

Communities and Local Government Committee

Oral evidence: Housing for older people, HC 370

Monday 4 December 2017

Ordered by the House of Commons to be published on 4 December 2017.

Watch the meeting

Members present: Mr Clive Betts (Chair); Bob Blackman; Helen Hayes; Kevin Hollinrake; Andrew Lewer; Fiona Onasanya; Mr Mark Prisk; Mary Robinson; Liz Twist.

Questions 193 – 235

Witnesses

[I:](#) Jacquell Runnalls, Co-opted Lead on Accessibility and Inclusive Design, Royal College of Occupational Therapists; Gill Moy, Director of Housing and Customer Services, Nottingham City Homes; Professor Carol Holland, Centre for Ageing Research, Lancaster University.

[II:](#) Anna Kear, Executive Director, UK Cohousing Network; Patrick Manwell, Consultant Architect, Archadia; Maria Brenton, Cohousing Consultant to the Older Women's Cohousing Community.

Examination of witnesses

Witnesses: Jacquell Runnalls, Gill Moy and Professor Carol Holland.

Q193 **Chair:** Welcome, and thank you very much for coming to give evidence to the Committee this afternoon. Before we begin, I will ask members of the Committee to put on record any particular interests they have that may be relevant to this inquiry. I am a vice-president of the Local Government Association.

Liz Twist: I am an elected member of Gateshead Council.

Mary Robinson: I employ a councillor in my team.

Helen Hayes: I also employ a councillor in my team.

Kevin Hollinrake: As do I.

Andrew Lewer: I am a vice-president of the LGA.



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Bob Blackman: As am I.

Chair: That is our interests declared. Over to you, could you say who you are and the organisation you are representing today?

Gill Moy: I am Gill Moy, Director of Housing and Customer Services at Nottingham City Homes in Nottingham.

Professor Holland: I am Professor Carol Holland. I am the Co-director of the Centre for Ageing Research at Lancaster University.

Jacquel Runnalls: I am Jacquel Runnalls, a senior occupational therapist in housing. I am here representing the Royal College of Occupational Therapists specialist section in housing.

Q194 **Chair:** Thank you very much for coming this afternoon. We have heard quite a bit of evidence about the link between having an unsuitable home and effects on people's health. What are the main aspects of unsuitable housing, and what is the impact on health, both physical and mental? I want you to give your views about that.

Gill Moy: The connectivity between poor-quality housing and health is well documented. I am sure you have received lots of evidence over the last few weeks around that. In Nottingham, we have recently conducted a BRE piece of research into the stock condition. We find that some of the worst conditions are within the private sector, both within owner-occupied and the private rented sector. We see considerable impacts on people's health. For example, 21% of the private rented stock in Nottingham has a category 1 hazard. That would be something that would increase an old person's risk of trips or falls, conditions related to fuel poverty and dampness and those kinds of conditions. There is a lot of connectivity between them.

From my point of view, I work for Nottingham City Homes, which is an arm's length management organisation that manages about 26,500 properties on behalf of Nottingham City Council. One of the big issues for us is having decent social housing so we can support people into accommodation. There is a real shortage in the supply of housing for older people, given the demand for it, because we have an ever-increasing ageing population. There is a disconnect between supply and demand within the city. With things like right to buy reducing the social housing stock, it becomes ever more difficult for us to find good housing solutions to older people's problems. The other issue is funding for aids and adaptations, and the speed with which we can do them.

Professor Holland: I have categorised this into three main areas. You have the impact of cold homes. There is a lot of evidence on the relationship between cold homes and chronic diseases, such as respiratory diseases, cardiovascular diseases, rheumatoid arthritis and those kinds of issues. It negatively affects mental health as well. Coldness can affect not just physical health but mental health.



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Another category would be the risk of falls. We also know that 75% of deaths related to falls are falls that have happened in the home, not out and about. They represent between 10% and 25% of ambulance calls to older adults. Falls are related to hazards in the home.

The other issue that we have evidence for is the relationship with the location of the home, so not just the unsuitability of the home itself, but the ability of people to get out and about, to get out of their homes in the first place, or for visitors to get into their homes if their friends have mobility impairments. There is also the need for people to access services and a social life. The location of homes is important as well. You have mobility, falls and cold homes.

Jacquel Runnalls: In terms of physical health, being able to move around your home environment safely and easily, and to be physically active, is inextricably linked to independent living, but also general resistance to illness. I know you touched on mental health. Research has shown that if people are sedentary, so they are not able to be active, they are three times more likely to be depressed than people who are active. There are also things like anxiety and depression in terms of security of tenure and affordability.

In terms of quality of life, that is also impacted by aspects such as social isolation, so what you touched on about being able to get out and about and be in your local community. Loneliness and isolation have been associated with increased mortality, with the risk potentially being about three times greater, apparently.

Q195 **Fiona Onasanya:** You were talking about cold homes, falls and location being factors. I wondered if we could look at things such as people being discharged from hospital because of the suitability of their homes and hospital readmissions. I wondered how you felt unsuitable housing would contribute to those factors.

Gill Moy: From our point of view, in Nottingham we run a project called Hospital to Home, which is all about trying to get people matched up to the right accommodation. It was partly conceived to reduce delayed transfers of care, but it spends a lot of time concentrating on early intervention/prevention. Housing has a massive role to play in that early intervention/prevention agenda, so preventing people from going into hospital in the first place, but then trying to prevent readmission.

We get a lot of our referrals from environmental health people, particularly when people are going into properties in the private rented sector where there are category 1 hazards and there is that risk to them. There is a role for the project to play in ensuring people are put into suitable housing that avoids the hospital admission in the first place.

Q196 **Fiona Onasanya:** Do you think unsuitable housing can contribute to the challenge, for example, if you are admitted into hospital and need to then be discharged but do not have a suitable home to go to? Do you think



that is a factor?

Gill Moy: Yes, absolutely. To give you an example, one of the first people we helped through the project was an old chap. I will call him Bill for the sake of a name. He was living above a pub, which sounds like a great place to live, but he could not get up the flights of stairs. He was very isolated and lonely. He fell, punctured a lung and broke some ribs, and ended up in hospital. He was in hospital for 30 weeks with delayed transfer of care because there was nowhere suitable for him to go. He was very much of the opinion, "What is the point of getting up in the morning? There is nothing for me to live for."

We managed to find him a place in an independent living scheme, where his quality of life was transformed. His health has improved. Most importantly, he has friends, people he can spend time with, so his mental health has significantly improved. Instead of getting up in the morning and thinking, "What is the point of living?", he has things to look forward to. That has a big impact on quality of life.

Professor Holland: Probably the reason I was invited to do this is because we did the evaluation of the ExtraCare Charitable Trust people moving in. We looked at how long people spent in hospital in the year before they moved in, with a follow-up the year after they moved in. We found a significant reduction from a median of five to seven days to a median of about one to two days for unplanned hospital visits. There are going to be some who are having very long stays in hospital and a whole range, but over the sample we found a significant reduction from before they moved into a supported living environment to the year after.

There are several possible reasons for this. ExtraCare has a wellbeing adviser, so a nurse, and a drop-in advice clinic where people can get advice on health issues. What we thought was happening was that people were getting to hospital perhaps sooner but before a crisis, so they were not spending as long there. Another reason is that people's homes in supported living are purpose built, so there are no access issues. They have a wet room shower. There are no steps or stairs. They are all very accessible.

The other thing is that there is care on site. Although they still need assessing for care in the same way anybody else would, care is readily available for them. They perhaps already know the carers, because their neighbours have them as well, even if they were not having care beforehand. Finally, the support is available to enable self-care from that wellbeing adviser, who is a nurse, so to help them learn how to look after any new tablets. This demonstrates that with the right support you can reduce the duration of hospital stays and help people get out quicker.

Jacqueline Runnalls: I think you have touched on the BRE report before, which estimated that the cost of poor housing to the NHS is now £1.4 billion. For all the reasons you said, it means that people are not able to be discharged. They are more likely to be readmitted if they are in a



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home that is unsafe, and are likely to have falls, and that is also cold and poorly insulated.

Also, there are health or care workers or occupational therapists, people who are going in, assessing and providing care to people in the home. If the property is poorly maintained, so there are hazards, or just generally limited space, restricted access and things like that, it may not lend itself to being adapted. These would all impact on the person's ability to receive the sort of care that they vitally need in the property, particularly hoists, special beds and other equipment.

Like I said, it might not be possible or appropriate to adapt the property, also for reasons like people's financial situation, security of tenure and landlord's permission. If you cannot adapt the property for any of these reasons, somebody may end up in quite an undignified position. They might end up being cared for in their front living room, because there is nowhere else for them to be discharged to. They might be sleeping, eating, toileting and washing in that one room, so it has a massive impact on both physical and mental health.

Fiona Onasanya: In some way, it impedes the health workers and carers.

Jacquel Runnalls: Yes, definitely, because you may not be able to adapt it. There may not be space to move around. Workers may also be at risk of tripping. If somewhere is cold and damp, I suppose you are less likely to stay there.

Q197 **Liz Twist:** I wanted to ask at what stage we identify the hazards or problems. Is it when a crisis occurs, and is there a better way of doing it?

Jacquel Runnalls: I would have thought so, yes, usually. That is what has been shown to be the catalyst for most people moving. That is why most people do not move until they are over 80 and it is a critical event. I know you touched on that before. Sometimes there will be workers or other people going in, but if people are not receiving that support theoretically they could be living in unsuitable and unsafe conditions for a very long time. Even if somebody is at risk of fire, sadly catastrophic events usually end up being a catalyst for them getting the care, again because maybe people do not know or are quite isolated. It all impacts together.

Gill Moy: The critical ones tend to come through environmental health, when they are called in to take action against a landlord for a property failing in terms of its hazards. Through the Hospital to Home project, we have found that health workers are becoming much more educated about what housing has to offer. We are able to intervene a lot earlier to prevent some of the admissions and readmissions into hospital. With stronger working between housing and health, we are intervening much earlier and trying to avoid some of the crises. There is a good news story



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there somewhere, but it is on a fairly small scale and is not replicated throughout the country. I went to the National Housing Federation meeting in London last Tuesday. I think a lot of housing organisations struggle to connect with their health colleagues.

Professor Holland: We did some qualitative work with people who had moved and looked at why they had made the move, so the things that had pushed them into making that move to the supported living retirement villages. It was a whole range. Sometimes it was a crisis, but for other people it was the increasing perception that things were not going to get better and that their own homes were unsuitable. It very much depended on them knowing what was available. A lot of people were advised to move there by their GP, or told about it by a social worker or somebody. They were all saying, "I wish I had known about this two years ago." That was a very common refrain: "I wish I had done this move a couple of years ago."

Q198 **Liz Twist:** There are two things there. The question I was going to ask is whether there should be a better way of spotting these kinds of potentially dangerous properties. I suppose the second thing is about how we can future-proof things to make them safer.

Jacquel Runnalls: In terms of future-proofing, we can go on to talk about lifetime or category 2 and category 3 homes. I do not know how you totally address that. It would depend on their tenure as well. If people are social housing tenants, they are more likely to see a housing officer or other people coming in, whereas, unfortunately, the largest number of older people are living in owner-occupied properties. If you are quite lonely and isolated, it is difficult.

One thing that has come out in research is the poor signposting to services. People are not aware of what is out there. They may not be on the internet, and a lot of things are online now. There is a decrease in some services being available, certainly information services, so it is quite hard to get out there. We need to be signposting much better.

Gill Moy: There is something to be said about doing some better branding of the offer. We run independent living schemes that you have to still be independent to go into. They are not care homes, but that is how they are perceived by many people: "You are not going to put me into a care home." There is something more about trying to do some rebranding around the different types of supported housing for older people that is available. That is something that could be done. It is a perception issue.

A lot of people do not consider moving into some form of supported housing until it is too late. The evidence shows that, if you get people to move before they reach a crisis point, the crisis is likely to happen much later; they are much likelier to settle and the barriers will be less.

Q199 **Liz Twist:** With social housing, presumably we know what the stock is



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like. Is there a case for having some other kind of stock survey? I know you said a lot were owner-occupied, but you have mentioned the private rental sector as well.

Jacqueline Runnalls: Some of the housing in the worst conditions is in the private rented sector. Anecdotally, I know some local authorities have private sector leasing schemes or teams, where they are trying to reach out and find those hazards. They register and license landlords. In terms of owner-occupiers, it is quite hard to reach.

Gill Moy: We have done a BRE stock condition survey in Nottingham, so we have a reasonable idea of what our housing stock is across all tenures. We know that about 19% will have a category 1 hazard. It goes up to 21% for the private rented sector.

Some of the challenge for owner-occupiers is that you have a lot of older people who are asset-rich; they have a house that is worth something but they are very revenue-poor and struggle to maintain it and do anything with it. If they tried to sell it, could they buy anything that is a suitable alternative? That is a bigger problem in certain parts of the country than in others.

Q200 **Mr Prisk:** This is a narrow point, perhaps for Ms Runnalls as an occupational therapist. I have seen evidence from some ambulance authorities suggesting that falls account for more like half of ambulance callouts. Given the importance of falls in the home, taking a step back, I wonder whether, as a society, we do enough to encourage people of my age group—50s, 60s and on—to be more physically active. That is looking at this issue from the other side of the equation. We are focused on the built environment, but I look at some societies in the far east where their frailty levels and decline are much less. Given the significance of falls in the home, I wonder whether you, as an occupational therapist, think there is more we could do.

Jacqueline Runnalls: There is an increasing recognition of falls. It is not my exact area of expertise, but from what I know there are falls prevention services that are set up. There is also work around enablement. I know a report was published last week for the Centre for Ageing Better. It was looking at holistic OT intervention in terms of re-ablement, but alongside repairs and adaptations. It not only increased physical function by 49% and reduced difficulties with activities of daily living by 75%, but it improved depression.

It goes back to the points I was making before. There are intrinsic links between being physically active and reduced risk of falls. There are definitely initiatives. Some local authorities or health services have falls prevention teams, and they employ OTs. It is very much seen as enabling, but it is not just one thing on its own; it is a whole broad spectrum.



Gill Moy: We just finished a three-year project that was funded through Sport England. It was a route to market for social housing tenants, but concentrated on older people as well. We implemented something called Golden Games, which was about getting people active and taking people out of the schemes. There is something socially isolating if all you ever do is bring all the services in and keep them in the scheme.

We did the Golden Games, had inter-scheme competitions and then brought them together, almost like an Olympic-type event. That has been great at mobilising people and getting them involved. We tried to encourage older people from the wider communities to come into the independent living schemes to take part. We were very successful.

Q201 **Mary Robinson:** Gill, I am interested in your point about branding and working on that idea. Is there something of a stigma attached to going into an older persons' supported home? We need to remember that a lot of people may be living on their own, but their family will be living in other areas. They may have a desire to keep their mother or father living in that home independently, as they would see it. Do we need to work on the way that we talk about this, in terms of branding and promotion?

Gill Moy: We do, and a lot of organisations are moving away from the term "sheltered housing." That in itself suggests a bit of care and a home, as if it is some kind of institution. We call all our schemes independent living schemes. We have been successful. We used to have 150-odd of them that we struggled to let. My colleague sent me an email today saying we have only one property that has been empty for more than 50 days, because we have been successful in turning people's perceptions around.

We also did a project called Grander Designs, which was trying to modernise it. A lot of local authority-built sheltered schemes are quite institutionalised. If you go in, they have the chairs round the edges and the tables. We have completely redesigned them and given them a boutique hotel finish. They look amazing. I would want to move into one when I was older, whereas when you look at the ones we have not done you think they have a bit of a sense of an old persons' home. That rebranding is very important in challenging people's perceptions about what independent living is.

Q202 **Mary Robinson:** If that was taken up as a national campaign, what sort of effect do you think it would have on people's lives?

Gill Moy: It would be huge. One of the benefits we get from it as the local authority, apart from the business case in terms of reducing our average re-let times and maximising income for us as an organisation, is freeing up family accommodation. We are losing quite a lot of our general-needs stock through the right to buy, so freeing up accommodation by moving older people into independent living has a benefit. It is a benefit for the older person as well, who might be living in



socially isolated conditions. Moving into an independent living scheme can be a positive experience all round.

Jacquel Runnalls: Touching on the labelling aspect, not in terms of supported housing but when we are talking about category 2, so lifetime homes, and category 3 housing, if we are looking at people living in mainstream, inclusively designed properties, there is a lot to be done in advertising those properties. If we are asking developers to build to those standards, people need to know what it is they are buying.

Where I work, we have category 2 and 3 properties for sale, and I get involved in the design. We look at how we market them and floorplans, and it is about people knowing what they are buying. There have been studies showing that people do not know that they are living in a lifetime home or a category 2, so they do not know what the features are. They might choose to move there if they knew. There is a need for marketing across all tenures, and that would be in mainstream housing, not necessarily supported housing.

Professor Holland: The other side of the coin is that there are not enough of them. The nice, high-end retirement villages, which are very popular, have a waiting list. They release the flats and they are all gone within a day. There simply are not enough of those. Although people have a range of choices, there are not enough of these supported living with a community hub, a restaurant and all the things that people want to make a village. There are simply not enough of them, so there are both sides.

Q203 **Fiona Onasanya:** Touching on that, what impact can moving home have? That is what I was thinking prior to this, and listening to the discussion that has come about. What sort of impact does moving have on their health and wellbeing? As you have said, some of the social housing has chairs round the outside and a table in the centre.

Professor Holland: Moving from where?

Fiona Onasanya: Moving from their own homes into some sort of assisted care home.

Professor Holland: It depends quite a lot on whether people are moving in the context of a crisis. That is one thing to consider. Where people are moving out of choice, because they are planning for their older life and perhaps thinking, "I am fine now but I might not be in 10 years' time," it seems to have positive impacts. People moving to residential care are often moving in the context of quite serious crises or are not very well. If you look at things like the mortality in the year following, for moving to residential care it is quite high, but for moving to sheltered housing it is not—it is no different from staying in your original home.

Q204 **Fiona Onasanya:** If their home is unsuitable, as we were talking about before, and they need to move, what sort of effect does that have on their health and wellbeing? I am not saying something has gone majorly



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wrong, but if the property is not suitable.

Gill Moy: It can be that, initially, they are quite afraid and it is a massive upheaval. Moving for anybody at any age can be quite stressful. When you are older, that becomes doubly so, as it is for the people who care for them. It can be quite a stressful experience initially, but once people move into some form of supported accommodation they very quickly come to realise the benefits that brings to them.

It comes back to the point about where that is located and where people are going. Is it close to support networks that they already have? Moving somebody from one place to another without those support networks being in place means it continues to be quite stressful for that person. It is horses for courses in managing how you do it. There is a plus side, in terms of people's sense of security. We have not talked about that. Supported housing often brings a greater sense of security for people, especially if they have been bereaved and suddenly find themselves living alone. It brings lots of mental health benefits to older people.

Fiona Onasanya: It could have quite a positive impact on their health and wellbeing.

Gill Moy: It could have a positive impact. Generally, that is what we find as the overall impact. There are always going to be some cases where they find it difficult to settle. The vast majority of people, once they have moved, say, "I wish we had done this years sooner." That is my experience.

Professor Holland: We did a lot of measurements, to put that into numbers. We found a significant reduction in depression symptoms over five years; that is not necessarily people with clinical depression but with depression symptoms. We are just starting to look at the four to five-year data. We have had a long-term reduction in anxiety. We had an increase in perceived health. This is relative to a control group who were not moving. We found reductions in visits to GPs. As I have just said, we found reductions in how long people spent in hospital. We found improvement in certain aspects of memory, because people were integrating more and were more active.

There are a whole host of positive benefits, particularly over the first 12 to 18 months, where most of our evidence is. We are starting to get the four-year evidence now, and it is looking very similar. Some of it is levelling off. It is not continuing to go up, but it is not going down. There is quite a lot of evidence that a positive move is very beneficial.

Gill Moy: People's financial wellbeing also improves, which has a huge impact on people's mental health. If they are feeling under pressure because of having bills to pay, should they move somewhere smaller that is more energy efficient, they will have money to spend on the things they want, including better nutrition and so on.



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Jacqueline Runnalls: I do not want to sound negative, but there are other aspects about affordability and security of tenure. That is a big thing. The possible negatives, say if somebody is "older old" and living with dementia, or is blind or has visual impairment, mean that moving can be quite disorientating, certainly initially. You would need support to get to know your new environment. That is where location is key. Particularly, research has shown that older people do not tend to move a large geographical distance. That goes back to your point about what is available in your local area, so whether you are forced to go outwith your locality.

Q205 **Mr Prisk:** Most of our constituents live in conventional mainstream housing, whether they are tenants or owner occupiers. What do you each feel would be the best way that, if they are going to stay there, we can ensure they are able to do so both healthily and safely? I understand that there is no one silver bullet here, but is there one particular area where you think, "This is the real area"? If we are talking about the existing housing stock and people staying there, what is the one area we, as a Committee, ought to focus on?

Jacqueline Runnalls: The first thing is about signposting to what is out there. As I have touched on before, evidence shows that holistic adaptations can really help. Given that 70% of disabled facilities grants go to older people, I suppose DFGs and adaptations would have the biggest impact on people living in mainstream homes. While the DFG funding has increased, the service provision is variable. We need good streamlined services.

Other difficulties are the test of resources and the limit of the DFG. I know there has been a lot of debate about whether that should be increased. Most adaptations that help people to remain in their own home are around £7,000. If you are looking at somebody remaining in a property that is not generally accessible, you are probably looking at adapting ground floor living. If it is a house, for example, you might ramp the front entrance, and you may have to extend the rear of the property to accommodate a bedroom and a wet room bathroom. You need to think about carers as well, so you need the space. And £30,000 does not go a long way to accommodate that.

Another thing Foundations has pointed out is that only 47% of local authorities have policies whereby, under the regulatory reform order, you can use the discretionary element of DFGs. They can be used in a more flexible, preventative way, aside from the mandatory element of disabled facilities grant. I know certain areas have looked at delayed discharge and step-down flats, but particularly handypersons, repair schemes, and fuel poverty and energy efficiency initiatives. Some look at relocation grants, so helping them to move if their current property is not suitable to adapt. A lot of that is around support and practical support. All those things together help people to stay in their own home.

Q206 **Mr Prisk:** For you, the reform of the DFG and its availability to those



outside the social sector, because of the way the rules work and so on, would be helpful.

Jacquel Runnalls: It would be helpful. In terms of social housing, I know from my own experience that what has really helped, particularly with councils or housing associations, is where they have a housing OT, if they are looking at refurbishments or improvement programmes, so looking at future proofing even in decent homes, when you take the bath out, you do not replace it with a bath; you might put a wet floor shower in. You might look at improvements to the kitchen, so whether you have a waist-height oven.

It even comes down to what windows and doors you use. Often your new uPVC doors, although they are nice and energy efficient, create a tripping hazard, and you cannot open the window. A lot of the new security doors are very difficult and confusing for older people to use. We have found they are less secure, because you have to engage the lock; it does not just close itself. People have ended up sitting indoors with the door effectively open, and they have not realised that, so ironically they are less secure. There are lots of things that we can do to help people remain in their property across all tenures.

Professor Holland: The adaptations to the home are important, but we should also think about the environment outside the home. If you are in a home that is completely inaccessible to your friends or relatives, or there is no bus service, and your environment outside the home is not age friendly, you are going to be isolated. You are going to struggle to get a healthy diet because you cannot get to the shops properly. You are not going to be physically active, because it is too difficult to get out and about in your environment. Maybe there is no bench between you and the shop, when you could walk as long as there was a bench or toilet there. The age friendliness of your environment is very important too, not just concentrating on the home itself.

Gill Moy: I totally agree with my colleagues, so I will pick on something different, which is assistive technology, particularly in the private sector. If you live in social housing, you are much more likely to have access to it because housing professionals are aware of it. We are much more likely to pick up people we think would benefit from it. It is very underutilised in the private sector. That could be telehealth, assistive technology, or even just a community alarm service. I have recently got my next-door neighbour, who is a retired consultant, on to one. The risk of trips and falls for her is massive. It is the role that can play in keeping people safe, so if something happens help is at hand at the touch of a button.

It is a much underutilised resource, but one that is coming under increasing threats as local government adult social care and health services are struggling financially. I am not saying it is an easy area for them to cut. When you compare it to the acute needs and statutory responsibilities they have, when they are prioritising where the funding should go, assistive technology is one thing that is starting to slip. That is



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a shame, especially when you look at discharge to assess, which is how hospitals are now approaching delayed transfers of care. They discharge and then do the assessment. There is a role there. If we are putting people back into their homes before they have been assessed, assistive technology could have a huge role in terms of prevention and early intervention.

Q207 Mr Prisk: We have heard quite a lot from previous witnesses about the question of age-friendly homes. I think at least two of you have mentioned some of the category 2 and indeed category 3 homes. There is some written evidence that suggests that this has a direct bearing on the numbers of hospital discharges and so on. What is the evidence showing that these homes are absolutely better for the older person?

Jacquel Runnalls: Initially, if people choose to stay at home and they are in a well-adapted property in their local community, that will suit some people. I suppose they would not generally provide level access, adaptability and internal space. An older type property, or a new one, may not have the wider doors, hallways, downstairs toilet, and generally they are much more expensive and difficult to adapt.

You touched on this as well. You only have access to certain rooms within your own property if it is adapted, whereas if you are in a category 2, or particularly 3, you would generally have access throughout the whole of the property. We have had instances in category 3, so wheelchair-accessible housing, where somebody who could potentially only stay on the ground floor was able to take part fully in family life. Particularly if it is schemes of properties that are built to category 2 or 3, there is the issue about visitability, so you can visit your friends and neighbours. That is thinking about lifetime neighbourhoods.

In terms of inclusive design, I touched on labelling before. You may not necessarily know that you are in a category 2 or 3, but if you are in an adapted mainstream property you may have a ramp to the front door or a step lift, which are not very aesthetically pleasing. They are not inclusive. Even if you adapt it, in that way you are still having to maintain, service and replace them in the future. There are lots of reasons why a category 2 or 3 would be more suitable in that sense.

Q208 Kevin Hollinrake: We spend a lot of money adapting properties to suit people with various different needs. When those properties become vacant, are we doing enough to make sure those properties are set aside for people who really need them?

Jacquel Runnalls: That is quite a large part of my job as a housing occupational therapist. We need to unpick it. What do we mean by accessible or adapted and how do we classify them? I can talk about accessible housing registers in a minute. It is also how they are advertised and let, often through choice-based lettings. It is using things like the accessible housing register. A common misconception is that adapted properties are accessible, which is not always the case. You may



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have an older style house with a stairlift, but it would not necessarily be accessible.

If it is adapted, there are people, such as housing OTs, working across the teams, who would know who was waiting for that property and do a match. Usually we would find somebody who can make best use of that adapted property. In terms of adaptations, it would be identifying somebody for that property. The other thing that we can do is set up systems so the surveyors and people going out to look at those properties can identify and flag them up. We can then categorise them accordingly.

Q209 Kevin Hollinrake: I know we can do these things, but we have had some written evidence saying generally local authorities were not doing that. There was not a register in lots of local authorities. That was probably a rare occurrence. Therefore, this matching was not necessarily taking place.

Jacquel Runnalls: There is increasing evidence. I think around 2014 the Chartered Institute of Housing saw the benefits of employing people such as housing occupational therapists to specifically address those issues. Also, the term "register" is slightly confusing. I think Leonard Cheshire found that about 83% of UK housing providers do not have an accessible housing register. "Register" is slightly confusing because most people do not actually have a register, unless they have done a full stock survey. Although when you do the full stock survey you can discount a lot of properties, it is not until you have the full stock survey that you can have the register. Often, you might categorise the properties ad hoc, as they come up. The accessible housing registers also probably need updating, certainly in line with category 2 and 3.

If they are used properly, they can be a good idea, but there is quite a lot of confusion. Using the categories can be helpful. If you use the same categories, people understand what the attributes are for a property. The point of the London accessible housing register was to be linked in with choice-based lettings to give people an informed choice. I think people have invariably found that, certainly for older people, just accessing choice-based lettings is quite cumbersome; that is another issue. Housing OTs have ended up doing the direct matching. Because generally we would know who is waiting for those properties, we can do that.

Gill Moy: Nottingham City Homes runs a choice-based lettings scheme with, I think, 13 HomeLink partners that we have. We know where our adapted stock is. On our databases, we keep a record of where that stock is adapted. We would pick it up at the point the property becomes void. Within my directorate, I manage the voids and we do all the allocations. We have one co-ordinated team doing that who sit side by side, so if any were missed we would have that.



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We also keep a database of people who are waiting for adapted accommodation. Those people are generally allocated a support worker. We would not necessarily expect them to bid for something. If an adapted property comes through, we would look at the people who we have waiting and best match them. We work very closely with our occupational therapy teams, which go out, visit the property and say, "Yes, that is suitable," "No, it is not," or, "If you did this little bit of work, that would make it accessible." It is about trying to do that kind of best match.

When we are talking about general-needs stock, where we do major adaptations, we try to match people to a more suitable property, but there are some cases when we will do the adaptation. Sometimes they are quite extensive adaptations. We sometimes lose some of those properties through things like the right to buy. Because of the very nature of them, they are still eligible for right to buy, so there are some issues about us losing adapted stock as well. We make our best endeavours to ensure we match people to the property and make the best match we possibly can. It is dealt with slightly outside of the ordinary allocation rules, if that makes sense.

Jacqueline Runnalls: I know there was a case study through the Royal College of OTs' "Living, not Existing" campaign. They had identified an empty property and spent a one-off £23,000 adapting it. It helped a gentleman who was in nursing care, which we touched on before, which was costing £57,000 a year, so having that input helps. There was another article by a housing manager in a housing association. She was saying that she felt employing people such as housing OTs probably saved them about £100,000 a year, through having that input, advice and timeliness, and making sure that the right people get the right properties and that they are used effectively.

Gill Moy: We are building new homes in Nottingham, and where we do a new-build scheme sometimes we will build a specific property with a family in mind. If there are extensive adaptations needed for a family, we would do those adaptations as part of the new build. It is trying to make best use, and we are not doing half a job by trying to do an adaptation to a property that cannot quite meet the needs of the family. We do it at the new-build stage, where we can.

Jacqueline Runnalls: I know tenants are up in arms when they see stairlifts coming out, but there is an issue if the stairlift in a property is very old or there are eight or so steps up to the front door. There are times when it is conducive to remove the adaptation. If someone was under-occupying, it could be used by a large family. It is having that knowledge of housing stock and being realistic at the same time.

Gill Moy: New homes should be built to lifetime standards, so you know that the properties will allow us to put in a through-the-floor stairlift. If



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we come across a family that needs that type of adaptation, we know the stock that is more readily available for us to adapt at that point.

Q210 **Bob Blackman:** Before I move on to other areas, how much of a challenge is the number of occupational therapists available to do the research on aids and adaptations, and the type of work in terms of the requirement of properties?

Jacquel Runnalls: It is probably very limited. Anecdotally, in social care they are very pressured. In terms of housing occupational therapists, they are growing as people are recognising their benefits. Our membership is about 300 people. They are employed across housing associations and housing departments. As you touched on, often the housing department will call on the social care OTs to do that sort of thing. People are looking to do more research, but we definitely need more people.

Bob Blackman: Given the savings that can be made.

Jacquel Runnalls: Yes. As I said, the Royal College of OTs has a campaign where it is trying to evidence the cost savings. At the moment, we need more housing examples. It is something that we ought to be pushing out there. I do not think people realise because the OTs just get on with the work and do it. You are probably right; we should be out there. Getting more evidence is critical too.

Q211 **Bob Blackman:** Moving on to the specialist housing areas, what is the impact on people's health and life expectancy of moving into specialist housing from un-adapted housing?

Professor Holland: We know quite a lot of the impacts on health and wellbeing. They are generally positive. I do not think we know the impact on life expectancy yet. As I have said before, we have evidence for an increase in perceived health, fewer days in hospital, a reduction in GP visits and a general reduction overall in NHS costs attached to each person from before moving in to the first year after moving in.

We also have evidence of things like memory not declining at the same rate, for example. My area of interest is the prevention of things like dementia and frailty, so those aspects are very positive. There is a lot of evidence from that side. In terms of life expectancy, we do not quite have that evidence yet.

Gill Moy: The question is even broader than that. Nottingham is geographically quite a small city, and we know in some areas of the city your life expectancy will be 10 years shorter than two miles away in the more affluent areas. We see that, while life expectancy is increasing, the level of healthy life expectancy is not increasing on the same trajectory. People are living longer, but with poorer health. In one part of our city, if you are a female living in Bilborough, I think your healthy life expectancy is around 18 years less than if you live in Wollaton West, which is a stone's throw away—it is probably a couple of miles. To my mind, there



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is a huge issue about healthy life expectancy and life expectancy. There is potentially scope for more research to be done around what is driving some of those issues.

Professor Holland: We looked at the socioeconomic status impacts of people who are moving in. There is quite a variety of people from different backgrounds moving into extra care environments. We looked at the increase in perceived health, which is a very big measure of basic health and perceived health itself. It is an excellent measure. We found that, although the people from higher socioeconomic status had higher perceived health when they first moved in, the increase in perceived health was greater for people from lower socioeconomic backgrounds. It was having a bigger impact.

The other measure we looked at was mobility, so people who have poorer mobility versus better mobility. We know mobility impairment is associated with depression—that is a very well-founded piece of research. We found that the increase in mood, so the improvement in depression, was greatest for the people with mobility impairments, who were able to get out and about a lot more once they were moved into these accessible homes. There are specific impacts for specific groups of people that are different for people who have fewer problems, so it works.

Q212 **Bob Blackman:** Are you able to quantify these savings on both healthcare and social care?

Professor Holland: Yes. We did an estimate of each person's NHS cost. We looked at the published NHS tariffs for a GP visit, a nurse visit or an outpatient appointment. We did an average. We did not do it for specific surgical procedures. We just did it for an average night in hospital, because there was a whole range of things people were having. It was retrospective, so when they first moved in it was the previous 12 months, and then 12 months later we looked at the following 12 months. Between those two, there was a 38% reduction in NHS costs for the people who were in the sample at both time points. That was driven by things like numbers of nights in hospital and visits to the GP, so it had quite an impact.

Social care costs were using ExtraCare costs, because they were providing the social care. They reduced a little, but not to the same extent. Again, there were differences between groups of people. We took a measure of frailty, so using a frailty profile, and categorised people as frail, prefrail and not frail. The reduction in NHS costs was greatest for the frailest, because they are the most expensive to start with.

Gill Moy: We did our Hospital to Home project over a 17-month period. It was an investment of £126,000. The savings we found to the NHS were £482,000. To adult social care, they were just over £300,000. As a housing organisation, we saved just over £140,000. The return was huge: every £1 invested returned £6.40 in savings.



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That is purely the monetary terms. When you look at the improvements in people's quality of life, they are significant as well. Carers are the people who often get missed when we are having these debates, and 48% of carers reported an improvement in their quality of life, because we had managed to rehouse people or make adaptations to their home that made their quality of life significantly better.

Q213 Bob Blackman: Have you been able to assess whether that is because care is being provided directly to a larger group of people, probably in the same facility, or because there is a community created of people with similar types of challenges?

Gill Moy: We have rehoused people into mainstream housing, whether that is housing dedicated to older people or just better accommodation. It is not really taking into account the cost of care. It is just the savings the project has delivered through reducing people having to go into residential care or stay in hospital.

Q214 Bob Blackman: I was going to come on to that in a second.

Jacquel Runnalls: I read research that identified the cumulative onsite care that it saved, in terms of people having to visit individual properties. In terms of quality of life, to what you are saying about the carer or somebody's spouse, with extra care people can move together. That has a massive impact as well.

You touched on the community aspect. Some of the extra care schemes now have cafes and onsite restaurants, so family, friends or the local community can visit. There is that social engagement and generally improved quality of life. That goes back to the impacts we touched on right at the start that would reduce costs to health and social care generally.

Professor Holland: Improving the health of the carers is very important, because they are a group that can suffer a lot of social isolation themselves, and are often older as well. Examples would be where a carer was a full-time carer, because maybe their spouse had dementia or had had a stroke and needed care 24 hours a day. They move into somewhere like ExtraCare and have some care coming in. Even if they only want to go out for a short period, at least they are getting out, and they do not have to go too far to get to the coffee shop, the bar, the choir or whatever.

Q215 Bob Blackman: The other area, which I think you were just about to touch on, is the challenge of specialist housing versus residential care. What is the evidence of people being placed in residential care when they should not be in residential care, but should be in specialist housing, which would be more suitable for their needs?

Gill Moy: It is not one of the areas I would have a lot of knowledge of, in terms of the numbers.



Bob Blackman: Is there evidence for this?

Jacquel Runnalls: Quite a few studies have shown that people are in residential when they should not be. There was a study of one extra care scheme in Sussex. It found that 77% of the residents would otherwise have been in residential and nursing care. Just comparing the costs in themselves—

Q216 **Bob Blackman:** I was going to ask that. What is the impact of that on cost?

Jacquel Runnalls: Sorry, I do not know that.

Bob Blackman: Clearly, there is going to be a difference in residential care compared to other forms.

Jacquel Runnalls: Yes. In residential care, you would be on your own in a room generally. There are the community facilities. In extra care you could be a couple living together too. I am pretty sure there has been research to show that numbers of people are in residential care unnecessarily. It probably goes back to the supply aspect as well.

Professor Holland: We looked at whether places such as an extra care kind of facility can be for the very frail and people with dementia as well. Very few people move out of them because the care is not sufficient, so they seem to cope quite well with both the fit and the frail. They include people with dementia or who are quite frail in an active environment, which is positive for everybody. There is some resistance on the part of the fit and active to seeing too many people with Zimmer frames and mobility scooters, or with dementia, in the same environment. Generally, the feeling is, "In five years' time that could be me, and she is being cared for."

The evidence seems to suggest that even people who are really quite frail, or not quite at the end stages of dementia but living with dementia, can be cared for appropriately, if there is the appropriate support in the extra care. Some sheltered accommodation does not supply that kind of care. You could not stay there. In places where there is specific support for people with dementia, people can stay. Residential care, and especially nursing care, would be far more expensive. As you say, they are not just sitting in one bedroom; they have a whole flat and their partner with them. They have the coffee shop there and there are activities going on that are more like normal village activities rather than care home activities.

Gill Moy: In Nottingham, we are converting two tower blocks. We have two tower blocks that are designated as independent living for older people. They are in a beautiful location in the middle of a park, so it is a great place to be as you are getting older. We are going to be converting that into an extra care scheme. We are building a new block in the middle that will provide extra care facilities. If people who are living in the two high-rise blocks need the extra care, they can buy into that.



They can get the support if they need it and have some of the communal facilities that we talked about.

It allows people to make that progression in terms of their housing journey. If you go from being relatively independent and you start to decline, you need something a bit more supportive. It allows you to continue on that housing journey without uprooting you and putting you somewhere different. It keeps you where all your support networks are. That is proving to be quite popular. We did a lot of local consultation with residents in the area, and they thought it was a really good idea.

As part of that, we are also looking at having a step-down accommodation or a step-up accommodation to try to keep people out of hospital, so we have that mix between people who are very fit and able and people who need a lot more support. There is nothing worse than where you have a scheme where everybody is very highly dependent. In terms of the branding and the offer, it is not much better than a care home as people would see it.

Q217 Fiona Onasanya: To what extent is housing included in the health and social care integration? To what extent does housing form part of that?

Gill Moy: I speak from quite a privileged position, because Nottingham had one of the few sustainability and transformation plans that mentioned housing. We have had a lot of credit for the work we have done in including that. I sit on the health and wellbeing board, so housing has that seat at the board. That is not replicated across the country. There are huge advantages in terms of that integrated health and housing offer.

In Nottingham, the housing workforce is part of the wider health workforce. We are making referrals where we see things of concern, whether there is a safeguarding issue or people who need help and support. We see ourselves as a part of that wider workforce. In Nottingham, we have 26,500 tenancies. We make up a quarter of the population within the city. Given our ability to get messages out around screening for older people, and as with flu jabs in our independent living schemes, there is a role for us to play in that health agenda.

From our point of view, some of our tenants suffer some of the worst health inequalities, so it is important for us that we are part of that wider health agenda in the city. Nottingham is far more advanced than some other parts of the country.

Jacqueline Runnalls: Foundations and the King's Fund have done research. Of the 44 STPs, apparently three out of four mentioned housing, but only two—I think it is you and Nottinghamshire—put it in the narrative. There is probably a lot more work to be done.

Q218 Fiona Onasanya: We need to take account of the housing in health and social care.



Gill Moy: I have been leading on a piece of work on the Hospital to Home project in the city, which looks at how we use that and develop a common framework across the whole STP footprint. People who are not health professionals find the health world incredibly complicated. Looking at it from a health point of view, trying to understand the world of housing, you have RMOs, retained services, charities and RPs. Who the heck do I go to to get support if I am trying to get somebody discharged from hospital?

Having this as part of the integrated hospital discharge teams, which is something we are moving to, will be of real benefit to health colleagues. They will have to go to just one place, and we will make the connectivity in terms of housing colleagues, so taking some of the myth out of things. For us working within hospitals, it will give us a much better understanding of some of the problems that our health colleagues are facing, so we can help in addressing them.

Q219 **Fiona Onasanya:** Do you think that social housing has a particular role to play?

Gill Moy: Yes, certainly in the city, where almost a quarter of the population are living in one of our social houses. We are quite a big player. We are a trusted partner for many of our tenants. We are able to get in and support health activities, whereas some of the health professionals might struggle to do that. It is really important.

Q220 **Chair:** Thank you very much indeed for coming to give evidence to us this afternoon. Thank you. That is appreciated.

Examination of witnesses

Witnesses: Anna Kear, Patrick Manwell and Maria Brenton.

Q221 **Chair:** Thank you for coming to give evidence to us. If you could say who you are and the organisation you are representing, that would be helpful.

Patrick Manwell: I am Patrick Manwell. I am an architect and founder of Archadia, an architectural practice. I have stepped down from leading that and I am just working as a consultant. I have spent the last 35 years working on housing for older people, and I feel I have seen a whole range of developments. We have worked on remodelling as well as building extra care. Our clients have been predominantly housing associations and councils. Most of our work has been in the south-east.

Maria Brenton: I am Maria Brenton. I am the UK Cohousing Network's senior cohousing ambassador. I have worked with the OWCH group, the Older Women's Cohousing Community, for very many years to realise, in



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High Barnet, the first and so far only senior cohousing community, which they moved into last Christmas.

Anna Kear: I am Anna Kear. I am the executive director of the UK Cohousing Network.

Q222 **Chair:** Thank you very much for coming. From the evidence you have given us about senior cohousing and multigenerational homes, I must say they were not terms that I instinctively felt I knew an awful lot about. Perhaps I had never heard them before we came to this evidence session. Is senior cohousing really a possibility for older people in this country?

Anna Kear: Shall I start by giving a quick definition of cohousing?

Chair: Yes.

Anna Kear: That is quite an important start. Cohousing is quite different. These are intentional communities created and run by their residents. This makes them different from the usual approach that you see to providing housing for older people. This is about older people taking control and deciding how they want to live. It is about people planning ahead and making their vision for how they want to live happen, and they are actively involved in that in the long term. Cohousing can be specific, so the group chooses whether it wants to be specifically a senior group, or whether it wants to be an intergenerational group; it spans both those remits.

Maria Brenton: For instance, the OWCH group is 26 women who live in 25 flats that have been purpose built. They worked with the architects to design them. It was opened this time last year. They live as an entirely self-managing group. The age range is 51 to 88, so quite wide. They manage every aspect of the building and of living there together as a group. They have cooking, cleaning and garden rotas. They have a communal meal at regular intervals. When I left there on Friday, they were planning Christmas day for the 14 of them who would be there over Christmas. It is entirely independent and based on: "We do not like being done unto."

Patrick Manwell: Shall I say something about multigenerational homes?

Chair: Yes.

Patrick Manwell: They are perhaps the least clear. We have done some projects recently that we have badged as multigenerational. We worked using some of the principles in the HAPPI report, which was about older people. One scheme is for older people, and one scheme is occupied by younger people. Both schemes seem to be working extremely well. They have deck access, which we feel gives the possibility of a sense of community. They are all fully accessible and lift-served. They all have potential for easy access showering.



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You might say that is just what the new part M category 2 housing is, and it is what that is. Talking about that, we may all be interested in some other ideas about multigenerational living that we have probably heard something about. It is not a particularly strongly developed concept, either here or in the rest of Europe, other than cohousing. If you take cohousing out of it, there is not a great deal that is multigenerational. By that I would probably mean a housing development that is designed to have a section suitable for older people, a section of family housing and a section for students. I do not think there is a great deal of that around.

It is interesting that, at the moment, they are running a programme of 29 projects across Germany encouraging people to build multigenerational housing. Some of those are cohousing groups, but not absolutely all of them. I think there probably will be more to look at in the future.

There is a scheme in the Netherlands run by an organisation called the Humanitas Foundation. It is a care home, and it has brought students in and let rooms within the scheme to these students at no rent. They put back into the scheme so many hours to help older people, to talk to them, to be there when they have their birthday and to talk to them, particularly when they are ill, apparently, when people can feel very isolated.

There are a whole range of ways of seeing multigenerational housing. I am sure there are some schemes in this country, but we probably have not badged them as multigenerational. If we adopt category 2 for a percentage of homes in all new developments, that would probably aid its development in future.

Q223 Chair: These are very niche offers, for a small number of people who really want to get involved, design their own environment and then go and live in it.

Anna Kear: They are. We have 20 established, lived-in cohousing projects across the UK: 18 in England, one in Wales and one in Scotland. As Maria mentioned, OWCH is the only one identified as senior cohousing in the country. We have our second senior project on site at the moment and three further intergenerational projects. They are relatively small scale, but that is partly because they are so difficult. They do not have the kind of business infrastructure that you would expect of traditional builds like housebuilders, housing associations and councils.

Generally, these are projects that have been put together with people using their own capital to produce their homes. That is partly why they have remained in that small and niche bracket. We have a whole list of people who are looking to develop projects. The Housing and Planning Minister announced at our conference last week that there will now be significant investment in community-led housing, recognising that there is a need to, in effect, pump-prime this new emerging market. It is akin to a start-up business, in that we will start to change that. Cohousing is



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enabling people to articulate their demand and their desires of how they want to live, which is not happening anywhere else in the marketplace.

We are also looking to work with partners. A lot of the groups have partnered with developers, and some with housing associations. This is relatively new. OWCH was only the second project to have been multi-tenure, so to involve social rent and work in partnership with a housing association. We have wanted to encourage this kind of partnership working to make the whole process a lot easier, but also for it to be a two-way relationship, so the housing association or local authority benefits as well.

We did some workshops with the Housing Associations' Charitable Trust and the Housing Learning and Improvement Network on some of the learning from cohousing and how housing associations and councils could look at it, in terms of how they approach their strategies for older people and associated planning policies, and start moving towards a system of coproducing that with older people to reflect those changing demands. To answer your question, we are looking more broadly than just a niche product, at how it might influence the mainstream.

Q224 Chair: What would be your aspiration in five years' time: rapid expansion of these cohousing schemes, with more of them looking at the needs of older people?

Anna Kear: Yes. We have done some indicative modelling. That influenced the Community Housing Fund to say, if there is some pump-priming money to go in there, to support the infrastructure, to provide the technical support to groups and to foster those partnership relationships, there could be a growth in the market. We know there is the latent demand there. We are projecting that on a fairly low level of what we know at the moment. When OWCH had its coverage on the BBC, we found that there were 4 million hits on that article, just because people are really interested in what it has achieved.

Maria Brenton: Because of the exposure on BBC News over Christmas, the group also had 400 emails from women saying, "Can we come? Do you have a vacancy, either for us or for my mother?" I have been involved with two senior cohousing projects, one that failed that I was a member of, and the OWCH one. The more that cohousing has been recognised by older people generally, the greater the demand. We have had a huge amount of interest from older people, because they are looking for not just age-proofed and suitable housing, but a sense of community.

Much of my work was based on the Dutch model. In my research in Holland, older people said there are three aspects here. The first is "I do not want to end up like my parents: lonely and isolated." The second is, "I want to feel secure, so that somebody would notice if I did not appear one morning." The third is, "I do not want to be stuck somewhere with somebody else telling me what to do." All those elements come together.



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They have a movement in Holland of 200 to 300 senior cohousing communities. It has been promoted by Dutch Governments as an answer to societal ageing. It has been very warmly welcomed by older people who have been assisted to do it. We modelled the OWCH project on that, but it took us 18 years to realise it.

Patrick Manwell: On the German pilots I mentioned, it is quite interesting that they have obviously put out a brief to people with an emphasis on housing for low-income people and people with special needs. It seems that some of the cohousing groups have responded to that and are proposing quite integrated solutions. By setting cohousing groups a challenge, you do not need to make it what might appear a rather middle-class preoccupation.

Q225 **Chair:** That was going to be my next question. Is it suitable for all older people?

Maria Brenton: It is not everyone's cup of tea.

Chair: What about people who have special health or care needs, or family responsibilities. Would they be easily able to join in with one of these groups? If you have particular health problems, you may not feel you can devote the time and effort to be part of a group and do all the work necessary to create a joint housing project.

Maria Brenton: Yes, it is a lot of work. People with serious health problems would certainly be deterred from doing it. One of the things that we are about is trying to get it made easier and the obstacles removed in our society, so it is as easy to do as it is in Holland, Denmark or Sweden.

Anna Kear: Some of this is about thinking differently. We have just followed the discussion about health. This is a very proactive movement. I think I heard some earlier evidence given by Sue Adams from Care & Repair England about the range of what we categorise as older people being from 50 to 100. There is a massive number of generations in that area. With cohousing, we are seeing the younger and more active elderly proactively planning ahead and thinking about how they want to live. In effect, they are thinking ahead about how they want to live healthily, rather than planning for getting ill, if that makes sense.

That is not to say it is exclusively about that, and I am sure Maria can talk more about it. In terms of OWCH, the women there have talked about looking out for each other and supporting each other. If they need to commission care, they can do that collectively, rather than people doing that individually. That can save the state, in terms of people being clustered in the same area.

Cohousing does not come from that perspective. It does not come from thinking only about getting ill; it comes from thinking about how we stay active and healthy. For example, the shared spaces in the common room



are quite often used for yoga classes, film watching and things like that, on the much more proactive side.

Maria Brenton: Cohousing is not a care model. It is about ageing actively and not getting to the kind of crisis point that you have been hearing about, where people get to a certain degree of frailty in their lives with very few choices available to them. It is about taking action and thinking ahead before that happens—particularly in the younger ages, such as the 60s—and banding together to get the most out of life together, without waiting for a management company, a retirement company or a housing association to manage everything and take your decisions for you. It is about staying in charge of your own life, and working together to do that. It is a healthy, preventive, active model, not an illness-centred one.

Anna Kear: I often quote the Centre for Ageing Better report from 2015 on later life. It identified three key dimensions of a good later life, which were health, financial security and social connections. That was consistent regardless of age, gender or disability. Those were the consistent factors that came up. They had the impact on how people felt, whether they were satisfied with their lives, if their life had meaning and this essential element of feeling in control. That is key to that social connectedness and control that cohousing offers. It is quite different from traditional forms of housing for older people.

Patrick Manwell: Returning to the German example, they have been very keen to develop Mehrgenerationenhäuser, which sounds a bit like multigenerational houses. In fact, they try to combine services. They try to have combined services in one building, so the “house” just refers to the building; it is not housing. They might have care for people with Alzheimer’s, together with a nursery facility, together with younger older people volunteering. If you put that next to a cohousing scheme, it is a completely different idea. Nobody has really tried that, but there are other thoughts out there. That would automatically provide support quite close by as people age.

Q226 **Fiona Onasanya:** Touching on the last point that you raised about services and facilities, what is currently available, should they require care and things, in these cohousing schemes?

Patrick Manwell: I will have to pass that on, because I am not really a cohousing expert.

Fiona Onasanya: I mean in both types of housing, so multigenerational as well.

Patrick Manwell: On the multigenerational front, there is not much of an example in the UK at the moment. All our specialist housing tends to be the extra care model, where we have tried to put the services in the building. Of course, these are quite large buildings now. I think you heard from previous witnesses that these schemes work better with more



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flats, because, if you have support services within them, that helps the finances of the whole thing.

People quote Australian, American and New Zealand models for these developments, but the land use in those areas is completely different from European land use. That is part of the reason why the development of these things is quite slow. It is almost segregating older people away from the communities. We heard in that earlier session about how people really benefit from being close to the community in which they have been living previously. We need to look for smaller scale models that we can drop into communities, probably with less care, if they are fully accessible and adaptable. We have heard how that tends to reduce the care need.

Beyond that, we have to think of them as ordinary housing, where care can be delivered to people in their own homes, but in these kinds of homes where they are liable to stay for longer. That is my personal thought on it. It does not really address cohousing but that is the multigenerational idea.

Q227 Fiona Onasanya: No, of course. In the multigenerational idea, if care was needed, are you saying they would not have that provision there?

Patrick Manwell: "Multigenerational" is not defined anywhere. There is not a building type that you can say is the only type of multigenerational housing. It is such a fluffy concept. All ordinary housing is multigenerational almost by definition; people of all ages live in all sorts of housing. It is a strange concept at one level. A lot of it is just about carers that people would receive in their own homes. There is obviously a difference if you can put it next to a hub of some sort where care is being sourced from, as in the German model. We have had this idea in the UK before about hubs where care can be delivered, mostly for elderly people only, which would help support people in an area. You could have a hub in an old sheltered scheme, and it would help support people not only in that scheme but within the district. I do not know if it has happened that successfully, but that is what extra care potentially offers you, not just in the scheme but with outreach.

Anna Kear: I would like to add something in terms of cohousing. We do not suggest that it is a care model at all, but rather like the neighbourliness of the past. This is really important, because everybody has their own home, but they have shared areas and shared facilities where people are looking out for each other. For example, if somebody has been in hospital, they may come home to their own apartment but their neighbours will bring meals round. It is much more of a self-sufficient model. It is quite different from the view that the state has to do everything for everybody. This is about people saying, "Actually, it is not. There are a certain number of things that we can do ourselves." That means that the services that the state provides are kept for the most needy and the most extreme, rather than having to be provided for everyone.



In terms of the shared facilities, there is usually a common house where people socialise. This can be multigenerational cohousing as well as senior cohousing. It is where people get together. They generally cook together once or twice a week. They create their own activities, in effect. I mentioned yoga but there can be film nights. Quite often they have shared gardens to grow vegetables, which may include having workshop areas where people can be sociable. It is all about this natural social interaction that you create, which is not forced or "done unto," but it is what keeps people's brains ticking over and keeps them alive.

It is because of that that we are getting interest from huge amounts of the public who say, "Actually, I really like that. It does not feel like I am going into specialist housing for older people; it feels like I am making a positive choice about the next chapter in my life." It is quite a different perspective.

Maria Brenton: Most of the time, all that most older people need is everyday help and some human contact. I would like to take the conversation away from being a care model; you had that in your last session. Cohousing is about living: living with friendly, neighbourly people around a certain set of values where people commit to mutual support, sharing responsibility, collaborating and organising their own lives together as a group. It is very different from the average sheltered housing or, certainly, care homes. It is where people are autonomous, have power and control, make decisions together and do not wait for some authority on high to make them for them.

There is a real qualitative difference. We get lots of visitors. We have had lots of officials from the DCLG and the GLA up at the new scheme in Barnet. We say, "How are we different from an ordinary, traditional sheltered housing scheme? It is because we take the decisions." We do not wait around for somebody else to take them for us. We are autonomous. We do everything here ourselves. We have sorted out the service charges and decided what they are. We employ a gardener where we want to. We employ a window cleaner where we want to. We do everything.

We are basing that on a wide age range. One of the questions suggested to us was, "How would you compare this with, for instance, a very sociable retirement community? Are they not the same thing?" No, they are not necessarily. It might suit an awful lot of old people where there is a big retirement village with lots of amenities like a golf course, swimming pool and whatever, but those things tend to cut them off from the outside world because they do not need to go and seek them somewhere else. There is lots of sociability and they can afford to have lots of amenities, but they are not necessarily in charge of anything and they are not necessarily part of the decision making. There are encouraging signs of this happening but it is coming very slowly.

Q228 **Fiona Onasanya:** That is fantastic, but the angle that I was coming from



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was: if care is needed and you feel it is needed in this autonomous environment where you can make your own decisions, and you can get involved in things as and when you decide to, is that care available?

Maria Brenton: I will give you an example. Eight years ago, before the group moved in, one of the women, who was in her 60s then, had to have heart surgery. The consultant said, "You have to be in three weeks because you live alone," and she said, "I do not want to be in three weeks." She sent an email around to the whole group and they immediately put together a rota from all over London. They lived in 12 different local authorities in London. They came and, for the first week, there was always somebody staying overnight with her. They did her shopping, her cooking and they went for walks with her. They enabled her to be out of hospital very effectively.

That was at great cost to themselves; some of them lived outside London. I asked her to ask her consultant how much he thought we saved the health service—this was eight years ago—and he said it was between £4,000 and £8,000. It is much easier to do that now. Somebody who has just had a hip operation in the OWCH group came home. Her shopping has been done for her. Her meals were brought round for her. People looked out for her until she was on her feet again, which is much easier if we are all there as neighbours. Care is about looking out for people. We make it very clear that we are not a professional body giving personal care; we will enable you to access the right professional services for that.

Anna Kear: There are no services provided on site. Cohousing is much more like people living in ordinary housing. The difference is that they have created a space where they are interacting socially. There are no services delivered to them. Anything that they choose to do, they will be commissioning themselves. The difference, however, is that if there are care needs—there might be a couple of people who have medical care needs—they can commission those collectively. Equally, they can commission them individually. There are groups developing that are looking at connecting with the local health centre services at the moment and saying, "This is helpful," because, as a group of older people clustered together, it will be easier to provide those local health services in that area. That might help distinguish the difference.

Patrick Manwell: It strikes me that if the cohousing group is a mixed-age group, which lots of them are—Anna will know better than I do but, looking across Europe, lots of the groups are of mixed ages—that will inherently provide mutual support in a more natural way. We know historically from sheltered housing that, when it was built, people went in being independent and then, 20 years on, you had a scheme that needed enormous amounts of care. Having one single age group always concentrates the need for care. In a way, you then begin to ask, "How will you supply the care if you have concentrated all the need?" If you



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have multiple generations, you do not concentrate the care in one place; you probably get more natural mutual support.

Q229 Helen Hayes: What are the barriers to establishing more of this type of housing in the UK? Do they relate to our planning systems, the availability of land and finance, or are they more about a lack of knowledge or cohesion in terms of groups proactively coming together to do this?

Anna Kear: I can tell you that there are an awful lot of barriers. The fundamental one is cultural. We are not used to people doing things for themselves, and certainly not housing and housing development. That culture is relatively recent in our history, but it seems really different from what happens in other parts of the world, where it is more normal for people to create their own housing solutions.

The problem with that is that our systems in this country are set up for large organisations, such as large housebuilders and local authority housing associations, which have access to the capital and professional services to deliver these homes. That is why we have been working really hard with Government on creating this new community housing fund, to redress some of that balance and enable groups to get access to the professional technical skills and support and to the funding, which is not all necessarily about affordable housing grants—some of it might be, but some of it is the development finance to release equity. People cannot necessarily use the equity in their property if they are living in it while developing their new homes, so it is about creating a system in which they can do that.

There are lots of issues. Certainly there is an issue with the planning system as well, because of it being responsive to large organisations. There are issues with land allocations and things like that. We are promoting that the community-led housing approach can access sites that would not be available through normal development. Generally, it generates a huge amount of support in the local community for developing these homes because it is reflecting local people.

There are other barriers. Tax is a huge barrier, for example. We have schemes saying that they are potentially being charged three times stamp duty during the process of buying land and developing it for the final process. If we are going to enable these groups to thrive—I have talked about the latent demand—we have to look at the whole system and think a little differently about how we encourage this real start-up and innovation in housing, because it can aid with the problem of housing supply. The Government have recently termed it the “broken housing market.”

The old persons’ housing market is massive and it is part of the whole housing market. If you look at how we enable people to make positive choices about how they want to live in later life, they are releasing those family homes that affect the whole housing market. You are not just



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investing in housing that is specifically targeted at older people, but it is affecting the whole housing market. It sounds as though relatively small changes could lead to a big solution in that situation.

Maria Brenton: As I said earlier, it took OWCH 18 years to get going and to realise what we wanted to do. That was partly because the group was always absolutely clear that it wanted to be mixed tenure, so we had to find a housing association partner. We went through about eight and finally ended up with one that did the business for us, and Hanover funded the whole scheme for us and then sold it to us.

However, the local authority attitudes around the place bordered on indifferent to hostile. We were told informally, when we got the site in High Barnet, that we would not be welcomed by adult social care services because the women would be seen as making demands on their social care budget. They also felt that they had "quite enough sheltered housing and alms-houses around the place, thank you very much." That put two years on our project. We had to do an awful lot of lobbying and marketing in order to get over that kind of deafness to what we were about, saying, "We are not sheltered housing and we are not going to make demands."

The whole argument for developments elsewhere, for example in Holland, is that Dutch Governments have always seen cohousing as a way of reducing demand on health and social care services because it kept people active, healthy and happy. In Barnet, the first question I had from the leader of the council seven years ago was, "Prove it." You cannot naturally just prove that.

Q230 **Helen Hayes:** You said a little about the financing of the OWCH scheme. Generally speaking, what are the models of financing for cohousing? What are the tenure models that typically apply?

Maria Brenton: As Anna said, there are only two mixed-tenure cohousing schemes realised in the country because it is so difficult. Our scheme was funded by Hanover; 17 leaseholders bought from Hanover and a very small housing association bought the social rentals, and we worked together very happily. There are many other ways of financing it, which Anna can fill you in on.

Anna Kear: People often get muddled up with cohousing and tenures. Cohousing is not a tenure; it is really a way of living and it can therefore be multi-tenure, because the idea is to try to be inclusive and to enable people to live there with different incomes. It can be leaseholder ownership where people are buying the properties. It can be shared ownership. It can be affordable rent or social rent. We even have schemes where people have created something called mutual home ownership, so as a group they own the whole project jointly, and they have shares rather than owning part of it. People have been very creative because there has not been access to ready finance to do these



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projects, so it is mostly done through people getting equity-release loans and funding this out of their own pockets.

That said, we have increasingly got some grants from Government where there has been funding for community-led housing in the past. It has been quite difficult, particularly for cohousing and some groups of cohousing, because that funding has generally been linked to geography. Groups across London, such as older women or LGBT groups, from which we have a lot of interest, cannot necessarily access funding that is allocated to a local community of place. We are looking to change all that.

There is a lot of social investment and private sector support from some building societies, such as the Ecology Building Society and Charity Bank, that understand what cohousing are about. They are adapting and being quite creative with their models to support those groups. As the market is expanding, more and more people are getting interested in this.

Q231 Helen Hayes: Where cohousing has an element of social housing within it, how does the needs and allocations process that local authorities have in this country for social housing come together with the self-selecting and values-driven culture of a cohousing community, which is reliant on people having a shared basis of values?

Anna Kear: It can vary hugely according to the local authority and its outlook. We have examples where a local authority has been very understanding of the nature of cohousing and where the nomination process works around whether somebody has the right fit for that community—they might have even stayed there in the guest room and got to know this community—and is eligible for social housing. In other areas, there have been more hoops to jump through.

Maria Brenton: This has been well established through history, with co-operative housing having arrangements with local authorities to choose its own recruits from the local lists. The OWCH group allocates the tenancies itself and the council does not have any say in that. That is because it was not a planning requirement on us that we provide social housing, so it did not get nominations. The flats were in fact funded through a social investment grant by the Tudor Trust, and we agreed with it and with the small housing association landlord the allocation criteria, which we keep to very strictly, that they had to meet all the usual requirements of eligibility for social housing, but the group does them. In Holland and Denmark it is standard for groups to do the allocations themselves, even when the building is owned by a housing association.

Q232 Helen Hayes: Can you say a little more about the conditions, in Holland, Denmark and other places where cohousing is more common, that have led to that expansion and have enabled it to be a mainstream part of the spectrum of housing that is provided?



Maria Brenton: Going back to what Anna said earlier, there is a huge cultural difference. Holland is a place that takes for granted that you will self-build. In fact, it has had an official policy—I am not sure whether it became law but it was certainly in existence since 2005—that a third of all new homes should be built through self-build and private initiatives.

Q233 **Helen Hayes:** Can I just push you a little on that, taking another field altogether? It used to be said, when we talked about the evening economy in this country, that the reason there was such a successful and civilised approach on the continent as opposed to some of what went on in our towns and cities was cultural, but, when you probe that, it is about the policy and regulatory framework that apply, and we made some changes here that helped us do it a lot better. Culture can be an explanation for why things cannot happen in one place and can happen in another place, and the Committee and the inquiry are keen to understand the full range of possibilities available and, if something is a good idea, how we make it more possible here. I want to push you a little further on that.

Maria Brenton: The lever that worked in Holland, which has had cohousing for the last three decades, is that successive Governments have all subscribed to the view that this is a better way of ageing and that they wanted local authorities and housing associations to facilitate it. They made seed-corn grants available to local groups in order to build their own cohousing communities.

A few years ago I came across a group of families in Amersfoort who got together, all of whom had one member who had had a stroke. They wanted to live as a cohousing community where they could share the care for those family members. They were able to access the seed-corn grant from the province, which is called collective private commissioning. It was a staged grant where they were given funding for a project manager, who would get them up to speed on a business plan, help them realise the finance, pool mortgages and all that kind of stuff. It is obviously about levers, procedures and policies that facilitate, but that is all predicated on the fact that we work with citizens and we want citizens to have much more of a voice than perhaps is the case here.

Anna Kear: That is why we have looked at using the community housing fund as an opportunity to set up community-led housing hubs. For example, the Mayor of London has launched the community-led housing hub for Londoners to provide that kind of support to groups. There are other things. For example, in Germany there is the Baugruppen model, which looks at allocating land for projects. That makes a difference in terms of speeding things up, because it presents a real opportunity. We find that a lot of people create the group and are quite active as a group, but it is a really long stage of being in that group until they find a site. It is when people get access to a site that things really get going. This does not have to be a new-build site; there are quite a lot of innovative



examples of people doing mixed-use developments, using old buildings and things like that to create their cohousing schemes.

Patrick Manwell: It seems to me, looking at this slightly from the outside, that the developer role is pretty critical. You have worked with Hanover. The K1 development in Cambridge has a developer involved. We have to create a way for there to be something in it for the developer; otherwise developers might wonder what they are doing it for. I know how difficult the development process is. When you are working with a group, I can imagine that it is even more complicated, and you will probably not be that quick on your feet to get sites and things. Some good expertise helps groups, but there has to be a way of rewarding developers for getting involved, or maybe we need more socially orientated developers. That seems to me to be an issue.

Q234 **Helen Hayes:** The final question from me is about the role of design in older people's housing. Lots of older people's housing in this country looks of a type; it screams out to you as you walk down the street that it is older people's housing. Even now, there is a generation of baby boomers in their 70s who are thinking about the choices for the future, and many of those people have had a completely different experience from older people of the past, in terms of the types of housing they have lived in, the modernisation of housing stock in this country and so on. I want to ask about the role of design and whether we need a complete rethink, in that a lot of the design features that make older people's housing accessible do not necessarily have to be very visible.

Patrick Manwell: I agree with that, but there is a slight difficulty here because specialist schemes tend to be quite big by comparison with the rest of the buildings in the area, which are often individual houses. You can spot retirement schemes, even small ones of 30 flats or so, from a mile off, but you can spot an alms-house a mile off. I am not sure that there is anything wrong with them being identifiable. We have done some schemes where we have worked very hard to make them read more like a series of buildings, rather than one giant building, but it is very difficult to escape the fact that they are one big scheme.

Q235 **Helen Hayes:** The only thing wrong with it would be if it was deterring people from making choices that would be better for them in the long term and would lead to a better quality of life.

Patrick Manwell: I agree, but the anecdotal evidence I have is that people definitely do not want to move into care homes, and they are much happier to move into specialist housing where they have their own front door and their own flat. If you design it well, it has a balcony and it has access areas that encourage people to interact, it can be a very attractive product at almost any scale.

Maria Brenton: Talking to and involving the end user is not a very characteristic relationship in this country. The OWCH group worked through a whole series of workshops with Pollard Thomas Edwards, the



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architects, to bring their input into the design. The architects say, “We are the ones holding the pencil but we want your ideas.” The place has won seven housing awards in one year, and it is absolutely lovely. It has no sense of being a care home or a sheltered housing set-up. It is really very nice. They have loads of space, lots of big windows, very generous balconies, loads of storage—all the things that most developers do not think necessary to put into older people’s housing.

Anna Kear: That is critical to what cohousing is, because it is a coproduction process with the groups working alongside a developer, be that the housing association or a private developer. They look very different because of that; they do not look like your typical older persons’ housing scheme or even your typical housing scheme, because they have so much input from the people involved.

The feedback that we have had is that it does not lengthen the process. It is really important that it is this balanced process of coproduction, with a balanced understanding of the power relationship there. The groups themselves need to learn some key skills to interact well in terms of that coproduction process.

Chair: Thank you very much for coming to give evidence to us this afternoon. It is much appreciated.