs than in most ECH schemes, in particular offering a service to people aged 60-70 with complex and often long-standing physical and mental health needs or learning disabilities. This is marketed as Assisted Living.

One respondent, a housing association, was alone in stating that they included within their *partners* ‘residents – existing and potential’. This is an area that should be improved upon under future Tenant Services Authority arrangements.

Differentiating the Product

For ECH providers marketing is not only a ‘moveable feast’ but may also be treated with quite different degrees of importance and ways of approach. The value placed *on* and investment placed *in* marketing by a private sector provider may, for example, be quite at odds with the way a small housing association with a secure stream of referrals might assess and deploy marketing strategies. On the other hand, we found that some of the larger scale not-for-profit providers produced some of the most informative and most customer-friendly marketing material. Some was the most sophisticated we encountered and comprehensive in explaining and illustrating all aspects of ECH and what it means to move there. Not for profit providers appear most skilled and most informative in harnessing a value framework with the practicalities of care choice and delivery. The marketing literature of some not for profit providers- Extra Care Charitable Trust; Joseph Rowntree Housing Trust, St Monica Trust- and some private providers such as Oakbridge Retirement Villages and Shaw *extracare* are notable exemplars in addressing and balancing lifestyle and care needs information and in bringing values and philosophy to the fore.

As a general rule, effective marketing depends on being able to convey the product/concept/service accurately, unambiguously and in a form easily understood by the consumer. This notion of ‘effective marketing’ has something of a split personality where ECH is concerned. It can be highly effective in a way specific to the particular provider undertaking the marketing and quite singular to *his version* of what *he* defines ECH to be. This is measured simply and narrowly by his success in securing and sustaining purchasers, in making a profit and thereby providing a commercial return to investors and shareholders.

Customer satisfaction obviously plays a part but it is unlikely to be the overriding measure of success because elderly customers will come and go, they can be idiosyncratic in their assessments of their environment and they rarely collectivise in a

sustained way to complain or to take action against a perceived common cause. For the provider and the commissioner sales and/or occupancy (resource efficiency) rates are the main driver and primary gauge of success.

The marketing of ECH may appear less effective, however, in the general sense of trying to convey what government and consumer interest groups hold to be the most appropriate or useful description since individual providers have a commercial or operational interest in *differentiating their product*. As a result, actually shaping the description of ECH on offer to fit the *individual provider's* vision, values, resources, philosophy, catchment, financial objectives, funding and *his* perception of consumer wants and needs is, essentially what marketing is about.

It is the integration of care that primarily distinguishes ECH from other forms of sheltered accommodation. Yet it is the spatial, lifestyle, specification aspects that still tend to dominate brochures and other media. This is unlikely to change overnight for the reasons cited above. Glossy brochures showcasing the style and attractiveness of a development are clearly important and have a part to play in marketing. But a number of providers reported that the overwhelming concern of customers is 'how are you going to deal with my care needs'. If so, we would suggest that the sector follows the lead of providers who do produce high quality lifestyle brochures but who also enclose dedicated step by step guides to care, services, tenure, leasehold arrangements, reservation and entry procedures, 'legals' and removals and *in the current climate* an easily understood note on how the provider may be able to help those who can't sell their home quickly. For providers generally, much of this already takes place *de facto* in chats on site or in the customer's home. However, it would raise awareness, reduce anxieties and boost occupancy if it was transposed and distributed as leaflets. We acknowledge here that some providers will prefer not to formalise or publicise this because the 'flexibility' they offer may vary significantly between their customers and may be private. Furthermore, executives can face, as one indicated, difficulties in steering through their boards and investors financial deals that delay capital receipts.

The ECH description is consolidated or adjusted over time as customers subsequently subscribe to it (success and satisfaction here being represented as initial sales and repeat business). Management systems and service arrangements gradually refine to address issues, iron out problems and improve all round efficiency.

Presenting and distinguishing successfully your product/service from that of a competitor, particularly in circumstances where there is a high degree of common ground that might make it difficult for the consumer to tell them apart, is what gives a provider a 'marketing edge'. In the private sector this success equates with sales, referrals (a form of customer retention), re-sales and a pride in the intrinsic quality of the product but also in comparison with that offered by competitors (differentiation). As we noted above, marketing in this sector is overtly *consumerist* and tends to elevate lifestyle first and foremost while still successfully putting in place (though not always detailing fully in literature) the means to anticipate and service progressive need.

It is in the interest of private providers especially to create devices that present their offer to the consumer as *characteristically different*. This distinction might reflect '*tangibles*' such as the pricing of the accommodation, quality of the buildings, luxurious fittings and furnishings; the location; scope and delivery of services; the nature of the facilities and amenities provided. '*Intangibles*' may take the form of exclusiveness, privacy, independence or the cultivation of a certain ambience or entry to a community of like-minded people, 'a peer club'.

In the public and not for profit sectors the goals are likely to be more closely related to a 'vision' (driven by certain social/moral/ethical aims and principles) and to a service strategy (shaped directly by official housing and care policy objectives) and by imperatives of affordability and social inclusion and for community cohesion. Here,

success may be measured by achieving those 'public' aims through overall occupancy and through the degree to which the needs of particular groups/localities are met (the allocation of scarce resources and delivery of public goods) and perceived. And how they produce gains or attenuate disutilities in other areas of policy and expenditure.

Notwithstanding its flaws and omissions, effective marketing in this sector secures profitability, meets important social goals and enables the provider to expand the model and to deliver a degree of social and economic capital in the community. This raises a challenge perhaps for government – that of publicising to opinion leaders, selected professionals and to the general public *directly* (perhaps in the form of a PR campaign through the national and regional media) the 'nuts and bolts' of this social and community capital. Delineating how housing with care really does offer a range of particular and more general societal benefits. These may not be understood or perceived. They should be brought onto more accessible and universal 'radar'. We explore these in the Planning section of this paper.

Branding

Branding is an important and proven means of creating awareness of a company and is a primary marketing tool. It is one of the most powerful means of 'differentiating' a product or business and it is skilfully deployed by a number of ECH providers. A prevailing description of branding is that it is 'a set of associations with a product' which in turn are actively promoted and marketed. At its most simple, branding may be no more than the name of the company but its currency and permeation will then depend on the way it is marketed. **(16)**

At a more sophisticated level it may involve the use of logos, trade marks, patents and may be used as catch-all for each of the company's products eg Sony or Panasonic or it may be deployed as an 'umbrella' enabling businesses with varying degrees of attachment to the 'parent brand' to piggy back on its profile. Virgin is an example of a powerful brand with high public recognition but is essentially a collection of quite disparate businesses only really united by the prefix 'Virgin' and by their *varying* degrees of formal and financial attachment to the parent company. Other brands meanwhile may be essentially franchises.

For some businesses, branding is viewed primarily as promoting the company, while for others it is a means of raising awareness of both the company and the product or market it is active in. It will sometimes achieve this dual purpose by attaching a link between the name and the product/market defining a clear relationship. To a customer the use of Acme Retirement makes it far clearer what business the company is in than if it had called itself just Acme or Acme Homes. Dyson is well known to most people but there are many Dysons. We become clearer about its business when its full brand name Dyson Vacuums is employed. Branding is therefore also a form of qualification.

It is instructive to work through the lists of housing with care providers. Excluding local authorities, it is surprising how many providers have names which on first hearing and seeing, and without resort to further qualification, do not immediately convey that they offer this form of housing.

Branding helps marketing because it is a means of identification, differentiation, recognition and loyalty, recollection and reference. It can be used to convey a vision and to promote an image. It may facilitate certain values, important in extra care housing, *trust, assurance, independence, security, care*. It is a means to harness interest and generate influence. It can be a means by which a company or product is 'elevated to the next level'. Its' role may be to add value or to convey a 'big idea'.

So what is its relevance to extra care housing? Well, first and foremost the housing with care sector is notable for three things; i) its lack of truly national players; ii) a still low level of public awareness with some confusion of descriptions and models; and iii) a multiplicity of providers and names. Branding is a valuable means of defining both the company and product and distinguishing it from the general pack. This is most effectively done where providers have brand names that evoke directly and unambiguously what they do. Extra Care Charitable Trust and Retirement Villages are clear examples. Their brand conveys their activity and should make marketing far more straightforward whether in an advertisement, on a sales board, in a bank presentation or in a listing in Yellow Pages. They have very effectively cornered the generic term for their specific activity. In a sector where there is evidence of a lack of public awareness and confusion over terms, they have a head start. Both are effective for another reason. One conveys very clearly a value and a vision; the other conveys a lifestyle and a type of community which invokes an image which attracts many older people

Other providers adopt a different approach. Some will use a family name that evokes interest and affinity locally and this can be highly successful because it trades on developing trust, establishing personal relationships and promoting direct accountability. Among not for profit providers, using the name of church organisations as the 'brand' is also highly effective for similar reasons and is instrumental in conveying *instantly* values, ethics, moral philosophy. It also reaps the benefits of 'localism' and draws on the 'constituency' and networks of the congregation. Others, deploy names that have a 'healthcare' ring to them and this makes their 'refined' offer evident to the consumer.

One such business had 'invested heavily' in creating awareness of its brand and considered that this had been a highly successful marketing tool but one which could only truly succeed if the staff understood the aim of associating it with a certain level of service. Here, there was a requirement that from Directors to management and through to local site managers all personnel 'must have a quality about them' which matched the aura and reputation sought for the brand itself. Put simply, people can make or break the brand and consolidate or erode investment. This was pointed up also in discussions with some not for profit organisations who said their 'brands' were associated with trust and compassion and that these values must be evident in their staff. They were the *litmus test* for what people had read in brochures or heard by way of reputation. Staff are seen as the 'custodian' of the brand and this may explain the increasing 'frontline' use of staff with care backgrounds in the sales and marketing process while, at the rear, providers in all sectors are also drawing on trained and qualified sales, marketing and IT professionals to assemble strategy, plan data collection, scope targets and refine product differentiation. Branding plays a key part in this.

A number of providers, particularly in the private sector, have developed brand names that have their origins in previous enterprises but where goodwill and awareness has accrued over a period making it unnecessary to change. Some simply select names that have a certain aura or which convey an image or level of quality, and this works for most. In the case of RSLs, names tend to fall in to two groups, an association with a place/area/person or a generic term that seeks to describe their aims or function.

Marketing a Vision

A final word on values and vision. The concept, clientele and diversity of providers makes extra care housing an interesting testing ground for the practical application of social, moral and faith principles. This distinguishes it further from the drivers of mainstream housing. Trust and reassurance are central tenets of successful marketing in this sector – more than in any other form of large-scale housing. The provider must

account for frailty, infirmity, age, uncertainty and must anticipate the onset of progressive needs in both the built and service structures he puts in place. These must be viable or a breach of trust results and this would compromise him in the market place. This is a tall order but overwhelmingly providers in all sectors share a strong and evident common interest in the welfare of older people. Some go further. Listening to contributors, a desirable value framework for extra care housing might consolidate the following:

- Promotion of the principle that age, health or financial means should not be a barrier to achieving a desirable quality of life in old age
- A diversity of choice and tenure that enables inclusion and which also recognises aspiration as well as need in older age
- Encouragement and facilitation wherever possible of an active lifestyle to promote independence and well-being
- A housing model that *anticipates* as well as meets the changing needs of society
- Independence, dignity, security, fulfilment for older people with care needs
- Quality of care, attention and service

2. THE MARKETING PROCESS

Marketing to Multiple Constituencies

Marketing is far more holistic and wide-ranging than is generally realised. For many providers, the marketing process begins not with the consumer but with a range of other stakeholders who are integral to the realisation of an ECH project. When asked, 'other than customers and their families who else do you market to' respondents listed:

| | |
|--------------------------------------|----------------------------|
| local commissioners | the planning authority |
| influential healthcare professionals | local community (at large) |
| local authorities | clubs and societies |
| social services | advocates for older people |
| primary care trusts | investors |
| adult care teams | banks and shareholders |
| GPs | certain types of business |
| hospitals | solicitors |

Funders

Funders are the starting point for the marketing process. They include banks, venture capitalists, joint venture partners, the land-owner (if he is co-venturing by 'putting in' his land for a deferred gain later), individual backers and consortia. As we noted earlier, it may also be the contractor who takes an equity stake to provide working capital and 'police' his construction risk. This enables his financial interest to grow with the provider's success. Or he may offer financial support indirectly by discounting his build price or graduating payment in return for an incentive at the completion of sales. Either way, like more conventional lenders, he will need to see a financial feasibility and a marketing strategy and be persuaded of their viability.

The housing recession and the specific impact of the 'credit crunch' have been detailed elsewhere (17) but it is important to underscore here the increased pressure that a recessionary climate places on ECH providers generally to market their case and compete more effectively for a shrinking pot of development finance. Barriers to funding are now artificially high while, tantalisingly, interest rates are at their lowest for 350 years. The situation is compounded further by a sharp reduction in the number of major lending institutions prepared and/or *able* to take risks with new housing projects at a time when people can't sell their homes and the market is fraught with uncertainty. It doesn't help that providers are struggling currently to shift existing stock for sale.

If loans are to be secured then the applicant may find that he needs to have done his homework to a far greater degree than before. Past assumptions no longer hold. Applicants now need to demonstrate that they know their stuff and have a positive financial profile. Briefly, lenders will require the following:

- Clear evidence of a successful and longstanding profit record
- Detailed financial feasibilities and cash flows
- A supporting risk strategy if the costs/sales schedule falters
- Default provision –ability to repay the loan on demand
- Extent to which the applicant is investing his own funds –and *his* risk exposure
- A requirement that the lender/applicant funding ratio is narrowed

- Proven experience and expertise in ECH –with supporting references
- Comprehensive and professional market appraisal –housing with care needs, property values, evidence of recent transactions, demographics, future growth and opportunities, detail of the company previous sales records
- An explanation of the tenure and income arrangements with illustrative ‘scenario modelling’
- Evidence of beneficial partnership (local authorities, PCT, land owners, investors)
- A requirement for conditionality (including withdrawal) in the land deal
- Planning consent in place or evidence of certainty
- An exit plan if the project fails

Commissioners

Since establishing the Extra Care Housing Fund in 2004 to promote ECH to local authorities in particular the Department of Health has allocated capital grants of £227m, in partnership with the Homes and Communities Agency (formerly the Housing Corporation). Overwhelmingly, these have been for new build with some refurbishment/redevelopment. £147m of this was provided in the period 2004-2008 with a further £80m dedicated currently to 25 new projects split between 2008-09 and 2009-10. **(18)** With substantial funding and a flow of supported referrals at stake providers naturally are keen to convey local need, suitable sites, the benefits of partnering, their expertise and experience, their ‘localism’ in many instances and in the case of not for profit players their vision and values. A number also cited the importance of exploring outreach and day care arrangements with local authorities. A general theme was the ability of the provider to ‘ease pressures’ on the local authority.

A number of RSLs stated that for them the marketing process begins with promoting proposals for new extra care schemes and services to commissioning authorities and to strategic housing authorities. One typified the general approach ..*“we would then have an on-going programme of marketing and joint working to ensure referrals are forthcoming and raise awareness of our services, via the local media.”* Those engaged in a sustained dialogue with commissioners across a number of authorities emphasised the importance of understanding what makes local government tick –what is the local authority psyche, what are its objectives, who are the primary decision makers. One drew attention to the need to base marketing on a detailed knowledge of the process and philosophical context in which budgets are actually arrived at and **the importance of understanding the commercial emphasis of ensuring that ECH is seen or can be seen to be more cost effective than residential care.**

It was observed that the knowledge of ECH on the part of commissioners varied significantly according to individuals and teams and between authorities. Some, for example, are not readily convinced that ECH can deal with the needs of very frail people requiring large packages of care as effectively as can be done at home in the community. One not for profit provider emphasised the importance of convincing commissioners to treat older people as ‘consumers’ rather than as the frail elderly and to also recognise tenure and capital development realities.

Another pointed to the lead times, 2-4 years, of getting developments underway as a further complication in the time frame of putting provision actually in place. There is a concern among some respondents that commissioners can be ‘too safe’ and must be prepared to take risks to move the supply chain forward. We were told that many commissioners have never set foot on an ECH development and that when they do

there is often a transformation in their approach. We were left in no doubt by some providers that there is a significant and ongoing marketing challenge here.

One identified 'making the case for sales' (capital receipts) on a development where the commissioner is 'investing' large sums of public money really aimed at rental and affordability as a notable area of misconception. The role of sales in helping to fund communal facilities for example is not properly understood. Elsewhere, it was also suggested that while some private providers *are* beginning to edge towards offering some affordable rental units this initiative may end in failure unless those providers bring on board development and management staff with a detailed understanding of local government and its commissioning processes.

A number of respondents said that 'marketing' between provider and commissioner was very significant. Housing associations emphasised this. For others the relationship was 'quite important'. The few private providers who responded on this subject thought it useful but not vital. Importance increases where there is a mix of local authority and private provision. This requires joint promotional activity and each sales channel benefits from the other's activity

ECH clearly prospers where the local authority places it at the centre of its strategies for meeting the care and housing needs of older people. The local authority has a powerful role to play which can include raising awareness of the concept, nurturing potential providers, funding care packages and investing in development. Bristol provides a strong example of a local authority which has a clear game plan for ECH and strong external delivery partnerships; so too do Oxford City and Oxfordshire. Elsewhere, and despite recession, respondents to this study provided evidence of the relative health of ECH vis a vis other housing markets. They reported strategies and new development emerging in a number of areas including Northumbria, Cornwall, Notting Hill, Hull, Isle of Wight, East Midlands, North and West Yorkshire.

Conversely, development of ECH is also greatly facilitated where there is an active and 'engaged' local provider or potential provider, with strong networks, determined to put the local authority under pressure to rise to the challenge of housing with care provision. As one put it, having a strong presence in the Borough, being a well-recognised organisation, having strategic and operational relationships and having built good connections with local groups, local councillors and the local MP all help to create a positive climate for ECH.

Marketing to Specific Groups

Almost without exception ECH provision is seen as *for* and therefore *marketed exclusively to* older people. Marketing reflects this. No private sector respondent either provided for or anticipated providing for the extra care housing needs of younger people with a long-term disability. One housing association reported that its local authority is keen to ensure that a scheme currently in development should be marketed to and targeted at people with learning disabilities but noted that there was 'some tension here'. Some respondents were charities dedicated to older people and therefore had a strongly defined remit. One housing association did state that they will offer accommodation to people 50+ with large care packages.

Some providers draw attention in their promotional material to specialist care provision offered elsewhere in their 'group', in the case of the private sector often a care home subsidiary independent of the ECH site. One RSL echoed the approach of a number of others in having an allocations policy in its ECH strategy for people with mild dementia but not marketing this to the fore. At the time of writing, the Department of Health published the National Dementia Strategy (19) and some private sector providers reported that they have developed integrated care models where specialist nursing and dementia provision are no longer seen as one-off initiatives but, rather, as *the way*

forward. Meeting the needs of people with dementia is seen by an increasing number of private providers as a growth area. Providers specialising in continuing care and 'retirement villages' based on graduated need are notable proponents. Some providers qualify their marketing slightly by defining more narrowly their preferred market and niche, 'we market specifically to older people *with significant care needs* and to people with dementia'.

In most instances, marketing is also conditioned by geography, especially in promoting the value of being a 'local' provider. This is seen as reinforcing links with the community, demonstrating local knowledge, providing local employment, an ability to offer outreach services and a reassurance that the provider is of a scale where the individual resident still matters. This was strikingly evident in the development and marketing strategies of charitable trusts and RSLs who place great store by their 'localism' and community roots and a number told us that this was an important factor in assuaging the anxieties of elderly people at the time of their move. For one notable regional not for profit provider this *localism* appears to provide a highly effective basis for engaging with local businesses and exploring how their corporate social responsibility programmes might 'fit' with the social and financial aims of the provider.

One interesting response described evidence of 'affluence' as the primary driver in a marketing strategy aimed at families and businesses in well researched and well-heeled post codes. This provider's model is high value and is aimed at high worth individuals. It is a focused strategy supported by evidence. Direct mailing lists are obtained for specific age groups within a set radius of the development and which meet certain levels of value and income to ensure they can afford the property and ongoing charges

A leading private sector 'continuing care' developer had refined this further and had centred his target market on people with certain wealth and demographic profiles within a 20 minute drive of the company's urban sites and 40 minutes for rural. Software, based on the 2001 Census but updated and refined, was developed to 'age' the population within the preferred drive-time catchments. Marketing strategies were fine-tuned further by 'investing' them with information on land and property values culled from the land registry and websites such as www.upmystreet.com and by applying and cross-referencing with other wealth indicators to create a marketing 'totem pole'. Then, the marketing team 'applied common sense'.

Elsewhere, some local authority respondents interpreted their marketing role as securing referrals to the team from GPs, District Nurses, Social Services, Care Managers and explaining ECH to families. As a general point, a number of local authority staff believe they have a role to play in increasing awareness and demystifying the concept. Given the national coverage and information frameworks available to local authorities and to PCTs and the arrival of the new Homes and Communities Agency (20) there may be significant opportunity to review performance, consolidate interest and pool resources in a re-launch of a national awareness campaign. Clearly this would also need to involve the private and not for profit sectors.

Marketing ECH to Planners: "We are in New Territory"

A superficial assessment of the planning prospects for extra care housing might suggest that this is a sector in which the case for development should not only be relatively straightforward, some would say a foregone conclusion, but one in which we might expect to see its active encouragement by planning authorities. After all, there are some obvious precedents and merits to support this view:

- The general currency of the concept across the public, private and not for profit sectors and in the planning of national and local policies for the integration of

the care, housing, health and financial needs of older people. This was given political impetus by the CLG's national housing strategy for older people, *Lifetime Homes*, *Lifetime Neighbourhoods* and recent Action Plan **(21)**.

- A rising demographic that continues to ensure that supply will remain significantly adrift of demand for many years to come and in which housing with care provision for some groups and localities is exceptionally scarce
- A lengthy pre-history to the current housing with care models stretching back over 3 decades which helped raise awareness generally of housing options for older people and paved the way for the modern variants
- A raft of reports from central government over the last 5 years which have identified an increasingly pressing need to put in place 'built' housing with care solutions that integrate policy, make best use of resources across all three sectors, which anticipate the demographic and which ease pressure on public services. This includes PPS3 Housing (Nov 2006) which requires Regional Spatial Strategies to set housing targets that reflect future demographic trends and age profiles and which meet 'the accommodation requirements of specific groups, in particular families with children and older and disabled people.' **(22)**
- The practical evidence of commitment demonstrated by some £227m of direct investment in ECH programmes by the Department of Health since 2004, unlocking a further £800m in capital grants, loans and land values
- Additional large scale resource investment by local authorities and by the former Housing Corporation, now the Homes and Communities Agency, including utilising CLG and DH Public Private Partnerships monies
- Investment (2008) in nearly 10,000 units for sale and over 6,000 for rent by local authorities and over 23,000 for rent by RSLs.
- The increasing support of Primary Care Trusts, healthcare and social service professionals to services that address prevention and early intervention
- Extensive community, interest group and advocate support
- Continuous promotion, illumination and leverage of the concept by a number of influential policy communities including the Housing LIN and trade organisations such as the Retirement Housing Group and ARHM
- Support from influential opinion leaders within the planning profession, notably the RTPI and the Planning Officers Society
- The support of most of the principal national advocates for older people, including Help the Aged, Age Concern, the Alzheimers Society, EAC, Counsel and Care
- An extensive and longstanding tradition of academic research that evidences need, value, good practice and the empirical benefits of ECH **(23)**
- On the ground evidence that exists in the form of circa 42,000 built units at January 2009.

Yet despite this apparently supportive policy and funding climate, the process of submitting a planning application and of securing a planning consent can prove surprisingly difficult. Winning a planning application for ECH requires an effective marketing strategy to 'sell' both the concept and the location to planning officers and to planning committees. The difficulties encountered in some applications suggest that success in conveying the benefits of ECH is uneven. There is a robust marketing case to be made here. So what might these benefits be?

Promoting the Benefits of Extra Care Housing

ECH can relieve pressure on public services. This can save money, improve efficiency of service delivery, transfer responsibilities to specialised operators and free public sector health and social service professionals to concentrate on commissioning and quality assurance—rather than direct provision and management of housing with care

The fact that many local authorities actually commission projects, enter in to partnerships and work jointly to promote this integrated solution suggests that they view it as valid and beneficial

ECH contributes to the development of 'social capital' in the community, it has a widely subscribed 'social utility' as a neighbourhood resource.

The increasing scale of ECH developments also enhances their role in building 'economic capital' in the local economy , creating construction jobs; providing long term employment and training to staff (women in particular); strengthening local procurement

The age profile, restricted mobility and relatively static nature of many ECH residents also means that, overwhelmingly, when they do venture out to shop they tend to spend locally

ECH sites are often transformative. Smaller scale projects are sources of local improvement and amenity. Larger projects, some covering 5 acres or more, can be significant vehicles for wider regeneration particularly in urban backwaters. They raise confidence, attract interest to adjoining sites and can be a factor in boosting inward investment

Developments of this type attract relatively low levels of car ownership and fewer car journeys than comparable sized 'mainstream' housing developments, helping in many instances to reduce CO2 emissions. The 'duality' of providing homes as part of a business is an efficient use of land, energy and materials. Many developments are also the only available means for saving and redeveloping listed or heritage assets which have fallen in to disuse and disrepair. These often become a central feature of the redevelopment project

The development of ECH also means that older people are invariably trading down and freeing larger housing stock back in to the supply chain. This is good for families in particular. Frequently these properties will require modernisation and this will provide employment for smaller tradesmen and custom for building materials suppliers

Developments provided individually by or in partnerships between local authorities, housing associations and charitable trusts (and increasingly with private providers also) are often strongly 'affordability-led' even where these offer purchase options. This meets statutory and community objectives

Larger scale developments –like mainstream residential projects –are frequently subject to planning gain and may offer benefits to the community at large in the form of amenity, improvements to the public realm or contributions to infrastructure, usually through a Section 106 Agreement

There are also less perceptible benefits to the community –not least in the way ECH developments act as a focus for certain clubs and societies sustaining their activities and helping them to raise funds and affirm their social worth. Many act as informal referral agencies, others as advocates for the interests of older people and many provide a vital social nexus that residents continue to access helping to promote 'normalisation' and stimulate independence

In many instances, ECH developments also enable older relatives to keep on living near or to move closer to their families. This makes an important contribution to the emotional and practical well-being of family, kinship and friendship networks. In turn, these help to preserve certain social mores, which invest our civic and value framework. Put simply, providing housing with care for older people and integrating it with the local community is a plus for sustainability and a building block in citizenship

It would seem, however, that developers/providers are not always successful in making this case for ECH to the local planning authority. So it is important to distinguish what may be ineffective, incomplete or simply lazy marketing from a genuine grievance that the local authority has failed to do its homework in understanding the benefits of the project or has compared it unfavourably with an alternative use for the site or is just being unhelpful. Planning authorities should not be strangers to extra care housing, after all it is often promoted widely within their own authorities by colleagues from other teams, ie. social services, care, health, housing. There have also been two publications in recent years dedicated to the planning context of housing for older people, one specifically for ECH, co-written by and circulated to planning officers.

The first of these publications by the Planning Officers Society and the Retirement Housing Group **(24)** noted that there were (and in most instances still continue to be) a number of areas in which applicants and planning applications encounter difficulties in persuading planning authorities to support their case.

Generally, planning policies do not adequately or specifically address the needs of frail older people:

- Site specific allocations to meet these needs are lacking.
- No specific planning guidance exists in relation to high level needs; there should be far more focus on the needs of elderly people in Local Plans and Regional Spatial Strategies.
- The need to encourage positive provision for ECH, especially as part of mixed use and regeneration schemes.
- Developers, in turn, should select 'sustainable' sites.
- All local authorities should be aware of elderly housing needs in their area.
- Planning Officers should be aware of the concept, should read appropriate literature and policy documents and should visit ECH developments to view the concept at first hand.
- Understanding of the concept is particularly important in the context of demands on the planning process to deliver 'affordable housing'. They should understand the necessary and justifiable distinctions between the two.
- There should be more joined up thinking between care, housing and planning professionals within local authorities.
- The sector requires an 'agreed planning definition' of extra care housing (at Nov 2003 the previous, but only broadly relevant, guidance was Circular 82/69 *Housing Standards and Costs: Accommodation Specifically designed for Old People- Supplementary Guidance*).

Finally, the POS/RHG paper suggested that developers seeking to provide accommodation for older people should '*market more effectively*' to the local community at the pre-and planning stages of the application.

More recently, in 2007, The Royal Town Planning Institute produced a Good Practice Note on Extra Care Housing published by CSIP and the Housing LIN. It aimed “ to support urban and regional planning professionals engaged in forward planning and development management to respond to the growing demand for extra care housing in England.” (25)

It reminded us that recent government policy initiatives had sought to take account of the needs of an ageing society and highlighted the emergence of joined up thinking in the housing and planning green papers and the health and social care white papers. (26) The challenge facing planning authorities was summed up sparingly.

“What is clear is that local authorities, providers and commissioners need to recognise and plan for an ageing population by providing a wide choice of extra care housing. We are in new territory which requires us all to promote well-being, independence and choice.” (27)

The intention of the Good Practice Note was to “help planning and housing officers, developers and service providers work together to provide an extra care housing offer that addresses the needs of our ageing population...This guidance promotes the good practices which will underpin and deliver our vision for a National Housing Strategy for an Ageing Society.” So what were the issues to resolve and the practices to put in place?

- The availability of appropriate housing for older people is an area where major changes are required over the next 10-20 years
- Planners need to develop and implement planning policies and development control practice which promote appropriate housing models and reflect changing demand
- Whatever the business imperatives or asset management issues, planners need to be clear about the strategic importance of any proposal as well as local or regional planning considerations
- The RTPI paper urges planning authorities to familiarise themselves with national policy guidance on planning and housing needs assessments (notably for older people); guidance set out in the National Housing Strategy for an Ageing Population; RSS and LDF policy requirements; the local Housing Market Assessment; Supplementary Planning Guidance; and specific site considerations such as location, building design and layout and ancillary features such as parking
- The RTPI saw a number of benefits of ECH to local authorities: it meets community development and land use objectives; meets aims for health and older people in Local Area Agreements; meets strategic housing policy and social care objectives; promotes independence and widens housing choice; meets ‘safe and secure’ environment objectives.
- It also offers benefits to PCTs providing a sheltered environment to meet health needs; a potential base for outreach clinics and services; helps reduce take up of acute hospital bed days; and provides opportunities to develop forms of intermediate care.
- In respect of ‘planning deficits’ the RTPI notes that “rural extra care housing schemes that draw residents from urban areas are generally counter to planning policy” and that rural needs “are most likely to be met within

existing rural villages and market towns, where the development of extra care housing will support services generally.” (28) The RTPI described ECH as characterised by a number of features and complexities that made it distinct from mainstream housing and it is clear that if ‘marketing’ the case locally is to be effective then these must be explained and resolved. They include: explaining and illustrating differences in design and layout to meet progressive needs; a note on the different funding and tenure routes and implications for affordability; the need to secure understanding and assessment of rapidly expanding markets and needs; the benefits to the wider community of integrating care and service delivery; the uses of technology.

- The RTPI paper also pointed up the problems already evident in establishing authoritatively and locally levels of need and demand particularly with regard to type and size of dwellings. At the time, and still, local planning authorities lack this information, not least because strategies for ECH in local authorities are still in their infancy. And do these (now emerging) strategies account for ECH for rent, leasehold and shared ownership.
- Finally, ECH is not registered as a whole by CSCI (to be replaced by the Care Quality Commission) though delivery of domiciliary care to individuals is. Planners and applicants need to make the distinctions clear at the time of application. It is another area where difficulties have been encountered.

When Does ‘Marketing’ a Project Commence

As we described above, marketing commences much earlier than might be assumed. Providers in all sectors are alert generally to the need to promote a development as early as possible, although what they variously consider to be the most effective or precise starting point will differ according to local circumstances, budgets and partnering arrangements. Almost everyone we contacted commences marketing (and they did view this as ‘marketing’) when a site is acquired or when the planning application is submitted. The main responses were as follows:

- The moment a piece of land is identified
- At conception of the project
- At feasibility stage we commence marketing in the local community
- On securing planning consent (press releases are issued to build awareness) but prior to construction
- Once a development or management contract has been awarded or an allocation agreed
- Ideally 18 months before a development opens
- As part of the pre-planning application (this was more evident where a professional planning specialist was on board)
- The moment a site is identified and before acquisition –we undertake surveys of local demographics; house prices, market reports
- On start of construction usually allowing a full year for marketing
- From the moment we give first thought to a bid -the marketing team is involved in the assembly of our funding bids helping to work through preferred partner applications

- For us it doesn't really start in any formal sense. Our projects are typically small cottage schemes and village based and word of mouth does the trick and saves on expensive marketing. Our larger new projects will be marketed from conception however.
- We produce a marketing plan 12 months before opening, starting low key in the first few months via local newsletters.
- More formal targeting takes place 8-9 months before completion.

Written Marketing Strategy

Most private and not for profit providers said they have a written marketing strategy. Those predominantly care home led with marginal ECH provision had less detailed strategies and were less reliant on demographic research. The nature of their specialism means that they have continuous high demand and the need for strategies and spending time on them is regarded by some as less pressing.

A number of local authorities who responded said they had no written strategy because the system operated through referral. We have noted elsewhere that many local authorities do not have a strategy for ECH in any case so questions on marketing are academic. Where partnerships existed marketing was seen as the preserve of the provider. One local authority spoke of having a 'corporate marketing strategy' covering all housing, care and support services

Research and Review

Private and not for profit providers generally do undertake research on local demographics and property values. A small number are quite sophisticated in their approach- some employing professional help to assemble data banks and identify emerging trends. One leading not for profit provider states that it has shown the way in B2B marketing, cause-related marketing, direct mailing and was alone, as far as we could determine, in having an effective grant application strategy. Marketing programmes of this type require considerable imagination and skilful and professional management and are clearly very effective. However, they will not suit all providers and appear to work best where there is a degree of 'scale' and long term planning in the organisation.

In most instances, however, market research amounts to very little beyond collating and extrapolating facts and figures on local age cohorts and property values. Though one RSL emphasised that they cast their net widely by collating data from agencies such as Supporting People, Adult Social Care, National Housing Federation and other specialist housing bodies such as Age Concern and Help the Aged and 'government sponsored research'. Others simply rely on basic census information.

No respondent mentioned the term 'the competition'. Respondents were split on the frequency of review. About half review performance monthly, the other annually. In one instance it was reviewed annually on the basis of void turnover and changes in demand for certain services or properties. Two reported that they work through their findings with external agencies but were an exception. Notwithstanding a handful of impressive exceptions there is a general lack of detailed planning and use of sophisticated analytical tools. Information gathering appears quite rudimentary in the sector. Surprisingly few mentioned learning from previous experience. Only a handful stated that their staff undertook training in marketing. The majority described their marketing budget as 'adequate'. Yet there is a rich seam of information, guidance and experience available for providers to draw on. We have already cited the EAC and DoH websites as primary sources. But commissioners and providers may find it very useful here, by

way of longitudinal context, to visit the work undertaken by PSSRU at the University of Kent as part of the Evaluation of the Extra Care Housing Initiative, covering the period since February 2005, and in particular the highly accessible Housing and Care for Older People Newsletter. This contributes valuable research on models, characteristics of developments, financial feasibility, staff and management experiences, scope of service provision, health and well-being, relationships with the community and on outreach. (29)

Techniques, Tools, Targets : Most Effective Forms of Marketing

A regular mix of advertising and dedicated PR is seen by most providers as necessary to raise and sustain awareness both of ECH as a concept and of particular developments. Commissioners also underscored this. Advertising is also used as a medium for 'drip-feeding' the audience with key messages and in some instances with 'incentives'. The most effective forms cited were:

- Direct marketing through printed and electronic media
- Direct Mail to a target audience, based on purchased and in-house data
- On-site sales functions
- 'Association', investment in and wide promotion of a 'brand'
- Computer Generated Images of the development
- Advertising in the local *free* newspaper
- Personal endorsements by residents
- Relationship marketing
- Magazine advertising
- Publishing of own in-house magazine
- Resident 'endorsement'
- Seminars to professionals and commissioners and to key political figures
- Cause-related marketing
- Establishing a community presence through own charity shops
- Newspaper advertising
- Signage at developments and around town and in shops
- Posters and leaflets in GP surgeries
- Website advertising (use of residential sales sites such as Rightmove)
- Website features –on own and third party sites
- Reliance on local reputation and a small group of key opinion leaders in the community
- Assembly of a 2500 name local mailing list and use of local networks
- Editorial in the nationals regionals
- Making ourselves aware to certain types of businesses and societies
- Keeping up our brand awareness (only one of three mentions of the term 'brand')

- For one RSL it was a combination of the ever-ready activity of the local core team and its own reputation
- Word of mouth, a number of smaller and local providers saw this as their optimum tool
- Joint promotions (press or leaflets via Adult Social Care/Supporting People commissioners)
- Specific briefings to referral and assessment teams
- Create events for on site photo opportunities to flag in local media
- Q&A Days (on ECH) on site with one to one staffing available to customers
- ‘Shoe leather’ – getting out in to the community and also undertaking home visits
- Promotional events and advertising in shopping centres
- Information and leaflets/posters in libraries
- Target much of our effort at the family looking for solutions for their parents
- Open days using the show flat - we advertise these in advance in the local paper
- Inviting Adult Social Care workers, hospital discharge teams and GPs to visit our completed schemes
- Permeability, making the completed development open for use by the entire local community even if the users (clubs, societies, businesses, schools, churches) are not themselves ‘customers’. But this permeability will result in ‘osmosis’ in the community and spread the word about the quality and care on offer.
- Showcasing – eg using a development to promote local and specialist categories of ‘Britain in Bloom’ and having the judging taking place on the development; or using the development’s facilities to host local theatre, musicals, concerts, business exhibitions, fashion shows, dinners, celebrations
- People, having the right sales people- mature, empathetic, calm and assured, prepared to spend time and ‘dedicated’ to a particular customer to oversee their move from start to finish. Absolutely no ‘hard sell’

What Should A Customer Expect To See In the Marketing Pack

The following list is compiled from the questionnaire responses and from our review of the many brochures sent to us. It offers a simple (by no means definitive or exhaustive) guide to the information and advice that a customer should expect to see in the primary marketing literature. A number of not for profit providers, in particular, excel in the information they provide and their ‘offer’ is enhanced further in some instances by the research they conduct directly or which they sponsor on housing with care generally, on aspects of frailty or need such as dementia or on the specific merits of their model or a single development. **(30)** One leading not for profit provider emphasised the importance of also setting out in the marketing literature the ‘boundaries’ and ‘limitations’ of ECH to make it clear what is *not* provided. This amplifies a more general view that some customers may be under a misconception about lifestyle on the one hand and the extent of care available on the other.

Research can be a powerful marketing tool accruing expertise, authority, verifiability. It is surprising that more providers do not sponsor research initiatives. At the most basic

(but often the most valuable) level this can take the form of a simple questionnaire to residents on the provider's existing developments eliciting *their* views on everything from specification and accommodation, service charges, quality of care, professionalism of the company and whether the reality measured up to the brochure. **(31)** Very few respondents referred to *written* consumer feedback or to involving residents help shape marketing literature. A number do, however, encourage residents to meet with prospective customers and show them their own accommodation as a form of assurance and endorsement. Providers who publish in-house magazines regularly deploy items featuring contented residents.

The Provider

- Who they are
- Background in delivering ECH
- Ethos/philosophy
- Expertise and experience of the management team and staff
- Key partners
- Financial strength
- Long term plan

Extra Care Housing

- The concept: what is it, who is it for
- How housing with care works
- Meeting progressive needs: me *and* my partner
- Services and support
- Meals, laundry, shopping
- Activity and independence
- Social life on site and in the community
- Support services; GP, social services and pharmacy arrangements
- Fixtures and fittings, what's included/what do I bring
- Access, mobility parking, getting out and about
- How it affects my family
- What sort of life can I expect
- Benefits advice (where appropriate)

Financial Details

- Prices/rents
- Lease Purchase
- Guide to fees and capital cost
- Lease transfer and charges
- Breakdown of service charge, community fee, other charges and living costs

- Eligibility criteria: age, needs, geographical, referral
- Rent models/affordability
- Rent to buy options
- Shared ownership
- Q & A section

Accommodation

- Range of accommodation by site
- Communal facilities
- Securing a property; waiting lists; priority arrangements
- Removals and assistance
- Guest accommodation

Site Plan

- Location of /direction to development
- Overall site plan
- Location of individual properties
- Photo-montage of activities
- Environs of scheme
- Facilities

Some providers commented generally that brochures should be written in simple straightforward language with a clear explanation of what is on offer and what residents could expect from ECH. Where appropriate, consideration should be given to printing marketing material in large print, in Braille and also in other languages to reflect the needs and geographical catchment of a development. Since most relationships are built in the community and marketing and 'sales/referrals' take place locally we describe below the written marketing offer of a not for profit provider which has made a considerable success of its local roots and which understands the importance of scope, detail and clarity in the information it provides to its customers.

Marketing 'Localism'

Originating in a large regional capital this not for profit trust confines its developments and services to the conurbation and outlying counties. There are geographical qualifying criteria which shape and focus the marketing strategy. Residential eligibility is dependent on living in the catchment of a number of county and local authorities. This enables the provider to concentrate resources and build relationships in a specific region. In turn, this has enabled it to establish itself as a primary, if not the leading, provider of continuing care in the region. It is a natural focus for consumers and their families and advisers and is a foremost referral point for health, housing and social services professionals.

In marketing terms, this allows the provider to elevate its base in the local community. It deploys its local knowledge, its local relationships and its local recruitment and procurement as a significant selling point. It is not a national chain with senior staff

remote from the day to day operation, it is not driven by 'site opportunism', it is 'not passing through'. Like many not for profit, RSL and smaller private sector providers its staff are local and its trustees are drawn from and engaged with the local community.

This provider's marketing success can be attributed to a range of factors including its ethos and culture and a value framework which is to the fore in much of its marketing literature. This is supported by the location and quality of its developments; the professionalism of its staff and services; the strength of its relationships and networks; and by the readiness of its residents to commend it to others.

But this success is also due to its local origins and to embedding '**localism**' as part of its continuing service and development strategy. So while its vision for the future is to continue to develop its services 'to meet the changing needs of a changing society', part of this drive envisages expansion into the wider geographical area around its home base. Accordingly, at the core of the marketing strategy there is a clearly articulated 'vision' which emphasises changing needs, independence, dignity, fulfilment and the quality of care and service.

Marketing literature embraces corporate brochures, an annual review and an explanation of the provider's origins and purpose. A dedicated leaflet explains extra care housing. Other leaflets offer advice and guidance on eligibility criteria; waiting lists and reservations; types of accommodation; the range of care and support available; onward care needs; facilities and sites; and costs and service charges.

Site brochures detail location, accommodation, unit dimensions, site plans, facilities, environs. A regular newsletter reports on site activity, development progress, news items, resident features and 'people' This is sent out as part of the marketing bundle and reinforces the sense of 'community' to which customers are attracted. This provider also offers outreach services and has a dedicated leaflet addressing philosophy and approach, services at home, standards and training, a cost menu and links to key contacts such as health and care professionals. Overall, its marketing literature raises and answers successfully the questions that older people and their families will wish to ask.

USP Unique Selling Proposition

A common feature of USPs was the emphasis on a model which promoted well-being and also offered the resident an alternative to nursing or residential care (we touched on this earlier in the questionnaire but raised it again in the strategy section). The questionnaire responses were:

- Choice, experience, expertise
- How we *enable* the purchaser to actually move
- Our partnership approach to ECH
- We are inclusive; open to all
- Trust
- Inclusive design intended to be aesthetically pleasing but also functional
- Quality of the built environment
- On-site care and support 24/7 from a single provider
- A unique financial model based on an actuarial pooled-finance scheme
- Care Suites, an owner-occupier-led concept promoted as a distinctive alternative to care homes. The right of tenure with choice of 125 year lease or rent within a 'care' environment

- Compassionate and respectful
- Quality of management
- Nurtures spiritual and physical well-being
- Independent living with care
- We are considered specialists in what we do
- 'Home for life' with intensive care available if required
- Choice with opportunity not to have to go in to nursing care or a residential home
- Activity and stimulus
- Our organisational set up, in having both a research and operational arm
- We are able to search, demonstrate, influence. That is, put theory in to practice.
- The beauty and tranquility of the (rural) setting
- Assisted living for complex physical and mental health needs
- Enabling couples to continue to live together rather than one having to leave for a care home
- Offer low cost home ownership
- 2 bed 'flexi apartments'
- Range of tenure options
- Whole package is provided within a single organisation
- Quality and range of on site communal facilities
- Events and activities programme
- A technology infrastructure that enables partners with dementia to remain in place
- We offer a *lifestyle*

Most Useful Site-based Events

In an effort to understand the importance providers attached to 'show casing' their developments to customers, we asked them to list what they saw as the most useful site-based events. It was noted that site staff including the manager and care staff were often deployed at these events to answer questions and in particular to provide an appropriate 'caring face' when personal needs were raised. The primary events cited were:

- Open days and fetes
- Tours of show homes
- Press events and photo opportunities
- Viewing days for professionals
- Lunches for Healthcare professionals
- Social exhibitions
- Local interest group meetings

- Coffee mornings
- Open evenings
- Our 'village fetes'
- Some smaller operators did not use site-based events

Show Home and Restaurant

Nearly all private and not for profit sector providers reported that they use furnished show homes as part of their marketing strategy. Local authority respondents generally said that they did not. For most, the restaurant is a primary tool and this forms part of sales visits with customers and their families. Inviting prospective residents to lunch or coffee in the restaurant was seen as having a number of attractions. It provides an opportunity to meet with existing residents; enables customers to check out the quality of food and service; it is a 'relaxing sales aid'; because of its central location it showcases the *range* of communal facilities; it is a useful 'window' on site activity. A few respondents said they don't use it in this way but do feature the restaurant in brochures, editorials and other promotional literature. It can also be the case that the restaurant tends to attract the most dependent and frail residents and during marketing some providers may wish to avoid customers leaving with an impression that the development feels 'institutional'.

Meeting Staff and the Manager

Virtually all respondents said that customers and their families met staff and the Manager as part of the sales and marketing process. Most placed great store by this and added that 'care staff' were always prominent in on-site marketing events, often acting as 'hosts' and informal promoters of the development. They are seen as 'empathic'. Some providers may incentivise senior on-site staff to assist with sales. A longstanding private developer of continuing care and retirement village communities emphasised the importance of giving personal 'one to one' attention to elderly purchasers over as long a period as it takes. And when speaking to clubs and societies to raise awareness of ECH to do so in a 'personal' rather than a corporate capacity. Pressed on this he explained that he and his team did not 'canvas' at such events or in any way offer a 'direct sell' of their development. Rather, they spoke generically about ECH and what it could offer older people and then simply waited for those listening to make up their own minds in their own time. Adopting a low-key approach resulted in potential customers turning up on site of their own accord and their interest was stronger for that reason.

Advertising and Media Coverage

Advertising remains a primary tool for the private sector and only slightly less so for some of the larger not for profit providers. Others said it was used more occasionally to *reinforce* awareness. Nearly all respondents said media coverage is important. Some actively 'create' media events and send in features. Surprisingly few issue a regular press release. The extent of coverage reported split evenly between 'significant' and 'occasional'. The larger players and those promoting lifestyle are more likely to have a PR professional on their staff or to retain a PR consultancy charged with the task of keeping the company and the brand in the public eye. A number of Managing Directors and Chief Executives actively cultivate personal links to key property editors and writers. One effective means of winning valuable editorial coverage is to regularly submit developments for high profile housing awards and to promote the entrant/provider on the back of nomination or outright success. This is likely to be given

an interesting and arguably overdue fillip with the launch in 2009 of the 'resident-led' *Housing with Care Awards* which will be open to all housing schemes for older people which provide care services. Categories will cover small, medium and large schemes or developments, retirement villages, ECH, Very Sheltered, Assisted Living and Close and Continuing Care. **(32)**

It is worth noting here that the number of popular sources through which extra care housing can be featured or promoted is actually quite limited. There are less than half a dozen independent magazines which either directly or tangentially cover news or features from the sector and these tend towards lifestyle rather than need. The most well known are *Saga Magazine*; *Over-50 Magazine*; *Your New Home*; *Retirement Today*; *Senior Living* published in association with the housing charity Elderly Accommodation Counsel; *Active Life*; *Senior Moments*; and *Yours Magazine*. A further few focus on finance in retirement and by their very 'pitch' and readership essentially exclude the vast majority of older people and ECH customers. They include *Moneyweek*; *Investors Chronicle: Which? (Care Options in Retirement)*; *Money-Observer*.

Among the 'nationals' *The Daily Telegraph*, *Daily Express* and *Daily Mail* are the most likely to provide editorial and features on retirement housing generally –partly because of their readership profiles and partly because they have been more effective in winning related advertising. *The Times* also has a property day and *The Sunday Times*, *The Sunday Telegraph* and *The Observer* and *The Financial Times* on Saturday all have property pages or supplements. But it would be true to say that unless you can conjure an unusual angle it is hard for material on extra care housing to displace the preoccupation with aspirational lifestyles, homes abroad, the latest architect designed home in North London or eco-living in rural Gloucestershire. One housing association uses the trade press to market their developments citing *Inside Housing*, *UK Construction* and *Local Government News* as valued outlets.

What is most noticeable is that while there are relatively few national outlets for ECH publicity and promotion –and there may be a case for the establishment of a new volume magazine capable of sales on the high street –there are numerous (in fact hundreds) of local and regional newspapers and other publications in related fields that need news and which are generally responsive to a good story.

What providers at large lack, and this is another example of the need for raised awareness, is simple advice and guidance on how to put press releases together; how to spot a media opportunity; how to create a media event; assemble a local press contact directory; gain insight in to how to develop a different news 'angle'; and coaching on how to develop a story capable of becoming a feature. This is an area where a series of regional workshops could prove of great value.

A favoured option of some providers –across all sectors, is to produce their own in-house magazine or newsletter which is distributed within the community. Invariably, these are provided at no cost to the reader and their content tends to centre on the latest development, on specification and accommodation, on services and facilities and on the merits of joining a 'peer community'. Many will carry features on residents who have already made the move, a valuable form of endorsement. In some instances, providers have arrangements for these to be delivered inside the local free newspaper; others are content to bear the costs of direct mail shots; while most will simply leave their magazines as freebies on site, in health centres and surgeries, in shopping centres and drop them off to a web of clubs and societies.

At the more expensive lifestyle end of the private sector and in the case of at least one not for profit provider in-house magazines are made available through subscription. This may seem perverse when you are trying to sell a product but in fact can be a rather effective form of target marketing. Subscription has two advantages. First, it helps to separate those who are 'genuinely interested' in the development from those whose interest is cursory. The theory goes. '*why else would they pay for it?*' Second, a subscription model (sometimes at cost or free, in the latter case you usually have to complete a personal details form, often on-line) is a valuable means of identifying potential customers and building a data-base. A number of providers use their magazines in this way as a vehicle to collate information about people and post-codes.

The Marketing Team

Most private sector respondents said that they have a dedicated marketing team. A few reported that they retained a professional PR adviser. No responding local authority had an adviser. One housing association did. Some providers are now seeking out specialists with long-term experience of marketing retirement and mainstream housing to improve their performance. Some have already recruited, or intend to as they grow, people with IT and data base building skills. Others believe it is enough to buy off the peg data-bases and then work on these within the team. In nearly all cases we found that the team is headed by a Director or by a senior manager. The size of team varies, with no real pattern emerging, but most appear to be between 3-7 people.

Marketing Team Backgrounds

The composition of the marketing team is something we sought to draw out and is likely to be of keen interest to providers generally. The mix varies depending on the sector but private providers tend to employ a combination of general sales staff and professional marketers. Talking with respondents, our perception is that providers are increasingly recruiting people with *proven* sales and marketing backgrounds. This is likely to be both a natural step in the 'professionalising' of a housing business but, looking forward, may also be a requirement from funders and directors seeking to strengthen data collection, forecasting and sales and marketing performance. One provider had a planning specialist and a land manager as part of their *marketing* team pointing up various synergies.

Involvement of Care Staff in Marketing

We asked providers if and to what extent people with a care background were part of their marketing team and in what roles they were involved. Answers were as follows:

- A RGN heads the team jointly with a professional marketer
- Care staff participate in a professional new homes sales training course
- Care and marketing staff convene regularly as part of an overall extra care promotions team
- There is continuous liaison between the operations (care) and marketing teams
- Care staff attend automatically marketing and strategy meetings, their ideas are encouraged
- Care staff help to appraise/comment on marketing results
- Care staff are assigned the primary role in visiting potential customers at home
- Managers are used outside the development for outreach marketing in the community. They are perceived as good ambassadors

- Care staff are very much involved in 'show-arounds' and in hosting evening functions
- Social workers have been instrumental in marketing and promoting the scheme; they have identified prospective applicants and have promoted it through one to one meetings with applicants and through use of a DVD.
- Care managers are not so involved in marketing at present but we intend to utilise them significantly as we move forward with our development programme.
- We intend to use care staff primarily for seminars, talks to the community, meetings with prospective customers
- One Domiciliary Care Manager for an extra care service reported that she liaised directly with the PCT who then make referrals

Why Customers Choose Us

We asked those we contacted why *they* thought customers chose their product. The answers below may have been given by a number of respondents:

- Design and buildings extremely 'client-centred'
- Designs are often 'leading edge'
- We are trusted
- Our sales model is quite distinct
- Reputation for delivery, meaning what we say, and reassurance
- Peace of mind for relatives
- Best practice standards
- We are an *established* care provider (a known commodity with a reputation)
- Owner-operated team providing personal contact
- Effective sales team
- Value for Money (RSL)
- Affordability (RSL)
- Accessibility and location of schemes
- We are *local*
- Our partnership approach (RSL)
- Effective problem solver for complex needs
- Perceived to improve the quality of life of marginalized people with special needs
- Homely atmosphere
- a 'Home for life'
- High levels of care available
- Contemporary model with leading edge design; we don't feel institutional
- Our extensive partnership arrangements and expertise
- We are the only scheme in the area

- High quality services
- Well maintained accommodation
- Because we are a charity
- We are a brand new product in the area with a very modern design
- We are family-owned and run
- Little competition locally, ahead of the field

Using Residents and Families as ‘Advocates’

It was important –not least given a number of reports and policies that have promoted the value of involving older people in helping to shape and inform housing with care options **(33)**, to establish the extent to which providers in all sectors involved residents in marketing and promotion as advocates. Potentially, it is a double-edged sword with residents capable of offering a powerful ‘peer’ endorsement of a development and of the provider. But it can also open up the possibility of unhelpful comment and feedback if not managed. However, most respondents were confident that where residents were involved they would be satisfied customers and would be effective promoters. Accordingly, most providers encourage new customers to meet existing residents. Responses were as follows:

- Relatives are invited to attend and to in-put to on-site events
- They are strong advocates and seen as such by staff and marketing teams
- We are not too preoccupied about the importance of resident marketing
- We feature residents in our magazines and in some cases DVDs but not in active endorsement or in on site marketing
- We ask residents to provide marketing testimonials to new customers
- Our residents are encouraged to have lunch in the restaurant with prospective customers
- Sales teams build 2-way relationships with tenants who are proud to show off apartments
- Residents participate in our design panel –providing feedback on what works and doesn’t
- Residents provide comments for case studies we use in brochures
- We encourage prospective customers to support us at planning applications and in consultations with the community
- We have a volunteering scheme whereby residents can come forward to get involved in showing prospective customers around communal and living facilities
- We have an Older Peoples Involvement Group which helps us with marketing
- Some said that personal endorsements from their residents was one of the most effective marketing tools
- Some providers reported that they have no arrangements with residents and families

Marketing Split Between Primary and Secondary Consumers

In the questionnaire, we described '*primary consumers*' as the customer (the prospective resident) and '*secondary consumers*' as their family and friends. The latter are often involved to a high degree in assisting the former with their housing choice. On some developments there is a '*tertiary consumer*', a trusted professional, lawyer, GP, person with power of attorney or trustee. To avoid complication and because of lower rates of incidence, we did not include these within the questionnaire.

Private sector providers said that most time was spent with family and friends (secondary consumers). Generally around 70-80 per cent of time was devoted to the family and friends and around 30 to 20 per cent with the primary consumer. This rose to 80-20 for those people with learning difficulties/mental health needs. Local authorities and housing association respondents said their time was generally split evenly at 50-50 per cent. One private sector provider described a two-tier approach in which most of the time and effort was spent with sons and daughters in their late 60s and early 70s on behalf of parents in their late 80s and early 90s. Here, the marketing process was actually being conducted on two levels. Openly for the elderly parent and subliminally (though not by intention) for the children, who could be potential customers 5-10 years down the line.

Who Deals with the Financial Side of the Purchase

For private providers this was invariably a member of the sales team. Often this function was assigned to the senior member. In some instances the role was split between the sales manager (the conveyance) and the care manager (domiciliary services and charges). One respondent underlined the need to have individual specialists handle their own areas, eg sales and care arrangements, but overseen by a senior manager. Housing associations cited the member of staff conducting the care assessment, usually a care/support manager or team leader. One delegated functions between Sales and Letting Advisors (purchase price and service charges) and the Council's Financial Assessment Officers for explaining and assessing the cost of care services.

Raising Profile in the Community: Building Networks

Providers were asked how they marketed their profile in the local community:

- Ongoing contacts with key interest groups and charities eg Age Concern, Alheimers Society,
- Road shows at local events to promote benefits of ECH
- Signage and advertising
- Actively secure space in community publications; church diaries and year books
- Notices in GP surgeries, health centres
- Community posters
- Talks to local interest groups
- Each development sets up a focus group of local councillors, interested parties and societies and has a tenant representative to promote the scheme (RSL)
- Presentations to local forums and tenants groups (RSL)
- Working with over-50s groups
- We are active with the interest groups which represent our clients

- Local web site advertising
- Press releases
- Via networking with local social services
- Key relationship is with the social services department
- A strategy of approaching local shops, businesses, hairdressers, restaurants and other places which older people use. We also persuade these to display our promotional material
- Approach local age-related clubs and societies and care support groups
- The local history, music, civic and archaeology societies are good sources of interest
- Sponsor local charities for 'profile'
- Intend to invite local schools to site to attract PR
- Purchase a local data-base
- We have developed a strategy for working with local businesses
- Regularly meet local businesses and invite them to the development
- Promote our work to our suppliers
- Sponsorship of staff annual 'stars' awards
- We create a 'Friends Network' for our developments
- Community newsletters
- Stands in the local shopping centre and in supermarkets
- Displays in local estate agents
- We employ a 'facilities and events manager' to liaise with the community
- Host a significant range of community meetings and events on site in our facilities regardless of any interest in the development itself –its just good PR
- We have an 'open door' policy for clubs and societies
- Our restaurant is made available to community and business groups
- Parish websites
- Have brochures available at housing offices and help points
- We provide information in a number of languages
- We identify and work with business stakeholders using them to promote our reputation in the workplace locally

Only one respondent mentioned use of local estate agents; a couple mentioned web-based agents. Rightmove and Upmystreet were viewed as the most useful sites. Very few seem aware of the CSR opportunities for charity fund raising; profile; potential clients; aids and equipment donations etc. We return to this later.

How Would Providers Improve Marketing

We asked participants how marketing/awareness of ECH could be improved

Improving Marketing

- Standardise terminology and definitions: people are confused
- Provide a simple message so that ECH means *the same thing to everyone*, consumer and professional
- Better information to and the creation of opportunities for healthcare professionals to visit as many ECH schemes as possible – many are really not familiar with the reality
- More widespread awareness of ECH as a *positive alternative* to a care home
- We must find better ways to reduce the uncertainty of older people and their families
- Customers and families don't understand the concept or grasp the quality until they visit -so more visits to completed developments should be encouraged
- Planning officers and councillors frequently misconceive the purpose and quality of ECH, they need better educating. They must come to site
- Local and central government must both play a more active role in promoting and enabling ECH as an alternative to care homes
- Improved sales techniques are needed which are sensitised to the circumstances of elderly people
- Cultivate a better understanding of the sector (developments and needs of older sellers/buyers) by commercial estate agents –their role could be significant but they don't understand the concept or how to handle the anxieties of elderly vendors
- Easier access/navigation on the Rightmove website
- Brighter and more upbeat 'retirement property listings' on web sites
- More funding for 'awareness'
- Learn from the experience of New Zealand, US, Canada and Australia where the model of ECH is far better promoted and established –publish case studies for us to read
- We need to promote far more effectively the ethos of 'independence'
- Establish a national media campaign for ECH
- Better promotion via organisations like Age Concern and Help the Aged
- Instigate local awareness 'drives' with the commissioners
- Clearer explanations in the media of the *care* element of ECH –the focus is invariably on the buildings and the lifestyle end of the sector
- Introduce a regulated or self-assessment system where all providers could be assessed and attain an *approval mark* and become part of a list (meeting certain criteria) approved for referral eg adapt the EAC Quality of Information Mark

The EAC Quality of Information Mark

This last point, made by a number of respondents, betrays a lack of awareness of the existence of a 'quality mark' for housing with care. Launched in December 2007, the EAC Quality of Information Mark is essentially a means for extracting from providers information about their housing with care developments to raise awareness and quality. On delivery of the necessary information and data and, by implication, matching up to certain standards and requirements, providers are awarded the Mark. They are required to complete a detailed 7 page questionnaire designed to capture complex information on buildings, specification, accommodation, facilities, services, tenure, location, lifestyle, staffing, ethos and purpose, residents, measurement of performance, costs and charges etc. The Mark is accredited to those providers completing the questionnaire comprehensively and satisfactorily and has to be renewed annually. Developments awarded the Mark are highlighted on EAC's website and providers are encouraged to incorporate the QI Mark logo into their marketing and publicity material. At November 2008 some 1770 developments carried the QI Mark including 472 housing with care schemes. **(34)**

The Mark provides an effective basis for increasing awareness of ECH and for exerting a degree of peer pressure in raising quality standards. Regardless of its relative nascence, the fact that many providers are either not familiar with it or choose not to engage with it by failing to complete the questionnaire suggests that concentrated support should be provided by government to promote it more aggressively. **A simple way of doing this is to promote by exclusion.** This could involve linking a national media campaign highlighting the merits of achieving a quality mark with the clear implication that customers should be cautious about signing up for developments (providers) which have not achieved and do not bear the mark. In turn, and positively, providers should be made aware that they *will* benefit directly from achieving the mark because government is investing resources in promoting it in the media and to local authorities, PCTs, clubs, societies and interest groups.

What Could Other Providers Learn From *Your* Experience

- That it is vital that everyone shares experiences and information
- Promotion of ECH should be an impartial, non-commercial exercise to benefit *older people* and not the providers of ECH
- Policy makers must raise the profile and status of ECH at national level to ensure local teams and services can translate this into a 'manageable strategy'
- Understanding 'real time' local housing availability and how to signpost appropriate providers
- Use professional sales and marketing personnel from the healthcare sector and *not* the property sector
- The benefits of partnership working
- Sharing of ideas and maybe of staff
- Having a good call handling service in place to deal sensitively and helpfully with the enquiries of elderly people and their families, also a dedicated local number
- Try to ensure continuity of your sales/lettings staff and managers – disruption causes anxiety and uncertainty with older customers

- Disseminate and build on the good practice of other providers –learn lessons from each other
- Instigate regular dialogue in the sector and joined up thinking, establish a forum
- Make sure your fixed costs are covered
- Care packages should be sold at a *fixed* price service agreed in advance rather than ‘on the meter’
- Meeting ‘real’ people on site is far more productive than DVDs and CGI displays, customers want to meet staff and have time to talk and ask questions
- Staging events on site before the development is completed tends to backfire, wait until everything is ready
- Very difficult to recruit qualified care staff ,this could be a significant issue for an expanding ECH sector

Where Could Government Do More to Help Market and Expand Provision

- More investment in development
- More funding to promote awareness
- Extend the work previously done by CSIP and the Housing LIN to the *general public*
- Impose a standard term –there is still widespread confusion about ECH
- Provide forums for exchange of experience/dialogue/networking
- Make funding sources for people in ECH more transparent
- Support respite and holiday use of ECH developments for people living in the community
- Address a general negativity to the private sector, providers regard this as frustrating when most elderly are actually homeowners
- More regard and positive promotion of the private sector for its *superior* efficiency
- Provision of research to promote the quality of life and financial benefits of ECH
- Need to update both the Town and Country Planning (Use Classes) Order 1987 (as amended) and the Care Standards Act 2000 to properly allow for the variety of elderly care models, especially in the private sector. Clear and more effective guidance can then be issued to local authorities for determining planning applications.
- See Planning Section in main report
- Ensure that ECH does not discriminate against people with mental health problems
- lower the age criterion for entry from 60 (for this group) to accord with normal ECH of 55 years.

3. MARKETING IN A RECESSION

A central theme of this paper is the effect recession is having on marketing and 'sales', and indeed on the investment strategies of providers. A recent Factsheet by the Housing Learning and Improvement Network **(35)** noted that many features of the 1989-93 recession are being repeated, with sales abruptly terminated, the substitution of rent for sale and the disposal of whole developments. RSLs are having to renegotiate funding arrangements, are concerned about breaching covenants and are hesitant about entering in to new commitments. Many private providers, reliant on outright sale and capital receipts, are exposed. The process of borrowing is now far more complex and conditional for all players.

Even so, and notwithstanding pressures in the sector, the Factsheet strikes a note of cautious optimism..."*Generally, the credit crunch does not appear as yet to have stopped funding for extra care specifically.*" It reports that RSLs are seen as a better risk than lending to mainstream developers for sale. Further, because of DH and Homes and Communities Agency (HCA) funding programmes, the eligibility of people with housing with care needs for a range of benefits makes development of ECH " *a more secure proposition than some other social housing.*" **(36)** Accordingly, there may be emerging opportunities to now provide ECH in place of other forms of housing.

Lessons from the Healthcare Sector: An Alternative View of ECH

A recent seminar led by the Savills Healthcare Team, while essentially centred on the prospects for the health, hospital and care home sectors, highlighted a number of general trends that also apply in what they saw as the larger scale territory of extra care housing, Assisted Living, Close Care, Continuing Care Retirement Centres (CCRCs) and retirement villages. Emphasising the underlying strength of the 'healthcare market', Savills suggest that recession is producing a 'flight to quality'; the purchase by stronger players of under performing assets; the release of sites; the withdrawal from some areas where there is now effectively little activity or competition; and lenders doing business only with experienced and profitable entrepreneurs. **(37)**

What also emerges is the need to professionalise further marketing strategies and techniques, starting with far more detailed market (needs/trends/location) research and more cogent development feasibilities. It was stated by a number of developers and funders present 'that the best ECH sites were now falling to the care home sector and this would prevent them from being used for housing with care'. Some already have consents in place and a number are said to be in highly suitable locations for ECH. Some would simply be land-banked and either resold later or the new buyer would assess the merits of entering ECH. For the moment, however, the profits are still seen to lie in the care home and residential care sector.

A number of trends evident in healthcare will resonate with ECH; an increase in mergers; an interest in exploring acquisitions; pressure from local authority commissioners on care operators to graduate to 'supported living' provision; a diversification into care for people with brain injury, provision of medium secure facilities and housing for the long term disabled.

Savills note that larger scale housing with care has caught the attention of some of the larger healthcare groups, particularly Assisted Living models and retirement villages. These are seen as having higher entry costs and are perceived as likely to struggle with large holding costs which increase exposure and place pressure on private sector providers to offer deals to purchasers to achieve early sales. Savills also report that while land is available it is subject more and more to 'conditionality'. Looking on, developers in the healthcare sector are said to see growth in ECH largely in the private sector, at significant density and very much based on lifestyle rather than needs. **(38)**

Emerging Trends

So what are the observable trends this far into the recession?

Financial:

- Development finance is far more difficult to obtain and is likely to have a depressive effect on supply
- Where they are prepared to lend, institutional lenders are limiting risk by radically reducing 'gearing'; by confining lending to experienced providers with a record of profitability; by requiring far more detailed business plans; by insisting on very competitive land deals and reduced exposure through flexible forms of 'conditionality' such as low cost and longer term contract options, deferred payment and discounts against profit share
- Potential new entrants to the ECH sector are likely to experience severe difficulties in raising institutional finance
- In the 'Healthcare Sector' generally (primarily care homes, nursing homes, and assisted living but also *some* ECH) a number of banks and building societies are no longer in the market to lend
- Those who do remain have imposed much stricter lending criteria which not only increase the difficulty of securing a loan but have forced *reductions in the amount of loan available*. This militates against the development of larger scale projects which hitherto have brought 'economies of scale' and greater profitability but which now risk exposure. This has implications for the timing and size of individual projects and for development programmes at large

Outcomes

- A 'flight to quality': arguably there is always a market for a high end product attracting high worth customers. There is some evidence for this in the responses of upmarket private ECH providers
- The downside is that provision for the majority may contract/deteriorate as some providers cut back on operating costs or simply withdraw from the market
- Anecdotal evidence suggests that some sites and land banks are already being sold off for other forms of development, thereby losing potential ECH supply. A number of providers commented on this
- On the other hand it is possible that larger care home/nursing providers may re-evaluate the ECH market and decide to test the water if land becomes available. Overall, this market continues to enjoy a degree of buoyancy. Savills note that overall occupancy was 91% in March 2007 and that after 10 years of volatility and successive closures this sector has an underlying strength. **(39)** Currently the healthcare sector is reported to be outbidding residential developers for land. Some of the prime sites for extra care housing may now fall to other types of care provider. This suggests that ECH providers should explore the possibility of partnerships and joint venture with other care providers where there is a distinct and viable affinity of purpose
- We may see mergers between ECH and other care providers
- There may be a (short term) shift to care at home and 'staying put' if people cant sell. ECH providers with outreach strategies/facilities may fare better as a result

Other Pressures

- The effects of a deeply entrenched housing recession mean that older sellers, like everyone else, will have an inability to transact
- Their position may be undermined further by the greater likelihood that their properties are more likely to require further investment to update and equip. Younger purchasers are experiencing great difficulty in raising mortgages for the purchase price let alone additional borrowing for refurbishment
- This situation is also likely to affect the 'enabling' strategies of some private sector ECH providers who hitherto may have set aside funds for part-exchange programmes
- Part exchange is a high risk and is usually an early casualty of any housing recession since it increases exposure significantly and the likelihood of subsequent write down and loss. The late 1980s and early 1990s provide numerous examples of sheltered, serviced living and close care providers who overreached their financial capacity through ill-judged part-exchange initiatives designed to 'feed' expanding development programmes

The Impact of Recession on Respondents

Most private providers told us that they were already experiencing impact from the recession. A few said they were not under pressure and did not expect to be so because of the nature or geography of their market; their 'niche' or size of development. Local Authority respondents reported that they were largely insulated. Asked how recession manifests itself the main effects were reported as:

- A fall off in trade, especially in properties for sale
- Reservations falling through
- Sale of customer's home collapses
- Reticence of people to take on a new financial commitment
- People unable to afford properties for sale (RSL)
- Some reported 'a lack of buyer motivation' in the present climate
- Two said they had cancelled reservations after a period of time had lapsed to enable them to market units afresh
- A number were now cautious about taking on further sale or shared ownership units
- Others said there had been no fall off in interest but people were unable to sell own homes
- Two said they had recalibrated their approach to sales and marketing and were confident they would not be affected by the downturn
- There is concern about new build, mixed tenure schemes which are regarded as risky in the current climate as they depend on 'down-sizers' who cannot sell

What are ECH Providers Doing About It?

There were some interesting responses to this question and it will be instructive to monitor how some of these initiatives and devices fare over the next 12 months. In particular, there is an argument for revisiting providers to ascertain which have proved to be successful, whether any have become 'permanent' and whether new models of

tenure and partnership have taken root. We encountered a general level of confidence across all sectors that providers themselves and ECH as a destination would 'ride the recession' even if there might be a few storms along the way. Some local authorities and RSLs, in some cases just embarking on ECH, were actually very positive about investment and expansion.

There were some encouraging stories. One not for profit provider in London told us that it is currently looking to expand and diversify its extra care housing offer by developing a mixed tenure model which will offer homes for sale and for rent. It described this ambition as part of a 5 year plan, its thinking having been influenced by what it sees as 'the large reservoir of unmet demand and by the success of mixed income mixed tenure schemes elsewhere'. It was not deflected by recession and now intended to 'vary its rental model' so that rental properties would be available generally and not just to those on housing benefit. It is currently exploring with local authorities how to progress a mixed model of ECH with 30-40 units for rent clustered around communal facilities but incorporating alongside a selection of private properties for leasehold sale to be funded by its own resources.

A national not for profit provider is currently 'developing several schemes from a zero position' in North Yorkshire and the East of England. Another not for profit provider in Cornwall affirmed a commitment to two ECH projects though these would be delayed until it could be more certain that the leasehold units it intends to offer for sale can be sold in a more positive climate to help fund the projects overall. In Oxfordshire, we learned of the first fruits of a new joint venture between local authorities and a not for profit trust and of a detailed and imaginative strategy to grow ECH provision through partnership. In Nottingham, a local RSL described its intentions to 're-model existing services to provide extra care solutions'.

Naturally, there is a greater degree of caution and some reticence in the private sector because of the dependency on outright sales. However, we found a good deal of imagination and pragmatism. One private provider echoed a widely held position 'to take a view' and to defer the arrival of capital receipts. Providers across all sectors report that purchasers have so far been responsive to ideas such as 'rent to buy' or graduated purchase or shared ownership or deferred completion. A private developer advised that it was proving more difficult to persuade directors and shareholders to support 'rent to buy' but that this had to be a realistic alternative to *no sales, no service income* and *rising voids*. Another underscored the merit of 'transferring the problem of the customer's failure to sell to the provider' and enabling the latter to conjure the means to work through the situation. One said it was better to 'flex the product you are offering' to the customer than to have the customer trying to do this with their own buyer. 'Soft rental packages' and 'guaranteed buy backs' were better than no custom and no movement or income at all.

It is clear from the comments of many that imaginative, flexible and sometimes 'bespoke' one-off deals are being negotiated with customers who are struggling to sell their existing homes. The general view is that it is better, wherever possible, to move customers onto site in to rented or temporary accommodation and to service their care needs (thereby at least securing an income stream) and applying invention thereafter to get their sale moving. This was summed up by one provider as 'OK, we accept that times are hard for both of us, how much can you afford?'

The actions taken by providers so far (April 2009) include:

- Promoting our Assisted Living homes through a rental model –freeing up capital and giving people time to sell
- More home visits, more time dedicated to purchasers

- Extending choice to purchasers by introducing *Rent to Buy* schemes
- Introducing an Assisted Move scheme to reduce the stress of moving home
- Service charge holidays
- Care costs holidays (rolled up in to the eventual purchase price)
- Reducing the price of our apartments prior to first release
- Encouraging relatives to assist a purchase by offering shared ownership and then enabling 'staircasing' thereafter as the resident sells their own home
- Offering promotions, financial assistance and sales incentives
- Introducing 'try before you buy'
- Extending the period of reservation
- Flexible rental packages
- We offer a 'side agreement' to the lease whereby residents pay a market rent until they have the capital to pay the outstanding balance. The rent can be rolled up interest free and deferred for 12 months
- Renting through a short term non assured tenancy for a maximum period of 12 months. The rent is set at affordable housing levels
- Shared ownership (minimum investment 1%) for up to 3 years with the rent in year one rolled up and payment deferred for 12 months
- Providing advice on third party companies who offer part-exchange arrangements
- A 2 year holiday on paying for meals and energy bills
- Providing help to sell the customer's own property by 'managing' the selling agent
- Assuaging the worries of residents who have opted to make a 'rent to buy' move (without having sold) by providing our own staff to keep their existing property in good selling order
- Dedicating a team of Benefit Staff to maximise people's income (RSL)
- Actively helping customers with their own sales and making home visits to reassure them that we will still have a place for them
- Converting sales to rent
- Offering Part Exchange –we operate a scheme whereby an independent part/ex company provide a valuation of the purchaser's property which we can then purchase to enable a move
- Offering a shared ownership option to purchasers from 50-95% in 5% increments on a temporary or permanent basis
- We explore renting or selling and are prepared to take a charge over a property if a purchaser cannot sell
- A not for profit provider provides an 'easy move' flier explaining the opportunity to move immediately on a rental basis while awaiting the sale of the residents own property
- Target marketing our leasehold schemes and promoting their benefits as an alternative to more expensive and less flexible residential models.

- We are emphasising the high insulation qualities and lower energy costs of our units.
- We are market testing to ascertain demand for having small numbers of family houses on our ECH schemes –this helps with cross subsidy and widens the market catchment

RSLs reported no problems with rented flats, with rents set at an affordable level and Tenant Services Advisers acting as advocates for residents, helping with benefit entitlement. A number of housing associations said they are not seeing a slowing of interest in ECH for sale and are confident about the product and predict that sales will improve long term. Some pointed out that they had ECH developments in the pipeline and expected to see them through. At least two private providers saw ‘opportunities’ arising from the recession, new sites, cheaper land, reduced cost of borrowing, the closure of some marginal operators, a further strengthening of their ‘offer’ and their brand and further professionalisation of the sector. The table below sets out how recession can produce negative and positive impacts for private providers of housing and care for older people.

| Negative Impacts | Positive Impacts |
|--|--|
| <p>Decline in housing values affects equity levels and ability to pay. Purchasers see fall in their selling prices and developer/provider may have little room for adjustment if sales have fallen generally and banks exert pressure for loan repayments.</p> | <p>Providers vary their model to incorporate (as some already are doing) a <i>mix</i> of housing tenure solutions including short and long term rental.</p> <p>New products emerge – currently as ‘private one-off deals’ but if successful will embed in the marketing process in due course.</p> |
| <p>Difficulties in housing market may lead to longer sales periods resulting in permanent loss of some purchasers.</p> <p>Rising unemployment among female part-time workers may spur growth of cheaper informal care at home, which may close off sales further. Recession may initiate a new cycle of domiciliary care that competes advantageously against ECH.</p> | <p>Providers vary model to offer a more graduated ‘radial’ service which includes domiciliary care and outreach services within the community; together with respite care, day care, holidays etc <i>on site</i> for those on waiting lists.</p> <p>May adversely affect ECH but would stimulate building/care/service solutions <i>in the community</i>. Would help to mop up unemployment.</p> <p>Recession often puts low paid female workers out of work. These may form a nucleus for an expansion of <i>neighbourhood housing with care</i>.</p> |
| <p>Consumers trapped by falling sales values and inability to sell may increasingly opt to stay put and install aids, adaptations, telecare solutions. They may withdraw from the ECH market</p> | <p>This may provide a significant watershed in meeting needs at home and fit directly with Government objectives to create Lifetime Homes, both through new build <i>but also</i> through the intro of home technology and adaptations. <i>In the short term this may help meet the housing with care</i></p> |

| | |
|--|---|
| | <p><i>supply lag</i> while new developments are being commissioned. Telecare solutions may prove to be the best option –along with small core and cluster village schemes –for the rural market.</p> |
| <p>Land banks may have to be written down causing developers financial difficulty. Financial failure of contractors Failure to invest and develop may raise barriers to future re-entry and shift market elsewhere to some degree.</p> | <p>Recession may bring back land prices to affordable levels helping to <i>encourage</i> development of ECH. Recession is reducing the price of land – larger ECH providers with a profit record can borrow cheaply and ‘land bank’ for the future. Weaker players may disappear from the sector leaving the field to developers of ‘scale’ and to efficient, niche-led smaller players Some care home operators are expressing interest in ECH.</p> |

4. MARKETING DEFICITS

Can Marketing ECH to the 'Mainstream' be a Form of Exclusion

As well as the positive promotional and awareness benefits that accrue from marketing it is also the case that successful marketing of the needs of one group may reinforce lack of attention for others. Marketing can be 'excluding' in two obvious ways, first by not taking account of the specific needs of a particular group within the promotion of a concept that some would see as elastic enough to accommodate them and, second, in consequence it can inadvertently shift attention and resources away from those special needs pushing them down the agenda.

Marketing can be a zero-sum process, producing winners and losers and the successful marketer concentrates on what works for their business or agency. They are unlikely to broaden their strategy unless their core business is failing or they see an opportunity to expand and reach out to new markets. However, embracing new constituencies and responding to unfamiliar needs can be diverting and problematical. It requires new areas of expertise that the provider almost certainly lacks (otherwise he would be doing it already) and bolting on a 'going concern' with that expertise in place will still be a management distraction at the least.

Unsurprisingly, our research found that provision and therefore marketing is directed almost exclusively at older people with care needs and rarely acknowledges or embraces the needs of other groups which might be met within mainstream ECH solutions or which might be the focus for a new solution. The main reasons cited for not providing ECH for and marketing to other groups with special needs include:

- Lack of expertise
- Unable to recruit qualified and trained staff
- Health, safety and regulatory issues
- Dispersal of the 'market', lack of density
- Absence of economies of scale
- Difficult learning curves
- Unknown market
- Development finance might be difficult to raise
- Lack of shareholder support
- There are others who can do this better
- Referral criteria agreed with Adult Social Care Commissioners focus on the needs of older people

Only a few identified who these special needs groups might actually be; even fewer had given it any thought. With the exception of three specialised providers we spoke to, no respondent cited the needs of groups like people with short-term illness or with head injuries; people from BME communities or older people returning from the prison system or older people on low incomes or localised provision for the rural elderly. One respondent contacted us to report their frustration that after 6 years they were still unable to bring forward with local professionals a proposal they had worked up for a Chinese ECH scheme in London, despite what they saw as clear evidence of demand. Two housing associations reported that they marketed and provided a service for older people with mental health needs.

Just two providers we spoke to expressed a potential future interest in addressing the needs of younger people with long-term disability. One said they would market to younger age groups with care needs/ and who seek independent living if the local authority would allow it. Both saw this as an area for growth.

Few have ever looked beyond the elderly and many would say that their terms of reference preclude this. Others cite restrictions of DH funding to provision for people over 55. Some would favour the lowering of age criteria to allow flexibility in meeting the needs of a resident's (younger) relative. Another exception advocated would be relaxing criteria to accommodate older parents with a Downs Syndrome child. An interesting response, not least in that it defined one view of ECH, was that the provider's model 'did not market to *independent* old people.'

It *could* be argued that by failing to integrate these groups within their mainstream developments providers will effectively exclude them and that marketing strategies will reinforce this exclusion. But is this *really* exclusion and do we truly have a *marketing deficit*?

The reality is that in most cases these groups rely on their needs being addressed in a more dedicated way by specialised providers or in specialised circumstances which may include factors such as location and the presence of a strong cultural nexus in the case of providing for BME extra care housing. Mainstream providers are simply playing to their own strengths. Diverging from the less complex but higher volume needs of the general elderly population to the highly specific and dispersed needs of people with chronic, short-term or unpredictable medical conditions would pose serious investment, financial, management, service, staffing and health and safety challenges they are not equipped to meet. Mainstream providers will say that in any case they have a valuable and legitimate role to play catering for the general and progressive needs of the majority. And there is a long way to go before supply approaches demand. However, this does not mean that they are excluding the minority.

There are valid arguments on both sides. On the one, that the integration of a wider range of groups and needs should be a core aim for mainstream extra care housing provision. The principle being that special needs should not be 'ghettoised'. On the other, there are sound and sometimes compelling arguments for creating dedicated housing with care solutions for people whose needs may be medical, cultural, short term or who are much younger than the general ECH population and who would be better accommodated within their own age cohort.

If there is a form of exclusion caused by the marketing of ECH it probably lies as much in the 'age-exclusivity' of mainstream provision. Because ECH is presented and promoted almost entirely as for people over 55, with the 'age in place' frequently 20 or more years higher we have come to accept that this is what extra care housing is, provision of housing with care for older and much older people. The marketing *does* reinforce this and, in turn, what awareness we do have of extra care housing centres overwhelmingly on provision for older people *in general* with the primary exception of dedicated provision for people with dementia.

Because we are so focused on this mainstream age-related model we rarely look further at, engage with or learn from the other forms of highly successful extra care housing that meet other special needs both within and especially outside of the elderly population. Quite often, because of numbers, incidence, locality and local health partnership arrangements these are met by specialised care home operators or by charities and trusts dedicated to the group in question. A number responded to our questionnaire to point this out. Reinforcing that they consider that they are providing a form of housing with care. One independent operator who contacted us has 39 homes specialising in providing housing with care for adults with learning difficulties; people

with mental health problems other than dementia. A new retirement village developer is, however, exploring how to integrate accommodation for young disabled people.

But there are compelling examples of organisations (beyond the scope of this study) who do not readily spring to mind when we talk of ECH yet who are highly successful and long standing proponents of forms of housing with care. They rarely feature when we talk of promoting awareness and their interests have not been to the fore in the general debate on ECH during the last 6-7 years. Thus the National Society for Epilepsy meets the housing with care needs of over 300 epileptics and the very fact of its specialisation, its specific application of resources and expertise and its fostering of an empathic and independent community makes its developments centres of excellence that are unlikely to be replicated within a more general establishment. **(40)** It is also a good example of an organisation that is able to transcend the primary barrier to entry for housing with care, *age*.

Similarly, the Beacon Centre for the Blind has over the course of 130 years developed a range of local housing with care options for visually impaired people and has recently in partnership with Dudley MBC, Wolverhampton City Council and Bromford Group developed 71 extra care housing apartments and facilities at Sedgley near Dudley to meet “the specific needs of people with visual impairment”. This incidentally offers a mix of both rented and shared ownership tenure **(41)**

In the private sector, in particular, where issues of financial return, efficiency of land take, ability to purchase at often high values, and the ‘scaling’ of services to fund delivery are *high level drivers*, and where the demands of partnership and meeting specific policy and needs objectives are more likely to be *low level*, there is an understandable marketing prejudice towards the largest social common denominator.

The result is that certain ‘social groups’ such as people on low incomes and elders from BME communities are, for the most part, not planned or written for and therefore not embraced by private sector marketing strategies. Similarly, although there have been material advances in recent years in the development of dementia facilities and more are certain to follow, the provision of permanent housing with care for the younger long-term disabled and for stroke victims and of short term respite facilities for those recovering from trauma and injury are extremely rare. It is an uncomfortable fact that even if expertise was in place their presence on a ‘mainstream’ development (particularly one that promotes lifestyle) would almost certainly affect perceptions of the provider and the development and offer an unwelcome reminder to those who seek and strive for active independence that health and life are decidedly fragile.

Providers have no responsibility, policy or moral, to meet the needs of these groups and we can forget that a mainstream development might not in any case be the most suitable environment to meet these specialist needs and might not be the preferred choice of the consumer. Perhaps the key marketing point to make here is that unless we create a greater awareness of the housing with care needs of certain groups currently outside the mainstream then the success of prevailing marketing activity could result in them being ‘out of sight, out of mind’. There is therefore much to learn from the work of highly specialised providers of housing with care.

Meeting Non-Mainstream Special Needs

BME Communities

With a few exceptions, the needs of BME communities are overlooked at best, marginalised for the most part and excluded at worst. Provision is scarce and geographically delimited. Their absence from mainstream provision also challenges both local and central government strategies for social and community cohesion. In the

case of BME elders, their lower numbers and their geographical and cultural detachment from the type of locations where private sector providers prefer to site their developments mean that they do not figure readily on the provider's horizon. BME communities are moreover not the homogeneous social structures they are sometimes portrayed to be. Rather, they can be more complex and more segmented than other communities. Their needs are diverse and may be unfamiliar. They may not readily transpose to the usual and established common denominators within ECH developments or readily 'fit' with familiar social and cultural mores. Essentially, they are an 'unknown' in a sector which thrives and depends on eliminating uncertainty.

There is a significant challenge ahead in rethinking housing with care solutions for what is likely to be a more diverse community... "*our older population is increasingly diverse. Future generations of older people will be more ethnically diverse and family structures more complex.*" (42) While some not for profit and a larger number of RSL providers have sought to address the housing with care needs of BME elders the ECH sector at large has not anticipated or begun to meet the challenge of provision now posed by an increasing and ageing range of ethnic communities.

Their greater incidence in or close to deprived inner city areas where private providers have little incentive to develop; their consequent remoteness from purpose-built ECH developments; and a perception (set to be increasingly misplaced) that they are too few in numbers to 'fit the model' has kept them off the private sector's radar. Furthermore, many BME elders are disproportionately likely to be less well-off than older people from white ethnic backgrounds so there is the additional barrier of affordability. Accordingly, development solutions have either been delivered through a housing association specialising in BME provision, through local authority intervention –through a community partnership- or through a not for profit organisation. Coverage remains very low and uneven.

Irrespective of the reasons for non-inclusion there are awareness, marketing and supply deficits that need to be addressed. It is unhelpful and misguided to set aside 'dedicated' solutions (BME projects for BME elders) if people only feel comfortable within their own communities. Not providing this option would simply deny people from BME communities a valuable and needed housing with care opportunity. However, if broader societal goals for social and financial inclusion, for equitable treatment and for community cohesion are to be met then housing with care providers in all sectors must be encouraged to explore and create solutions that positively welcome and integrate BME elders within mainstream developments. In turn, people from BME communities will need to be reassured that they can thrive and enjoy life in the latter. A number of respondents we spoke to felt that there was an acute lack of awareness of ECH (in contrast with better known sheltered housing) within BME communities, compounded by lack of provision. A significant promotional and confidence building exercise lies ahead.

Two respondents underscored these deficits and both have chosen to pursue 'dedicated' rather than integrated solutions – in one case because opportunities for integration were less favoured by the BME community. People wish to remain within their peer group. One respondent is an adviser to a national housing association who is trying to establish the 'first BME extra care development of its type' in the South West. This was described as for a particular minority group. The second example came from the chair of a Chinese society (referred to earlier) who has for 6 years been trying to establish an ECH scheme for 'frail and disabled Chinese people in London'. No such *dedicated* provision currently exists, although a number of RSL and local authority schemes in the capital *do* provide housing with care to Chinese elders within their sheltered housing schemes. We were advised that this 'project' has so far involved approaches to the former Housing Corporation, to 4 London boroughs and to two

leading national housing associations (one of which is now assessing the project). A Chinese Welfare Trust has recently been established to raise money and awareness.

The lack of extra care housing provision for BME elders is well documented over a long period. A recent Race Equality Foundation briefing paper reflects that despite their needs being raised in an important study by Age Concern and the Help the Aged Housing Trust in 1984 **(43)** the fact remains that 25 years later

*“There is clear evidence, however, that much of the response from mainstream providers to the identified housing-related needs of BME elders has been limited, with an emphasis particularly on the provision of sheltered schemes targeted a particular ethnic groups. Less emphasis has been given to addressing housing needs within the existing (or sheltered but non-ethnic specific) housing, or to meeting the need for extra care...The response of mainstream providers can be said to have fallen short of the needs and aspirations of an increasingly diverse older population.” **(44)***

This lack of provision in the ‘mainstream’ is not only significant for its failure to develop and grow choice but also, tellingly, for its oversight in anticipating and keeping pace with a rapid acceleration in demographic change, in the needs of BME older people and in the volume of demand. The demographics show that BME communities are undergoing a significant ‘ageing’. In 1991 only 3 % of people from BME groups were of pensionable age -compared to 17% for people from white backgrounds. While this proportion has remained relatively constant that for BME elders has altered substantially –the percentage had more than doubled to 7% by 2001 and a further 12% of people from BME groups are projected to reach pensionable age by 2011. The notion of a ‘demographic spike’ so widely used in the 1980s and 1990s to describe the anticipated policy and financial impact of ageing in the general population may be implicit in the emphasis placed by the Policy and Research Institute on Ageing and Ethnicity on growth in the numbers of BME elders and its likely impact on housing and care investment. **(45)**

Demand for extra care housing is certain to increase in BME communities as awareness of its benefits (and of its relative scarcity) increases and as the numbers of BME elders rise. This is an important area for further work that should focus on establishing levels, types and location of need within BME communities and determine how provider solutions can be shaped and delivered (see Housing LIN Report, Developing Extra Care Housing for BME elders – the issues, examples and challenges and examples).

Older People on Low Incomes

*“There are two nations in old age, and they are increasingly polarised by housing wealth. Housing wealth accounts for 42% of household wealth, up from 22 per cent in 1971. The wealthiest 30 per cent of children will have access to 58 per cent of housing wealth by 2013, rising to 66 per cent by 2023. On the one hand this is the story of the consolidation of advantage, of a generation of people who have done well for themselves and can afford to fund the next generation of advantage. On the other hand there is also the prospect of the consolidation of poverty. For those who have missed out on life’s chances, for whatever reason, those chances become fewer in old age, and the opportunities to replenish meagre resources diminish. And even among those with significant housing assets, income can be low.” **(46)***

In the case of people on low incomes there is, in the private sector, the obvious barrier of affordability. For most, outright purchase or more commonly long leasehold are simply out of the question because they lack capital in the form of equity. They are not typically owner-occupiers and the private model is structured to synchronise with the prevailing owner-occupier model (although the experience of recession may introduce more flexibility). Despite recession, the proportion of older people over the next ten years who own their homes is still set to rise. This reinforces the leasehold tenure preferred by the private sector not least because *it this model which financially makes private sector ECH work* but it also masks the problem of poverty in old age. It diverts us from the challenge of providing for people who may currently be excluded from extra care housing because of their financial circumstances.

Among the key findings of its October 2004 report the Joseph Rowntree Task Group on Housing, Money and Care for Older People made two observations that have a close bearing on the need for improved awareness of the housing and care choices available to older people and for a step change in the way in which they are presented and by implication marketed.

“Britain is still locked into a traditional welfare-rationing approach for people on low incomes, rather than a broader approach that applies to older people across all economic groups as citizens and consumers, and which draws in the private sector as partners.” (47)

It is conceivable that the new purchasing and rental arrangements occasioned by recession and resulting from the inability of older people to sell their own homes will embed as permanent features of a new financial landscape within the ECH sector. Many providers clearly believe that some measures will facilitate the emerge of ‘mixed income communities’ even on private sector developments and that public and private funding arrangements will need to adapt to achieve this end. Provision for people on low incomes is almost exclusively delivered by the public and not for profit sectors and is targeted at people supported by benefits and who will take up social and affordable ECH options. What is clear is that we now face a period in which the needs of those who may have housing equity but who cannot realise it or whose assets are insufficient to buy in to private developments will become more complex and more difficult to meet under existing arrangements.(48)

This is not a marketing issue but it is an issue of awareness and response. There is an assumption in the housing with care industry, as there is in most others, that the ‘market’ will take care of such problems and regulate and adapt to find solutions to such needs. There is little evidence of this in recent years but recession, perversely, now might prove to be a watershed. It is clear that we need a far greater connectivity between the research, policy, funding and provider communities to assess the size, characteristics and incidence of groups on low incomes whose housing with care needs are not met currently for one reason or another. The creation of a policy, funding (public and private) and tenure framework in which the idea of ‘mixed income/mixed tenure/mixed needs’ communities could proliferate might be a starting point.

Marketing ECH for People with Dementia

This is the primary area that providers have either diversified in to or where they expect in future to do so. A number who contacted us view it as an obvious next step and cite spatial, management, service and funding reasons for doing so. Many providers who don’t develop accommodation specifically for people with dementia do – *to a degree* - meet their needs *as these develop* – typically up to the point at which specialised and more intensive support is required and/or when the person becomes a concern or ‘nuisance’ to other residents. Others, while not providing dedicated facilities, do follow

an 'age in place' policy towards residents who develop dementia and in marketing terms this is seen as a valuable means of reassurance.

There is little doubt that a market exists. The DH and DWP estimate that based on current prevalence rates, the number of older people with dementia could rise from 684,000 to 1.7 Million by 2051 and that if we do nothing to improve the current housing situation occupied places in care homes and hospitals would need to rise by around 150 per cent (450,000 places to 1.13 Million by 2051). This could see expenditure on long term care rising more than threefold between 2002 and 2041. **(49)**

Two providers drew attention to their models in which the emphasis on couples and provision of two-bedroom accommodation with access to 24hour care enabled partners to remain together and not be separated when one developed dementia. Where the ECH provider does have dedicated dementia facilities they will be enabled usually to relocate 'internally'. Otherwise, they will be assessed for care elsewhere. Other providers retain specialist care homes to meet the needs of people with dementia.

One housing association reported that it had upgraded some of its ECH properties with additional technology to enable people with dementia to be accommodated and that it worked with commissioners and referral agencies to ensure that social services staff conducting care assessments are 'made aware' of the type of extra care services it can offer. It is currently exploring how it might increase its provision for this group. A new housing association provider in the North East reported that they are considering up to 25 % provision for people with dementia.

Interest in dementia provision is likely to gain fresh impetus following the Government's recent announcement of a new National Dementia Strategy **(50)** which will see the establishment of 'memory clinics', support for carers, behavioural therapy, better training for GPs and a review of treatment regimes. The more dementia is brought in to the open and the more awareness increases so we can expect to see new service and accommodation responses from ECH providers either diversifying for the first time or growing existing capacity. This will have implications for marketing, not least as a significant national political, financial and care impetus is given to a market of 684,000 people living with dementia of whom only a third, 222,000, are currently registered with social services or the NHS.

Active marketing or promotion of dementia facilities is low key, largely because there is a steady stream of referrals from public agencies and health and care professionals and partly because of 'perception' (which in some circumstances one might read as 'stigma'). One provider described a process where public bodies 'signpost clients to us'. The increasing volume of people with dementia may suggest to providers that they *do not need 'to compete'*. Their approach to 'supply' can be relatively passive, the market will come to them. So they do not need to invest significantly, if at all, in marketing and promotion.

There are, however, some quite significant exceptions to this and these often coincide where a provider wishes to convey values and philosophy or to promote a quality or new format of care or where they are meeting specific community, charitable and/or financial objectives. One provider in Lancashire has, for example, marketed strongly and effectively its new dementia care facility –developed as one of three 'communities' within an existing £45m retirement village, promoting the fact that it has become the first UK provider to gain a Gold Standard under a new accreditation scheme launched by the University of Stirling's Dementia Services Development Centre. A leading Midlands and North West based charitable trust has invested heavily in a programme of research and evaluation which is helping it to develop ground-breaking ways of assessing and managing the needs of people with dementia and of improving engagement and independence.

These are just two examples of significant and innovative work which should point the way to greater awareness of dementia facilities within ECH developments and which may announce a more open and effective approach to marketing. (51) It will become increasingly important for those who have specialised in dementia provision for some time and those who are funding research and testing ideas to publicise their experience and their achievements as a means of encouraging others in to the market.

Generally, where marketing does take place it tends to be directed at primary constituencies such as GPs, social workers, hospitals and to the local Alzheimers Society. In the case of the latter, this takes the form of open days, events, giving talks to the Society's members and running copy in their newsletters. There is also some limited marketing via church groups. But the impression overall, with the few exceptions noted, is that this is a 'captive market' and that marketing strategies are low key and rudimentary because thus far that's all they have had to be. However, this is likely to change significantly as larger ECH providers begin to diversify and seek to capture this market. Some private ECH providers indicated that they would be looking to develop dementia facilities in future particularly 'when providing developments in partnership with local authorities or jointly commissioned with Housing Associations.' This is a market set to grow significantly over the next 10 years.

Has Marketing to Planners Been Effective

In seeking to update if and how some of the issues identified in the two earlier papers we referred to had been resolved and mindful that a number of respondents had raised what they saw as only limited success in making the case for ECH to local planning authorities, we spoke with a planning practice with over 25 years experience in the field of retirement and housing with care. (52) Their comments, summarised below, and additional information provided in telephone conversations and meetings we had with providers suggest that there is a way to go yet before the case for ECH is universally accepted and applied. There remains an awareness and 'legibility' deficit.

Many local authorities treat this type of development as no different than C3, so for the planning officer it requires an element of 'affordable housing'.

In turn, many developers resist this and may struggle to convince that their schemes sometimes *do* have an affordable content (where residents rely on certain grants and benefits) and that ECH meets, in any case, significant social and policy objectives

However, some Planning Officers reject the notion that provision of care can be 'compatible' with or a quid pro quo for *not* having orthodox affordable housing. This view is often upheld by Housing Officers under pressure to meet more conventional, larger scale and more 'political' 'affordable needs' in the population at large. Some Housing Officers are trying to push affordable content to 50% or more on all housing applications.

It can be difficult to dissuade some officers from this position even where developments have Independent Living Units. Not for profit organisations may enjoy a better rate of success because of their values and status –but also because they are more likely to have local partnerships

Social services are nominating and supporting most of the residents through care funding programmes. But this can happen on private developments also and planning professionals have sought increasingly to demonstrate that as the SSD is supporting *some* residents with care funding so planning officers should accept this as an 'affordable' content to the scheme

The key reform would be to place ECH within a clear Use Class or give it one of its own. In the case of larger scale ECH and 'retirement village' applications, applicants have from time to time encountered a view among both officers and committee members that this form of housing is somehow 'inappropriate' and in their minds tantamount to 'granny ghettos'.

A number of providers described to us attitudes to their applications that varied between suspicion that they were a way of circumnavigating affordability criteria to cynicism that such developments simply isolated older people and actually failed to integrate them within the wider community. Some councillors have suggested that units within ECH schemes be allocated to young people with full capability or to younger people with disabilities and care needs. There is some merit to this argument and some providers don't rule it out for future consideration.

It was also noted that where officers and members had agreed to visit a completed development they were typically 'converted' by the reality of what were seen as high quality 'hotel like' complexes as far removed from old people's 'ghettos' as they could be. Many respondents supported this view and spoke of the lack of awareness and understanding that still dogged ECH. Planning officers were frequently 'too busy' to contemplate a visit to a completed development.

It is also evident from the feedback provided by one planning consultancy firm that we spoke to that some planning authorities are simply confused by the range of housing with care 'products' and the lack of a definitive model supported by clear cut planning guidance. This is all the more significant because many of the providers who contributed to *this* study told us that customers and their families were similarly confused by the descriptions and by the various models. Like planning officers and councillors they, too, were often cautious and uncertain until they visited site and saw the product at first hand.

We were advised that even after 25 years of progress elsewhere some local authorities are still resisting long won arguments on reduced car parking, reduced garden and amenity areas and reduced travel, traffic and emissions and the meeting of other social and community objectives that favour ECH.

How Can We Improve Marketing to Planning Authorities

The volume and increasing complexity of work placed on local authority planners means that there is little opportunity to go seeking specialist knowledge of new and still developing forms of housing such as ECH. Planners are certain to be under even greater pressure in the next 3 years as the government seeks to drive an inexorable rise in affordable housing starts and as planning changes arising from the Killian Pretty Report and the Taylor Review are put in place. **(53)** Unless ECH is included within their Local Development Frameworks (LDFs) and/or the fast-emerging new affordable housing programme (perhaps by making early and high level overtures to the new Homes and Communities Agency) then many of these problems of awareness, comprehension and wider planning 'legibility' look set to endure.

The fact that ECH strategies have not widely existed until relatively recently and are still rudimentary in many instances suggest that planners could have a difficult task in assessing the worth of an ECH application if the necessary statistics and models are not available to hand. Developers could assist by commissioning independent research and providing this with their applications. This should correlate with national and local policy objectives so that the wider context of the application is understood. This may also help reduce the room for challenge. However, this is just one element in a much

broader submission exercise. To market effectively, applications may need to embrace the following guide framework:

Supporting Statement:

Ensure that the application is supported by a detailed Supporting (Justification) Statement that shows clearly and with evidence locally how the development meets housing needs and relates to the strategic housing market assessment; how it relates to wider government policy affecting older people; its fit with the local authority's own policies regarding health/housing/care; and where it meets broader community objectives concerning safe environments, security, well-being, independence, access and employment, the local economy, sustainable development.

Fit With ECH Strategies:

Where the authority does have an ECH or similar strategy the Justification Statement should demonstrate how the application fits with this. The applicant should not simply make an assumption that the officer will take this for granted and waive through a consent.

Involving Older People in the Application:

Some providers have been very effective in conveying need and in winning support for ECH at the planning application stage by directly involving numbers of older people (often prospective customers and those with longer term interest) in writing to planners to support applications; in attending public meetings; in buttonholing councillors and MPs at 'surgeries'; and in attending in numbers meetings of the planning committee where they are highly visible and able to demonstrate support for provision from those who need it. This has been a highly effective strategy for some providers – one or two have it honed to a fine art. It is a credible example of participative democracy and gives the consumer an opportunity to have a direct say in the events which may shape their housing circumstances. It should be more widely deployed

Detailed Research:

The applicant should undertake or commission substantive research on local demographics; the extent of housing need among the target age cohorts; provide verifiable information on health and care needs now and on future prevalence and incidence (liaison with the PCT and Social Services); and ideally should demonstrate that older people have been involved in some way in helping to develop the thinking behind the proposal.

Relieving Pressure/demand on other services:

Explain how the development will relieve pressure on local authority and other public services and resources, GP services, NHS beds, social services, housing. Information can be assembled from local authority, PCT, DWP, DH and Census On line data sources.

Unlocking Housing Supply:

Show how by trading down older people moving to the development will release often family-size housing back in to the supply chain. This will spark refurbishment and renewal and will help local trades and small suppliers.

Tenure and Choice:

The applicant should explain the various forms of tenure and services available and show, if applicable, how residents are to be supported by grants and care funds. The application should offer guidance on choice and explain how progressive needs are addressed. Developers should consider ahead of an application the arguments in favour of mixed income communities where rental, shared ownership and long leasehold co-exist to offer choice and spread risk.

This has the added advantage of meeting government objectives to develop inclusive and sustainable communities.

Service Charges:

Planning Committees often ask about service and management charges although strictly this is not a planning issue. Nevertheless, the applicant should treat information on this as 'material' to the application since it explains how services are funded and allocated and what other charges are due to the operator. Examples should be included.

Support of Professionals:

Ideally, the application should have in place written support from local health and care professionals, even where the scheme is private and is not part of a commissioning arrangement. Where there is a relationship or more formal commissioning partnership this should be made explicit and explained in full. It is surprising how often awareness on the part of officers and the committee is simply 'assumed'.

Design and Specification:

Drawings should set out in detail the individual and communal arrangements for the proposed development including the dimensions and lay-out of a selection of individual units. An accompanying note should explain relevant technology and care facilities.

Community Use:

Applicants should draw attention to facilities and services, which are also to be made available to the wider community both on site and as outreach. Provide examples from community use of existing developments or write a programme if you don't have one (see Housing LIN Factsheet No.28 Day Care and Outreach in Extra Care Housing Sept 2008).

Funding:

The application should also be supported by a detailed statement on the funding of the development. The planning authority will need to be assured that development finance is in place and that detailed feasibilities have been carried out. In some instances it may be necessary for the applicant to provide a letter of support from the principal lender to affirm that funds are available to complete the project.

Site Visits:

Officers should be asked formally by the applicant to visit a completed scheme and the officer should be asked to encourage the planning committee to also do so.

Promotional Literature:

Brochures for existing developments should be made available to the planning authority as a means of illustrating extra care housing. Where a development is to be located in an area which is multi-ethnic the applicant should ensure that at least the primary material is offered in the prevailing languages used by the community.

Local Economy:

It is important to tell the planning authority what benefits an ECH development can bring to the local economy, construction phase jobs; permanent management and service employment; local procurement for everything from light bulbs to food, stationery to transport, painting and decorating, gardening and maintenance, removals to accountancy. What can residents contribute in local spend; which type of retailers and services will benefit directly.

Community Support:

Applicants should also be alert to the value of having community support. This may take the form of letters of support from local clubs and societies, from older people and their families and friends, from people neighbouring the site of the proposed development and from local GPs, District Nurses, carers, from churches and charities and from businesses and retailers which may meet the needs of older people or wish to support them in some way.

Environment and Resources:

Developers in this sector have generally (there are a few exceptions) been slow to adopt a 'green' approach to design, specification and conservation of resources. Planning authorities now require high-level detail from mainstream housing developers in support of their planning applications and ECH should not be an exception. Information should centre on:

- Life cycle costs of the project, demonstrating its durability and its long term affordability in keeping low the costs of maintenance and service charges for people on fixed incomes
- Utilising, ideally, a renewable source of energy such as a ground-source heat pump system which is 'green' but which also has an efficient 'pay back' period likely to assist in keeping running costs at a lower level
- BREEAM –if not formally pursuing an 'excellence' rating through a BREEAM application then the developer could at least win 'planning points' by replicating a number of the key environmental, waste reduction and energy use goals
- A statement on water use and conservation
- Where existing (and often heritage) buildings are refurbished refer to the 'embodied energy' saved in their rescue
- Provide a statement on bio-diversity
- Incorporate a note on activity and well-being and provision of amenity

Marketing ECH as an Economic Driver**Regeneration:**

Increasingly, ECH is big business. Assuming we have 40,000 units (inclusive of communal facilities) with an average base value of £100,000 then the sector currently is worth £4billion and at £150,000 unit value is worth £6billion .Developing an ECH project, particularly with densities in excess of 150 units, can have a significant renaissance effect on communities. This is especially true for those requiring and urging renewal where it can be introduced not only as a development project (singular benefit) in its own right but as a catalyst and engine for wider social and economic regeneration (multiple/overlapping benefits). Its land-take alone can range from as little as one acre to as many as 5 acres (more for some retirement villages)and progressive developers, architects and planners have come to understand its merits in terms of effective social and spatial master planning and also in terms of helping to 'soften' and 'socialise' planning applications. Some providers recognise this and have deliberately identified sites which fit this context.

It has the additional merit, of course, of allowing older and frailer people to remain in or close to the communities they have been attached to or to enable them to move directly in to areas of transformation where their families are seeking employment and housing. Indeed, there is a compelling case to be made for extra care housing as a

fundamental element in so called 'transformative' projects not simply because of its intrinsic social and housing merits for residents but also because it provides a 'leavening' and balancing quality to *new communities at large* which, typically, are predominated by younger families many of whom themselves are new to the area.

An ECH scheme can become a valuable focus for employment, care, voluntarism and interest groups, for the development or continuity of clubs and societies, as a source of inter-generational bonding, and a learning medium for schools and colleges. It can play an important part in the maturing of a community and in cultivating certain social mores and traditional values. It may be even be a factor in promoting 'citizenship' in the community.

In both its planning and development stages, ECH offers a wide range of opportunities for different forms of marketing. It isn't simply about 'selling' a home, a care package or a lifestyle. The most effective ECH marketers recognise this. Yet we encountered little evidence of providers, with a few notable and prescient exceptions, identifying and exploiting opportunities to either use an ECH project as the initiator and driver for wider community or neighbourhood regeneration or to 'hitch' it to the wagon of a regeneration consortium as a means of delivering 'social capital'.

Similarly, the majority of ECH providers have not to our knowledge taken the initiative to approach influential architects and master planners to present their 'merits' and get their aspirations built in to local master plans and in to the Local Development Framework. A few providers are aware of the need to influence the LDF and the Regional Spatial Strategy but most engage the services of planning specialists for the single purpose of assembling a planning application for *a specific site* rather than for their advice in working up a strategic development plan across a 3-5 year forward programme.

The Government has stated its determination to accelerate the house building programme with immediate effect (54) and the new Homes and Communities Agency is an obvious port of call for providers (RSLs will already be aware) to make a case for including ECH in regeneration and community renewal projects. But providers should be more ambitious and seek meetings with large scale house building consortia who typically will not plan for or themselves develop extra care housing but who are likely to be susceptible to the merits of including a form of housing that may help 'socialise' their planning applications and potentially act as an alternative to social/affordable housing quotas. There are a number of major players it is worth testing this approach with including Berkeley Group and its regional operating companies, Countryside Plc, Persimmon, Urban Splash, Wimpey, Bellway, Lovell, and Redrow

We noted in the planning section of this report that ECH provides both short-term boosts (*procurement, construction, fit-out; conveyancing, materials*) to the local economy and sustained benefits in the form of long term employment on site; and local purchasing and procurement by residents and by providers. Providing detail on this contribution to the local economy should be a matter of reflex to providers. By offering an 'open house' approach to the use of on site communal facilities, they can also deliver social and economic capital in to the local community. Providers should actively consider whether they can use surplus areas of land to develop facilities for the specific use of the community (drop in centre, crèche, day centre, training centre) or perhaps a private initiative of economic value such as a small business centre. The more the development is promoted for its wider community benefits the greater its profile and the greater the prospects of planning and other forms of investment.

Marketing to Business: Corporate Social Responsibility and Mutuality

“Corporate Social Responsibility is the continuing commitment by business to behave ethically and contribute to economic development while improving the quality of life of the workforce and their families as well as of the local community and society at large.” (55)

CSR is a familiar and serious objective for a large and increasing number of UK companies -global, national, regional and local. It permeates the philosophy of a business from the Boardroom to the shop floor and is acknowledged as an important and often indispensable area of interface between a company and the community. CSR is about being open and transparent, about willing to work with and engage local communities, being prepared to set aside funding and other resources (participation/secondment of staff) to support the aims, needs and activities of community and social organisations and of charities in particular. At the local level, it is likely to manifest as a willingness to help regularly with charitable fund-raising through social and promotional activity or quite commonly to support in a more formal and enduring way a nominated local charity with which the company may have or wish to build connections.

Promoting a company's social awareness and its 'community responsibilities' in this way is seen to strengthen its brand, its profile and its reputation. It can enable a business to work in new and productive ways. It is an increasingly essential part of a successful business strategy. Supporting the needs of others meets honourable social and moral objectives, the business 'puts back something into the community', while providing valuable publicity and goodwill capital that may translate commercially in areas such as customer awareness, retention and loyalty, free publicity, improved community and stakeholder relations and increased sales.

In developing a CSR programme few companies would demur that they are mindful of the potential goodwill and commercial benefits that can accrue from 'corporate giving'. The favoured route of larger and, increasingly, of many medium size companies is to establish a charitable trust or foundation through which corporate donations for a CSR programme can be distributed professionally and tax-efficiently. Major high street names such as Tesco, Sainsburys, the Coop, Nationwide Building Society, Barclays, Sky and John Lewis can support often large scale and quite significant social needs in this way. Often, larger trusts and foundations prefer to dedicate their interest to groups perceived as outside the mainstream, excluded by poverty, circumstance or experience. Accordingly, their interests are unlikely to coincide with extra care housing - although we know of a number of major foundations supporting work currently in areas such as the needs of the rural elderly, financially excluded older people and older people with special health needs. Invariably, this support is channelled through a detailed and highly competitive application process to charities working in the fields which the trust wishes to support. We are aware of only one ECH provider, a not for profit organisation, which has identified grant applications to trusts and foundations as a source of financial support for its activities and facilities.

It is at the local level, however, that providers of ECH have an opportunity to develop new means of support, funding, promotion and market awareness and through which they can build influential stakeholder networks in the community. These may be useful additionally in helping to secure land and property, raising finance, fundraising for equipment, in governance and in developing commercial initiatives and partnerships that serve the objectives of the ECH provider and their constituency. Building these relationships is not difficult but the process *does* necessitate having clear and viable objectives that strike a chord with the business community. So it is important that the

provider does his homework thoroughly on what matters to the business he is targeting before he makes any approach. We know that at the basic level a number of ECH providers do develop and sustain relationships with their 'suppliers' first and foremost, moving on to other local businesses (often owned by or connected to the relatives of residents) they have sought to involve in promotion and fundraising. One or two told us they had established 'A Friends of' model to engage business and community support but these were very much in a minority.

While positive and admirable, this is a long way from a structured and detailed strategy that seeks as its core objective to identify, engage and 'recruit' local and regional companies with an active and well funded corporate social responsibility programme. Many will already engage with the community in this way and they will often focus their support on charitable causes related to children, to disability and to profound or terminal illness. A scan of the news and social columns of most local newspapers will provide evidence of this. Yet very few are on the radar of ECH providers, primarily because they have not been approached, not had a case put to them and not been asked to support it. When an approach is made to a company it is crucial to ensure that the 'bid' for support is well-defined and that it makes clear what type or level of resource is being requested and how this synchronises with the interest of the business.

So what is it about ECH that might be of interest to local corporate givers, what might push their buttons? And what might we reasonably expect of such a relationship? There are three obvious areas of mutual interest:

1. Most of us have or will have elderly parents and someday soon most of us will have to make decisions about where they will live and how they will be supported –especially if their health deteriorates. As 'secondary consumers' we naturally need to be reassured by this. Company directors are no different from the rest of us in this regard. So there is a common ground of personal interest at the outset. Directors and senior managers are often influential opinion leaders, so they are valuable source of networking and recommendation in the community.
2. Unlike most of us, however, they also have *employees* similarly exercised about the choices they need to work through with their parents. So being seen to support causes of this type and to *promote ECH within the workplace* is good for employee relations and for staff and corporate well-being. Expressing and supporting an external interest in this way can be productive internally.
3. Furthermore, older employees approaching retirement may appreciate information, time off and practical support in helping to think through and plan for their own looming retirement needs

Which Type of Businesses to Approach

Start with those with commercial/procurement/associational/services links with an extra care development These include the contractor(s) who may wish to develop a long term contracting relationship with the provider. The same principles may apply to the design team, architects and quantity surveyors, and to the team handling the PR and marketing account. Solicitors are closely involved in ECH developments in conveyancing, in the transfer of leases, wills, powers of attorney and generally attending the legal needs of older people. Some will be trustees and executors. Estate agents play an important role in helping to sell the homes of older people moving to ECH and may also have a standing arrangement with the provider to assist in re-sales and valuations. They may also be involved in site finding. The restaurants requires catering suppliers, the admin team will have a stationery account. Some providers favour a relationship with a particular removal firm that may be encouraged to offer

discounts to their customers in return for repeat business. Window cleaning and maintenance are usually provided by reasonably sized local businesses who again will wish to foster a long term relationship. We can add landscape gardeners, taxis and transport companies and a range of other businesses who provide affinity services.

The important thing is to not leave this all to chance. The provider should have a clear strategy on what is, in effect, a form of B2B marketing by stating at the point of recruiting each of these services that he expects them to support activities, help with fund raising, provide resources and generally help with forward development and raising profile. In turn, this affinity relationship should build goodwill capital for these businesses in the community. Clearly, relationships need to be open, accountable and able to pass any test of probity and scrutiny.

How Can Businesses with a CSR Programme Provide Support

The most common forms of support originate in the work place of the business. Personnel, knowledge, time and expertise are obvious assets that businesses can deploy in assisting social causes. Practical and modest examples may include help with book-keeping; providing volunteers to organise social and fund-raising events; organising a weekly raffle or lottery to purchase aids and equipment; help with gardening and shopping; providing transport on a regular basis; taking residents out. But it also includes financial support usually directed at a specific objective. On occasion this can be funding at an instrumental level. One of the most striking examples of this is the donation provided by the FW Plaxton Charitable Trust to help enable the development by Joseph Rowntree Housing Trust of Plaxton Court in Scarborough. Less ambitiously, a CSR strategy might include the following:

- Information
- Committing staff to fund raising
- Supporting events
- Corporate giving
- Employee giving
- Articles/free ads in the company newsletter
- Opportunities to address the workforce
- Referrals and awareness-building
- Endorsement
- Sponsorship
- Donations of goods and services
- Buying units for their own workers and retaining these
- Donating land
- Partnering with the ECH provider

The first echelon of businesses for a provider to target are its suppliers. Business Link identifies the potential *quid pro quo* that can develop in this relationship. *Business in the Community* defines responsible business as the process by which a company manages, measures and reports on its commitment to improve its positive impact on society and the environment. CSR takes this further when organisations *voluntarily* take further steps to improve the quality of life of their employees, their families and for the local community and society at large **(56)**

Business Link suggests that companies which understand the benefits of working with socially focused organisations will be attracted by CSR because of the direct and indirect benefits this produces for the company:

- It helps build a reputation
- Attracts and retains employees - they stay longer
- This reduces costs of disruption and recruitment
- It can contribute to better motivation and productivity
- Develops pride in the company
- Staff have an opportunity to help in the community
- They gain esteem and self-worth
- Investors have a higher regard for companies practising CSR
- CSR makes for great publicity
- The charities/groups (ECH providers) a business supports can sometimes be an important source of sales for its products and services

For those working with ECH providers there is the added dimension that at some time someone in their close family may need to explore options for housing with care. So having a relationship based on goodwill with a provider is useful and amounts to social capital for the individual employee and for the business. For the provider, CSR activity and relationships are almost certain to expose the development to new custom. It develops economic capital. So it works all round.

Businesses and organisations involved in development and social regeneration have increasingly to address a raft of trends and issues in which having a clear view on corporate social responsibility can be a material factor in developing a successful relationship with the community. In turn, this can improve their strategic and commercial performance. Below are some of the factors likely to be encountered in the development of extra care housing which could closely affect a business making its mark:

- Public demand for ethical trading
- Value for money
- Local procurement for 'local' projects
- Training and employment of local people
- Understanding and providing what the market wants
- Environmental issues –taking a responsible approach to land, scarce resources and to bio-diversity
- Conservation and heritage
- Social and occupational mobility
- Changing consumer perceptions/behaviour
- Awareness and impact of policy change
- Planning regulations –Local Development Framework
- Globalisation and IT
- Funding criteria

- Community giving
- Willingness to partner

Cause-Relate Marketing

One provider in particular has been imaginative in developing 'Cause-Related Marketing' in which it trades on the positive associational benefits between a product or service and the act and satisfaction (ideally enduring) of charitable giving. It notes that in a survey undertaken by Business in the Community 83% of consumers had purchased a product because of its association with a charity. This form of marketing plays directly to the moral and altruistic values held by consumers. Put simply, the association of a product with a charitable content or spin-off is likely to materially increase the likelihood of purchase or take-up. Its attraction is that it works well for both individuals and for businesses.

The former are driven by a range of values –often particular and related to personal experience; the latter mindful of the benefits of Corporate Social Responsibility, an increasingly powerful and indispensable tool in the corporate marketer's armoury. CSR can raise brand awareness, increase company profile and give a business a valuable marketing edge. So, an active willingness –pro-active in the case of many larger corporations- to engage with charitable giving to meet the needs of vulnerable groups is commercially as much as morally attractive.

In the sphere of extra care housing and the needs of older people there are notable 'value drivers'. The age of the cohort being 'assisted' through purchase; issues of frailty that concern us all; our willingness to demonstrate that we 'care'; the fact that we all know someone elderly, usually a parent or relative; a 'reciprocity' factor ie the sense that in giving to others they would also do the same for us (*there but for the grace of god...*); and self-insurance, the knowledge that we will all be old and perhaps in need of support one day so any small amount of giving now, helps to contribute to the infrastructure we may need in the future.

5. THINGS TO THINK ABOUT

Some final thoughts

Below we provide some concluding thoughts on the insights offered by providers in their marketing descriptions of ECH; how they view entry to the ‘market’ and the conditions that now prevail; how they promote their developments to consumers and where they place emphasis in improving awareness of extra care housing or more specifically in ‘making a sale’. We add also a footnote on commissioning and disparities in coverage –a significant issue for ECH commissioners and providers to resolve if housing with care is to gain further ground. Finally, we turn to how providers are dealing with matters of process –planning, funding, new tenure arrangements- and with the exigencies of recession.

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| <p>Describing Extra Care Housing</p> | <p>Product differentiation (ie making distinctions between schemes/models/services) is important in all sectors and not to be underestimated. It is unlikely to be surrendered so new means of conveying a <i>universal</i> description may need to be bolted on to corporate packs. The public, the media, elected members and some local authority professionals, notably planners and housing officers, remain confused by the term extra care housing. A more planned and sustained effort via local authorities and PCTs is required to get key professionals and decision-makers and opinion leaders to achieve a better understanding, eg. to visit finished schemes.</p> |
| <p>The Market</p> | <p>ECH is a ‘<i>market</i>’ and subject to market principles. It is so far not a wholly effective means of meeting the needs of vulnerable people. Penetration is low despite major government pump priming. Recession may slow the pace of development at a time when supply is significantly out of synch with latent need. Further intervention may be necessary to protect gains to date and to expand supply.</p> |
| <p>Barriers to Entry</p> | <p>Expanding supply is compounded by barriers to entry – funding, low lender confidence, inability of purchasers to sell properties, the rising scale and complexity of developments, planning delays, the need for expertise and an ability to take a ‘long view’. This means issues of supply will in the private and not for profit sectors largely have to be addressed by <i>existing</i> providers. New entrants into these sub-sectors currently look unlikely.</p> |
| <p>Awareness</p> | <p>Barriers to entry also contribute to a lack of awareness and understanding. This may be a factor in the slow pace of development and expansion of supply. Neutral (non corporate) information on ECH needs to be <i>conveyed in a large scale way to the general public</i>. The use of a range of terms to describe housing with care is understandable commercially but may contribute to this lack of clarity</p> |
| <p>Marketing Mix</p> | <p>Marketing inevitably reinforces the interests of the mainstream but largely overlooks the special needs of certain groups.</p> |

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| | <p>It is important that the background and expertise of care staff is now coming through in marketing teams and strategies. Market research is still relatively basic and information should be shared/disseminated freely by public agencies if they wish to encourage ECH.</p> <p>The most effective marketing is 'localism'. There are some ground breaking initiatives in areas like CSR, use of research, data-banking and community networking that should be shared and taken up more widely.</p> <p>There is a strong consensus that off –plan marketing is not the way to do business; strategies are more successful where older people meet with dedicated staff and develop a relationship. Staff with care backgrounds have a key role to play here.</p> |
| Consumers | <p>50-70% of marketing is focused on the secondary consumer Residents are <i>insufficiently involved</i> in design and services development. Consumer feedback is generally limited and needs to be improved sharply. Residents need to be treated as a resource rather than as 'patients'.</p> <p>No respondent cited having undertaken a consumer questionnaire of any size.</p> <p>There are some notable initiatives in keeping couples together when one partner suffers dementia or frailty – these should be advertised and explored more widely.</p> |
| Commissioners and Local Authorities | <p>Local authorities must improve research on the needs of elderly people locally; there appears to be an alarming deficit in the scope and detail of housing with care strategies. <i>In many cases they simply do not exist.</i></p> <p>Respondents suggest that the performance of local authorities in this area can be very uneven and may hinder development.</p> <p>In some authorities knowledge of ECH is significantly lacking There is an emerging opportunity for commissioners to take a progressive lead in exploring partnerships with private providers.</p> <p>Social care commissioners should be a primary conduit for channelling information on ECH to their local communities.</p> |
| Coverage | <p>Nationally ECH coverage is very uneven – between districts, providers and tenures. A large number of local authorities have very low levels of provision of any sort. These should be identified and pressed to improve their coverage. Market penetration remains low and is likely to be exacerbated in the short term by recession; rural coverage is poor and given density and land constraints <i>requires a new and reduced scale/new form of ECH –probably telecare driven.</i> There are clear frustrations in respect of BME provision but we saw no substantive evidence that this will be resolved other than by government -central and local -taking a lead.</p> |

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| Intelligence | While there are notable exceptions, much market research/intelligence is limited and guidance may be required through publications and workshops to help providers shorten the learning curve. Dissemination of best practice and learning media might be best achieved through workshops and direct meetings and networking and programmes of visits to successful or innovative schemes. The Housing LIN is an invaluable resource in this field. |
| PR/Media | For providers, the key target is the local media. Some exploit it effectively. Many do not. Again, help in working through and populating a media/PR strategy would be valuable. The media should be used increasingly to promote the concept of ECH rather than as a limited medium for sales. <i>This requires a national lead.</i> |
| Inclusion | There are clear deficits of provision for BME elders, for special needs groups and for certain groups whose access to ECH is limited by their financial circumstances. Current marketing and development programmes largely reinforce this 'marginalisation'. |
| Literature | Generally, marketing literature is good to impressive. But there is a predominance of information and bias in favour of buildings and facilities rather than ethos, care, and how future needs are met. More is required on staff, professionalism, philosophy, values, community, independence and the needs of couples. (See Housing LIN information leaflet) |
| Economy | Few providers convey the wider economic benefits of ECH and the building of social and community capital. The role of ECH as a regeneration vehicle is underestimated; Providers should detail and highlight employment and procurement benefits and <i>their</i> capital investment and spend in the local community. Local authorities should assist in providing relevant information. |
| Planning | Planning is becoming more complex and determination is taking longer and longer. This affects investment and delivery of supply. Although ECH developments are increasing in scale and complexity there is still a sense of DIY in the sector. Providers need to ensure they have access to expert planning advice and that they also plan strategically for the longer term and not just <i>ad hoc</i> by site. A raft of reforms/improvements to the planning system are held to be necessary and overdue (see below). |
| Recession | Recession has not resulted in any provider we contacted turning their back on ECH and walking away. A few were slowing development for sale and some public sector providers were deferring but not abandoning projects. Conversely, a number of LAs were now entering the market with enthusiasm. Overall, there was an unexpected buoyancy |

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| | <p>about the long term prospects of ECH. One note of caution is that private providers may struggle to secure funding for sites on which they have consents.</p> |
| Flexible Take-Up | <p>The recession has had some positive effects. New tenure, financing and service arrangements should be monitored and assessed over the next 12 months as a means to improve take-up and to recalibrate the structure and offer of some ECH communities.</p> <p>There is evidence of a mixed tenure/mixed income approach taking hold out of necessity – but could this be the basis for the development of new progressive clusters of housing with care.</p> |
| Outreach | <p>Providing facilities, services and staff which can be deployed in the community to those unable or unwilling to make the move to an ECH development looks increasingly practical and is certainly a means of securing income, achieving economies of scale, keeping staff in employment, meeting an evident need, increasing awareness of the development and also building interest and waiting lists.</p> <p>One consequence of the inability to sell existing properties is that many older people will have to stay put. This situation will also be consolidated by new Lifetime Home arrangements from 2011. The upshot could be a rapid expansion in domiciliary care in the community. ECH providers should be alert to this and compete through an outreach model.</p> |
| New Tools | <p>The following need to be ‘advertised’ within the sector at large</p> <ul style="list-style-type: none"> • Cause related marketing • B2B marketing • Research |

Contributors Views on Possible Ways Forward

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| <p>Descriptions</p> | <p>Given marketing differences in descriptions of ECH and reports of the confusion this can cause it will be useful for commissioners, planners, providers and ultimately for consumers to have access to a <i>single</i> 'defining explanation' that ideally all can subscribe to.</p> <p>One option would be to update the generic leaflet on ECH developed by the Housing LIN and re-distribute this. Providers can still retain their 'differentiation' but also sign up to a common definition of ECH to reduce consumer uncertainty. This might serve as a rubric/check list for best practice. One way forward might be to distribute it to all commissioning organisations and to relevant clubs, societies and older people's organisations.</p> <p>This study has shown that we still need to define the boundaries/limitations of ECH –establish where the gaps in provision are and how these can be addressed. Developing regional workshops on extra care housing – on site at ECH developments – would provide an opportunity for planners and commissioners to see the concept at first hand.</p> |
| <p>Investment/Expansion Partnering</p> | <p>A number of providers urged intervention to safeguard the gains made to date in developing ECH provision. There were fears that recession might undermine these. Some asked that the government should act as a 'broker' linking major house builders and regeneration consortia with ECH providers and meeting with the Home Builders Federation. Others would like to see a high level approach made to the new Homes and Communities Agency to embed ECH into large scale mixed tenure housing projects. Among the planning improvements suggested were that ECH should be a 'swap' in some instances for affordable and social housing; and that it should be much more effectively promoted as a means to sustainable communities. One solution is to work more closely with the HCA Academy to articulate this.</p> |
| <p>Planning</p> | <p>Planning was a key area of discussion. Some providers would like to see the creation of a specific class/use dedicated to ECH. Others think we should have the means to accelerate planning applications for projects meeting the needs of older people and other vulnerable groups. Ways forward included 'requiring' local authorities to make land and density provision for these groups. Ensuring that ECH is incorporated in the RSS and Local Area Agreements.</p> <p>It was suggested that all providers be circulated with guidance on how they submit ECH to the Local Development Framework. A number favour revising</p> |

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| | <p>affordable housing criteria to allow the possibility of ECH being treated as an <i>alternative</i> provided that the application contains an agreed measure of rental and low cost for sale housing with care.</p> |
| Land | <p>The supply of appropriate sites can be an obstacle even though land prices are now falling and competition is less intense. But, looking ahead, providers advocated action to ensure that when the upturn does come we are ready to grasp the opportunity to expand provision. They want government to ensure that public agencies with redundant land assets circulate ECH providers.</p> <p>A more formal option might be to create a small agency to marry land with social uses of this type. A number favour formally zoning land/sites for ECH.</p> <p>Another way to promote extra care housing and help unlock site opportunities would be to integrate other forms of housing and uses <i>within</i> ECH developments (special needs, family, business and training centres) And to work with RDAs and local authorities to identify employment land that can be re-zoned for ECH.</p> |
| Regeneration | <p>Some of the larger ECH providers have given a lead on the value of aligning ECH with wider regeneration. They favour incorporating, as a requirement, an element of ECH in regeneration projects delivering a certain threshold of housing. This was seen as part of a strategic approach to the HCA and the Tenant Services Agency. Providers urged that the HCA plans and funds ECH as an essential part of its new affordable homes strategy and that local authorities and RDAs support this.</p> |
| Design | <p>Design was generally a source of pride and a number of providers cited it as part of their USP. Even so, the design and specification of ECH could be bolder, more cutting edge and more innovative in its use of technology. The Housing LIN are working with CABE on design for homecare and there is ongoing research by the school of architecture at The University of Sheffield looking at future design guidance. In addition the Technology Strategy Board, a public body connected with the Department for Business Enterprise & Regulatory Reform (BERR), is currently working on 'smart care' projects and on Assisted Living, but its work does not appear to be well advertised.</p> <p>ECH, unlike other housing sectors, is not big on awards. The consensus is that it should be. This offers a further opportunity to explore with CABE and the RIBA a prestigious annual national design award for ECH projects and extensions to raise quality and awareness. A way forward in the short term could be to</p> |

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| | <p>approach the HCA Academy to incorporate from 2010 ECH categories in their newly launched Homes & Communities Academy Awards.</p> |
| <p>Levelling the Curve</p> | <p>Despite the many events, seminars and workshops convened by the Housing LIN, many providers would welcome the opportunity to meet more regularly to update experience and skills and to network with colleagues across the three sectors. This offers an opportunity, perhaps on a twice yearly basis, to take the pulse of the ECH market and identify where research, intervention, information may be useful. For providers, the experience it provides may help to shorten their learning curve. Bringing providers together in this way may also help to accelerate an emerging mixed economy of provision cited in this study.</p> |
| <p>Local Authorities</p> | <p>The study also points up the strategic planning deficit in a number of local authorities. Many lack a coherent ECH policy or strategy and this affects commissioning, awareness, investment and provision. We need to identify and understand the position of those authorities with low levels of supply and explore if and how this may be addressed. There is a notable lack of supply in rural areas and this might form the basis for a meeting with organisations like the Rural Services Network and the Commission for Rural Communities.</p> |
| <p>Raising Awareness</p> | <p>The permeability of ECH at a 'national' level and its osmosis by the <i>general public</i> remains low according to providers. Coverage in national dailies is marginal except at the higher cost 'lifestyle' end of the market. Promoting ECH through local and regional newspapers and by disseminating information via local authorities and clubs and societies are regarded as more effective tools by providers – the overwhelming majority of whom trade on their 'localism'.</p> |
| <p>Learning from Specialist Providers</p> | <p>It is clear that there are some interesting and innovative forms of housing with care delivered to smaller groups with special needs not embraced by mainstream ECH. The learning and management experience of housing with care generally will be richer for understanding more fully the work of these providers.</p> |
| <p>Innovation</p> | <p>There are some innovative schemes which combine ECH with GP and community health outreach services located within an integrated 'Hub'. Policy, funding, practicality, integrated approaches to healthcare and now the exigencies of recession suggest that this more diversified model should be explored further. Major retailers are also expressing an interest in integrating</p> |

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| | <p>housing with supermarkets. ECH offers an interesting opportunity to explore 'living above the shop'.</p> |
| <p>Market Research & Marketing</p> | <p>It is clear that many providers would benefit from further workshops and generic 'how to' guides. A number of contributors to this study asked for advice, information and for best practice examples. These are areas in which organisations like EAC can play a valuable instructive role. There is much here that could be disseminated in this way.</p> |
| <p>Finance and Tenure</p> | <p>Providers commented that eligibility criteria are confusing for many older people and their families.</p> <p>There is a case for better promotion and understanding of the financial support available to those considering ECH.</p> |
| <p>Consulting Consumers</p> | <p>Few providers have put in place 'feedback' or 'consultative' structures with their consumers. By and large structured engagement with consumers is quite limited. Yet they represent a major resource for policy makers, providers and for commissioners to draw on. Consumers can offer valuable feedback on services, design, tenure, finance and marketing. Creating a 'user-centric' 'forum' to convey views and data would strengthen participation, assist empowerment and further legitimate policy, delivery and management outcomes</p> |
| <p>Quality, Regulation and Inspection</p> | <p>The EAC Quality of Information Mark provides a highly regarded measure of intent and performance in the sector and invites further development. In such a way that providers and consumers look to it as a mark of excellence and an assurance that what is on offer really is 'housing with care'.</p> <p>Further clarity is needed on the future role of the Care Quality Commission and its relationship with the Tenant Services Authority.</p> |

Relevant Housing LIN publications

Factsheets

Housing LIN Factsheet No.7: Private Sector Provision of ECH

Housing LIN Factsheet No.12: An Introduction to Extra Care in Rural Areas

Housing LIN Factsheet No.17: The Potential for Independent Care Home Providers to Develop ECH

Housing LIN Factsheet No.30: Extra Care Housing and the Credit Crunch

Technical Briefs

Technical Brief No.2: Funding Extra Care Housing

Technical Brief No.3: Mixed Tenure in Extra Care Housing

Reports/toolkits

ECH for Older People: an introduction for commissioners

The Extra Care Toolkit

ECH-Development planning, control & management – RTPi Good Practice Note 8

Shared Equity – Using the Private Finance Initiative to boost ECH

Whose Market? – Understanding the demand for ECH

NOTES

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2. Mapping Care of Older People; Analysis of England's Long Term Care Markets Deloitte 2008
3. The two key stages in the professionalisation of the private sheltered sector came 14 and 18 years respectively after early developers like McCarthy and Stone and English Courtyard Association pioneered their models. 1991 saw the establishment of the Association of Retirement Housing Managers (ARHM) which now represents 61 organisations managing over 100,000 retirement properties. It has developed a Code of Practice for the industry, a Good Practice Guide, works closely with the government's Ombudsman and has forged strong links with key policy communities. Its' developer counterpart –the Retirement Housing Group- emerged 4 years later and operates under the auspices of the Home Builders Federation. It has produced a series of reports and position statements on the industry including on planning reform (see ref 24). In the ECH sector recent initiatives have taken place to establish an interest group representing private sector retirement villages.
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15. Statistics on Housing with Care in England EAC Jan 2008

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18. see www.dh.gov.uk/en/socialcare 4 Feb 2009 and www.pssru.ac.uk
19. www.alzheimers.org.uk and www.guardian.co.uk/2009/Feb/03/dementia and www.timesonline.co.uk 4 Feb
20. www.communities.gov.uk and www.homesandcommunities.gov.uk and PSSRU Evaluation of Extra Care Housing Initiative www.PSSRU.ac.uk
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Our Health, Our Care, Our Say: A New Direction for Community Services DoH 2005
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25. *Extra Care Housing: Development planning, control and management –RTPI Good Practice Note 8* 2007
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28. RTPI 2007. For a more detailed note on rural provision see *An Introduction to Extra Care Housing in Rural Areas* Housing LIN Fact Sheet No 12 CSIP D o H
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Appendix One: Variations in Description of Forms of Extra Care Housing

Orders of St John Care Trust/Oxfordshire CC/Oxford City Council

“Extra Care’ offers flexible care and support, a safe environment and rights and control to people in their own home, with the back up of 24 hour support from housing, social care and health service teams. It can provide access to meals, domestic support, leisure and recreational facilities. Older people are able to live independently in their ‘extra care’ homes, whilst taking advantage of a range of facilities and support.” (Isis Court Care Apartments leaflet)

Pennine Housing 2000

‘Extra care housing offers older people, who are frailer or disabled, their own home together with the help they need to stay independent.’ (correspondence with Pennine Housing 2000)

Milecastle

“The scheme will have a mix of more independent and able residents together with those who are very frail. Some will be getting a lot of care and support, others will be living independently. The accommodation will be accessible, easy to manage and support residents to be as independent as possible” (The Manors, West Wylam brochure but derived from the Housing LIN leaflet on ECH)

Shaw Healthcare

“a public and private sector partnership that combines extra care housing with a range of short stay inpatient beds for intermediary and palliative care, along with a unit for the younger physically disabled...it develops the model further by combining extra care housing with a community hospital and GP practice.” (extracts from Combining ECH with Health Care Services at Barton Mews CSIP Case Study No 40 Simon Evans)

Oakbridge Retirement Villages

“Assisted Living is right for you if you need help to manage daily activities, but do not want to move in to a traditional care home. It offers the perfect balance between independence and support. We offer professional and highly skilled on site care and support services to provide assistance with all aspects of day to day living...Individual risk and needs assessments give us a clearer idea of what you need..” (Assisted Living at The Grange, Buckshaw Retirement Village)

St Monica Trust

“The Trust is committed to encouraging residents to maintain their independence and remain in their own homes for as long as possible. A choice of services is available ... to ensure this is a reality for all our residents. As needs change, a specialist team can deliver home care and support services to residents in their own apartments and help is on hand around the clock to deal with unexpected emergencies.” (St Monica Trust, Cote Lane brochure)

Adlington-MHA

“MHA’s approach to person-centred care, developed over many years of working with older people, with focus on the individual’s needs and provision of care and support to maintain privacy, dignity, independence and choice. Specialist care staff are on hand around the clock to offer personal support and deliver care, as

required, to support older people to achieve well-being and lead satisfying lives and to enable couples to stay together.” Adlington Independent Living brochure, Rhos on Sea)

The Extra Care Charitable Trust

“Our approach is founded on the charitable principle that age, health or financial means shouldn’t be a barrier to achieving an enjoyable quality of life in later years. We view an active lifestyle, which promotes independence and well-being, as the key to achieving this. We are working in partnership with like-minded local authorities, regeneration bodies, charitable trusts and developers to enable more people to benefit from the later lifestyle they deserve.”

(from www.extracare.hcdev.co.uk)

Birmingham City Council

“Extra care housing is committed to giving older people a range of options to live independently. It provides an attractive alternative for people who may otherwise need residential care. The success of ECH in Birmingham is due to the partnership between social landlords, the Housing and Constituencies Directorate and The Adults and Communities Directorate. Our goal is to ensure older people have dignity, choice and are able to keep personal responsibility for their day to day lives regardless of age or frailty.” (Extra Care Housing In Birmingham leaflet)

Joseph Rowntree Housing Trust

“ A caring, supportive and personalised range of services tailored to individual needs, first and foremost to maintain well-being. Services are provided to maintain, promote and sustain independence and to alleviate the restrictions of age and ageing.” (JRHT Plaxton Court –Questions and Answers)

Advantage

“Extra Care is designed to enable you to stay independent in your own home, with flexible support and care available as needed. As a resident, you will benefit from the freedom and financial security of living in your own home, but will be waving goodbye to some of the heavier responsibilities this usually carries...a team of qualified staff is on hand 24 hours a day, seven days a week” (Beechmere Extra Care Development brochure)

Other Housing LIN publications available in this format:

Housing LIN Reports available at www.dhcarenetworks.org.uk/housing :

- **Extra Care Housing Training & Workforce Competencies**
- **Yorkshire & the Humber Region - Extra Care Housing Regional Assessment Study (Report and Executive Summary)**
- **Preventative Care: the Role of Sheltered/Retirement Housing**
- **Developing Extra Care Housing for BME Elders**
- **Health for Life: Health Promotion in Extra Care Housing**
- **New Initiatives for People with Learning Disabilities: extra care housing models and similar provision**
- **Substance Users and Supported Housing: What's the Score?**
- **Dignity in Housing**
- **Enhancing Housing Choices for People with a Learning Disability**
- **Essex County Council Older Person's Housing Strategy**
- **Switched on to Telecare: Providing Health & Care Support through Home-based Telecare Monitoring in the UK & the US**
- **Older People's Services & Individual Budgets**
- **Healthy Hostels**
- **Remodelling Sheltered Housing and Residential Care Homes to Extra Care Housing - Advice to Housing and Care Providers**
- **Whose Market? Understanding the demand for Extra Care Housing: A Strategic Approach**
- **The impact of Choice Based Lettings on the access of vulnerable adults to social housing**

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