Current provision and emerging trends for housing and care for older people in the United Kingdom

An overview by PRP

August 2010
Specialist Housing Awards

Evening Standard Awards 2010  Winner - Best New Development in the Retirement Living Sector: St George’s Park
Housing Design Awards 2010  Winner - Project HAPPI Award - Kidbrooke
Housing Design Awards 2010  Three shortlisted Completed Schemes - Hartfields Village, Hirst Gardens and Our Lady’s Convent
Building for Life  Silver - Hirst Gardens / Gerald Court
Housing Design Awards 2009  Roll of Honour - Trees, Highgate
Local Authority Building Control Awards 2009  Building & Design Quality Award - Hawthorns, Bath and North East Somerset Local Authority Awards
UK Over 50s Housing Awards 2009  Most Outstanding Extra Care Scheme in the UK - Wood Court, LB Barnet
Pinders Awards 2009  Highly Commended - Glebelands, Wokingham
Highly Commended - Cedar Grange, (Launceston Care Homes), Cornwall
Highly Commended - Our Lady’s Convent, Loughborough
Civic Trust Awards 2009  Mention - Our Lady’s Convent, Loughborough
Pinders Awards 2008  Best Independent Living Award - St George’s Park
What House Awards 2008  Best Retirement Development - St George’s Park
Guardian Neighbourhood Awards 2008  Independent Living & Older People, Winner - Carnarvon Place

LOCATIONS

London
Surrey
Manchester
Edinburgh
Abu Dhabi
Moscow

SECTORS

Housing Design
Urban Regeneration
New Communities
Specialist Housing
Existing Buildings
Keyworker & Student Accommodation
Mixed Use
Healthcare
Education
Hotels & Leisure
International

SERVICES

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CONTENTS

Introduction 3
Why ‘Housing for Older People’? 4
Housing Older People across the Public & Private Sectors 4
Overall Trend 5
Current Models 6
Staying Put and the Lifetime Homes Initiative 7
Extra Care Sheltered Housing 8
Assisted Living 9
Residential Care and Nursing Homes 9
Dementia Care 10
Category 2 (Revisited) & Independent Living 11
Resource Centres 12
Intermediate Care 13
Retirement Villages 14
Beyond Extra Care 15
HAPPI future? 15
The Community Hub 16
Reshaping Extra Care 16
Future Models? 16
Case Study 1 - Kidbrooke Extra Care Housing 18
Case Study 2 - Christopher Boone’s Almshouses 20

APPENDIX

Planning Challenges: Housing and Care for Older People 22
Introduction

This report provides an overview of the current range of housing and care provision available to older people in the United Kingdom and looks at the emerging trends following the publication of the HAPPI report in December 2009 to suggest how we might respond to meet the changing aspirations and needs of a new generation of older people.

The demographics indicate a rapid increase in terms of the age of our population, with an increase in the number of people over the age of 60 set to rise by 2.4 million by 2026. At the same time, we are living longer, due to improvements in healthcare, healthier lifestyles and living conditions and as a consequence the number of people over the age of 85 is set to rise by 185%, to 2.3m over the next 30 years.

A combination of the two would suggest we are facing a serious challenge in terms of the scale of provision and affordability of suitable housing and care delivery.

However, we are also experiencing a generational change in the retirement sector. The new generation of ‘Baby Boomers’, relatively cash-rich through a higher level of home ownership, will have higher aspirations in terms of lifestyle in retirement. In 2004 the equity held by over 60’s in their residential properties was close to £1 trillion.

We will all seek to maintain our independence for as long as possible and the great majority of us will therefore wish to remain in our homes in the community for as long as possible.

Currently in the region of 85%-90% of older people with care needs live in their own homes in the community. The majority of older people living in the community rely on their spouses, families or communities for care and support in financial as well as emotional and physical terms. However, the satellite family has led to a breakdown in the more traditional support systems thereby placing greater demands on publicly funded home care services.

However, many of our existing homes are inappropriately designed and unsuited to cater for our changing needs as we get older. At the same time this poses the problem of under occupation of family homes at a time when new house-building is likely to be restricted by very challenging economic circumstances.

During the 1960’s and 70’s Sheltered Housing with various levels of support (Categories 1 & 2) was intensively developed by Local Authorities together with Residential Care and Nursing Homes which provided 24 hour care for the very frail. Acute Hospitals have provided for older people with more serious health problems or recovery periods following traumatic injuries.

The range of choice for older people has been very limited and as a result people have found themselves in sometimes inappropriate and expensive care institutions. Residential Care, for instance, was intended for tenants with more intensive care needs, however, many residents with low to moderate care needs moved into Care Homes to escape social isolation living alone in the community.

It is against this backdrop that the previous administration published Lifetime Homes and Lifetime Neighbourhoods (A National Housing Strategy for Housing in an Ageing Society) setting out an affordable and sustainable policy for housing ensuring that people are assessed for Home Care and, subject to eligibility and funding criteria, supported in their own homes as their needs arise.

However, in the same publication it was acknowledged that staying put in one’s own home will never be the solution for all as we become frailer and need social interaction as well as care and support.

In order to address this issue the HAPPI initiative (Housing an Ageing Population: Panel for Innovation) was launched last year to investigate how housing for older people needed to change to offer an attractive lifestyle alternative for residents.

The HAPPI report was published in December 2009.

Source: www.hm-treasury.gov.uk
Why ‘Housing for Older People’?

In view of the recent drive towards inclusive design standards and universal adoption of Lifetime Homes standards we might ask:

**Question:** Why do we need to make special housing provision for older people rather than making all housing suitable for everyone irrespective of age or ability?

We would suggest we need to do both in order to facilitate ‘staying put’ for the great majority whilst providing attractive alternatives for the rest. The provision of housing for older people, as with mainstream housing, should offer choice to both the public and private housing in terms of tenure and lifestyle.

What sets the housing for older people apart from mainstream housing is the need for:

- The spatial requirements for support and care for a wide range of physical, sensory and cognitive impairment to be delivered.
- Lifestyle alternatives and degree of communality that offer social engagement and active retirement as an alternative to increasing isolation in one’s own home.
- Housing that is unencumbered by maintenance and management issues, provides security at a time in life when we are most vulnerable.
- Housing that is conveniently located for easy access to the range of facilities that we require in order to retain our independence and enjoy healthy and fulfilled lives for as long as possible.

In response to these needs there is a number of housing and care models that have been developed that provide some choice depending on the level of care and support required. As we become more frail and dependent the range of choice inevitably narrows and further limited by issues of affordability.

Housing Older People across the Public & Private Sectors

Housing for Older People can be broadly divided in terms of the public and private sector provision.

Whilst the housing models might be very similar, sometimes the terminology employed differentiates the sectors such as in the case of Extra Care Sheltered housing which in the private sector is usually referred to as Assisted Living.

In response to the growing market for lifestyle retirement opportunities, the private sector provision has expanded with a substantial number of new developers targeting principally the upper end of the market with a range of housing and lifestyle products.

These models, often imported from the United States, Australia and South Africa, have included independent retirement living with a lifestyle focus, through to short term rental Assisted Living schemes which offer hotel style accommodation with larger suites in lieu of bedrooms. The majority of these developments avoid a direct involvement in care provision and rely on the local PCT and/or other external agencies to service the needs of their residents/tenants.

At the other end of the scale in terms of affordability is the public sector provision of Extra Care Sheltered housing which is generally affordable rental in its tenure with housing benefit providing a substantial proportion of the monthly rental. Capital funding in the public sector has until recently been drawn from a combination of sources including the Department of Health (Extra Care Housing grant), CLG & DoH PFI funding, Local Authority housing grant, the HCA and Housing Associations revenue streams. However, with the new period of austerity other funding streams will need to be found.

Between these two ends of the spectrum is a large ‘middle ground’ which in our perception is currently underprovided with the exception of a small number of private developers and housing associations that offer a mix of tenure in their developments.
Overall Trend

The overall trend in the provision of housing and care for older people has been geared, over the past decade or more, to shift care provision from institutional settings toward more independent models that integrate housing and support for older people into its community.

This trend is being driven both to meet our aspirations for independence and to respond to affordability challenges.

The Cost of Care

The cost of providing both healthcare and domiciliary care is in direct proportion to people's needs. The accommodation model becomes more institutional in character once their ability to look after themselves together with family and community support diminishes.

The cost per bedspace in an Acute Hospital is approximately £800-£1500 per day, whereas in a 24-hour Care Home or Nursing Home it will vary between £400-£1100 per week depending on the profile and funding sources of the residents. In both Extra Care and in Home Care settings care costs will average around £300-£450 per week but where 24-hour cover is required, is likely to be considerably more.

This shift away from the institutional care has been evidenced in recent years by:

- Initiatives to provide for intermediate care for rehabilitation accommodation/facilities to ease bed-blocking in Acute Hospitals.
- The shift in the resident profile in Care Homes and Nursing Homes (average age over 85) towards the upper end of the care spectrum, involving either extreme frailty or dementia sufferers. As a consequence, the period of 'compressed morbidity' is reduced and the length of stay in institutional settings - nursing homes, hospices and hospitals - is very much shortened to an average stay of a year or two.
- Increasing integration of Extra Care and Care Homes into larger scale housing developments, urban extensions and new communities.
- The development of community based resource centres to provide day care, respite care, and outreach service to older people in the community.
- The push towards Lifetime Homes and Lifetime Neighbourhoods in the development of new housing together with a variety of care and support arrangements including Home Care, floating support and handy person's services to facilitate staying put.
- Most recently the integration of Extra Care into the community where ease of access to local facilities (Lifetime Neighbourhoods) could avoid the duplication of facilities within the development.

At the same time the retirement market, offering lifestyle alternatives in the form of Assisted Living, Retirement Villages and Continuing Care Retirement Communities, has gathered pace (but slowed again since the recent economic downturn).
Current Models

Current Trends & New Models for Housing and Care in the Community

LEVEL OF DEPENDENCY

THE CARE CONTINUUM

Home Care - Lifetime Homes
Extra Care Sheltered (Assisted Living)
Specialist Residential Care Homes
Nursing Homes
Acute Hospitals

Independent Living - Lifetime Neighbourhoods
Integrated Care Housing & Health
Care in the Community - Resource Centres
Intermediate Care

Retirement Villages
Extra Care Retirement Villages
Continuing Care Retirement Communities
Staying Put and the Lifetime Homes Initiative

There is no question that many of us will elect to remain in our own homes for as long as possible and that new homes need therefore to be designed to facilitate this option. This has been recognized and embraced in government policy through the Lifetime Home and Lifetime Neighbourhood policy initiative. At the same time, the need to address the suitability of our existing housing stock to meet our changing needs has been recognized by funding programmes and initiatives such as ‘Care & Repair’ delivered through home improvement agencies. The Home Care market has been dramatically expanded with an annual budget in the region of £1.5 billion per annum.

Developments in technology (Assistive Technology) will facilitate care in the community.

Lifetime Homes standards, if universally applied, need to be carefully considered to strike the right balance between inclusivity, affordability and marketability. At the same time there might be a case for the Lifetime Homes initiative to be broadened to embrace the flexibility in family housing that will accommodate the changing needs of extended families - independence for grown-up children, parents and grand-parents. (See PRP’s publication - ‘A Home 4 Life’).

There are many reasons why the Home Care option should not be regarded as a panacea in terms of future provision for housing and care for older people:

- **Existing Housing Stock**: The great majority of the population will be living, for the foreseeable future, in our existing housing stock much of which is unsuitable in terms of the physical, sensory and cognitive needs of people as they get older and become frailer.
- **Existing Neighbourhoods**: The same applies to our existing neighbourhoods, many of which are unsympathetic to the needs of older people in terms of the amenities they offer and the security issues they present.
- **New Housing**: Whilst the policy initiative for all housing to be designed to more inclusive standards will enable ‘staying put’, a pragmatic balance must be struck in terms of level of inclusivity which we adopt and affordability and marketability.

- **Choice**: As at any other stage of our lives, society should offer older people a choice in terms of housing, lifestyle and care provision and whilst ‘staying put’ should be a viable option, alternatives should be available.
- **Social Exclusion and Isolation**: As older people become frailer and housebound they become increasingly isolated living in the community. Social isolation/lack of stimulation and boredom account for the premature mental deterioration of a very substantial number of people.
- **Increasing Dependency**: In the absence of living-in family or carers, a tipping point is reached beyond which Home Care becomes unaffordable due to the intensity of care required.
- **House-blocking**: As with the affordability issue to society posed by Bed-blocking by older people in Acute Hospitals requiring rehabilitation, there is an issue for our society in terms of the under-occupancy of family homes by older people in the community.
- **Dementia Care**: As with extreme frailty, there is a tipping point in terms of the viability and sustainability of caring for the increasing prevalence of dementia and mental infirmity in the community.
- **Home Care Provision**: Where provided by Home Care agencies, care packages are generally competitively tendered and awarded too often on the basis of lowest cost rather than quality of provision. As a result the system is often failing to provide adequate cover as people’s care needs become more intensive. The ageing process is not static. Agencies tender on the basis of time and resource. Demand can rapidly increase depending on the level of frailty of their clients which will accelerate in the context of social isolation and absence of other support structures.
- **Personal Care Plans**: The move towards individual choice and personal care packages (Supporting People & Putting People First initiatives) is again laudable in terms of offering choice and efficient in terms of enabling care to be tailored to suit individual needs, particularly at the less intensive end of the care spectrum. However, increasingly frail and confused older people are not capable of making these choices and must necessarily rely therefore on their families or care agencies to take decisions on their behalf. Commercial imperatives can mitigate against adequate and appropriate care provision particularly in the community.
Over the past 10 - 15 years the great majority of new sheltered accommodation developed in the affordable housing sector has been Extra Care Sheltered Housing. The model is a natural development of the Category 2.5 in the 1980’s. In terms of its typology it is essentially a hybrid between the residential care home with its central access corridor and traditional apartment blocks. It provides self-contained apartments for independent living together with a range of communal and support facilities that offer both opportunity for social interaction and the support facilities to enable care and support can be provided to tenants in their own homes.

The unit of accommodation in Extra Care has generally been a one bedroom flat designed to Lifetime Home, if not full wheelchair standards. More recently, however, a greater proportion of two bedroom flats has been included as the second bedroom offers greater flexibility as a second bedroom for relative or carer or simply more space in the interests of meeting higher aspirations and future-proofing.

Communal facilities would, as a minimum, generally include a resident’s Lounge and Dining Room, a Hairdressing Salon, Activity Room and Guest Bedroom. Care and support facilities would include one or more Assisted Bathrooms, Staff Office, Rest and Changing Facilities, a Laundry and full catering Kitchen.

Generally, these developments have averaged in size around 40 flats although in some cases as few as 30 flats have been provided or as many as 60 or more. The number of units generally has a direct relationship as to the range and scale of the communal and support accommodation that can be afforded. Very large Extra Care developments of up to 250-300 dwellings, sometimes referred to as Extra Care ‘Villages’, have been developed with very extensive facilities in the form of a ‘Village Centre’ around an ‘internal street’.

The move towards Extra Care, which is often regarded as an alternative to Care Homes, is entirely consistent with the general move away from institutional care towards housing based options. There are many examples of tenants moving into Extra Care flats from Care Homes and ‘taking on a new lease of life’ in their more independent setting.

Although generally developed by Housing Associations for affordable rental, some projects have been developed for shared ownership or, particularly in the case of larger schemes might offer mixed tenure with a proportion of leasehold sale, shared ownership and affordable rental.

The principal features and benefits of Extra Care are therefore:

- Self-contained flats promote independence.
- Communal facilities promote social interaction.
- Security.
- Care and support that can be tailored to individual need.
- Efficiency in terms of care delivery due to economies of scale.

Increasingly Extra Care developments are being seen as community based facilities from where care can be provided to older people in the surrounding community, rather than just their residents, and facilities that can be shared by the wider community.

Questions: With the move towards Lifetime Homes, will the need for sheltered housing of this type become superfluous? Or does the model need to be modified for more urban locations to integrate and rely on sharing facilities with the wider community to a greater extent?
Assisted Living

Assisted Living is generally the term applied to the private sector equivalent of Extra Care sheltered housing. However, there are a number of different models being developed that range from a close equivalent to Extra Care housing targeting the leasehold sale market, to distinctly different models, imported from the United States exclusively for short term rental. These take the form of upmarket Care Homes or Care ‘Hotels’ where residents can rent suites ranging in size from bedsit flats to 2 or 3 bedroom flats. They have minimal kitchens on the premise that residents will have most of their meals in a central dining room/restaurant. Sometimes separate dementia care wings are provided. The average age of residents is generally over 80 and most providers are targeting the upper end of the market.

Residential Care and Nursing Homes

Residential Care Homes, subject to registration (currently by CSci), were widely developed by local authorities and housing associations during the 1970’s and 80’s. They are referred to under a number of different tags including EPH’s (Elderly Persons Homes), Frail Elderly Homes, Category 3, EMI (Elderly Mentally Infirm - dementia care) etc.

They are differentiated from Nursing Homes, more by virtue of their staff profile (Registered Nurses or Community Psychiatric Nurses) than by significant differences in terms of the type of accommodation or standards. With the change in profile of residents of Residential Care Homes towards the higher end of the dependency scale, the two building types have effectively merged and are often dual registered as Care/Nursing Homes.

For purposes of this paper we will refer to the building typology as a Care Home.

Care Homes provide 24-hour care for their residents with waking night staff. The unit of accommodation is a bedroom with en-suite facilities. The minimum size is 12m² of usable floor space for the bedroom, however, most providers will exceed this to provide approximately 16m² excluding the 4m² en-suite facilities.

The bedrooms are generally grouped into wings/clusters each sharing a range of communal facilities that would normally include lounge and dining rooms, servery kitchenettes, assisted bathing, storage areas, disabled WC’s etc. Central accommodation includes full kitchen catering facilities, care staff rest and changing facilities, management and administration offices, central communal facilities for residents - lounge, dining, garden room, hairdressing salon, activity rooms and other service facilities.

Cluster sizes, in terms of bedroom numbers, will vary according to the care needs of the residents and the ratio of carers to residents - dementia care would normally require a minimum of 4 residents to a carer whilst this might be decreased to 1:5 for frail older people. A 60 bedroom Care Home is generally regarded as a cost efficient operational unit although during the 1990’s private care providers were building care homes as large as 120 bedrooms which attracted, quite rightly, a good deal of negative press for ‘warehousing older people’.

A large number of Care Homes were closed during the 1990’s and 2000’s for a range of different reasons including:

- New legislation particularly around minimum space standards and the expense of upgrading old building stock.
- The property boom which provided many private providers with an exit route.
- Local authority care budgets steadily being squeezed forcing many providers to charge private residents higher rates to cross subsidise LA funded residents.
- The promotion of Extra Care accommodation as a housing alternative to the institutional Care Home where people could live more independently and have care packages tailored to their individual needs.

However, the need for 24 hour care establishments will not be addressed by either Home Care or Extra Care particularly where Dementia Care is involved and we are seeing local authorities, housing associations and private providers re-entering this market and commissioning new Care Homes.

Question: Is there a less institutional alternative to the traditional Care Home model that could be integrated with older persons housing in the community?
Dementia Care

Dementia is still rapidly on the increase despite all the press coverage on effective new medication developed to slow the onset. By 2025 it is anticipated that there will be over 1 million people suffering from dementia in the United Kingdom.

Dementia takes many different forms but the most common is probably Alzheimer’s Disease which is usually a fairly rapid cellular degeneration affecting all aspects of the brain’s function.

Support and Care for older people with dementia is one of the major challenges facing us. As with all older people requiring care and support, the great majority of dementia sufferers live in the community where they are cared for by spouses or family with support from Home Care agencies. People suffering from more advanced levels of dementia require 24 hour care cover and the burden this places on carers in the community is often extremely onerous.

There will be some incidence of dementia in any housing development for older people and the design should take into account good practice in terms of design for dementia.

There are several different approaches to accommodating older people with mild to moderate levels of dementia in Extra Care housing. These range from small dedicated units or wings specifically for this group to clusters of flats with shared communal facilities to a pepper-potted approach where individual care needs are simply catered for within their flats. The latter appears to be the favoured option with most providers. However, where this is the favoured solution, it is accepted that as the disease progresses it is likely that the resident will have to move to more appropriate accommodation.

The care setting most widely adopted for moderate to severe dementia sufferers is the Care Home or Nursing Home and these are frequently specifically developed for the purpose or alternatively have clusters/wings dedicated for the group. Best practice suggests small scale groupings of bedrooms (6-8) sharing communal facilities in a domestic setting.

Questions: Should there be dementia specific provision in any substantial new development for older people and if so what form should this take? Should the policy be to support people in their own homes to the point where this becomes unsustainable and then to move them on to suitable 24-hour care accommodation?

PRP: Exning Court, Suffolk
A 34 unit extra care sheltered housing scheme incorporating dementia care - one cluster is dedicated to providing specialised accommodation for older people with mild to moderate dementia, although all of the flats have been designed to the same level to facilitate the changing needs of residents throughout.
Category 2 (Revisited) & Independent Living

In response to the changes in the procurement of care, the introduction of individual budgets and the rising costs of care provision, many Housing Associations are moving away from offering care services.

At the same time some have chosen to return to a building typology that is more closely associated with Category 2 sheltered accommodation in terms of offering minimal communal provision but without a warden’s flat and with the flats designed to ‘inclusive’ standards.

In addition to the flats the model therefore includes some communal facilities such as a lounge and activity spaces for the residents together with a small domestic kitchen for social functions and an administrative office for the housing manager. These developments are ideally located in more urban areas where they are close to public transport, shopping and other facilities.

This model has been developed for leasehold sale in the private sector for many years by developers such as McCarthy & Stone and is consistent with the promotion of the Lifetime Home, Lifetime Neighbourhood concept.

PRP: Carnarvon Place, Newbury
A Category 2 & Independent Living Scheme which provides housing for older people whilst fostering independence. In the interest of ‘future proofing’ the scheme provides predominantly two bedroom flats with generous space standards.
Resource Centres

The Resource Centre concept was developed in conjunction with the policy for ‘Care in the Community’ to provide multi-functional community-based centres which would both facilitate the delivery of Social and/or Primary Care and provide for the care needs of those who could no longer be supported in their own homes.

Although there are many different models and different tags (such as Centres of Excellence etc) the range of facilities that might be included is as follows:

- Residential Care
- Dementia Care
- Intermediate Care
- Respite Care
- Day Care
- Resource Data Base
- Outreach Facilities
- Healthy Living Centre.

A particular model referred to as an Integrated Care Resource Centre, developed by PRP and Friends of the Elderly, proposed a community resource and outreach centre from which a number of care providers could service the needs of older people in the community. Whilst this model would appear to align with the allocation of individual budgets for care arrangements, it is questionable as to whether care providers, sometimes in competition, would share resource and administration facilities?

Questions: As we move towards Lifetime Homes and Lifetime Neighbourhoods, should facilities of this type not be an essential component of each neighbourhood? To what extent could the facilities be multi-functional in terms of use by the wider community to avoid duplication?
Intermediate Care

Intermediate Care is the term for residential accommodation together with the rehabilitation facilities required to get older people ‘back on their feet’ so that they can return to their homes (whether this might be in a sheltered setting or in the community) following a traumatic injury, operation or severe illness which has required hospitalisation.

The policy initiative, introduced several years ago, was to address the issue of bed-blocking in Acute Hospitals where older people were hospitalised longer than necessary and at huge expense simply due to the lack of suitable rehabilitation accommodation.

The accommodation can take the form of Extra Care flats or Care Home bedrooms or it might be provided as a separate facility on hospital campuses.

Although we have been involved in a number of projects where Intermediate Care has been envisaged, it has rarely been included in the final product due to the cost of funding voids and the intermittent nature of the service required. Neither the health authority nor the housing/care provider has been prepared to pay for the void periods.

Question: Should there be provision for this function in larger housing developments for older people?
Retirement Villages

A ‘Retirement Village’ is the broad term for a larger scale age-restricted housing based community which promotes social interaction through common interests.

The models currently being developed vary widely in terms of their:

- Tenure
- Philosophy and provision of care and support
- Range and scale of communal facilities
- Relationship to their surrounding communities
- Density
- Location etc.

We would suggest that there are broadly 3 categories:

1. **Retirement [Lifestyle] Villages:** targeting the early retirees at the upper end of the market with a model for an easy-living, leisure-oriented retirement community. Generally the tenure would be leasehold sale with a substantial annual service charge. There are sometimes variations around tenure arrangements that involve ‘life-right’ or equity sharing between the freeholder and leaseholders. Care would generally not be included in this package but facilities might be included within the Village Centre for a visiting GP. Larger developments usually offer a range of communal and leisure facilities at the centre of the development.

2. **Extra Care Villages:** Are generally developed by Housing Associations. Tenure is generally mixed and usually pepperpotted to provide leasehold sale, shared ownership and affordable rental. 24 hour cover is usually offered in terms of care and support and facilities on site will include Office, Rest and Changing facilities for staff. The model is premised on taking care to people in their own apartments rather than taking people into care. A wide range of communal and leisure facilities is generally provided and is affordable due to the scale of these developments which would generally provide upwards of 150 dwellings in the form of either apartments, bungalows or cottages or a mix of the three. Whilst an Extra Care village might aspire to provide a ‘Home for Life’ the reality is that a proportion of residents will need to move on to 24 hour care institutions for dementia care or due to extreme frailty.

3. **Continuing Care Retirement Communities:** this model includes different forms of accommodation on one site and might include independent living, assisted living and care home accommodation. CCRC’s are generally developed by private developers for leasehold sale with flexible care packages that can be separately purchased. The independent living options will generally include apartments in small blocks, bungalows and/or cottages. The assisted living might be in a larger corridor access block linked to the communal facilities and the care home accommodation might include some dementia specific care arrangements in a care home of up to 50-60 bedrooms with en-suite facilities.

We have found the planning system to be generally unsympathetic towards these developments for reasons that we have outlined in our article entitled *Will our older people have a happy future?* appended to this document.
Beyond Extra Care - HAPPI Lessons from Europe and Scandinavia

Since the HAPPI Report was launched in early December last year, it has created a good deal of interest, particularly from those working in the sector. We believe that recommendations contained in the report should be applauded and embraced:

There is an urgent need for more attractive and contemporary retirement housing in strategic locations as an alternative for ‘young older people’ under-occupying family housing.

We need to re-examine some of our existing typologies and the way we design the dwellings in order to meet this need.

We need to be more creative in exploring and facilitating the provision of this housing in new ways, such as co-housing, that will be affordable for society.

There are undoubtedly some important lessons to be learned from northern European countries that appear to be some years ahead of us in their thinking and practice...

Much of the new development in the sector in the United Kingdom is unimaginative in its approach to design and formulaic in terms of the housing and care models that we tend to accept too readily.

Is it time for a paradigm shift in terms of what housing we provide for our ageing selves and how we provide it?

The HAPPI report includes a number of good pointers in terms of design quality and some broad recommendations for how various agencies need to respond to the challenge. However, it is not prescriptive in suggesting what models we should be building in the future.

HAPPI Future?

The HAPPI report promotes flexible, adaptable and contemporary housing that will provide an attractive alternative to young older people under-occupying family housing. However, it also includes a number of recommendations that challenge some of our existing models and typologies: such as the central corridor and single aspect flats in Extra Care developments.

There are clearly viability issues facing us in terms of the smaller 40 unit Extra Care schemes as well as questions being asked around the institutional nature of corridor access and single aspect flats.

Some of the key lessons from Europe were the continuity of care on offer through the strategic location of housing and care facilities; also the partnerships between local authorities, housing and care agencies and the developers who often had a long term stake (50 years) in the buildings.

So... How will our existing models need to adapt to suit our future needs?

We believe that there is no simple solution in terms of future models of housing with care. New housing and care facilities will need to be developed on a site specific basis as hybrid, mixed-tenure, community-integrated housing and facilities in response to local need, local networks and partnerships and, indeed, the precise location of the site relative to local facilities, amenities and transport.

Holland: de Plussenburgh, Rotterdam
Attractive Contemporary Retirement Housing located at the heart of a residential community close to shopping, transport and higher care facilities.
The Community Hub

‘Partnerships’ will be key and the partners must include the local authority in a pivotal role, the local health authority (PCT), private developers, RSLs, and the Care Providers.

The different elements that might be included within a hybrid development might include:

- Attractive Retirement Housing
- Cat 2 Sheltered housing (affordable housing equivalent)
- Extra Care/Assisted Living flats
- Care Home accommodation that might include intermediate care
- Day care and Resource Centre facilities
- Communal facilities that might include services (Meals/Laundry) for older people in the wider community

Alternatively, each one of these elements could stand alone, depending on the local circumstances.

Reshaping Extra Care

The cost of providing extensive and often under-utilised communal facilities within Extra Care has become a major issue together with the impact of personal care budgets. The scale and shape of Extra Care housing needs to adapt to address these issues.

Future Extra Care developments might therefore:

- Be larger... possibly upwards of 60 units to care village scale
- Be mixed tenure to be affordable
- Cater specifically for people with higher level of care needs
- Be better located near facilities, transport etc.
- Have less communal provision and avoid local duplication of facilities in the area
- Be combined with other housing/care provision as community ‘hubs’
- Share its facilities and services with older people in the surrounding community
- Be self-contained in more isolated rural situations
- Explore different typologies in terms of layout and circulation

Future Models?

To summarise, we think that the way forward will be through the development of a number of different models to meet local need and circumstances:

- Attractive retirement housing for the ‘young’ old focussed primarily at both the leasehold sale and affordable rental markets in desirable locations well connected with local facilities and transport.
- Community Based Continuing Care ‘hubs’ offering a range of different types of accommodation for different tenures and levels of dependency.
- Larger Extra Care developments that integrate more with the wider community.
- Co-housing initiatives that are funded, commissioned and managed by the residents.
- Community based specialist dementia care and nursing homes.

Whatever models we build, we will be increasingly reliant on public and private sector partnerships and creative financial models around ‘equity release’ from existing properties both in order to fund new development and care provision.

Sweden: Neptuna, Malmö

Attractive Retirement Housing in a prime location on the waterfront at the heart of a lifetime neighbourhood
Case Studies
This project sets an important precedent in placing attractive housing for older people at the heart of an urban regeneration scheme and in challenging some of the more institutional aspects of the Extra Care housing typology. The project embraces many of the principles and recommendations set out in the recently published HAPPI report which calls for innovative and attractive retirement housing for older people in good locations.

Site and Context - The site is immediately adjacent to a new linear park and a short walk from the community and transport ‘Hub’ which will be developed as part of a future phase. There is a strong pedestrian route on the northern side of the site linking the residential area through to the ‘Hub’.

Concept & Layout - Central to our design concept is the ‘Core & Cluster’ arrangement creating 5 residential ‘clusters’ rather than the widely-employed Extra Care typology of long double banked corridors and single aspect flats. An internal corridor is provided at first floor level connecting each cluster to the main communal areas. This provides sheltered and secure access for residents to the communal areas and also for care staff visiting residents. The circulation areas within each core are generously glazed ensuring high levels of daylight, natural ventilation and a dual aspect views into the courtyard and surrounding area. This arrangement will facilitate way-finding and create pleasant areas with small lounge and seating bays for casual social interaction.

The ‘Core & Cluster’ model also helps maximise the number of dual aspect flats. The ‘C’ shaped block is open to the new park to the east. A landscaped courtyard deck enables the park to ‘flow into the courtyard’, and provides a communal garden accessed from the residents’ private lounge and from each core. A large roof terrace located at fifth floor will provide an additional outdoor space with dramatic views over the surrounding parkland.

The Dwellings - The majority of the apartments will have 2 bedrooms with 3 habitable rooms and generous standards that significantly exceed normal standards for Extra Care housing. The flat layouts offer flexibility in use. The third habitable room can be used either as a carer’s bedroom, a study or larger dining room with sliding partitions enabling access between rooms. All apartments have generously proportioned private external balcony or terrace and are able to accommodate tables, chairs and plants. The balconies are generally recessed to provide sheltered ‘outdoor rooms’. Sliding timber shutters provide moveable solar shading.

Safety Security and Accessibility - The development will be wheelchair accessible throughout and all dwellings designed to wheelchair standards, with 10% even larger to comply with Greenwich BC’s wheelchair standards. The building will be fitted with smart assistive technology. Parking at 27% is located in a ground floor level undercroft in the centre of the block and generous storage for motorised scooters and bicycles is provided in the same area.

Case Study 1 - Kidbrooke Extra Care Housing

PRP: Kidbrooke, Blackheath, London – WINNER 2010 Housing Design Awards, HAPPI Project Scheme
Attractive apartments at the heart of a new residential quarter close to shopping & transport network.
Communal Facilities - Extensive communal facilities are provided at ground floor. These spaces are designed to enable access by the wider community, and will provide an active frontage to this part of the site. The main entrance opens into a double height foyer which will serve as a reception area and provide access to a range of facilities including a cafe, shop, internet space, cinema room and village hall. The Village Hall on the NW corner addresses the main entrance piazza and is intended for use by the wider community for events such as local group meetings, social gatherings, and activities for parents and children. The main residents’ restaurant and lounge will open onto a terrace with views over the parkland to the east.

Materials and Detailing - The architecture relies on high quality brick detailing, deep set reveals and materials will include areas of render and timber cladding. The outer skin is primarily facing brick giving a robust finish to the external envelope with render and elements of timber cladding used within the courtyard. The inset balconies to the flats are clad in timber providing texture and warmth at contact level. Baltimore are divided between floors providing a variety of opening proportions and articulation across the facade. The communal areas are expressed with larger areas of glazing to connect these spaces with the public realm, and provide an active frontage to the piazza.

Sustainability - The building will achieve a BREEAM rating of Excellent & include an energy centre with biomass boiler, retractable sun blinds, a high level of insulation and a range of other energy efficiency measures.
Case Study 2 - Christopher Boone’s Almshouses

A contemporary urban housing project for older people that challenges preconceptions and avoids the institutional character and limitations of central corridors and single aspect flats.

Scope and Context - This new development involves replacement of 62 almshouses for the Merchant Taylor’s Company. The Company currently owns two almshouse sites in the Blackheath Conservation Area, close to Lewisham High Street; one comprises Grade II Listed properties and the other 1960’s bungalows. None of the properties meet current standards and in many respects are now unsuitable in terms of meeting the needs of their older residents. PRP has assisted MTC in developing a redevelopment strategy that consolidates the accommodation on one site thereby releasing the Grade II listed properties for private sale after refurbishment.

The remaining site will be redeveloped in its entirety to provide the replacement accommodation for the 62 almshouses together with additional maisonettes and almshouses which will be for private sale. The receipts from the sale properties will make a significant contribution towards the funding of the new almshouses.

Location - The development site is well located both in terms of access to the High Street and therefore public transport routes and in relation to a Residential Care/Nursing Home also operated by the Merchant Taylors which is in close proximity.

Concept & Layout - The building typology employed for the new development is closely aligned with the aspirations and recommendations of the recently published HAPPI report which highlights the need for well located, community integrated housing which offers a lifestyle alternative to older people wishing to downsize from their homes in the community.

The new development is configured as a U-shaped block that wraps around a secure garden courtyard. The almshouse concept has been reinvented as dual aspect apartments, each with its own front door, accessed from gallery access walkways that overlook the courtyard and offer opportunities for social interaction.

Space Standards - The flat sizes are generous in terms of space standards - 61.5m² for one bedroom and 82.5m² for 2 bedroom - approximately 10-15% larger than the minimum standards. Each will have the benefit of winter gardens and/or balconies.

Communal Facilities - Communal facilities will be limited to a single multi-functional lounge/garden room where residents can assemble for social gatherings and activities and a communal laundry and storage areas.

The central courtyard will include allotments where residents can grow their own vegetables.
An Overview by PRP

Current Provision & Emerging Trends for Housing and Care provision for Older People August 2010

Site Layout

- Communal
- Ancillary
- 1 Bed Flat Type A (Wheelchair Accessible)
- 1 Bed Flat Type B (Wheelchair Accessible)
- 2 Bed Flat Type A (Wheelchair Accessible)
- 2 Bed Flat Type B
- 2 Bed Flat Type C
- 3 Bed Flat Type A (Private Sale)
- 3 Bed Flat Type B (Private Sale)
- 3 Bed Maisonette Type A (Private Sale)
- 3 Bed Maisonette Type B (Private Sale)
- 4 Bed Maisonette (Private Sale)

Proposed Trees
Existing Trees
PV Panels
Green Roof

1 Bed Flat - 61.5m²
2 Bed Flat - 82.5m²

Gallery access to apartments around a sheltered & secure courtyard garden.
FEATURE: HOUSING OLDER PEOPLE

Will older people have a happy future

European housing models for an ageing population offer interesting models for a market that needs encouraging here, argues architect Roger Battersby

The publication of the HAPPI (Housing an Ageing Population: Panel for Innovation) report in December last year highlighted the challenges we face as a society, if we are to meet the housing and care needs of our ageing population.

Recent government policy for older people embraces the laudable objectives of more personal choice in care provision through individual budgets and more ‘inclusive’ design for new homes and communities – Lifetime Homes and Lifetime Neighbourhoods – to enable people to ‘stay put’ and receive the care they need in their own homes. Remaining in our own homes as we get older will undoubtedly be the option of choice for most of us. However, this should not be seen as a panacea.

The fact is that whilst the great majority of older people with care needs are continue living in their own homes, these are often not ‘fit for purpose’ inflexible and difficult to adapt, expensive to maintain and inefficient in terms of energy consumption.

Added to this, the homes are often either in communities that might be alien environments for vulnerable older people or poorly located in terms of the facilities and services that we need as we get older.

Furthermore, as we become frailer and increasingly housebound, social isolation can become a major issue. Can we afford, as a society, to have a very significant proportion of our family housing stock under-occupied by older people?

The HAPPI panel confronted these issues and concluded that providing attractive alternatives to ‘staying put’ was an essential part of the solution. The report therefore recognises the extreme shortage of attractive housing alternatives for ‘young’ older people and sets out to promote its development.

Lessons from Europe
It was quickly apparent to the Panel that we are some years behind our European neighbours in tackling these issues. Generally, they appear to have a more cohesive strategic approach in terms of the government agencies working together on delivery: Housing, Health and Adult Social Services.

Local authorities play a pivotal role in the delivery process, identifying the local need, working with the communities, development agencies, housing management and care providers to identify sites and facilitate the development process.

Also evident from the range of new developments that the Panel visited, was the quality of attractive new retirement housing that was being built in strategic locations for ‘young’ older people. Usually it was close to shopping and health facilities and at the heart of communities to enable close links to be maintained with family and friends. The care and support burden is therefore shared by a large contingent of volunteers, friends and relatives from the neighbourhood.

In the UK there is a serious lack of retirement housing alternatives for an over-realism in our society.

There is often a dislocation between our key agencies of Health, Housing and Adult Social Services, particularly where funding mechanisms and availability is concerned. However, it is at Local Authority level that perhaps the greatest shift in awareness and strategy is required together with a fundamental reappraisal of both strategic planning and planning policy.

Costs and benefits
In moving towards a change in approach to planning policy for the sector, the inherent costs and

IF WE ARE TO HAVE ANY CHANCE OF MEETING THE CHALLENGE FACING US, DEVELOPERS NEED TO BE INCENTIVISED TO BUILD NEW RETIREMENT HOUSING THAT OFFERS AN ATTRACTIVE LIFESTYLE ALTERNATIVE TO PEOPLE UNDER-OCCUPYING FAMILY HOMES.
Planning use-classes

Our planning policy not only fails to facilitate new developments of this type but falls short of even acknowledging ‘housing with care’ in terms of Use Class as it falls between C3 – Housing, and C2 – Institutional. ‘Housing with care’ is often therefore classified as sui generis and contributions towards affordable housing under Section 106 Agreements and pricing standards etc. are subject to negotiation and can therefore become a lottery across different local authorities depending on their particular knowledge of the sector.

Our private sector clients are generally seeking a C2 classification to avoid punitive contributions towards affordable housing and thereby mitigate the additional costs of communal provision, whilst our RSL clients often try to avoid C2 classification for their mixed tenure developments because they believe that the ‘institutional’ tag will compromise the value of the leasehold sale element of the scheme. Although updated in 2005, the Planning Use Class Order is inflexible and in need of updating to reflect the growing housing with care sector

If a new Use Class could be established for housing with care and clear guidance could be given in terms of planning gain, affordable housing contribution etc., this would provide greater clarity for the developer. For instance, if such contributions could be mitigated by the provision of generous communal facilities some of which are accessible to the wider community, the provision of a crèche – which is commonplace in older persons’ housing developments in Europe – or the provision of 24-hour care/nursing within the development, the affordable housing contribution should be waived or reduced to reflect the mix of tenure.

It should be noted that the draft replacement London Plan, which was recently out to consultation, takes the opposite position on this. It proposes that all older persons housing with care developments, even the previously exempt C2 – institutional buildings, should be subject to the prevailing affordable housing contributions. This will only serve to further inhibit the development of the type of product the HAPPI report is seeking to promote along with all other housing for older people.

Local authorities need to develop strategic plans around their ageing populations based on housing and care needs assessments of future generations. They should look wider than the affordable housing needs of older people. Older home owners will have similar needs that should form part of this strategic review.

Housing provision for older people should be taken into account in any new residential development of significant scale, in the same way that affordable housing is considered. There is a strong case to be made for retirement housing to be interchangeable with affordable housing provision under Section 106 Agreements.
Location is key
If we are to move towards lifetime neighbourhoods to create sustainable communities whether through strategic intervention in existing settlement, urban regeneration or urban extensions/new communities, locating specialist housing for older people at the heart of these communities is critical. Housing for older people needs to be integrated and not marginalised. It needs to be located in mixed use developments where retail, entertainment and health facilities are easily accessible, where public transport is on hand and where parks and other amenity areas are within easy reach. It needs to be either within or close to the community ‘hub’.

This will not be achieved if left to market forces. Land needs to be allocated or zoned for this use within Local Development Frameworks. Older people have an important role to play in society. By placing their housing at the centre and promoting active communities that engage and integrate with the community, whilst also ensuring security, will bring benefits in terms of quality of life and slowing the ageing process and hence the cost to society.

We need new models
In a period of greater financial austerity in the wake of the credit crunch funding for new development from the public sector purse will be increasingly tight. We are going to have to make the most of what we have and target new funding to achieve best value.

What better place to start than facilitating appropriate housing for older people to meet this urgent need whilst simultaneously boosting availability of general needs housing. This will take a paradigm shift in planning policy if it is to succeed.

Local authorities also need to be open to new approaches such as facilitating co-housing projects which account for around 30% of new housing development in Denmark. Here groups of older people provide for themselves, working with agencies to release the equity in their own homes. Local authorities and planning policy can and must play a key role in facilitating this process by initially understanding the cost and benefit to society in developments of this kind and then accommodating them in strategic planning and policy terms.

The HAPPI report brings these and many other prerequisites for meeting our ageing population’s care and housing needs into sharp focus.

Roger Lattenby is managing director at PRP Architects responsible for its specialist housing design.
The Housing and Ageing Panel for Innovation (HAPPI), led by Lord Best, was commissioned by Communities and Local Government (CLG) and the Department of Health to gather good practice from Europe and put together proposals for housing older people.