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Personal Social Services Research Unit

Drivers and barriers to social care supply: Evidence from two local authorities

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PSSRU Discussion Paper 2020-03
September 2020
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ESHCRU Economics of Social and Health Care Research Unit

Acknowledgements and Disclaimer

We would like to express our thanks to all of the providers and LA representatives that gave their time to be interviewed, and to peer reviewers for very useful comments on a first draft. This report is based on independent research commissioned and funded by the National Institute for Health Research Policy Research Programme (NIHR PRP) through its Policy Research Unit in Economics of Health and Social Care Systems (ESHCRU, grant reference 103 0001). The views expressed are those of the authors and not necessarily those of the NHS, the NIHR, the Department of Health and Social Care, or its arm's length bodies, or other government departments.

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Preface

This report was based on research undertaken in 2018 and an initial draft version was written in late 2018 and peer-reviewed in early 2019. This final version, whilst incorporating responses to peer-review comments, is still based on the social care landscape at that time and does not take into account any subsequent changes. This is particularly relevant given the Covid-19 pandemic, which is having an ongoing, and will have a future, impact on social care markets.

Contents

Executive summary

- This report looked to assess the drivers and barriers to supply of social care in two local authorities, Bristol City Council and Kent County Council. The former is a unitary authority and the latter is a two-tiered county council. Both local authorities have areas of high wealth and deprivation.
- The initial draft of this report was written in late 2018 and the final version remains as if the adult social care and wider landscapes remain unaltered from that time. Ultimately, many changes have taken place, not least developments from the Covid-19 pandemic. The impact of the pandemic on these findings will be discussed elsewhere.
- The broad approach of the two local authorities, as elsewhere, is to reduce the reliance on care homes by encouraging the development of extra care housing and supporting people to live in their own homes.
- There is a wide range of social care services available in Bristol. As of February 2018, BCC spends almost £1.4m a week supporting nearly 3,200 older people with adult social care (£1.2m per week on over 2,300 working age adults), the vast majority of this (over £1m) being spent on supporting around a third of the total older people who are living in residential and nursing care.
- Kent has a large supply of adult social care, but availability of types of care can vary by location. Additionally, KCC provides enablement services in-house. In 2012-13, KCC supported over 34,000 adults, with two-thirds of these being over 65.
- Ten face-to-face semi-structured interviews with sixteen stakeholders in Kent and Bristol took place from October to December 2018. These included the Director of Older People and Physical Disability from KCC and the Head of Adult Care Commissioning from BCC. At provider level stakeholders from care home, domiciliary care and extra care housing providers were interviewed, and these included a range of local, regional and national providers.
- The interviews covered five key themes: demand, supply, staffing, relationship between providers and other stakeholders, and Extra Care Housing.

Demand

- There was a general view that those being supported by social care provider have much higher needs levels than compared to the past. LAs are seeing an increase in the needs levels of vulnerable adults, which has long-term implications for costs. However, providers also stated that with increasing needs levels, staffing needs to increase to support this, and that the pressures on staff were much greater.
- Self-funders pay more in Bristol and Kent – for Bristol can be almost double the LA rate in care homes and around £4 an hour higher in domiciliary care. A care home provider we spoke to in Bristol had only recently felt compelled to charge self-funders more following the introduction of a ceiling price by the council.
- In Kent it was strongly felt that the price that the council were willing to pay was very much determined by the level of supply in the area. There was also difficulties for providers who have rooms of different sizes and quality which meant that an indicative price given to prospective clients might not reflect the actual cost for certain rooms.
- Providers need to maintain occupancy or service-user levels in home care which means they are taking LA-funded residents or service users. In practice, some were genuinely concerned about their viability if they continued to be reliant on LA-funded residents.
- A preference for private payers was sometimes linked to the increased admin burden and time delays in receiving payment associated with dealing with LAs across providers.

- Even though BCC had main contractors for home care in Bristol, other home care providers felt there is still a place for them in the market, but that to survive they would need to increase their focus on self-funders if possible.
- In both Bristol and Kent the price paid was felt to have implications for quality delivered.
- In homecare, it was felt by smaller providers that accepting low prices and losses can be sustained short-term by larger, national, providers but that this would have implications for quality. For homecare, quality will be driven by the staff employed, so growth can also lead to problems with quality.
- Similarly in care homes, there was reference to higher care home fees being paid for a time by BCC which was then put to be used to improve standards and increase staffing levels, and in Kent it was acknowledged that low fees meant that standards had to be cut back somewhat, i.e. both general upkeep and the potential for investing in big renovation projects is reduced.
- Providers in general are using (any) higher fees to drive up quality and not profits.
- The CQC quality rating was seen as important. It was seen to be generating a need for continuous improvement in some providers, and it also was seen by some to be promoting positivity for the domiciliary and care home sectors overall. There were some worries over getting a lower rating over individual cases of personal error, where one mistake does not reflect the overall service.
- The rating does not necessarily impact on demand for care homes to a large extent, where it was generally felt that the key thing is the visit. There was some feeling in Kent that many were not aware of the CQC.
- It was felt that the impact of the rating may also depend on levels of competition. For example, a provider in Kent referred to another care home in a rural location that seemed happy to have a Requires Improvement rating as they could still charge a self-funding level of price and had no vacancies.

Supply

- There can be problems with the availability of supply, and particularly so for Kent, which is much larger. For Kent, there can be problems in certain areas with supply of provision for LA-supported service users, particularly care homes. For example, in West Kent there is a high level of affluence and so care homes can concentrate on demand from self-funders.
- In Bristol, difficulties can arise in provision where affluent wards contain the supply of provision then neighbouring poorer wards cannot afford the provision (e.g. for extra care housing). There was also a suggestion of an undersupply of residential care in South Bristol from a care home provider, with other areas in Bristol having stronger levels of competition.
- Market size can be very small. The home care providers we spoke to had specific market areas in Bristol, but many will work Bristol-wide. Care homes had relatively small markets where demand came from, based on previous location of resident or the location of their family. There could often be a border issue, e.g. someone living on the outskirts of Bristol in South Gloucestershire would not necessarily want to move in to a care home in Bristol, and vice versa.
- Expansion is not straightforward. One home care provider would look to do it if the volume of demand was there, but it would also depend on the area. Certain parts of Bristol, e.g. with one major road, were gridlocked at key times when care services are required. Growth can also lead to problems with quality in home care, as employing more staff then it cannot be guaranteed that it is the right staff.
- The supply-side of the market is greatly affected by staffing.

Staffing

- There is a core of staff that will stay with a provider over a number of years. However, for domiciliary care in particular, there is a lot of job hopping.
- The national living wage has driven up wages at the lowest level but has compressed the wage distribution across levels of seniority. One care home provider now paid the same wage for carers irrespective of qualifications, but qualifications were still seen as to stand staff in good stead for future progression.
- Pay for staff for most providers was tied to the rates paid by local authorities. KCC had helped with recruitment to some extent by putting extra money in which had gone specifically to domiciliary care staff.
- Training and progression was seen as important by some providers, and can encourage retention. The costs that providers faced in supporting staff in training and qualifications was seen increasingly as a difficulty.
- There can be issues for Kent with staffing in certain areas of the county. This can be for certain forms of care, e.g. affluent areas harder to recruit for domiciliary care, less affluent areas harder to recruit staff with appropriate skills (e.g. nursing), and areas neighbouring London and Medway find more difficulty recruiting with greater competition.
- Increased health and social care funding (e.g. Better Care Fund) did help to reduce these problems as KCC were able to put money directly towards increasing pay for domiciliary care workers (paying for travel, time to travel).
- In Bristol, staffing is a concern, but seen as more problematic in neighbouring LAs. There was also a suggestion that providers can take advantage of the large student population in Bristol.
- There are large seasonality and timing issues for staffing. Providers find it difficult to recruit around Christmas, and also summer holidays as lots of single mums are involved in the market. For this reason, finding staff for times outside of school hours can be difficult as well. Additionally, Fridays and Mondays can be difficult to staff if providers require staff to work one day on the weekend. Night staff are also difficult to recruit.
- These issues naturally put more pressure on the core staff that can be relied upon to be available to work the difficult hours, and can lead to burnout and losing staff, particularly as providers could not pay more to reflect this effort.
- Additional money to ease winter pressure was welcomed in Kent but felt that there was a lack of planning around this. Just putting money in to the system at very short notice, and subsequently withdrawing it at the end of winter, will not help to solve the problems and it was assumed that the level of staffing could just rise and fall at the appropriate times.
- Staffing may be more difficult for certain care homes based on location. For example, more rural homes may restrict potential recruits to those with own transport.
- Brexit will have implications for at least some providers.

Relationship between providers and other stakeholders

- Providers understood and accepted the general approach of their respective LAs to focus on care at home and in the community, but it was seen more as a means to cost-cutting than enabling local residents.
- Communication was seen as improving in Kent and deteriorating in Bristol. Bristol had seen a lot of change in the pricing of care and former partnership arrangements had been abandoned leaving providers feeling like they had little voice. In Kent, a new tender for community services

was co-produced by way of feedback and there was increased consultation. However, there was also a concern in Kent that the LA lacked the resource to achieve their strategic vision.

- There was a general concern in Bristol that private sector companies are misunderstood and that there is a preference for LAs to work with voluntary sector providers. The private sector in social care is generally looking improve services with any increase in fees.
- The quality rating system of the CQC was seen in a positive light, although with some concerns around how a provider's rating could easily fall based on a single case of personal error (see Demand above).
- Providers mentioned the (sometimes large) rise in fees to be paid to CQC. In some instances the cost had tripled for domiciliary care providers given it is based on number of service users receiving personal care.
- Consistency of inspectors was seen as useful, and potentially cost-saving for CQC where one inspector could inspect a providers' group of homes in an area where policies are consistent across homes.

Extra care housing

- The detailed information on extra care housing was drawn from providers in Bristol.
- Demand for extra care housing was strong, although the one provider had experienced an increase in voids, which was attributed to administrative factors rather than a fall in demand.
- A change in eligibility criteria for people nominated by the BCC had resulted in an increase in the level of needs among residents, but not necessarily an increase in the number of care hours required.
- Changes to the commissioning arrangements had led to a greater focus on a time and task approach, similar to that employed in domiciliary care. This had created more rigidity, and made it more difficult to finance the provision of 24-hour care, a central feature of extra care housing.
- Staffing arrangements were generally less difficult than for domiciliary care, partly because staff were based at a single location. However, low wage levels and alternative forms of employment affected staff recruitment and retention.
- Both providers operated a range of types of support for training and career development, and since they managed services in a range of locations, it was possible for staff to transfer to different roles within the organisation.
- Some CQC inspectors and health service staff demonstrated a lack of understanding of the role and contribution of extra care housing, and there was a need to engage with other agencies to promote the role of the sector.

Conclusions

- Both Kent and Bristol face similar drivers and barriers in the supply of adult social care, but the issues facing the former tend to be on a larger scale given their respective sizes.
- Needs levels are increasing in social care, which has implications for supply, workforce and funding. Quality is driven by price, as are staff wages, and markets tend to be relatively local.
- Cooperation between stakeholders is important and the future success of adult social care markets will depend on good communication and co-production between all involved.
- This was a small-scale study with no scope to gather views from those who use social care services nor other national organisations (e.g. CQC). This report is therefore likely to offer a fairly one-sided, provider-focussed, narrative on what drives and inhibits adult social care supply, although their views do correspond with previous research.

1. Introduction

This report presents the findings from stakeholder interviews to assess the drivers and barriers to local social care supply in two local authorities. This work was part of a wider research project with the overall aim to gain a better understanding of the factors that affect changes in the supply in local social care markets.

The report is important for policy for a number of reasons. First, at local government level there are questions as to the appropriate level of funding for adult social care, which will have knock-on implications for supply. There have been consistent cuts in social care funding across local authorities (LAs) in England as the level of central funding has been cut (Humphries *et al.*, 2016; Phillips & Simpson, 2017). This has led to a reduction in the level and number of people supported (Fernandez *et al.*, 2013), and these cuts will vary across LAs (Fernandez and Forder, 2015; Gray and Barford, 2018). For example, in the South East of England there is generally a greater share of self-funders, whereas in the North East of England it is lower. As such, local social care markets may be responding differently to the reduction in LA-funding, with some able to continue to have a vibrant market with plenty of social care options to choose from, whereas for other local markets there may be more provider exits and reduced levels of choice of available care.

There could also be large differences within LAs, and this is likely to be particularly so in larger local markets. For example, there may be distinctions in the availability of provision based on whether the area is rural or urban, and depending on the level of wealth within LAs. There may be other differences within LAs that may cause differences in social care provision availability, e.g. workforce and bordering other LAs.

Second, it is also important for policy that the drivers and barriers in local social care markets are assessed from a market management perspective. LAs have the statutory responsibility from the Care Act of maintaining a vibrant social care market with diversity in the choice of provision available, both in terms of the form of social care and the level of quality within those forms. As such, it is important to analyse differences both between and within LAs as to how provision, and therefore choice, varies. With LAs having an input to appropriate local markets, differences in areas in the supply (both forms and size), quality and price of social care could arise. Currently, adult social care funding is allocated through use of the Relative Needs Formula (RNF), which takes into account local variation in population, need and wealth to allow the same level of support to be provided to all those who are eligible (Vadean and Forder, 2018). The differences in service availability, quality

and/or price across LAs could raise equity issues nationally despite the level of support from funding being the same per (eligible) capita across LAs.

An increasing level of recent research has looked at various aspects of local social care markets in England. Forder and Allan (2014) assess the impact of competition on quality and price in the English care homes market, finding supporting evidence that the negative impact of competition on quality was caused through price, i.e. it is likely that competition for LA-funded placements cause reductions in quality. Hall *et al.* (2017) assessed local domiciliary care supply in England using both qualitative and quantitative analysis. Their findings from interviews with national and local stakeholders in six local authorities were that the pressures on suppliers came from their relationship with the NHS, commissioning practices, workforce, market instability and provision of quality. Quantitative analysis found that mismatches where supply was greater than expected demand, the former measured using workforce data and the latter using relative needs formula data, were positively related to higher staff vacancy rates and tenure in job and negatively related to additional hours worked. Bottery (2018) also assessed domiciliary care from the provider and commissioner perspective, Jefferson *et al.* (2017) qualitatively assessed the factors which influence adult social care commissioning by local authorities and Needham *et al.* (2018) assessed the role of LA market shaping in local care markets, identifying four types of LA market shaping practice based on whether rules and relationships with providers were weak or strong. Finally, related research looks to assess care home supply, quality and price at national and local level and quantitatively assesses the effect of LA adult social care expenditure on care home closures and local care home market supply (Allan and Nizalova, 2020).

1.1. Demand for social care

There will be an increasing demand for social care over time which will have implications for the supply-side of the market. A growing older population and a likely shortage in availability of informal carers over time will contribute to a growing demand (Pickard *et al.*, 2012; Pickard, 2015). In theory, increased demand would lead to further provider entry and/or higher prices.

However, a growing demand for social care services also has implications for the financing of social care (Comas-Herrera *et al.*, 2006). This is in turn has implications for social care supply. The receipt of social care is not free, and so people either pay for their receipt of social care out of their own pockets (private payers, or self-funders) or LAs pay for their care, subject to both needs and means testing. Other than a small proportion of care home residents (around 10%) that receive fully-funded care from the NHS, social care demand is roughly split 50-50 between self-funders and those

supported by their LA (LaingBuisson, 2015). As outlined earlier in the introduction, the level of support and number supported has been falling over time. This has led to concerns over the increasing level of cross-subsidisation, where self-funders are charged higher prices for the same services. This is particularly the case for the care homes market (Competition and Markets Authority, 2017), but there are concerns over low fees paid by LAs in the domiciliary care market, too (Bolton and Townson, 2018). Therefore, the overall effect of an increasing demand on social care market supply is difficult to assess. As demand rises, further reductions in the fees paid by LAs, relative to social care cost inflation, are likely. Whether cross-subsidisation would continue to be a viable strategy for providers is unknown, and therefore the shape and scope of local social care markets is open to question.

1.2. Report structure

The rest of the report is as follows. The details of the project are described in section 2, before there is an overview of the current situation facing the two LAs, as outlined by their Market Position Statements. There follows a general discussion of the key themes raised in the interviews with the adult social care stakeholders from both Bristol and Kent as to what drives and inhibits adult social care supply. The reporting of the findings from the interviews is broken in to five key themes: demand (including quality), supply, staffing, relationship between providers and other stakeholders (council and Care Quality Commission (CQC)), and extra care housing. Finally, in an appendix to the report, there is a discussion of housing for the elderly, providing a review of the current housing landscape for older people, including policy. There is a particular focus on specialised housing, including extra care housing, and the impact this has on social care outcomes.

2. Project details

This report looked to assess local social care markets, gaining a better understanding of the factors that affect supply. In particular, we present analysis for two LAs where providers and LA representatives were interviewed to assess the economic factors that promote or inhibit supply. This includes discussion of important policy areas such as demand, workforce and the relationship between providers and other social care market stakeholders.

The two authors conducted the interviews and data analysis, with consultation and discussion throughout. The themes and links between the themes were explored through reading and re-reading of the transcripts and quotations are included to put the findings in to context. An ethical application for the project was approved by the University of Kent SRC ethical research panel (SRCEA

ID 203). Two PPI representatives were recruited to the project from the Quality and Outcomes Policy Research Unit (QORU) Research Advisors Group and a meeting took place at the start of the project prior to analysis in which the aims of the project were discussed and from which particular areas were prioritised.

The two local authorities chosen to understand what drives and inhibits social care supply were Bristol and Kent. These LAs were selected for a number of reasons. First, the two LAs are of different form. The former is a unitary authority and Bristol City Council is the strategic commissioner of care and support in the area. The latter is a two-tiered county council and Kent County Council commission care and support for the county. This allowed the project to understand the differences and similarities that face single- and two-tier LAs in their supply of social care. Second, there are demographic differences within the two LAs, with both local authorities for example having areas of high wealth and deprivation. This enabled the project to assess any differences in problems with supply based on income and the supply of qualified staff, for example. Third, from a pragmatic aspect, there were cost and time considerations taken into account, and the researchers had previously had contact with Bristol City Council.

2.1. Stakeholder recruitment

Initially recruitment focussed on local authority representatives for both authorities. In Bristol, we then contacted providers through the local authority representatives using an e-mail advert to ask for interested parties to contact the research team. In Kent, the local authority representatives provided us with an e-mail introduction to the Kent Integrated Care Alliance (KICA), an independent representative body for care providers, from which we were able to recruit interviewees. We held ten face-to-face interviews with sixteen stakeholders in Kent and Bristol (see Table 1 for a list of participants). From a local authority perspective these included the Director of Older People and Physical Disability from Kent County Council (KCC) and the Head of Adult Care Commissioning from Bristol City Council (BCC). At provider level, stakeholders from care home, domiciliary care and extra care housing providers were interviewed, and these included a range of local, regional and national providers. Interviews were recorded with appropriate consent provided from all involved. The interviews were semi-structured with a topic guide broken down in to key themes (see section 4 below) used as a framework for discussion. The interviews took place between October and December 2018.

Table 1: List of participants

Interviewee	Provider/LA	Location
Head of Adult Care Commissioning	LA	Bristol
Contracts and Quality Manager for Adult Care and Support	LA	Bristol
Commissioning manager for extra care housing	LA	Bristol
Small multi-care home owner	Provider	Bristol
Domiciliary care agency owner	Provider	Bristol
Owner of a number of (regional) domiciliary care agencies	Provider	Bristol
Care manager of domiciliary care agency and extra care housing scheme	Provider	Bristol
Director of community services for housing, care and support organisation	Provider	Bristol
Manager of community services for housing, care and support organisation	Provider	Bristol
Regional Contracts and Development Manager of large national care home provider	Provider	Bristol/Kent
Chief executive of national housing with care professional network body	Provider	Bristol/Kent
Director for Older People and Physical Disability	LA	Kent
Adult social care commissioner	LA	Kent
Director of Kent Integrated Care Alliance and owner of integrated health and social care provision	Provider	Kent
Small multi-care home owner	Provider	Kent
Non-executive director of a domiciliary and agency care provider	Provider	Kent

3. Market overview

As outlined in section 1, The Care Act 2014 gave LAs a duty to maintain social care supply in local markets with choice both within and between different forms of social care. LAs will therefore play an important role in the supply-side of social care markets through market shaping in addition to

their role as commissioners of services for those whose social care is publicly-funded. The market shaping functions of LAs include the provision of market position statements, developed in conjunction with market stakeholders including providers. These outline the social care market context of each LA (e.g. current and future supply and demand) and the future plans for LA commissioning arrangements. The aim of the market position statement (MPS) is to allow providers the appropriate context from which strategic decisions can be made (IPC, 2016).

3.1. Bristol

In their MPS, updated in June 2018, BCC outline that the policy priority is for people to live in their own homes for as long as possible (Bristol City Council, 2018). To achieve this, BCC have a three tier system of adult social care, with tier one covering informal support, e.g. family, tier two being targeted support, e.g. for periods of re-ablement or low-level support to maintain independence, and tier three being long term formal social care support. BCC expects that nursing and residential demand will fall over time by focussing more resources in to tiers one and two, whilst domiciliary care demand will stabilise with alternative sources of social care compensating for the increase in demand from fewer people in institutional care.

Bristol is facing a strong population growth over the coming years, with projections suggesting the City will have a population of 546,000 in 2039, an increase of 23% from current population levels. There has been an increase in life expectancy in the last twenty years, the economy is growing, with an average wage of £28,000 and high employment levels. However there a number of areas of deprivation and there is a weakness in 'lower-skilled' occupations; a large proportion of Job Seeker's Allowance (JSA) claimants are looking for work in sales and customer services.

As of February 2018, BCC spends almost £1.4m a week supporting nearly 3,200 older people with adult social care (£1.2m per week on over 2,300 working age adults), the vast majority of this (over £1m) being spent on supporting around a third of the total older people who are living in residential and nursing care. Approximately 10% of those supported receive direct payments. More than 10% of those supported are in extra care housing and the cost to BCC is around 5% of total cost. Just over 14% of adult social care spending by BCC is spent on domiciliary care to support around a third of those supported, and the average weekly domiciliary package is almost 12 hours.

There are 113 care homes registered with the CQC within BCC boundaries, with 67 of these registered to provide care for older people and/or those living with dementia. The average size of residential homes in Bristol is small (17.5 beds). BCC has 91 residential and nursing home providers

on the BCC Residential Framework, but these do include a small number of homes outside of Bristol. There are 56 registered domiciliary care providers in Bristol, 47 of them registered to support older people and/or those living with dementia. BCC contracts 'main' and 'secondary' providers for 11 geographical areas in Bristol, with a number of community providers on framework contracts and 3 providers are commissioned to provide care overnight. There are 11 registered extra care housing schemes in Bristol, as well as a large number of community support services, including supported living (14 registered) and day services.

There are estimated to be 11,500 social care jobs in Bristol, with more than one in ten of these estimated to be jobs for direct payment recipients. The majority of the workforce is female, and the average age of workers is 41. Job vacancy and turnover rates stand at 9% and 27%, respectively, over 70% of new recruits come from within the adult social care sector, but there is a core of workers in Bristol with a strong level of experience (nearly two thirds have worked in the sector for at least three years).

3.2. Kent

KCC have both a MPS for community support (Kent County Council, 2016) and an accommodation strategy (Kent County Council, 2014) due to the two-tier nature of the county (i.e. housing decisions are made at a district level). KCC's MPS for community support outlines that they want to reduce crisis-driven care, and make support more personalised. KCC has three groups of interventions: promoting wellbeing, which looks to prevent or delay the need for people to enter the formal social care and health systems; promoting independence, which looks to provide short term support; and supporting and maintaining independence, where there is ongoing formal care and support for people to remain living in their own homes. KCC's accommodation strategy also outlines a scope for using the oversupply of residential care beds for intermediate care to reduce hospital stays. KCC's future direction is to increase the provision of ECH and other housing alternatives, and increase investment in community services to reduce the use of long-term residential care.

Kent has a population of 1.51m people but this is increasing (projected to increase by 5.6% by 2020), and there will be growth in the older population (by 10% for those aged 65 and over, 24% for those aged over 90) and more people are expected to be living with dementia. There is expected to only be a small rise in the number of unpaid carers in Kent by 2020 (10.8% of population from 10.7% in 2015). Whilst generally Kent is fairly well off, there are some areas of very high deprivation, with Thanet being the most deprived district.

KCC supported over 34,000 adults in 2012-13, with two-thirds of these being over 65. 12% of those supported were receiving direct payments. There are 227 domiciliary care providers in Kent, with 193 of these registered to provide services to older people and those living with dementia. KCC has 19 providers contracted to provide domiciliary care, and these provide 85% of services to those supported by KCC, with 50 other providers providing the other services. KCC provides enablement services in-house, and over 8,000 adults received this service in 2012/13.

KCC's accommodation strategy outlines that there is an overprovision of residential care services and underprovision of nursing care home places, but this does vary by area, where the situation can be reversed (e.g. in West of the county there is an oversupply of nursing beds). KCC acknowledge that high land prices do play a key role in the potential for supply to change, with high land costs in affluent areas of Kent. There are 575 care homes in Kent, with 362 of these registered to provide care to older people or those living with dementia. This has fallen over time (671 and 382 in 2012, respectively). Average care home size is 35, with nursing homes on average having 53 beds and residential homes 28 beds in size.

4. Stakeholder interviews

The stakeholder interviews were semi-structured and based around five key theme areas: demand, supply, staffing, relationship between providers and other stakeholders, and extra care housing.

4.1. Demand

Providers have seen a big change in needs levels of those they care for, and particularly so for those supported by LAs. People entering residential care in both Bristol and Kent are more like those who entered nursing home care in the past, and the average length of stay has reduced. Demand for residential care services has been maintained, partly due to the location to the particular organisations' homes.

"…the sort of people that are coming to residential care these days would without a doubt have been nursing care 15 years ago, without a doubt."
Small multi-care home owner, Kent

For domiciliary care, the impact of increased needs is that it can be difficult to complete the necessary tasks in the allocated time, and negotiations with the local authority for reimbursement can be very time-consuming. The change in the levels of need has also meant that the type of work undertaken has shifted from home-help (e.g. tidying, shopping) and domiciliary to domiciliary only. Shorter, 15 minute visits are also required, but providers were concerned that these were too short

for staff to provide adequate care. The providers were concerned that their work was increasingly focused on crisis management.

"…the funding has been drawn back…so we wait until people are absolutely in a point where they cannot live independently and then we tell them that we can only give them half an hour."
Owner of Integrated health and social care provision, Kent

Self-funders pay more in Bristol and Kent. For example, in Bristol the self-funder price can be almost double the council rate in care homes and around £4 an hour higher in domiciliary care. A care home provider we spoke to in Bristol had until recently maintained the same price for self-funders and LA-funded residents, but had felt pushed in to beginning to charge more to self-funders with the introduction of a ceiling price by the council. Third party top-ups[1] help but in Bristol it was felt that it was the general practice of the council to not have these, and that there was a lack of cohesion between what was discussed between commissioners and providers and what actually happened in practice (see also Relationship between providers and other stakeholders below).

It was felt in Kent that the price that the council were willing to pay was very much determined by the level of supply in the area. In addition, providers alluded to the council ordering care homes for prospective publicly-supported residents with the lowest price first, and higher prices pushed down the list. This was also felt to be a difficulty where care homes have rooms of different sizes and quality which meant that an indicative price might not reflect the actual cost for certain rooms.

Providers need to maintain occupancy levels in care homes and service-user levels in domiciliary care which means they are taking on those who are LA-supported. In practice, some were genuinely concerned about their viability if they continued to be reliant on LA-funded residents. A preference for private payers was also linked by many providers (both domiciliary care and care home) to the increased administrative burden and time delays in receiving payment that were associated with their relationships with councils.

"If you're dealing with a private payer…you get your fee, they get their service and it's quite straight forward. But for Local Authority funded payers, it's so much admin…[i]t takes our admin ladies in the office an awful, awful lot of time sometimes to sort out Local Authority fees and actually get paid what we're supposed to be."
Small multi-care home owner, Bristol

[1] A third party top-up is private funding, usually from a relative, which is used to 'top-up' the price paid by LAs for a care home place. This can allow a resident to move in to a care home which is priced above what the LA is willing to pay for this particular residents' place given their level of needs.

Quality is dependent on price and providers in general use higher fees to drive up quality. In domiciliary care, in both LAs the price paid was felt to have implications for quality delivered. For example, it was felt by one provider in Bristol that accepting low prices and losses can be sustained short-term by larger, national, providers but that this would have (negative) implications for quality. For domiciliary care in particular, quality will be primarily driven by the staff employed, so growth can also lead to problems with quality (see Supply below).

Similarly in care homes, quality was linked to the price paid by councils. In Bristol, higher council fees were paid for a time which was used to improve standards and increase staffing levels, and in Kent it was acknowledged that low fees meant that standards had to be cut back somewhat. Providers felt that with lower fees being paid both general upkeep and the potential for investing in big renovation projects is reduced.

4.2. Supply

For Kent, there can be problems in certain areas with supply of provision for LA-supported service users, particularly care homes. For example, it was noted by the Director for Older People and Physical Disability that in West Kent there is a high level of affluence and care homes can concentrate on demand from self-funders. This could have implications for KCC on budgets and finding placements. In Bristol, difficulties can arise in provision where affluent wards contain the supply of provision then poorer wards next door cannot afford the provision (e.g. for extra care housing).

Market size can be very small. The domiciliary care providers we spoke to had specific market areas in Bristol, but many providers will work Bristol-wide. Care homes in both LAs had relatively small markets where demand came from, based on previous location of resident or the location of their family. There could often be a border issue with prospective residents, for example someone living on the outskirts of Bristol in South Gloucestershire would not necessarily want to move in to a care home in Bristol, and *vice versa*.

Providers tended to keep the scope of their operations within specified geographical boundaries, and viewed the extension of their operations beyond a particular size as being liable to introduce diseconomies of scale. For example, one domiciliary care provider in Bristol would look to expand if the volume of demand was there. However, this would depend on the area, as for certain parts of Bristol expansion was not possible, e.g. one area was mentioned which had one major road that is gridlocked at key care service times. Another provider of domiciliary care preferred to establish a

new office with one of their experienced managers, rather than expand an existing office into a larger area. There were also providers that were happy with the market they had and did not see any expansion as necessary. Growth was also linked to potential problems with quality in domiciliary care, as a provider becomes increasingly reliant on employing more staff and not necessarily the right staff.

"I'm a firm believer that an office has a ceiling of capability. So, it becomes, when it gets to a large size, dysfunctional and immensely stressful within the working environment of the office."
Owner of a number of (regional) domiciliary care agencies, Bristol

4.3. Staffing

A priority for providers was the maintenance of a core of loyal, longstanding staff. The majority of care staff were female, often with family commitments. The remuneration of care staff was tied to the contracted rates from the local authorities, and support for staff was recognised as essential. Some care staff moved from job to job quite frequently, incentivised by small increases in pay, but all providers had a group of long-term staff and applications from frequent job changers were not viewed very favourably. Training and promotion from care staff positions to supervisory and management roles was regarded as an important means of valuing staff, as well as ensuring that trained senior staff were available to step in in case of care staff shortages. Providers were willing to support their staff in obtaining relevant qualifications and a number were explicit about encouraging staff to seek career advancement outside the provider organisation if that was what the person wanted. However, some providers were becoming concerned about the costs of providing training and qualifications.

Within urban areas, domiciliary care staff tended to live relatively close to their clients, meaning that some could operate without personal transport, but this was not the case in more dispersed areas. Where care staff lived close to their clients it was possible to schedule visits quite efficiently, although it was also the case that care staff might not wish to provide care to clients in their own community for reasons of confidentiality. For care homes, staffing may be more difficult based on location, for example it may restrict potential recruits to those with own transport.

There can be issues for Kent with staffing in certain areas of the county. For example, in Thanet it is difficult to recruit staff with appropriate skills to open nursing homes or homes focused on those living with dementia. There are links with the demand and funding issues outlined earlier, as Thanet will not have the self-funders required to be able to attract the staff with a suitable wage and KCC has budget pressures which put a limit on what they can afford to offer potential providers. The opposite is true for domiciliary care however, where it is easier to recruit in Thanet but in West Kent

there are very high employment levels, which reduces the need for people to move in to social care roles. For North Kent, it is the ability to move to neighbouring LAs (Medway, London Boroughs) which makes it difficult to recruit. For domiciliary care, reference was made to the size of the potential workforce limiting expansion of supply.

"The other thing is the supply of care staff. [W]e're a good employer, and therefore we don't have a huge amount of difficulty in recruiting, but I'm very conscious there's a fixed pool of people in any location who work in care and are willing to do so."
Owner of a number of (regional) domiciliary care agencies, Bristol

For providers, daily and seasonal variability in availability for work were particular challenges. The busiest time of day was 7:00–9:00, but staff with children had difficulty in finding before-school supervision or childcare arrangements during this period. One provider had difficulty with staffing on Fridays and Mondays due to staff having to work a day at the weekend and then wanting two consecutive days off. Similarly, school holidays presented problems, and several providers indicated that there was no point in advertising for staff in the pre-Christmas period. One domiciliary care provider emphasised the importance of computer scheduling to manage staffing arrangements and plan staffing availability for the summer holiday period. These time and seasonality issues naturally puts pressure on the core staff that can be relied upon to be available to work the difficult periods, and a provider in Kent noted that this can lead to burnout and losing staff, particularly as providers could not pay more to reflect this effort.

"We put a lot more pressure…on the good staff, you know, you only ever ring the good staff on a Friday night at seven o'clock because they're the ones that are going to do it. You can only do that for so long."
Owner of Integrated health and social care provision, Kent

In order to reduce demand at the busiest time of day, domiciliary care providers discussed with clients whether they would be prepared to wait until after 9:00 for their first visit. It was often difficult for providers to ensure that visits during the early morning period would be made at the scheduled time due to the pressure of work and traffic congestion, and an advantage of a later visit was that the staff would be less pressured and, also, that the visit was more likely to take place at the scheduled time. Such arrangements were more easy to make with self-funded clients since they did not require local authority sanction, but providers noted that the times scheduled for visits were not necessarily the most preferred times for the client, and rearranging the timing of visits might suit clients better. In some cases, clients were willing to have visits at different times on different days of the week. The importance of computer scheduling is noted above, and it is likely that this is another example of where such technology is crucial for the successful management of care provision.

As noted above, pay rates were constrained by the contractual rates offered by the local authority. Providers paid at least the NMW/NLW, or slightly more if they were able to do so. Providers recognised the difficult nature of care work, and would have been happy to pay more if their income from the local authority had been greater.

"It all depends on how forthcoming the council is…that's essentially where the problem is, we have to be able to pay the staff a wage that is showing that we value their work, but also that enables them to pay their bills."
Domiciliary care agency owner, Bristol

In Kent, recruitment issues in domiciliary care had been helped to some extent by KCC recently putting money in to specifically increase pay for domiciliary care workers, whilst BCC had previously had problems with the supply of domiciliary care because of low hourly rates.

At the same time, providers also needed to pay higher salaries for more experienced and more senior staff, and there was some concern that pay differentials were reduced due to the payment of the NMW/NLW. For example, one care home provider in Bristol now paid the same wage for carers irrespective of qualifications, but qualifications were still seen to stand staff in good stead for future progression (to senior carer, and beyond).

The majority of care staff in both local authorities were from the UK and living near to their place of work or clients, although in areas with more dispersed populations domiciliary care staff did have to travel further to attend to their clients. The extent to which services employed non-UK staff varied between areas and there was considerable uncertainty about the future availability of non-UK staff in the light of Brexit. Providers were also uncertain about the possibility of expanding the employment of UK-based care staff to meet growing future demand, given a lack of supply, although the decline in retail employment arising from the growth in online shopping was seen as a possible source of additional workers. In Bristol, the council felt there may be some scope to take advantage of the student population.

4.4. Relationship between providers and other stakeholders

4.4.1. Council

As noted in the respective MPS for each council, the broad approach of the two local authorities, as elsewhere, is to reduce the reliance on care homes by encouraging the development of extra care housing and supporting people to live in their own homes. Although the providers recognised the financial constraints under which the local authorities were operating, day-to-day pressures on their services made them question the direction of policy. The approach of the local authorities, of

expecting people to take more control over their lives was not seen as a means of enabling local residents, but more as a means of cutting costs to respond to the financial imperatives.

As part of the changes in local authority staffing, the former partnership arrangements in Bristol had been abandoned and the providers felt that there was no longer a forum to discuss matters jointly. For providers of domiciliary care services there was little opportunity to meet colleagues. Furthermore, private providers expressed the view that they were not very welcome and that the local authority would really prefer to work with non-profit providers. Private providers indicated that they wanted to work with the local authority and that although the profit-making aspect of their business was seen to be illegitimate, their view, and one that was generally held, was that profits were used to reinvest in the business, not just withdrawn as profits.

"…we're in a period of trying to re-engage and develop [a] different kind of more collaborative relationship with all of our markets, and I guess it would be honest to say it's a kind of slightly mixed bag…"
Head of Adult Care Commissioning, Bristol

"I think they thought we were just keeping all the money, but we didn't, we used that [higher funding from LA] to be able to raise the standards and increase the levels of staff to cater for the levels of need."
Small multi-care home owner, Bristol

In contrast, in Kent the providers did feel that relationships between providers and the local authority had improved, with more consultations and a better understanding of the private sector. However, providers were concerned that a lack of resources would prevent the local authority from achieving its strategic vision, particularly given the short timescale expected for changes. In addition, greater funding to ease winter pressures was welcomed in Kent but it was felt that there was a lack of planning around this. Adding money in to the system at very short notice, and subsequently withdrawing it at the end of winter, would not help to solve the problems and it was assumed that the level of staffing could just rise and fall at the appropriate times.

"…we're working more closely together, so an example being with our Care and Support in the Home tender which has gone out recently…we developed the specification and we shared it with the market and we got their feedback."
Adult social care commissioner, Kent

"I do think our local authority have got the vision to ensure that things are done differently, I think we've got good leadership now…[that] understands really well what the private market bring to the table."
Owner of Integrated health and social care provision, Kent

In emphasising their desire for a partnership approach, providers argued that they had developed expertise in their field. An example of this was the provision of training to other organisations. Private providers were also critical of the disparity in the costs of local authority and private provision. At the same time, for domiciliary care, the contractual rates being offered by the local authority were seen as implying that the local authority expected staff to be paid below the NLW/NMW. Contracts were set in terms of time and task, not including an allowance for travel between clients. In urban locations, where visits to clients could be more easily scheduled without too much travelling between clients, this was less of a problem than in more dispersed communities, but it still required travelling time to be reimbursed by the agency.

4.4.2. Care Quality Commission

The CQC and their rating system were seen in a positive light by some providers in generating a need for continuous improvement, and it also was seen by some to be promoting positivity for the domiciliary and care home sectors overall. The CQC rating was seen as important, and there were concerns about the use of a four-tier measurement system of quality and the implications this has for demand.

"The difference between good and requires improvement to the human brain, in my mind, is significant. If I was helping my dad to be placed in a care home and I saw requires improvement, I would think that is well below average, well below standard."
Regional Contracts and Development Manager of large national care home provider, Bristol/Kent

However, generally for care homes it was generally felt that the key thing is the visit, i.e. do prospective residents like the look and feel of the home.

"…when we've perhaps had "requires improvement" on an inspection report…you think oh no, you know, that's on our rating now, is that going to affect us? But realistically, it doesn't seem to have as big an impact as I would even expect it to. I think people are more concerned with having a look around the home, whether they like the home, whether they get on with the Manager and the staff, and whether the location's right for them."
Small multi-care home owner, Bristol

There were some worries, which came from providers of different social care services, over getting a lower rating from individual cases involving personal error, where one mistake does not reflect the overall service.

"…because we didn't do that on the paper [for] the one single client we were rated down to requiring improvement in both safe and also well-led."
Domiciliary care agency owner, Bristol

As noted above, the rating does not necessarily impact on demand for care homes to a large extent, and there was some feeling that many prospective clients were still not aware of the CQC. It was felt that the impact of the rating may also depend on levels of competition. For example, a provider in Kent gave an example of a rurally located care home that seemed happy to have a Requires Improvement rating as they could still charge a self-funding level of price and had no vacancies.

The fees paid for CQC have gone up, and it does impact on providers. This was particularly the case for domiciliary care providers, with one in Bristol pointing out that their fee had tripled as it is based on the number of service users receiving personal care. A consistency of inspectors was seen as a benefit, whilst a lack of, and individual differences between, inspectors were acknowledged. For example, a care home provider pointed to potential benefits to both themselves and CQC if one inspector could inspect a providers' group of homes in an area where policies are consistent across the homes.

4.5. Extra care housing

Extra care housing provides accommodation in self-contained dwellings, usually flats, together with a range of communal activities, usually including a catering service, and the availability of 24-hour care.[2] Accommodation, social activities and meals are paid for by the resident using their own financial resources, including benefits such as Housing Benefit, while care services are funded by the local authority, depending upon eligibility. Given the limited funds often available to residents, providers have to find ways of offering social activities at low or no cost to the residents, for example by involving voluntary organisations.

Interviews were conducted with a representative of a care provider that worked in partnership with an extra care housing provider in Bristol and with representatives of a provider of housing, care and support that was both the landlord and the care services provider for several extra care schemes in Bristol. The care provider worked in several local authority areas while the housing, care and support provider was based in Bristol and also operated in neighbouring local authorities. In both cases, the organisations undertook a range of activities, although not all were provided in Bristol. Both organisations offered domiciliary care services, and the housing, care and support provider also managed care homes and sheltered housing.

[2] The appendix to this report includes a review of the current housing for the elderly landscape and policy, with a focus on specialised housing, which includes extra care housing.

Both organisations worked in partnership with Bristol City Council. The majority of residents supported by the two organisations in the extra care housing schemes were nominated by the City Council, but the extra care providers were able to allocate their own tenants in up to 25 per cent of places to fill voids. Since most residents were nominated by Bristol City Council the residents were mainly Bristol residents, and tended to be previously living in the local area. Thus they were able to maintain links with the area in which they had been living.

The sizes of the extra care housing schemes concerned were in the range of 50 to 70 units of accommodation, although one of the schemes was in the process of being extended. The schemes provided self-contained accommodation for residents and communal facilities, including restaurants. A number of other extra care and retirement developments were available in Bristol, or were in the process of construction. Some of these were larger and provided more facilities, and were seen as being designed to cater for the private, self-payer market. The housing, care and support provider had experienced an increase in the number of voids in the previous year but this was viewed as an administrative issue rather than a fall in demand. The care provider reported that demand had remained high and that its housing provider partner had rarely had to draw on its waiting list.

The funding of catering for residents was included in the tenancy or service agreements and there was a potential conflict between the promotion of independent living and the provision of restaurant facilities. However, the value of restaurants for supporting social interaction, particularly for socially isolated residents, was recognised, as in previous studies of extra care housing. The relatively small size of the schemes and their location enabled them to provide services to the local community in a way that larger retirement schemes could not. However, there was a limit as to how far the schemes could be seen as community hubs, rather than the providers of some services. For example, restaurants were used by families of residents, such as at Christmas. However, a local presence was seen as enhancing the reputation of the scheme and possibly demonstrating its value to potential future residents.

A change in eligibility criteria for people nominated by Bristol City Council to require a minimum of five hours of care per week and to provide for more complex care needs, introduced in 2016, had resulted in an increase in the level of needs among residents. However, the increase in complexity of care needs was not necessarily accompanied by an increase in the number of care hours needed for supporting residents, for example those with mental health rather than physical health issues. In addition, for some residents an improvement in their condition could result in a reduction of their care requirements below the minimum of five hours. However, the contractual arrangements with Bristol City Council had changed to a time and task focus, which meant that care provision in extra

care housing had become more like domiciliary care provision, negating the outcome-based focus of the contracts with the City Council. In particular, the contracts for the care of individual residents meant that the providers had difficulty maintaining the 24-hour cover that is a feature of extra care housing. The respondents from the housing, care and support provider noted that an adjoining local authority which operated a time and task-based approach recognised this problem by providing a separate block payment to support night care.

The care provider had developed a long-term relationship with Bristol City Council and felt that the Council did not exercise as much close oversight as some other local authorities, possibly due to a degree of trust that had developed. The respondents indicated that day-to-day working arrangements with the Council were good, however the relationship between providers and the Council had changed with the demise of the meetings of the local Extra Care Housing Partnership, and this also meant that providers had less opportunity to meet. Care contracts were set to run for five years, and the prospect of having to re-tender for care contracts also meant that providers felt that there was more sense of being in competition with other providers than in the past.

Staffing arrangements in extra care housing were seen as less difficult than for domiciliary care, partly due to the different working arrangements, being based at a specific site and not needing to have a car to visit clients. The care provider also operated a domiciliary care service from their office in the extra care scheme, with the agreement of the housing provider, and this enabled staff to be reassigned if necessary. The housing, care and support provider had found that where staff did move between roles within the organisation, these were from domiciliary to building-based services (extra care housing or care homes). However, staff recruitment and retention was challenging in Bristol, and low pay and increasing expectations of care staff, for example in the handling of medication, were disincentives. Low pay was seen as the main issue, with care staff moving jobs for small improvements in pay. The care provider did pay above the National Minimum Wage in order to retain staff, but this was constrained by the low rate paid by Bristol City Council for the care contracts, and the lower rate paid for care in extra care housing than for domiciliary care. Both providers were concerned that future planned increases by Bristol City Council in contract rates would not be sufficient to meet the planned increases in the National Living Wage/National Minimum Wage in 2020. Both providers were very supportive of staff training and career development and progression, and also offered additional support to help staff. The care provider worked in partnership with a local college to provide a formal training programme, and the housing, care and support provider was developing apprenticeships. The care provider operated a ‘refer a

friend' scheme and the housing, care and support provider offered a number of benefits including emergency loans.

As for domiciliary care provision, the care provider reported that it was difficult to organise staffing for the early morning period, between 7:00 and 9:00, whereas more staff were available in the evening and seasonal issues did not present problems. The scheme was located in a residential area and perhaps the location meant that staff could be drawn from a fairly small area. However, the housing, care and support provider did not experience problems with staffing availability before 9:00 for its extra care schemes, although it did experience problems in relation to its domiciliary care provision. The housing, care and support provider also experienced problems in arranging night-time staffing and during school holidays. In order to manage the early morning period, the care provider negotiated the timing of visits with residents in a similar manner to domiciliary care providers, and also used night staff to undertake laundry tasks and visit residents who wished to get up before the morning shift started.

The extra care housing scheme where the care provider was based was a predominantly White British area of Bristol, but some staff were from other countries, mainly those in the European Union, and they had expressed concerns about their position following Brexit. The housing, care and support provider also employed some staff from other countries, including European Union and non-EU countries, but had not yet been affected by Brexit issues. However, it was recognised as likely to present a risk to future operations.

Technological developments such as motion sensors, and assistive technology were seen as valuable components in the support of residents, but the role of a person providing care was still regarded as central.

In terms of relationships with other organisations, the respondents reported that relationships with the Care Quality Commission were good, although the housing, care and support provider was disappointed that the CQC could no longer provide advice. There was some concern that CQC inspectors, like others, did not always understand the nature of extra care housing and could treat it in the same way as care homes, commenting on non-regulated areas such as the provision of activities and catering, rather than focusing on the provision of care.

Similarly, health service staff were not always clear about the difference between extra care housing and care homes, resulting in a lack of understanding about how extra care housing functioned. The providers organised services to help the transition from hospital back to their extra care accommodation, but a formal tenancy agreement needed to be set up before a person moved into

extra care and so they would have to return home or move to a temporary facility first. Engaging with GPs and pharmacists before the development of further provision was recognised to be very important in ensuring good relationships with the health service.

5. Conclusion

This report has assessed what drives and inhibits the supply of social care in two local authorities, one a city unitary authority and the other a large two-tier shire county. These two LAs were selected because of their type, demographic variations within the LAs and for reasons of pragmatism. Ten interviews of sixteen stakeholders took place, including representatives of the local authorities, and on the supply side providers of domiciliary care, care homes, and extra care housing. These were recorded and subsequently transcribed with the interviewees' agreement. The interviews focussed on five key themes: demand (including quality), supply, workforce, relationship between providers and other stakeholders, and extra care housing.

In terms of demand, needs levels are increasing, particularly for those supported by LAs, quality is driven by price and fees for those supported by LAs are being subsidised by those paying privately. There were concerns over the viability of providers if pressure on fees continued. Markets of providers were relatively local, and supply depended on the demographic and economic characteristics of local areas. The workforce is mainly female and working around family, which can have implications for service provision (time of day, seasonal). Staff remuneration was largely linked to the fees being paid by LAs. Relationships between providers and other stakeholders are important and will have an impact on provision.

The broad approach of the two local authorities, as elsewhere, is to reduce the reliance on care homes by encouraging the development of extra care housing and supporting people to live in their own homes. The functioning of extra care housing was explored with a care provider and a housing, care and support provider operating in Bristol, as well as in other local authority areas. Demand for extra care housing was strong, although the housing, care and support provider had experienced an increase in voids, which was attributed to administrative factors rather than a fall in demand. A change in eligibility criteria for people nominated by the local authority had resulted in an increase in the level of needs among residents, but not necessarily an increase in the number of care hours required. However, the commissioning arrangements had led to a greater focus on a time and task approach, similar to that employed in domiciliary care. This had created more rigidity, and made it more difficult to finance the provision of 24-hour care, a central feature of extra care housing.

Staffing arrangements, on the other hand, were generally less difficult than for domiciliary care, partly because staff were based at a single location, although low wage levels and alternative forms of employment affected staff recruitment and retention. Both providers operated a range of types of support for training and career development, and since they managed services in a range of locations, it was possible for staff to transfer to different roles within the organisation. The providers also highlighted a lack of understanding among some CQC inspectors and health service staff, and the need to engage with other agencies to promote the role of the sector.

Across the two LAs there are great similarities in the issues facing social care providers, from issues in staffing to the pressures on the funding of publicly-supported service users. Indeed, there seems to be a disconnect between the financing of social care and the implications of the policy direction that LAs are taking. The geographical problems faced by Kent being such a large county do also exist in Bristol, but naturally to a much smaller degree which means they are less of a direct problem. Given the similarities between the two LAs, it would be no surprise that these issues are facing most social care providers across the country in general, to one degree or another. For example, similar issues for domiciliary care have been found for other parts of the country (Bottery, 2018). Overall, the social care providers we interviewed care about the service they provide, are working very hard at providing quality services whilst facing a myriad of pressures, and there would seem to be practical ways in which LAs (e.g. training provision, provider forums, provider involvement in price setting) and the CQC (ratings, inspections frequency and consistency) could help to improve the situation facing providers.

The themes that have been assessed all have relationships with one another. For example, at a demand level, needs levels of those being supported by LAs are increasing. This has implications for supply in terms of the level of workforce employed, and indeed the training required (e.g. dementia training), which will have implications for the quality of care. This in turn then has implications for the remuneration of staff and the funding of social care. Increasing need levels of those supported by LAs has at least in part been caused by cuts to adult social care expenditure, and this reduced level of funding will have an impact on the relationship between providers and LA commissioners. Further, pressure on budgets is leading to fees that do not match with the costs of providing care, which is leading to potentially issues over the long term viability of providers.

5.1. Limitations

There are limitations to this report. First the report is based on the work from a one-year project with limited resources. This meant that certain elements of local social care markets were not

assessed as they were beyond the scope of the project, e.g. there were no interviews of service users nor of individual employers of carers, nor personal assistants. We also did not interview other stakeholders such as the CQC or larger provider organisations such as Care England. Providers that took part in interviews were those that expressed an interest in taking part in the research. These are naturally more likely to be skilled, higher quality providers on average and so the whole spectrum of quality of services is unlikely to have been covered in this project. The interviews therefore primarily give a provider-only view of the problems they face and the enablers that help them. Any views they may have on the performance of other stakeholders cannot be verified. Overall, the themes and problems that arose from the interviews were in line with broader national issues (e.g. payment for travel time).

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Appendix

Housing for Older People: Supporting Quality of Life

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A1. Introduction

It has been a long-standing government policy to help older people to live independent lives in their own homes wherever possible (Cmnd 8173, 1981; Cm 849, 1989; Cm 4169, 1998; Department for Communities and Local Government, Department of Health and Department for Work and Pensions, 2008; Cm 8378, 2012; Cm 8677, 2013). However, a substantial proportion of older people have some need for care or support, and a significant minority of those living in mainstream housing live in non-decent accommodation. The majority of those living in non-decent accommodation are owner-occupiers. In 2011, 96% of the usually resident population aged 65 and over were living in households and 3.7% were living in communal establishments, mainly care homes (Office for National Statistics, 2013, 2015). Among households where at least one member was aged 65 or over, some 5% were in sheltered housing in 2014 (Department for Communities and Local Government, 2016b, Annex Table 2.6). However, those in older age groups are much more likely to live in a care home. In 2011, 13.7% of older people aged 85 or over lived in care homes, and accounted for 59.2% of the care home population aged 65 and over (Office for National Statistics, 2014).

Housing is now seen as central to health and social wellbeing (House of Lords, 2013; National Health Service, 2017; House of Commons, 2018; Public Health England, 2018). However, relatively little attention was paid to housing issues prior to the 1990 National Health Service and Community Care Act (for example: Department of Health and Social Security, 1981; Audit Commission, 1986; Griffiths, 1988). The 1990 Act formalised the involvement of housing authorities in assessments for community care services, but progress was unsatisfactory (Audit Commission, 1998; Harrison and Heywood, 2000; Cameron *et al.*, 2001). The 1997–2010 Government supported the development of specialist housing in guidance for establishing joint strategies for housing and community care

(Department of Health and Department of the Environment, 1997), and reaffirmed the role of housing (Cm 4169, 1998).

A2. Housing characteristics

A2.1. Housing tenure and housing type

The majority of households live in owner-occupied properties, and accounted for 63% of all households in 2016–17. The proportion of households in owner occupation increased from 57% in 1981 to 71% in 2003, but then began to decline, although the proportion has remained steady from 2013–14. In 1981, the social rented sector accounted for 31% and the private rented sector accounted for 12% of households. Since 1981, the proportion of households in the social rented sector has declined steadily, and accounted for 17% of households in 2016–17. The proportion of households in the private rented sector remained at around 10% during the 1980s and 1990s, before steadily increasing in size to account for 20% of households in 2016–17, overtaking the proportion in the social rented sector in 2011–12. (Ministry of Housing, Communities and Local Government, 2018a, Annex Table 1.1.) Although the growth in private renting has been concentrated in younger age groups, there has also been an increase in private renting among households in the 55–64 and 65–74 age groups, but not among the oldest age groups (Department for Communities and Local Government, 2016b, Annex Table 1.2).

Older households are much more likely to be owner-occupiers than younger households. In 2014–15, 76% of households in which the oldest person was 55 or over were owner-occupiers, compared with 53% of households in which the oldest person was under 55 years of age (Department for Communities and Local Government, 2016b).

Among owner-occupiers, the number of households with a mortgage remained stable during the 1990s, before starting to decline in the mid-2000s, while the number of households without a mortgage gradually increased. Since 2013–14 the number of outright owners has exceeded the number of mortgagors, and in 2016–17 34% of all households were outright owners and 28% were mortgagors. (Ministry of Housing, Communities and Local Government, 2018a, Annex Table 1.2.) The increase in outright ownership is due, at least in part, to the ageing of the population, with people paying off their mortgages as they reach retirement age (Ministry of Housing, Communities and Local Government, 2018a). Thus, in 2014–15 62% of households in which the oldest person was 55 or over were owned outright, compared with 9% of households in which the oldest person was under 55 years of age (Department for Communities and Local Government, 2016b).

The tenure profile for London is very different to that for the rest of England, private renting being the most prevalent form of tenure in London. In 2016–17, 30% of households in London were in the private rented sector, compared with 19% in the rest of England; outright ownership accounted for 25% of households in London, compared with 36% elsewhere; buying with a mortgage accounted for 22% of households in London, compared with 30% elsewhere; and social renting accounted for 22% of households in London, compared with 16% elsewhere (Ministry of Housing, Communities and Local Government, 2018a). In London, the social rented sector was split equally between local authorities and housing associations, 11% of households in each case, whereas in the rest of England 10% of households rented from housing associations and 6% from local authorities.

Private rented dwellings are more likely to be older than owner-occupied dwellings and those in the social rented sector. In 2016, a third of private rented dwellings had been built before 1919, compared with 21% of owner-occupied dwellings and 7% in the social rented sector (Ministry of Housing, Communities and Local Government, 2018a). In the social rented sector, local authority housing tends to be older than housing association homes. Over 90% of owner-occupied dwellings were houses or bungalows, compared with around 60% of rented properties, and were much more likely to be detached. Owner-occupied dwellings were larger than rented homes, in terms of floor area, and private rented homes were larger than social rented homes. (Ministry of Housing, Communities and Local Government, 2018a.) Rented properties were also smaller than owner-occupied properties with the same number and types of bedrooms (Department for Communities and Local Government, 2017a).

Older households are much more likely to live in detached houses and bungalows than younger households, and much less likely to live in terraced houses or flats. In 2014–15, 38% of older households lived in detached homes or bungalows, compared with 16% of younger households, while 23% lived in terraced houses and 15% lived in flats, compared with 34% and 24%, respectively, of younger households. Similar proportions of older and younger households lived in semi-detached houses, approximately 25% in each case. Among older households, those where the oldest person was aged 75 or over were more likely to live in a bungalow and less likely to live in a terraced or detached house than those in the 55–64 and 65–74 age groups. (Department for Communities and Local Government, 2016b.)

A2.2. Housing location and house moves

The majority of households live in urban areas, but older households are less likely to live in urban areas and more likely to live in villages or in isolated dwellings (Department for Communities and

Local Government, 2016b). Older households are much less likely to have moved in recent years than younger households. In 2014–15, 9% had moved compared with 36% of younger households (Department for Communities and Local Government, 2016b). Although the majority of older households that had moved in the last three years had moved less than ten miles, they were more likely than younger households to have moved more than ten miles. Among the older households that did move, the most common reasons for moving were family or personal reasons (27%), to move to a smaller property (15%), or to live in a better neighbourhood (12%). Nine per cent reported that their accommodation was unsuitable, and 5% wanted larger accommodation (Department for Communities and Local Government, 2016b, Annex Table 1.9).

A2.3. Housing design

In 1996, older and younger households occupied similar-sized houses, as measured by the internal floor area. However, over the last 20 years the size of houses occupied by older households has increased, while those occupied by younger households have remained fairly constant. Similarly, the proportion of older households living in detached houses has increased, while the proportion of younger households living in semi-detached houses, detached houses and bungalows has declined and the proportion living in flats has increased. (Department for Communities and Local Government, 2016b.) In contrast, the overall proportion of younger and older households occupying terraced houses has remained relatively constant, although the proportion of households aged 75 and over living in terraced houses has declined (Department for Communities and Local Government, 2016b, Annex Table 2.1).

Older households are more likely to live in homes built between 1945 and 1990, whereas younger households are more likely to live in the oldest homes, built before 1919, or in homes built since 1990 (Department for Communities and Local Government, 2016b). Nonetheless, in 2014 one-third of older households lived in homes built before 1945, compared with 39% of younger households (Department for Communities and Local Government, 2016b, Annex Table 2.2). The UK has the oldest housing stock in Europe, and a very slow rate of housing replacement (Nicol *et al.*, 2016). In particular, individually owned older terraced houses are popular, but they are difficult to replace (Nicol *et al.*, 2016).

A2.4. Housing occupancy

In terms of living conditions, owner-occupied households are much less likely to be overcrowded, in terms of the number of bedrooms available, and much more likely to be classified as under-occupied, defined as having two or more bedrooms more than the notional number needed. One

per cent of owner-occupied households in 2016–17 were classified as overcrowded, compared with 7% in the social rented sector and 5% in the private rented sector; and 51% were classified as under-occupied, compared with 15% in the private rented sector and 8% in the social rented sector (Ministry of Housing, Communities and Local Government, 2018a). The level of overcrowding in the owner-occupied sector has remained relatively stable over the last 20 years, while under-occupation has increased considerably. In contrast, overcrowding has increased and under-occupancy has decreased in the rented sectors.

Older households are much more likely to be classified as under-occupying than younger households. In 2014–15, 51% of older households were under-occupying, compared with 23% of younger households (Department for Communities and Local Government, 2016b). In absolute terms, twice as many older households as younger households were under-occupying (Department for Communities and Local Government, 2016b, Annex Table 2.12). Older households were much more likely to be satisfied with their accommodation, but satisfaction increased with the number of spare bedrooms among both younger and older households. Among older households, 88% of those living in homes which met the bedroom standard were satisfied, rising to 94% with one spare bedroom and 97% with two or more spare bedrooms, the criterion for under-occupancy. (Department for Communities and Local Government, 2016b.)

A2.5. Housing conditions

Over the last 50 years the physical standard of housing has improved. In 1967, 25% of homes lacked one or more basic amenities (a bath or shower, an indoor WC, a wash hand basin, hot and cold water at three points) and 12% were deemed unfit for human habitation, as determined by an inspector by reference to the Housing Act 1957. By 1991, the proportion lacking one of the basic amenities had dropped to 1%, and the number is now almost too small to measure. In addition, the proportion deemed unfit for human habitation had dropped to 4% by 1996. (Department for Communities and Local Government, 2017c.)

However, despite the improvements in housing conditions over time, the Green Paper published in 2000 indicated that a sizable minority of people still faced severe problems with housing, as follows: poor quality; poor service from landlords; deteriorating housing estates; poor energy efficiency; a lack of choice for public-sector tenants and the concentration of the most disadvantaged people in the poorest housing; an inability for some homeowners, including many retired people, to afford maintenance; an inability for some purchasers to afford mortgage payments; and homelessness and rough sleeping (Department of the Environment, Transport and the Regions, 2000).

Following the 2000 Green Paper, a Decent Homes Standard was introduced, based on four criteria, not just the single test of fitness: the statutory minimum housing standard; being in a reasonable state of repair; providing reasonably modern facilities and services; and providing a reasonable degree of thermal comfort (Office of the Deputy Prime Minister, 2003a). In the initial version of the Decent Homes Standard, introduced in 2001, the statutory minimum housing standard was based on the test of fitness. However, the test of fitness was based on a set of requirements that homes had to meet, and did not distinguish between defective dwellings and genuine hazards, and some of the most serious hazards, including fire hazards and fall hazards, were not covered (Department of the Environment, Transport and the Regions, 2000; Adcock and Wilson, 2016). The 2000 Green Paper indicated that the binary, pass or fail, fitness test would be replaced by a health and safety rating scale. After an extensive period of testing, the Housing Health and Safety Rating System (HHSRS) was introduced by the Housing Act 2004 (Office of the Deputy Prime Minister, 2006; Adcock and Wilson, 2016) and incorporated in the Decent Homes Standard instead of the fitness standard. The statutory minimum housing standard was defined as freedom from Category 1 hazards identified via the HHSRS (Department for Communities and Local Government, 2006, 2017b). Category 1 hazards are those that represent a significant risk to the household (Department for Communities and Local Government, 2017c). In addition, an adjustment was made to the thermal comfort criterion in respect of ground and mid-floor flats (Department for Communities and Local Government, 2008).

Overall, 20% of dwellings failed to meet the Decent Homes Standard in 2016, compared with 35% in 2006 (Ministry of Housing, Communities and Local Government, 2018a). Private rented homes were most likely to be rated as non-decent (27%), while 20% of owner-occupied homes and 13% of social rented homes failed to meet the standard. Between 2006 and 2016, the proportion of non-decent homes declined across all tenures, although there was no further fall between 2014 and 2016 (Ministry of Housing, Communities and Local Government, 2018a).

In 2016, the main reason for failing to meet the Decent Homes Standard was the presence of Category 1 hazards. Category 1 hazards accounted for 12% of dwellings failing to meet the standard, while a lack of thermal comfort accounted for 7% of failures, disrepair for 4% and a lack of modern facilities and services for 2%. Housing association homes differed from homes in other tenures in that failure to meet the Decent Homes Standard was most likely to be due to a lack of thermal comfort. (Ministry of Housing, Communities and Local Government, 2018b.) The most common hazards assessed as Category 1, or as significantly worse than average, related to falls, including falls on stairs (12% of dwellings Category 1 or significantly worse than average), falls between levels (8%) and falls on the level (6%). Damp and fire hazards were recorded for 5% and 4% of dwellings,

respectively. (Ministry of Housing, Communities and Local Government, 2018b, Annex Table 2.5.) Among the homes that failed to meet the Decent Homes Standard, 81% failed on one of the four criteria, 16% on two of the criteria and 3% on three or four of the criteria (Ministry of Housing, Communities and Local Government, 2018b, Annex Table 3.2).

The growth of the private rented sector has been welcomed by the government as providing increased choice (Department for Communities and Local Government, 2015a). However, there is a greater proportion of non-decent homes in the private rented sector, as noted above, and there are concerns about the rental of unsafe and overcrowded accommodation, often concentrated in small areas, including the use of outbuildings ('beds in sheds') for residential accommodation (Department for Communities and Local Government, 2015a). Furthermore, despite the reduction in the proportion of non-decent private rented homes, the increase in the size of the sector resulted in an increase in the absolute number of non-decent properties between 2006 and 2014 (Bate, 2016).

In 2014, older households were just as likely as younger households to live in non-decent homes, but households aged 85 or over were more likely to live in a non-decent home, 29%, compared with 17–19% for the other age groups. In addition, although the proportion of non-decent homes fell between 1996 and 2014, the number of households aged 85 or over has doubled and thus the number of these households living in non-decent homes has remained at the same level (Department for Communities and Local Government, 2016b). Overall, older households lived in homes with lower levels of disrepair than younger households, however households aged 85 or over and households aged under 65 had the highest levels of disrepair. Among older households, lower levels of disrepair were associated with a higher household income, whereas among younger households the relationship was less clear.

Energy efficiency of homes has improved substantially between 1996 and 2014, for both younger and older households, reflecting the movement of households into newer homes and the implementation of energy efficiency measures in the housing stock (Department for Communities and Local Government, 2016b). However, in 2014, older households still tended to live in less energy efficient homes, and households with a person aged 85 or over were most likely to live in the least energy efficient homes.

A2.6. Accessibility

Apart from fitness for human habitation, most mainstream housing has been designed for families with children, and is not necessarily well-suited to older people or others with a disability. For 2014–

15, the English Housing Survey reported that 31% of all households had at least one person with a long-term illness or disability, ranging from 21% for younger households, that is, those where the oldest person was aged under 55, to 65% where the oldest person was aged 85 or over. For older households as a whole, where the oldest person was aged 55 or over, the proportion was 42% (Department for Communities and Local Government, 2016b, Annex Table 1.7). Over the last 50 years the physical standard of housing has improved, as noted above, but much mainstream housing is still poorly designed in terms of accessibility.

In recognition of the problems that poorly-designed homes posed for large parts of the population, a group of housing experts were brought together by the Joseph Rowntree Foundation in the early 1990s to develop the concept of 'Lifetime Homes', originally proposed by the Helen Hamlyn Foundation and Habinteg Housing Association, to create integrated and inclusive housing for people with a wide range of needs (Goodman, 2011). The 16 Lifetime Homes design criteria cover the approach and the entrance to the home, circulation within the home, and the positioning of services and controls, including the potential for adapting the home to suit the needs of a member of the household who becomes disabled or more frail. Some of the criteria, but not those relating to future adaptability, were adopted in a revised version of the relevant Building Regulations in the late 1990s, but in 2008 the UK Government adopted the Lifetime Homes standards for new homes (Department for Communities and Local Government, Department of Health and Department for Work and Pensions, 2008). However, the 2010 Coalition Government did not retain the targets for new building, and transferred responsibility for policy and implementation to local authorities (HM Government, 2011).

The Coalition Government took the view that introducing the Lifetime Homes Standards for new housing would be too onerous, given the likely cost and the level of predicted need, and also that the additional accessibility requirements of wheelchair users would often be greater than those provided by the Lifetime Homes Standards (Department for Communities and Local Government, 2013). This led to a proposal for a three-category set of accessibility standards covering visitable dwellings (Category 1), accessible and adaptable dwellings (Category 2), and wheelchair user dwellings (Category 3), and these were incorporated in Part M of the Building Regulations (HM Government, 2015).

In 2014, only 7% of homes in England had all four visitability features (level access, a flush threshold, sufficiently wide doors and circulation space, and a WC at the entrance level), while 25% had none of the features (Department for Communities and Local Government, 2016a, Annex Table 2.2). Homes built after 1990 were more likely to have all four visitability features, due to the requirements of

modern building regulations; 34% had all four features, compared with 7% of those built from 1981–1990 and one per cent of those built before 1965. Housing association dwellings were better designed than homes in other tenures, with 18% having the four visitability features, but even among housing association dwellings, 18% had none of the design features.

A3. Home modifications/adaptations

In order to help people remain in their own homes with increasing frailty, central government has made grants available for home modifications or adaptations (Department for Communities and Local Government, 2009; Cm 8872, 2014). Disabled Facilities Grants (DFGs) are available to homeowners and tenants and are arranged by local authority housing departments, but local authority tenants are not eligible for DFGs. Local authorities use funds from the Housing Revenue Account for adaptations to their own properties (Wilson and Fears, 2016). DFGs of up to £30,000 are available per application in England, £36,000 in Wales, depending on a means test, while minor adaptations, costing less than £1,000, are available without charge. Apart from adaptations to counter problems with mobility, many older people find maintaining their house and garden increasingly burdensome, and handyperson services are also available to assist with maintenance problems (Croucher *et al.*, 2012).

As noted above, only 7% of homes in England had four visitability features in 2014, accounting for 1.7 million homes. Of the remaining 21.7 million homes, 72% could be adapted to provide the four features, while 28% could not (Department for Communities and Local Government, 2016a). However, the potential for improving visitability depended on the age and the type of the home. Only 6% of homes built before 1919 could be made fully visitable with minor works and it would not have been feasible to make 55% fully visitable. Among homes built since 1990, 24% could be made fully visitable with minor works. However, 25% could not be made fully visitable, partly because homes built since 1990 include a relatively high proportion of flats, and it is often impracticable to redesign flats that are not already fully visitable. Terraced houses were also much more difficult to adapt than other types of houses. It was not feasible to make 50% of terraced houses fully visitable, compared with 15% of semi-detached and 14% of detached houses. Owner-occupied homes were the most easy to make fully visitable, partly because these were more likely to be detached houses, but 25% could not be adapted to make them fully visitable. Homes in the social rented sector were more easy to adapt than private rented homes, reflecting the age and type of houses in the private rented sector. One third of homes in the private rented sector had been built before 1919, and 36% were terraced houses.

There was little variation in the proportion of households with all four visitability features by the age of the oldest member of the household, and households where the oldest person was aged 65 or over were less likely to have no visitability features than younger households. Older households were also less likely to live in homes that could not be made fully visitable.

A further method of adapting homes to create smaller properties, and thus enable downsizing without having to move, is to subdivide existing buildings (Kingman, 2016). Kingman's calculations are based on dividing properties into smaller units according to the National Space Standards (Department for Communities and Local Government, 2015b), and then estimating the number of properties that could be divided from 2011 Population Census figures on the number of owner-occupied houses with three or more beds which were occupied by individuals or couples without children. Although the calculations assume that only a small proportion of owners (2.5%) might undertake such work, they do not appear to take account of the distribution of floor areas, that is, that only a proportion of such houses could, in theory, be converted. Kingman recognises that there would be practical constraints that meant that designing more than one dwelling within an existing building envelope might not be feasible, but does not discuss visitability. As noted above, the English Housing Survey shows that recently-built semi-detached and detached houses are most easily adapted for visitability, but the estimates of potential adaptability are only for adaptations of the existing property, not for subdividing it into additional properties.

Falling is a frequent event among older people and can have serious consequences. Each year, 35% of those aged 65 and over experience one or more falls; around 45% of people aged over 80 who live in the community fall each year, and between 10 and 25% sustain a serious injury (Department of Health, 2009). Hip fractures are the most frequent fragility fractures caused by falls and the commonest case of accident-related death. Fewer than half of older people with a hip fracture return to their usual place of residence, and for some it precipitates entry into a care home. In addition to the effects on individuals, falls create substantial costs for the health and social care services.

The review of evidence conducted by researchers at the University of the West of England for the Centre for Ageing Better about the role of home adaptations in improving later life indicated that most of the best work had been conducted in New Zealand and North America, where health and insurance records enabled researchers to link housing interventions to health outcomes (Powell *et al.*, 2017). The review found that there was strong evidence that minor home adaptations were an effective and cost-effective means of preventing falls and injuries, improving performance of everyday activities and improving mental health, and were particularly effective in improving

outcomes and reducing risk when combined with other home improvements, such as improving lighting and removing trip and fall hazards. The evidence also indicated that the greatest outcomes were achieved when individuals, families and carers were closely involved in the decision-making process, focusing on individual goals and what a person wants to achieve in their home. Although there was less evidence about the impact of major adaptations, there was evidence that major adaptations could help to support people in achieving outcomes in some circumstances. Evidence on the overall return on investment (ROI) from home adaptations was not available, except in relation to the prevention of falls on stairs, and here the calculation of the costs and benefits of preventive work showed a positive ROI of 62p per £1, and a payback period of less than eight months. However, the review also found that delays in installing adaptations could reduce their effectiveness, and that people could be put off installing adaptations until they reached a point of crisis, partly to avoid changing or 'medicalising' their home. In addition, the review identified differences between policy and practice in different types of housing tenure, and that very little research had been conducted into changes made without statutory help.

Curtis and Beecham (2018) examined the costs of major and minor home adaptations and suggest that the DFG cost thresholds may need to be re-examined. Although the lowest contract prices for major adaptations fell below the DFG cost threshold of £30,000, the mean and higher contract prices exceeded the threshold. The mean cost of most minor adaptations fell below the £1,000 threshold, but the cost of fitting a shower over a bath exceeded the threshold. The study also found that staff time made a substantial contribution to the overall cost. The independent review by Mackintosh *et al.* (2018) came to a similar conclusion. They noted that the upper limit of £30,000 had not increased since 2008 and had not kept pace with inflation. In addition, building costs varied by region, particularly for larger extensions, for which the average cost in London was £55,000 in 2016/17. They recommended that the maximum amount of the DFG should be increased in line with inflation, with a regional weighting based on building costs and an amount for professional fees (Mackintosh *et al.*, 2018).

Most DFGs are used to install level-access showers, and to provide stairlifts and ramps (Mackintosh *et al.*, 2018). The majority of allocations are made to older people and, since the majority of older people are homeowners, most DFGs are made to homeowners. However, a disproportionate number of grants are made to tenants in social rented properties, while tenants in the private rented sector receive a small proportion of grants, despite living in the poorest quality accommodation (Mackintosh *et al.*, 2018). Mackintosh *et al.* note that tenants in social rented properties have a clear route through the system, with landlords assisting in the process, whereas

private tenants are disadvantaged by a lack of information about the availability of grants, a reluctance by some landlords to agree to changes to the property and the relatively short-term nature of private sector tenancies. A lack of information about how to obtain help with adaptations was also found to be a particular concern among people living in ethnic minority communities (Croucher, 2008). From their study, Mackintosh *et al.* report that two-thirds of grants were taken forward and that homeowners were more likely to drop out than tenants, although there were regional differences. Relatively little information was available about the reasons for not proceeding, but about one-quarter dropped out because they were required to contribute to the cost, which explained why homeowners were more likely to drop out. However, there was no means of knowing whether people who withdrew from the grant process undertook adaptations independently.

A4. Relocation

For people who find that their home is no longer manageable and cannot be adapted to suit their requirements, moving to alternative accommodation may be a more appropriate solution. This may take the form of a privately-arranged move to a more convenient, usually smaller home, or a move to more specialised housing or a care home. Such moves are often described as 'downsizing'. However, although the national housing strategy published in 2008, *Lifetime Homes, Lifetime Neighbourhoods*, provided a coherent framework for local authorities to plan, commission and develop housing for older people, in practice it resulted in a focus on specialist housing and housing related care and support services, rather than on mainstream housing (All Party Parliamentary Group on Housing and Care for Older People, 2011).

Encouraging older people to downsize to a smaller property has been seen as a means of freeing-up family housing for younger people (Appleton, 2002; Homes and Communities Agency, 2009). As noted above, older households are much more likely to be classified as under-occupying than younger households, and this has been seen as an issue of inter-generational equity, with older generations being criticised for hoarding living space and over-consuming housing by under-occupying larger properties (Griffith, 2011). However, Pannell *et al.* (2012) report that the discussion of downsizing and under-occupation, especially from the government, was seen by older people as upsetting, annoying and distressing, and reflected a lack of concern or understanding of wellbeing and quality of life issues from an older person's perspective.

Furthermore, new housing in the UK is the smallest in Western Europe, even when compared with countries with similar population densities, and there has been an emphasis on the number of bedrooms rather than the overall floor area (RIBA, 2011). Although it may be more appropriate to

measure space needs in terms of floor area rather than the number of bedrooms (RIBA, 2011; Kneale *et al.*, 2013), the number of bedrooms has a major influence. In the house purchase market, the number of bedrooms is central to valuations, and influences consumer behaviour (RIBA, 2011), while for the social rented sector the government introduced financial penalties in 2013 for people aged under 65 deemed to be living in properties with spare bedrooms by reducing the level of Housing Benefit payable (Department for Work and Pensions, 2012).

Much of the focus of the report by Griffith was on people aged 65 and over. Kneale *et al.* (2013) note that the 55–64 age group had escaped the attention of discussions on downsizing and argue that the issue of under-occupation should not be confined to those aged 65. Griffith noted that the 55–64 age group had the highest rate of homeownership, but as baby boomers moved into retirement, owner-occupiers would increasingly dominate retirement (Griffith, 2011). The English Housing Survey figures for 2014–15 demonstrate the changing proportions of owner-occupiers by age. Nonetheless, for 2014–15 the proportion of owner-occupied households in which the oldest person was aged 55–64 was only slightly smaller than the corresponding proportions for the 65–74 and the 75–84 age groups, 76% compared with 77% (Department for Communities and Local Government, 2016b, Annex Table 1.2).

The activities of older people can require at least as much space as those of younger people (Appleton, 2002; Kneale *et al.*, 2013), and older people who move may move to a similar, if not a larger-sized home (NHBC Foundation, 2017; Resolution Foundation, 2018). As noted above, in the 2014–15 English Housing Survey 5% of older people reported that they moved to live in a larger property, compared with 17% of younger people, although 15% moved to a smaller property, while 27% moved for family or personal reasons and 12% moved to live in a better neighbourhood (Department for Communities and Local Government, 2016b). Older people tend to spend more time at home than younger people (Adams, 2009; Croucher, 2008; Levitt Bernstein, 2011), and require room for hobbies, storage of accumulated possessions and accommodation for guests, including adults and grandchildren (Appleton, 2002; Croucher, 2008; Pannell *et al.*, 2012; Kneale *et al.*, 2013; Torrington, 2014). A common criticism of new housing is that there is not enough storage space (RIBA, 2011). For older people in particular, storage for a lifetime's collection of possessions and for mobility and other care aids, and in some cases a need to make modifications to suit their care and support needs, means that moving should be to enable 'rightsizing', rather than downsizing simply based on the number of bedrooms (Beach, 2016). In addition, some couples may need to sleep separately for health reasons or overnight accommodation may be needed for a carer,

bathrooms and toilets may need to be large enough for a carer to provide assistance, and additional space may be needed to store medical or mobility equipment (Appleton, 2002; Torrington, 2014).

Kneale *et al.* (2013) also note that the housing crisis has led to an increase in the number of adult children returning to their parents' home. This, together with the postponement of parenthood and the need to provide accommodation for elderly parents and relatives, means that criticisms of people in the baby boomer generation for 'hoarding housing' do not acknowledge the complexities of inter-generational relationships. Although only a small proportion of older people live in true multigenerational households, that is, households of three generations, there has been a small net increase of such households, and larger increases in the proportion of households where older people lived with one or more generations (Kneale *et al.*, 2013).

The majority of people report that they are satisfied with their home, both among the general adult population (Ipsos MORI Social Research Institute, 2016) and the older population (Clough *et al.*, 2004), but many would like to make changes to the internal or external layout (Ipsos MORI Social Research Institute, 2016). Although 80% of the public did not identify the need for the installation of any accessible housing features in the following five years, 46% of disabled people and 59% of disabled people aged 65 or over did so (Ipsos MORI Social Research Institute, 2016). As noted above, satisfaction with accommodation increased with the number of spare bedrooms across the age range.

However, there has been a shortage of family houses, and mainstream housebuilders have focused on housing for younger people (House of Lords, 2013), although some are becoming more interested in developing for older people since they have more equity (Pannell *et al.*, 2012). Although downsizing by older people from larger family houses could enable growing families to move up the housing ladder and thus help those at the bottom of the ladder to enter the housing market, the market would become unbalanced without the development of more family houses (Wood and Vibert, 2017). Furthermore, the majority of larger family houses that become available to younger households do so as a result of mortality, rather than downsizing (Pannell *et al.*, 2012), and encouraging people in their 50s and 60s to downsize would have more impact on the availability of larger properties. Older people who do move tend to downsize, but this means that there are fewer smaller properties available to younger people. In order to investigate the implications of downsizing, Pannell *et al.* show that, in aggregate terms, there are sufficient one- and two-bedroomed properties occupied by younger households to accommodate older under-occupying households. However, only around half of older owner-occupiers, accounting for 2 million households, could move into a smaller owner-occupied property, while the remainder would have to

change tenure. In addition to changes in tenure, such reductions in under-occupancy would also entail significant changes in location and in the type of accommodation occupied.

Although downsizing, or rightsizing, can enable older people to move to a more convenient home, there are several factors that may deter people from moving, and recognising these would help to identify how to support people to move (Beach, 2016). As noted above, the supply of suitable housing can be a major disincentive, as can the cost. Wood (2013) reports that, of the 43% people aged over 60 who stated that it would be difficult to move, 45% stated that moving would be too expensive and 26% stated that there were no suitable properties available. Downsizing may help to reduce running costs and, for owner-occupiers, it can release capital, providing that the costs of moving are less than the difference between the selling and the buying price (Pannell *et al.*, 2012). However, the amount of capital released will depend upon the size of the properties bought and sold and their locations. Pannell *et al.* note that large capital gains can be achieved in London, as well as in the southern part of England and the North West, but elsewhere moves within regions would not release more than £50,000. A study of homeowners aged over 55 who moved between 2010 and 2016 found that 24% of moves involved only a modest amount of equity release or additional investment, up to £25,000, although 12% resulted in equity release of over £200,000 (NHBC Foundation, 2017). However, people may not recognise the benefit, financial or otherwise, of downsizing (Beach, 2016). For example, freeing up capital means that it has to be invested to maintain its value or earn interest (Pannell *et al.*, 2012).

In addition to the issues of the cost of moving and the supply of alternative accommodation, the emotional attachment to the existing home and possessions can be a substantial deterrent to moving (Beach, 2016). Apart from the emotional connections, the practicalities of disposing of possessions can be demanding, as can the process of engaging with the housing market. Wood (2013) reports that 50% of those who stated that it would be difficult to move indicated that the process of packing up belongings would be too stressful and 29% indicated that they would find the process physically difficult. Downsizing might also be seen as a process of downgrading to poorer quality housing, while having sufficient space to accommodate guests and provide hospitality are important to many people (Beach, 2016), as noted above. Furthermore, a strong attachment to the local neighbourhood, enabling a feeling of community-belonging and contacts with neighbours, can offer a sense of security to people as they grow older (Croucher, 2008; All Party Parliamentary Group on Housing and Care for Older People, 2016). As noted above, among older households that moved, the majority moved less than ten miles. However, older people often abandon attempts to move

since they cannot find suitable or attractive housing available locally, or the cost is prohibitive (All Party Parliamentary Group on Housing and Care for Older People, 2016).

Nonetheless, many households do consider moving (Wood, 2013; Beach, 2016). Wood reports that 58% of people aged over 60 were interested in moving, 33% wanted to downsize, and 25% would be interested in buying a retirement property. Similarly, Beach found that 33% of homeowners aged 55 and over were considering downsizing or expected to consider it in the future, and 16% had already done so. The most frequent reason given for downsizing or for considering it was to reduce home maintenance, reported by 56% of respondents (Beach, 2016). A reduction in garden maintenance is also an important factor in considering whether to move, but access to a garden or outside space is still important for many older people, provided it can be easily maintained (Beach, 2016).

However, compared with the studies by Wood (2013) and Beach (2016), the study of people aged 50 and over for the Centre for Ageing Better reported much lower levels of interest in moving. In this study, 72% of the respondents stated that they did not intend to move in the future (Ipsos MORI, 2015b). There can be a reluctance to plan for future needs for care or assistance or for home modifications (Croucher, 2008; Ipsos MORI, 2015a; Renaut *et al.*, 2015; Beach, 2016). A large proportion of people not considering a move view their current home as suited to their needs, but their property may become less suitable as they get older (Wood, 2013; Beach, 2016), and people need support to plan ahead before developing significant care and support needs (Commission on Funding of Care and Support, 2011; Beach, 2016).

The NHBC Foundation study surveyed homeowners who moved into new-build homes, and, similarly to the group studied by Beach, moving to a home that was easier to manage or that was in a better state of repair were the most important reasons for moving (NHBC Foundation, 2017). As noted above, modern building regulations mean that recently-built homes are more likely to have the accessibility features necessary for visitability by most people, including wheelchair users (Department for Communities and Local Government, 2016a). However, even new housing is not necessarily age-friendly, and there has been little attempt to meet the breadth of expectations and aspirations of older people for later life (DWELL, 2016). Individual examples of specialised design for ageing do exist, for example Hawkes with Porteus (2015), but these are outside the mainstream. Building on the design principles recommended in the HAPPI report (Homes and Communities Agency, 2009), the DWELL research project aimed to take a new approach to the design of age-friendly housing by working with professional stakeholders, communities and residents to explore third-agers' housing aspirations and to use this to develop a series of typologies for mainstream, general-needs housing (DWELL, 2016). An alternative approach is for older people to work together

to build their own cohousing community. Such developments are more common in other countries, but a few have been created in the UK, for example the Older Women's Cohousing Community (OWCH) in North London (Brenton, 2017).

A5. Specialised housing

Specialised housing began in the UK in the Middle Ages with almshouses (Tinker, 1997), and a number of retirement communities were developed in the late 19th and early 20th centuries (Hearnden, 1983). The majority of specialised housing is rented, although private, for-profit providers have developed leasehold retirement housing, as well as larger retirement villages. Most specialised housing is sheltered housing, developed from the 1950s onwards, primarily to meet housing rather than care needs. Part of the rationale for developing sheltered housing was to release other housing for younger families (Ministry of Local Government and Planning, 1951), in the same way that older people have been encouraged to downsize to release family housing for younger buyers.

Sheltered housing developed in parallel with residential care and with similar levels of provision (Oldman, 2000). However, sheltered housing was managed by housing departments and developed relatively independently. Although sheltered housing represented a relatively generous form of housing provision ('So Much for So Few', Middleton, 1987), it became less attractive over time and increasingly difficult to let (Tinker *et al.*, 1995). Furthermore, the long-standing aim of government policy to enable people to live independently in their own homes contributed to a decline in support for sheltered housing and a steep reduction in the number of new developments in the 1990s (Tinker *et al.*, 1999; Oldman, 2000). However, it remains the main form of provision of specialised housing. Some sheltered housing has been remodelled to adapt to changing care needs, while onsite warden cover has been removed from mainstream sheltered housing for financial reasons (LaingBuisson, 2016).

The English Housing Survey includes older households, that is, those with a person aged 55 or over, living in sheltered housing. Despite the problems with some sheltered housing being difficult to let, the condition of sheltered housing is generally better than other housing, reflecting the fact that it tends to be newer. In 2014, households in sheltered housing were less likely than other households to live in a non-decent home, the average level of disrepair was lower, and levels of energy efficiency were higher (Department for Communities and Local Government, 2016b).

Townsend (1962) viewed sheltered housing as a better alternative to residential care for many residents of care homes and, later, Booth (1985) queried whether all residents required the degree of care provided, and argued that sheltered housing would be more appropriate. However, from the late 1970s, increasing dissatisfaction with residential care led to various innovations based on the enhancement of sheltered housing by incorporating care and support, and by the 1980s a form of sheltered housing with additional care was being promoted as an alternative to residential care (Reed *et al.*, 1980). Such developments were termed 'very sheltered housing' and offered self-contained apartments ('Your Own Front Door'), together with communal facilities and care and support, as required.

Increasingly, this form of housing with care has been seen as a means of providing flexible care and support within a housing setting, and has been supported by the government through the provision of capital funding. A wide range of types of housing with care have been developed, mainly by not-for-profit housing associations, although private providers have also introduced care services in some retirement housing. A variety of terms have been used for specialist housing, including very sheltered housing, but private providers prefer terms such as assisted living. Housing with care schemes managed by housing associations are usually termed extra care housing, and this term has been adopted by government and other bodies, particularly in the social care sector (LaingBuisson, 2016). Housing associations and private companies have also developed larger care villages. Smaller extra care schemes may offer social/affordable rent or a mix of rent and leasehold options, while care villages usually offer a mix of tenure arrangements, including social/affordable rent, market rent and leasehold tenure arrangements. By providing tenure on a housing model, housing with care offers an alternative to residential care with security of tenure. In addition, leasehold tenure arrangements enable owner-occupiers to protect their housing equity, unlike in a care home where, at present, their capital would normally be used to pay the fees of the home until it had diminished to the point when they became eligible for some public funding. In practice, however, the opportunity for owner-occupiers to protect their housing equity in this way is limited since the majority of specialised housing, including housing with care, is rented. As noted above, 76% of older households were owner occupied in 2014–15. In contrast, in 2016, 68% of housing with care and 74% of housing with support, approximately equivalent to sheltered housing, was rented (LaingBuisson, 2016). Furthermore, some of the most popular retirement areas have relatively low levels of provision, both of housing with care and housing with support (LaingBuisson, 2016).

Although there is no agreed definition of extra care housing, it can be recognised by a number of characteristics (LaingBuisson, 2016), in particular: living accommodation provided in self-contained

housing units; the availability of 24 hour care; and access to communal facilities and services. Retirement villages offer a wider range of social and leisure activities and more accommodation for purchase than smaller schemes, and are often designed to appeal to individuals seeking to downsize for a 'lifestyle' change. However, they do offer care and support where required, and some are specifically designed as extra care villages.

The provision of communal facilities is a key element of extra care housing. However, these can account for up to 40% of the floor area of the premises (All Party Parliamentary Group on Housing and Care for Older People, 2012; LaingBuisson, 2016), and paying the service charges required can be beyond the means of residents with modest incomes and local authority funders. Following the economic downturn after 2009, the All Party Parliamentary Group on Housing and Care for Older People (2012) recommended that any reductions in facilities in new developments should be in communal areas. It argued that there should be no reduction in the quality of individual apartments, since these would need to remain sufficiently attractive to appeal to older people considering downsizing from a family home. The report did recognise that larger developments could support a greater range of facilities, but that more schemes would have to make use of neighbouring amenities and reduce the communal space, along the lines seen in some other European provision, where living and communal facilities are often provided in separate buildings (Homes and Communities Agency, 2009). The report did indicate that an area for social interaction, including kitchen facilities, would still need to be provided. However, changes to the facilities offered may make schemes less suitable for more dependent residents, for example where no communal dining facilities are provided, and also less attractive to future residents. Callaghan *et al.* (2009) report that many residents and staff felt that restaurants were important in helping residents to develop friendships, and that lunchtime could be the main time for residents to meet other people.

In 2002, plans were announced for an expansion in extra care provision (Department of Health, 2002), and subsequently the Extra Care Housing Fund was created to develop innovative housing with care arrangements (Department of Health, undated). Further guidance was published in 2003 (Office of the Deputy Prime Minister, 2003b), and in 2003 the UK government announced the provision of additional capital funding, via the Extra Care Housing Fund, to stimulate the development of innovative types of housing with care (Department of Health, 2003). From a policy perspective, extra care housing has often been contrasted with residential care homes (Cm 6499, 2005; Care Services Improvement Partnership, 2006; LaingBuisson, 2016) and has become viewed by some commissioners as a more enabling and homely alternative (Fletcher *et al.*, 1999).

Increasingly, extra care housing has been seen as a means by which local authorities can help to support people outside residential care and promote the personalisation agenda and maximise people's independence (Cm 6499, 2005; HM Government, 2007; Department of Health, 2014) while reducing costs (Kent County Council, 2016; Bristol City Council, 2018).

However, care homes will still be needed for residents requiring high levels of nursing care or continuous monitoring and so extra care housing should be seen as a possible alternative to care homes providing personal care ('residential homes') rather than those providing nursing care (LaingBuisson, 2016). Furthermore, although the provision of extra care housing has steadily increased, there is still much less extra care housing than care home provision, and much less than in more mature retirement housing markets such as the USA and Australia (Local Government Association, 2017). Figures compiled by the Elderly Accommodation Counsel for the inquiry by the House of Commons Communities and Local Government Committee (House of Commons, 2018) record 74,677 housing with care and 523,207 housing with support apartments in the UK in 2017 (Housing Learning & Improvement Network, 2017). In comparison, there were 454,858 care home beds in the UK in December 2016 (Competition and Markets Authority, 2017).

The national housing strategy published in 2008, *Lifetime Homes, Lifetime Neighbourhoods*, indicated that a strategic approach was needed to meet future housing pressures arising from population ageing. In particular, the number of people aged 85 or over was projected to increase by 184% by 2036 and the number of people aged 65 or over with dementia was projected to increase by 154% by 2051.

In order to support local strategic planning and development of accommodation with care, the Department of Health and the Department for Communities and Local Government published a toolkit to accompany the national strategy (Care Services Improvement Partnership, 2008). The approach developed in the toolkit recognised that new forms of housing, such as extra care housing and housing-based accommodation for people with dementia, would need to be balanced by phasing out some older accommodation and models of care. In addition, the introduction of greater choice for owner-occupiers, in line with the recognition in the national strategy that the focus on renting in specialised housing did not meet older people's expectations, would mean a reduction in the proportion of accommodation available to rent. The toolkit anticipated that there would be a reduction in rented sheltered housing and in traditional residential care in both the public and private sectors. However, additional investment in care homes is also needed, particularly to support increasing numbers of people with nursing and dementia care needs (Competition and Markets Authority, 2017). Drawing on the toolkit, the Elderly Accommodation Counsel and the Housing

Learning & Improvement Network have developed an online housing forecasting tool, the *Strategic Housing for Older People Analysis Tool* (SHOP@). Using this tool produced a forecast total shortfall of nearly 600,000 units of accommodation by 2035 (Housing Learning & Improvement Network, 2017). This included 157,860 units of accommodation of housing with care, 230,580 units of sheltered housing and 202,500 care home beds. Owner-occupier leasehold properties accounted for just under half (46%) of the projected shortfall of housing with care, but for almost all of the projected shortfall of sheltered housing.

A number of studies have compared the characteristics of older people living in extra care housing with those of care home residents (Netten *et al.*, 2011; Darton *et al.*, 2012), or with those of people living in mainstream housing in the community (Kingston *et al.*, 2001; Bernard *et al.*, 2007; Holland *et al.*, 2015, 2017), or with both (Callaghan and Towers, 2014; Phillips *et al.*, 2015). Comparisons between the people living in different settings depend on the sampling procedures employed. However, the evaluation of 19 of the extra care schemes supported by the Extra Care Housing Fund (Netten *et al.*, 2011) found that, overall, people who moved into extra care were substantially less physically and cognitively impaired than those who moved into care homes, although several schemes had a significant minority of residents with high levels of physical dependency. A number of the schemes were intended to make specific provision for people with dementia, but levels of severe cognitive impairment were very low compared with care homes (Darton *et al.*, 2012). In the ASSET study, conducted in 2012–2014, residents in extra care housing were, on average, less dependent, both physically and cognitively, than those living in care homes, although a minority of residents had similar levels of dependency to those in care homes (NIHR School for Social Care Research, undated). However, in the subsequent ECHO study, conducted in 2015–2017, there was some reported increase in the care needs of residents moving into extra care housing, in line with a change in the eligibility criteria used in the nomination of residents supported by one of the participating local authorities (NIHR School for Social Care Research, 2018).

In 1961, the concept of a 'balanced population' of tenants of sheltered housing was advocated (Ministry of Housing and Local Government and Ministry of Health, 1961). This was seen as necessary for tenants to provide mutual support and to reduce demands on the warden (Butler *et al.*, 1983). The development of extra care housing has reactivated the issue of a balanced community (Robson *et al.*, 1997). Extra care providers often aim for a balance of care needs among residents, such as one-third with high, one-third with medium and one-third with low needs (Wright *et al.*, 2010), although there are differences in the interpretation of these categories (Murphy and Miller, 2008), and resident profiles vary considerably (Croucher *et al.*, 2007). Furthermore, changes in care needs resulting from

increases in eligibility criteria place a strain on this, particularly in maintaining relationships between residents with lower and higher levels of need (Callaghan *et al.*, 2009).

In the case of people living with dementia, extra care housing schemes are usually able to accept people in the early stages of the disease and support people who develop dementia while they are residents (Fletcher *et al.*, 1999; Department of Health, 2003; Vallelly *et al.*, 2006). However, evidence from collective settings suggests that integration is unpopular with residents living without dementia (O'Malley and Croucher, 2005) and, where the lives of other residents appear to be affected by the behaviour of residents with dementia, a move to a care home may be encouraged (Oldman, 2000). Recent research has examined the role of specialist and generic extra care housing in supporting people living with dementia. It may be easier to provide more dementia-friendly design in specialist schemes, but this would appear to be at the cost of promoting independence. In addition, as suggested by O'Malley and Croucher, residents living with dementia in generic extra care housing schemes may be at risk of social exclusion due to the attitudes of other residents (Evans *et al.*, 2018). Catering for a range of needs among residents highlights the importance of ensuring that the aims and philosophy of the scheme are made clear to prospective residents through accurate promotional material.

Drawing on the data collected in the evaluation of extra care schemes supported by the Extra Care Housing Fund and surveys of care homes, a subset of matched individuals living in extra care housing and care homes was created using propensity score matching. This showed that the accommodation, living and social care costs associated with living in extra care housing were slightly lower than those for care homes (Bäumker *et al.*, 2011; Netten *et al.*, 2011). Using a similar matching procedure to compare the outcomes of social care for people living in extra care housing with their counterparts living in mainstream housing in the wider community, social care outcomes for residents living in extra care housing were significantly higher than for people living in the community with similar levels of care need. However, there was no difference in expected outcomes, that is, in the absence of services (Darton *et al.*, in preparation).

In a longitudinal study of almost 4,000 residents in extra care housing, Kneale (2011) found that about one quarter experienced a reduction in care needs. Compared with a matched group of people living in the community, there were fewer admissions to hospital and fewer falls, and residents in extra care were also less likely to move to institutional, mainly residential or nursing home care. In the light of these findings, Kneale suggested that moving into extra care housing could achieve cost savings by reducing the rate of transition into institutional accommodation and reduce

the costs associated with falls and hospitalisation, with consequent benefits to the quality of life of older people.

Extra care housing schemes are often in a position to make their facilities available to the wider community, in line with government policy for improving and strengthening support within communities (Cm 8378, 2012). Extra care schemes are usually designed in accordance with the principles of progressive privacy (Fletcher *et al.*, 1999; Torrington, 2004), so that there is a physical barrier between the areas used by the public and areas used solely by residents and staff. Although there can be tensions between residents and visitors to a scheme (Callaghan *et al.*, 2009), sharing facilities can increase cost-effectiveness, provide activities for local residents and thus reduce social isolation and encourage preventative approaches to health and wellbeing (Evans *et al.*, 2017). Also, providing activities to local residents advertises a scheme to potential new residents (LaingBuisson, 2016). However, for schemes to act as successful community hubs they need to be located in residential areas and have facilities that are accessible to the public (Evans *et al.*, 2017). Thus, although retirement villages usually have a wider range of facilities than smaller extra care schemes, their location can make them less suitable for providing their facilities to the wider community than more centrally-located, smaller schemes.

As noted above, following the 2009 economic downturn, the All Party Parliamentary Group on Housing and Care for Older People (2012) indicated that more schemes would have to make use of neighbouring amenities and reduce the provision of communal space, while maintaining the quality of individual apartments. However, in order to cater for increasing levels of frailty among residents, particularly where they are living with dementia, buildings need to be designed with facilities located closely together (Evans *et al.*, 2017, 2018). Thus, the provision of comprehensive facilities is necessary both for supporting increasingly frail residents and to offer services to the wider community.

It is important that the aims and philosophy of the scheme, and what to expect on moving in, are made clear to prospective residents, for example through accurate promotional material. This is particularly important if the scheme caters for a range of needs among residents, or provides facilities to the wider community (Croucher *et al.*, 2006; Callaghan *et al.*, 2009).

A6. Summary

It has been a long-standing government policy to help older people live in their own homes wherever possible. However, little attention was given to the role of housing in supporting health

and wellbeing until the 1990 National Health Service and Community Care Act. Although over 90% of older people live in mainstream housing, as opposed to specialist housing or other communal establishments, much of the focus on mainstream housing has been on housing for families with children. The national housing strategy published in 2008 was intended to provide a framework for housing for older people, but it resulted in a focus on specialist housing and housing related care and support services, rather than mainstream housing. Downsizing to smaller accommodation, either within the mainstream housing sector or to specialist forms of housing, has been promoted as a means of freeing-up family housing for younger people. However, the slow rate of housing replacement and a focus on building new homes for families means that the supply of suitable new accommodation is limited. In the mainstream sector, older people wishing to move to a smaller property may be in competition with younger people seeking to move into similar housing.

The majority of households live in owner-occupied properties, particularly among the older population. Three-quarters of households containing someone aged 55 or over lived in an owner-occupied property in 2014–15, and, partly due to the ageing population, outright ownership is increasing. However, there has been a growth in private renting among younger age groups and in the 55–64 and 65–74 age groups, and the private rented sector has expanded at the expense of the social rented sector, overtaking it in 2011–12.

In 1996, houses occupied by older and younger households were similar, in terms of floor area, but houses occupied by older households have become relatively larger over the last 20 years. Older households are also much more likely to be classified as under-occupying, in terms of the number of spare bedrooms, than younger households. In 2014–15, older households were much more likely to express satisfaction with their accommodation, but increases in satisfaction were associated with the number of spare bedrooms across the age groups. The majority of people report that they are satisfied with their home, both among the general adult population and the older population. Nonetheless, many older households do consider moving, often in order to downsize to a smaller property. However, several factors may deter people from moving, including both practical and emotional considerations. Older people tend to spend more time at home than younger people, and require space for home-based activities, the storage of possessions and accommodation for visitors. Commentators often refer to the need to support ‘rightsizing’, rather than downsizing defined simply in terms of reducing the number of bedrooms.

The physical standard of housing has improved significantly over the last 50 years, with very few dwellings now lacking basic amenities or being deemed unfit for human habitation. However, in 2016 20% of dwellings still failed to meet the Decent Homes Standard, including 12% that failed to

meet the standard due to hazards representing significant risk to the household. Private rented houses were most likely and social rented houses were least likely to be rated as non-decent. The oldest households, with people aged 85 or over, were more likely to live in non-decent homes, and the increase in the number of such households has meant that the total number living in non-decent housing had not fallen. The oldest households also experienced some of the highest levels of housing disrepair, and were most likely to live in the least energy efficient homes.

Although the physical standard of mainstream housing has improved, much is poorly designed for somebody with a disability. Only 7% of homes in England had four visitability features in 2014, whereas 31% of all households in 2014–15 had at least one person with a long-term illness or disability, rising to 42% of households containing somebody aged 55 or over. Recently-built houses are more likely to be more accessible than older houses, but the majority do not have the four visitability features. An analysis of the potential to adapt homes to provide the four visitability features indicated that 72% of homes could be adapted, but the potential for improving visitability depended on the age and the type of the home. Older properties and terraced houses were more difficult to adapt. These types of properties form a substantial part of the private rented sector, and homes in the private rented sector were more difficult to adapt than those in the social rented sector.

There is good evidence for the cost-effectiveness of minor home adaptations, but less definitive evidence about the impact of larger scale adaptations. However, an approach involving combining a number of home improvements, and undertaken in collaboration with individuals, their families and carers appears to be beneficial, whereas delays in installing adaptations can reduce their effectiveness. There can be a reluctance to plan for future needs for care or assistance or for home modifications. However, the home may become less suitable as the person gets older, and people need support to plan ahead before developing significant care and support needs.

Means-tested grants (Disabled Facilities Grants, or DFGs) are available to help people remain in their own homes while managing increasing frailty, and grants for minor adaptations are not means tested. DFGs are available to homeowners and tenants, except for local authority tenants. Since most older people are homeowners, the majority of DFGs are allocated to homeowners, but homeowners are more likely not to proceed with an application, partly because of the means-tested requirement to contribute to the cost. However, tenants in the social rented sector receive a disproportionate number of grants, while private sector tenants, who occupy the poorest quality housing, receive relatively few grants. Although a number of studies have collected general

information about the housing preferences of older people, including their reasons for moving or not moving, only a few specialised studies have examined housing preferences in detail, and little is known about adaptations made independently of statutory help.

Specialised housing includes a range of types of housing provision, but the majority is sheltered housing, which was originally developed primarily to meet housing rather than care needs. However, increasing dissatisfaction with residential care in the 1970s led to the development of enhanced forms of sheltered housing incorporating care and support, and this became known as very sheltered housing. A variety of forms of specialised housing has been developed, mainly by not-for-profit housing associations, but private providers have introduced care services into some of their retirement housing. Housing with care schemes managed by housing associations are now usually termed extra care housing, while private providers prefer terms such as assisted living.

Extra care housing can take a variety of forms, but the principal features include self-contained living accommodation, the availability of 24-hour care, and access to communal facilities and services. Larger retirement villages offer a wider range of social and leisure activities and more accommodation for purchase, and are often designed to appeal to individuals seeking to downsize. However, retirement villages offer care and support where required, and some are specifically designed as extra care villages.

Increasingly, extra care housing has been seen as a means by which local authorities can help to support people outside residential care, including supporting people living with dementia, while reducing costs. Comparisons with outcomes for residents living in residential care or in mainstream housing in the community indicate that extra care housing can provide significant advantages, in terms of improved social care outcomes and a reduction in care needs, with associated cost savings and benefits to quality of life. However, although the provision of extra care housing has steadily increased, there is much less extra care housing than care home provision. Use of the *Strategic Housing for Older People Analysis Tool* produced a forecast shortfall of nearly 600,000 units of accommodation by 2035, including nearly 160,000 units of accommodation of housing with care, more than twice the 2017 level of provision. In addition, the majority of extra care housing is offered for rent, and leasehold properties designed to appeal to homeowners accounted for almost half of the projected shortfall.

Extra care providers often aim for a balance of care needs among residents, such as one-third with high, one-third with medium and one-third with low needs. However, changes in care needs resulting from increases in eligibility criteria place a strain on this, particularly in maintaining

relationships between residents with lower and higher levels of need. In the case of people living with dementia, extra care housing schemes seem to be able to accept people in the early stages of the disease and support people who develop dementia while they are residents. Recent research indicates that it may be easier to provide more dementia-friendly design in specialist schemes, but this would appear to be at the cost of promoting independence. Catering for a range of needs among residents highlights the importance of ensuring that the aims and philosophy of the scheme are made clear to prospective residents.

The provision of communal facilities is a key element of extra care housing. Concerns about the cost of providing communal facilities led to recommendations in 2012 that any reductions in facilities in new developments should be in communal areas rather than in the quality of individual apartments. However, changes to the facilities offered may make schemes less suitable for more dependent residents, for example where no communal dining facilities are provided, as well as being less attractive to future residents. In addition, and depending on their location, extra care housing schemes may be in a position to make their facilities available to the wider community. Despite larger retirement villages having more facilities, they may be located away from centres of population, and more centrally-located, smaller schemes are likely to be in a better position to act as community hubs. Although there can be tensions between residents and visitors to a scheme, sharing facilities can increase cost-effectiveness, provide activities for local residents and thus reduce social isolation and encourage preventative approaches to health and wellbeing.

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