July 2020

Planning need assessment for Caldwell Development Limited

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EXECUTIVE SUMMARY

T1 Background

Carterwood Chartered Surveyors has been commissioned to prepare a need assessment on behalf of Caldwell Development Limited in relation to the development of a care village to include extra care apartments and a care home at Caldwell House, Uplawmoor, Glasgow, G78 4DU. Carterwood has been asked to prepare a need assessment of the subject site based on a market catchment area for each of the care home and extra care elements of the proposed scheme.

T2 National overview

The population of the UK is set to age dramatically over the coming years, with a substantial increase in the number of people living to over the age of 85, when dependency levels and the prevalence of dementia increase dramatically. Nationally, approximately 30 per cent of existing care home provision is not to the standard required to cope with the needs and expectations of today's elderly care home residents.

T3 Indicative need for elderly care home market standard beds (2021)

Basis of assessment	Market catchment area (c. 5.5 miles)
Indicative need including all planned beds	209
Indicative need including beds under construction	209

T4 Indicative need for private extra care units (2021)

Basis of assessment	Market catchment area (c. 10.0 miles)
Indicative need including all planned private units	945
Indicative need including units under construction	1,220

T5 Conclusions and recommendations

- There is a significant need requirement for 209 elderly care home market standard bedspaces in the market catchment area, with the predicted need increasing to 264 market standard bedspaces by 2031. In addition, there are no planned bedspaces further highlighting the need requirement for the proposed subject care home.
- An assessment of dedicated dementia provision in the market catchment shows a large need for 120 beds, with neither of the existing homes in the catchment area providing dedicated dementia bedspaces.
- The analysis of private extra care provision in the market catchment shows an enormous need for 945 units, despite including all planned schemes and given development has not commenced on either of the planned schemes the need requirement increases to 1,220 units. Projected need increases markedly to 1,120 units in 2031, reflecting the sustained and escalating nature of the requirement.
- The council's strategy recognises the need for new and innovative forms of elderly care accommodation, particularly extra care. We conclude there is both a compelling quantitative and qualitative need for the proposed development, which seeks to cater for the full range of dependency levels within a sustainable community setting.

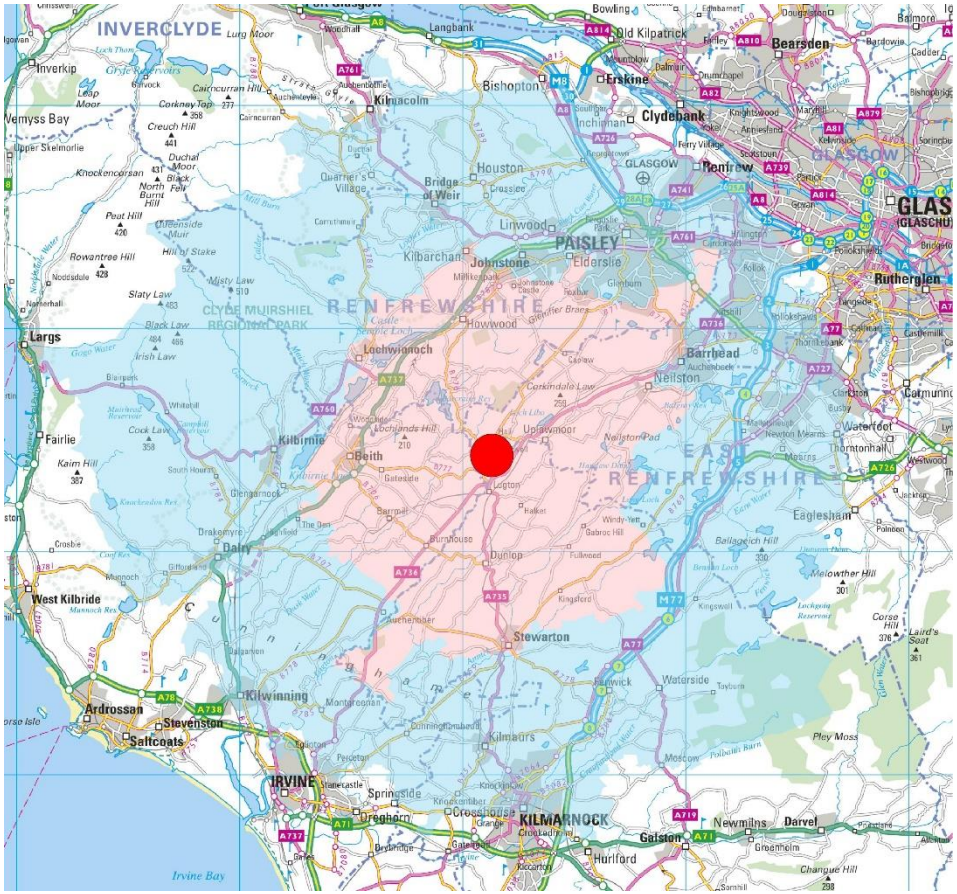

Figure 1: Location of the proposed scheme and our bases of assessment

Note: Proposed care village indicated by the red dot. Our assessment of care home need is based on a market catchment extending to circa 5.5 miles (shaded pink) and need for extra care is based on the larger combined area, circa 10-mile radius (shaded blue and pink).

Full definitions for care home and extra care are provided in sections 5 & 6, on page 8 of the report.

INTRODUCTION

1. Introduction

1.1. Carterwood Chartered Surveyors has been commissioned to prepare a need assessment on behalf of Caldwell Development Limited in relation to the development of a care village to include extra care apartments and a care home at Caldwell House, Uplawmoor, Glasgow, G78 4DU.

1.2. Carterwood has been asked to prepare a need assessment of the subject site based on a market catchment area for each of the care home and extra care elements of the proposed scheme.

1.3. In this report, we have considered the national context of both the care home and extra care markets, together with a detailed study of the catchment areas of the two elements of the proposed development.

Limitations to advice

1.4. We reserve the right to alter our advice once United Kingdom's has exited fully from the European Union ('Brexit') and the outcome of any negotiated agreements are known.

1.5. The outbreak of the Novel Coronavirus (COVID-19), declared by the World Health Organisation as a "Global Pandemic" on the 11th March 2020, has had huge global impact. Market activity is being affected in many sectors. We have endeavoured to reflect the impact in our analysis, but we reserve the right to alter our advice if there is an unpredictable change in market, financial or economic circumstances. The current response to COVID-19 means that we are faced with an unprecedented set of circumstances on which to base a judgement.

T6 Instruction summary

Client	Caldwell Development Limited
Site address	Caldwell House, Uplawmoor, Glasgow, G78 4DU
Purpose of advice	Comprehensive planning need assessment
Date of terms of engagement	11 June 2020
Date of planning research	26 June 2020
Date of report	3 July 2020
Prepared by	Alex Taylor MA MRICS and reviewed by Peter Nurse BSc (Hons) MRICS.

2. Carterwood

2.1. The company has grown from two founding directors to a team of over 25 and provides advice across the care sector to a range of operators, developers and other stakeholders.

2.2. Examples of private sector clients who have regularly commissioned need assessments or site feasibility studies include:

- Porthaven Care Homes
- Gracewell Healthcare
- Hallmark Healthcare
- Care UK
- Caring Homes
- Signature Senior Lifestyle
- Barchester Healthcare
- Octopus Healthcare
- Retirement Villages
- LNT Care Developments
- Richmond Villages
- Audley Court Limited
- Four Seasons Health Care

2.3. Similarly, examples of Carterwood clients in the not-for-profit sector include:

- Anchor
- The Royal British Legion
- The ExtraCare Charitable Trust
- Leonard Cheshire Disability
- Sanctuary Care
- Jewish Care
- Brendoncare
- Care South
- Healthcare Management Trust
- Greensleeves Homes Trust
- Milestones Trust
- The Orders of St John Care Trust

2.4. Carterwood's client base represents the majority of operators currently seeking to develop new care homes and extra care schemes across the United Kingdom. Accordingly, we are in an almost unique position in the sector, having assessed over 2,000 sites since 2008, for a range of providers across a range of scheme types and care categories.

3. Our approach

3.1. Our report is split into sections as follows:

National context and key definitions

3.2. We outline some key definitions and background explanatory text for the social care sector. We also consider the national overview of the demand and supply factors currently influencing the care home and extra care sectors, with an emphasis on the growing demographic pressures in relation to the United Kingdom's ageing population and the increasing prevalence of dementia.

The proposal

3.3. We provide a description of the proposed scheme, its position on the elderly social care spectrum and research findings in relation to the wider benefits of care villages.

Commissioning overview

3.4. We present a review of the relevant strategy documentation from East Renfrewshire Council.

Care home need

3.5. We undertake a detailed demand and supply analysis of the proposed care home based on the market catchment area and outline a full methodology of our approach as well as the results of our analysis.

Extra care need

3.6. We assess the existing and planned supply of extra care schemes within the market catchment area. We include our methodology and outline the difficulties in assessing the need for extra care units more generally in the private sector.

Conclusions

3.7. We present our empirical, evidence-based assessment of the need for market standard care home bedspaces and extra care units within the market catchment area. We also provide an overview of the key qualitative and quantitative factors influencing our opinion of need for the proposed scheme.

4. Sources of information

4.1. We have utilised the following sources of information:

- Census 2011 population statistics;
- ONS 2018-based population projections;
- LaingBuisson Dementia Care Services;
- LaingBuisson's Care Homes for Older People UK Market Report (30th edition)
- A–Z Care Homes Guide;
- Carterwood database;
- www.careinspectorate.com;
- Alzheimer's Society;
- Department of Health;
- Relevant planning departments;
- Contains Ordnance Survey data © Crown copyright and database right (since 2010);
- Contains LPS Intellectual Property © Crown copyright and database right (since 2016);
- Centre for Policy on Ageing: A profile of residents in Bupa care homes: results from the 2012 Bupa Census;
- East Renfrewshire Council;
- Alzheimer's Society: Low expectations: Attitudes on choice, care and community for people with dementia in care homes, February 2013;
- Glenigan;
- Planning Pipe;
- LaingBuisson's Extra Care Housing UK Market Report.

NATIONAL CONTEXT AND KEY DEFINITIONS

5. Definition of a care home

5.1. Care homes fall within Class 8 ("residential institution") of The Town and Country Planning (Use Classes) Scotland Order 1997.

5.2. The Regulation of Care (Scotland) Act 2001 states that a “care home service” is a service which provides accommodation, together with nursing, personal care or personal support, for persons by reason of their vulnerability or need; but the expression does not include:

- a hospital;
- a public, independent or grant-aided school;
- an independent health care service; or
- a service excepted from this definition by regulations.

5.3. The Care Inspectorate regulates and inspects care services in Scotland to make sure that they meet the right standards. The Care Inspectorate also jointly inspect with other regulators to check how well different organisations in local areas work to support adults and children.

5.4. There are over 18,000 care homes in the United Kingdom, over 11,000 of which care for elderly people, according to the *A–Z Care Homes Guide (as at 1st January 2020).*

Personal care and nursing

5.5. To assist the reader, we provide below an explanation of the difference between personal care and nursing care, both of which can be provided within registered care facilities. The subject care home will be seeking to provide both personal and nursing care together with specialist dementia care.

5.6. Care homes providing personal care for the elderly, or residential care homes for the elderly, as they are also referred to, provide both short-term and long-term accommodation to elderly people. They also offer help with personal hygiene, continence management, food and diet management, counselling and support, simple treatments, personal assistance with dressing, mechanical or manual aids, and assistance getting up from or going to bed.

5.7. Nursing homes offer the same services as personal care homes, with registered nurses also available to provide nursing care 24 hours per day, to care for residents with complex health issues that can only be administered by nursing staff.

6. Definition of extra care

6.1. Accommodation for older people has traditionally been limited to three options:

A. Remaining in the family home;
B. Moving into sheltered housing accommodation;
C. Moving into a residential care environment.

6.2. Extra care accommodation has evolved in recent years to respond to the growing need from older people for greater choice, quality and independence.

6.3. As the supply of extra care has expanded, so has the number of different models and designs, making it difficult to define this form of accommodation. However, the Department of Health (DoH) has identified three common features. These are as follows:

A. It is first and foremost a type of residential accommodation. It is a person’s own home. It is not a care home or a hospital and this is reflected in the nature of its occupancy through ownership whether it be lease or tenancy.
B. It is accommodation that has been specifically designed, built or adapted to facilitate the care and support needs of its owners or tenants.
C. Access to care and support is available 24 hours per day.

6.4. Extra care schemes fall within Class 8 ("residential institution") of The Town and Country Planning (Use Classes) Scotland Order 1997. This is because they provide both accommodation and care/support on a 24-hour/day basis.

Extra care models

6.5. Extra care (often used as a generic term) is frequently referred to as a concept rather than a type of accommodation and the term covers a range of different accommodation models.

6.6. Extra care housing is referred to by various different names, again depending upon whether the accommodation is operated by a provider/developer or social services. Current terms used include independent living, extra care, very sheltered housing, assisted living, category 2.5 accommodation and close care.

6.7. The accommodation options offered range from flats or housing to a small village model. The accommodation provided is available on a variety of tenures; shared ownership, long leasehold and rent (social and private).

6.8. Central to the philosophy of extra care is that it should provide a “home for life”. The accommodation element of the scheme is not registered by the Care

Inspectorate. The care required by the residents will be provided either by an in-house or external domiciliary care agency, which is regulated by the Care Inspectorate.

6.9. The Elderly Accommodation Counsel (EAC) provide a set of definitions of the different types of elderly specialist housing as follows:

- Age exclusive housing is designed, built and let/sold exclusively to older people (typically 50+ or 55+), but without supportive on-site management and usually without any shared facilities except perhaps a garden.
- Sheltered housing (also known as retirement housing) is mainly for rent and let through local councils or housing associations, usually for people on low income. Sheltered housing is also available to lease or buy from private providers including housing associations.
- Enhanced sheltered housing has additional services in situ to enable older people to retain their independence for as long as possible. Mostly for renting, but also leasehold or purchase.
- Extra care (also known as assisted living) schemes are designed for independent living with a service to provide personal or nursing care on site 24/7. Typically for renting by RSL's, but also increasing for leasing and purchase.

6.10. Within the wider definition of "housing with care" a form of older people's housing exists called "enhanced sheltered housing". This is in response to a few hybrid schemes that have been developed over the years that seek to provide some form of on-site facilities/amenities and/or some form of additional support packages to scheme residents, but do not meet the full definition of extra care housing. We have also included this element of specialist retirement housing within our global 'extra care' definition. This is because many schemes which meet the requirements of 'extra care' are labelled as 'enhanced sheltered' in the EAC data and vice versa.

6.11. It is important to remember that there is NO statutory definition and these "labels" are applied to schemes without any regulatory rigour or set of standards. We are aware, for example, that schemes by the same operator providing the same services are coded as either 'enhanced sheltered housing' or 'extra care' within their portfolio in the EAC housing directory.

6.12. In addition to these definitions are further sub-definitions of specialist older people's housing, also referenced in the EAC directory, as follows:

- Close care – elderly people's accommodation linked to a registered care home;
- Care village / CCRC (continuing care retirement community) – large schemes offering an extended range of services for older people; often providing a range of accommodation types and with many including a registered care home on the site (although this is not compulsory).

6.13. For the avoidance of doubt if the scheme were to be referred to as a "care village" this does not mean that it is no longer considered to be extra care or assisted living, but that it is ALSO categorisable as a care village.

6.14. The lack of a statutory definition is one of the main reasons for confusion in this sector by social services, planners, residents and policy makers alike.

6.15. The proposed scheme meets several of the various definitions of specialist housing for older people and for ease and consistency we have used the term 'extra care' throughout this report, whilst not disregarding the comments and observations above. We also use the terms "housing with care" and "extra care / enhanced sheltered housing" where appropriate for context. We have assumed that the term assisted living can be used interchangeably with extra care as it meets the same criteria definition and only differs in the subject scheme by individual unit size and target market dependency levels.

Typical extra care resident profile

6.16. There is a strong wish amongst elderly Britons to remain independent as long as possible. Extra care units appeal to this sentiment, given the style and design of the accommodation, and the creation of a valuable legal interest – i.e. sale on a long leasehold basis or 'market rent' becoming an increasing option available.

6.17. The decision to move into retirement housing is often strongly influenced by immediate relatives. The more confused the elderly person, the more this applies. Aspects such as accessibility and convenience for visiting relatives play a major role. Elderly people generally seek to move to care facilities either close to their own homes or close to relatives' homes. Sometimes, therefore, this may involve the resident moving away from his or her own area.

6.18. In operational extra care developments of which we are aware, the residents typically range in age between 70 and 90 years, with an average resident age of around 80 years. Interestingly, this is similar to the age profile of a registered care home, but care homes now cater to residents with much higher dependency levels and where their needs often cannot be catered to due to complex dementia or provision for 24 hour a day on-site nursing care.

6.19. Typically, single females occupy 65–70 per cent of units, married couples 20–25 per cent, and single males 10 per cent of the units. The key issues leading people to move into extra care are health and care needs, often prompted by the death of a spouse or partner.

7. Elderly population trends and market size

Population

7.1. The elderly UK population is set to grow dramatically over the coming years, and the predicted rapid increase in elderly population is likely to continue to drive demand for both non-residential care, such as extra care schemes and other accommodation options, as well as care home beds.

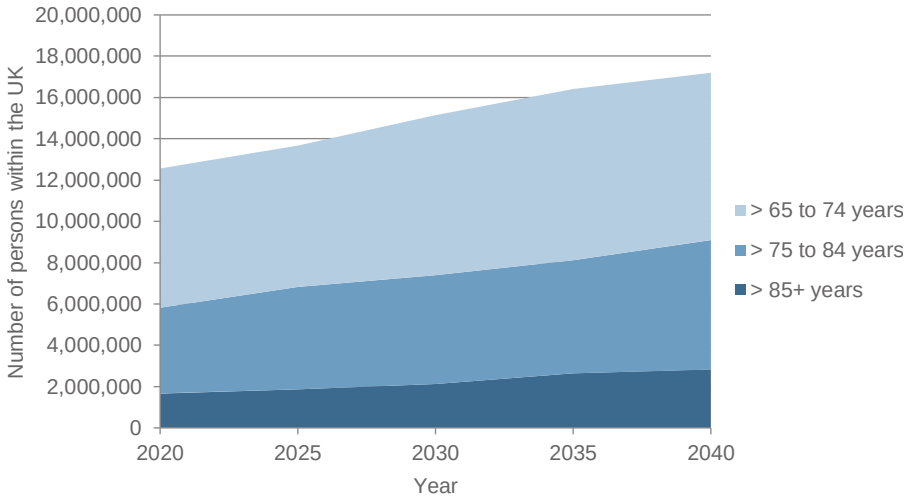

Figure 2: UK population growth 2020 to 2040

Source: 2011 Census, government population projections.

7.2. LaingBuisson's *Care Homes for Older People UK Market Report (30th edition)* states that the percentage of the UK population over the age of 85 is projected to multiply more than five times, from 1.68 million in 2020 (2.4 per cent of the population) to c. 8.49 million in 2111 (10.0 per cent of the population), while the 75- to 84-year-old segment will rise from 4.167 million in 2020 (6.3 per cent of the population) to 7.9 million in 2111 (9.3 per cent of the population).

7.3. The demand for care rises dramatically with age. Approximately 0.59 per cent of people aged 65 to 74 live in a care home or in a long-stay hospital setting, rising to 14.8 per cent for the over-85s.

Home ownership

7.4. The levels of home ownership amongst the elderly are very high nationally as illustrated by the data from the 2011 Census below.

T7 Household ownership (2011) where HRP is aged 65+ years or older

Tenure	UK`	
	No.	%
Owner occupied: owns outright	8,328,967	30.8
Owner occupied: owns with a mortgage/loan	8,864,183	32.8
Owner occupied: shared ownership	192,880	0.7
Rented from: council (local authority)	2,649,127	9.8
Rented from: registered social landlord	2,260,664	8.4
Rented from: private landlord / letting agency	3,994,718	14.8
Rented from: other	384,606	1.4
Living rent free	366,352	1.4
All households*	27,041,497	100.0

Source: 2011 Census, government population projections.

7.5. Home ownership levels of the aged are very important for the analysis of private extra care accommodation, as those property occupiers who own their own home will not be able to access RSL support through affordable rental options and instead will need to access alternatives that are available for private sale.

7.6. Home ownership levels vary considerably across the UK and higher levels are generally found in areas of higher affluence and vice versa.

National provision of private extra care

7.7. Determining the size of the extra care market is dependent on the definition of 'extra care', which we discuss in detail in Section 6 of this report. We have utilised our own dataset which is sourced from EAC and updated to include our own research.

7.8. We have included total market supply of private extra care and enhanced sheltered housing for this dataset and defined as 'without care/support' to illustrate the concentration of existing supply in this accommodation type. 'Extra care' within our definition is included within the 'with care/support' accommodation types.

T8 Private specialist older people's housing OPH supply (UK)

Scheme type	Total Schemes	Private units for sale or rent	% of private units
Without care/support			
Age exclusive	1,020	16,040	9.0
Sheltered	3,758	131,663	74.2
Sub-total	4,778	147,703	83.2
With care/support			
Enhanced sheltered	336	13,877	7.8
Extra care	487	15,955	9.0
Sub-total	823	29,832	16.8
All schemes			
Total	5,601	177,535	100.0

T9 Specialist OPH housing supply by year of development (UK)

Year of development	Total Schemes	Private units for sale or rent	% of private units
Unknown	512	9,564	5.4
Prior to 1970	153	2,258	1.3
1970s	54	1,052	0.6
1980s	1,888	60,044	33.8
1990s	862	26,501	14.9
2000s	928	34,835	19.6
2010s	1,204	43,281	24.4
Total	5,601	177,535	100.0

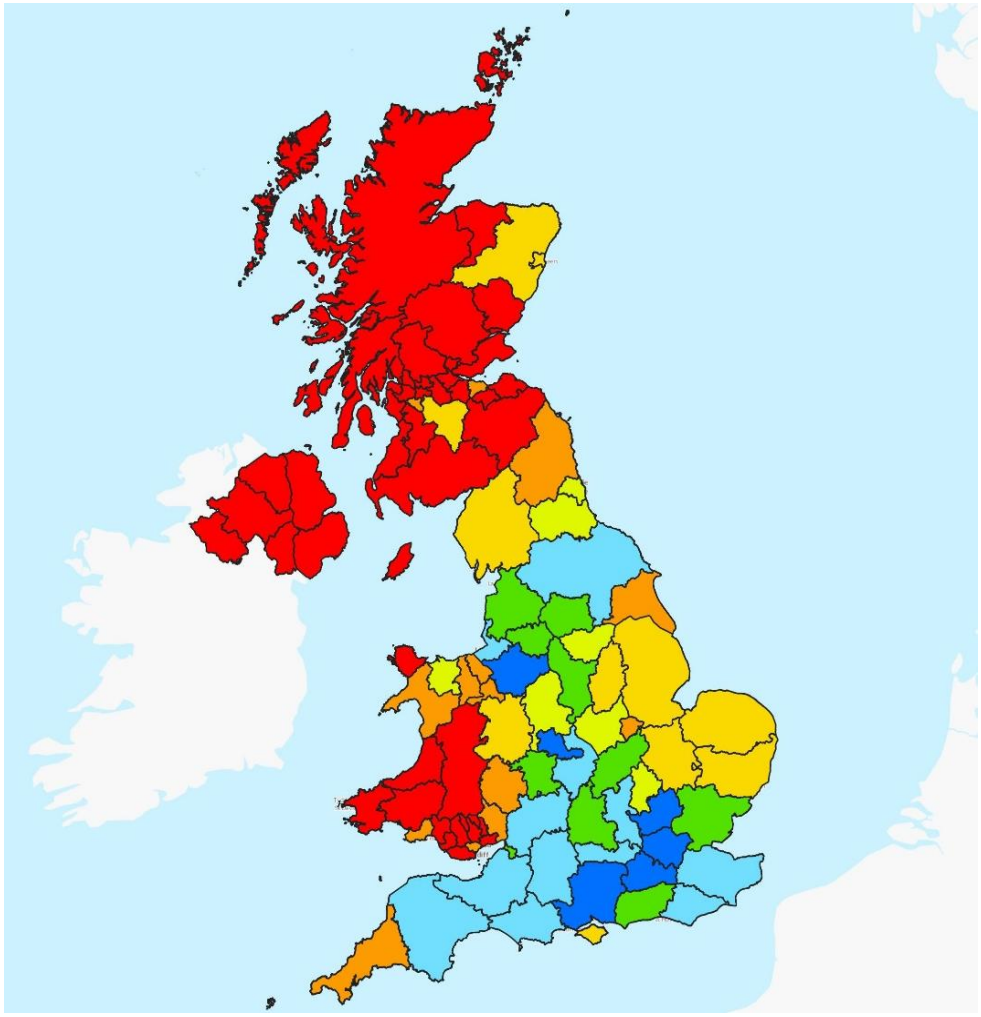

Figure 3: Supply of private extra care by simplified "county" area

National provision of care homes

7.9. LaingBuisson's *Care Homes for Older People UK Market Report (30th edition)* states that as of March 2019 there were approximately 464,800 registered nursing and personal care bedspaces for the elderly and physically disabled in the United Kingdom. There was a general reduction in capacity from the mid-1990s until approximately 2007, since when capacity has remained broadly static or marginally increased.

7.10. While capacity has reduced from the 1995 peak of 557,400, evidence now indicates that a new phase of essential expansion is underway across the country, as the number of very old people at risk of entering a care home rises significantly.

7.11. According to our care home database, approximately 330,000 of these beds have en-suite provision, meaning that over 28 per cent of current registered bedspaces do not conform to the current market standard of providing a bedroom with en-suite facilities.

8. The growing need for dementia care

8.1. 'The term "dementia" describes a set of symptoms that include loss of memory, mood changes and problems with communication and reasoning. There are many types of dementia, the most common being Alzheimer's disease and vascular dementia. Dementia is progressive, which means the symptoms gradually get worse' (source: Alzheimer's Society website).

8.2. Both personal care and nursing homes can provide care to persons suffering from dementia and/or Alzheimer's disease. Whilst the preference is always to try to maintain an individual's independence at home, this is not always possible, given the nature of the condition.

8.3. Nationally, there are a large number of mixed-registration homes caring for both elderly frail and dementia sufferers; this is acknowledged to be operationally challenging, as most homes lack the specialist design and layout to meet the complex needs of the service users' requirements.

8.4. The following statistics have been sourced directly from the Alzheimer's Society website, which provides useful background on the condition and its growing importance in the UK social and health care sector:

- There are currently 850,000 people with dementia in the UK, with numbers set to rise to 1.6 million by 2040;
- 209,600 people will develop dementia this year, that's one every 3 minutes;
- One in six people over the age of 80 have dementia.
- 70 per cent of people in care homes have dementia or severe memory problems.
- There are over 42,000 people under 65 with dementia in the UK.
- More than 25,000 people from black, Asian and minority ethnic groups in the UK are affected.
- Two thirds of the cost of dementia is paid by people with dementia and their families.
- Unpaid carers supporting someone with dementia save the UK economy £13.9 billion a year.
- The total cost of care for people with dementia in the UK is £34.7 billion. This is set to rise sharply over the next two decades, to £94.1 billion by 2040.
- The cost of social care for people with dementia is set to nearly treble by 2040, increasing from £15.7 billion to £45.4 billion.
- Dementia is one of the main causes of disability later in life, ahead of cancer, cardiovascular disease and stroke. As a country we spend much less on dementia than on these other conditions.
- Alzheimer's disease is the most common type of dementia, affecting between 50 and 75 per cent of those diagnosed. Other types of dementia include vascular dementia, affecting up to 20 per cent of those diagnosed, frontotemporal dementia, affecting 2 per cent, and dementia with Lewy bodies between 10 and 15 per cent.
- Delaying the onset of dementia by 5 years would halve the number of deaths from the condition, saving 30,000 lives a year.

8.5. An article published in the Lancet medical journal in March 2018 supports the above statistics, saying: 'Dementia is a devastating disease that brings fear, confusion, and loneliness to the lives of patients and their families. Today, around 850 000 people in the UK are living with dementia, costing the National Health Service (NHS) and UK society more than £26 billion annually. By 2025, it is estimated that over 1 million people in the UK will be affected, with the prevalence and costs of care for these patients expected to double by 2050' (source: The Lancet March 2018).

8.6. The Alzheimer's Society's report *Low expectations: Attitudes on choice, care and community for people with dementia in care homes*, February 2013, sets out quantitative and qualitative research on dementia provision in the UK, which recognises that for people with moderate and severe dementia needs an elderly care home placement may be the safest and most sustainable option available. Their report states that:

8.7. *'While there has been significant focus on delivering care to people in the community in recent years, care homes remain often the most appropriate place of*

care for many people with dementia, especially those with more advanced dementia' (page 5).

8.8. It goes on to state that:

8.9. *'There is significant evidence that the environment that people with dementia live in can have profound implications for their quality of life. Dementia can make it difficult for people to negotiate environments, potentially increasing the risk of accidents. Furthermore, many people with dementia are prone to walking about, and need environments which can enable this while remaining safe and secure'* (page 26).

8.10. *'The focus on new-build care homes should be on how environments can support good quality of life for residents, and existing good practice design guidance should be considered early on in building processes'* (page 29).

8.11. Whilst the document also considers other outcomes in a very positive light (including domiciliary care and other alternatives), the above illustrates that provision of residential care is an important part of the approach required to tackle the increasing demographic pressures and increased levels of acuity in care home placements.

9. Key issues for the sector

9.1. The national requirement for the development of new elderly care provision is growing. This is due to a number of factors, including:

- The increasing dependency level of service users;
- Increasing expectations from regulators and the marketplace;
- Many existing elderly care homes are converted, and are unsuitable for use in their current configuration without physical adaptation of the property;
- Constantly changing population demographics leading to a much older and more dependent population;
- The significant and growing increase in the incidence of dementia in older people;
- Impact of older people on the NHS and wider health care policy as levels of dependency increase and the burden of this age group on NHS facilities increases. This is also linked to the impact of social care funding and responsibility for paying for social care over the coming decades;
- The increasing requirement for extra care and other alternative forms of housing accommodation as an alternative to care homes, where suitable for the requirements of the residents;
- National Living Wage and its implications on staff retention and recruitment and sustainability of certain care homes;
- Impact of Brexit on the healthcare sector.

9.2. In response to these changing demographics, market-based and regulatory factors, the subject scheme will meet a wide variety of needs for the elderly population in the area.

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THE PROPOSAL

10. Description of proposal

10.1. The proposed care home is to comprise 100 per cent single occupancy accommodation, with each bedroom equipped with an en-suite wetroom.

10.2. In addition, the care village will provide a range of extra care units, designed for varying degrees of dependency of older people who need care. This is beneficial because as the level of acuity generally increases with age, individuals will be able to receive the amount of care they require, and in terms of the units, this care will be able to be administered easily within the person's own home.

10.3. It is anticipated that as a result of this development, a large number of full- and part-time jobs will be created, across a range of job types, from higher grade management positions to care workers and ancillary staff.

10.4. Further details in respect of the proposal can be found in the planning statement accompanying the application.

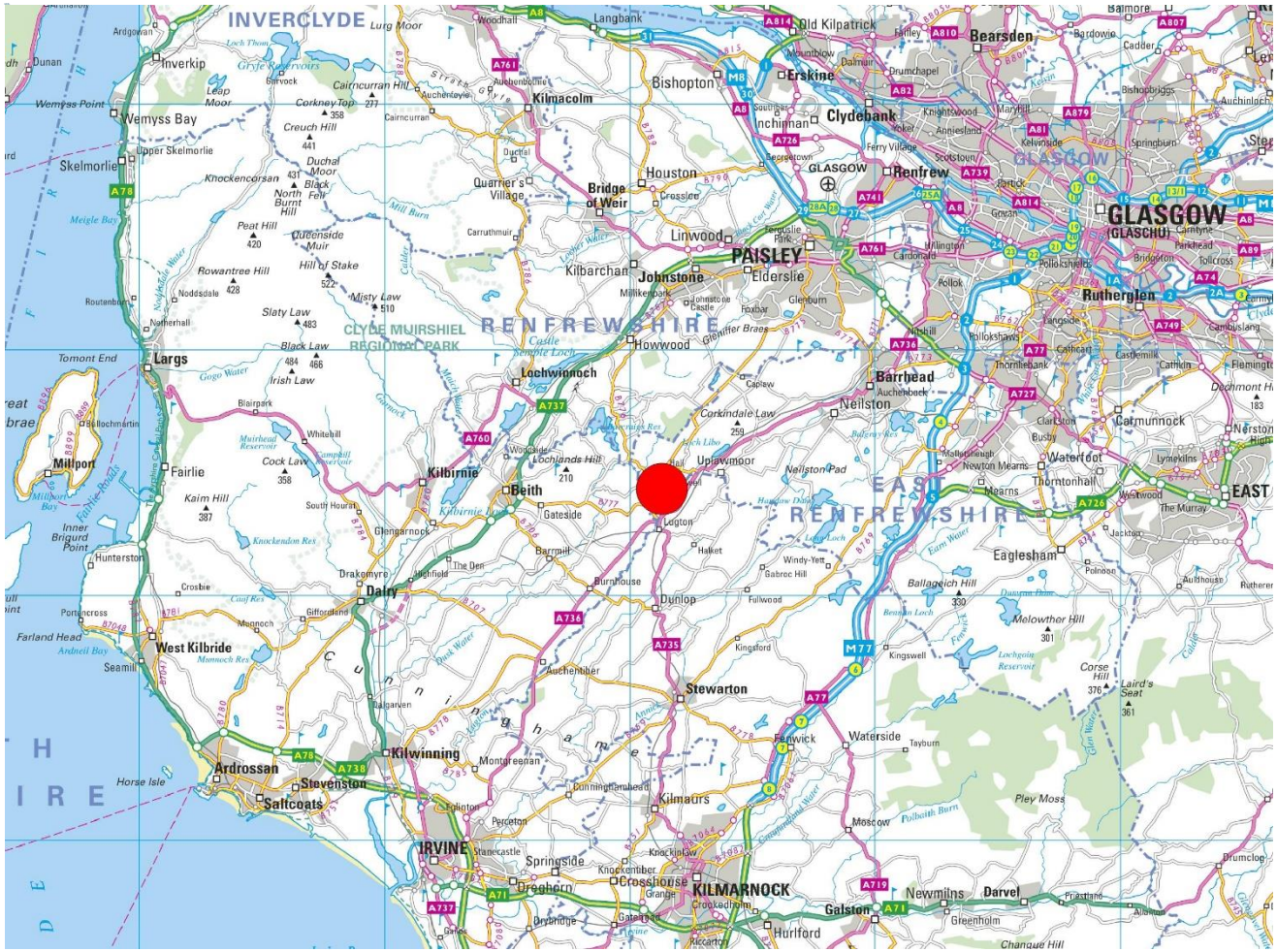

Figure 4: Location map of the subject site

11. The proposed care village – its position in the local market

Elderly care spectrum

11.1. Following our earlier review of the social care sector, to illustrate where we consider the proposed scheme lies within the various models of care provided in the UK long-term elderly-care market, we have compared the subject care home against other accommodation types in respect of care provided, cost of care, accommodation type and regulation. Table 10 below shows the range of options available within this "spectrum of care".

11.2. Increasingly, prospective service users do not make a decision to move into a care home until later in life, and sometimes the catalyst for a move is a fall or illness causing a short-term hospital stay. Due to the increasing requirements placed upon the NHS and hospital beds, as well as the introduction of delayed-discharge legislation, which imposes fines for "blocked beds" upon local authorities, hospital stays are increasingly shorter and a stay in a care home servicing this higher level of dependency may be the only short-term option.

11.3. A substantial variant to the provision elements of the care spectrum below is informal/family care. An estimated six million people provide significant support to elderly relatives, neighbours and friends. This allows many thousands of people to remain in their own homes, particularly when the support is alongside home care and/or day care. The effect of the above is to delay the older person's move into a care home, maybe even to the extent of bypassing it altogether and only moving into a care home or hospital when dependency is very high. Thus, a range of care requirements and a range of services co-exist, sometimes with considerable overlapping.

The proposed care home

11.4. The proposed care home will be capable of caring for residents of all dependency levels, including those with higher dependency levels, who require nursing care or dementia care within a specialist unit specifically designed to cater to their requirements. Without this capability a number of very high-dependency care home residents would otherwise experience an enforced hospital stay.

The proposed extra care units

11.5. The extra care units will cater for older people with lower dependency levels than the care home beds but with the provision of care that is flexible and adaptable as additional care is required, with support being available 24 hours a day. The units create an environment that allows people with care needs to maintain their independence for as long as possible.

T10 Elderly care spectrum

Accommodation	Standard housing	Sheltered housing	Extra care/independent living/assisted living	Care homes	Care homes with nursing	Hospitals
Care provided	Domiciliary care			Personal care	Nursing and medical care	
Cost of care	Low to medium and highly variable			Medium to high	High	Very high
Accommodation type	Standard housing	Specialist elderly housing		Residential setting		
Care Inspectorate regulation	Regulated only if care provided			Highly regulated – all care and accommodation		
Proposed community		Requirements met in the proposed extra care apartments		Requirements met in the proposed care home		

12. Tangible benefits for the wider community

Benefits to the housing chain

12.1. Extra care and other specialist housing for older people offer a unique combination of independence and security of lifestyle within a socially active and supportive community. Here, older people are able to continue to live in their own space, supported by a comprehensive and flexible network of personal care services and activities.

12.2. People moving into a scheme will release large family homes back into the community, which is key to offering more options for families living locally.

12.3. A report ("The top of the ladder", prepared in September 2013) by Demos, the leading cross-party think tank, has considered the above issue in significant detail. We have considered some of the key issues and findings raised as part of this research and reproduced below:

12.4. *'Retirement properties make up just 2 per cent of the UK housing stock, or 533,000 homes, with just over 100,000 to buy. One in four (25 per cent) over 60s would be interested in buying a retirement property – equating to 3.5 million people nationally.*

12.5. *'More than half (58 per cent) of people over 60 were interested in moving. More than half (57 per cent) of those interested in moving wanted to downsize by at least one bedroom, rising to 76 per cent among older people currently occupying three-, four- and five-bedroom homes. These figures show that 33 per cent of over 60s want to downsize, which equates to 4.6 million over 60s nationally. More than four in five (83 per cent) of the over 60s living in England (so not Scotland, Wales or Northern Ireland) own their own homes, and 64 per cent own their home without a mortgage. This equates to £1.28 trillion in housing wealth, of which £1.23 trillion is unmortgaged. This is far more than the amount of savings this group has (£769 billion). Therefore the over 60s interested in downsizing specifically are sitting on £400 billion of housing wealth.*

12.6. *'If just half of the 58 per cent of over 60s interested in moving (downsizing and otherwise) as reported in our survey were able to move, this would release around £356 billion worth of (mainly family-sized) property – with nearly half being three-bedroom and 20 per cent being four-bedroom homes.*

12.7. *'If those wanting to buy a retirement property were able to do so, this would release £307 billion worth of housing.*

12.8. *'Combining New Policy Institute (NPI) analysis of current market chain effects of older people dying and moving each year with our own analysis of ELSA, we can estimate that if all those interested in buying retirement property were able to do so, 3.5 million older people would be able to move, freeing up 3.29 million properties, including nearly 2 million three-bedroom homes. 'If just half of those interested in downsizing more generally were able to do so, 4 million older people would be able to move, freeing up 3.5 million homes.'*

12.9. The report's key conclusions are summed up in the following statement:

12.10. *'We conclude by reflecting on the fact that the housing needs of our rapidly ageing population (the number of over 85s will double by 2030) is the next big challenge this government faces. And yet the costs associated with overcoming this are far lower than those related to the effects of the ageing population on health or social care. The money is there already – locked up in over a trillion pounds' worth of assets across the country. Hundreds of millions of pounds could be released to stimulate the housing market if (low-cost) steps were taken to unlock the supply to meet the demand already there – let alone if demand were further stimulated. While there must always be a place for social housing and affordable tenancy for older people, the vast majority of older people can be helped into more appropriate owner-occupied housing without any direct delivery costs incurred by government or local authorities.'*

12.11. New research in 2020., prepared by the Centre for the Study of Financial Innovation, also supports the above housing chain benefits and is described in detail in Section **Error! Reference source not found.** on page 28 of this report.

Employment and economic benefits

12.12. The subject scheme will provide full-time and part-time roles in order to fulfil its obligations to residents and fulfil any care and support requirements. Below is a breakdown of our estimated roles / occupations and long-term job creation. This is based upon data collected by Worcester Research in 2016 on the Bishopstoke Park retirement village in Hampshire, England, operated by Anchor Hanover, of over 160 units in size.

T11 Direct employment generated		
Job role	Number of people employed	
	Bishopstoke Park actual	Subject scheme estimates
Management, professional, associate professional	8	8 – 10
Skilled manual, admin and clerical	12	12 – 15
Caring, machine occupations, elementary roles	45 (mostly part time average - 20 hours pw)	45 - 60
Total	65	65 - 85

12.13. In addition to directly employing a local workforce, schemes also employ the services of a wide range of local companies in the provision of services in order to service a scheme of this size. Data quoted in the Housing for Later Life report in 2011 estimated an average 40-unit extra care apartment scheme provides investment of approximately £5m into older people's housing and the local economy (in 2020 costs this would be significantly higher having been subject to 10 years' inflation). The report also found that around 50 people were needed for construction.

12.14. The Worcester Research group applied the above construction cost and utilised other research of their own as part of a resident survey and identified the following economic contribution for a typical 150-unit village:

- £15m in initial investment in capital asset (we estimate this to be greater and more likely to be in the region of £20 to £30m for a large 150-unit village).
- Approximately 187 jobs during the construction phase.
- £1.7m in on-going salary to local workers.
- At least £160,000 per annum in additional business to local suppliers.
- Around £1.3m expenditure in the local economy from residents (including multiplier effects).
- Between £152,000 and £190,000 in additional council tax to support local service provision.

Health & wellbeing and benefits to the NHS and Social Services

12.15. We have reviewed the House of Commons report of Housing for Older People (2nd report 2017/9) which neatly summarises the available body of evidence on the benefits to health and wellbeing and the direct positive impact on the NHS and budgets:

12.16. *"There is a significant body of evidence on the health and wellbeing benefits to older people of living in specialist housing and the resultant savings to the NHS and social care. This is particularly the case for extra care housing, which has onsite care and support and communal facilities. In addition, this type of housing helps family and carers finding it challenging to provide enough care and support.*

12.17. *Research by the International Longevity Centre-UK found that around a quarter of people who moved into extra care housing with social care needs (or went on to develop them) experienced an improvement within five years, were less likely to be admitted to hospital overnight and had fewer falls. Subsequent research found that, in comparison to older people in the general community, extra care residents reported having a higher quality of life, a higher sense of control and lower levels of loneliness.*

12.18. *While at Aston University, Professor Holland led a three-year study on the impact on older people's health of living in the ExtraCare Charitable Trust's extra care schemes. Professor Holland's study found that the NHS costs for those in the sample were reduced by 38% and that the costs for frail residents had reduced by 51%. In addition, local authority costs of providing lower and higher-level social care were 17.8% (£1,222) and 26% (£4,556) lower respectively on average per person per year.*

12.19. *With regards to retirement housing, research from the University of Reading showed that it can help combat social isolation and promote fitness, with over 80% of owner occupiers of retirement housing taking part reporting feeling happier in their new home and nearly a third feeling that their health had improved.*

12.20. *Providers of sheltered housing emphasised their role in helping older people to stay healthy, reducing hospital admissions and delayed transfers of care, thereby generating savings to health and social care budgets. Research by Demos estimated the value of sheltered housing to the NHS and social care at £486 million per year, of which £17.8 million amounted to reduced loneliness."*

12.21. Sometimes NHS CCG teams are concerned about the impact on their local doctors' surgeries. However, evidence indicates that there is a positive benefit in line with the evidence base above and regardless the subject scheme will not impact directly who we anticipate will hold periodic surgeries in-house within the development. This serves to reduce the number of GP visits, as the requirement for GP input is heavily controlled by care staff understanding the clinical requirements for each service user.

12.22. The visiting GP can also combine multiple visits into one trip. The presence of on-site care staff also reduces the number of unnecessary trips to GPs, thereby

reducing waiting lists rather than increasing them. The concentration of individuals within one place should also assist in reducing the need for community nurses and there are obvious advantages of having residents within one geographic location.

12.23. Further, the pressure on GPs will not be a direct result of the proposed development – demand is not created, it is catered for and the new scheme will provide much needed facilities to help battle the rising demographics pressure across the area.

12.24. In addition, some local authority Social Services teams are concerned that new schemes bring in people from outside of the area who will drain local authority budgets. However, having conducted a plethora of studies across the UK and spoken with a host of social services teams, our general observation is that local authority placements both into and out of any local authority are neutral.

12.25. There is no doubt that several residents will move into an area when a new scheme is developed. However, this goes both ways and as new schemes are developed in neighbouring boroughs and an equivalent proportion of people will therefore leave their authority area and funding requirements will reduce. Funding pressure by social services to and from neighbouring and surrounding local authorities therefore compensate each other. In effect, there are just as likely to be as many people leaving the area as there are migrating into the area, and these two factors effectively cancel each other out.

A wellness hub for older people

12.26. At a time when financial constraints are forcing some day care facilities to close, the central core or 'hub' of the proposed sustainable development will fulfil an increasing need for a welcoming community where older people living locally, who may well be lonely or bored, can enjoy a variety of pursuits and experience activity, friendship and a sense of belonging.

12.27. We understand that the provision of a medical centre is also being considered for the scheme which would be available for the use of those living in the village as well as those living in the wider community.

12.28. These facilities will be available for use by healthcare professionals delivering post-operative, rehabilitation and respite care to anyone within the local community needing such services, enabling local healthcare professionals, both NHS and private, to prescribe or advise attendance at various clinics (i.e. falls prevention, stroke rehabilitation and assessment clinics, physiotherapy, long-term conditions management and the promotion of self-care, including expert patients' programmes, cognitive stimulation and pulmonary and cardiac rehabilitation programmes).

13. Empirical research into benefits of a retirement village for its residents

13.1. The primary purpose of the literature on care villages has been to evaluate the success of existing schemes. In addition, while the volume of literature has gradually increased, to date there remain only a handful of papers that document and evaluate primary research from UK schemes. We have extracted the text below verbatim from a report prepared by Tetlow King, published in 2011, which summarises the empirical evidence available in respect of the benefits of care villages to the individuals who are cared for within the developments. We have also reviewed a report prepared by CASS Business School, entitled 'Does Living In A Retirement Village Extend Life Expectancy?'.

Planning and Delivering Continuing Care Retirement Communities (Tetlow King 2011)

13.2. 'There are two recent large scale longitudinal studies of CCRCs, one by Bernard et al. (2004) of Berryhill Village operated by the ExtraCare Charitable Trust and the other by Croucher et al. (2003) of Hartrigg Oaks, operated by the Joseph Rowntree Housing Trust.

13.3. 'Both of these studies offer in depth accounts of living in retirement communities. More recently an evaluation of the first 10 years of Hartrigg Oaks has been produced by the residents and staff (JRF 2009). The other UK based studies cover smaller time frames (e.g. Evans and Means 2007) and so adopt different methods and sample sizes, ranging from around 15 participants to over 100. Another approach by Biggs et al. (2001) adopts a comparative analysis, comparing those within a CCRC to a sample from the wider community. This produces an effective analysis of life within a retirement community as it enables direct comparisons to be drawn. Across these evaluations a number of key themes can be identified.

'Safety and Security

13.4. 'A number of sources refer to the sense of safety and security experienced by residents (e.g. Phillips et al. 2001, Baker 2002, Biggs et al. 2001). This is most often related to knowing that care staff are available on site day and night, and knowing that help is available across a range of domains, including home maintenance (Croucher 2006). It is also acknowledged that being in such a community reduces the risk of being a victim of crime or harassment.

'Health

13.5. 'Within a CCRC, the onsite care provision ensures that all residents are fully cared for and supported. Hayes (2006) acknowledges that this provides residents with peace of mind from knowing that they can stay at home even if their care needs change. Throughout their comparative studies both Croucher (2006) and Biggs et al. (2001) found that the self-reported health status of residents within the village tended to remain much higher than those living outside.'

'Social Inclusion

13.6. 'The issue of social inclusion is commonly cited as an important reason for moving into such a community. Social inclusion is a key theme throughout government policy and it is widely recognised that older age groups with reduced mobility increasingly suffer from social exclusion (Battersby 2007; OCSI 2009). It is well documented that CCRCs offer opportunities for companionship and social interaction. This occurs both formally within organised clubs or activities and informally within communal areas (see for example Bernard et al. 2007; Croucher 2006; JRF 2009; Evans and Means 2007 and Phillips et al. 2001). Some authors report instances of conflict or marginalisation of those who don't fit in with the norm (Croucher et al. 2006; Phillips et al. 2001). In general however this is heavily outweighed by the volume of evidence documenting the mutual support that exists between residents, creating a true sense of place and community spirit.'

Living in a retirement village extends life expectancy
The case of Whiteley Village (Surrey, England)

13.7. 'The increasing number of people we expect will require residential care at some point in their lives provides a new impetus to examine how retirement village communities can cater for the needs of their residents. This report is particularly commendable because it examines the records of residents of Whiteley Village, covering 100 years of its existence including their longevity experience.'

13.8. 'It finds that Villagers, particularly females, live longer than the average for England & Wales and this advantage was especially pronounced when pensioner poverty was higher than it is today. This is particularly remarkable since eligibility to become a resident of Whiteley, usually at around normal retirement age, is based on having limited financial means, i.e. people who would be expected to die sooner on average.'

13.9. 'This advantage continues today if one compares the longevity of Whiteley Villagers with the poorest 20% of pensioners in England & Wales. The key message therefore is that as well as increasing quality of life, housing with care communities such as Whiteley Village can also extend life expectancy.'

13.10. 'As the residential care sector continues to respond to the needs of our rapidly ageing society, I hope that policymakers and the social care sector can take heart in knowing that, whilst socio-economic inequalities in life expectancy sadly still

exist, the right housing with care community might just be able to ameliorate the effects of deprivation and address those inequalities in later life' (page 4).

'Executive summary

13.11. 'The benefits or otherwise of communal living in later life are of considerable interest in the context of a growing and increasingly elderly population because of the continuously rising cost pressures on health and social care and the need to provide more suitable accommodation. Such establishments have the capacity to provide in one location all the needs of residents whilst providing a stimulating and high quality living environment which insulates residents from the day-to-day problems of growing old. Whiteley Village, currently celebrating its 100th anniversary, is one of the main forerunners of this kind of retirement living anywhere in the world. The aim of this study is to investigate the possible benefits of retirement village life with respect to life expectancy, i.e. whether Villagers live longer on average than the general population. Our results show that there is strong statistical evidence that female residents, in particular, receive a substantial boost to their longevity when compared to the wider population – at one point in time reaching close to five years. Whiteley's longevity advantage is even greater once we take account of the fact that the resident population is drawn from the poorest pensioners, who would be expected to experience higher mortality rates. Although we were unable to find sufficient statistical evidence that the male residents of Whiteley outlive their counterparts in the wider population, there was certainly evidence that the majority lived at least as long on average (i.e. the effects of living at Whiteley appears to combat the inequalities caused by social deprivation)' (page 5).

13.12. The research document concludes that there are significant benefits of living at Whiteley that help to combat the inequalities caused by social deprivation. The report concludes that as well as increasing quality of life, housing with care communities such as Whiteley Village can also extend life expectancy.

The Joseph Rowntree Foundation

13.13. In addition to the above commentary, we have considered the Joseph Rowntree Foundation paper, published in April 2006, called "*Making the Case for Care Villages*". Drawing on previously published studies and data from an on-going comparative evaluation of seven different housing with care schemes for older people, they found that evidence shows very clearly that older people see care villages as a positive choice.

13.14. We have extracted a few examples of the research that underpins the key observations made on the benefits.

13.15. 'Care Villages also play an important role in promoting health and well-being. Increased opportunities for social interaction and engagement can reduce the experience of social isolation, with consequent benefits to health, well-being, and quality of life…'

13.16. '...Living in a purpose-built, barrier-free, efficiently heated environment removes many of the difficulties and dangers of living in inappropriate accommodation, in particular the risk of falls. Resident groups can be effectively targeted for health promotion initiatives... On-site catering services can promote healthy eating, and cater for particular dietary requirements and ensure that everyone has the opportunity to have a hot, nutritious meal every day.'

Benefits of domiciliary care delivery in community setting

13.17. In addition, provision of domiciliary care and support to occupants of the extra care units can be provided in much smaller time segments than is possible to achieve in someone's own home in a traditional way. Often visits in traditional home care within a person's own home are limited to a minimum of 30 minutes or even an hour, which is very impractical to meet the needs of the person concerned if they require a more bespoke service. There is greater consistency in case delivery compared to traditional care as home care delivery is easier to control.

13.18. In the proposed scheme, we understand that escorting duties and home visits would be offered in time intervals of as little as 15 minutes, to offer a tailored approach to care provision and fully meet the social as well as care-driven needs of the residents across the care dependency spectrum.

COMMISSIONING ENQUIRIES

14. Commissioning and local authority overview

14.1. The outline proposals for the proposed Caldwell House Care Village were discussed with the Commissioning and Planning Manager at East Renfrewshire Health and Social Care Partnership on 25th August 2020, in order to involve Social Work in the plans at an early stage.

14.2. We have also conducted a review of the following documentation:

- People Homes. Brighter Futures - Our Strategy for Housing in East Renfrewshire (2017-2022).
- Strategic Development Plan - Proposed Plan - Background Report. January 2016 - Glasgow and the Clyde Valley / Housing Need and Demand Assessment (May 2015)

People Homes. Brighter Futures - Our Strategy for Housing in East Renfrewshire (2017-2022)

Our people

14.3. *'East Renfrewshire has an ageing population, with one of the highest proportions of over 60s in the country and the second highest increase in the over 80s in Scotland. 28.6% of the population will be age 65+ by 2037' (page 9)*

14.4. *'29% of adults with additional support needs live in supported accommodation locally (against 19% in Scotland), with ongoing re-design of existing accommodation and support services challenged by the limited alternative housing options locally.' (page 9)*

14.5. *'In summary, East Renfrewshire faces great changes in its population in the coming years. We expect our population to continue to increase, to have more elderly residents, to see a decline in death rates and to have an increase in the number of households, as more people live alone.' (page 9)*

14.6. *'East Renfrewshire is already one of the most ethnically and culturally diverse communities in the country, with significant Muslim and Jewish communities, with trends expected to continue.' (page 9)*

Shaping our vision

14.7. *'The Public Bodies (Joint Working) (Scotland) Act 2014 identifies appropriate good quality housing and housing services as important contributors to improving health and wellbeing. Being able to live safely and comfortably at home for as long as possible is important to many older and disabled people who want to live independently.*

14.8. *There are nine National Health and Wellbeing Outcomes to be delivered through Integration, the housing contribution is reflected most clearly in*

- *Outcome 2: This aims to support people to live independently at home or in a homely setting for as long as possible; and*
- *Outcome 9: This aims to use available resources effectively and efficiently in provision of health and social care services. (page 10)*

14.9. *Local priorities - The "Fairer East Ren" plan currently being developed by the Community Planning Partnership will be the new Local Outcomes Improvement Plan (LOIP) for East Renfrewshire. This will replace the existing Single Outcome Agreement (SOA).*

14.10. *These reflect national priorities and provide the overall plan for what the Council and its partners hope to achieve for the local area. Our work to improve housing and related services directly supports this "bigger vision".*

14.11. *The key themes of the LOIP are:*

- *Tackling Poverty*
- *Reducing Social Isolation & Loneliness*
- *Mental Health & Wellbeing*
- *Employability*

Priority 3: Facilitate Independent Living

14.12. *'Supportive Services: The housing sector contributes greatly to enabling and supporting older people, disabled people, and those with support needs and long term conditions to remain independent at home. Planning for, and responding to the housing and support needs of these groups needs a joint approach by housing providers, HSCP and other partners. This also allows us to respond as effectively as possible to support the shift to self-directed support, and facilitate independent living.' (page 19)*

14.13. *An ageing population: n East Renfrewshire the very elderly population (85+) is set to grow at a higher rate than nationally, in addition to the population ageing generally. Also, the number of people living with a long-standing limiting illness is increasing with people living longer (but not healthier) lives.*

14.14. *The number of people with dementia in Scotland is expected to double between 2011 and 2031. The results will be an increasing demand on housing, care and support services to enable people to remain independent. National policy is to 'shift*

the balance of care' to support people to remain at home independently as long as possible, rather than in care homes or hospitals. Providing the right housing and support at the right time will be critical in preventing crisis and unplanned hospital admissions. We will focus on delivering a range of new housing to meet a lifetime of needs, as well as targeted options for retirement living and dementia friendly design.

14.15. *Enabling independent living: Disability and long term conditions can have significant implications for suitable housing options and support to allow people to live independently. The ageing population means people living longer, but a significant number have mobility or other long term conditions which require adaptations or support to remain independent. In recent years a substantial increase in the number of young adults or families with disabled children have requested housing assistance - such as adapting their current home or renting/buying an alternative home.*

14.16. *Where homes cannot be adapted a key challenge is in finding an alternative home locally which is both suitable and affordable. The current re-design of existing accommodation and support for adults with additional support needs increases pressure for suitable homes via the general housing supply. (Page 19)*

14.17. *Our strategy: We will work to ensure our vulnerable residents are able to live as safely and independently as possible, with appropriate care and support. We will also make support available to those who require it in order to prevent housing crisis, and assist in finding sustainable housing solutions.*

Strategic Development Plan - Proposed Plan - Background Report January 2016 - Glasgow and the Clyde Valley / Housing Need and Demand Assessment (May 2015)

Demographic Changes

14.18. *'East Renfrewshire has a diverse population, with significant changes expected in future years, in particular an increasingly older population (over 65's) up to 2029. This has an impact on the type of housing and facilities that will require to be provided in future years. Reshaping of health and social care services for older people, adults with learning disabilities and others with complex needs is also underway. This presents a growing demand for more accessible accommodation and support services, and is already putting pressure on existing housing stock, budgets and services.' (Page 191)*

Stock Profile and Pressures

14.19. *'The impacts of Welfare Reform and increasing single person and small households are also exerting pressure. In part this is due to a mismatch of available stock size and type locally with identified needs for affordable housing. This has significant implications for the Council and its partners in fulfilling our corporate responsibilities towards those affected by homelessness and others with particular housing and support requirements.' (Page 191)*

14.20. *'A key objective of the LHS and LDP will also be to continue to address unmet housing needs and to ensure that new housing is delivered across all tenures. This includes properties suitably designed and of a size and type to meet the needs of a range of households within the area. This also includes first time buyers, those seeking to move, meeting the needs of the increasing elderly population and those with a disability.' (Page 191)*

Conclusions

14.21. The council's strategy is in line with the majority of councils' commissioning strategies across the country in that it is seeking to reduce the amount of residential care it commissions and increase community-based services, with older people living in their homes for as long as possible.

14.22. However, the documentation clearly identifies a number of key demand drivers for new care home bedspaces, as the demographic pressures of an ageing population become manifest over the coming decade.

14.23. The subject scheme will provide a care home and extra care units within a care village where elderly residents can take comfort from the fact that care provision can be increased in line with care needs. Should a person's care requirements increase to a stage where 24-hour care or specialist nursing or dementia care is required, this will be available within the care home on site.

14.24. In addition, the proposed care village will seek to address national concerns over the lack of specialist housing for older people.

NEED ASSESSMENT FOR PROPOSED CARE HOME

15. Methodology for assessing need for general elderly care

15.1. Current and future demand for elderly care is influenced by a host of factors. These include the balance between demand and supply in any given area, and can also be influenced by social, political, regulatory and financial issues.

15.2. In our opinion, taking all factors into account, the most appropriate means of assessing whether a particular area or proposed development has sufficient demand to warrant additional beds seeks to measure the difference between demand for elderly care home beds and the current and future supply; below we provide a fuller explanation of the process used.

Demand

15.3. We assess demand based upon Census 2011 population statistics and have applied elderly population growth rates to determine the current and future demand for beds.

15.4. We have adopted LaingBuisson's measure of "Age Standardised Demand" (ASD). ASD is a tool used to predict the risk of an elderly person being in a residential setting at a given age.

15.5. The methodology involves taking population statistics by age (65–74, 75–84 and 85+ years) and applying standard UK patterns of care home admission. It must be understood that ASD is, therefore, a function of population; it is not a direct measure of demand for care services and is only an indicator of them. It is, however, the industry-recognised approach to determining demand for care in a residential setting.

Current supply

15.6. We provide a detailed analysis of the existing competing care provision, which analyses the quality of accommodation, total number of bedspaces and market distribution between private operators, groups, local authority and voluntary operators.

15.7. In the event of any anomaly in our subscribed data source, *A–Z Care Homes Guide*, we cross-reference against the Care Inspectorate website and, where necessary, we review the home's/operator's website or telephone the home directly to confirm the query.

15.8. In our assessment, we include care homes registered for either personal or nursing care and those that provide both forms of care. There is no industry-recognised measure of assessing the demand for solely nursing care or solely personal care, as yet.

Planned supply

15.9. We assess planned supply within the catchment area by conducting a review of all applications for new care home beds within the planning system. From our data sources, we review all planning applications for new care home beds (both new-build and extensions) that have been granted, refused, withdrawn or are pending decision. This is cross-referenced against the online planning website for the relevant local authority and, where an anomaly exists, we contact the planning officer, if required.

15.10. We undertake enquiries with the relevant local authority and utilise our own data information sources and market knowledge to determine the number of planned beds, either with planning permission or under construction. Additional bedspaces in the area are of key importance as they are likely to be of a high standard and provide significant competition to the proposed community once completed and trading.

15.11. We search for planning applications submitted over the past 3 years. Where an application has been refused or withdrawn, we enter the postcode into the local authority online planning facility to identify if a subsequent application or appeal application has been submitted. We would note that the planning registers that we subscribe to are not definitive and may exclude some applications as they rely upon each local authority for provision of the information.

15.12. A significant proportion of planned care home beds are never implemented; however, we include all planned bedspaces regardless of their deliverability. It should be noted that beds granted permission, but not yet under construction, have potential for alternative residential Class 9 schemes to take their place.

15.13. We then differentiate the planned schemes depending on whether construction has commenced.

Estimating the balance of provision for elderly care home beds

15.14. We combine the results of our demand analysis with our assessment of the existing supply and planned provision to provide a measure of the balance of provision position within the catchment.

15.15. The measure provides a ‘maximum planned supply” scenario assuming all planned beds are developed and operational, regardless of the construction status or long-term deliverability, and is likely to overstate the number of beds that will actually come forward from the planning system.

15.16. We consider that this methodology is a logical, industry-recognised means of establishing if there is a need for additional elderly care home beds in any given area.

15.17. Going forward, it is harder to predict future industry trends and there are other factors that may influence the longer-term demand for care services, which include:

- Political and regulatory change;
- Funding constraints;
- Increase in adaptive technology and "telecare", prolonging the ability for people to remain in their own homes;
- Medical advancement.

15.18. We provide an indicative balance of provision between the years 2021 and 2033 in Section 31; these estimates assume that all other factors remain equal, with the only variance being the increased demand for care based upon the rise in the number of elderly persons.

COVID-19 market impact

15.19. Since our instructions were received, the coronavirus has made a significant impact on the care home and wider national and international markets. At this early stage, it is impossible to predict the eventual impact and outcome on the care home sector. However, at a national level, our earliest preliminary estimate projects an approximate reduction in occupancy in the short term of 8 percentage points over the next 12 months before occupancy returns to pre-COVID-19 outbreak levels in 2022 - 2023, before continuing to increase with elderly population growth over the next few decades.

15.20. It is also impossible to accurately predict the number of home closures that outbreaks in individual homes or the financial and staffing challenges may have on the current supply or the volume of new planned stock coming through.

15.21. Any local market assessment will need to be based upon a detailed local level investigation into the specific homes in the area to ascertain the true impact on the local market. It is a binary equation and homes will either be affected, and some will not and therefore any impact will be localised to the individual home level. It is totally inappropriate to contact homes for such a purpose at this time of national need.

15.22. Our view overall, is that occupancy levels will recover to close to previous levels very close to the time when this home will be operational, given the 2 year development and construction period and therefore the net impact of coronavirus at this stage for this site will be broadly neutral and does not materially impact upon our recommendations at this time.

16. Market standard beds

16.1. In calculating the current supply of beds, we assess the total provision of market standard beds. We define market standard beds as the total number of bedrooms operated by each home that provide en-suite facilities. An en-suite is defined as providing a WC and wash hand basin, and does not necessarily provide shower/bathing facilities.

16.2. We do not assess the shortfall of bedspaces based upon the total registered capacity. A care home's total registered capacity is often greater, as it includes the maximum number of bedspaces that the care home is registered to provide by the sector's regulator, the Care Inspectorate. This registered provision will therefore include:

- Market standard bedrooms;
- Under-sized bedrooms;
- Homes with internal or external stepped access – which therefore limit the level of physical acuity that a resident must have in order to occupy the room;
- Bedrooms accessed via narrow corridors – making them unsuitable for people confined to a wheelchair;
- Bedrooms accessed without a shaft lift – a significant challenge in the provision of any care, but particularly when providing high dependency nursing care;
- Bedrooms of an inappropriate size and shape – preventing two care assistants from being able to assist a person into and out of their own bed;
- Historic shared occupancy rooms – now only 'marketable' as single occupancy bedrooms, as market expectations and commissioning standards rise;
- Bedrooms that lack en-suite facilities – which for the last 20+ years have been actively encouraged wherever possible in new developments by the government's regulator as well as by the market. Both are trying to drive increased quality and meet basic expectations that current referrals and their next of kin see as mandatory.

16.3. We are aware of some local authorities previously arguing that, as the Care Inspectorate continues to register existing care homes that do not comply with the definition of a market standard, the total registered capacity should be the appropriate basis of assessment of market supply.

16.4. However, this argument fails to take account of the rising levels of acuity and dependency levels of referrals into residential care. The profile of care home occupants has changed markedly over the past 5 to 10 years, and failure to address the shortcomings in the existing standard of care home supply will mean inadequate accommodation for those who require the most care over the coming years, as the well-publicised rapidly ageing population starts to take effect.

16.5. In our opinion, it is the local authority, and not the government's regulator, that holds the ability to influence developments and drive environmental quality forward. In this respect, Carterwood has been involved in a considerable number of successful planning applications and has submitted need assessments using an identical methodology to that prepared as part of these submissions, where the need case has been accepted by the relevant local authority during the application process. In each instance the adult social care team accepted that whilst the total registered capacity was greater than the number of market standard bedspaces, the issue of quality, design and type of bedspace could not be ignored, and the premise of assessing bedspaces on a market standard basis was accepted by each respective council.

16.6. We adopt market standard beds due to the rising expectations of quality required by service users as well as previous regulatory requirements to provide en-suite facilities and best practice. We consider that, going forward, homes that do not provide adequate en-suite facilities will fast become obsolete.

16.7. This method of assessing supply, utilising market standard beds, is accepted market practice by all of the operators we currently undertake feasibility work for when considering the development of new facilities. We have prepared over 800 site feasibility/need assessments over the past three years, all of which adopt the market standard bed approach.

16.8. All new care homes provide en-suite facilities, and many provide larger en-suite wet/shower rooms to enable the service user to be bathed without the necessity for larger communal bathrooms, and therefore all new beds are classified as market standard. It should be noted that the quality of en-suite provision in existing homes may vary significantly, from large wetroom facilities to small converted cupboards with a WC and wash hand basin. There are also other factors that influence what determines a market standard bedroom, including room size, layout and configuration, as well as a host of factors not related to the physical environment, most importantly the quality of care being provided to service users. However, with the information available, and without making qualitative judgements as to the calibre of any home, we consider it the most appropriate measure of elderly care home provision available upon which to assess need.

16.9. The type of en-suite within the proposed community will be market leading in both its quality and size, with each unit equipped with a very large wetroom, and superior to the vast majority of existing and planned en-suites.

17. Care home basis of assessment

17.1. We have undertaken our detailed assessment of the demand and supply position of the proposed care home by adopting a market catchment area, shaded pink in the map opposite.

17.2. We have previously analysed resident data provided by a number of care home operators for modern purpose-built operational homes akin to that of the proposed care home. From this information, we have calculated the mean distance travelled by each resident into the respective home. The headline results of our research are provided below:

T12 Average distance travelled to a care home

Comparable location	Average distance travelled by resident (miles)
Location 1: Rural location	5.7
Location 2: Rural location with good A-road links	5.4
Location 3: Urban location	4.3
Overall average	5.2

Source: Carterwood.

17.3. The location accords most closely to Location 2 in the table above; however, it extends from 4.1 to 7.9 miles and is broadly based upon an average 5.5-mile radius. This catchment reflects the proximity to the A736. The market catchment area is shaded pink in Figure 5 opposite.

17.4. All care homes will inevitably draw service users in some instances from substantially further than a typical catchment. If the family is the key decision maker in the placement decision, then sometimes the service user may move significant distances, which can distort catchment area analysis. Conversely, if the local authority is the key decision maker, then the service user's choice can be highly constrained to vacant beds in a small number of local more affordable homes.

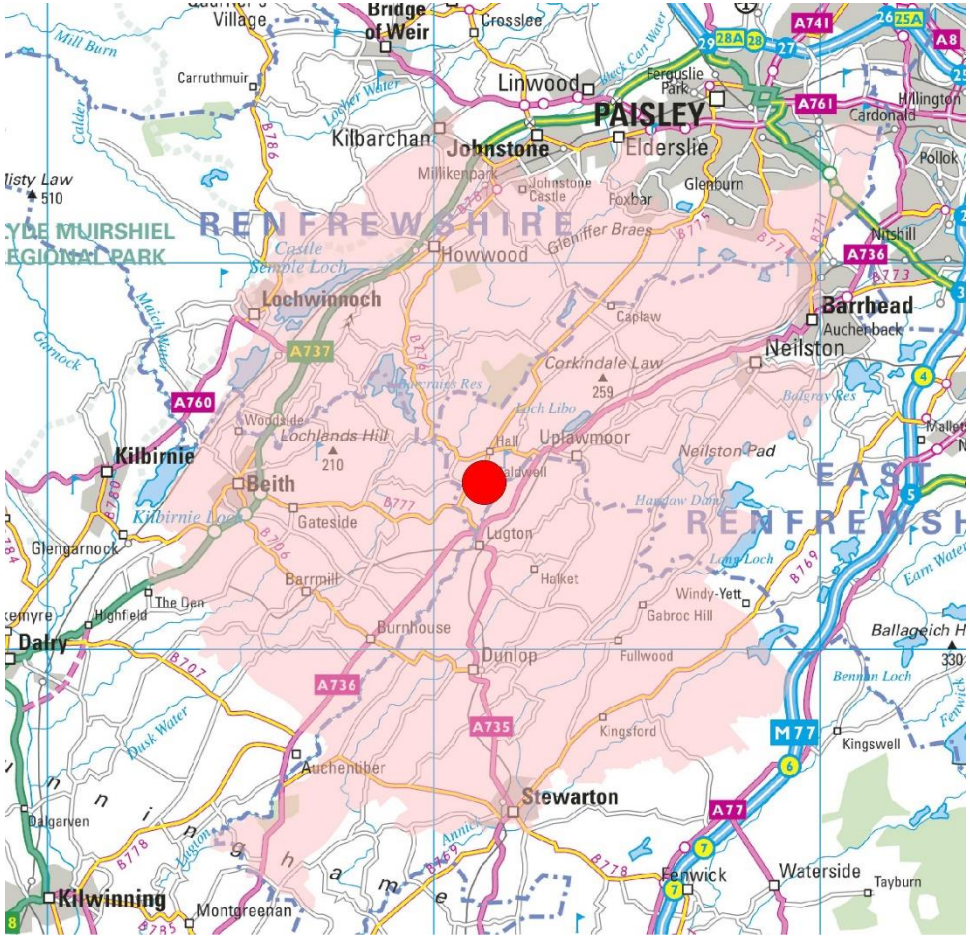

Figure 5: Catchment areas

The red spot shows the approximate location of the subject site. The area shaded pink comprises our market catchment area.

18. Demographics

18.1. We have assessed demand based upon ONS based 2018 population statistics and have extrapolated expected elderly population growth rates for East Renfrewshire Council area (the local authority in which the site is located) to determine current and future need for care home beds.

18.2. The total projected population for the market catchment area as at 2021 is 53,202, and the graph opposite shows the growth of the population aged over 65 years during the 12 years to 2020.

18.3. Table T13 shows the number of people at risk of requiring care in a residential setting by year. Our assessment of demand for residential care, as at 2021, is therefore 264 within the market catchment.

18.4. The demand for care home beds is expected to rise between 2021 and 2033 by c. 30 per cent for the market catchment assuming all other things remain equal, further indicating an increased demand for additional market standard bedspaces.

18.5. This calculation is based upon LaingBuisson's Age Standardised Demand rates for determining the risk of entering a residential care establishment.

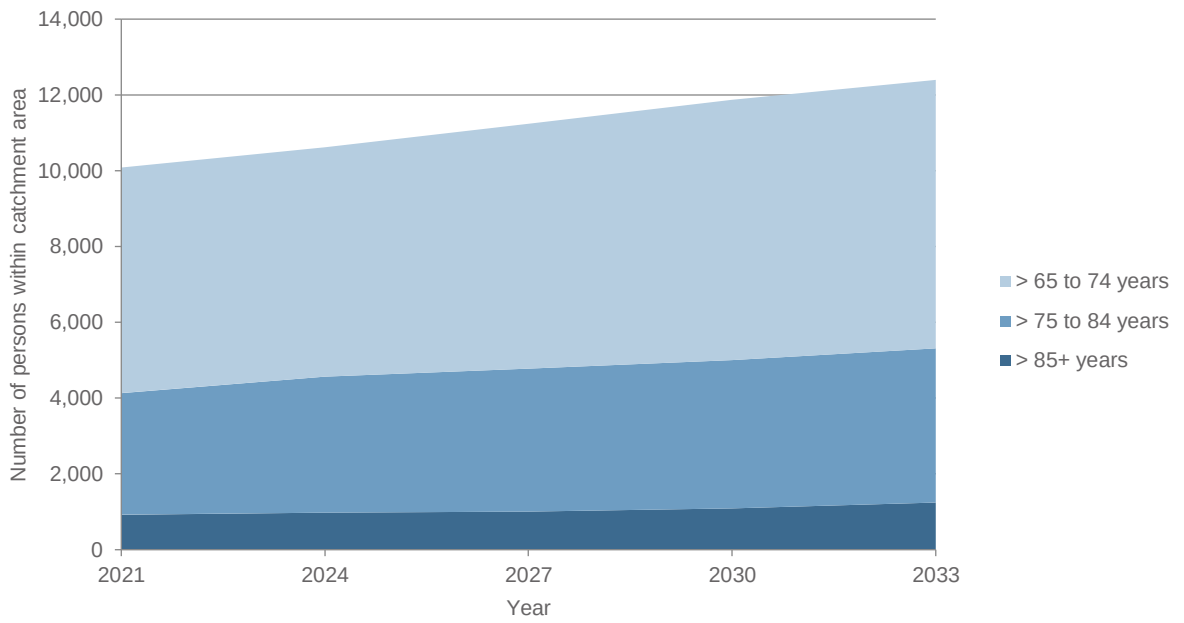

Figure 6: Population of older people by age band within the market catchment area

T13 Key demographic indicators (2021)	
People	Market catchment area
Population indicators	
Total population	53,202
Total population aged 75 and above	4,134
Percentage of people aged 75 years and above (%)	7.8
Demand	
Indicative demand for residential care beds	264

Source: Census 2011, ONS Population Projections.

19. Supply of existing care homes

19.1. We have assessed supply based upon market standard bedspaces, which we define as any registered bedroom providing a minimum of en-suite WC and wash hand basin.

19.2. Within the market catchment area, there are only two care homes, providing 61 registered bedspaces, 55 of which are equipped with an en-suite. This equates to 90 per cent of registered bedspaces meeting the criteria of 'market standard', which is above the UK average of 72 per cent. Although a large majority of bedspaces are equipped with an en-suite within the catchment area, for both personal care and nursing care, most only offer WC and wash hand basin only, with few, if any, offering bedrooms with en-suite wetrooms of the same size and specification to that proposed by the subject scheme.

19.3. Figure 7 shows the competition in the market catchment by geographical distance to the subject site. There is limited supply within 3.5 miles of the subject site.

T14 Nursing and personal care provision

Care category	Number of homes	Registered beds	Market standard beds	Percentage of market standard beds (%)
Market catchment area				
Personal care	1	16	10	63
Nursing care	1	45	45	100
Overall	2	61	55	90

Source: A-Z Care Homes Guide, Care Inspectorate, Carterwood.

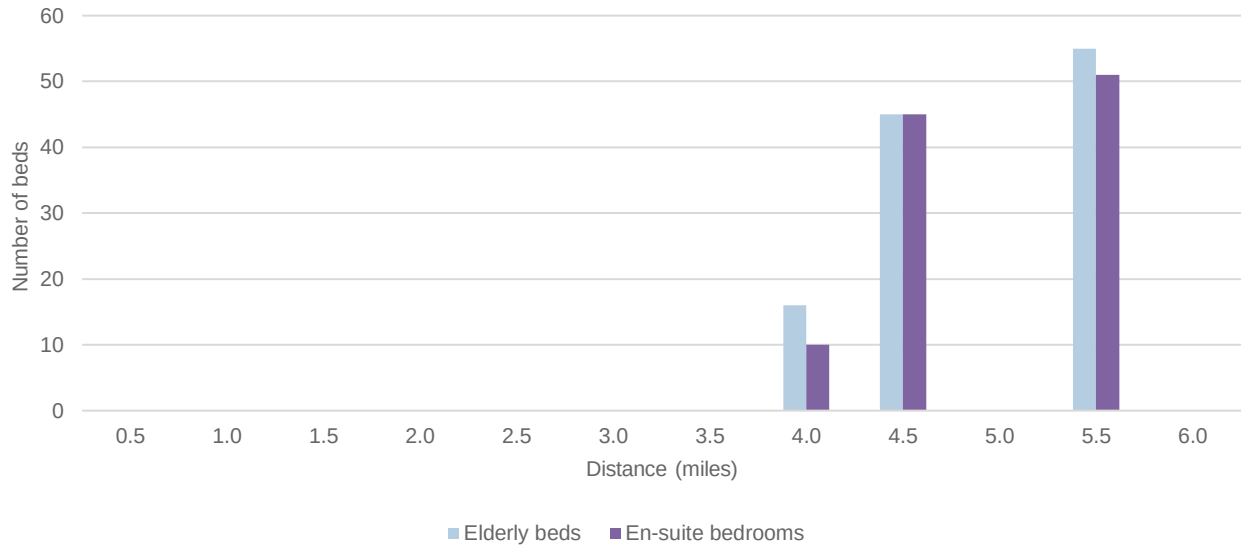

Figure 7: Existing registered capacity by distance from the subject site (market catchment)

20. Planned supply

20.1. We have reviewed all planning applications submitted for new care home beds, with the relevant local authority planning departments' online planning registers. We have looked at all planning applications submitted within the last 3 years. This research was carried out on the 26 June 2020.

20.2. There are no planned bedspaces within the market catchment area.

20.3. We have been unable to confirm definitively if this is the situation with current applications in the area for a Class 8 elderly care use.

21. Dementia

Methodology

21.1. Estimating the prevalence of dementia within a given population is difficult, due to the constraints of the available data, the nature of the condition and the range of acuity levels of sufferers. Much of the current research focuses upon existing prevalence rates based upon sample studies. We have assessed demand and supply for dementia by comparing the following:

- The number of persons requiring an elderly nursing home bed with dementia as the primary cause of admission;
- The number of market standard bedspaces providing dedicated dementia care, either within a dedicated dementia elderly nursing home or a dedicated dementia unit within a mixed-registration home, available within the catchment area.

Demand

21.2. Our measure is based upon research carried out within Bupa elderly nursing homes in 2011, which indicates that 45.6 per cent of residents within the surveyed elderly nursing homes were admitted with dementia as a primary cause. Therefore, utilising this prevalence rate, we have calculated the demand within each catchment area from residents with dementia as a primary cause of admission in Table T15, opposite. Best practice states that people living with dementia should be cared for within a specialist, dedicated dementia environment.

21.3. This measure, by definition, assumes that a principal reason for admission to care in a residential setting was based upon the dementia condition. However, it should be noted that there may be other physical frailty in addition to this measure. Conversely, there will also be a larger pool of dementia sufferers who would have been admitted due to a physical frailty/disability, but who now also suffer from some form of dementia.

Supply

21.4. We have provided the total number of market standard bedspaces within dedicated dementia elderly nursing homes, or units within mixed registration homes, in Table T15. This analysis does not take account of the supply within mixed-registration homes, where residents with dementia are mixed with those without dementia and there are no dedicated units. However, whilst such services are capable of accommodating service users with dementia, it is considered best practice to care for residents living with dementia within a specialist, dedicated dementia environment

Demand vs. Supply

21.5. Our analysis shows significant undersupply of 120 dedicated dementia bedspaces within the market catchment area. Therefore, 100 per cent of people living with dementia as a primary cause of admission to an elderly care home are unable to be cared for within a specialist, dedicated dementia elderly home or unit within the market catchment. There are no planned dedicated dementia bedspaces, also highlighting the future requirement.

T15 Indicative need for dedicated dementia bedspaces (2021)

Bases of assessment	Market catchment
Total demand for care home beds	264
Demand for dedicated dementia beds based upon Bupa survey	120
Supply of market standard dedicated dementia beds	0
Planned supply of market standard dedicated dementia beds	0
Indicative need for market standard dedicated dementia beds	120
Indicative need as a percentage of demand	100

Sources: A-Z Care Homes Guide, Centre for Policy on Aging: A profile of residents in Bupa care homes: results from the 2012 Bupa Census, Census 2011, Population Projections, LaingBuisson Care Homes for Older People UK Market report 30th edition.

21.6. While this measure is an indicative assessment and should not be used as a definitive measure due to the limitations of assessing demand and supply of dementia provision in isolation of total capacity for all older people's services, it provides an empirical indication of the catchment's need for specialist dementia beds.

22. Care home competition map

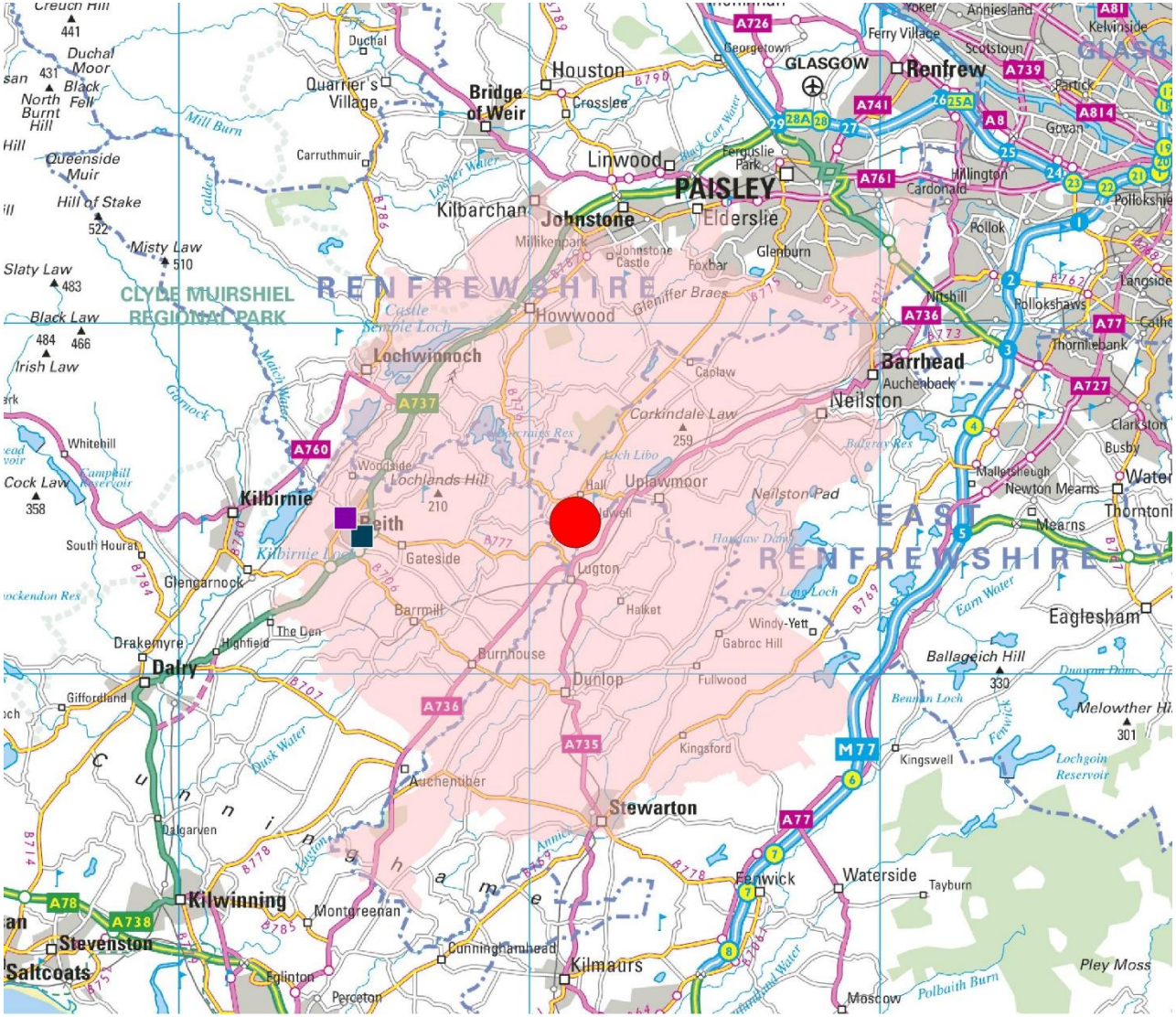

Figure 8: Existing care homes and planned schemes within the catchment area.

Please note that the locations of all plotted care homes and planned schemes are approximate only.

NEED ASSESSMENT FOR PROPOSED EXTRA CARE

23. Difficulties in assessing demand for extra care

23.1. Extra care housing in its current form is a relatively new concept and there is a lack of a suitable measure, equivalent to LaingBuisson's Age Standardised Demand model, of estimating demand for care home beds.

23.2. LaingBuisson's own Extra Care Housing UK Market Report does not provide a tool for assessing demand, but instead refers to a number of demographic factors that are likely to influence demand, as follows:

- an expansion of the older population;
- a reduction in the pool of young adults available for training as nurses or care assistants to work in the community or care homes;
- an increase in the number of middle-aged people looking after children and a parent;
- an increase in the proportion of older people with a living child;
- changes in the health and dependency levels of older people;
- changes in the patterns of immigration by potential care workers and emigration by trained care staff.

23.3. The difficulty in trying to accurately assess demand for extra care housing is that, due to the relatively new nature of the product, there is no position of over-supply upon which to assess a position of balance. Essentially, the additional supply creates "demand" when it is developed.

23.4. Notwithstanding the difficulties identified above, in our methodology, following, we utilise a number of key assumptions to identify a potential market size for prospective purchasers of a private leasehold extra care unit.

24. Methodology to determine shortfall of extra care

24.1. Taking into account some of the difficulties in assessing demand for extra care we have, in our assessment of need for extra care units, utilised a toolkit for producing accommodation strategies for older people which is detailed below.

Need

24.2. In 2011, the Housing Learning and Improvement Network (LIN) first published the Strategic Housing for Older People Resource Pack (SHOP). The SHOP analysis tool is a method used to forecast the demand for specialist housing for older people in England and Wales. It is endorsed by the Department of Health and Care Services and the Welsh Government and provides data on the likely requirement for specialist housing for older people and care home bedspaces. It is used by local authorities' planning and social care teams in order to understand their existing supply and enable informed decisions to be made with regard to current and future need for appropriate care and housing provision for older people.

24.3. The approach used in SHOP seeks to balance the conventional estimates of need against the direction of policy (for example, in relation to enhanced sheltered and extra care forms of accommodation) and need in the market (in relation to ownership options) in all forms of specialised provision for older people. The key factors include: the substantial increase in the elderly population demographic, the high proportion of those aged over 65 living in property that they own (although this is not always suitable) and the rapidly increasing cost of caring for the elderly population.

24.4. It also considers that understanding the pace and scale of growth of the elderly demographic in a particular locality is not the same as predicting future demand for particular types of accommodation and/or care. Although residential care homes and nursing homes were traditionally seen as the main option for those with increasing care needs, demand for residential care beds has started to decline due to local funding policies and the availability of new forms of accommodation and care.

24.5. Until recently, new forms of provision such as 'housing and care' were not widely recognised as providing an alternative to residential care. Such accommodation is becoming more sought after; maintaining an individual's independence within their own, specifically designed property, the provision of a range of services and, most importantly, where increasing levels of care can be bought in as needs change. The report considers the factors involved in this change including: longevity, drugs and treatments, accessibility/availability, wealth, attitude to risk and information about services.

24.6. SHOP asks, 'What accommodation do people want?' The report provides a breakdown of people's preferences, should they need care. The highest percentage (62 per cent) chose to stay in their own home with care and support from friends and family. However, it questions whether this decision may have been heavily influenced by limited choice rather than real preference. Furthermore, it cites that an individual's choice is influenced by their care professionals and family and friends, and the choice comes down to what is actually available in the local community, with a decision often taken following an event (a fall, crisis or illness, etc.), when need is greatest.

24.7. SHOP suggests indicative levels of provision of various forms of accommodation for older people, including private extra care available for sale on a long leasehold basis. According to this approach, the toolkit indicates the ratio of required units per 1,000 of the population aged 75 years and above for private leasehold extra care is 30 units. Essentially this suggests that a total of 3 per cent of the elderly population will require an extra care housing unit in any given area. It also suggests that a further 10 units per 1,000 of the population over 75 years of enhanced sheltered housing for sale are required (defined as provision with some care needs or provision of on-site amenities/facilities for residents), which we have included within our analysis.

24.8. Projections of demand for the various forms of care and accommodation are therefore not easy, and depend on a number of factors in each locality. The estimates of demand for sheltered housing, enhanced sheltered housing and extra care per thousand of the relevant 75+ population used in SHOP were based on evidence of elderly people's preferences in 2011.

24.9. Since 2011 there has been considerable change with regard to the availability of funding, and local authorities are seeking alternative, more cost effective means of providing care and accommodation. There has also been a significant increase in the development of extra care housing and the wider recognition of the many benefits of this form of accommodation and care by the elderly population.

24.10. The Housing LIN recently announced that they are in the process of updating their SHOP analysis resource pack as a result of the Government's Social Care White Paper 'Caring for our future'. The paper is committed to providing support to help local authorities develop their market capacity to provide greater choice for users and drive up quality in care standards. Since the first edition of the SHOP toolkit, we consider that the increasing availability and knowledge of new forms of accommodation and care is likely to have increased demand for these schemes set against a decline in demand for residential care.

24.11. There are many reasons for promoting the development of a wide range of care and accommodation for older people, and its availability can reduce the demand for community care and support. Research from Aston University has recently shown that the NHS saved more than £1,000 per year on each resident living in the Extra Care Charitable Trust's schemes between 2012 and 2015. It also frees up family housing at the time when the level of under-utilisation is often at its greatest and can enable older people to retain their housing equity whilst benefitting from the improvements in design, economy and security that such schemes can offer.

24.12. Given the national and local agendas to support people in the community within their own homes or extra care accommodation, it is expected that the future requirement for extra care provision will increase due to the increasing awareness of the benefits of extra care. We await a response from the Housing LIN with regard to timescales for their review of the SHOP toolkit, which we understand will include future prevalence rate projections that reflect market aspirations and commissioning intent and will also take into account varying leasehold percentages depending upon the relative affluence of the locality.

24.13. Please refer to the Strategic Housing for Older People (SHOP) Resource Pack on the Housing LIN website for full details of the methodology.

24.14. Carterwood has been involved in numerous successful planning applications and has submitted needs assessments using an identical methodology to that prepared as part of these submissions, where the need case has been accepted by the relevant local authority during the application process.

24.15. In each instance the SHOP toolkit was accepted by each respective council. However, this method of assessing demand is a relative rather than absolute measure of demand and therefore cannot be considered as a definitive assessment of demand. This notwithstanding, we consider this method provides as good a basis of assessment as any other indication of the current balance between the potential demand for extra care units and current supply, and have therefore conducted our analysis on this basis. We consider this method to provide the minimum demand within the adopted catchment area.

Existing supply

24.16. We have reviewed the Elderly Accommodation Counsel's (EAC) website www.housingcare.org to determine the current supply of extra care accommodation within the market catchment.

24.17. We have researched all schemes classified as follows:

- Extra care/assisted living;

- Close care;
- Retirement village;
- Enhanced sheltered housing (for sale only).

24.18. We have conducted some additional research to ensure that each scheme conforms to the recognised definition of extra care, namely that 24-hour on-site care is provided or that it meets the definitions of enhanced sheltered housing as per the housingcare.org.uk website. We have not included any registered social landlord schemes and have only included schemes catering to the private market.

24.19. We have specifically not considered any traditional sheltered housing or other similar schemes in our analysis of current supply.

24.20. We have provided some analysis in respect of tenure, age, unit size and distance from the subject site in our analysis of current provision overleaf.

Planned supply

24.21. We assess planned supply by conducting a review of schemes in the planning system with an application submitted for additional extra care schemes.

24.22. From our data sources, we have reviewed all the planning applications that have been granted, refused, withdrawn or are pending decision. This has been cross-referenced against the online planning website for the relevant local authority and where an anomaly exists we have contacted the planning officer if required.

24.23. We have made enquiries with the relevant local authority and used our own data information sources and market knowledge to determine the number of planned units, either in the planning process or under construction. Additional units in the area are of key importance, as they are likely to be of a high standard and provide significant competition to the proposed development once completed and trading. We have searched for planning applications submitted over the past 3 years.

24.24. Where an application has been refused or withdrawn, we have entered the postcode into the local authority online planning facility to identify if a subsequent application or appeal application has been submitted. The results of this are included within the report.

24.25. Where a planning application has been granted, we have cross-referenced the postcode against our existing supply to ascertain if the scheme is operational. If it is, we have included it within the operational provision and not within the planning table.

24.26. We would note that the planning registers that we subscribe to are not definitive and may exclude some applications as they rely upon each local authority for provision of the information.

24.27. We have excluded any sheltered housing, category II sheltered housing schemes or affordable extra care schemes from our analysis.

COVID-19 market impact

24.28. The coronavirus has made a significant impact on the social care sector and wider national and international markets. At this early stage, it is impossible to predict the eventual impact and outcome on the retirement housing and extra care sector.

24.29. Any local market assessment will need to be based upon a detailed local level investigation into the specific schemes in the area to ascertain the true impact on the local market. It is a binary equation and schemes will either be affected, and some will not and therefore any impact will be localised to the individual scheme level. It is totally inappropriate to contact local schemes for such a purpose at this time of national need.

24.30. Our view overall, is that retirement housing and extra care / retirement village developments provide the ideal compromise for looking after the very elderly between traditional housing and a care home. Traditional housing is not preferable for the lonely isolated elderly with little or no community support and protection. Care homes have been adversely affected (although have very unfairly been portrayed by the press, given they cater for the frailest 3 percent of elderly people in the country).

24.31. Retirement communities allow residents to self-isolate effectively within their own homes, but crucially they can also have trained on-site care and support if required. This not only means they will be effectively looked after, but also that debilitating damage caused by loneliness and social isolation is mitigated.

24.32. Since the outbreak of COVID-19, we consider that local authorities and social services teams should be looking at their policies and expanding any previous estimate prepared for need for this type of accommodation rather than reducing or maintaining need requests at pre-COVID-19 levels.

25. Extra care basis of assessment

25.1. In collaboration with the Associated Retirement Community Operators (ARCO) and its members we conducted a national research project to calculate the distance travelled by extra care housing residents from their last place of residence. The research concluded that circa 69 per cent of residents travelled within 10 miles.

25.2. We have based our detailed assessment of the demand and supply position of the proposed private extra care scheme on a market catchment area, shaded blue in the map opposite, extending to a radius of circa 10 miles from the subject site having regard to the localised road networks, and the density of population as characteristics of the surrounding area to the south west.

25.3. The decision to enter an extra care scheme is choice rather than need driven. Hence people are willing to travel much further to find an extra care scheme (particularly a larger care village) that meets their demands than they are to find an appropriate care home.

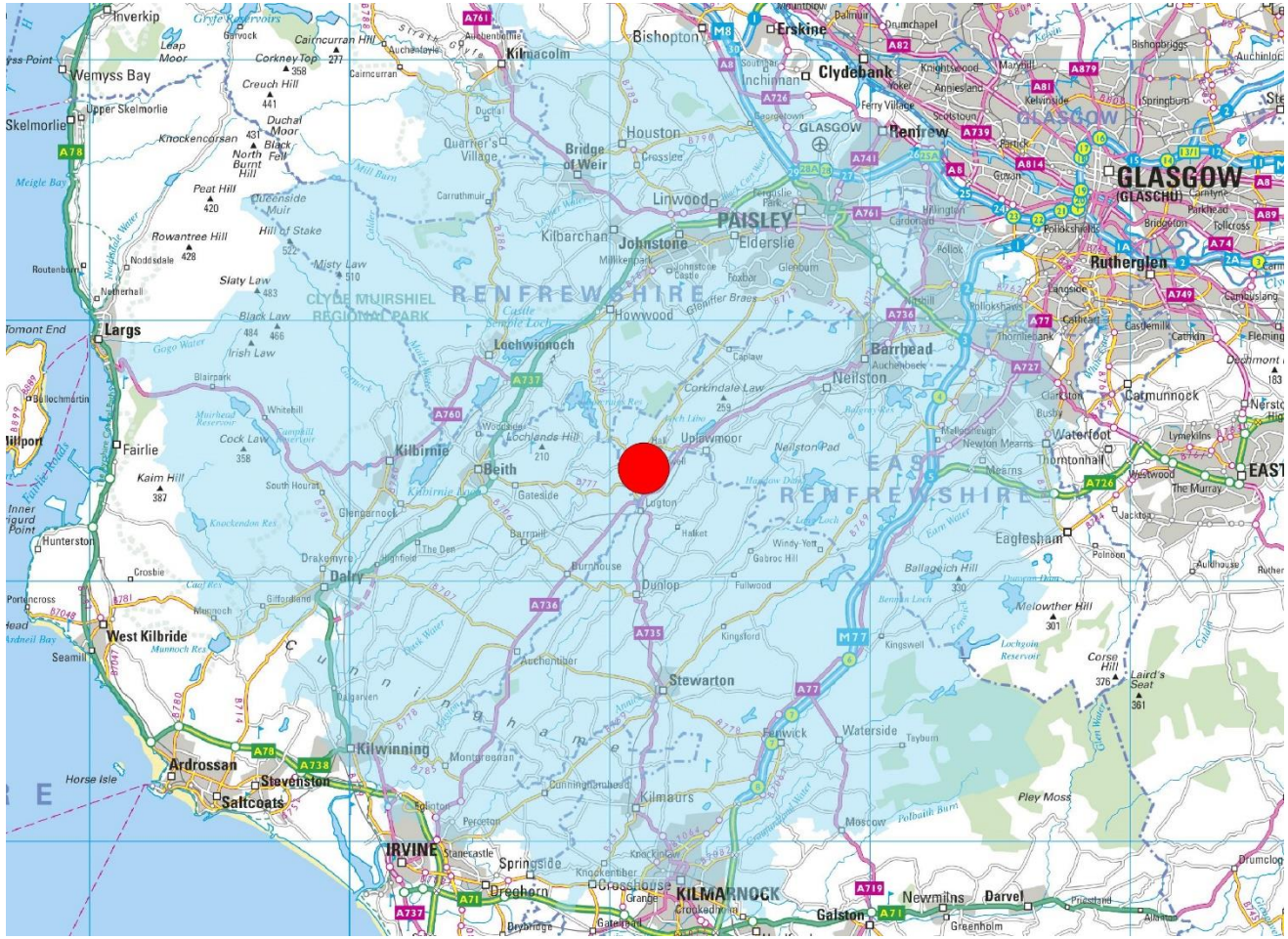

Figure 9: Extra care bases of assessment

The red spot shows the approximate location of the proposed care village. The light blue shaded area illustrates the market catchment area.

26. Existing private extra care schemes

26.1. We have analysed current supply using the EAC Housing Option website, www.housingcare.org.uk. We have included within our analysis any scheme in the catchment that seeks to provide 24-hour on-site care and support (where the accommodation is not intended to be registered as a care home with Care Inspectorate) seeking to sell the units on long leasehold basis at market rates. The EAC website breaks down the type of accommodation into three main sub-groups, within the criteria of close care, extra care, and care/retirement villages. These scheme types are summarised below.

26.2. There is only one leasehold extra care/enhanced sheltered housing scheme within the market catchment area which is located circa 10-miles distant and the details are provided below in T16.

T16 Summary of competing schemes

Map ref	Scheme	Manager / operator	No. of units	Distance from subject site (miles)	Year of construction	Scheme type	Extra care unit tenure
1	Hilltree Court, 96 Fenwick Road, Giffnock, Glasgow, G46 6AA	YourLife Management Services	57	9.8	2013	Extra care	Leasehold.

Source: EAC Housing Options, Operator websites.

27. Planned private extra care supply

27.1. We have reviewed all planning applications submitted for new extra care units, with the relevant local authority planning departments' online planning registers. We have looked at all planning applications submitted within the last 3 years.

27.2. We have identified two planning applications for additional extra care units in the market catchment area, of which one have been granted permission and the other is pending decision.

27.3. We understand that construction has not commenced on the granted scheme (A).

27.4. We have provided our opinion of the construction status based upon publicly available documentation, and our own knowledge of the schemes. We have graded a scheme as having a 'yes' 'construction commenced' if there is some indication, either through an operator's or developer's website, that the scheme is progressing or, naturally, if construction has commenced on site. Schemes with a 'no' may still be developed, but there is no indication that construction is due to commence in the near future.

T17 Summary of planned provision

Map ref	Site address	Applicant	Scheme	Net extra care units	Construction commenced	Distance from subject scheme (miles)	Planning ref /date granted
A	Factory Netherplace Works, 180 Netherplace Road, Newton Mearns, Glasgow, Strathclyde, G77 6PP	Newton Mearns Projects Ltd	Construction of retirement residential community, care home and multi-purpose village centre and formation of new access road from Aurs Road (major) with SUDS.	252	No	6.8	2017/0359/TP - 03/04/2020
B	Former Isobel Mair School Play, Drumby Crescent, Clarkston, Glasgow, Strathclyde, G76 7HJ	Northcare Ltd	Erection of 68 bedroom care home including spa facilities, cafe, cocktail bar and cinema room and 23 assisted living apartments with associated car parking and landscaping including community garden (major).	23	Pending decision	9.9	2020/0287/TP

Source: subscribed data sources and relevant planning departments.

28. Extra care competition map

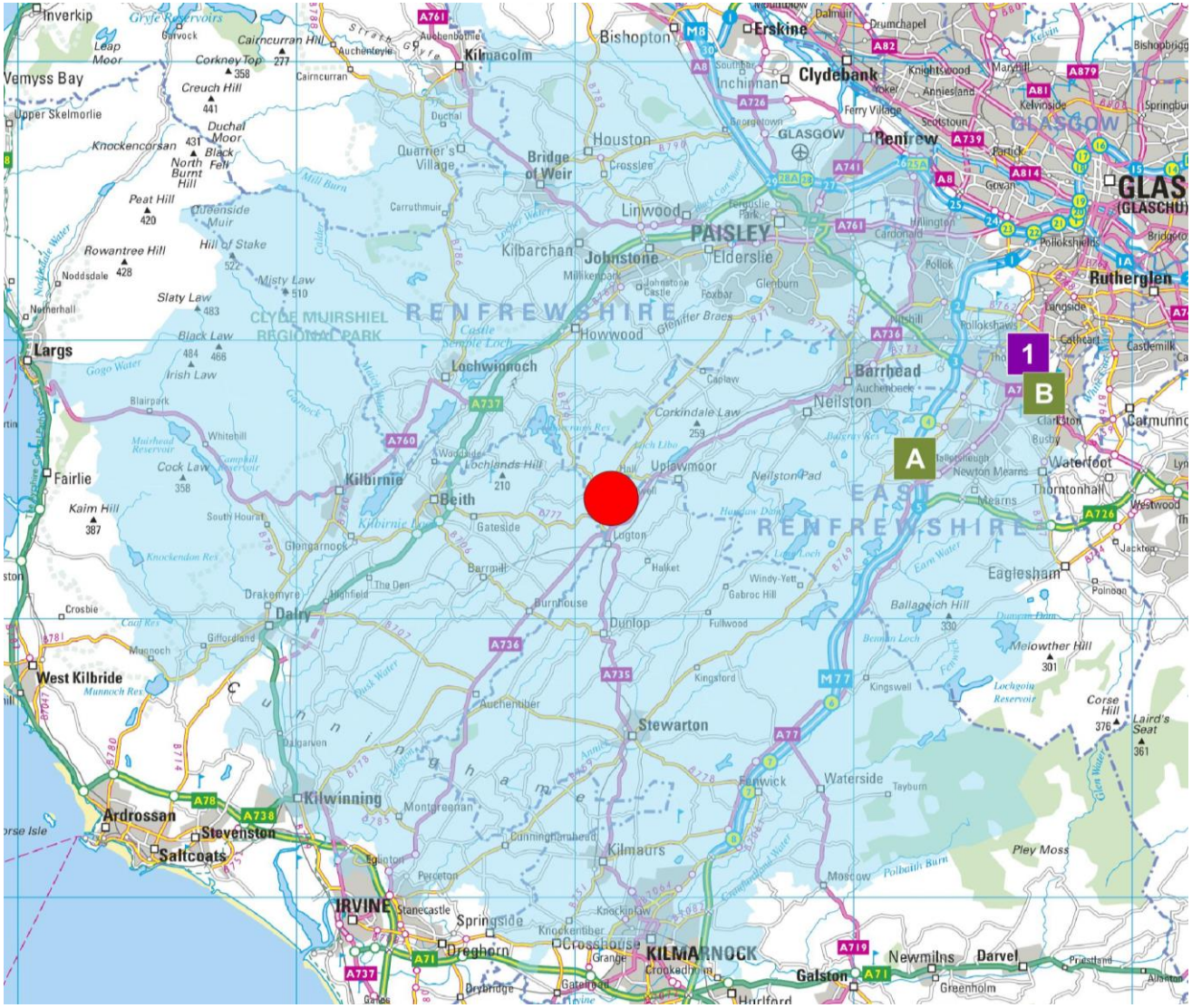

Figure 10: Existing private extra care and planned schemes within the catchment area.

Key:

- The proposed care village
- Existing private extra care schemes
- Planned private extra care schemes

Please note that the locations of all existing and planned schemes are approximate only.

CONCLUSIONS

29. Indicative need for elderly care home beds

29.1. Given that there are no planned bedspaces within the catchment area our assessment of need in 2021 within the market catchment area indicates a need for 209 market standard bedspaces.

29.2. People living with dementia are not well catered for, with neither of the existing homes in the catchment having dedicated specialist dementia units offering living environments that accord with best practice in caring for people with such needs. Our analysis indicates there is a significant unmet need for dedicated dementia provision in the catchment.

T18 Indicative need for additional elderly care home beds (2021)

Demand	Market catchment area
Estimated need for elderly care home beds	264
Supply	
Current supply of elderly market standard bedrooms	55
Beds pending decision	0
Beds granted permission but not under construction	0
Beds granted permission and under construction	0
Total planned and existing market standard beds	55
Indicative need	
Indicative need including all planned beds	209
Indicative need only including beds under construction	209

Source: 2011 Census, A-Z Care Homes Guide.

30. Indicative need for extra care units

30.1. By applying our demand methodology to the catchment area, we have calculated the potential pool of demand for private leasehold extra care units from people aged 75 years and above. Our analysis, assuming all planned units have been developed and are operational, indicates that there is a significant need for 945 private extra care units within the market catchment area.

30.2. However, given that none of the planned beds are under construction, our more realistic assessment of the balance of provision indicates an increased need for 1,220 in the market catchment.

30.3. We therefore consider that there is an evident need for extra care accommodation for private leasehold sale within the assessed area.

T19 Indicative need for extra care units (2021)

Basis of assessment	Market catchment area
Need	
Population aged 75 years and above	31,924
Need – based upon ratio of 40 people per 1,000 population aged 75 years and above	1,277
Supply	
Current provision of private extra care units	57
Units pending decision	23
Units granted permission but construction not started	252
Units granted permission and under construction	0
Total supply of private extra care units	332
Indicative need	
Indicative need including all planned private units	945
Indicative need including units under construction	1,220

Source: Census 2011, Government population projections, Housing LIN.

31. Need growth

Care home

31.1. Need growth in the future is based on the 2018-based ONS projected population figures for older people until 2031. This assumes that the demand for care home beds, which is based upon LaingBuisson's ASD rates, will remain at the same rate in the future. This is unlikely to happen given the historic trend of ASD as alternatives to residential care are developed and expanded upon, but nevertheless it indicates the significant weight of the future demographic trends over the coming years on potential demand.

31.2. Our analysis below illustrates the indicative need assuming the existing provision remains equal and that all the planned units are developed. The analysis therefore overestimates the supply, given that a number of the planned schemes are unlikely to be developed.

T20 Indicative need for market standard bedspaces

Catchment	2021	2026	2031
Market catchment area	209	238	264

Source: 2011 Census, A-Z Care Homes Guide

31.3. This indicative need is expected to increase to 264 market standard beds within the market catchment in 2031 (assuming demand prevalence rates remain constant), reflecting the sustained and escalating nature of need in the future.

Extra care

31.4. Shortfall growth in the future is determined using 2018-based ONS projected population figures for older people until 2031 and assumes that the demand for extra care units, which is based upon the Housing LIN SHOP tool, will remain at the same rate in the future. Our analysis below illustrates the shortfall assuming the existing provision remains equal and that all the planned units are developed.

T21 Indicative need for private extra care units

Catchment	2021	2026	2031
Market catchment area	945	1,060	1,120

Sources: Housing LIN, Census 2011, government population projections, EAC Housing Options

31.5. Our analysis estimates that the indicative need will rise to 1,120 private extra care units in 2031 for the market catchment, given the demographic profile and growth rates of the area.

31.6. The need for private extra care units will therefore continue to grow and create a sustained level of unmet need in the catchment area.

32. Impact of the proposed development – commonly raised questions

32.1. Carterwood is a market leader in the provision of need and demographic analyses in the social care sector. As part of this expertise we have been involved in a large number of need assessments submitted to support planning applications and there are a number of consistent themes that have been raised by adult social care teams and commissioning departments in respect of new care developments and their impact upon the local area.

32.2. We have therefore summarised below a number of commonly raised queries and issues to pre-empt areas where there may be uncertainty or ambiguity in the need case:

Issue – the proposed development may impact upon existing health and social services and GPs in particular who are already over-stretched

32.3. The care home will not impact directly who we anticipate will hold periodic surgeries in-house within the care home. This serves to reduce the number of GP visits as the requirement for GP input is heavily controlled by qualified nursing staff understanding the clinical requirements for each service user.

32.4. The visiting GP can also combine multiple visits into one trip. The presence of on-site care staff also reduces the number of unnecessary trips to GPs, thereby reducing waiting lists rather than increasing them.

32.5. The concentration of individuals within one place should also assist in reducing the requirement for community nurses and there are obvious advantages of having residents within one geographic location.

32.6. Further the pressure on GPs will not be a direct result of the proposed development – demand is not created it is catered for and the new scheme will provide much required facilities to help battle the rising demographics pressure across the area.

Issue – the proposed development may impact upon already stretched local authority budgets

32.7. Having conducted a plethora of studies across the UK and spoken with a host of social services teams, our general observation is that local authority placements both into and out of any local authority tend to be broadly neutral.

32.8. There is no doubt that a number of referrals will move into an area when a new home is developed. Placements by social services to and from neighbouring and surrounding local authorities compensate for each other. In effect, there are just as likely to be as many people leaving the area as there are migrating into the area, and these two factors effectively cancel each other out.

32.9. We are also aware of the challenge faced by local authorities in funding long-term care to those elderly who do not meet current saving thresholds. A further potential issue relates to prospective self-funding service users who exhaust their funds and are therefore obliged to seek local authority support for payment of on-going care.

32.10. In enquiries we have conducted with neighbouring county councils and social services departments, we have ascertained that this type of funding requirement generally tends to amount to less than 1 per cent of the total social services budget for older people (although we have not been able to confirm the exact proportion for the subject site in the timescales required for this advice – we would be more than happy to assist the council in analysing this information if required by social services).

32.11. Also, in our experience, the incidence of this scenario developing is very low compared to the vast majority of self-funding service users, who continue to fund their care throughout the duration of their stay. To guard against this potential issue further, operators often allocate a budget within their own financial modelling for this very issue to ensure that residents' needs can be met and the home is genuinely a 'home for life' if required. Also, their admission process and eligibility criteria ensure that any self-funding residents have proof of funds to support themselves financially, normally for a minimum period of two years.

33. Key conclusions

Need for the proposed care home

33.1. We consider there to be sufficient demand within the market catchment area of the subject scheme to support the proposed care home.

33.2. Our analysis indicates that demand in the market catchment will increase significantly during the next 10 years to 2031, with the unmet need for care home beds rising to over 264 market standard bedspaces.

33.3. Furthermore, despite a willingness and appetite to reduce residential care reliance, the demographic pressures will make this highly problematic and some additional provision of the quality expected by the current purchasers of care will need to be factored into any global social care decision-making process.

33.4. The provision of a care home within the proposed care village scheme enables potential residents of the extra care units to rest assured that should their care needs increase to a position where 24-hour care is required, they can remain on site by moving into the care home. This is also particularly important for a couple who may choose to move to the care village when one partner requires specialist dementia care and the other can live within an extra care unit close by.

Need for the proposed extra care scheme

33.5. Our market catchment analysis indicates that there is a very substantial unmet need for private extra care units in the area with more than sufficient demand to support the proposed extra care units, by a considerable distance.

33.6. We consider the site to be ideally suited to the development of extra care units and that it will fill a major shortfall of need for such accommodation in the area.

33.7. Furthermore, our analysis indicates a strong increase in demand over the coming years.

Qualitative aspects

33.8. In addition to the quantitative need identified within our report, the proposed scheme brings qualitative benefits, as follows:

- State-of-the-art facilities;
- Use of a suitable and sustainable site;
- A substantial scheme offering a variety of accommodation types;
- The ability to care for people with all levels of need, covering the full spectrum of care;
- Transforming the paradigm under which health and social care professionals currently work;
- Community facilities that meet local needs, promote social integration and raise awareness about dementia.

33.9. The proposed scheme provides a major element of its accommodation within extra care housing, which has been identified by the local authority as meeting its future commissioning strategy and requirements – as highlighted in our own review of the commissioning documentation.

33.10. We therefore conclude that there is both a compelling quantitative and qualitative need for the proposed development in providing a unique care environment, which is supported by the commissioning strategy of the Council. In our view significant weight should be given to this need in the assessment of the planning application by the local authority.

APPENDICES

A: LIST OF TABLES AND FIGURES

Tables

Figures

B: DEFINITIONS AND RESERVATIONS

Timing of advice

Our work commenced on the date of instruction and our research was undertaken at varying times during the period prior to completion of this report.

The report, information and advice provided during our work were prepared and given to address the specific circumstances as at the time the report was prepared and the specific needs of the instructing party at that time. Carterwood has no obligation to update any such information or conclusions after that time unless it has agreed to do so in writing and subject to additional cost.

Data analysis and sources of information

Details of our principal information sources are set out in the appendices and we have satisfied ourselves, so far as possible, that the information presented in our report is consistent with other information such as made available to us in the course of our work in accordance with the terms of our engagement letter. We have not, however, sought to establish the reliability of the sources by reference to other evidence.

The report includes data and information provided by third parties of which Carterwood is not able to control or verify the accuracy.

We must emphasise that the realisation of any prospective financial information or market or statistical estimates set out within our report is dependent on the continuing validity of the assumptions on which it is based. The assumptions will need to be reviewed and revised to reflect market conditions. We accept no responsibility for the realisation of the prospective financial or market information. Actual results are likely to be different from those shown in our analysis because events and circumstances frequently do not occur as expected, and the differences may be material.

Measuring and predicting demand is not an exact science, and it should be appreciated that there are likely to be statistical and market related factors that could cause deviations in predicted outcomes to actual ones.

We have undertaken certain analytical activities on the underlying data to arrive at the information presented. We do not accept responsibility for the underlying data.

Where we have adapted and combined different data sources to provide additional analysis and insight, this has been undertaken with reasonable care and skill. The tools used and analysis undertaken are subject to both internal and external data-checking, proof reading and quality assurance. However, when undertaking complex statistical analysis it is understood that the degree of accuracy is never finite and there is inevitably variance in any findings, which must be carefully weighed up with all other aspects of the decision-making process.

The estimates and conclusions contained in this report have been conscientiously prepared in the light of our experience in the property market and information that we were able to collect, but their accuracy is in no way guaranteed.

All advice has been prepared on a 'desktop' basis and where we have prepared advice on a headline basis, we have conducted a higher level and less detailed review of the market. All our headline advice is subject to the results of comprehensive analysis before finalising the decision-making process. Where we have provided 'comprehensive' advice, we have used reasonable skill and endeavours in our analysis of primary and secondary (for example, Census, Land Registry, etc.) data sources, but we remain reliant upon the quality of information from third parties, and all references above to accuracy, statistics and market analytics remain valid.

Purpose and use

The report has been prepared for the sole use of the signatories of this letter and solely for the purposes stated in the report and should not be relied upon for any other purposes. The report is given in confidence to signatories of the engagement letter and should not be quoted, referred to or shown to any other parties without our prior consent.

The data and information should not be used as the sole basis for any business decision, and Carterwood shall not be liable for any decisions taken on the basis of the same.

This report is for general informative purposes only and does not constitute a formal valuation, appraisal or recommendation. It is only for the use of the persons to whom it is addressed and no responsibility can be accepted to any third party for the whole or any part of its contents. It may not be published, reproduced or quoted in part or in whole, nor may it be used as a basis for any contract, prospectus, agreement or other document without prior consent, which will not be unreasonably withheld.

Validity

The outbreak of the Novel Coronavirus (COVID-19), declared by the World Health Organisation as a "Global Pandemic" on the 11th March 2020, has impacted global financial markets. Market activity is being impacted in many sectors. As at the date of this advice, we consider it is difficult to confirm the findings/recommendations as there is limited evidence for comparison purposes and there remains much uncertainty in the market. The current response to COVID-19 means that we are faced with an unprecedented set of circumstances on which to base a judgement. Furthermore, our reports do not take into account any implications or effects of the United Kingdom's exit from the European Union ('Brexit') and any negotiated agreements. All advice given is applicable as at the date of the report commissioned. It may be appropriate to review a commissioned report once the future economic impact of the pandemic has been more fully modelled and clarification of the terms of Brexit has been achieved.

As is customary with market studies, our findings should be regarded as valid as at the date of the report and should be subject to examination at regular intervals, particularly given the uncertainty surrounding COVID-19.

Intellectual property

Except where indicated, the report provided and any accompanying documentation and materials, together with all of the intellectual property rights (including copyright and trademarks) contained within it, belong to Carterwood, and ownership will not pass to you.