Housing and the environment

Creative Responses to Ageing

Ageing in place

When discussing later life housing, there can be a tendency to focus on specialist accommodation, such as care homes and sheltered housing. But 93% of people over 65 live in mainstream housing and many seek to remain there for as long as it is practical (Keenan, 2010; Pannell et al., 2012). The term 'ageing in place' is often used to describe initiatives and policies that seek to facilitate people ageing in their own homes.

Pastalan (1997) suggests that while ageing in place sounds appealing both to policy-makers (who see it as cost-effective) and to older people (who see it as a mechanism for receiving support), the concept is not always well-defined. Ageing in place incorporates elements beyond simply adapting housing for an older population. The concept of 'home' incorporates symbolic elements of emotional, social and personal identity (Sixsmith and Sixsmith, 2008; Wiles et al., 2012). For example, an individual may resist adaptations that would make a home more accessible because of the symbolic loss of independence (Sixsmith and Sixsmith, 2008).

Ageing in place also goes beyond the immediate home environment to consider location within the wider community and neighbourhood (Perez et al., 2001; Sixsmith and Sixsmith, 2008; Wiles et al., 2012; Van Dijk et al., 2014). Factors such as a positive perception of the local area, the presence of local amenities, good neighbourhood relationships and good transport links have an impact on whether is desirable and practical to remain at home.

Ageing in place can have negative dimensions as well as positive. Some homes may be practically unsuited to changing needs, for example because it is impossible to put in place mobility adaptations. This can result in needs being unmet, or people becoming more isolated (Sixsmith and Sixsmith, 2008; Hillcoat-Nalletamby and Ogg, 2013). Hillcoat-Nalletamby and Ogg (2013) point out that the majority of older people have some elements of their home or community that they are dissatisfied with. They suggest that some individuals may adapt their expectations to their living circumstances because of a perceived lack of alternatives. As a result, older people may describe themselves as satisfied with a home that is not fully suitable for their needs. Hillcoat-Nalletamby and Ogg (2013) also suggest that some discussions of ageing in place conflate attachment to people with attachment to place.

Key Points

- The vast majority of older people live in mainstream housing, and many would like to remain there as they age
- Ageing in place incorporates many factors, including identity, emotional ties, practical home adaptations, neighbourhood amenities and community connections. As a consequences, decisions about ageing in place are likely to be very individual.

DOWNSIZING

Some housing policies encourage older people to 'downsize', both in order to reduce costs, but also in order to free up larger houses for families. This can potentially reinforce the negative perception that older people are unfairly taking up resources. However, Pannell et al. (2012) point out that it is not only older people who 'under-occupy' – many younger households do too.

In some instances, downsizing can facilitate ageing in place, for example when individuals pre-emptively move to a home that they expect to be able to remain in as they age. However, this is dependent on there being appealing and suitable homes within the community where people wish to live.

Designing for ageing communities

A briefing by the Royal Town Planning Institute noted that government strategies on ageing often do not consider the built environment, particularly beyond the home (Pinoncely, 2015). It emphasizes the importance of planning communities which have good access to green spaces and local amenities, and which facilitate community engagement. RIBA (2017) similarly note an absence of evidence on designing public spaces, workplaces, retail and leisure facilities to meet the needs of an ageing population.

Part M of the Building Regulations 2010 sets standards intended to ensure that new houses are accessible and useable by people with mobility difficulties, including wheelchair users. However, many houses in the UK do not currently meet these standards. For example, only 13% of dwellings currently have level access and a flush threshold (although in 58% of cases, level access could be relatively easily created) and 51% of wheelchair users report that it is difficult to manoeuvre their wheelchairs within their home (Department for Communities and Local Government, 2017).

Housing supposedly designed for older people often does not reflect their actual preferences. For example, most older people wish to live in a property with at least 2 bedrooms, yet specialist housing is typically either single bedroom or bedsit (Pannell et al., 2012). Similarly, most older people are owner occupiers, yet retirement housing is predominantly rented. The National Housing Federation (2011) report a number of factors that older people value in later life housing options, including good design, facilitating freedom and choice but also having help available if needed. They conclude that there is a need to design and build larger, more accessible later-life housing, which may appeal to people who do not wish to (or cannot) remain in their current home, but who perceive traditional options such as sheltered housing as unappealing.

Inclusive Design

A number of studies have emphasized that good design can make housing and the wider built environment more accessible for people with long-term health conditions and disabilities.

Research by the Thomas Pocklington Trust and Stirling University highlighted a number of adaptations that can make home and other environments more accessible for people with dementia and sight-loss. These include thinking about lighting design, designing kitchens to be safer and easier to use, and using contrasting colours to make it easier for people to locate switches and doors, and avoid hazards. They emphasise the importance of consulting the individuals concerned, and striking a balance between managing risk and facilitating choice. (Greasley-Adams et al., undated)

A substantial proportion of falls in the older population occur outside the home, and outside falls often relate to modifiable features such as poor maintenance (Downton and Andrews, 1991; Li et al., 2006). Fear of falling can also deter older people from physical activity and community participation. (Bruce et al., 2002; Deshpande et al., 2008; Sixsmith and Sixsmith, 2008). However, assessments of older people at risk of falls often focus on risks inside the home, while audit tools designed to assess outside spaces have largely not addressed older people at risk of falls (Li et al., 2006; Curl et al., 2016).

Curl et al. (2016) designed their own tool for assessing risks of falling outside the house. However, they highlight that healthcare practitioners are often uncertain how to report hazards, or see it as outside their remit. Newton et al. (2010) report clear and consistent preferences for older people about the design of the local built environment. This included well-maintained footways, an absence of temporary obstacles, plenty of well-maintained seating and safe pedestrian crossings. Clear signage, well-maintained toilets and bus shelters, and greenery were also highlighted as important features.

Technology and adaptation

Sixsmith and Sixsmith (2008) suggest that technological adaptations, often called telecare can help facilitate ageing in place. One example they give is the reassurance value of providing call buttons or sensors to summon help if someone falls at home. Technology undoubtedly can offer reassurance for some, and also facilitate independence – for example, being able to turn on the lights without asking for help (Milligan et al., 2011). However, at present, there is limited evidence regarding the overall effectiveness of telecare in preventing hospital admissions or reducing costs (Barlow et al., 2007; Mistry, 2011; Steventon et al., 2013; Henderson et al., 2014)

Greenhalgh et al. (2015) suggest there needs to be a move away from focusing on assistive technology itself to instead consider how technology is used in context. For example many telecare systems rely on users wearing a pendant at all times. In practice, users often do not wear the pendant, either because they find it cumbersome, or because they do not want to wear a visible assistance device (Walsh and Callan, 2011; Mort et al., 2013; Gómez, 2015). In some cases, they may adapt a selective approach – e.g. only putting on a pendant before a task they see as particularly risky (Mort et al., 2013). Even where individuals are wearing their pendant at the time of a fall, they may forget to use it (Milligan et al., 2011). Technology is only effective if it is well suited to the context and the people who use it.

One possible solution may be to integrate assistive functions within other technologies. For example, mass-market virtual assistant devices can be voice-commanded to make phonecalls and control household electrics such as lighting and heating. There are early reports of these functions having benefits for older and partially-sighted users (Christopherson, 2017; Woyke, 2017). Using a mass-market device may be seen as less stigmatizing than as assistive device, and in emergencies individuals may be less likely to forget a system they already routinely use. However, Procter et al. (2014) highlight that technology often requires customization to make it suitable for an individual's needs, and that this is not always taken into account when technology is designed and installed. As a result, individuals may end up making their own adaptations (e.g. covering buttons that are often activated accidentally). In the case of the virtual assistant device, one reported problem is that the software's voice is not clear to people with hearing impairments, and there is not presently a feature to adjust this (Woyke, 2017). Options to customize technology to individual needs are therefore important for maximizing its assistive use.

Some commentators have expressed concern that, particularly that in the context of shrinking budgets and tighter eligibility thresholds, the use of telecare could in some instances become coercive and intrusive (Kenner, 2002; Mort et al., 2013). Older people may feel they have no choice but to accept technology into their home that they do not want, perhaps in response to emotional pressure from families or statutory services. At times, this can be rooted in rather patronizing views of older people's capacity and choices: that they cannot decide for themselves whether they want or need technology. Newer systems can automatically monitor someone's movements– for example, whether or not they are in bed, or whether they have travelled a certain distance beyond their home. This raises potential dilemmas over confidentiality and privacy: for example, should family members be provided with detailed information about someone's movements? (Milligan et al., 2011). In such situations, the desires of carers and statutory services to keep individuals safe may not align with the individual's own interests and choices. Again, preferences are likely to be highly personal. For example, some individuals with dementia may find carrying a mobile phone reassuring, while others see it as impinging on their independence (Brittain et al., 2010)

The full vision of ageing in place (discussed on page 1) includes factors such as emotional and community connections to a place and the people in it. Technology does not on its own meet the requirements of aspect of ageing in place. Indeed, there is a potential danger that ensuring physical safety through technology may result in social and emotional needs of individuals being less well-addressed (Milligan et al., 2011). While telecare users emphasise that it cannot substitute for face-to-face care, in practice telecare is often marketed as being cost-effective, within a broader context of financial austerity. (Milligan et al., 2011; Mort et al., 2013). Cost-effectiveness calculations often ultimately derive from assuming that technology can substitute for personal interactions. Technology can therefore only be a part of ageing in place.

A sense of home

Discussions of later-life housing can tend to focus on functional issues, such as whether the space is physically suitable for access needs. However, emotional connections to home, and a sense of ownership over space and items within it are also important. Models of successful ageing emphasise the psychological importance of a sense of control over the external environment, either through being able to directly take action, or through accepting and adapting to limitations (Stones and Gullifer, 2014). Home can also be important for a sense of continuity of places, people and objects.

One frequently stated reason for preferring to age in place, rather than downsizing or moving to more specialized accommodation is wishing to retain personal items (Gott et al., 2004; Pannell et al., 2012). In settings such as care homes, there may be restrictions on what can be brought and how much control the individual can exercise over their own space (Cook et al., 2015; Milte et al., 2016; van Hoof et al., 2016). Since admission to a care home often follows an crisis or a decline in ability, decisions on possessions may be taken by a relative rather than the individual (van Hoof et al., 2016). Care home residents interviewed by van Hoof et al. (2016) also stressed the importance of having control over their own entertainment activities, such as being able to choose what to watch on their own television.

Tanner et al. (2008) highlight the importance of personalization in a sense of home – individuals spoke about gardens they had laid out, or personal items. One benefit of adaptations can be that they allow people to continue or regain control over their home environment. But Tanner et al. also noted some participants had negative perceptions of modifications where they felt this had resulted in sense of loss of control over space – e.g. extensive modifications had been requested by someone else, or modification had been performed to a standard specification that was less convenient for the individual.

Heywood (2004) points out that home can also have an impact on other aspects of personal identity – for example, inappropriate arrangements for bathing or using the toilet have an impact upon self-esteem, which in turn may act as a barrier to social participation.

Stones and Gullifer (2014) spoke to people over 85 living in their own homes in Australia. They found that participants emphasized the autonomy and privacy of being in their own home. Home was also an important site of identity and purpose. As a consequence, individuals wanted to remain at home, despite substantial challenges. However, attachment to home was potentially a weaker force for some, compared to very negative views of the alternatives, with later-life residential options seen as involving a loss of identity and self. They also note that interventions need to be targeted to individuals. For example, if someone sees cooking as a core part of their identity, adaptations to help them continue to cook simple meals at home would be more appropriate than supplying pre-prepared microwave meals.

KEY POINTS

Tanner et al. (2008) highlight three dimensions of home:

- The physical home (the raw materials of the building, and its space and layout)
- The social home (a site where someone interacts with cohabitants, but also with visitors, neighbours and a wider community)
- The personal home (a site where someone can express themselves, and feel familiarity, security and belonging)

They argue that discussions of home adaptations can tend to focus on physical aspects of housing as expense of personal and social meaning. This can result in adaptations that don't address the way home is actually being used. It can also deter people from seeking assistance, because they are concerned they will not be given a say in changes made to their home.

Pets

Wanting to retain a pet who is 'part of the family' has been highlighted as one factor deterring older people may be reluctant to move into specialist accommodation (Morley and Fook, 2005; McNicholas, 2007; Wiles et al., 2012). Later-life service providers do not always recognize the sensitivity of this issue for older people.

Age-friendly Cities

The World Health Organization (2007) has produced a checklist of features of Age Friendly Cities. They stress the importance of involving older people in assessing a city's strengths and weaknesses.

Menec et al. (2011) draw upon ecological principles to discuss the connection between age friendly cities and social connectivity. They emphasise the interconnected nature of environmental factors, and that there is a need for more inter-disciplinary work – for example thinking about mobility in the context of being able to drive. Ecological theory also particularly emphasises the issue of 'fit' between person and environment. As a consequence, different older people have different needs – active older people who can drive are likely to value having a range of participation opportunities but may not particularly require services to be close by. In contrast, those who cannot drive and are less able to participate in social activities may place a much higher value on proximity of essential services. Related to this, the 'fit' between individuals and their community may change, both as the individual's needs change, and as the community evolves.

Golant (2014) notes the benefits of community approaches to ageing, but suggests the consider of 'age friendly communities' is too broad, and may duplicate other initiatives. Principles such as safe, attractive mixed-use communities that encourage walking are already well established within urban design. He argues that in the context of resource constraints, age-friendly initiatives will in practice face choices – for example, is keeping older people comfortable a higher priority than facilitating autonomy? Equally, decisions on issues such as housing in practice require prioritisation – which needs are most pressing, and where is the threshold for assistance? Offering a list of ideal criteria does not help policy-makers take difficult decisions. He also notes that age friendly communities are often most actively promoted in areas where there is already strong local leadership recognising the needs of older people. Often, these are also more affluent communities, meaning that age-friendly initiatives may not reach the most marginalised older people. Golant and others also point out that the literature has primarily been descriptive, rather than offering evaluation of age friendly initiatives (Lui et al., 2009; Golant, 2014).

Conceptualising 'Age-Friendly Cities'

Lui et al. (2009) highlight that the literature on age friendly communities stresses the need to integrate 'top-down' and 'bottom-up' approaches, and to think about the physical and social environment in an integrated way. However, overall there tends to be a bigger emphasis on grassroots community development of integrated social communities.

(Adapted from Lui et al., 2009)

Some items on the WHO checklist

Outdoor spaces & buildings
- ✓ Clean, pleasant and accessible
- ✓ Well-maintained and safe

Transportation
- ✓ Reliable and frequent public transport.
- ✓ Roads are well-maintained with clear signage

Housing
- ✓ Sufficient affordable housing close to services and community
- ✓ Adaptation/ maintenance services understand the needs of older people

Social participation
- ✓ Community events at an accessible time and place
- ✓ Range of activities that appeal to diverse older people

Respect & social inclusion
- ✓ Older people are regularly consulted by public and community services
- ✓ Positive media images of older people
- ✓ Older people 's past and present contributions are recognised

Civic participation & employment
- ✓ Flexible options for volunteering and working.
- ✓ Support for self-employment and post-retirement planning

Communication & information
- ✓ Friendly person-to-person service available on request
- ✓ Printed information and technology is clear and easy to understand

Community & health services
- ✓ Available and accessible
- ✓ Staff are respectful and understand the needs of older people

Rural ageing

The literature on age-friendly communities has tended to emphasise urban environments (Lui et al., 2009; Keating et al., 2013). Since the WHO checklist was based on cities, Canada consulted with its rural communities to develop its own checklist of age-friendly features for rural environments (Gallagher et al., n.d.). As with urban environments, they found that interconnections between physical and social elements of community were important, but that these interconnections were different for rural areas. However, the features identified were also relatively specific to the Canadian context: for example, an emphasis on snow clearance.

Keating et al. (2013) drew upon the ecological model of 'goodness of fit' between the individual and environment to consider the needs of rural communities. They sought to move beyond a checklist of features, and instead consider more dynamically what facilities meet the needs of which older residents. In their research, they noted two contrasting views of rural areas. On the one hand, rural communities are often presented as 'bypassed', with declining services and young people moving out. In this context, it may be seen as impractical to expect communities to invest more in ageing when services are already in decline. On the other hand, there is also the bucolic image of the rural idyll, in which natural beauty and strong community ties make up for the lack of formal services. These types of rural communities may attract recent retirees. Of course, in practice rural communities take many forms, and may have aspects of both of these elements of rurality. In line with their emphasis on goodness of fit, Keating et. al highlight that different communities meet the needs of different older people – less wealthy ageing residents may be priced out of affluent rural communities.

Burholt and Dobbs (2012) reviewed literature on rural ageing in Europe and reported that over half of published papers related to access to health services and/or health behaviours. There were far fewer papers focusing on social or familial relationships, the rural lifecourse, technology or civic and community engagement. Rural ageing has therefore been primarily approached from a biomedical perspective of barriers to care, rather than considering social and cultural aspects of ageing in a rural environment. Burhold and Dobbs also suggest that there has been a tendency in research on rural ageing to describe what older people are doing rather than to explore why they are doing it.

Stockdale (2011) points out limited research on rural ageing in the UK, despite the fact that rural communities tend to have older populations and hence may be more affected by population ageing. Different countries define rurality in different ways, and much of the research on rural ageing has taken place in countries that are far more sparsely populated than England, meaning findings from elsewhere may not be readily translated to the English context (Keating and Phillips, 2008; Manthorpe et al., 2008; Burholt and Dobbs, 2012). The notion of a binary between rural and urban may also be too simplistic. It is plausible that as people in rural communities age, they may move from the most remote locations to larger settlements (Stockdale, 2011). Manthorpe et al. (2008) also point out variation between rural communities in the England, and the impact of localised decisions and service reorganisation. They suggest that using 'rural' as a general term to describe diverse areas may not be helpful. However, they also point out that the urban/rural distinction is underpinned by a tension regarding resource allocation: how to strike a balance between equity, service availability and resource efficiency.

Several commentators have also highlighted a distinction between those who age in a rural community they have lived in for many decades, compared to those who move to the country in middle or later life (Wenger, 2001; Stockdale, 2011; Stockdale and MacLeod, 2013). For example, Jones and Heley (2016) note different patterns of community participation in ageing Welsh communities. Recent incomers were more likely to engage in formal organisations, while longer-term residents were more likely to participate in informal networks and activities. These informal activities were often harder to describe and capture, and hence may be underrepresented in research on the lives of older people in rural communities.

Fear of Crime

There is a popular perception that older people are particularly fearful of crime, and overestimate risk. However, data from the Crime Survey of England and Wales shows that older people are less likely than younger people to see themselves at risk of being a victim of crime (Office for National Statistics, 2017b). A meta-analysis of the academic literature similarly found no consistent association between age and fear of crime (Collins, 2016).

One reason for this apparent inconsistency is the type of measure used – older people are often more fearful of crime at night, but not under other circumstances (LaGrange and Ferraro, 1989; Greve et al., 2017). It also appears that older people are more likely to modify their behavior in order to mitigate fear of crime (Greve et al., 2017). Ceccato and Bamzar (2016) point to a range of environmental factors affecting perception of safety, including lines of sight, numbers of passers-by, and design appeal. Solymosi et al. (2015) suggest the need for a more dynamic understanding of 'fear of crime', reflecting the fact that such fears are often very specific to a particular time and place.

There have been mixed findings as to whether fear of crime affects physical activity, although older people often raise it as a potential concern (Foster et al., 2014; Moran et al., 2014; Ribeiro et al., 2015). In some instances, older people with good mobility may in fact walk further to avoid areas seen as unsafe (Ceccato and Bamzar, 2016). Neighbourhood crime is also associated with poorer mental health among older people in the English Longitudinal Study of Ageing (Dustmann and Fasani, 2016).

Older people also tend to be more concerned than younger people regarding online crime and identity fraud (Office for National Statistics, 2017b). In some cases, this may also limit social participation, for example where information about community events and services is primarily available online. It may also prevent some older people from using the internet as an alternative to services they find inaccessible (e.g. for shopping). However, it is important to note that many older people do use the internet for a range of activities, and that non-use of the internet among older adults is associated with factors such as gender, disability and education, as well as solely age (van Deursen and Helsper, 2015; Office for National Statistics, 2017a).

Transport

Discussions of community participation and 'ageing in place' emphasise transport as an important element of remaining part of a community (World Health Organization, 2007; Van Dijk et al., 2014). Lack of transport can result in older people being unable to access healthcare, community facilities and healthy food, and make it harder to implement improvements to services for older people (Windle et al., 2011; Mackett and Thoreau, 2015).

Concessionary travel has increased take up of bus services, had important community benefits and is cost-effective (Greener Journeys, 2014; Mackett and Thoreau, 2015). However, data from the English Longitudinal Study of Ageing suggests that public transport still does not meet the needs of many older people, primarily due to a lack of services (Holley-Moore and Creighton, 2015). Community transport services specifically intended for older people can help to address shortfalls in traditional bus services, but also has limitations, e.g. a lack of flexibility (Shergold and Parkhurst, 2012).

Driving is important for many older people, especially in rural areas, where some facilities may be difficult to access without a private car (Menec et al., 2011; Shergold and Parkhurst, 2012). Driving can facilitate social engagement and have a symbolic importance, as a marker of independence and of identity (Gilhooly et al., 2002; Whitehead et al., 2006; Smith et al., 2007; Curl et al., 2014; Pachana et al., 2016). In some instances, concerns about losing a driving licence could be a deterrent to seeking healthcare (Olsen et al., 2014). Some older people who can drive may be unwilling to drive under certain circumstances (e.g. at night), potentially limiting social participation (Shergold and Parkhurst, 2012).

Informally arranged 'lifts' can be an important supplement to formal transport services. However, some older people may see relying on others as a loss of independence, or be reluctant to ask for assistance (Gilhooly et al., 2002; Ahern and Hine, 2012; Shergold and Parkhurst, 2012).

Places to age

UK Network of Age Friendly Cities

The UK Network of Age Friendly Cities is affiliated to the international WHO global network. There is a core steering group, and member cities such as Glasgow, Belfast, Manchester and Nottingham share their strategies and initiatives. (MICRA, n.d.)

The Role of Older People in Researching Age-Friendly Communities

An age-friendly research project in Manchester produced a report focusing on the experiences of the older people co-investigators within the project, emphasizing their knowledge and expertise with regard to the local community and offering thoughts and practical tips on involving older people in research on age-friendly environments (Buffel, 2015).

> *"When you live in an area you get a feel for it, you have an intuitive knowledge about the place, you read local papers and get local magazines, see notices, recognise faces and know the places where staff are kind and willing to help.... All this helps when interviewing another person and trying to understand their perspective."*

(Views on using older community co-researchers Buffel, 2015:81)

Walkability Audit

Age Friendly Ireland and the Centre for Excellence in Universal Design arranged 'walkability audits'. Local people walked a chosen route alongside the scheme planner and local authority officers. They made comments as they walked the route, before filling out an audit form. The project involved people with a range of needs, including older people, people with vision loss and parents with prams. It highlighted issues such as the impact of overgrown vegetation and whether crossings allowed pedestrians enough time to safely cross. The project was used to make broad recommendations regarding issues that make public spaces more or less useable for individuals, but was also used to draw up local action plans for improvement. The walkability tool and guidance was also made available for other towns (Age Friendly Ireland and National Disability Authority, 2015).

Inclusive Design for Getting Outdoors (ID GO)

This was a project involving researchers from Edinburgh, Warwick and Salford, looking at inclusive design to encourage people aged over 65 to get outdoors. It included surveys of older people, audits of local neighbourhoods and surveys of designers, and identified a number of key features important to older people in their local environment. One component of the project highlighted the importance of gardens in offering a practical space for activities such as hanging out washing; a pleasant view; and an opportunity for fresh air and local socialization. Other aspects of the project looked at pedestrian-friendly initiatives and tactile paving. The project website includes survey results and design advice (ID GO, 2014)

Pride of Place

Age UK (n.d.) have offered guidance for how councillors – and indeed, local authority staff - can help improve neighbourhoods for local people. They emphasise the importance of often fairly minor actions, for example:

- Reporting problems in the local environment such as damaged paving slabs, and ensuring those are addressed promptly
- Having regular ward surgeries and ward walkabouts to be aware of local concerns
- Ensuring there is suitable provision of public transport, toilets and seating

The report suggests that proactive action is often overall cost-effective for the public purse – for example, pavement repairs are likely to be much cheaper than the consequences of someone either falling, or moving into residential care because they feel unable to manage in the community.

Age-UK is also promoting a 'Change One Thing' scheme, aimed at facilitating groups of older people to identify one local priority in their neighbourhood, and campaign for change.

Housing

Older Women's Co-Housing (OWCH)

In London, a group of women over 50 developed their own co-housing scheme, within a purpose built block of flats. Co-housing is housing that is run by its residents, aiming to strike a balance between privacy and a sense of community. Each resident has her own flat (owned or socially rented), with a shared common room, guest room and laundry. OWCH members selected the architect for the scheme and were directly involved in designing the scheme. They also focused on community building, ensuring everyone living in the scheme had a shared purpose and agreed guidelines on how to live together. Media coverage of the scheme resulted in around 400 women contacting OWCH asking to be put on a waiting list or seeking advice on developing their own scheme. A report sets out a number of difficulties in developing the scheme and how they were overcome, including financial arrangements that encouraged housing developers to be involved, and negotiating arrangements for socially-rented accommodation that would retain the community's say over its membership. Non-resident members can participate in the community and thus more readily settle in when a vacancy arises (Brenton, 2017; Older Women's Co-Housing, n.d.)

'Rightsizer' housing

Birmingham City Council identified that older social tenants were often under-occupying larger homes. Housing allocated for older people was often too small, unappealing and sometimes had been poorly converted. As a consequence, older tenants were often reluctant to move. The Councils consulted with older people and drew up a specification for housing based on their comments. The design was for attractive dormer bungalows that could offer single-floor accessible accommodation if required, but also offered a spare first-floor bedroom for visitors or carers. The Council has also worked with housing trusts to deliver 5 extra care 'villages', each offering 250 units of housing across a mix of tenures (LGA, 2017)

Independent Living

Essex County Council worked with the twelve district councils in Essex to explore and remove barriers to meeting an unmet demand for independent living options. The County Council undertook a demand analysis and set a target of 1,800 units of extra care housing over 5 years,43% for rent and 57% for ownership. They also invested £27 million of capital funding to deliver their model of independent living. This would be developments of 60 or more attractive, self-contained one or two bedroom apartments, in a town or large village with good public transport links. Each scheme would be evenly split between those with mild, moderate and high care needs, with care delivered through direct payments, with choice. Schemes also potentially could include health outreach and reablement facilities. The County Council worked with district councils to draw up a joint policy statement and embed it within Local Plans. The financial case projects an annual saving of £3,900 per person. As at September 2017, 3 schemes were open, and another 7 were under construction or had submitted for planning permission (LGA, 2017).

Household Living for people with dementia

Dementia Care (2015), a charity in Newcastle, highlight that while many people living in extra care housing have dementia, there has been limited consideration given to dementia within the design or operation of such schemes. As a consequence, extra care is often an interim measure, rather than offering a home for life. Dementia Care offer a model of 5 bedroom bungalows, arranged around a close of 5 similar properties, based on a design from the University of Stirling. Each bungalow has a team leader, and there is a focus on encouraging people with middle or high-level dementia to be as independent as possible. The cluster of bungalows allows for group activities to be viable. The staffing levels are higher than residential care, but the scheme aims to maintain independence for longer, and hence prevent people from requiring nursing or hospital care.

In the North-West, the 'Belong' scheme offers villages designed for people with dementia, including independent living apartments, community hubs and 'households' of 11 or 12 residents, providing care for those with substantial needs (Best and Porteus, 2016; Belong, n.d.)

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