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# Housing Options for Older People





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*King's* Fund

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# Introduction: The housing challenge

The homes currently being planned and built will contribute to the housing stock in 20 years time. Yet the demands of an ageing society often come low on the list of current strategic priorities, with the housing concerns of first-time buyers and young families appearing more immediate. Recent government-backed programmes for new affordable housing do not specifically promote houses for older people. But looking ahead to 2026, the rising number of older people, combined with increased longevity, will create a much greater need for properties suitable for the impaired and averagely frail very old. This calls for a commitment to new ‘lifetime’ homes, constructed with the lifestyles of older people in mind. There is a need to plan ahead for the whole of the ageing population, not just those who will be eligible for state-supported social care. This includes the increasing number of ageing owner-occupiers who require suitable smaller properties into which to downsize – the so-called ‘last-time movers’ as opposed to the ‘first-time buyers’.

This paper provides some background information on issues addressed in the ‘Housing and extra care housing’ section of Chapter 9 (‘New influences on care’) of this Review, including references to some studies that have recently been published on these subjects.

Adequate housing is just as crucial to people’s independence as social care (Allardice 2005) and older people want the choice of staying in their own homes as they become more dependent. This can present a challenge, but perhaps not one that is quite as daunting as sometimes presented. As pointed out by one housing consultant (Appleton *et al* 2005), the current picture looks less onerous if one inverts the prevalence of difficulty outlined in the Supplementary Report on the General Household Survey 2001 (Office for National Statistics 2001).

- 78 per cent of those aged 85 and over have *no* cognitive impairment.
- 79 per cent of those aged 85 and over *are* able to bathe themselves.
- 98 per cent of those aged 85 and over *can* get around their home successfully *if it is on a single level*.

These statistics suggest that a significant proportion of the ‘very old’ should be able to continue living in their own homes for longer if they receive appropriate support. Properties therefore need to have the potential for assistive technology features such as stair-lifts, and/or ground floor bedrooms and bathrooms. In addition, older people need to be more aware both of what is available in terms of adaptations and what they might require in the future. Age Concern’s LifeForce Survey asked older people without adaptations to predict what they might need in the future, and all groups of older people underestimated the likely levels of adaptation required (Edwards and Harding 2006).

Research into how far, and at what cost, the existing housing stock can be modified to accommodate different types of assistive technology has been carried out by King’s

College, London and the University of Reading, with a focus on social rented housing (Tinker and Lansley 2005). A range of assistive technology adaptations was considered including telecare and stair-lifts. Access and mobility issues played a major role in determining whether a property could be adapted to meet an elderly person's abilities; many properties, for example, could not be made accessible to wheel-chairs. Obstacles to adaptations included changes in floor level within the same floor, a small bathroom or one with no scope for enlargement, concrete structures, and restricted areas around the property. The Office of the Deputy Prime Minister has looked at the need for properties to be adaptable. In 2004 it announced a potentially helpful review of the Building Regulations to look at changes that would help people to remain in their own homes as they aged, with a view to legislating by 2007.

The 2006 government White Paper, *Our Health, Our Care, Our Say* (Department of Health 2006), recognised that there is a growing evidence base showing that preventative measures involving a range of services, including suitable housing, 'can achieve significant improvements in well-being'. The government's strategic framework, *Quality and Choice for Older People's Housing* (Department of the Environment, Transport and the Regions 2001), outlined five key areas of policy development for older people's housing.

- **Diversity and choice** Ensuring the provision of services that are responsive to all older people's needs and preferences.
- **Information and advice** Ensuring that information and advice is accessible both to professionals and older people themselves on the variety of housing and support options available.
- **Flexible service provision** Assisting local authorities and service providers to review housing and service models to improve flexibility.
- **Quality** Emphasising the importance of quality of housing and support services, both in terms of ensuring homes are warm and safe and in monitoring the services provided.
- **Joint-working** Improving the integration of services delivered at the local level by housing, social services and health authorities.

This framework is put forward as 'a first step' in meeting the changing expectations and needs of the older population, 'bringing together housing, support and care options to provide older people with a good life at home'.

# Current housing arrangements for older people

Around 30 per cent of all UK households are currently headed by someone aged 60 or over (Easterbrook 2005), but the current provision of housing for the elderly is of very variable quality. According to the English House Condition Survey 2001, 35 per cent of people aged over 60 lived in property that did not meet its ‘decent home’ standards, slightly above the overall proportion of 33 per cent for the population as a whole. But the rate was above 40 per cent when the older person was either aged 85 and over, resident in the same house for 30 years or more, or a private tenant (Office of the Deputy Prime Minister 2003).

There are clear age-related differences in the tenure of housing (see Table 1), which will influence the provision of, and payment for, long-term care in the future. Home ownership has steadily increased so that 80 per cent of those who will reach the age of 65 over the next 20 years already own their own homes. This means there will be a bigger market for privately-owned homes suitable for older people, including the very old. As well as wanting the opportunity to downsize into smaller owner-occupied units, there is also the possibility that in future some older people may choose to sell and move into suitable rented accommodation in order to release capital, creating a market for accessible privately rented properties.

The data also indicates that the proportion of people living in the social rented sector is smaller among those who will reach retirement in the next two decades than among people already over 65. Nonetheless, the proportion remains significant. Someone in this housing sector who can no longer cope alone at home is more likely to qualify for state-supported care in a residential or nursing home than an owner-occupier, because property assets would normally be included in the means-testing assessment for a care home place

**TABLE 1: AGE OF HOUSEHOLD REFERENCE PERSON, BY HOUSING TENURE**

Tenure	Age 45–64 (%)	Age 65–74 (%)	Age 75+ (%)
Owned outright	32	69	64
Buying with a mortgage	47	7	2
<b>All owners</b>	<b>80</b>	<b>76</b>	<b>67</b>
Rented from council	10	13	18
Rented from residential social landlord	5	7	10
<b>All social rented sector tenants</b>	<b>14</b>	<b>20</b>	<b>28</b>
<b>Rented privately</b>	<b>6</b>	<b>4</b>	<b>6</b>

Source: Office of the Deputy Prime Minister website  
 Note: Residents of communal establishments not included.

(although this is not the case if a spouse, or other qualifying individual, remains living in the property). So if frail elderly people in social housing are to be offered housing choices other than traditional care homes, there will be a need for the social rented sector to expand its range of options that are suitable for those with dependency.

Further detailed data from various sources covering the living arrangements and housing tenure of older people are presented in a recent report from the International Longevity Centre UK on meeting the housing needs of an ageing population (Edwards and Harding 2006).



# New housing models

The policy shift towards supporting older people so that they can continue to live in their own homes for longer has been a significant trend in social care over the past decade. In terms of the fabric of the accommodation, Home Improvement Agencies can provide advice, support and assistance to owner-occupier elderly people to help them repair, improve, maintain or adapt their homes to meet changing needs. The agencies are usually small, not-for-profit organisations, funded and supported by local and central government.

Even so, an older person and their family can still feel, at a time of crisis, that a very stark choice is presented between moving into a care home or putting in place a complex domiciliary care package. Various housing-with-care models have evolved with the aim of offering a middle ground, with the flexibility to address a range of changing care needs. At best, the different housing models should offer a continuum of housing and care options for older people.

There are no hard and fast definitions of the various types of housing options aimed specifically at older people, and many terms are used in different ways by different organisations. Many of these new models of housing with care have emerged fairly recently and will continue to evolve. The labels include assisted living, sheltered, enhanced sheltered, very sheltered, close care, and extra care housing.

- **Sheltered housing** This is usually comprised of a number of self-contained, independent homes – flats and sometimes bungalows – each with their own front doors. A lower age limit of 55 or 60 is common. The individual units are linked to an emergency alarm service, and include design features to make life easier for elderly people. There is usually an on-site warden, and communal facilities such as a lounge and laundry. Rental and privately-owned sheltered housing is available, although not always on the same site. There is a trend towards providing a higher level of support, to create ‘enhanced sheltered housing’. Residents have security of tenure.
- **Extra care housing (or very sheltered housing)** These units offer an older person self-contained accommodation with their own front door, but also provide a significantly higher level of support than sheltered accommodation. Round-the-clock care is available, and nursing care is sometimes on offer. The service element is integral to the extra care product, and not an added extra. There are additional facilities (for example, in terms of bathroom design) for the less mobile. The communal facilities tend to include social and practical facilities, such as lounges and laundries, but can be more extensive with gyms and a small shop, depending on the size of the whole scheme. A meals service is usually on offer. Extra care housing can sometimes provide a permanent home for life, and (for some people) an alternative to a move into residential care. It aims to promote independent living and a higher quality of life than in a care home. Extra care housing models often combine very naturally with the use of telecare systems (see Background Paper 7 (‘Telecare’)). Extra care can also, in principle,

provide respite care or intermediate care after an elderly person's discharge from hospital. Residents have security of tenure.

- **Close care housing** This is a 'half-way' option whereby independent flats or bungalows are built on the same site as a residential care home. The units are available for rent or purchase, and can follow the model of either sheltered or extra care housing. Some services (such as cleaning) are included in the service charge and other services can be purchased from the care home. If a resident needs greater support, a move into the care home is possible so that the resident can maintain a continuity of social life as they become more dependent. Residents have security of tenure.
- **Retirement villages** These comprise estates or village-sized developments of bungalows, flats and/or houses, intended for older people. The 'village' can offer different levels of support, and a range of types of accommodation, to suit various levels of dependency. Residents have security of tenure. The Joseph Rowntree Foundation has pioneered the provision of retirement villages.
- **Abbeyfield society** These units usually offer a bed-sit arrangement, often with an *en suite* bathroom, but most meals are taken communally. Thus the accommodation is not self-contained, so does not satisfy the usual criteria for sheltered or extra care housing.

There are many different models for ownership, and new developments are increasingly offering a mix of types of tenure, although not necessarily on the same site. However, research by the Joseph Rowntree Foundation has pointed to the current polarisation of specialist housing provision:

*Registered Social Landlords (RSLs) and local authorities develop social rented provision largely for low-income older people, and the private sector develops extra care type housing for sale for more wealthy people. This contrasts with the general housing market, where there is a growing trend to create mixed-tenure communities. The group believes that there needs to be a much greater flexibility of tenure and housing options, in order to break down the current polarisation and barriers between welfare and private provision.*

(Joseph Rowntree Foundation 2004)

There are a number of different categories of tenure for housing with care.

- **Registered social landlords** These are not-for-profit housing providers that are approved and regulated by the government through the Housing Corporation. The majority of registered social landlords are housing associations, which are now the biggest providers of new homes for rent for people in housing need. In some local authority areas the whole social housing stock has been turned over to a registered social landlord to manage. Registered social landlord eligibility criteria usually cover health, disabilities, loneliness, fear, isolation from friends and family, and inability to buy a property. In some cases, registered social landlords also offer shared-ownership schemes, which help people who cannot buy a home outright (see below).
- **Private retirement housing** There is already a thriving private market in retirement homes, with more than 100,000 retirement for sale units already built. These properties are usually sold on a long (99 or 125 years) lease in England. The private sector, which has invested heavily in traditional sheltered housing, has been slower to move into extra care schemes, and expansion of this housing with care sector has been relatively modest. Developers' definitions of extra care are also sometimes closer to assisted living. Developers of owner-occupied extra care units include Retirement Security and McCarthy & Stone (which in recent years has expanded from private sheltered housing

into private extra care). Owners of private retirement housing pay a service charge, which can be quite high, to cover maintenance, onsite staff, an alarm system and domestic support. Optional charged services include meals and additional support and care. In some cases the developer or freeholder has a first option right to buy back the property if it is put up for sale, which can have a negative impact on the price. There is also privately owned housing, which is available for rent, usually situated within an owner-occupied development, but occasionally in a rental-only development.

- **Life interest plans** These offer the opportunity to purchase the right to occupy a retirement property for the rest of one's life, or for both lifetimes in the case of couples. This reduces the capital outlay when moving into a retirement home, but can involve quite a difficult judgment of value. If the older person's plans change, the sale price on a life interest property may be low.
- **Shared ownership** Such schemes offer a person the opportunity to purchase a stake in a property if they cannot afford to buy it outright. Rent is paid on the residual share. This option is usually only offered by housing associations. On sale, the resident receives the appropriate proportion of the whole value of the property. In some cases, there can be the potential to increase the proportion of the property that is owned, for instance, when financial circumstances permit.

# Availability of extra care housing

The commonly-expressed preference of dependent older people to avoid a move into a residential care home has encouraged particular interest in extra care housing. However, as Table 2 shows, even when using a very wide definition of extra care, the provision of extra care units currently lags far behind that of sheltered units, at only 3.4 units per 1,000 people aged 65 and over, compared with 60.1 units for sheltered housing. Extra care is only available to a limited number of people; approximately 20,000 older people live in self-contained extra care schemes, compared with over a third of a million residents of care homes and a comparable number of people receiving dispersed home care in the community (Laing & Buisson 2005). Elderly Accommodation Counsel figures (see Table 2) also show considerable regional variation in availability, ranging from 1.9 units per 1,000 in Yorkshire and Humberside, to 5.4 units per 1,000 in the West Midlands. The 20/20 Vision Project – a group of national older people’s housing stakeholders – recommended in its report that the government should consider tripling the number of extra care units to over 75,000 during the next 10 years (Allardice 2005).

The older a person is, the more likely they are to be living in sheltered or extra care accommodation. As Table 3 demonstrates, for all age bands these options are also more popular among people living alone; together they are currently accommodating around one in four of those over the age of 85 who are living alone. (These figures are for Great Britain, not England.)

Unpublished research for the King’s Fund Care Services Inquiry concluded that the current expansion of Extra Care housing ‘is largely driven by local authorities responding to funding opportunities from the Department of Health working with registered social landlords and voluntary sector partners’. It also discovered evidence of charitable money

**TABLE 2: EXTRA CARE AND SHELTERED HOUSING UNITS IN ENGLAND, JULY 2005**

	Rent			Sale	All	Population of 65+	Units per 1,000 (65+)		
	Local authority	Residential social landlord	Both				Rent	Sale	All
<b>Extra care* housing</b>	5,558	14,904	20,462	6,162	26,624	7,807,600	2.6	0.8	3.4
<b>Sheltered housing</b>	183,073	195,549	378,622	90,782	469,404	7,807,600	48.5	11.6	60.1

Source: Based on figures from the Elderly Accommodation Counsel (personal communication 2005)  
 \* Includes extra care, very sheltered, close care and assisted living.

**TABLE 3: THE PREVALENCE OF EXTRA CARE AND SHELTERED HOUSING (COMBINED\*), BY AGE**

	Percentage of age cohort living in sheltered accommodation For all household types (For those living alone)				
	Age 65–69	Age 70–74	Age 75–79	Age 80–84	Age 85+
Resident warden	2 (3)	4 (8)	7 (12)	8 (13)	15 (19)
No resident warden	2 (5)	3 (8)	3 (6)	5 (9)	4 (5)
<b>Total</b>	<b>4 (8)</b>	<b>7 (16)</b>	<b>10 (18)</b>	<b>13 (22)</b>	<b>20 (24)</b>

Source: Office for National Statistics 2001

\* A broad definition of sheltered accommodation is used, which includes both traditional sheltered and extra care housing.  
Note: Figures exclude those living in communal establishments such as residential or nursing homes.

being used to enable providers to enhance the quality of schemes and make rents more affordable. However, it found that privately developed schemes were less common: ‘Although the private sector is moving strongly to increase the volume of retirement housing for sale, this is generally only in areas where there are high concentrations of older owner-occupiers and, usually, without provision or capacity to support people with high dependency levels’ (Leather and Molyneux 2005).

Extra care housing developments have also had to position themselves within the existing regulatory structure. Sheltered housing and extra care housing that does not offer personal or nursing care also falls outside the Care Standards Act 2000. But the organisation providing the personal care must register. The Department of Health Guidance on this issue states: ‘Where it is clearly the case that personal care is being provided in a person’s *own home*, then registration as a domiciliary care agency is likely to be required. There will be no registration as a care home, irrespective of the level of personal care available’. The guidance also says, ‘In the case of extra care housing or supported housing, possession of an assured tenancy will generally mean that a person has a right to deny entry to other people, including care workers, without this having an effect on their right to occupy the dwelling’. Since receipt of care is not a condition of extra care tenancy, the accommodation and care are not being provided ‘together’ in the way that the Act appears to mean. This is of relevance in terms of financing models, and affects eligibility for various state benefits, such as Supporting People grants and Attendance Allowance for state-funded users, which are available for those in their own homes but not for care home residents.

The government is encouraging extra care housing as a key element in extending the housing with care choices of older people. The Department of Health’s Extra Care Housing Fund is providing £87 million in 2004–6 to enable social services and their housing partners to provide new extra care housing. During the same period, the Housing Corporation has provided funds of £93 million. A further £60 million will be available for 2006–8 (Department of Health 2005a). The original target of 1,500 new extra care housing places in 2004–6 was overtaken, with the government estimating it would achieve 3,076 new units in 2004–6 under its Extra Care Housing fund. In 2005, the then Community Health minister, Stephen Ladyman, said that he considered extra care housing, rather than care homes or sheltered accommodation, would become ‘the dominant model’ for older people’s accommodation over the next generation. He continued, ‘If we can create

innovative schemes with flexible support on tap, then people will choose extra care in preference to sheltered accommodation because they will know that when their needs change they can be catered for without having to move again' (Department of Health 2005b).

# Benefits of extra care housing

Extra care housing offers the potential for independent, active living and avoids the one-size-fits-all approach to care provision. The amount of care and support offered to an older person can be adjusted to account for varying need, and can be provided within the same accommodation. This meets the desire of older people to have control over their own lives, including the retention of financial control. For the growing proportion of home owners, leasehold provision offers the option of maintaining housing equity. A property-owner who moves into a care home may be expected to spend-down much of the value of the former home (unless a partner or other qualifying individual remains in residence) whereas funds that are reinvested in an extra care unit will not be assessed in the current means-testing regime. Thus older people who are keen for their children to inherit their assets may find extra care housing attractive.

Although the evidence is limited, there are suggestions that extra care housing can avoid unnecessary admittance into a care home. One survey of a group of older people recently admitted to residential care looked at whether extra care would have offered an alternative. In 28 of the 36 cases, the decision to enter a care home followed a critical event such as a fall and/or hospital admission. In the absence of community-based 24-hour care, residential care was seen by relatives and professional teams as the option of least risk, with the older person agreeing to the decision in order to avoid being a burden. It was estimated that two-thirds of those surveyed could instead have entered extra care either currently or at the time of an earlier move (Sitwell and Kerlake 2004). The extra care model can be tailored for specific groups of potential residents. Extra care housing can also help to limit the splitting up of elderly couples when an elderly carer can no longer cope alone.

A recent, and thorough, review of all the evidence relating to new models of housing with care, including extra care housing, found support for the idea that it is the combination of independence and security that older people seem to value particularly (Croucher *et al* 2006). The review said that 'Knowing staff were there to help in emergencies or provide more regular care also reduced people's feelings and/or fears of being dependent on family members'. Several of the studies reviewed by Croucher and colleagues indicated that family members continued to give considerable care and support to older relatives, but that the housing with care model allowed the responsibility for caring to be shared with others. The studies also suggested that choice and control were key reasons behind a high level of satisfaction among residents of different schemes: 'Across the studies a consistent view from residents was the importance of not being forced to take part in social activities, or being able to choose when to participate in activities and social events and when to withdraw.' The literature review concluded that housing with care 'offers a valued combination of independence and security' and that 'there is also evidence that housing with care offers opportunities for companionship and mutual support'. However, it

pointed out that the evidence consistently reported that the very frail and people with sensory and cognitive impairments were on the margins of social groups and networks. In addition, it found that the evidence regarding whether housing with care provides a home for life, or offers a substitute for residential or nursing home care, was ‘ambivalent’.

There are individual studies that suggest extra care residents tend to show a reduction in need. The Extra Care Charitable Trust (which runs 25 housing/care schemes with 2,000 residents) cites independent research from 1997 showing that extra care residents demonstrated significant improvements in their condition after admission: on average, the superficial physical assessment score jumped by more than 50 per cent; there was a mobility improvement of more than 35 per cent; a 20 per cent improvement in daily living functions; a 10 per cent increase in sensory ability; and a 25 per cent reduction in medication use. The majority of residents had transferred from hospital or nursing homes, and the greatest improvements were seen in the first 10 weeks in extra care. It is of course unclear whether people would have improved anyway after discharge from hospital and since no control group was reported, caution is needed. Nonetheless, there is sufficient promise to justify a more rigorous analysis. A number of other studies (reviewed in Croucher *et al* 2006) looked at the impact of housing with care on the health status of residents, and found positive results, although it was difficult to generalise across studies.

The extra care model can be tailored for specific groups of potential residents. For example, the Sonali Gardens scheme, launched in July 2004 in Tower Hamlets, sought to break down some of the barriers and provide an environment that was attractive to the elderly of Bangladeshi and Asian origins. Around 80 per cent of staff speak one of Urdu, Sylheti or Bangla. During Ramadan, care staff working hours were adjusted to allow for the fasting period, and a communal meal was provided in the day-centre after the fast was broken.

Flexibility is generally one of the strengths of extra care and it is expected that the model will continue to evolve. For instance, the 20/20 Vision project suggests that an awareness is needed to avoid extra care being perceived as too institutional for future generations: ‘Any specialist housing may be tagged as institutional because the criteria for residency are controlled. If only frail people are admitted, extra care is likely to be regarded as institutional in the future... As with sheltered housing, the design, services, staff working practices and its relationship with the local community can contribute to or dispel this image’ (Allardice 2005).

Despite the various benefits, for a proportion of residents, extra care housing cannot provide a home for life, and a final move into residential care may become inevitable. Although extra care housing normally has 24-hour onsite care, it does not provide the same level of support as the care home model, which is designed specifically for people who have unpredictable and continuous need – particularly people with severe dementia. Again, Croucher and colleagues (2006) provide an extensive review of studies into the circumstances in which residents move on to residential and nursing care homes.



# Extra care housing and dementia

A housing-based model for dementia care could replace residential care for some people with moderate to severe dementia. Given the projected increase in the number of people over 85, this could be a significant driver of the demand for extra care housing. All too often, it is left to a spouse to care for the person with dementia, and when the burden becomes too great, one or both partners are moved into care homes and are often separated. Extra care accommodation offers the opportunity for couples to remain together, and for those living alone to receive the necessary support to enable them to continue living in a home of their own.

A longitudinal study by Housing 21 looked at the success of extra care housing for people with dementia (Vallelly forthcoming). Some 48 residents with an average age of 85.6 years were involved in the first wave, of whom 16 were still resident in extra care after three years. In total, 103 people with dementia were included, with data collected on up to five occasions over a three-year period. The high specification design of the units included features such as colour-coded corridors, to aid those with dementia. Care packages ranged from 1.5 hours a week to 21 hours a week. The average number of hours of care for residents in some cases declined slightly over the period. In the first nine months, four people died and four moved on to nursing homes; the average stay for those who left extra care housing, for whatever reason, was just over two years. In the qualitative investigations, the majority of residents reported being happy with their surroundings. The combination of being independent and being cared for was appreciated. However, some tenants said that they felt isolated and lonely, and found it difficult to make friends. There was a need to 'reconcile the tension' between respecting someone's privacy and providing a stimulating environment. Publication of the full study is due at the end of April 2006. It suggests that extra care housing is working for the majority of people with dementia, extending their independent lives and providing a good quality of life.

A number of questions relate specifically to the provision of extra care housing to people with dementia (for a full discussion of the issues, see *The Challenges of Providing Extra Care Housing to People with Dementia* (Housing Learning and Improvement Network 2004)). Should people with dementia be housed in a separate wing or development from the other elderly residents? Hanover Housing Association has opted against this in favour of an integrated, dementia-friendly model. Other providers have made different decisions. A related decision is whether there should be a distinction between permitting people who already exhibit dementia symptoms to move into an extra care housing scheme, and encouraging existing residents who develop dementia to remain in a scheme. Some providers recommend that an older person should move in to the new extra care home as soon as possible once there are signs of dementia taking hold, so that the resident can settle in and establish friendships and relationships before the dementia becomes more severe.

A higher level of care is necessary in order to enable someone with moderate to severe dementia to remain in an extra care setting. Local authorities are sometimes unenthusiastic about providing this extra care. The higher level of care also potentially creates a grey area over the question of whether the extra care facility is providing a level of care more normally associated with a care home. According to the Department of Health guidance, having a valid tenancy is fundamental to the distinction between housing and residential care. But someone with advanced dementia may not themselves be able to enter into a valid tenancy if they can no longer understand it.

# Cost models for extra care housing

The high upfront costs of setting up an extra care housing scheme mean that creative funding packages are often necessary. Such packages vary, depending on whether the accommodation is designed for social housing or private purchasers, or a combination of both. The following section draws on information from a report by King and colleagues (2005).

## Capital costs

The basic capital finance for most extra care housing schemes (at least where there is a large social rental element) are: Social Housing Grant (only for registered social landlords), Department of Health grant, mortgage and contribution of land and/or buildings from one of the partners involved in the development such as the local authority. Money received in rent will often be used to repay loans and interest. Further funding may come from charitable donations, PFI/public–private partnerships, social services funds to pay for telecare, and so on. In addition, primary care trusts could in principle fund the health-related elements. A small contribution to capital costs of equipment such as alarms and telecare could in the end come from the revenue streams of Housing Benefit and/or the Supporting People grant that is payable to eligible residents.

The timescale of a new-build extra care housing development can be up to four years, taking into account obtaining and purchasing land planning approvals, assembling funding and building. It is estimated that a development with 35–40 flats for ‘affordable’ or low cost rents has build costs of £4 million, and that £2.6 million–£2.8 million (65–70 per cent) of the costs need to be provided by public subsidy in order to achieve target rents (Riseborough and Fletcher 2004).

Remodelling existing buildings into extra care can take less time and be completed at lower cost but this will depend on how much remodelling is needed. The demand for outdated sheltered housing has fallen, and many such schemes are hard to rent. The cost of conversion to extra care housing varies considerably, but in some cases is viable and can produce another stream of social extra care housing. The Housing Learning and Improvement Network suggests that remodelling a suitable existing sheltered housing scheme to provide 30 extra care flats with ‘affordable’ rents would cost £2 million in average building costs with a £2.2 million public subsidy required to achieve target rents (Riseborough and Fletcher 2004).

## Mixed tenure

The mixed-tenure option, where an extra care development combines rental, sale and possibly shared ownership units, has proved popular with purchasers. It can also help the

financial viability of a project by reducing borrowings and (if the private units are sold at above cost) subsidising the associated social rented housing. The funds recouped from sales can also be used to subsidise communal facilities. The sales can be on an outright or shared ownership basis, and when implemented as a shared ownership, the residual rent is often funded by Housing Benefit. One challenge for the developer is to ensure that the service charges are affordable for all types of resident in a mixed-tenure set-up.

Mixed tenure is a possible approach to establishing a viable extra care scheme in a rural area. The minimum size of an extra care home development is usually around 30–40 units to make it economic, and demand in a sparsely populated area may not otherwise support such a project.

However, private extra care properties are not cheap. The April 2005 financial results from McCarthy & Stone give the average sales price of their extra care units as just over £200,000 (McCarthy & Stone 2005). An expansion of private sector provision of extra care homes might encourage more affordable prices.

## Revenue funding

Extra care offers a range of services (accommodation, accommodation-related services, support and care), the costs of which tend to be met from a variety of revenue streams. As well as private funds, the sources of funding for lower income residents include: Housing Benefit, Council Tax Benefit, Supporting People grants, means-tested social services funded care (including Direct Payments), and Attendance Allowance.

From the older person's point of view, an extra care home is still a home and eligibility for various state benefits remains the same. Similarly, charges for domiciliary care services will continue to be means-tested according to the local authority's rules. Because of the wide variety of funding streams, some locally and some centrally provided, overall cost comparisons between residential and extra care homes are complex, although case studies suggest potential cost-benefits from the local authority's point of view (*see below*).

Primary care trusts are often asked to contribute to health services provided in an extra care housing scheme. In particular, they are likely to fund intermediate care units, which are not eligible for either Housing Benefit or Supporting People grants.

Making a scheme's facilities (a gym, restaurant or shop) available for use by people living nearby can provide other revenue opportunities. It can also promote social inclusion and cross-generational contact. However, issues of privacy and security need to be considered, and there can be resistance from residents.

## Hybrid systems

The Joseph Rowntree Foundation (JRF) at its Hartrigg Oaks extra care village offers residents a variety of flexible funding options for both the residence fee (covering the cost of living in the property) and the community fee (for care and support and property maintenance). The JRF does not subsidise the community, and the scheme receives no state support (beyond what residents are entitled to claim in the way of benefits).

Residence fee options are:

- **a full refundable fee**, whereby the occupant deposits a sum of money equivalent to the market value of the property. This is refunded if the resident moves out of Hartrigg Oaks
- **a smaller non-refundable fee** (unless the resident leaves within a specified period in which case a partial repayment is made). The amount depends on the age of the person and value of the property
- **an annual fee**, in effect a rent paid monthly.

The Community fee also has three options.

- **A standard fee** In effect this is an average fee in return for which the resident is entitled to whatever level of care is needed. The fee is based on the person's age on arrival. Generally, some residents with lower needs subsidise those with greater needs, in the knowledge that as they themselves age and need more care there will be no fee increase.
- **A reduced fee plus a one-off capital sum** This might suit an asset-rich, income-poor resident.
- **Fees for care, or pay-as-you-go** Under this option, a resident pays for the care that they actually receive, plus a fixed sum towards property maintenance and basic community nursing costs.

# Does extra care housing save money?

Extra care housing offers potential quality-of-life benefits but whether it costs less overall than alternative care packages is a complex question. The answer often depends on the point of view from which the relative costs are being assessed. Extra care housing can be cheaper to social services because the housing costs are often covered by Housing Benefit and Supporting People grants. But when these income streams plus the cost of state-funded domiciliary care are all taken into account, it can prove more expensive for the state overall than a care home place. The financial outcomes for the older person depends on many variables including whether the individual qualifies for means-tested financial support and state benefits. The different charging policies of local authorities in England for home-based care also mean that it is impossible to generalise. Finally, the strong support and the recent availability of government funds for extra care schemes can tend to make the financial picture look more attractive than it might be in the longer term if those subsidies were no longer available.

Croucher and colleagues' literature review (2006) surveyed the evaluations to date of the cost-effectiveness of housing with care. It concluded that: 'As yet the evidence does not demonstrate that housing with care offers a cost-effective alternative to residential care, or to care in the home. The complexities of costing services must be noted, alongside local variation in costs and charges, as well as the personal financial resources available to individuals'. The review confirmed the difficulties of arriving at an overview of cost-effectiveness and the 'scant' amount of evidence currently available. In addition, it raised the issue that while housing with care supposedly offers a better quality of life, and greater independence and autonomy, 'how can these relatively intangible factors be brought into the costing equation?'

An important issue is the question of relative costs from the point of view of a local authority, as this will affect a council's decision whether or not to invest in extra care housing. A December 2005 modelling exercise commissioned by the Housing Learning and Improvement Network (Housing Learning and Improvement Network 2005) evaluated possible models for the expansion of extra care housing in the Yorkshire and Humber region over the next 10 years, doing so from the perspective of the council. It looked at three options, and compared them with a base case that only adjusted extra care provision for population growth. It forecast that the number of older people requiring care in the region would increase from 119,400 in 2003 to 136,000 in 2015. The base case assumed that the proportion of the population aged 65 and over requiring care services in any setting would remain steady at 15 per cent, and that the proportion going into residential care would also remain unchanged. The three scenarios were as follows.

- **Option 1** Extra care housing increases in line with population growth and replaces 16 per cent of residential care and 1 per cent of sheltered housing.
- **Option 2** Extra care housing increases in line with population growth and replaces 40 per cent of residential care and 2 per cent of sheltered housing.

**TABLE 4: COMPARATIVE CURRENT BUILD AND OPERATING COSTS OF DIFFERENT CARE SETTINGS**

Care setting	Average capital cost per head 2004/5 (£)	Average operating cost per week (£)
Nursing care	44,006	359
Residential care	56,256	338
Extra care housing	86,882	185
Sheltered housing	62,554	142
Home care	n/a	73

Source: Housing Learning and Improvement Network 2005

- **Option 3** Extra care housing increases in line with population growth and replaces 68 per cent of residential care and 3.5 per cent of sheltered housing.

The estimated existing average capital and operating costs for the different types of care in the Yorkshire and Humber region are shown in Table 4 (the level of care differs between the different settings).

Comparisons were undertaken using discounted cash-flow analysis to determine the net present value (NPV) of costs of the base case and the three scenarios (see Table 5). All three had higher capital costs than the base case, because of the high capital costs of extra care housing, but lower operating costs. A summary of the total net benefit/cost NPV as compared with the base case is shown in the table (a negative number represents a higher cost than the base case).

Projected costs were then reduced by assuming a greater proportion of remodelled existing housing and a lower cash cost of care over the long term. It was also assumed that for the model of extra care housing to work at its best, it should include a broad mix of people with different levels of need – from those requiring no care to those needing 24-hour care. Otherwise, half the projected future residents would have been in residential care, and the remainder in sheltered accommodation and low-level care settings. This resulted in Option 1 producing a net cost benefit of £5.4 million, and this was the preferred

**TABLE 5: SUMMARY OF NET BENEFITS AND COSTS OF THE THREE EXTRA CARE HOUSING SCENARIOS COMPARED WITH THE BASE CASE SCENARIO**

	Total net benefit/cost net present value (capital + operating) (£million)	Capital costs net present value (£million)	Operating costs net present value (£million)
<b>Option 1</b>	-21.9	-135.6	113.6
<b>Option 2</b>	-143.0	-447.5	304.5
<b>Option 3</b>	-382.0	-904.6	522.6

Source: Housing Learning and Improvement Network 2005

option. The Yorkshire and Humber work is probably the most detailed attempt to model a region-wide implementation of extra care housing, from the local authority's point of view. But even these detailed projected future costs only included direct capital and operating costs and did not attempt to factor in wider issues such as the impact on state benefits of different care settings, or the financial impact of owner-occupiers releasing housing equity when downshifting into smaller units such as extra care housing.

Most cost analyses have been conducted on a much smaller scale as part of pilot implementations. An example of a scheme aimed specifically at people with dementia is Portland House, an extra care unit for eight older people, which was opened in February 2003. During 2004, St Helens Social Services, Merseyside, commissioned an evaluation of Portland House. The evaluation was favourable, reporting that residents were able to maintain a high degree of independent and active living. For example, the average number of outings undertaken by residents per month in winter was 20, with a range of 14 to 26 and higher numbers in summer if the weather was good. This contrasted with lower numbers of outings among residents living in other forms of residential care. At that point, the cost to tenants was approximately £112 per week for rent, service charge, heating and refurbishment. Tenants had on average a disposable income of £95 per week to cover food, outings, clothes and personal care costs. The cost to social services was approximately £90 per week for personal care but, on average, £40 of this could be recovered in charges. The Housing Benefit/Supporting People costs were £271 per week. The evaluation put the total cost for all care and support in Portland House at £360 per week. This compared with the costs at that time of £327 per week for general residential care and of £358 per week for specialist care. The care home fees would have been paid from the social services' budget but on average £120 per week would have been recouped in charges, with residents then being allowed to keep around £18 a week in personal allowance (St Helen's MBC 2004).

An enhanced extra care housing scheme specifically aimed at avoiding admittance to residential care is Dray Court, commissioned by Guildford Borough Council in October 2003 and evaluated in June 2004 by Grimwood and Andrews (2004). At the time of the evaluation, Dray Court provided enhanced extra care housing for eight people, and residents had to need at least one of the following: home care outside normal care hours; four or more home care visits per day; or occasional home care to respond to an unstable condition. Of the respondents surveyed, 57 per cent came from their own home, including council accommodation, 29 per cent were admitted from residential care homes, and 14 per cent came from an acute hospital setting.

The evaluation put forward the following cost analysis, illustrating how the question of cost/benefits depends on whose point of view is being taken and the interplay between housing-with-care costs and the benefits system. Of the eight tenants, five indicated that they would have had to have been considered for residential care, were it not for the availability of enhanced extra care. The cost of five places in a care home place would have been £1,475 per week to Surrey County Council; the net figure from the council's perspective would have been £1,075, on the basis that, on average, an £80 contribution was paid by the older person to their care home fees. The weekly cost of the enhanced extra care scheme at Dray Court represented an average cost per tenant per week of £185, that is, £925 per week for five tenants. This calculation was made on the assumption that the current unit cost for in-house home-based care was (a high) £17.30 per hour and that



**TABLE 6: PROJECTED COMPARATIVE COSTS FOR RESIDENTIAL AND ENHANCED EXTRA CARE HOUSING, BY NUMBER OF TENANTS**

Costs	5 tenants		10 tenants		15 tenants		20 tenants	
	Week	Year	Week	Year	Week	Year	Week	Year
Residential	£1,075	£55,900	£2,150	£111,800	£3,225	£167,700	£4,300	£223,600
Enhanced extra care housing	£925	£48,100	£1,850	£96,200	£2,775	£144,300	£3,700	£192,400

Source: Calculated using figures from evaluation of Dray Court enhanced extra care housing scheme (Grimwood and Andrews 2004)

376.25 hours of home-based care was provided across eight tenants during the month of May (acknowledging that the recorded figure of 376.25 hours does not take into account ‘unrecorded’ contact hours or standby hours). The overall cost of £925 per week for five tenants does not take into account any contributions made by the tenant to the cost of their home care, but these were likely to be small. It also only considered the care costs (and not accommodation costs).

The figures were extrapolated to give a set of comparative costs for residential and enhanced extra care as more tenants joined the scheme up to a maximum of 20. In this projection (see Table 6), the level of standby time was assumed to be minimal.

In order to compare like with like, the total costs of extra care, incorporating the accommodation element, also needed to be considered. The weekly average rent for a one bedroom property at Dray Court was £140.99 per week, inclusive of all support, including staff costs. However, the rent and management element was eligible for Housing Benefit, while the support element would be eligible for the Supporting People grant. This would shift costs away from the local authority (but not from the state as a whole). There was also a general housing resource benefit to the council if a tenant moved out of family-size council accommodation in order to take up residency at Dray Court, thus releasing the council flat to someone on the waiting list. (However, this benefit would also be the case if the older person moved into a care home.) The evaluation judged that the overall cost impact appeared broadly positive from the local authority’s point of view.

Further wider financial benefits were expected in instances where a tenant was enabled to return home more speedily from hospital (one existing tenant indicated that this was the case). This was because the average cost of a day’s stay in hospital was estimated in the region of £350 in an acute hospital and £275 in a community hospital, that is, £2,450 per week and £1,925 per week respectively. (These figures appear high compared with other, independent estimates for England.)

At the other end of the spectrum, an example of a purely owner-occupier leasehold development is Blake Court in North London. It is one of the developments owned by Retirement Security Ltd (RSL), which is a leading provider and manager of private extra care housing for sale. Blake Court is a development of 73 units, built in 1997. The service charge includes a fixed amount of care or support a week. The properties are supposed to be affordable by anyone who owns a three bedroom semi-detached house in the area, who is in receipt of Attendance Allowance and who has no income other than the State Retirement Pension. (A one bedroom flat at Blake Court advertised in March 2006 was on

the market at £345,000, with a monthly service charge of £410.) All services are provided by a company whose only shareholders are the leaseholders at Blake Court. In terms of health and care, there is low use of state services, with leaseholders making little demand on social services. Retirement Security says that in the year to July 2004, the 1,540 owners of units in RSL's 29 developments spent less than four nights in hospital, compared with an average of 17 nights nationally for the same age cohort. Their average age was 83 years. (In practice, the RSL unit owners are of above average economic status, and would therefore be expected to spend less time than the average in hospital anyway (McCarthy 2004)).

In summary, any estimate of the cost impact of extra care housing will be based on a number of changeable assumptions. In an initial comparison with residential and nursing care homes, the capital costs can look more expensive because the accommodation units are much larger. It is generally accepted (Laing & Buisson 2005) that the cost of building and maintaining an extra care unit is higher than a single bedroom in a residential care home. But the ongoing cost profiles of different housing options will depend on an individual's type and scale of care needs, and extra care can prove cheaper over time. The cost argument will also depend on which costs are taken into account. According to Laing & Buisson (2005), 'There are early indications that very sheltered housing may reduce the incidence and duration of admission to hospital; if this proves to be the case, it will generate significant savings for the NHS that should be considered when comparing forms of care'. From the viewpoint of self-funders, extra care will probably be cheaper for less dependent people than a residential home (Laing & Buisson 2005), but for someone who is very dependent this may well not be the case because of higher domiciliary care costs. The final financial outcome for a self-funder is likely to be dependent on changes in property values, and the final judgment by individuals will be based on their perceptions of the value of the relative benefits of each housing option.

# Barriers to expansion

There are significant up-front capital costs when setting up an extra care housing scheme. The government is keen to see the development of public–private partnerships for extra care in order to increase supply and also to promote new models of provision. However, such partnerships have yet to become widespread. The Association of Retirement Housing Managers (ARHM) is pessimistic, saying that most local authorities ‘have no proper housing need assessments to justify private sector investment’. There appears to be a cultural divide between the public and private sector, and considerable friction over which side deserves to have the upper hand in terms of decision-making about a project. Despite the ARHM’s pessimism that the outlook for partnerships is bleak, the Association does suggest some ways in which partnerships could work. These include the provision of a site by a local authority in return for a mixed-tenure development, or a public grant towards a mixed-tenure private development that includes rental units for the local authority.

In its 2004 study, the Joseph Rowntree Foundation (JRF) concluded that greater collaborative working between the public and private sectors was desirable:

*In addition to developing capital and revenue models that will appeal to the range of financial circumstances of older people, there is also a need for a much more pro-active approach from local authorities and their partners to stimulate and promote the development of the private and mixed-tenure markets in their area. Although the housing and regeneration arms of local authorities actively work with private house-builders, this does not seem to apply so much to the private retirement housing market. How many local authorities, for example, in planning to shift the balance of provision from residential care to housing-based models of care, such as extra care housing, explicitly include housing for sale as part of their plans. And how many approach private sector players as potential partners?*

(Joseph Rowntree Foundation 2004)

This view was echoed by the 20/20 Vision project, which recommended that the regional housing board and local authorities consider the development of mixed income, outright sale extra care developments (Allardice 2005).

One of the biggest obstacles cited by private developers is obtaining land and planning permission. Private developers complain of difficulties obtaining planning consent, limited land availability, and ‘public sector prejudice’. The Joseph Rowntree Foundation also found that planning obstacles were inhibiting private sector developments (Joseph Rowntree Foundation 2004). A partnership with the local authority can help to overcome this problem if the council provides a site. Remodelling existing social sheltered units into extra care units also has the benefit of using an existing site, although the initial capital costs can sometimes be more expensive than a new-build scheme, depending on the degree of remodelling necessary.

Any ambitious extra care housing scheme demands good co-ordination between housing, social services, planning and health. The provider needs to be able to rely on the provision of, for example, community nursing. Such services for older people can either be available from the existing local community, or need to be incorporated into the scheme. Social services departments sometimes complain that the input from health is not available, and that primary care trusts are not receptive towards extra care schemes. Unless there is a clear model showing potential savings, housing and health are sometimes not interested.

The 20/20 Vision project suggested that individual respondents would appreciate clearer information about Supporting People and that eligibility should be extended to owner-occupiers and private leaseholders. The project also suggested integrating housing with care models into mainstream social care funding in view of the complications with sheltered housing models, which currently receive Housing Benefit, Supporting People grants and local authority grants for care (Allardice 2005).

# Conclusions

The housing demands of an ageing society need to come higher on the list of current government strategic priorities, including the needs of owner-occupiers who require suitable smaller properties into which to downsize. Given the preference of older people to remain in their own homes as long as possible, more could be done to inform older people about the availability and potential of adaptations.

On present evidence, the likely future trends in housing for older people will demonstrate a number of shifts over the next 20 years, many of which are highlighted in the main Review.

- A decline in the proportional demand for care home places (although this will in part depend on the availability of suitable alternatives, especially for people with dementia who can be supported in their own homes).
- A growing demand for extra care housing – an option that offers the potential for extended independent living and better quality of life for some older people who can no longer manage in their own homes.
- A continuing proportional decline in the demand for rented conventional sheltered housing. This is likely to encourage remodelling of any excess supply into extra care housing.
- A growing demand for owner-occupied retirement housing, including extra care housing.
- Greater collaboration between housing, social care and health in order to enable older people, when appropriate, to avoid moves into care homes.
- The greater use of assistive technology and telecare to enable the frail elderly to remain safely in their own homes (see Background Paper 7 ('Telecare')).

Regarding extra care housing specifically, this type of housing-with-care will be able to offer some older people a more independent style of living and will enable a proportion of older people to avoid or postpone entry into a residential care home. It can avoid the often stark choice for an older person and their family between admittance to a care home and putting in place a complex community care package.

However, it is not yet clear how many people will have the choice of extra care. Demand for this type of accommodation is likely to increase as its existence becomes better known, but the limited availability of sites for new developments is likely to constrain growth in the market. This is likely to mean that only a minority of dependent older people will be able to enjoy purpose-built extra care accommodation.

Against this backdrop, proponents of extra care argue that the flexibility of the extra care housing concept is such that it should be viewed more generally as an approach to care, which could be extended to people in their own homes. Some extra care schemes in the future could thus be organised as 'virtual' communities, supported by telecare equipment, so that the extra care concept can be applied to various accommodation options.

Such thinking is part of the view that there should be more of a continuum of housing and care options available for older people, with a smooth interface between intensive home care packages and dedicated extra care units. Put the other way around, better and more flexible support to people in their own homes, as proposed in the main Review, will also help to reduce future growth in demand for extra care housing to levels that might realistically be met.

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