Housing Learning & Improvement Network

Care Services Improvement Partnership CSIP

Health and Social Care
Change Agent Team

Linking the Evidence-base to Outcomes: A Consultation Study for Essex County Council's Older Persons Housing Strategy

This study provides an example of how key data on the household characteristics of older people can inform and underpin local planning strategies and documents such as Housing Strategies for Older People, Housing Market Assessments, Supporting People strategies and applications for sheltered housing funding pots.

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Contents:

1. Executive Summary

- This study provides an example of how key data on the household characteristics of older people can inform and underpin local planning strategies and documents such as Housing Strategies for Older People, Housing Market Assessments, Supporting People strategies and applications for sheltered housing funding pots.

- ***Population ageing is an irreversible trend and a major driver of future housing markets.*** The 65+ population in Essex is projected to grow from around 220,000 in 2001 to 325,000 in 2021, an increase of almost 50%. Sustainable strategies are therefore necessary to cope with changing demand for housing and housing-related services. ***Demand for domiciliary care, day care, home adaptations, handyman services, specialist housing and full time nursing and residential care is very likely to rise in all areas*** due to demographic drivers of illness and disability. For example, this study estimates a county-wide increase of around 8,000 people over 65 with dementia from 2001to 2021. In addition, demand will be influenced by changing standards of acceptable quality of life amongst older generations.

- ***Accommodation becomes a key defining environment as we age***. Older people spend a much greater amount of their time at home than other age groups. As our physical capacity declines with age, the condition, design and location of housing becomes increasingly influential on our health, mobility, social inclusion and wellbeing.

- ***Age, ill-health and disability are useful indicators of likely demand for housing-related services***, such as maintenance work, adaptations, and domiciliary support services. They are also drivers of demand for specialist accommodation, such as sheltered or Extra Care housing.

- Survey data show ***tenure is a useful proxy for wealth inequalities and socio-economic groupings, which are in turn predictors of patterns of ill-health and disability.*** Disadvantaged populations show 'premature' ill-health and disability in comparison to the general population. This gap is most noticeable in 'early' old age. In the Essex population aged 50-64, almost three times as many people report a long-term limiting illness and 'not good' health in social rented tenures than owner occupiers.

- Sources such as the 2001 Census can be used to create a profile of older populations in any given local or regional area. Planners can then consider how the circumstances of older populations will affect demands for three main housing options for older people, which are to:
    a) Remain at home and adapt and maintain as necessary
    b) Move to mainstream or purpose-built specialist housing to be close to relatives or friends, possibly involving downsizing property
    c) Move to purpose-built specialist housing with a high degree of care, such as sheltered, Extra Care or residential housing.

- Planners can consider how demand for housing and housing-related care will evolve in different areas. For example, demand for specialist housing in the private rented and leasehold sector is likely to increase where large concentrations of high socio-economic groups exist. Suitable development sites close to these communities should be earmarked, and information services to promote these options should be available.

- On the other hand, where populations of low social economic groups exist, services will need to act preventatively to reduce the likely burden of ill-health, disability, social exclusion. Funding pots for Supporting People or social-rented sheltered and Extra Care housing could be strategically invested in or close to these areas. Where large groups of older homeowners and private renters exist with relative income deprivation, services will need to help overcome the likely backlog of repairs, maintenance and demand for adaptations. Information on housing and service options may need to be made more accessible.

In Essex County Council

- The County has a comparable distribution of age, tenure, and ill-health and disability to the East of England.
- However, considerable variation exists between different Districts in terms of patterns of tenure, ill-health and disability. For example:

    - Rochford, Brentwood, Castle Point and Tendring have relatively higher rates of people aged 50+ in comparison to the County Average. Harlow, Basildon and Colchester have relatively lower rates.
    - Harlow, Basildon and Tendring show a relatively high rate of older people with limiting long-term illness and 'not good health' in comparision to the County average. Uttlesford, Chelmsford and Brentwood show relatively lower rates.
    - Owner occupancy is relatively high in Castle Point, Rochford, Tendring and Maldon. It is relatively low in Basildon, Braintree and Harlow where social and private rented tenures are higher.

- Data on specialist housing for older people points to a likely shortfall in low-level and intermediate, Sheltered and Extra Care specialist housing across all Districts. Of all the categories, sheltered housing is currently the most well provisioned, although the social sector outnumbers leasehold by almost 3-1. Thousands of new and reconditioned units will be necessary to meet both existing needs and emerging demand for the leasehold sector in the specialist market, as well as to respond to policy directives to modernise care provision, (for example, through increasing the availability of Extra Care housing at the expense of nursing and residential care.) A simple no-change scenario for prevalence rates of people receiving local authority Supporting People funding for sheltered housing indicates a County-wide increase of around 5,000 between 2001 and 2021 based on demographic trends. In addition to this, a Department of Health standardised projection estimates a county-level increase in people in care homes (i.e. nursing or residential care) of around 4,000 by 2025.

2. Background

This report has been produced for the Housing LIN by the International Longevity Centre-UK, an independent, non-partisan think-tank dedicated to addressing issues of longevity, ageing and population change. It is based on a detailed review of the demand and supply of accommodation for older people for Essex County Council and is intended to enable planners, commissioners and providers of housing to take into account the housing needs and aspirations of older people.

This has been influenced by ILC UK's 2006 publication, *Building our Futures*, which was designed to assist local planners in preparing Older Person's Housing Strategies and advisory work with local government.

3. Report rationale

This report shows how data about the circumstances, geography and size of local older populations are useful for analysing of the likely evolution of demand for housing and housing-related care in future. This data can be used to help planners consider existing and future housing provision along the lines of three general housing options which will cover the great majority of older people. These are to:

- Remain in your own home, adapt/maintain the property as required and organise equipment and support if needed.
- Move to different location (e.g. closer to shops, family amenities, better climate) or accommodation with different design or facilities. (e.g. better access, one level, lower maintenance)
- Move to specialist housing with a degree of in house-support (e.g. sheltered, Extra Care, residential or nursing home accommodation.)

Predicting demand is important in helping planners to determine:

- Investment in health and social services that promote independence
- The extent and nature of specialist provision such as sheltered housing
- The environmental and housing arrangements that will enable people to continue to be integrated within local neighbourhoods as they age.
- Strategies for managing the local housing market both public and private
- How new build developments can respond to an ageing population. (for example via Section 106 agreements or guidelines for statutory planning.)
- Investment in information services to assist individuals in planning for their future needs

It is hoped that some of the information below will prove a useful starting point for many of these questions. Planners may wish to refer to demographic data when considering multiple applications for development sites and give preference to those that feature older people's housing where necessary.

3.1 Relationship between living alone and age

Living with a partner implies access to a degree of social contact and informal care. Spouses are the largest recipients of informal care given by individuals (ELSA 2002). There are also links between living alone and mental and physical health. The table below analyses the proportion of older people in Essex not living in a couple. This includes those living with other people, such as friends, family, and in communal establishments.

People aged 50+ not living in couples, Essex and East of England, 2001.

	50+		**50-59**		**60-69**		**70-79**		**80-89**		**90+**	
	No	%	No	%	No	%	No	%	No	%	No	%
East Eng.	550949	30%	137334	19%	119304	23%	156942	39%	115665	63%	21704	85%
Essex	135752	30%	33331	19%	29057	23%	38654	39%	29323	64%	5387	86%

A clear gradient is observed with age: between 50 and 59, only 19% are not living in couples. By 80-89, this rises to 64%, and by 90+, 86%. A small variation was observed at the District level. For example, Harlow and Tendring reported 33% of all 50+ were not living in couples, compared the County average of 30%. However, given the inclusion of other household types into these figures it is difficult to ascertain much in terms of differences in older people living alone. Rather, planners should be aware that increasing numbers of people not living in couples at later ages implies a burden of care which must be met by families, friends and public services.

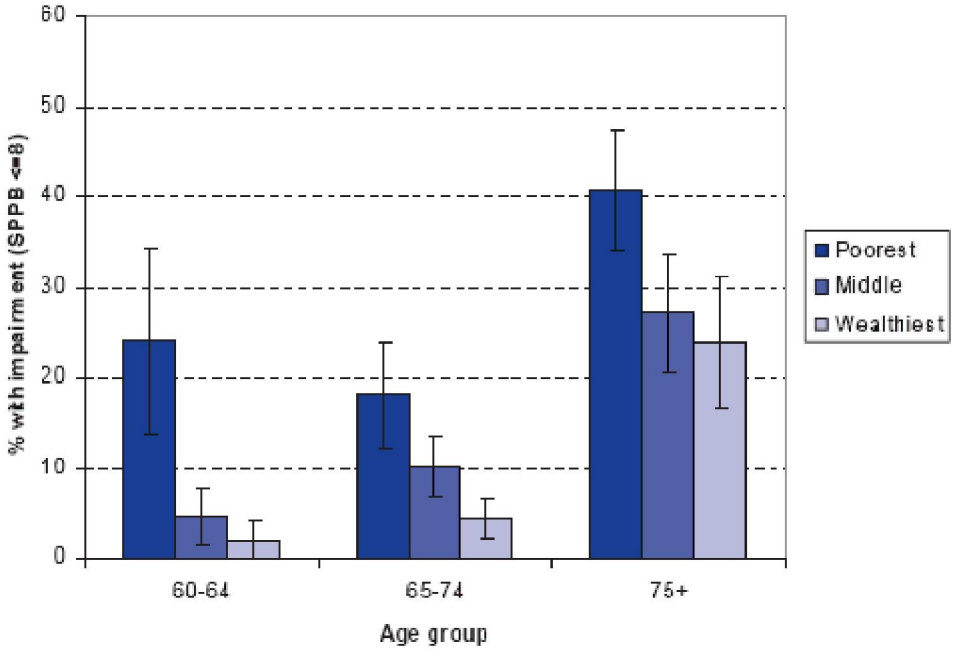
3.2 The relationship between age, health and disability, and tenure: study rationale

This report maintains that given the close link between age and illness and disability, the distribution of populations by age has major implications for public services and housing-related care strategies, for example: community based non-acute healthcare services, specialist housing, housing-related care provision and preventative strategies to maintain wellbeing and independence in later life.

Furthermore, data on tenure, health, disability and deprivation should be useful to local planners in considering the circumstances and means of older populations. Tenure is closely linked to need for adaptations, health and disability and social class (Lifeforce survey 2005). In addition, it is a useful indicator of access to capital and the ability to provide for care and housing needs in later life.

Wealth and socio-economic status is an enormous differential in terms of health and disability in older populations. Planners can use two key assumptions that emerge from survey data; firstly that chronic health conditions and disability strongly correlate to the overall socio-economic patterns of different older populations. This is particularly notable in 'young old' age (i.e. 50 to mid 70s) where numerous conditions, such as reporting balance or dizziness problems, show the largest inequalities (ELSA 2006).

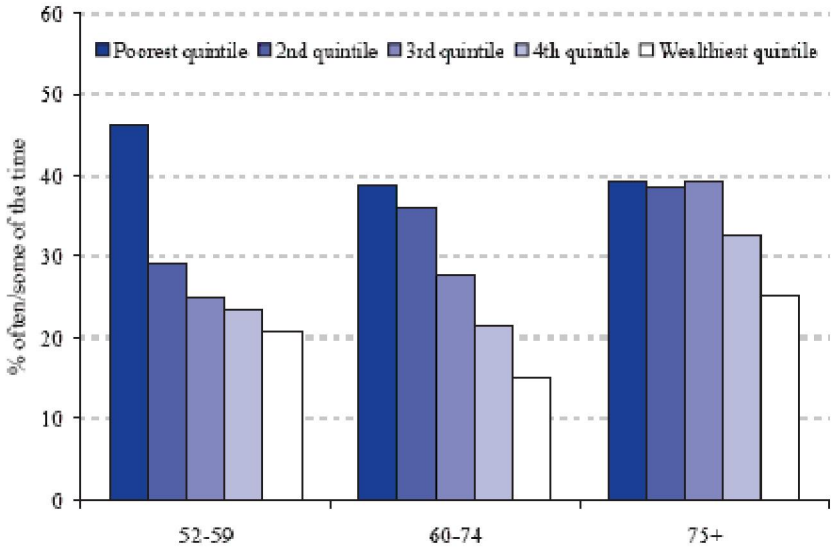
Impairment on SPPB, by age and age-specific wealth quintile, men, with 95% confidence intervals[1]



Source: ELSA 2006

Futhermore, socio-economic status corresponds to non-health-related indicators of quality of life and wellbeing. For example, over double the amount of older people in the poorest groups report loneliness in the 60-74 age range as compared to the wealthiest groups.

Feel isolated from other people by age and wealth



1

The Short Physical Performance Battery (SPPB) score combines the results of the gait speed, chair stand and balance tests (Guralnik et al., 2000) and is predictive at the pre-clinical stage of later disability. The chart above shows that the inequality gap for disability is widest in 'younger' old age, but closes significantly towards 'old old' age as more affluent groups enter their delayed ages of high prevalence for disability. To a greater of lesser degree, a similar pattern of prevalence along socio-economic lines exists for most diseases and chronic conditions.

Source: ELSA 2006.

Again, the inequalities by social class are most discernable in earlier phases of older life (but remain significant in later life). Housing, care and related support services will need to reflect the fact that older disadvantaged groups are more likely to carry the greater burden of need.

3.3 Tenure as a proxy for socio economic status

The links between wealth and health and wellbeing amongst older people is therefore clear. This is supported by findings from the original ILC-UK report *Building our Futures* based on data on the relationship between *housing type* and health, disability and socio-economic class from the Age Concern Lifeforce Survey. This report however has reworked the data to feature tenure as the most useful key variable, given that this is most useful for accessing data from the 2001 Census.

As can be seen in the table below, tenure is a reasonable proxy for social class. Some 54.6% of social renters and 40% of private renters are grade D or E, compared to 19.9% of owner occupiers. Conversely, only 8.1% of social renters and 16.3% of private renters are social grade AB, compared to 28.8% of owner-occupiers.

Relationship between social grade and tenure

Social grade	Owner Occupier	Socially rented tenant	Private Tenant
AB	28.8%	8.1%	16.3%
C1	30.4%	19.0%	33.8%
C2	20.9%	18.3%	10.0%
D	7.7%	12.1%	12.5%
E	12.2%	42.5%	27.5%
	100.0%	100.0%	100.0%

Source: Lifeforce Survey 2005

Data from the Census 2001 supports this relationship in that patterns of ill-health and disability appear to be biased against social and private-rented tenures, as would be expected from a proxy for social class (see section 3.3).

Further tables detailing the relationship between tenure, health, disability, adaptations and self-reported disposition for considering move in future or a move to a care or sheltered home is available in the Appendix.

3.4 Impact of older people's circumstances on planning for services and housing

All of the Districts featured in this study will wish to consider how population ageing will affect demand for public services. As is stated often in this study, demand for domiciliary care, day care, home adaptations, handyman services, specialist housing and full time nursing and residential care is *very likely to rise in all areas* due to both overwhelming demographic drivers of chronic illness and disability and changing standards of acceptable quality of life amongst older generations.

Planners can assume a 'double whammy' rule of socio-economic status: not only are those people with the lowest incomes the *most likely* to display poor health and disability, they are also the *least likely* to be able to afford to provide the adaptations and care services needed to manage related illness and disability themselves, and therefore will require the most resource-intensive interaction with local authorities.

Planners should consider, given their growing role in acting as strategic enablers for overall cross-societal housing and community sustainability, to what extent public and private sector can be engaged to reflect the nature of circumstances and inequalities amongst local older population. For example, where large concentrations of **high socio-economic groups** exist with a relative lack of deprivation:

- Is sufficient specialist housing available in the private sector?
- Does provision reflect likely higher demand for leasehold tenures?
- Are information services helping to ensure these populations are aware of their varied options?
- Can new development sites that are well suited for older persons specialist housing (i.e. close to existing communities, amenities and public transport) be earmarked?

On the other hand, where populations of **low social economic groups** exist:

- Can services act preventatively to reduce the likely inequalities in health and disability translating into reduced independence and increased demand for care?
- Can Registered Social Landlords be engaged to ensure information on housing and service options is delivered to older people?
- Can private landlords with older tenants be made aware of their responsibilities in keeping older people's accommodation to 'decent' standards?
- Where large groups of older homeowners exist with relative income deprivation, can services help overcome their likely backlog of repairs and maintenance before these impact on health?

This data analysis aims to provide guidance as to how the size and circumstances of the older populations of each District might have implications for local service provision. It is essentially an overview, looking at the district-level picture, but should provide a useful starting point for further analysis in depth, possibly down to Census Area Statistic (CAS) ward, where inequalities and variation are more likely to reveal themselves.

4. Essex overview of health, disability and tenure

4.1 Limiting long-term illness

The data on health and disability is analysed under the premise that the presence of a LLTI represents a common situation for many older people which need not, therefore, represent a major constriction on lifestyle. However, when coupled with poor health, represented here as reporting 'not good' health in the Census, it is likely to result in demand for more resource-intensive housing-based care interventions and re-housing solutions, and is therefore of interest to planners. This is assumption is supported by the fact that the majority of older people report a LLTI (~70% for those 85 and over) whereas the minority report a LLTI and 'not good' health (~29% for those 85+, see Section 3.3 below).[2]

Similarly, the majority of older people live in mainstream housing (90%), but the minority require specialist or care intensive housing solutions. [3]

4.2 Tenure and disability in Essex

Tenure and health in 50+ population, Essex (2001)

Essex population 50+	No. people	% of total pop.	% of tenure group
All people	456924	100.0%	
All people with LLTI	148296	32.5%	
All people with LLTI and not good health	60691	13.3%	
Tenure: owner occupiers	373179	81.7%	100.0%
Owner occupiers with LLTI	107383	23.5%	28.8%
Owner occupiers with LLTI and not good health	42401	9.3%	11.4%
Tenure: social rented housing	61802	13.5%	100.0%
Social rented tenure with LLTI	31937	7.0%	51.7%
Social rented tenure with LLTI and not good health	15069	3.3%	24.4%
Tenure: private rented & rent free	21759	4.8%	100.0%
Private rented & rent free tenures with LLTI	8976	2.0%	41.3%
Private rented & rent free tenures with LLTI and not good health	4003	0.9%	18.4%

[2] Furthermore, only a small proportion of the Essex population report 'not good' health in the absence of a LLTI, (5% of the population over 50 and 1.5% of the population over 65).
[3] Housing for Older People Development Group (HOPDEV), 2005.

Key fact: social and private renters show a disproportionate burden of ill health and disability

The table above demonstrates that the macro-picture relationship between tenure and health applies equally to the Essex population. Some 28% of owner occupiers 50+ report a LLTI and 11.4% report a LLTI and not good health. In contrast, rates are much higher in people aged 50+ in private rented tenures; 41.3% report a LLTI and 18.4 report a LLTI and 'not good' health. Social rented tenures show higher rates still, at 51.7% and 24.4% respectively, *around double those of owner occupiers.*

It is useful to note that owner-occupiers represent the majority of all over 50s, (81.7%.) Social rented tenure represents the next largest group (13.5%) followed by private renters at (4.8%). Although this study devotes considerable attention to non-owner occupiers, planners should bear in mind that homeownership is by far the dominant tenure.

4.3. The effect of age on tenure, health and disability in Essex.

As discussed earlier, age has a significant effect on health and disability within all tenure groups, revealing inequalities to be sharpest in 'early and middle' old age (i.e. 50-84).

Effect of age on health inequalities by tenure (2001)

Tenure group: Essex	No. 50-64:	%	No. 65-84:	%	No. 85+:	%
All people	245604		188958		22178	
All people with LLTI	51327	20.9%	81265	43.0%	15704	70.8%
All people with LLTI and not good health	22671	9.2%	31435	16.6%	6585	29.7%
Owner occupiers	212267		146734		14178	
Owner occupiers with LLTI	38798	**18.3%**	58681	**40.0%**	9904	**69.9%**
Owner occupiers with LLTI and not good health	15938	**7.5%**	21598	**14.7%**	4083	**28.8%**
Socially rented tenures	22425		33427		5950	
Social rented tenure with LLTI	9409	**42.0%**	18200	**54.4%**	4328	**72.7%**
Social rented tenure with LLTI and not good health	5137	**22.9%**	8037	**24.0%**	1895	**31.8%**
Private rented & rent free tenures	10912		8797		2050	
Private rented & rent free tenures with LLTI	3120	**28.6%**	4384	**49.8%**	1472	**71.8%**

Private rented & rent free tenures with LLTI and not good health	1596	**14.6%**	1800	**20.5%**	607	**29.6%**

Key fact: the health inequalities between tenure groups are most noticeable in early later life (i.e. 50-64).

Rates of LLTI show considerable inequality, but rates of LLTI *and* 'not good' health are even more marked. Almost *three times as many people in social rented tenures report a LLTI and 'not good' health than owner occupiers* at these ages. Private rented tenures also show higher rates of reported LLTI and LLTI and 'not good' health.

By the 65-84 age group, however, this gap has narrowed to 40% of owner-occupiers reporting LLTI compared with 54.4% of social renters and 49.8% of private renters.

Interestingly, the gap is more or less closed by the 85+ age range. This is consistent with major surveys into ageing, such as the English Longitudinal Study on Ageing, which observe a balancing effect of age. However, given the heavy weighting of the older population towards the younger age groups (the 85+ represent only 5% or so of the total population over 50) the inequalities revealed at younger ages are particularly relevant to inequalities in the older population in general.

Information on tenure is therefore a useful parameter for analysing the health circumstances of the older Essex population. Furthermore, it is also representative of wealth and economic means.

5. District data tables

5.1 District populations by age

The table below analyses the distribution of older people in the various Essex District Councils in 2001 by 10 year age grouping from 50 to 90+. As an overall comparison figures have been included for the East of England region.

East of England, Essex, and Essex Districts by 10 year age group, total no.s and % of population

Area	Total pop	All 50+	50 to 59	60 to 69	70-79	80 to 89	90+
East of England	5388140	1825252	707870	510554	407903	198925	35789
% of total pop		33.9%	13.1%	9.5%	7.6%	3.7%	0.7%
Essex	1310833	456924	179806	127204	100729	49185	8489
% of total pop		34.9%	13.7%	9.7%	7.7%	3.8%	0.6%
Harlow	78764	23000	8343	6781	5784	2092	281
% of total pop		**29.2%**	10.6%	8.6%	7.3%	2.7%	0.4%
Basildon	165665	52496	21081	14979	11439	4997	732
% of total pop		**31.7%**	12.7%	9.0%	6.9%	3.0%	0.4%
Colchester	155805	49562	20420	13319	10434	5389	953
% of total pop		**31.8%**	13.1%	8.5%	6.7%	3.5%	0.6%
Chelmsford	157074	51092	21448	14163	10353	5128	833
% of total pop		**32.5%**	13.7%	9.0%	6.6%	3.3%	0.5%
Braintree	132175	43244	18307	11382	8946	4609	921
% of total pop		**32.7%**	13.9%	8.6%	6.8%	3.5%	0.7%
Uttlesford	68943	23776	10254	6440	4652	2430	493
% of total pop		**34.5%**	14.9%	9.3%	6.7%	3.5%	0.7%
Epping Forest	120907	42689	17037	11375	9648	4629	814
% of total pop		**35.3%**	14.1%	9.4%	8.0%	3.8%	0.7%
Maldon	59424	21241	9276	5978	3907	2080	370
% of total pop		**35.7%**	15.6%	10.1%	6.6%	3.5%	0.6%
Rochford	78487	28928	11323	8314	6359	2932	440
% of total pop		**36.9%**	14.4%	10.6%	8.1%	3.7%	0.6%
Brentwood	68455	25447	9621	7238	5814	2774	492
% of total pop		**37.2%**	14.1%	10.6%	8.5%	4.1%	0.7%
Castle Point	86613	33060	13728	9414	6825	3093	487
% of total pop		**38.2%**	15.8%	10.9%	7.9%	3.6%	0.6%
Tendring	138542	62390	18968	17822	16568	9032	1673
% of total pop		**45.0%**	13.7%	12.9%	12.0%	6.5%	1.2%

Districts are marked in yellow where age groups display a higher % than the county average (% to nearest whole number – not marked if equal to county average.) Source: Census 2001.

The Districts in the table above are ranked by their total population aged 50+ column from lowest percentage to highest. Harlow therefore has the lowest proportion of over 50s at 29.2% of the population, and Tendring the highest at 45%. In particular, the four Districts with the highest proportion of over 50s, **Rochford, Brentwood**, **Castle Point** and **Tendring,** have 50+ populations respectively 5%, 7%, 10% and 29% larger than the Essex average. These represent very significant differences which will be explored later.

The table also looks at the age breakdown of each District population by 10 year age band. Planners should expect older age groups to grow in all areas, with a resulting increase in demand for specialist housing and housing-related care. These trends are likely to be magnified, however, in Districts with larger than average older age groups 'in waiting', for example, **Brentwood** and **Tendring**.

Braintree, Uttlesford, Epping Forest, Maldon, Rochford and **Castle Point** currently show 'average' and below average proportions of the 'old old' (i.e. 80-89, 90+). In addition, they also show relatively larger groupings of 'young old' (i.e. 50-59 and 60-69). These Districts may wish to further investigate what effect these potentially 'hidden' groups could have on public services as they progress through into the age ranges associated with increased frailty and demand for care, imaginably over the next 20 years.

5.2 Health and disability; Limiting long–term illness

An analysis of the health status of older populations is also useful considering the current and future circumstances of populations. The table below looks at the proportions of each age group reporting a limiting long term illness (LLTI) in the 2001 Census.[4] Districts have been ranked according to the percentage of all people over 50 reporting a LLTI, from Uttlesford (lowest, 27%) to Tendring (highest, 39%.)

[4] The age groups in the source Census Area Statistic output table are grouped by unusual ages, 50-59, 60-64, 65 to 84 and 85+. As it is not possible to break these down by tenure data must be presented along age groups. To facilitate the analysis however the 50 to 59 and 60 to 64 groups have been merged into a 50 to 64 group.

Comparison of reported limiting long-term illness (LLTI) by age groups in East of England, Essex, and District councils (2001).

	All 50+ LLTI	as % of 50+	**50 to 64: LLTI**	as % of 50-64	**65 to 84: LLTI**	as % of 65-84	**85+: LLTI**	as % of 85+
East of England	590345	32%	203246	21%	324378	43%	62721	70%
Essex	148296	32%	51327	21%	81265	43%	15704	71%
Uttlesford	6392	**27%**	2130	16%	3448	38%	814	69%
Chelmsford	14741	**29%**	5051	18%	7952	40%	1738	72%
Brentwood	7311	**29%**	2331	18%	4165	38%	815	70%
Maldon	6447	**30%**	2445	20%	3352	43%	650	70%
Braintree	13228	**31%**	4658	19%	7137	43%	1433	69%
Rochford	9069	**31%**	2963	19%	5107	42%	999	72%
Epping Forest	13407	**31%**	4641	20%	7256	41%	1510	69%
Colchester	15853	**32%**	5835	21%	8302	43%	1716	70%
Castle Point	10775	**33%**	4023	21%	5787	45%	965	75%
Basildon	18636	**35%**	6837	24%	10206	47%	1593	74%
Harlow	8182	**35%**	2765	24%	4800	46%	617	71%
Tendring	24255	**39%**	7648	28%	13753	46%	2854	70%

Districts are marked in yellow where age groups display a higher proportion of people reporting a LLTI and 'not good' health than the county average (% to nearest whole number – not marked if equal to county average.) Source: Census 2001.

Again, the overall Essex average is comparable to the East of England region. Also, we see considerable variation between the Districts. Four Districts emerge as having proportionately larger percentages of the 50+ population reporting a LLTI than the County average, **Castle point** (33%), **Basildon** (35%), **Harlow** (35%) and **Tendring** (39%). They constitute respective groups around 3%, 9%, 9%, and 22% greater than would be expected along the Essex average.

Prevalence of reporting a LLTI increases with age in all Districts. As a County average, this is 21% of people in the 50-64 age group, rising to 43% in the 65-84 group and 71% amongst the 85+. Districts have been marked in yellow where a group reports a higher percentage than the county average.

Districts with higher proportions of over 50s reporting LLTI show a fairly unsurprising breakdown of LLTI by 10 year age groups. Rochford and Chelmsford do display a marginally higher proportion of LLTI in the 85+ but the difference is slight. Interestingly, however, Harlow and Tendring show only average rates of LLTI in the 85+ group despite high prevalence amongst the 50+ as a whole. This may indicate that overall rates will be higher in future as the 50-64 and 65 to 85 groups move through into later life.

5.3 Health and disability: limiting long-term illness and poor health

As discussed above, reporting a LLTI is common in older life amongst the national and Essex population, becoming a majority condition in 'old old' (e.g. 85+) age groups. Given that the considerable *minority* of older people require intensive housing and

housing related care solutions, it is likely to be more useful as an indicator of manageable disability amongst the older population than demand for intensive care solutions.

However, having *LLTI and poor health* remains a minority condition even amongst 'old old' age groups. It is therefore more likely to assist in identifying a 'hard core' of older people in need of a greater degree of care.

The table below analyses groups reporting a LLTI and 'not good' health (the worst choice of three options in the 2001 census) in the older population. The East of England region is included for comparison. Districts are ranked by percentage of all people 50+ reporting a LLTI and 'not good' health from the lowest (Uttlesford 10%) to the highest (Tendring 17%).

Comparison of reported limiting long term illness (LLTI) and 'not good' health by age groups in East of England, Essex, and District councils (2001).

	50+ LLTI in 'not good health'	% of age group LLTI & not good health	**50-64 LLTI in 'not good health'**	% of age group LLTI & not good health	**65-84 LLTI in 'not good health'**	% of age group LLTI & not good health	**85+ LLTI in 'not good health'**	% of age group LLTI & not good health
East	242626	**13%**	90957	9%	125385	16%	26284	29%
Essex	**60691**	**13%**	**22671**	**9%**	**31435**	**17%**	**6585**	**30%**
Uttlesford	2399	**10%**	829	6%	1262	14%	308	26%
Chelmsford	5614	**11%**	2018	7%	2904	14%	692	29%
Brentwood	2844	**11%**	947	7%	1550	14%	347	30%
Maldon	2536	**12%**	1040	8%	1229	16%	267	29%
Braintree	5242	**12%**	1929	8%	2750	17%	563	27%
Rochford	3603	**12%**	1229	8%	1945	16%	429	31%
Colchester	6314	**13%**	2558	9%	3040	16%	716	29%
Epping Forest	5602	**13%**	2057	9%	2901	16%	644	29%
Castle Point	4508	**14%**	1809	10%	2275	18%	424	33%
Basildon	8141	**15%**	3250	11%	4164	19%	727	34%
Harlow	3599	**16%**	1327	11%	1995	19%	277	32%
Tendring	10289	**17%**	3678	13%	5420	18%	1191	29%

Districts are marked in yellow where age groups display a higher proportion of people reporting a LLTI than the county average (% to nearest whole number – not marked if equal to county average.) Source: Census 2001.

Similar to the table above on LLTI, **Castle Point, Basildon, Harlow** and **Tendring** rank as having the highest proportions of 50+ reporting a LLTI and 'not good' health (14%, 15%, 16% and 17% respectively.)

All areas show an expected increase in prevalence of LLTI and 'not good' health with age. Given the overall rankings by total population over 50+ there are few 'anomalies' in the age breakdowns; although interestingly the 85+ group in Tendring ranks at just

below average despite the high overall rates of poor health and disability amongst older people in the District.

5.4 Older populations and tenure

As discussed previously, tenure and age is not only linked to issues health and disability, but is also a reasonable proxy for socio-economic groupings. It is helpful therefore when considering a number of factors, such as how populations will age, when disability will instigate a demand for housing-related care solutions, and which populations may require either a more developed private markets for housing and care or greater publicly-funded housing and services.

The table below displays tenure in the older Essex population by age group. Social and all private renters are grouped here together, as this study assumes the most useful single distinction is between owner occupiers and non-owner occupiers. As mentioned previously, this is due to somewhat similar patterns in terms of health and economic status (SEU 2004/5) and assumed access to capital via housing equity.

The table also acts as an indicator of home ownership, as Districts with a low proportion of social and private renters can be assumed to have a higher proportion of owner occupiers, and vice versa.[5]

Districts are ranked according to proportions of all 50+ in social or private rented tenures, from Castle Point (7%) to Harlow (35%).

East of England, Essex, and Essex District Councils by age group and tenure (2001).

	All 50+ private/ social rented tenures	As % of all 50+ all tenures	**50 to 64: private/ social rented tenures**	As % of 50 to 64 all tenures	**65 to 84: private/ social rented tenures**	As % of 65 to 84 all tenures	**85+ private/ social rented tenures**	As % 85+ all tenures
East	348729	**19%**	157472	16%	191257	25%	33661	38%
Essex	75561	**17%**	33337	14%	42224	22%	8000	36%
Castle Point	2365	**7%**	1110	6%	1255	10%	268	21%
Rochford	2838	**10%**	1126	7%	1712	14%	405	29%
Tendring	7804	**13%**	3332	12%	4472	15%	899	22%
Brentwood	3365	**13%**	1469	11%	1896	18%	388	33%
Maldon	2893	**14%**	1373	11%	1520	19%	317	34%
Chelmsford	7654	**15%**	3203	11%	4451	22%	950	39%
Colchester	7898	**16%**	3922	14%	3976	20%	904	37%
Epping Forest	7619	**18%**	3250	14%	4369	25%	921	42%

[5] The Census groups respondents into three tenure categories: 1). owner occupiers, 2). tenants of Social landlords (social renters) and 3). tenants of private landlords (private renters) and non-owner occupiers living rent-free. For simplicity, the latter category is grouped here as private renters.

Uttlesford	4558	**19%**	2042	15%	2516	28%	490	42%
Basildon	11174	**21%**	5065	18%	6109	28%	994	46%
Braintree	9349	**22%**	4124	17%	5225	31%	890	43%
Harlow	8046	**35%**	3323	28%	4723	45%	579	67%

Districts are marked in yellow where age groups display a higher proportion of people reporting social and private rented tenures than the county average (% to nearest whole number – not marked if equal to county average.) Source: Census 2001.

As an Essex average, the % of social and private renters increases with age, from 17% in the 50 to 64 age group to 15% at 65 to 84 and 36% at 85+.

At a District level there is considerable variation. Four Districts show above average levels of social and private renters in the 50+ population, **Epping Forest** (18%), **Uttlesford** (19%) **Basildon,** (21%) **Braintree** (22%) and **Harlow** (35%). However, as would be expected, owner occupiers constitute the majority of all older people in all age groupings apart from one example (Harlow, 85+, 67% in social rented housing).

A break down of tenure by age group reveals slightly lower rates of social and private tenancy at younger ages in some Districts than might be expected given the overall picture – Epping Forest has relatively high levels of social and private tenancy in both the 65 to 84 and 85+ age groups (25% and 42% respectively) but average levels at the 50 to 64 age range (17%), underlining the likely increase in homeownership in later life in coming decades.

5.5 Specialist housing provision for older people in Essex

This study uses data provided by the Elderly Accommodation Counsel (EAC) to assess the provision of specialist housing in Essex and the Essex Districts. Data is not exhaustive, but is deemed to be a fair representation of overall figures and therefore useful for comparison with other factors such as size and proportion of the older population, health and tenure trends. It should be noted that EAC data is continuously accumulated (i.e. 2007) whereas the Census population data originates in 2001. As the objective is to provide a rough guide to specialist housing provision at a District level however, the findings are likely to remain useful to some degree.

Estimated provision of specialist housing by category, Essex and Districts, 2007.

	Social rented				**RSL Total**	**Leasehold or mixed tenure**				**Leasehold total**
Housing type	L	M	N	S		L	M	N	S	
Basildon	3	2018	160	30	**2211**	0	220	78	0	**298**
Braintree	21	812	34	0	**867**	20	512	0	0	**532**
Brentwood	21	555	81	12	**669**	0	314	0	0	**314**
Castle Point	0	319	0	0	**319**	0	70	0	0	**70**

Chelmsford	46	1141	24	10	**1221**	0	702	0	0	**702**
Colchester	10	899	90	0	**999**	0	203	0	13	**216**
Epping Forest	28	726	79	36	**869**	0	263	0	0	**263**
*Harlow**	*0*	*112*	*0*	*0*	***112***	*0*	*0*	*0*	*0*	***0***
Maldon	42	790	0	8	**840**	0	229	14	0	**243**
Rochford	14	651	50	71	**786**	10	272	114	85	**481**
Tendring	516	810	70	97	**1493**	0	719	44	128	**891**
Uttlesford	21	618	0	46	**685**	0	176	0	0	**176**
Essex CC Total	**722**	**9451**	**588**	**310**	**11071**	**30**	**3680**	**250**	**226**	**4186**

* The EAC database had significant data gaps in Harlow. Results have been included but should be discounted. *Source: EAC*

The table above shows specialist housing for older people in Essex by both tenure and housing type. The Elderly Accommodation Counsel (EAC) lists specialist housing by the Scottish Supporting People categories of L, M, N and S:

L : Housing designated for older people (i.e. some design features or simply designated or prioritised housing for older people)
M : Sheltered housing
N: Very sheltered housing & Extra Care. (In Essex, all category N housing is listed by the EAC as Extra Care.)
S: Amenity housing (i.e. very basic additional features from mainstream housing.)

If we take the EAC data as a good indicator of overall provision, it is clear that the data suggests some considerable gaps.

It is difficult to ascertain what an ideal level of provision would look like. However, it appears relatively clear that the social rented sector is better catered for, particularly sheltered housing. Extra Care housing however is under-represented in most areas, particularly Braintree, Castlepoint, Chelmsford, Maldon and Uttlesford. There also appears to be low or very low provision of intermediary and low-level categories 'S' and 'L' in most areas.

In the leasehold sector, it is clear that almost all types of specialist housing provision are currently underprovided for. This is particularly true of categories 'S', 'L' and 'N' (Extra Care housing), with one exception for Rochford.

To create a more useful anaylsis of the true level of provision for specialist housing, it is useful to compare the number of units relative to the size of the older population in each District.

Specialist housing provision by pop. 65+ per unit, Essex and Essex Districts.

	Registered Social Landlord					Leasehold or mixed tenure				
Housing category	**L**	**M**	**N - (Extra Care)**	**S**	**All RSL**	**L**	**M**	**N - (Extra Care)**	**S**	**All Lease-hold**
Basildon	7945	12	149	794	**11**		108	306		**80**
Braintree	892	23	551		**22**	937	37			**35**
Brentwood	571	22	148	999	**18**		38			**38**
Castle Point		45			**45**		204			**204**
Chelmsford	488	20	936	2247	**18**		32			**32**
Colchester	2200	24	244		**22**		108		1692	**102**
Epping Forest	707	27	251	550	**23**		75			**75**
Harlow*	*?*	*102*	*?*	*?*	***102***	*?*	*?*	*?*	*?*	***?***
Maldon	209	11		1096	**10**		38	627		**36**
Rochford	958	21	268	189	**17**	1341	49	118	158	**28**
Tendring	66	42	490	354	**23**		48	780	268	**38**
Uttlesford	483	16		221	**15**		58			**58**
Essex CC Total	292	22	359	681	**19**	7038	57	845	934	**50**
Essex CC excl.Harlow	277	21	340	644	**18**	6658	54	799	884	**48**

Note:

- *Blank cells indicate no data on availability of units (i.e. estimated to have no or very low provision)*
- *Low numbers indicate fewer people 65+ per unit (i.e. higher provision.) High numbers indicate more people 65+ per unit (i.e. low provision.)*

**Data missing for Harlow*

By tenure, it is again clear that *levels of leasehold provision are low across most of the county*, being outnumbered by social provision by 2 to 1 (the county average is 48 people 65+ per leasehold unit compared to 18 people 65+ per social rented unit.) Leasehold provision is particularly scarce in Castle Point, Colchester, Basildon and Epping Forest compared to the Essex average (204, 102, 80 and 75 people 65+ per unit compared to Essex at 48.) As owner occupancy represents the majority tenure for people aged 65+ in all Districts at all ages 50+,[6] this is likely to indicate *some degree of under-provision of leasehold specialist housing in all areas.*

By category, it is clear that there are significant gaps in **Extra Care** provision as mentioned previously. Braintree, Castle Point, Chelmsford, Maldon, Tendring and Uttlesford show either very little or low levels of provision in the social rented sector, and *all Districts apart from Rochford show very little or low levels of provision in the leasehold sector*. This is likely to indicate a shortfall in demand, particularly in wealthier districts.

[6] See 4.4 – the one exception is Harlow, 85+ age group, where social and private renters constitute a majority (67%).

Again, as mentioned above, **sheltered housing** (category M) appears to be relatively well provided for, particularly in the social rented sector. This may be due to a legacy of traditional models of care. In the leasehold sector, provision is reasonably high in comparison to other categories, however Castle Point, Basildon, Colchester and Epping Forest show notably lower provision that the County average, (204, 108, 108, and 75 people aged 65+ per unit compared to 54 for Essex) and this may point to a shortfall.

Other categories of specialist housing (i.e. 'L' and 'S') appear to be relatively under-developed in Essex in both social rented and leasehold sector, although there are a few exceptions. Tendring has a very number of category 'L' housing (516 units), equal to only 66 people over 65+ per unit. Elsewhere provision in categories 'L' and 'S' housing is much lower, particularly in the leasehold sector, with the one exception being category 'S' housing in Tendring and Rochford, where a medium level of provision is estimated. Given the likely growing need for a useful alternative between both mainstream housing and more care-intensive, specialised accommodation such as sheltered housing and extra care*, it is likely that these figures point to a significant shortfall in categories 'L' and 'S' housing across Essex.*

5.6 Specialist housing and tenure patterns

It is also useful to revisit tenure patterns in the Essex older population when drawing conclusions as to the provision of leasehold specialist accommodation (see Section 4.4). As noted previously, in areas we see the majority of all older people are owner occupiers, although rates for the 50+ are highest in **Colchester** (84% owner occupancy) **Chelmsford,** (85%) **Maldon,** (86%) **Brentwood,** (87%) **Tendring,** (87%) **Rochford** (90%) **and Castle Point** (93%) compared to the County average.

These districts are therefore more likely to face higher future demand for leasehold specialist housing for older people, given that owner occupiers will have equity to invest and may also have owner occupancy aspirations. In particular, Colchester and Castle Point (which has the highest level of homeownership at 89%) have either low or very low provision across all categories. Brentwood, Malden and Tendring have a relatively good provision of leasehold sheltered housing (category 'M') but little or no provision in categories 'S' and 'L', and 'N' (i.e. Extra Care.) Rochford is the exception with a more developed market.

Conversely, owner occupancy is much lower in Harlow and Braintree compared to other Districts, although still the majority tenure. Demand for specialist housing in the social rented sector is therefore likely to be greater than elsewhere in Essex.

The figures in section 4 .5 and 4.6 should be useful in providing impetus for further studies looking at the impact of population ageing and older household circumstances on demand for specialist housing. Planners should bear in mind that as all age groups are set to grow, demand for *all types of specialist housing is likely to rise.* All areas will most likely wish to consider to what extent additional provision may be needed in future, particularly so in the case of Districts with apparently low provision according to the analysis above.

5. 7 Deprivation data

Information on tenure has some limitations if used to group people by broad economic means and social class. Deprivation data is therefore useful as supporting information when considering the circumstances of older populations, considering the wider impact of factors such as amenities and services, transport, anti-social behaviour and the social cohesion of the community as a whole has on quality of life.

Essex Districts by Index of Deprivation averages, 2004

Area	Rank of average score decile	Rank of average rank decile	Rank of Income decile
Tendring	**3**	3	3
Harlow	**4**	3	6
Basildon	**4**	5	3
Braintree	**7**	7	5
Castle Point	**7**	7	7
Colchester	**7**	7	4
Epping Forest	**7**	7	6
Maldon	**8**	8	9
Brentwood	**9**	9	10
Rochford	**9**	10	9
Chelmsford	**10**	10	6
Uttlesford	**10**	10	10

Source: Department of Communities and Local Government 2004

Communities and Local Government provides deprivation summaries for each local Super Output Area. District level rankings take the form of both average scores on the deprivation index (which are themselves then ranked 1-354 by English District) and average ranking across the six different categories of deprivation (again, these are then ranked 1-354.) Both are usually taken into consideration when considering the deprivation status of a District. Given the similarity of results between the two methods it is not necessary to produce an average between the two here. Average score is used here as it provides more variation. Using average rank would not change the order of Districts.

In the table above, both rankings have been split into deciles – i.e. those Districts with a score of '10' rank in the top 10% least deprived areas in the England. A score of '1' would represent membership of the most deprived 10% in England. Deprivation is calculated along the lines of seven factors, income, employment, health and disability, living environment, barriers to housing and services, education and skills, and crime. It must be cautioned that is not possible to gauge the balance of deprivation between the different factors here. Furthermore, scores apply to all ages and are not older-person specific.

County level summaries are not provided for Essex. It is not therefore possible to ascertain a county 'average' by which to judge the rankings. It is clear however that Essex is largely not a deprived county. All but three Districts score well above the English

average (a mid point between deciles 5 and 6); Tendring (3), Harlow (4), and Basildon (5).

5.8 Older homeowners and social deprivation

So far this study has assumed that owner-occupancy correlates with relative wealth. Yet deprivation data is a useful measure in establishing whether it is likely that there are large groups of homeowners with limited means. All Districts will wish to consider how they can identify older homeowners in relative poverty, given this tenure represents the majority of all 65+ in all areas. This group is likely to present particular challenges given they are unlikely to have the capital to carry out refurbishment and repairs to their property, yet have the sole responsibility for doing so.

Tendring, **Basildon** and **Harlow** rank as having high levels of social deprivation. By revisiting earlier data on tenures, we see they additionally show the highest rates of LLTI and 'not good health' (15-17% of all 50+.) Tendring shows very high rates of owner occupancy (87%, given 13% social and private rented) as does Basildon (79%). Although Harlow shows the highest proportion of older social and private renters (35%) it must be remembered that owner occupancy still constitutes a majority of 65%. As owner occupiers are a large group in all these Districts, planner will want to make particular consideration of how poverty and ill-health in this group can be tackled.

6. Current and future Local Authority-sponsored specialist housing placements

This section uses data on the numbers and age of older people currently receiving Local Authority funding for specialist housing placements to analyse the relationship between service provision and older groups. It also includes a basic analysis of the implications of population ageing to overall demand.

6.1 Current specialist housing provision by age

Supporting People-funded sheltered housing placements by age, Essex, 2006.

Age group	% all placements
<50	1%
50-54	1%
55-59	2%
60-64	3%
65-69	5%
70-74	10%
75-79	16%
80-84	24%
85+	38%
TOTAL	**100%**

Source: Essex Supporting People 2006. Based on a sample of 4,985 households

Essex County Council has data on age for 4,985 of the 8,770 people receiving Supporting People-funded sheltered housing placements in the County, expressed by 5 year age group in the table above. The relationship between age and numbers of placements is clear. In this dataset the 80+ represent 62% of sheltered housing placements, but as a whole constitute only 4.1% of the total Essex population. The over 65s represent 93% of placements known by age. The under 50s represent just over 1% of all placements.

It should be noted that this data excludes those people receiving very sheltered and Extra Care placements. A similar analysis would be useful as and when data on age becomes available through the review of Supporting People services for Older People in Essex[7].

6.2 Population projections by age

The table below shows an Essex County Council population projection for Essex in 2021 compared to figures for 2001.

[7] For information see http://supportingpeople.essexcc.gov.uk

Comparison of Essex 2001 population by age with 2021 projection

Age group	2001	2021	Change 2000 to 2021:
20--24	69600	71500	1900
25--29	78200	79200	1000
30--34	96700	84600	-12100
35--39	101800	77800	-24000
40--44	92100	81200	-10900
45--49	85500	86300	800
50--54	97600	97600	0
55--59	82600	98100	15500
60--64	66600	87500	20900
65--69	60600	79200	18600
70--74	54800	85800	31000
75--79	45900	66700	20800
80--84	31600	45400	13800
85+	26400	49700	23300
Total 20+	990000	1090600	100600

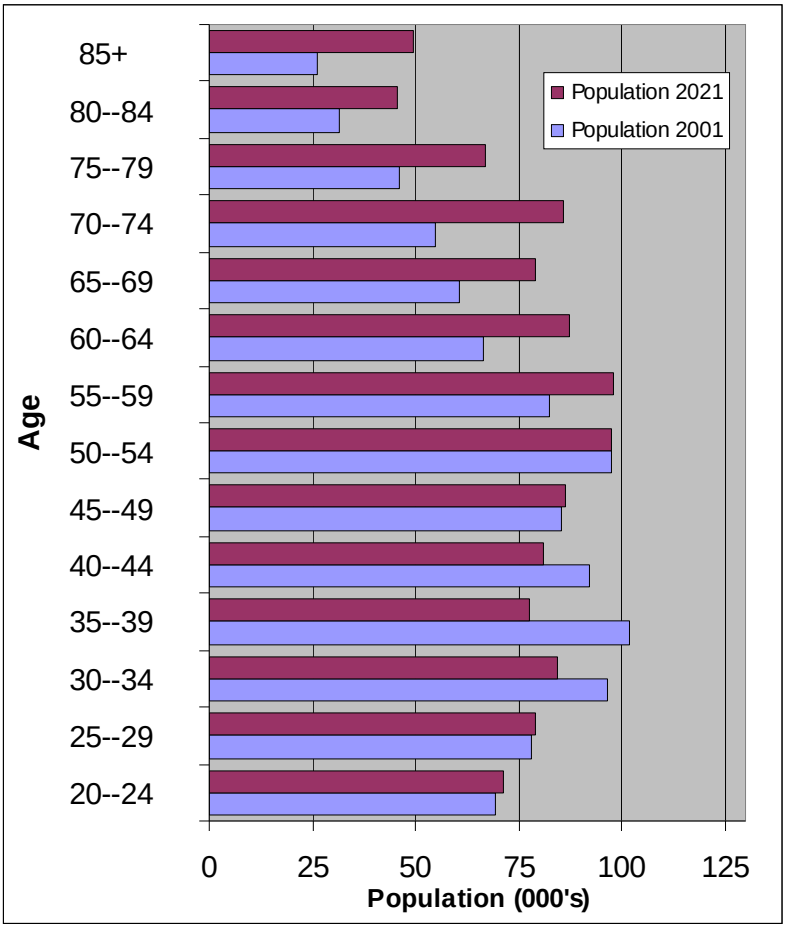
Source: ONS 2001, GAD 2004

These point to very similar patterns of demographic change as would be expected across the UK. The population shows overall growth (+100,000 2001 to 2021) with either a negligible increase or sizeable reduction in the younger age groups (20-50), and large increases in older age groups. The total numbers of people aged 65+ are projected to grow from around 220,000 to 325,000, an increase of about 105,000, or almost 50%.[8] Due to the smaller sizes of older cohorts (e.g. 85+) relative growth will greater. For example, an additional 23,000 people aged 85 and over by 2021 represents a virtual doubling of the age group from 2001.

It may be more helpful to visualize the changes in the chart below:

[8] Projected increase of 65+ is from 219,300 in 2001 to 326,800 in 2021. An increase of 49%.

Comparison of Essex population by age, 2001 and 2021 (ONS and Essex projections)



6.3 Future specialist housing demand

This study includes a basic projection of demand for local authority funding for sheltered housing placements as an example of how population ageing might affect wider services. A simple, no-change scenario can be used with population projections to calculate future numbers of people requiring funding. It must be stated that the function of this not to provide a forecast, but an attempt to indicate the scale of the challenge facing preventative initiatives designed to reduce demand for such services and keep people in their own homes for longer. Eventual funding allocations are as much a policy issue as a demographic one.

Prevalence of Local Authority sponsored places in sheltered housing by age group

Age	Likelihood by age group
<55	0.0%
55--59	0.1%
60--64	0.3%
65--69	0.4%
70--74	0.9%
75--79	1.7%
80--84	3.8%
85--89	5.5%
90+	10.6%

Source; Essex Supporting People 2006

The table above shows the % of people current receiving Supporting People funding for sheltered housing in Essex for whom age is known. As a rough guide, the prevalence rate appears to increase by just under double for each rise in 5 year age group. Note: these numbers are for sheltered housing only, not Extra Care or residential care.

When these prevalence rates by age are applied to population projections it is possible to speculate what demand for placements might resemble in future, given no change in likelihood of requiring care or the needs assessment criteria applied to applicants (see table below).[9]

Given that data on age is only known for 57% of people receiving funding for sheltered housing, the subtotal is therefore increased by factor of 1.75 to estimate a 'true' total reflecting the missing 43% of people of unknown age.

At a rough estimate, demand could increase from 8,700 to 14,000 people from 2001 to 2021, a growth of around 60% in 20 years. Given the unlikelihood of no-change scenarios and the mismatch between the year used to calculate population (2001) and placements (2006) this projection should be treated as a very general guide. Furthermore, as stated above, eventual provision is as much as policy issue as a demographic one. Similar estimates using data on Extra Care and residential care home numbers would be useful future analysis for planners.

[9] Essex Supporting People estimates provision of sheltered housing placements to have remained largely stable since 2001.

Extrapolation of population projections with people receiving local authority funding for sheltered housing, 2001 -2021

		2001		2016		2021	
Age	**Pop. (2001)**	**Places (2006)**	**Pop.**	**Places**	**Pop.**	**Places**	**Projected Increase 2001-2021**
20--24	69600	1	75000	1	71500	1	**0**
25--29	78200	4	78300	4	79200	4	**0**
30--34	96700	11	74600	8	84600	10	**-1**
35--39	101800	17	80900	14	77800	13	**-4**
40--44	92100	18	86000	17	81200	16	**-2**
45--49	85500	15	98800	17	86300	15	**0**
50--54	97600	42	99900	43	97600	42	**0**
55--59	82600	76	88800	82	98100	90	**14**
60--64	66600	167	80900	203	87500	219	**52**
65--69	60600	271	90600	405	79200	354	**83**
70--74	54800	481	74200	651	85800	753	**272**
75--79	45900	780	54200	921	66700	1133	**353**
80--84	31600	1201	40400	1535	45400	1725	**524**
85+	26400	1901	43000	3096	49700	3579	**1678**
Sub-total	990000	4985	1065600	6998	1090600	7955	**2970**
	Estimated 'true' TOTAL (x1.75)	**8724**		**12247**		**13921**	**5197**

Source: Essex County Council 2006, ONS 2001.

The table below considers how lower demand for sheltered housing could affect future numbers given possible preventative measures which successfully keep people in their own homes for longer. In this scenario, the numbers of people requiring funding for sheltered housing for each future age group is re-calculated using the prevalence rate of the younger 5-year cohort (e.g. the 2006 prevalence rate of the 80-84 group is applied to the projected 2021 85-89 population.)

Effect of lowered prevalence rate on projected numbers of people requiring Supporting People funding for sheltered housing, 2006 to 2021.

Age	2006	Projected 2021	With effect of lowered prevalence rates - 2021
20--24	1	1	--
25--29	4	4	1
30--34	11	10	4
35--39	17	13	9
40--44	18	16	14
45--49	15	15	17
50--54	42	42	17
55--59	76	90	42
60--64	167	219	81
65--69	271	354	199
70--74	481	753	384
75--79	780	1133	585
80--84	1201	1725	772
85+	1901	3579	1889
Sub-total	4985	7955	4013
Estimated 'true' TOTAL (x1.75)	**8724**	**13921**	**7013**

This has the effect of roughly halving demand in 2021 (from 13,921 to 7013). In essence, if demand for Supporting People funding for sheltered housing in 2021 by age group reflected prevalence rates of around 4 to 5 years lower than in 2001, it is possible that overall levels of provision would not have to change enormously. This would be an extraordinarily challenging target indeed, and given likely inaccuracies in the methodology used to calculate it should be largely interpreted as an indication of the considerable scale of preventative measures necessary to mitigate the impact of demographic change on housing and care services. Furthermore, it is difficult to ignore imperatives of increased capacity in sheltered housing for the minority who will need it.

It is interesting to support this with estimates of total numbers of people in care homes provided by the Department of Health. These estimates use data on people living in care homes/nursing homes from the 2001 Census and apply to the percentages to projected population figures.

Estimate of total Essex population aged 65 and over living in a care home with or without nursing, 2008 to 2025

	2008	2010	2015	2020	2025	Increase 2008-2025
Total population aged 65 and over living in a care home with or without nursing	6,699	7,007	7,958	9,041	10,649	**3950**

Source: Projecting Older People Population Information System (POPPI), DH.

An additional 3,950 people requiring accommodation in care homes by 2025 would represent an increase of around 58%, a figure which sits well with the estimated increase in demand for local authority funding for sheltered housing. This is unsurprising given that both are based on the effect of no-change prevalence rates on demographic change.

Although well-targeted preventative services may be able to reduce demand for sheltered, Extra Care, residential and nursing home accommodation, it is worth considering the likely clinical drivers behind demand. For example, when current prevalence rates for dementia[10] are applied to population projections, the result is a county-wide increase of around 8,000 people over 65 with dementia from 2001 to 2021. Given the high level of residential and nursing home care associated with advanced stages of the condition, it is difficult to escape the conclusion that a considerable growth in demand for care-intensive residential accommodation is very probable.

[10] As high as 1 in 5 for the 85+, according to Alzheimer International.

6.Summaries

This section brings together many of the salient conclusions from each section into District summaries. Planners are reminded that population ageing will occur in all areas of Essex together with a high likelihood of rising demand for all types of housing and housing related care relevant to older age groups. Patterns of health, disability, tenure, and deprivation should help identify the most appropriate future balance of services and housing provision in each District, rather being grounds for presence or absence of any such interventions.

Basildon

Key points:

- Relative overall social and income deprivation (in Essex context, all ages)
- Lower than average 80+ population
- Higher than average LLTI and LLTI and not good health
- Possible shortfall of low and intermediate needs housing (categories 'S' and 'L') in both leasehold and social sector.

Measure	Essex (Average)	Basildon
Percentage of pop. 50+	35%	Below av - 32%
50+ reporting LLTI	32%	Above av - 35%
50+ reporting LLTI & 'not good health'	13%	Above av -15%
tenure: % 50 in social or private rented housing	17%	Above av - 21%
Deprivation index	n/a	5

Basildon has lower than average 50+ population, particularly so in terms of the 'old old' + (0.4 % aged 90+ compared to 0.6% in Essex.) However, health and disability appear to be higher than the County average across all age brackets (for example 34% of 85+ report a LLTI and 'not good' health compared 30% in Essex).

In the social sector, there are relatively high level of provision of sheltered housing and Extra Care housing (category 'M' and 'N') but lower provision of low and intermediate housing (categories 'S' and 'L'). In the leasehold sector, levels of sheltered housing and Extra Care housing are somewhat low, but very low / no provision for categories 'S' and 'L'.

Braintree

Key points:

- High rate of social and private rented tenure
- Likely shortage of Extra Care housing and category 'S' and 'L' housing in social and leasehold tenures.

Measure	Essex (Average)	Braintree
Percentage of pop. 50+	35%	Below av - 33%
50+ reporting LLTI	32%	Below av - 31%
50+ reporting LLTI & 'not good health'	13%	Below Av - 12%
tenure: % 50 in social or private rented housing	17%	Above av - 22%
Deprivation index	n/a	7

Braintree has a generally close to county average picture of the size of the 50+ population 50+. There is a high rate of social and private rented tenure, particularly at later ages (28% of 65-84 and 46% of 85+ compared to 22% and 36% in Essex.) In terms of health and disability it is slightly better than the average, although it does have one of the lowest proportions of people aged 85+ reporting a LLTI and 'not good' health.

In the social sector, there is a reasonably high provision of sheltered housing but low / very low provision of Extra Care housing (category 'N') and intermediate / low needs housing (categories 'S' and 'L'). In the leasehold sector, there are relatively high levels of provision for sheltered housing but low or very low levels of Extra Care housing and intermediate / low needs housing.

Brentwood

Key points:

- Better than average patterns health and disability
- Very low deprivation
- Lower proportion of social and private rented tenures (i.e. higher proportion of home ownership)
- Likely shortage of Extra Care housing in leasehold sector

Measure	Essex (Average)	Brentwood
Percentage of pop. 50+	35%	Above av - 37%
50+ reporting LLTI	32%	Below av - 29%
50+ reporting LLTI & 'not good health'	13%	Below Av - 11%
tenure: % 50 in social or private rented housing	17%	Below av- 13%
Deprivation index	n/a	9

Although the older population of 50+ is marginally higher than the County average across all ages, health and disability rates are slightly lower. This is most pronounced at the 65-84 age group (14% report LLTI and 'not good health' compared to 17% in Essex.) Health and disability 'catch up' with the Essex average in the 85+. Brentwood ranks as one of the least deprived Districts in England (9th decile).

In the social sector, there is a reasonably high provision of sheltered housing and Extra Care housing (categories 'M' and 'N') and some provision of intermediate and/or low needs housing (categories 'S' and 'L'). In the leasehold sector, there are relatively high levels of provision for sheltered housing but very low levels of Extra Care housing and intermediate / low needs housing. *This points to a shortfall in provision given wider tenure patterns in the older population and relative lack of overall deprivation.*

Castle Point

Key points:

- Higher than average 50-64 population
- Very low social and private tenures (i.e. high homeownership)
- Low provision all round in both leasehold and social sector specialist housing

Measure	Essex (Average)	Castle Point
Percentage of pop. 50+	35%	Above av - 38%
50+ reporting LLTI	32%	Above av - 33%
50+ reporting LLTI & 'not good health'	13%	Above av - 14%
tenure: % 50 in social or private rented housing	17%	Lowest - 7%
Deprivation index	n/a	7

Castle Point shows a higher than average population over 50+ (38% compared to 35% in Essex) particularly so for the 50 to 60 group (15.8% to 13.7%.) Rates of LLTI and poor health are slightly higher than average, the difference being most pronounced in the 85+ (33% report LLTI and 'not good' health compared to 30% in Essex – 2nd highest in the County). Castle Point has the lowest proportion of social and private renters for any Essex District (7%) indicating a very high level of homeownership amongst the 50+ (93%).

There is low / very low provision for Extra Care housing and intermediate / low needs housing in both the social and leasehold sector, although there is some sheltered housing. *This points to a considerable shortfall in provision given wider tenure patterns in the older population and relative lack of overall deprivation.*

Chelmsford

Key points

- Lower than average prevalence of health and disability
- Good provision of specialist housing
- Likely shortfall in leasehold Extra Care housing and housing categories 'S' and 'L'
- Very low overall deprivation

Measure	Essex (Average)	Chelmsford
Percentage of pop. 50+	35%	Below av - 33%
50+ reporting LLTI	32%	Below av - 29%
50+ reporting LLTI & 'not good health'	13%	Below Av - 11%
tenure: % 50 in social or private rented housing	17%	Below av - 15%
Deprivation index	n/a	Joint highest - 10

Chelmsford shows slightly under average proportions of people aged 50+, with slightly lower rates of LLTI and poor health (e.g. 14% 65-84 LLTI and 'not good' health compared to 17% in Essex). These rates 'catch up' in older age groups (e.g. 29% of 85+ compared to 30% in Essex.) There are lower than average rates of social and private rented tenancy, (11% of 50-64 compared to 14% in Essex) although in the 85+ these are actually higher than average (39% compared to 36%). Provision of specialist housing appears to above average, with a high provision of leasehold tenures in the sector. Given the relative lack of overall deprivation in Chelmsford (10th decile), this is not unsurprising.

In the social sector, there are high levels of provision of sheltered housing (category 'M') and some provision of Extra Care housing (category 'N') and intermediate / low needs housing (categories 'S' and 'L'). In the leasehold sector, there are relatively high levels of provision for sheltered housing but very low levels of Extra Care housing and intermediate / low needs housing. *This points to a shortfall in provision given wider tenure patterns in the older population and relative lack of overall deprivation.*

Colchester

Key points:

- Overall average picture in terms of age, health, disability, tenure
- Average overall deprivation but worse than average income deprivation.
- Likely shortage of sheltered and Extra Care housing in leasehold tenure.

Measure	Essex (Average)	Colchester
Percentage of pop. 50+	35%	Below av - 32%
50+ reporting LLTI	32%	Average - 32%
50+ reporting LLTI & 'not good health'	13%	Average - 13%
tenure: % 50 in social or private rented housing	17%	Below av - 16%
Deprivation index	n/a	7

Colchester lies very close to the Essex average on most scores. Deprivation is very standard for Essex (7th decile) although income deprivation is relatively high (4th decile).

This may point to difficult circumstances for the majority of people 50+ who are owner-occupiers (83%) who have responsibility for the maintenance of their homes, suggesting

a need for outreach services offering a combination of maintenance, adaptations, handyman and domiciliary care services.

In the social sector, there are reasonable levels of provision of sheltered housing (category 'M') and Extra Care housing (category 'N'), but low / very levels of intermediate and low needs housing (categories 'S' and 'L'). In the leasehold sector, there are relatively low levels of provision for sheltered housing and very low levels of Extra Care Housing and intermediate / low needs housing. *This is may to point to some degree of shortfall in provision given wider tenure patterns in the older population.*

Epping Forest

Key points:

- Overall average picture in terms of age, health, disability, tenure
- Likely shortage of sheltered housing and Extra Care housing in leasehold tenure.

Measure	Essex (Average)	Epping Forest
Percentage of pop. 50+	35%	Average - 35%
50+ reporting LLTI	32%	Below av - 31%
50+ reporting LLTI & 'not good health'	13%	Average - 13%
tenure: % 50 in social or private rented housing	17%	Above av - 18%
Availability of specialist housing (Pop 65+ per placement)	15	Below av - 17
Provision of leasehold specialist housing relative to tenure of local population 65+ (factor)	3	Below av -4
Deprivation index	n/a	7

Epping Forest lies very close to the Essex average on most scores. There does appear to be a relatively high level of social and private rented tenures in later life (25% of the 65 to 84 compared to 22% in Essex, and 42% of 85+ compared to 36%). Deprivation is standard by Essex standards (7th decile).

In the social sector, there are reasonable levels of provision of sheltered housing (category 'M') and Extra Care housing (category 'N'), with some intermediate and low needs housing (categories 'S' and 'L'). In the leasehold sector, there are relatively low levels of provision for sheltered housing and very low levels of Extra Care housing and intermediate / low needs housing. *This points to a shortfall in provision given wider tenure patterns in the older population.*

Harlow

Key points:

- Below average levels of population 50+
- High levels of disability and poor health in older population
- Very high social and private rented tenures
- High deprivation (relative to Essex)

Measure	Essex (Average)	Harlow
Percentage of pop. 50+	35%	Lowest - 29%
50+ reporting LLTI	32%	Above av - 35%
50+ reporting LLTI & 'not good health'	13%	Above Average - 16%
tenure: % 50 in social or private rented housing	17%	Highest - 35%
Deprivation index	n/a	4

Harlow has the lowest proportion of the population over 50+ in the County (29% compared to 35% in Essex) with low rates carrying through into the 'old old' (80-90 represent 2.7% of pop compared to 3.8% in Essex) However, the District shows relatively high levels health and disability (16% of 50+ report LLTI and 'not good' health compared to 13% in Essex).

Harlow has very high levels of social and private rented tenancy in the older population (35% of all 50+ compared to 17% on Essex.) This remains pronounced in all age groups (45% of 65-84 compared to 22% in Essex, and 67% of 85+ compared to 36%).

Data gaps have obstructed an analysis of specialist housing, although it is likely that patterns of tenure and health will correspond to high demand for sheltered and Extra Care housing, particularly in the social sector.

Maldon

Key points

- Close to Essex average in many factors
- Likely shortage of Extra Care Housing in both social and leasehold tenures.

Measure	Essex (Average)	Maldon
Percentage of pop. 50+	35%	Above av - 36%
50+ reporting LLTI	32%	Below av - 30%
50+ reporting LLTI & 'not good health'	13%	Below Average - 12%
tenure: % 50 in social or private rented housing	17%	Below av - 14%
Deprivation index	n/a	8

Maldon does not show considerable differences to the Essex average in terms of size and characteristics of its older populations. There is a slightly larger 'young old' population (50-59s represent 15.6% of population compared to 13.7% across Essex).

Health and disability rates are slightly lower than the average but not by an enormous amount. Tenure rates show a slightly lower rate of social and private renters in the 65-84 group (19% as opposed to 22% in Essex) and therefore a higher rate of homeownership. Maldon has low rates of overall deprivation and income deprivation by both County and English standards (ranking in the 8th decile and 9th decile respectively.)

In the social sector, there are high levels of provision of sheltered housing (category 'M') and intermediate / low needs housing (category 'L'), but very low provision of Extra Care Housing (category 'N'). In the leasehold sector, there are relatively high levels of provision for sheltered housing but very low levels of Extra Care housing and intermediate / low needs housing. *This points to a shortfall in provision given wider tenure patterns in the older population and relative lack of social deprivation.*

Rochford

Key points

- Low social and private rented tenures (i.e. high homeownership)
- Very low deprivation
- Close to Essex average in other factors

Measure	Essex (Average)	Rochford
Percentage of pop. 50+	35%	Above av - 37%
50+ reporting LLTI	32%	Below av - 31%
50+ reporting LLTI & 'not good health'	13%	Below Average - 12%
tenure: % 50 in social or private rented housing	17%	Below av - 10
Deprivation index	n/a	9

Rochford does not show considerable different to the Essex average in terms of size and characteristics of its older population. The District has slightly higher than average population 50+ , (37% of the population compared to 35% in Essex) but the differences are not large. Health and disability rates are slightly lower than the average but not by an enormous amount. Tenure rates do show some variation, however, with low rates of private and social rented tenancy at all ages, particularly in the 50-64 group (7% compared to 14% in Essex) but also other ages too (14% at 64-85 compared to 22% in Essex and 29% for 85+ compared to 36%.) Rochford ranks in the least deprived decile for English Districts (10th).

Rochford has one of the most developed specialist housing markets in the County, with a high level of provision for all types both social rented and leasehold. Planners should consider how this market can be supported and allowed to grow in line with demographic and aspirational trends.

Tendring

Key points:

- High proportion of people 50+
- High proportion of poor health and disability
- Low social and private rented tenures (high level of homeownership)
- High overall deprivation

Measure	Essex (Average)	Tendring
Percentage of pop. 50+	35%	Highest - 45%
50+ reporting LLTI	32%	Highest - 39%
50+ reporting LLTI & 'not good health'	13%	Highest - 17%
tenure: % 50 in social or private rented housing	17%	Below av - 13%
Deprivation index	n/a	Lowest - 3

Tendring shows some marked trends in terms of size and characteristics of the older population. The 50+ represent 45% of the total population, the highest in Essex. Rates remain high at all ages, particularly in the 'old old' (the 80-89 constitute 6.5% of the population compared to 3.8% in Essex, the 90+ 1.2% compared to 0.6.) which is approximately double the county average.

Health and disability amongst these older populations is also high. Overall, 17% of all people 50+ report a LLTI and 'not good' health, the highest in Essex, compared to a County average of 13%. This imbalance appears to be concentrated in the 'young old' (13% in the 50-64 group compared to 9% in Essex) but not dissimilar from the average at other ages. This represents a significant challenge as to how the independence and functioning of this group can be maintained as they age over the next two decades.

Perhaps surprisingly, rates of private and social rented tenancy are low (13% of 50+ compared to 17% in Essex) indicating a high level of homeownership. Rates are particularly low in the 'old old' with only 22% of 85+ in social and private rented tenancy compared to 36% in Essex (2nd lowest in the county.)

Tendring shows the highest levels of overall deprivation for any District in Essex (3rd decile). The data points to a large body of homeowners at all levels living in relative poverty with high levels of poor health and disability. More so than in other districts, planners will need to assume a large amount of relatively impoverished older homeowners will not be able to adapt and maintain their homes themselves. Schemes to promote interventions such as adaptations, maintenance and handyman services will be necessary to keep these populations independent for as long as possible and avoid unsuitable housing conditions further exacerbating poor health and disability.

In the social sector, there are high levels of provision of intermediate and low needs housing (category 'L') and reasonable levels of sheltered housing (category 'M') and Extra Care housing (category 'N'). In the leasehold sector, there are reasonable levels of provision for sheltered and category 'S' housing but very low levels of Extra Care housing. Some degree of shortfall in Extra Care housing is therefore apparent in the social rented sector, as well as a degree of shortfall in Extra Care Housing and Sheltered housing in the leasehold sector.

Uttlesford

Key points:

- Very low prevalence of poor health and disability
- Above average levels of private and social rented tenure in 65+
- Very low deprivation
- Likely shortage of Extra Care housing in both social and leasehold tenures.

Measure	Essex (Average)	Uttlesford
Percentage of pop. 50+	35%	Average - 35%
50+ reporting LLTI	32%	Lowest - 27%
50+ reporting LLTI & 'not good health'	13%	Lowest - 10%
tenure: % 50 in social or private rented housing	17%	Above av - 19%
Deprivation index	n/a	Joint highest - 10

The District shows an average number of people aged over 50+. There is a concentration in the 50-59, with 60-89 slightly under average, although the differences are slight. Uttlesford ranks in the 10th least-deprived Districts in the UK in terms of both overall deprivation and income deprivation.

Unsurprisingly, the District shows the lowest prevalence of poor health and disability in the County at all older ages. Of those aged 50-64, 6% in the District report LLTI and 'not good' health compared to 9% as the Essex average. At 65-84, this stands at 14% compared to 17%, and at 85+, 26% compared to 30%.

Tenure rates in the 50+ show slightly above average numbers of people in social and private rented tenures (19% for all 50+ compared to 17% for the 50+ county average). In the older age groups these differences are more pronounced - 28% in the 65 to 84 group, compared the 22% in Essex, and 42% in the 85+ group, compared to 36% in Essex.

In the social sector, there are high levels of provision of sheltered housing (category 'M'), reasonable levels of provision of intermediate and low needs housing (category 'L' and 'S') but very low provision of Extra Care housing (category 'N'). In the leasehold sector, there are reasonable levels of provision for sheltered housing, but low or very low levels of provision for Extra Care housing and intermediate and low needs housing. *This points to a considerable shortfall in leasehold provision given wider tenure patterns in the older population and relative lack of social deprivation. Furthermore, the sizable 50+ population in social or private rented tenures indicates a like shortfall in the social rented sector, particularly Extra Care housing.*

7. Conclusion

The Strategic Planning Framework – Essex County Council

The study has proved useful in outlining the main trends of inequality in tenure, deprivation, age, health and disability in the Essex composite districts. The policy impact of the study has operated at two levels. Firstly, it has contributed to the ongoing re-calibration of local strategies to include housing and care issues. Furthermore, it has raised questions as to what further research would be useful.

Current expenditure in the Essex Adult Social Care was previously felt to not reflect an evidence-based approach in terms of the overall allocation to older people. The study has been useful in supporting an existing and ongoing review of Supporting People spending priorities, for example, the allocation of new supported housing placements amongst Districts.

Furthermore, the study has supported a review of the £8m Essex Supporting People budget for preventative Older People services. Currently, 80% of the budget is being spent on sheltered housing schemes. This limits access to preventative services for people in their own homes, whether owner-occupied, social rented or private rented. ECC's Social Services department also funds preventative and care services in the community such as adaptations, handyman services and domiciliary-care in the mainstream housing sector. As SP and Social Services are moving towards more evidence-based distribution of their budgets, the data is expected to inform a tenure-neutral policy on expenditure.

The Essex Local Area Agreement (LAA) followed the county model in being created to filter down into delivery targets of District-level Local Strategic Partnerships (LSPs). Because housing is a District function, the County-level LAA made very little reference to housing. The Essex Older Person's Housing Strategy has sought to use the study alongside other data to provide an evidence base to support the argument for stronger inclusion of older people's housing issues into the LAA.

The study was also felt to be useful in helping County planners decide allocations for the Housing Corporation's Supported Housing Grant amongst the composite districts of each Housing Sub-region. The data assisted in the realisation that deprived areas should receive priority, based on the health, disability and wealth inequalities identified by the study.

The study also pointed to a strategic role at the County-level in helping Districts identify Section 106 priorities. Section 106 allows local authorities to set demands for community resources as a condition of planning permission for developments, such as affordable housing or community resources. Data on the characteristics of district-level older populations is expected to be helpful in ensuring the older people's housing and community needs receive a higher priority in future.

As a result of the study, planners also identified useful areas for future work. Further research on the value of preventative spending would be the vital 'link' in translating data on tenure, health, disability and age trends into policy action as an end result.

This is particularly the case in Extra Care Housing provision, where Districts must venture to provide the housing stock, but the County must actually commission the social care and work with existing and prospective residents on their care choices. The greater the evidence-base on likely future demand, the less chance of mismatch between housing stock, demand, and allocation care and low-level preventative resources.

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- **Dignity in housing**
- **Enhancing Housing Choices for People with a Learning Disability**

Factsheet no.1:	**Extra Care Housing - What is it?**
Factsheet no.2:	**Commissioning and Funding Extra Care Housing**
Factsheet no.3:	**New Provisions for Older People with Learning Disabilities**
Factsheet no.4:	**Models of Extra Care Housing and Retirement Communities**
Factsheet no.5:	**Assistive Technology in Extra Care Housing**
Factsheet no.6:	**Design Principles for Extra Care**
Factsheet no.7:	**Private Sector Provision of Extra Care Housing**
Factsheet no.8:	**User Involvement in Extra Care Housing**
Factsheet no.9:	**Workforce Issues in Extra Care Housing**
Factsheet no.10:	**Refurbishing or remodelling sheltered housing: a checklist for developiong Extra Care**
Factsheet no.11:	**An Introduction to Extra Care Housing and Intermediate Care**
Factsheet no.12:	**An Introduction to Extra Care Housing in Rural Areas**
Factsheet no.13:	**Eco Housing: Taking Extra Care with environmentally friendly design**
Factsheet no 14:	**Supporting People with Dementia in Extra Care Housing: an introduction to the the issues**
Factsheet no 15:	**Extra Care Housing Options for Older People with Functional Mental Health Problems**
Factsheet no 16:	**Extra Care Housing Models and Older Homeless people**
Factsheet no 17:	**The Potential for Independent Care Home Providers to develop Extra Care Housing**
Factsheet no 18:	**Delivering End of Life Care in Housing with Care Setting**
Factsheet no 19:	**Charging for Care and Support in Extra Care Housing**
Case Study Report:	**Achieving Success in the Development of Extra Care Schemes for Older People**
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