APPENDIX 2

Annual Report of the Director of Public Health 2018

Healthy Housing for the Third Age: Improving Older People's Health through Housing

November 2018.

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All those who assisted in distributing the survey

Foreword

This is my third Annual Public Health report, and this year following discussion with a wide range of stakeholders across the council including colleagues in Planning, Regeneration, Communities, Adult Social Care and Housing we have chosen to concentrate on the topic of Older People's Health and Housing.

There is a wide body of evidence that shows the link between good housing and health. Thurrock has a growing and ageing population, and significant opportunity and plans for regeneration, including the building of new homes. Evidence suggests that issues related to accessibility, affordable warmth, managing gardens, maintenance requirements and running costs, and in some cases isolation from facilities, services and friends and family can make the existing homes of the population unsuitable for their needs in older age.

As a local authority, our ambitious place making agenda provides a once in a lifetime opportunity creating attractive housing and communities that meet the needs of our population as they age, and keep them as healthy and independent for as long as possible.

Thurrock is about to develop an Older People's Housing Strategy, and I hope that this report will be a useful resource in informing this vital piece of strategic planning. Finally, I would like to thank Andrea Clement, Assistant Director and Consultant in Public Health who has led production of the main report, and to the members of my team and wider council officers, who have contributed to its production
Ian Wake, Director of Public Health.

We know we have real issues with housing. We don't have enough and we must build more. It's as simple as that. The public health impact of housing is massive - physical health, emotional well-being, employment, enabled communities, social care and so on. The question for us is how we get the right mix and balance. We need to help young people get on the housing ladder, but that does not mean we build separate communities for an older population. This would only lead to a divided borough.

We need to focus on how we can help people not just live longer, but live better. This means housing that allows independence but enables support.

This Annual Report is a vital piece of work. It outlines how we can make the decisions that will allow us to build for the housing needs of the future. The old and infirm are an integrated and valued part of Thurrock, but we need to ensure we plan now for the housing they need.

I thank the Director of Public Health and the team for their typically excellent efforts.

Leading on from this will be a separate JSNA product which talks about the young side of the housing spectrum and how we enable the chance to grow via making sure they can put a roof over their own heads. From here, a cross department effort will be put in place to review the skills and training mix across the ASELA corridor to ensure we are training the workforce we need to deliver these new and innovative housing options. Ability to deliver is vital.

The public health team continues to lead from the front and is supporting innovation across local government and with partners, on social care, mental health, and now on housing.
Councillor James Halden, Cabinet Portfolio Holder for Education and Health.

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Chapter 1: Background

1.1 Rationale for the topic

One of the main goals of our Health and Wellbeing Strategy is to make sure Thurrock provides "Healthier Environments" and this encompasses ensuring that homes are developed that keep people well and independent and that strong, well connected communities are built.

There is a wide body of evidence that shows the link between good housing and health. Housing is widely accepted to be a key determinant of health and can impact positively and negatively on an individual's physical and mental health, in turn affecting the demand for and use of health and social care resources.

Thurrock has a growing and ageing population. Nationally the population is living longer, albeit not necessarily healthier, lives. Within Thurrock, the over 65yrs+ population is estimated at 23,700 (2017) and is projected to grow by 5% by 2020, and potentially by 46% by 2035. Evidence suggests that issues related to accessibility, affordable warmth, managing gardens, maintenance requirements and running costs, and in some cases isolation from facilities, services and friends and family can make the existing homes of the population unsuitable for their needs in older age.

Given the growing and ageing population in Thurrock, this report aims to answer the following questions for the population aged 65+:

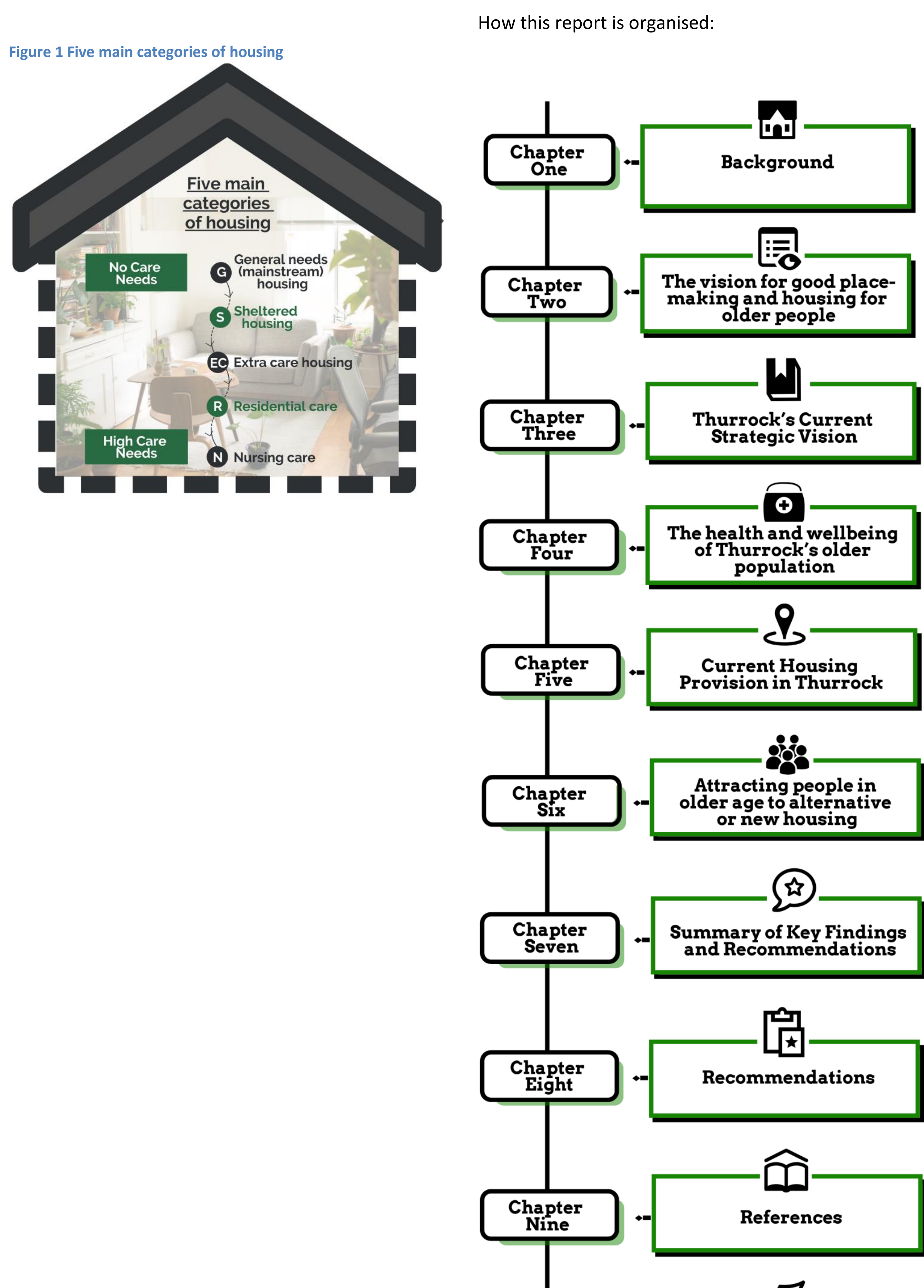
- What impact will demographic change have on the needs for new and existing housing stock across all tenures in the next 20 years?
- What types of housing do our elderly population want and what are the impacts of choosing to move to a home more suitable for later life?
- When considering a move to more suitable housing, what would make the option attractive to our elderly population?
- What impacts does housing have on health and how can we enhance the positives and mitigate against the negatives? And how can we ensure they are better understood by those affected, thereby enabling them to better care for themselves?

Whilst this report primarily considers older people aged 65 and over, it is important to note that being old is more about a state of mind related to health and remaining independent rather than an arbitrary age, and individuals will become old at different ages. Additionally, 'older people' are not a homogenous group and within this group there are younger old and older old (often referred to as 3rd and 4th age older people), and different needs and preferences as with any other group. Furthermore, there is a need for a person to consider their housing situation prior to becoming old.

Definitions vary, in terms of the types of housing, for this report only accommodation options that provide a self-contained unit of accommodation (kitchen, bathroom, toilet behind a front door which only that household can use) are included. This would cover mainstream housing options, sheltered housing schemes and specialist retirement housing schemes that provide self-contained units of accommodation alongside communal facilities (lounges, dining rooms etc.) and care packages (see figure overleaf).

How this report is organised:

Figure 1 Five main categories of housing



Questions not addressed by this Report

Residential and nursing care are not addressed by this report. Additionally, we know that in Thurrock, the ratio of earnings to house price remains consistently above average and this issue of affordability, whilst touched upon, is not addressed in detail in this report. The issue of housing affordability for all ages within our population will be addressed in a dedicated Joint Strategic Needs Assessment in early 2019.

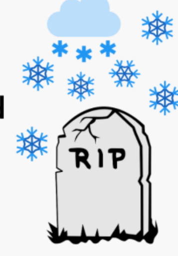
1.2 The relationship between housing and health

The design, quality and standards of homes and neighbourhoods have measurable impacts on physical and mental health. Housing was identified as an important social determinant of health and wellbeing in the Marmot Strategic Review of Health Inequalities (2010) and a number of housing related factors are now included in the Public Health Outcomes Framework. The housing and health link becomes increasingly important with age. Older people spend an average of 80% of their time at home; they are at risk of falls and more susceptible to cold or damp related health problems. Mental health is also affected by poor housing, with key factors including lack of control of home environment, financial pressures, fuel poverty and housing insecurity. (1) A 2011 report for the then Department of Communities and Local Government concluded that accessible and well-designed homes and neighbourhoods can enhance health and wellbeing. (2) Vulnerable people over 75, particularly low income older homeowners, are the group most likely to live in poor housing, with a million occupying non-decent homes. (3)

While there is now a wealth of research linking housing and health, the relationship is a complex one given that such links do not necessarily mean there is a causal connection. Nonetheless, it is clear that poor housing can be a contributory factor to exacerbating a number of health conditions just as good housing may be protective.

Figure 2 the impact on housing on health

Excess winter deaths (EWD) and cold related ill health

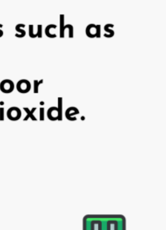


- Cold homes have a serious impact on older people's health
- The Marmot review (2011) found a strong relationship between cold temperatures and cardiovascular / respiratory diseases.
- Residents who live in cold homes have a 20% greater risk of EWD
- Cold housing can increase the level of minor illnesses, exacerbate existing conditions and negatively effect mental health
- More than 90% of EWD occur in the 60+ age group.

Indoor Air Quality

- People living in damp mouldy homes are more likely to experience health problems e.g respiratory infections.
- Exposure to house dust mites can trigger allergic reactions such as eczema; repeated exposure can lead to asthma.
- Insufficient ventilation in houses can lead to increased indoor pollutants such as radon, carbon monoxide and nitrogen dioxide.

Housing, hospital discharge and reduction of re-admissions



- Older people discharged to unsafe, cold, unsuitable homes are more likely to return to hospital
- Older peoples' health is better if they are discharged when medically ready, addressing housing shortcomings is key in effective hospital discharge.
- Delays in receiving appropriate housing or adaptions can delay discharge from hospital.
- 51% of care home residents were moved there after a hospital stay due to their home being unsuitable.

Falls

- One in three aged 65yrs+ and one in two aged 80yrs+ will suffer a fall each year with the home being the most common place for falls.
- Over 75% of deaths due to falls occur at home.
- Poor quality housing leads to increased risks of falls.
- Falls are also more frequent and serious in cold homes, likely due to restricted mobility caused by exacerbated arthritic and rheumatic symptoms.

Mental Health

- Exposure to louder noise due to poor home insulation can result in increased stress and anxiety levels, and also lead to risks of ischemic heart disease.
- Depression / feelings of isolation can develop as people feel they cannot escape their situation.
- It is estimated that 11% of aged 65yrs+ are often or always lonely and that neighbourhoods that exclude older people can exacerbate isolation and feelings of loneliness.

Economic Impact

- Each fall in the home can cost from £67 (cut/bruise) to £59,246 (quadriplegic fall) to treat.
- Up to £600 million of treatment costs could be saved nationally in the first year, if housing hazards were removed / reduced to an acceptable level.
- There is a link between poor housing and educational underachievement: this generation could lose up to £14.8 billion in lost earnings as a result of poor housing.

1.3 National Strategic context

Recent research commissioned by sky news (4) identifies that the country is facing five different types of housing crisis, playing out simultaneously across the country. They are:

Figure 3 Five different types of housing crisis

The research identifies that Thurrock is ranked 45th worse out of 390 local authorities' areas in terms of lack of supply and 261st for access to credit. Distribution, quality and demand rate comparatively better ranking 345th, 326th and 309th respectively. This report will look at data on all of these issues.

This next section summarises the national context in relation to older people's housing.

The Housing White Paper – Fixing our Broken Housing Market

In February 2017, the government published their housing white paper (5) outlining the issues and priorities for tackling the current housing situation in the UK. The paper outlines that not enough local authorities are planning for the homes they need; 40% of local authorities do not have a plan that meets the projected growth in households in their area. Additionally, house building is too slow and there is a construction industry which relies on a small number of big players (ten house building firms build around 60% of new private homes).

The white paper stresses that there is a need to have the right homes in the right places and that it is important to take into account the needs of different groups, of which older people are specified as one of these groups. There is also a need to build homes faster along with a suitable and sustainable natural environment and a need to diversify the housing market and open it up to smaller builders and those who will embrace new and innovative and efficient methods.

The white paper sets out specific recommendations of which several relate directly to older people. These are:

- make sure every part of country has an up to date, ambitious plan so that local communities decide where development should go
- give communities a stronger voice in the design of new housing to drive up the quality and character of a new development
- encourage the development of housing that meets the needs of our future population
- help the most vulnerable who need support with their housing,
- develop a sustainable and workable approach to funding supported housing in the future

The white paper states that offering older people a better choice of accommodation can help them live independently for longer and help reduce costs to social care and health systems. It pledges to explore ways to stimulate the market to deliver new homes for older people and to explore further the barriers to moving home and find sustainable solutions and to build on the evidence that already exists to help deliver outcomes that are best for older people.

The paper highlights that the government wants to support the growth of custom build homes and enable people to choose the design and layout of their home, while developers find the site, secures planning permission and build the property. It recognises that this may present a less risky model for builders as the house is effectively sold before it is built and there is more demand from these types of homes, including amongst older people. It proposes to generate a conversation about this along with improved information and advice for older people on housing choices, advice on adaptations, looking at how community living could work, and also innovative models of housing with support available.

Finally it states that the government is introducing a new statutory duty through the Neighbourhood Planning Bill on the Secretary of State to produce guidance for local planning authorities on how their local development documents should meet the housing needs of older and disabled people.

Communities and Local Government Select Committee Enquiry

The Select Committee enquiry (6), published in February 2018, undertook a review of the evidence across older people's housing and calls for a national strategy to be developed which brings together and improves policy on housing for older people. It calls for this strategy to be established in consultation with older people and encompassing the recommendations of the committee, which included but was not limited to:

- a range of measures to help older people to overcome barriers to moving should be implemented
- national planning policy framework should be amended to emphasise the importance of planning for the older population
- Councils should publish a strategy explaining how they intend to meet the housing needs of older people, and in their Local Plans identify a target proportion of new housing to be developed for older people.
- All new homes should be age proofed to meet the current and future needs of older people

The enquiry noted that older people should be able to choose from a wide choice of housing which can accommodate their needs and preferences, including across the social and private sectors,

smaller or better designed general needs housing, accessible housing, specialist housing, including retirement homes and extra care homes and cohousing.

In September 2018, the Government published a response to the enquiry (7) outlining what action had been taken to date and what was being taken forward in the future. Whilst there is no national strategy planned as yet, it outlined the following:

- A green paper will be published in the autumn setting out the proposals to reform care and support in autumn 2018 and housing will form part of the considerations
- Optional technical standards have been added into building regulations which have been developed from the lifetime's homes standard (see Chapter 2 for more detail).
- The disabled facilities grant will be reviewed (see below)
- The prime minister has launched the four grand challenges – one on Ageing Society, which aims to meet the needs of the elderly population (see below)
- A consultation occurred during July and August 2018 on the length of tenancies, which if approved may mean landlords are more amenable to making adaptations
- A "how to sell" guide is being developed to provide clear advice on the selling process and factors homeowners should take into account
- The Government is keen to encourage innovative approaches especially from local authorities and housing associations recognising there may be an equity gap which makes it difficult for older household to purchase a new home
- The Government continues to consider the range of housing available to older people including innovative models and those which support interactions across generations.

Prime Minister's Grand Challenges

In May 2018, the Prime Minister announced four "Grand Challenges" (8) as part of the Industrial Strategy which aims to ensure that the UK takes advantage of major global changes, improving people's lives and the country's productivity. One of the first four challenges announced was an "Ageing Society" and this will try and use innovation to help meet the needs of an ageing population. Housing is recognised as a key part of this Grand Challenge.

Disabled Facilities Grant Review

In 2018, a review of the Disabled Facilities Grant is planned and will be undertaken by Foundations, The Building Research Establishment, Ferret Information System and an Occupational Therapist. (9) The review seeks to ensure that the home adaptation policy is fit for purpose and funds are being allocated as effectively as possible. When the outcome of the report is released, this may have implications for older people's housing, as older people form a significant user group of this grant fund.

Care Act 2014

The Care Act 2014 (10) stated that housing is a crucial health related service which should be integrated with care and support and health services; additionally, suitability of living accommodation is a core component or an individual's wellbeing and when developing integrated services, local authorities should consider the central role of housing within integration. The Act

stipulates that Councils are required to ensure that there is sufficient capacity and capability to meet anticipated needs for all people in their area needing care and support.

The Act stipulates that Councils need to be proactive at shaping and developing the market. Through the process of producing market position statements councils are engaging with the market to promote a variety of accommodation to match the needs and choices of the local population. Local authorities should encourage a choice of service type, for example, a variety of different living options such as shared lives, extra care housing, supported living, support provided at home, and live in domiciliary care as alternatives to homes care. Local authorities should consider how they can encourage the development of accommodation options that can support choice and promote wellbeing. The needs of older and vulnerable residents should be reflected within local authority's development plans with reference to local requirements for inclusive mainstream housing and specialist accommodation and /or housing services.

A National Memorandum of Understanding

In 2018, a national memorandum of understanding (MOU) (11) was devised to bring together key organisations, decision makers and implementers from across public and voluntary sector to maximise opportunities to embed the role of housing in joined up action on improving health and better health and social care services. The MOU sets out the shared commitment to joint action, principles for joint working, context and framework for cross sector partnerships, and shared success criteria. It aims to promote housing sector contribution to addressing the wider determinants of health, health equity, improving peoples experience and outcomes, preventing ill health and safeguarding; and promoting the adaption of existing homes and the building of new accessible housing with support which is environmentally sustainable and resilient to future climate change and changing needs and aspirations.

Chapter 2: The vision for good place-making and housing for older people

2.1 Introduction

Given the known links between housing and health, it is vitally important that appropriate housing is available for older people as and when they need it, however suitable housing in isolation only goes so far in maintaining health and wellbeing. There is a need to look at housing in the context of the place agenda and wider public realm.

The public realm is defined as any space that is open to all, and includes the space between buildings, parks and open spaces. However, there is consensus that it goes beyond the physical attributes of a place, and also encompasses social and cultural factors and the sense of community. The design of a place can have a significant impact upon the physical and mental health of communities and can also bring wider economic, environmental and social and cultural benefits if successful (12). Given our ageing population, it is important to consider how this wider place-making agenda can accommodate the ageing population, and how these can be built into housing development proposals.

This chapter aims to explore the vision for both housing and good place-making in the context of older people. This has been done by appraising the national and local policies and guidance, along with evidence from the academic literature and case studies from other areas. The chapter is broken down into four key sub-sections:

a) The vision for good place-making – this sub-section aims to describe what a healthy place looks like, and what age-friendly features should be incorporated into the design of a new development.
b) The vision for new mainstream housing – this subsection aims to describe the features that all new mainstream housing in the Local Plan should incorporate to make them better suited to the older population.
c) The vision for existing stock – this subsection aims to describe the considerations for older people who live in existing mainstream housing and how they can be supported to continue doing so
d) The vision for specialist housing – this subsection aims to describe what good specialist housing looks like and how this could be developed and incorporated into the Local Plan.

Summary of Vision

- All new developments should have the principles of the Healthy New Towns Programme at the core
- All new developments should have age-friendly place-making features incorporated into their design, including transport, green space, community, employment and volunteering, safety and security and digital inclusion.
- All new housing, including mainstream housing, should be built according to HAPPI principles
- Older people wishing to continue living in existing stock should be supported to do so through the use of adaptations and telecare where appropriate
- There should be a wide range of specialised housing available, of the appropriate tenure and in sufficient quantity. New specialised housing should involve local people in the design.

2.2 The Vision for Good Place-Making

Summary

- The place in which someone lives has a marked impact upon their health and should be considered hand in hand with housing when designing new developments.
- Healthy place principles such as those developed by NHS England's Healthy New Towns Programme provide a standard against which new places should be developed to enhance the positives of a place and minimise the negatives.
- By creating healthy places now, there is the opportunity to affect the health of the current and future population of older people.
- Given that older people are more susceptible to the impacts of a place on their health, age friendly features should be incorporated into healthy places.
- Considerations relating to transport, community, safety and security, green spaces, employment and volunteering, and digital features are all relevant to an age-friendly place.
- For Thurrock, the vision is to have both the Healthy New Towns principles and age friendly features made into a mandatory element of all new developments as part of the local plan.

Good place-making is essential across the life-course; where people live has a significant effect on both physical and mental health and can either create barriers to living a healthy life or create an opportunity to prevent ill health and promote a healthy lifestyle.

There is a growing evidence base on the components of a healthy place and taking a people centred approach to understanding firstly how a place is used by its residents is key. (12) The National planning policy framework (13) was updated in 2018 and states that planning policies should aim to achieve healthy, inclusive and safe places which promote social interactions, are safe and accessible and enable and support healthy lifestyles. NHS England, recently proposed ten principles for a healthy place, emerging from its Healthy New Towns Programme (14) which looked at how health and wellbeing can be planned and designed into new places. This programme prioritised planning and designing a healthy built environment, creating innovative models of healthcare and encouraging strong and connected communities. The Healthy New Towns ten principles are detailed below.

Figure 4 Healthy New Towns Ten Principles

Healthy New Towns Programme
Ten principles

Plan ahead collectively

Involvement of local, professional and resident communities can be achieved through early engagement and collaboration between people and organisations. Creating healthier places depends on this support and involvement.

Plan integrated health services that meet local needs

Providing appropriate services requires an understanding of specific health needs and how these will change as the population changes. Physical, mental and social care needs should be met in a joined up way.

Connect, involve and empower people and communities

Involving residents in decision making and shaping developments can lead to a greater sense of connection with the place, and enabling residents to share resources, skills and knowledge to benefit their community can improve quality of life.

Create compact neighbourhoods

Well connected, mixed use places which enable walking and cycling by people of all ages and abilities can build strong, healthy communities which encourage social interaction.

Maximise active travel

Creating neighbourhoods which enable active travel will encourage physical activity and create greater likelihood of physical activity being sustained as part of the daily routine.

Inspire and enable healthy eating

Careful place-making can give residents easy access to nutritious food and limit access to less healthy foods such as takeaways.

Foster health in homes and buildings

Buildings which are comfortable, offer character and build a sense of community and pride have a positive impact on people's health.

Enable healthy play and leisure

A wide range of things to do in places designed to make it easy to join in, alongside technology to promote this, can enable people of all ages and abilities to come together and become active.

Provide health services that will help people stay well

New neighbourhoods create opportunities to strengthen primary care and other out of hospital services, building integrated teams and linking with local assets.

Create integrated health centres

Providing a range of health services on a single site can make it quicker and easier for people to get support, advice, diagnostic and treatment services in a joined up way.

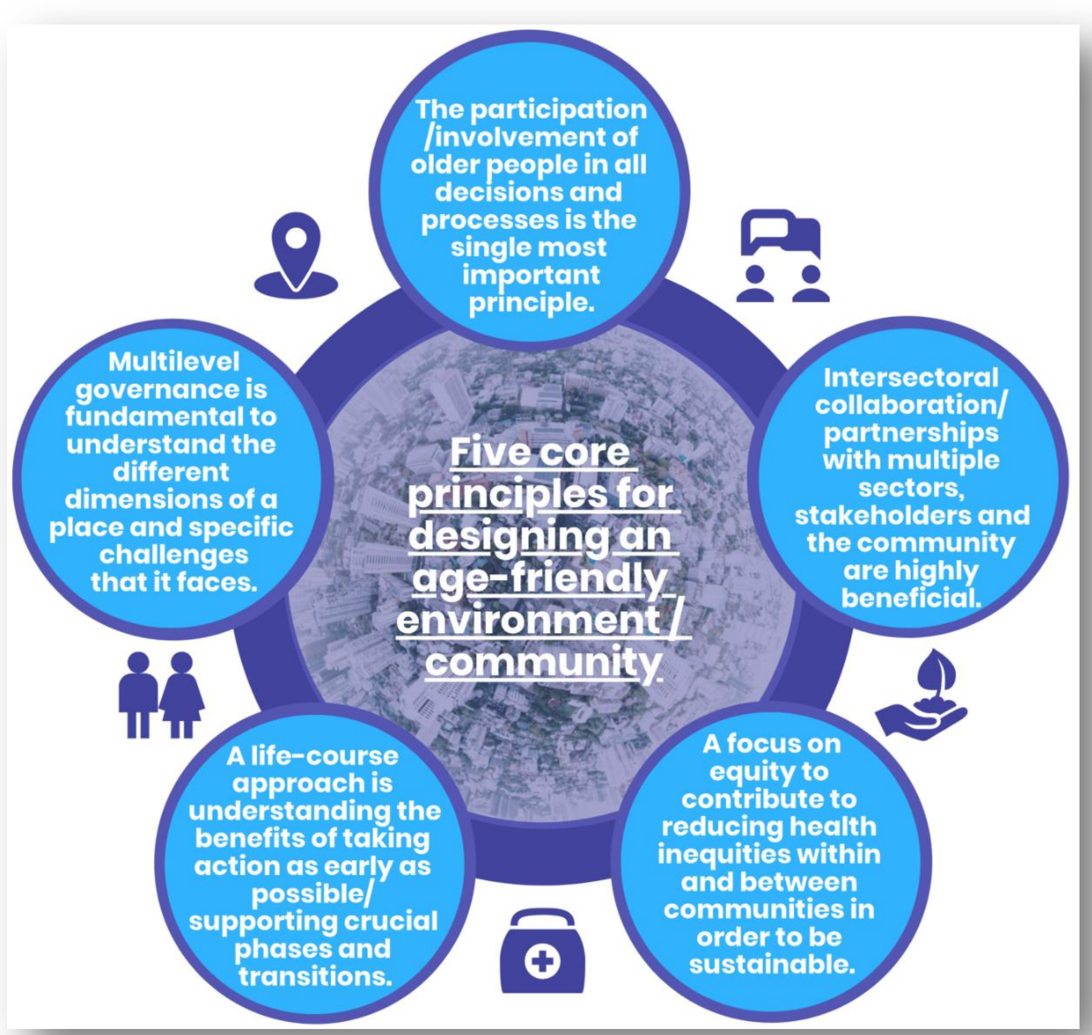
These principles are relevant to designing a healthy place for across the life course rather than focusing specifically on older people. However, they are important and relevant to older people for two reasons; firstly, because older people are still affected and influenced by their surroundings, this will impact on their health going forward into older age, and secondly, health in old age is shaped by the health of the person throughout the life-course and therefore creating healthier places which improve the health of the population as a whole is likely to result in a healthier older people's population in the future. The vision is therefore to adopt healthy place principles, such as the Healthy New Towns principles in all new developments going forwards.

Nevertheless, there has been a significant amount of work done globally and nationally specifically around older people and the wider place-making agenda, most notably by the World Health Organisation with its age friendly agenda. The age-friendly initiative aims to promote active ageing to be a life-long process shaped by several factors that, along and together, favour health, participation and security in older adult life. In a practical sense, it adapts its structures and services to be accessible and inclusive of older people with varying needs and capacities. (15) Older people are arguably more susceptible to the positive and negative impacts of a place, and therefore incorporation of age-friendly features within a healthy place is important as these can enhance the potential benefits of a healthier place by better enabling older people to be active participants in it.

It is widely acknowledged that an age-friendly community holds at its heart, the recognition of the wide range of capacities and resources amongst older people and the respect for their decisions and lifestyle choices, recognising that ageing related needs and preferences may change. (15)

The WHO identified five core principles for designing an age-friendly community (16) and suggested an approach, as outlined below.

Figure 5 WHO Five Core Principles



There is a large amount of research on what age friendly features may be considered in the wider place-making context and why, most notably by the WHO, and these are summarised below.

Figure 6 Age friendly considerations

The next part of this subsection describes what age friendly features may be considered in the wider place-making context and why.

Figure 7 age friendly features that may be considered

Community

It is widely acknowledged that being part of a community and participating in social, leisure, cultural, and spiritual activities and community events can help to address social exclusion and isolation, and improve physical and mental health. it is widely accepted that older people should be included as full partners in their community with respect to decisions which affect them and they should be consulted by public, voluntary and commercial services on ways to serve them better.

Work, Volunteering and Education

Age friendly community's should enable and provide options for older people to continue to contribute to their communities through paid employment, voluntary work, micro-enterprise, timeBank, education and/or civic/political activities. This can improve health and bring social benefits, and provide greater income. From a society perspective, this can also help sustain economic growth.

Getting around

Public transport is preferred for many older people, and the availability, affordability, and accessibility of public transport can impact on an older person's ability to move around a place, access services, and participate in community activities. It should be comfortable, safe, not overcrowded, with appropriate stopping points, appropriate frequency and good signage. Older people also walk more, however their walking speed/distance decreases. It is important that places have safe walkways, with resting places and safe pedestrian crossings.

Health Facilities

Integrated, holistic services are the most effective way of providing care and this is even more relevant in the case of older people who are more likely to have multiple comorbidities alongside social factors. Taking a joined up place based approach can help in preventing, delaying and reducing future demand for health and care services. These health services need not only to be provided in a joined up way, but it is also important that these health care services are accessible close to an older person's home and with good transport links.

Shops and Leisure Facilities

Older people's housing tends to be best located in non-remote areas that have good access to town centre amenities and facilities. Several features of age friendly buildings which should be considered are: lifts, escalators, ramps, wide doorways and passages, suitable stairs (not too high or steep) with railings, non-slip flooring, rest areas with comfortable seating, adequate signage, public toilets with disabled access.

Crime and Neighbourhood Safety

A secure environment strongly affects older people's willingness to move about in the local community which in turn affects their independence, physical health, social integration and emotional well-being. Street lighting, violence, crime, drugs and homelessness in public places are concerns expressed everywhere.

Green Space

Green space should be available to all and in the UK the Green Flag Award is a recognised standard of quality for green spaces. Green space is of social, environmental and economic value, as it can contribute toward social connectedness, and have a function in overcoming loneliness, isolation and inactivity.

Digital Environment

Of great value to older people with information readily available, it can be socially beneficial with social media helping them to stay in contact with friends/relatives and people who share an interest. Internet usage decreases with age, therefore older people may not be benefiting as much from the potential social benefits of technology. Technologies can provide access to in home health and social care i.e. telemedicine which includes alerts to remind people to take their medications and apps to track dementia patients.

2.3 The Vision for New Mainstream Housing

Summary

- Not everyone can, or would wish to live in a specialist home, therefore new mainstream housing needs to be appropriate across the life course and enable healthy ageing-in place.
- Building regulations have been updated to make homes more accessible, however some of these regulations remain optional. Additionally, they do not incorporate other important features which make would make a home appropriate across the life-course.
- HAPPI have a list of ten criteria which are best practice for older people's housing; however these are considered to be an exemplar standard for all housing and should be applied more widely.
- There is likely to be costs savings to the NHS and wider society of building homes which are appropriate across the life-course.

We know that the number of older people is increasing, and people are living longer but not necessarily in good health. As a person ages, there is often a change in health and social care needs and personal preferences which may make their current home, in its current state inappropriate and some older people choose to move into specialist housing. However, not all older people can or indeed want to live in a specialist home, so new homes built moving forward need to be better designed to enable ageing in place.

This would mean that the property would be designed to enable flexibility, reducing the need for major adaptations which require often costly buildings work and which are often difficult to install in poorly designed homes. Current national guidance has been updated recently to encourage planners and developers to consider the older population in the design and build of homes.

The 2008 national strategy: "Lifetime Homes, Lifetime Neighbourhoods", (17) stated that housing should be designed with growing older in mind and should need the needs of all age groups with homes being adaptable 'homes for life'. It proposed that all new housing was to be built to Lifetime Home standards by 2013 however these standards are no longer mandatory.

Building regulation standards (18) have since been updated to partially incorporate lifetime homes standards around accessibility however beyond ensuring there is 'reasonable provision' for people to gain access to, and use the dwelling and its facilities, which is a mandatory inclusion, other requirements are optional so there is a risk that these optional standards will not be included in the plans for a significant number of new homes.

The Housing our Ageing Population Panel (HAPPI) (19) was borne out of the 2008 national strategy and focused on improving the quality of life of older people by influencing the availability and choice of quality homes, challenging the perceptions of mainstream and specialised housing for older people, raising aspirations of older people to demand quality homes and spreading awareness of possibilities offered through innovation. The panel devised ten key standards for the design of

housing for older people which need to be considered which go further than the life time homes standards. These are outlined below.

Figure 8 Ten Key Standards for Housing for Older People

Whilst these standards are for older people, HAPPI standards are generally held up to be an exemplar for mainstream houses also.

The DWELL study (20) also found that adaptability or future proofing of homes is important. It describes how flexible design strategies fall into three broad categories:

- Construction – how easy it is to add to or change the structure of the building i.e. giving occupants the option to knock through walls
- Plan – the size, connectivity and definition of internal spaces which enables different spaces to be used in different ways
- Services – the ease of changing or replacing building services in the life span of the building e.g. heating

A partial regulatory impact assessment conducted by the Communities and Local Government suggested that building to lifetime homes standards could reduce or delay the need for people to move into residential care, reduce the demand for temporary residential care when people are discharged from hospital, free up hospital beds where people are ready to be discharged but cannot due to shortages in care arrangements or accommodation and reduce the need for home care. (21) However there is limited evidence of the cost effectiveness of building homes appropriate across the life course. A modelling exercise (22) found that building to the Lifetime Homes Standard could realise savings to the NHS and wider society compared to a home built to current building regulations[a], although these savings were small [b] however this based on assumptions which would likely become more accurate with further research. Whilst further research is needed, this demonstrates that building future proofed mainstream homes have the potential to result in cost savings to both the NHS and wider system.

Within Thurrock, data is not collected on the number of homes which meet this standard currently and it is not part of mandatory policy, although the optional new building regulations are currently being considered as part of the development of the Local Plan.

2.4 The vision for existing homes

Summary

- It is known that the majority of the older population wish to remain in their current homes, however many mainstream homes are unsuitable for changing health and social care needs.
- Energy efficiency, safety and security are key areas in which housing may not be appropriate as a person becomes older.
- There is evidence that both housing adaptations and telecare are effective and potentially cost effective in allowing older people to remain independent for longer, however more research is needed to evaluate these interventions in specific groups and to test interventions across diverse populations.

[a] This study was conducted in 2012 prior to the update to Building Regulations to partially incorporate lifetime homes accessibility standards

[b] An extra £194 of savings to the NHS over 60 years, or £700 if potential adaptations to bathrooms and bedrooms were made compared to a home built to building regulations, and an extra £1600 of savings over 60 years to wider society or £8,600 if potential adaptations to bathrooms and bedrooms were made.

We know that the majority of people wish to live in their current homes as they age, and given what we know about changing health and social care needs, then it is likely that people will need support and their homes may need adapting in order for this wish to be realised.

The Local Government Association (2016) calls for a sufficiently funded system(s) to enable older people to modify their homes to support prevention and positive ageing in a way that generates savings to health care services. Alongside modifying homes, integrating housing, health and care can support older people to live independently in their own home for longer. There are three key issues to be considered when adapting homes, which are: (23)

- Energy efficiency
- Safety
- Security

Each of these three issues will be dealt with separately below.

2.4.1 Energy Efficiency

Many older homes are not energy efficient and this can have a significant impact on the health of the people who live there through inadequate temperature control and high costs of heating which reduces the finances available for other things. This is known as fuel poverty and older people are particularly susceptible to this – further information is included in chapter 4.

We know that older people are much more likely to be affected by a cold home. There is therefore a need to ensure that homes are modified, or arrangements are made, to enable older people to be able to adequately heat their homes. National government provides a winter fuel payment to eligible people to assist with paying increased energy bills. However, there are several changes which can also be made to the home itself to increase the energy efficiency. These include: new boilers and insulations, draught proofing, loft / under floor insulation, better/improved heating systems and double glazing. Many older people could also potentially use their current systems more efficiently including better informed use of heating systems, timers, thermostat controls, cladding hot water tanks, insulation of windows and use of draft excluders. (24)

There is evidence to suggest that warmth and energy efficiency can lead to improvements in general health, respiratory health and mental health, particularly in those with existing chronic respiratory disease. (25) This is particularly relevant to older people who we know are more likely to have chronic respiratory disease and other comorbidities, and struggle to keep their homes warm for either financial or maintenance reasons.

However, there is also evidence to show that older people can be unaware of energy efficiency programmes and schemes they could benefit from, also there is uncertainty about using such initiatives if there is a risk of short term cost implications (24) The Department of Energy and Climate Change suggested that factors such as advice and information from a trusted source and financial incentives could trigger behaviour change. For Thurrock this means there is a need to consider how to improve knowledge of benefits available and existing support services.

One of the HAPPI standards described in the previous sections is that homes are energy efficient and well insulated but also well ventilated and able to avoid overheating, however many existing homes are not.

2.4.2 Safety

Older people are at increased risk of unintentional injury in the home due to falls, trips and slips for example. There are several ways in which safety can be improved in existing housing stock, for example through housing adaptations and telecare solutions. As the risk of having an accident decreases, the ability and confidence of a person is likely to increase which may enable them to have greater independence and which in turn can lead to improvements in quality of life.

There is strong evidence that minor home adaptations are effective and cost effective for preventing falls and injuries, improving performance of everyday activities and improving mental health. There is also strong evidence that minor adaptations are particularly effective at improving outcomes and reducing risk when they are combined with other necessary repairs and home improvements, such as improving lighting and removing trip and fall hazards. (26)

The evidence for major adaptations is more limited; but what is available suggests that greatest outcomes are achieved when individuals, families and carers are closely involved in decision making process, focusing on individual goals and what a person wants to achieve in the home. There is also evidence that delays in installing adaptations can reduce their effectiveness. (26)

Evidence of cost effectiveness is limited however. Most available evidence is from other countries and there is insufficient evidence to provide an appropriate estimate of the benefits associated with different adaptations in the UK, and for older people specifically. One aspect that has been measured is return on investment of home interventions in preventing falls on stairs. Preventive work to mitigate worse than average hazards associated with falls on stairs among households with an adult aged 65 and over would correspond to a positive Return on investment of 62p for every £1 and a payback period of less than 8 months. This particular study concluded that adapting homes could offset the need for residential care for many older people and reported that the average disabled facilities grant (used to adapt home) is £7000 compared to average residential care cost per person of £29,000 per year.

Another group of adaptations is assistive technology or alternatively named ‘telecare’. This can also include “smart homes” which are defined as: “purpose built living spaces that provide interactive technologies and unobtrusive support systems tenable people to enjoy a high level of independence, activity, participation or wellbeing than could otherwise be afforded”. (27)

Assistive technology has been shown to help maintain functional status (27) and promote independence. (28) Additionally, appropriately selected assistive technologies can lead to potential savings in formal care services. (28)

Possible safety issues with telecare have been identified (27) and include systems failing during emergencies, possible errors in medication dosages which would not be recorded, functioning during power outages and the impact of fitting these systems on fittings such as carpets which then may themselves present a trip hazard.

Evidence suggests that telecare is generally acceptable to older people however older people can have concerns about the technology such as cost, usability, information security and privacy and technology being used in place of face to face contact; and also concerns about information in terms of privacy and what information should be collected and transferred and who should make decisions about this. Many older people feel that this should be up to the older person themselves, not a carer or family member. (29) Additional barriers to adoption identified in the evidence are perception of need, stigma and fear of dependence and lack of training. (30)

An economic modelling study (31) found that adaptive technologies could lead to reductions in the demand for other health and social care services worth on average, using a 'central model', £579 per recipient per annum. The services also lead to an improvement in the quality of life of recipients worth £1522 per annum.

In summary, there is a large body of evidence for both housing adaptions and telecare however high quality, conclusive evidence of effectiveness and cost effectiveness which is generalizable to the UK is lacking. Available evidence however points to the value of providing these schemes albeit with further study of effectiveness in specific groups required and field testing of packages and devices in diverse populations. (32) Housing adaptations and telecare may also result in benefits to the family and informal carers of older people by decreasing reliance on others for some tasks, however it is important that the older person needs to be feel in control of these adaptations, rather than it being something which is 'done to them'. (32)

Aside from adaptations and telecare which assist an older person with activities of daily living, many older people find that maintaining their current home becomes difficult as they grow older. There are handyperson services available which can assist older people with small jobs such as:

- small repairs (putting up curtain rails, shelves and pictures)
- safety measures - fitting smoke alarms, carbon monoxide detectors and grab rails
- home security - door and window locks, door chains and door viewers
- energy efficiency checks - installing draught excluders, radiator heat reflectors and energy efficient lightbulbs. It is usually a charged for service. (33)

These have been reported to be cost effective. One source found that for every £1 spent on the handy person service the savings to health and care is £4.28 (based on savings that result solely from falls risk reduction and not including many of the other impacts and wider fiscal and social benefits e.g. improved wellbeing, reduced anxiety). (34)

In one local handyperson service, there was a 36% reduction in falls risk, and improved wellbeing was a key outcome for 90% of older handy person service users. (34) The effectiveness and cost effectiveness of such schemes require further assessment however to determine the extent to which these assist all groups within the older persons population.

Within Thurrock, the Well Homes project aims to support residents in the private sector to live healthily in their homes by addressing home hazards and promoting health, wellbeing and

independence, and has shown positive outcomes. An expansion of this service is planned moving forwards (see chapter 6).

There are other interventions which are not considered in this report as they do not alter the quality of the home or place, which may directly influence an older person's safety in the home – such as house sharing schemes in which an older person shares a house with a younger person who provides some basic care and companionship in return for a low rent. However, these remain highly relevant and there would be value in reviewing the evidence of effectiveness of other schemes that support older people living at home, how acceptable they are to the older population and how they may be provided in this context.

2.4.3 Security

Older people can tend to fear crime more than other groups and this can limit their social activities, social interaction and reduce outdoor physical activity. Crime is often cited as a concern by older people (see chapter 6) and fear of crime can also include concerns about online and telephone scams and cold-callers. This may impact upon the confidence of an older person to live independently.

Home security improvements, either as standalone interventions or as a part of a combined security and non-security intervention package, may have positive impact on fear of crime. However, evidence for housing improvement interventions in the UK are mixed; and the evidence shows that installation of CCTV does not impact upon fear of crime. (35)

2.5 The vision for specialist housing

Summary

- Around 25% of the older people population nationally would consider moving, and many of these would consider moving into a specialist home.
- The key barrier to moving into a specialist home is the lack of appropriate homes.
- Nationally, there is a lack of vision and planning in some local authorities with regards to specialist housing; the local plan provides an opportunity to indicate what is required and to work with developers on a variety of specialist housing options.
- Specialist housing should be co-produced/co-designed with local people to ensure it is designed with their needs in mind.
- Evidence of best practice for specialist housing is limited, and focuses on housing with care. The evidence suggests that housing with care schemes can promote health improvement and quality of life as well as social interaction for many residents.
- Predicting the demand for specialist homes is subject to great uncertainty and estimates range from an increase by between 35 and 70% nationally.
- Encouraging older people to downsize may have the impact of freeing up larger families homes which may contribute towards alleviating overcrowding, however this issue is highly complex.
- Older people may not free up finances by downsizing and there needs to be emphasis on other 'pull' factors to make specialist housing more attractive.

There is a proportion of the older population who do wish to move home in older age, and many of this group would consider moving into a specialist home. However, a key barrier to moving is the perceived lack of appropriate housing available to move into. (36) The vision for Thurrock is to take

the opportunity presented through the local plan, to invest in building the mix of new specialist homes that older people want and need.

Following the Neighbourhood Planning Act 2017, (37) the national planning policy framework was updated at the beginning of 2018 to specifically reference older people, and now calls for the size, type, and tenure of housing needed for different groups in the community, including older people, to be accessed and reflected in planning policies. However, nationally, it is felt that there is a lack of interest and vision concerning older people's housing in local strategies (and not only in planning strategies, also for older people, housing, health and social care) and local authorities need to have much clearer policies and strategies in relation to hosing and older people. Despite the increasing demand for specialist housing and the substantial assets of some older people, there is potentially a gap in the market. (38)

Specialist housing for older people can come in many forms and the terms used to describe types of specialist housing can be used differently and interchangeably which can make discussions on this topic confusing and unwieldy. Specialist housing is designed with older people in mind (such as walk in showers, all on one level, appropriate size) and can range from the older person living independently, through to separate dwellings with communal facilities and some level of support, through to extra-care housing in which older people live in their own dwelling but with 24 hours support available.

A market assessment of older people's housing in England (39) – of both specialist retirement developments and mainstream housing suitable for people aged 55 and above was conducted in 2012, looking to address three key questions of quality of life, market impacts and choice, availability and affordability. It looked to understand both the current situation and projections forward to 2033 for older person only households.

The assessment found that there was very limited choice for older person households moving home to accommodate their support needs (in terms of tenure, location, size, affordability and type of care/support). There was a limited range of models of specialist housing although there have been increases in retirement villages and housing with care schemes. Additionally, when compared with existing housing tenure for older people where typically 70% is owner occupied, there is much less, specialist housing available for purchase (30%). It was also found that there has been little progress in integrating a housing offer for older people in mainstream developments and that wider choice and availability of mainstream housing may reduce the need for more specialist housing.

It is important that the choice to move or not remains with the older person and those who prefer to remain in mainstream housing are supported to do so. The market assessment identified three types of movers amongst older people households:

- 'lifestyle movers (typically younger old) move to the coast or countryside, abroad for example, seeking better quality of life
- 'planners' (typically middle age range) move before they need to and while they still have the energy, influential factors include onset of health problems and realisation that existing housing will become less suitable, but it is important that they remain in control.

- 'crisis movers' (often the older age) typically hang onto their existing housing as long as possible until they have to move due to accident or ill health. This group are less likely to have any choice and more likely to end up in a care home even if that is not their preference and other housing would have met their needs better.

Clearly, the latter 'crisis mover' is the least desirable option. There has been extensive research and consultation with older people on both the reasons for moving house in later life, and the barriers and this is covered in Chapter 4 of this report.

As the older adult market is very diverse, so should be the models of housing available to them. However, there is more variety in the types of housing for older people internationally than in the UK, which has mostly focused on residential care homes and traditional sheltered housing until recently. Some options available for older people internationally include:

Cohousing: *Cohousing communities are created and run by their residents. Each household has a self-contained, private home but residents come together to manage their community and share activities. Cohousing is a way of combating the alienation and isolation many experience today, recreating the 'neighbourly support of the past'. This can happen anywhere, in an existing street or starting a new community using empty homes or building new.*

Garden Suites: *A specialist version of a "tiny house", designed with features specifically for older persons. A garden suite is a self-contained living area usually located on the grounds of a single-family home. Suites can be detached or attached to the other dwelling. Garden suites are also known as 'granny pods' or can be understood in the UK as a 'granny annex'.*

Intergenerational Housing: *Developments that house older people as well as younger people and families to create a dynamic community. Some schemes have 'buddy programs' which match older residents to younger ones for mutually beneficial social relationships as well as practical help for the older person.*

While places like the USA, Australia, and mainland Europe have embraced more innovative solutions for older adult housing, the UK has made a shift towards new types of schemes. The recent trend in specialist housing in the UK has been towards models that promote and extend independence, which include models such as Sheltered/Retirement Housing and Extra-Care. There are no official definitions for these models of housing which makes it difficult to evaluate and compare schemes, as the service provision is not necessarily consistent across the market. However, for the purpose of this report, we will be using the following definitions:

Sheltered/ Retirement Housing/Villages: *Housing developments in which residents have their own flat or bungalow in a block, or on a small estate, where all the other residents are older people (usually over 55). With a few exceptions, all developments (or 'schemes') provide independent, self-contained homes with their own front doors. Properties in most schemes are designed to make life a little easier for older people - with features like raised electric sockets, lowered worktops, walk-in showers, and so on. Some will usually be designed to accommodate wheelchair users. And they are usually linked to an emergency alarm service (sometimes called 'community alarm service') to call help if needed. Many schemes also have their own 'manager' or 'warden', either living on-site or nearby, whose job is to manage the scheme and help arrange any services residents need. Managed*

schemes will also usually have some shared or communal facilities such as a lounge for residents to meet, a laundry, a guest flat and a garden.

Extra-Care: *Schemes with self-contained specialist housing units (whether rented, private purchase leasehold, or shared ownership), a care team on site providing 24-hour care, seven days a week, and access to communal facilities, such as a restaurant or activities room.*

These models differ only subtly and are often referred to with the blanket term 'housing with care'. A literature review of specialist housing was undertaken as part of developing this report and the full review is available in Appendix 1. Unfortunately, at present, evidence for the effectiveness of specific schemes at improving particular elements of health and wellbeing of residents is scarce. The formal evaluations that have taken place are all of extra-care and retirement schemes. However, as stated above, there are no official definitions and as such these terms do not describe a standard service. The common definitions do not specify the level of care provided or the degree of dependency of residents, and these can vary widely between schemes. This has implications for costs and charges and makes direct comparisons between extra care housing schemes, and between extra care housing schemes and care homes or home care, difficult. One scheme, therefore, cannot be said to be typical or representative of extra care housing in general.

The evidence that is available suggests that housing with care schemes can promote health improvement and quality of life as well as social interaction for many residents.

Most schemes include some form of communal facilities and social activities for residents as improved social interaction is a key part of the extra-care ethos. The available evidence shows that targeting social isolation amongst residents does have positive effects, though there is less evidence of the impact on loneliness. (40) (41) (42) (43) (44) The one study that looked directly at loneliness did see a small but significant difference in favour of retirement communities (for those in good health). (44)

A number of studies found that marginalized groups within schemes, including men and those with higher needs like dementia do not necessarily experience the social benefits of extra-care, as schemes (as well as other residents) can be alienating. (40) (41) (45) The evidence is in favour of the positive effects of the social aspects of housing with care but more research is needed to draw conclusions about its effect on loneliness amongst a generalizable group.

Overall, the evidence suggests that residents of housing with care enjoy a good quality of life (46) (40) (44) (47) and, where measured, it is higher than a comparable group of community dwelling adults. (44) (46) However, objective measures of QOL are not commonly used and conclusions surrounding QOL are often inferred from general positive comments.

Residents of housing with care are generally frailer than the population of older adults living in general needs housing in the community so any improvement in health should be understood in this context. For example, some residents experience an initial improvement followed by a decline and this may be due to the nature of the health status of many residents. However, the overall picture from the evidence is that housing with care can contribute positively to the health of residents. There is a lower mortality rate in extra care than care homes (48) and a lower likelihood of entering institutional care than those receiving domiciliary care in the community. (49) At the very least,

there is evidence that extra care can help residents maintain their health status where it would have declined in a community context.

When it comes to the use of health services, the evidence, again, needs to be viewed in the context of the frailer condition of those in housing with care when compared to community dwellers. There were actually more instances of inpatient care needed by those in extra care than a matched sample in the community but the average length of a hospital stay was less than half of the comparison group. (50) Extra-care contributed to this by ensuring that residents had an appropriate environment and support at home to allow for timely discharge. There is also evidence that less intense use of nurse and GP services contributed to a 50% reduction in health care costs for extra care residents. (46)

The evidence for the cost effectiveness of extra-care is somewhat mixed. Though many studies have shown long-term savings for extra-care over other institutional options, there is also evidence for higher costs. (46) (51) (52) (53) (54) This is likely due to the variability of service provision and size between schemes. The only study that attempted to account for this variability concluded that the probability that extra care is more cost effective than residential care homes is 76%. (51) It should also be noted that where there are higher costs associated with a move to extra care, they are accompanied by improved care outcomes and quality of life.

The general picture of housing with care based on the evidence from this review is a positive one. It does appear that this model offers some key features that contribute to positive outcomes for residents. Autonomy and control over living environment were the most mentioned elements contributing to nearly all outcomes followed by opportunities for social interaction, support and age appropriate design. These features should be considered highly important when planning housing for older adults. However there are still gaps in the evidence regarding the appropriateness of housing with care for everybody, particularly those with higher care needs; as this review did not include evidence surrounding dementia specific schemes, this question is in relation to non-condition-specific schemes. There is also a lack of evidence around housing-with-care models as homes for life and how well the support on offer can cope with people in extreme old age. More research is also needed around other types of schemes besides extra-care and retirement housing if the UK is to offer a wide variety of options to a diverse market of older adults.

2.5.1 Case Studies

Though nearly all of the little available evidence focuses on extra-care, there are other models of older adult housing that may be worth consideration. Below are three case studies each outlining a different type of scheme, some unique features and key elements or ideas to apply to future schemes. Included as a fourth case study is an outline of the two developments in Thurrock

Case Study #1: Older Women's Cohousing (OWCH) group

OWCH Source: Housing LIN

Cohousing is a new concept in UK housing, though it has a long tradition in northern Europe and the USA. The cohousing model originated in Denmark in the 1960s. It aspires to encourage independent living within a social environment through shared goods, services, meals and chores. Residents self-manage the scheme and agree to a set of shared values which are intended to ease social cohesion.

The UK's first cohousing scheme was recently completed, after 18 years of planning and development, in High Barnet. New Ground opened in late 2016 consisting of 25 purpose built homes for 26 women aged between 51 and 88 as well as communal spaces and facilities. New Ground is a self-managed intentional community in which the residents were active in the design process from the very beginning to ensure that the result fit the needs and wants of its intended community.

The OWCH group was not just a consultation of future residents, members set up regular social activities in the years before the site opened to build a strong social structure which resulted in an active community where the women know and can rely on their neighbours for help and support. There are outings and activities that residents arrange as well as a weekly communal meal. The women were motivated by the avoidance of loneliness as they got older as well as retaining autonomy and agency over their lives.

A cohousing model like this one requires forethought and the acknowledgement of the realities of aging as well as a desire to live in a community of other older people. Support for senior cohousing projects is encouraged by the authors and contributors of the HAPPI reports.

Key principles:

1. Consult with end users when designing housing for older adults
2. Communal facilities
3. Social architecture- facilitate meaningful relationships through activities, etc.
4. Mixed ages
5. Allow for an element of self-management to allow residents to engage and retain agency

Case Study #2: Halton Court, Greenwich

Halton Court Source: Housing LIN

Halton Court is a 170-unit scheme for over 55s, part of Kidbrooke Village, the regeneration of the now demolished Ferrier Estate in Greenwich, London. Halton Court provides part of the affordable housing contribution under the Section 106 Agreement for Kidbrooke Village. At design stage the scheme Halton Court won the HAPPI category of the 2010 Housing Design Awards. It is distinguished by: award winning quality design; very generous private and communal spaces; the scale and range of facilities; a dense urban setting; located on a prominent site of a major regeneration scheme; prioritised for older people seeking to downsize. Lettings in the first two months of opening were at double the rate anticipated.

The scheme challenges the orthodoxy of large extra care housing schemes in that, although this is a large scheme with generous facilities, it is firmly a housing-led scheme rather than driven by social care. There are no requirements for residents to have any care needs to live here, and currently any care needs are met through domiciliary care services. Lettings are made through the choice-based lettings system of Greenwich's housing department rather than social care referrals from social services. However, the scale of this development will allow both on-site care and operation of the scheme to be developed on a more flexible basis than traditional extra care housing.

Sixty percent of the self-contained apartments are 2-bedroom, in response to this being the most common size desired by older 'downsizers'. There are a large number of communal facilities, which serve both residents and the public including a restaurant, hairdressers, spa and a Village Hall that all ensure the scheme is at the heart of the community. There are also guest suites for visitors to stay in, allowing connections with family and friends to remain active.

Key Principles:

1. Future-proof care ready design can attract older people wishing to move to a smaller home regardless of care needs
2. Incorporate HAPPI design principles
3. Ensure the scheme is in a dynamic location at the heart of the community
4. Priority for the rented homes is given to council or housing association tenants who are living in family-sized housing and want to downsize.

Case Study #3: Buccleuch House, Hackney

Buccleuch House; Source: Housing LIN

Buccleuch House, a purpose-built 41-apartment scheme for older Hackney residents which is integrated within a larger mixed apartment block. The Hanover flats for older people are targeted at tenants for affordable rent, and although not an extra care housing scheme, also provide communal facilities at ground level. The scheme won the HAPPI award at the 2013 Housing Design Awards in addition to a Project Award.

The final design provides a total of 107 new homes. Of this total, 41 are designed for older people for affordable rent and with associated communal facilities, 28 are affordable rent and shared ownership apartments and 38 are private sale. The new homes vary from 1 bedroom flats to 4 bedroom homes. All homes meet or exceed London Housing Design Guide standards, including Lifetime Homes and give residents the choice to be alone or socialize with others.

Design follows the HAPPI recommendations from overarching principles through to detailed design. For those who want to remain fully independent and arrange care at home as and when they need it, this often means new types of easy to manage, spacious, accessible, two bedroom houses, or flats with lift access. For those who prefer to live in a managed, group setting or have higher care needs, it means extra care housing and residential care facilities that welcome those with dementia. And for the growing 'middle ground' - those who value their independence but would like to know they can always find company when they seek it - it means new forms of 'care ready' retirement homes. It also means more local shops, community and health facilities and better public transport.

Designed for local people, it reflects and accommodates Hackney's diverse population in a dignified, practical and equitable way. As a contemporary, high density, mixed residential building on the edge of a common in one of London's poorest and most densely populated boroughs, the new Buccleuch House exemplifies these principles.

Key Principles:

1. Make strategic use of smaller development opportunities
2. Flexible, open flat layouts
3. It can be appropriate for housing for older people to be physically and socially integrated with other types of housing.

Case Study #4: Bruyns Court and Calcutta Road, Thurrock

Bruyn's Court Source: Housing LIN

Bruyns Court

Thurrock Council invested in a major new development of 25 flats at Derry Avenue in South Ockendon designed specifically for older people. Bruyns Court has been designed in accordance with the HAPPI report housing design recommendations. The location is ideal as it is close to shops and other local amenities such as the South Ockendon Centre (the community hub). 18 of the flats have two bedrooms so that people with live in carers can accommodate them, and this also makes them suitable for couples who for health reasons, need to sleep in separate rooms. The flats are very energy efficient and well insulated so easy to heat in the winter. Each flat has its own balcony or patio and the windows have been designed to ensure ample natural light. For people who spend a lot of time at home, access to an outside space and having plenty of natural light, is a great bonus. There is plenty of storage for mobility scooters, and the bathrooms were designed so that they can easily be turned into wet rooms, should the need arise. People living at the scheme will have access to a secure shared garden and there is a garden room which residents can use for social gatherings and meetings, as well as a variety of spaces in the scheme where neighbours can socialise.

Calcutta Road

This housing scheme in Tilbury, also being developed by the Council, is the 2nd to be designed to follow the recommendations of the HAPPI report. The scheme comprises 31 one-bedroom flats and 4 two-bedroom duplexes, with communal facilities. All homes are dual aspect, wheelchair adaptable, and with a private outdoor balcony or patio. The scheme will feature three main landscaped external spaces: a small public space fronting onto Calcutta Road, a secure shared podium-level garden and an allotment garden to the north of the scheme. Completion is expected in late 2019.

Key Principles:

1. Incorporate HAPPI design principles
2. Ensure the scheme is in a dynamic location at the heart of the community
3. Ensure there are communal areas and outside space

2.5.2 Projecting the demand for specialist housing

Projecting the demand for specialist housing is subject to great uncertainty. There are significant unknowns in terms of projected changes in the future such as how length of stay in specialist housing will change, how the health and housing needs of older people will change, and how these needs could be met through alternatives such as assistive technology. Additionally, we anticipate that the older population today will be different to older people in future due to factors such as retirement ages changes, medical advances, and different social and political attitudes which all may affect housing needs and preferences. Additionally society is more mobile now and more likely to travel and less likely to stay in or around the place of birth or close to family members. Crude analysis has shown that the size of specialist housing stock nationally will need to increase by anything between 35-70%. (39)

The Strategic Housing Market Assessment for South Essex (May 2016) (55) show the prevalence rates for different types of specialist housing persons aged 75 and over in South Essex as:

- Demand for 125 sheltered housing units per 1000 additional 75+ population
- Demand for 20 enhanced sheltered housing units per 1000 additional 75+ population
- Demand for 25 extra care units with 24/7 support per 1000 additional 75+ population

These figures may not sufficiently take into account the anticipated significant regeneration that is set to occur within Thurrock and how this may affect the older population; however what these prevalence rates may mean for Thurrock in the future is discussed in Chapter Four.

Encouraging older people, who may be under-occupying larger family homes, to downsize is often viewed as a way in which to contribute towards addressing the overcrowding[c] issues currently facing the UK. This is because if there was an adequate supply of suitably located, well designed, supported housing for older people, this could result in an increased release onto the market of under occupied family homes. (38)

Of the 8 million households nationally that under occupy, just over half (4.2 million) are older person households which leaves 3.8 million under occupiers amongst other households (39) so it is important to recognise that many households under-occupy, not just older people. However many older people recognise the pressure to downsize and there is some evidence that the framing of the downsizing debate is upsetting, annoying and distressing and reflects a lack of concern or understanding of wellbeing and quality of life issues from an older person's perspective. (39)

Reducing overcrowding by tackling under-occupancy, however, is a complex issue. As houses are typically released after the death of the occupant, downsizing will only free up additional larger homes if older people move as they approach older age. Additionally, there is an issue of whether younger families have sufficient wealth to be able to purchase or rent a larger home and many may find it easier to build up equity through purchasing a smaller home.

[c] Overcrowding was originally defined in the Housing Act 1985 as wherever two or more persons, aged ten and over of opposite sexes and not living together as husband and wife have to sleep in the same room. However this is recognised by the Government as not being a 'generous' standard as it enables kitchens and livings rooms, in theory to be classed as a bedroom, and there is no limit on the number of people of the same sex who could sleep in the same room.

Older people are often encouraged to downsize as a means to free up finances, however it is likely that only those living in the largest homes or most expensive areas are likely to be able to gain financially from downsizing, given that most older people who move do not actually want to reduce the overall size of their living area by a significant proportion (20) and the difference in market value between, say a 3 and 4 bedroom property is fairly small. This means that there needs to be other 'pull' factors which encourage older people to move.

There are differences between the proportions of under-occupiers by tenure with 68% of older owner-occupiers under-occupying compared to 19% of social renters. (56) Despite this, only 23% of specialist housing (56) is available to buy which indicates again that the market for specialist housing does not reflect the tenure choice that older people may actually want.

2.5.3 Funding for Specialist Housing

The Government recently consulted on the sustainability and funding of sheltered and extra care housing, and short term supported housing. (57) This included a proposal for 'sheltered rent' (keeping 100% of funding for housing costs within the welfare system and with a cap) and a ring fenced, local authority administered grant for short term provision.

In terms of sheltered and extra-care housing there were concerns about what fell within the definition of sheltered and extra care scheme and whether providers would be able to recover the full costs of providing these schemes. Respondents were concerned about whether the proposed 'sheltered rent' would be set at the right level and may risk future supply, whereas a regulation of gross rent would be complex to deliver. The government has subsequently decided not to pursue the proposed regulatory approach and committed to continuing the dialogue with providers.

In terms of short term supported housing, there was no consensus on either the correct definition or the right funding model. Concerns were expressed about moving from a demand led funding model to a commissioning model for housing cost and the change in risk profile that developers needed to take into account would increase borrowing costs and reduce supply. As a result of this the government concluded that they would continue to provide funding via the welfare system rather than proceeding with the grant model for short term accommodation.

2.5.4 Challenges associated with specialist housing

There is currently a very short supply of specialist housing nationally and it is thought that general house builders are reluctant to get into the specialist housing market for several reasons including a difficulty selling properties in the previous housing market downturn, the fact that retirement developments take longer from inception to completion than mainstream housing and sales tend to be slower so finance is tied up for longer. Many house builders do not have experience in this market and volume house builders have not specifically researched the older persons market as a cohort and they do not want to segment their offer towards older people, although this may be changing slightly over time and some developers are becoming interested in developing new products such as products focusing on the age 55/60 cohort. Additionally it can be harder to find suitable sites on which to build these developments and there can be sometimes complex planning issues (56) with disputes (for example) around what constitutes housing and what constitutes a care home with discrepancy in these between local authorities.

It is also believed that older people less likely to buy off plan as they want to see the building in the flesh. Therefore more attracted to those building which will be completed in relatively short timescales rather than those which take years.

The Local Government Association (2017)

Reviewed several case studies and identified that the following key themes to consider when planning housing for older people.

- Have a clear vision which promotes awareness and changing attitudes
- Co-production with older people is very important and many council involve people in the specification, design, delivery and review of housing offers aimed at older people.
- Sustaining older people in mainstream housing – commissioning and providing home improvement agency type services across council boundaries offers scope for economies of scale that can support and foster innovation in improving existing accommodation, commissioning these over extended contract periods allows these types of services to be more financially sustainable.
- Commissioning independent and /or charitable organisations to provide service to older people to maintain their existing homes, means they can broker and attract other sources of funding that are not necessarily available to councils which enable them to add value.
- Plan for an ageing population using a mix of demographic data, planning tools alongside localised contextual information and what older people say is important.
- Local plans can be a valuable mechanism and signal what is required across all housing tenures, proactively engaging with housing developers at pre-application stage supports the delivery of well targeted and considered housing proposals.
- Encouraging and supporting private sector retirement housing development that is well designed is an important part of helping create housing diversity and help meet the future housing needs of older home owners.
- Delivering mixed tenure care-ready housing that can successfully meet the needs of people with care needs is an effective and attractive proposition to those who wish to rightsize and those who want to avoid moves to registered forms of care.
- Take an integrated approach and develop relationships between councils, and their NHS partners as this supports the development of effective and integrated housing and health responses to an ageing population.
- Supporting older people to return to their homes in a timely way following hospital admission, and providing practical assistance by assessing and removing hazards in the home to prevent hospital admission.

2.5.5 Focus on Dementia

Dementia prevalence is known to increase with age and in Thurrock the estimated number of people aged 65+ with dementia could increase from 1,526 in 2017 to 2,673 in 2035 – an increase of 75.16%. Further information is available in Chapter 2. Given this increase in prevalence, it is important to bear in mind the specific needs of older people with Dementia in terms of housing and environment,

and there is a drive to create dementia-friendly communities. There is a large body of literature around Dementia friendly communities, which are defined as:

"Geographic areas where people with dementia are understood, respected and supported, and confident they can contribute to community life. In a dementia-friendly community people are aware of and understand dementia, and people with dementia feel included and involved, and have choice and control over their day-to-day lives. A dementia-friendly community is made up of individuals, businesses, organizations, services, and faith communities that support the needs of people with dementia". (58)

The aim of dementia friendly communities is to improve quality of life for people with dementia regardless of where they live.

A key element affecting quality of life for someone with dementia is where they live and the most common choice for the majority of people with dementia is to remain in their own homes with support or move into a residential or nursing home setting. Issues for older people, such as loneliness and isolation tend to be exacerbated when the older person has dementia. (59)

The Alzheimer's Society (2018) has published guidance on delivering a dementia friendly approach to housing. (58) It suggests that there are three key areas for consideration: people, place and process. In terms of people, all housing staff including landlords, housing teams, and support workers for example, should have awareness and understanding of dementia, have ability to interact with and communicate effectively with people who have dementia and be able to recognise needs. In terms of place, the creation and maintenance of suitable housing can support people living with dementia. This includes the interior and exterior of buildings, areas around buildings and locations and includes retrofitting existing housing. Additionally, physical spaces should be easy to navigate and be accessible. In terms of process, the process for accessing residential provision and housing related services such as adaptations should be designed to reduce barriers for people with dementia. There should be clear opportunities for people with dementia to contribute to decisions about their homes.

In terms of Housing, the following housing provisions should be considered: (58)

- Adaptations, built environment and design
- Assistive technologies including telecare
- Access to outdoor spaces
- Support of family and paid carers in private homes
- Training of staff in housing sector appropriate to the setting in which they work and their roles
- Maintenance of a tenancy if a person with dementia is temporarily admitted to care.

Many of these principles reflect general age-friendly principles however, there is also likely to be a need for specific developments to cater for the needs of people with dementia.

Dementia Care (2015) identified that extra care housing is increasingly being provided however this is an extra step in the dementia journey which delays but does not remove the need for residential or nursing care. It felt that some form of specialist dementia housing model is needed as an alternative to moving to care home, where people often decline quickly.

It therefore developed a model of small group, independent supported living model for people with middle to late stage dementia and in most cases through to end of life.

This model consisted of 5 or move five bed bungalows built following dementia design guidelines. These buildings would be owned by a housing association or registered social landlord and the residents have a secure tenancy for life. Each resident has their own room with toilet and washbasin. There is a communal lounge, dining room, conservatory and kitchen/utility room. An enclosed rear garden is available. Bungalows can be same sex or mixed depending on individuals concerned. (Design does not currently support couples living together). Each bungalow managed by a team leader and supported by specialist support workers. There is a member of staff in the bungalow at all times on a. 12 hour shift system. Core principle of care is supported living and residents encouraged to do as much as they are able unlike in a care home. The benefit of bungalows being co-located was that activities can be organised across all bungalows.

Costs are shared between public and private funding broken down as follows:

• Placement care – standard weekly cost for care, in most cases paid by Adult Social Services or the CCG (through Continuing Health Care funding).

• Additional one-to-one care or end-of-life palliative care is funded by Adult Social Services or the CCG on a case-by-case basis.

• Rent and service charge – paid privately or through housing benefit (depending on the individual's personal circumstances).

• Food and personal expenses – managed by Dementia Care against a weekly budget, paid by residents.

Although the level of staffing and care is higher than residential care home, it was felt that for care commissioners the costs are typically at or below the standard rate for placement care, and significantly below the cost for nursing care or intensive home support. The study authors felt that there could be real savings in terms of avoiding costly admissions to hospital. Evidence gathered through case studies of two residents and comparing 17 activities of daily living over time suggests that this model provides:

- higher quality of life, choice and control
- continued independence for longer
- low use of anti-psychotic medication
- no emergency and fewer non-emergency admissions,
- earlier discharge from hospital and better reablement, and
- a greater chance to pass away in a homely environment.

However, this was based only on two case studies and further research is needed to confirm these results.

In terms of the wider place making agenda, the Local Government Association (2015) (60) states that the physical environment (and people's homes) play a key role in determining the extent to which people with dementia will find their communities' dementia friendly. The built environment in terms of orientation, wayfinding and familiarity all contribute to an accessible environment for

people with dementia, as does removing clutter and disorientating visual and auditory stimuli. The Local Government Association suggests that Councils should encourage developers to consider how design can support dementia friendly communities in for example, the layout of roads and streetscape, the design of adequate and legible signage, the design of wider and pedestrian only pavements with clearly defined edges, provision of more drop off and pick up points outside of public venues, good lighting and acoustics, appropriate seating and toilet facilities and the provision of more handrails at road crossings. Clearly, there is a great deal of overlap with what is considered to be an age friendly environment in this list. Additionally, the Local Government Association suggests that housing providers, people with dementia and their carers should to consider assistive technology such as aids and adaptations, both low and hi-tech which can help them remain independent for longer.

2.5.6 Dementia Friendly Communities Case studies.

Small community organisations and bigger companies worked on dementia awareness and to develop good practice in the Bradford Dementia Friendly Communities Programme. (61) This programme had a specific "Bradford approach' to creating dementia friendly communities across the geographically and culturally diverse part of Bradford city and district. In the first phase, they drew up an action plan identifying what changes they could make and how they would implement them. The second phase involved targeting a council ward with a high proportion of older people and working with shops, business and community groups in that ward. Individual interviews, group discussions, online questionnaire, workshop and meetings were used to evaluate the programme and the key findings were that there were variable levels of awareness and consequently scope for increased training and promoting dementia awareness. Practical difficulties such as accessing appropriate public transport and the patchiness of some services and resources need to be addressed. The evaluation also found that the experience of living with dementia is affected by existing inequalities in the population such as those based on race and economic deprivation and there was a need to provide support for carers.

The strengths of the Bradford programme were its local focus, having specific cross district communities (engaging different communities and finding common interests and links), raising awareness of dementia and of dementia friendly communities, changing organisations to become more dementia friendly, integration and inclusion concentrating on removal of barriers to mainstream activity and services (although there are some benefits of some separate services just for people with dementia). The challenges were found to be commitment to long term investment in the programme, constraints on public sector funding, transport, mixed level of awareness, patchiness in services and resources, and social and economic barriers such as individuals not being able to join and attend groups.

The York Dementia Friendly Communities Programme, (62) also evaluated via interviews, online questionnaire, and observation of meetings, found awareness and training to be a strength as was, intergenerational work, dementia friendly businesses and organisations, drawing and building on cultural and community assets and putting people with dementia at the heart of the programme.

The barriers and challenges of the York Programme were found to be the low impact on carers, engaging with specific individuals and groups, for example, single people living on their own, engaging with people with dementia through small projects, information sharing and

communication, for example, sharing information on who wants to use a befriending service. This evaluation also found that the programme had not had sufficient impact on public services.

Both the Bradford and York Dementia Friendly Communities Programmes identified learning to take forwards which is summarised below.

Learning from the Bradford and York Dementia Friendly Communities Programmes.

Place

- Focus on local communities - not a one size fits all.
- Inequality of access including transport is a barrier.
- The housing needs of people with dementia are not well understood.
- There is inequality of access and transport is a barrier.
- Faith groups have physical resources which can be used.
- The pace of the place could be slowed by providing quiet places.

People

- Awareness of changing but change takes longer.
- Although general awareness still needs to grow, a rights movement is emerging.
- Increasing focus on the rights of people with dementia.
- Important to understand diversity and address its impacts.
- Role and contribution of carers in vital
- More support is needed from general practice.
- Dementia has different consequences for women.

Resources

- Investment in health and social care needs balancing.
- Scope for more dementia friendly resources to be identified.
- Both integrated and separate dementia friendly activities should be provided.
- Need to invest long term in community support for people with dementia.
- Effort is needed to connect Dementia Friendly Communities to mainstream work.

Networks

- Personal and organisational networking help to build the Dementia Friendly Communities movement.
- Active involvement of people with dementia, carers and supporters is required in defining and promoting dementia friendly communities.
- Social capital and human scale supports the creation of Dementia Friendly Communities and local grown, home grown groups flourish

Chapter 3: Thurrock's Current Strategic Vision

This next section summarises the current strategic vision and priorities for Thurrock and how they are relevant for older people.

3.1 Planning

The Local Plan

Thurrock Council is progressing with the development of a Local Plan, covering all of the Council's administrative area. The Local Plan will determine the amount and distribution of new development providing a comprehensive and long term planning framework for the period up to 2037 (along with planning policies for the determination of planning applications). Preparation of the Local Plan must follow a number of stages to ensure that local people and stakeholders are fully engaged in the process and its content is based on robust evidence, the proper consideration and testing of alternative strategies and then finally, external examination by an independent planning inspector appointed by the Secretary of State. It is anticipated that the Local Plan will be adopted in 2022; however, the next stage of public consultation is due to commence in early 2019, with a draft Local Plan being published for consultation in summer 2020.

The Local Plan must be based on robust evidence about the economic, social and environmental characteristics and prospects of the area. The Council has completed or is in the process of completing studies relating to housing needs, employment land needs, and housing land availability (including the assessment of over 450 sites to assess their potential for delivering housing) amongst others.

The Council has already adopted a supplementary planning document, the 'Thurrock Design Guide', in March 2017. This document sets out the overarching design principles that need to be applied to new development schemes to ensure that they are of a high design quality and respond appropriately to the local context.

Housing, Planning and Advisory Group

The Health and Wellbeing Board's Housing & Planning Advisory Group is a multi-agency group which considers the health and well-being implications of major planning applications, and provides advice and guidance on the health, social care, community development, and designing out crime implications of proposed new developments. The Group comprises representatives from Thurrock Clinical Commissioning Group (CCG), NHS England (Essex Area Team), the Community and Voluntary Sector (Thurrock CVS), as well as the Council's Planning, Housing, Adults, Health and Commissioning, Public Health, Regeneration, and Children's Services Departments, and Essex Police. It aims to influence planning policy and thereby developers so that planning applications when received, have already taken into consideration the impact of the proposed development on health and wellbeing. The Group also plays a role in promoting good design and sustainable communities, as well as influencing the provision of good quality housing for older people in line with the recommendations of the Housing our Ageing Population: Panel for Innovation (the HAPPI report).

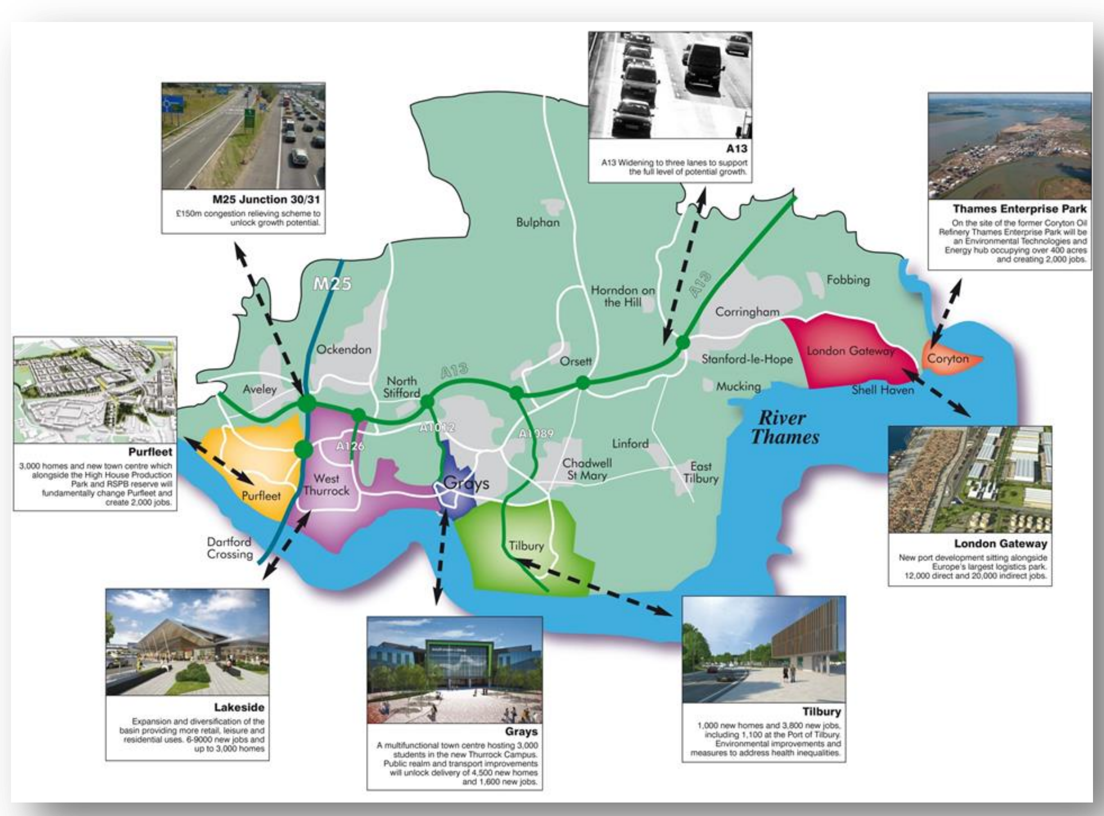
Specifically, the purpose of the Housing and Planning Advisory Group is to:

- Review emerging development plans,
- Identify how Section 106 monies might best be used to enhance Health and Wellbeing,
- Contribute to emerging planning policy and strategy,
- Provide an opinion on plans as part of the formal consultation process on major developments, and
- Act as a conduit for consultations with NHS Property Services.

The Advisory Group is consulted on all planning applications and pre applications for housing developments of 10 units or more, residential care homes, and other developments relevant to health and well-being.

3.2 Regeneration

The main priority for Regeneration in Thurrock is responding to the anticipated demand for 32,000 new homes by 2037 and ensuring that this growth comes with the required level of infrastructure (for example schools, health facilities, and high quality public realm). There will also be a need to contribute towards the need for 24,500 new jobs in the area. Activity in Thurrock is currently formed around six growth hubs namely Purfleet, Lakeside and West Thurrock, Grays, Tilbury, London Gateway and Thames Enterprise Park.



The quality of the design of the public realm during this significant regeneration, in terms of healthy places has potential to impact upon the health of the population across the life course, additionally age friendly features can also positively affect the health of an older person. This regeneration

presents an opportunity to design places with the Healthy New Town Programme Principles and age friendly features in mind.

3.3 Housing

In 2015, Thurrock Council published its 5-year plan for housing within the borough in the Housing Strategy 2015-2020. This strategy also lays out the council's longer term vision for housing over the next thirty years. The strategy aims to ensure quality housing across all tenures, not only for council tenants but for home owners and those renting in the private sector as well. Along with improving the Council's current stock of housing through the Transforming Homes Programme, Thurrock Council and Thurrock Regeneration Ltd. have set an ambitious target of building 1,000 new homes by 2020. Housing is a huge investment in the growth of Thurrock while supporting and improving health and wellbeing.

The strategy lays out three main priorities: *Raising the Bar, In On the Ground Floor and Looking Ahead*. These priorities, which run across the five priorities of Thurrock's Community Strategy, aim to guide work to deliver high quality housing and services, proactively support residents to maximise health, wellbeing and employment outcomes and to create sustainable communities with increased housing supply.

Source: Thurrock Council Housing Strategy 2015-2020

Leading the way *in providing well-designed, high quality, sustainable and aspirational homes that promote community cohesion and a healthy lifestyle*	**Increasing the supply** *of family homes to support growing families, making best use of our existing stock.*	**Enabling young people** *and single households to access the housing market with financial assistance including shared equity and increasing the provision of studio and one bedroom homes*
Creating apprenticeship opportunities *with our partners and support residents to access training and employment pathways with targeted programmes for council tenants*	**Creating attractive housing for older people** *that encourages independence and wellbeing*	**Reducing health inequalities** *across the borough through targeted interventions and joint working*
Safeguarding our residents *and deliver preventative measures to reduce violent crime and anti-social behaviour*	WHAT DOES THIS MEAN FOR THURROCK?	**Providing a range of suitable accommodation** *to support those with learning disabilities and mental health needs now and in the future*
Improving the quality *of our own stock, prioritising those with damp and mould*	**Ensuring that residents** *living in the private sector also benefit from high quality housing*	**Engaging with private landlords** *to increase the availability of homes in the private rented sector working with neighbouring boroughs*
Attracting and working collaboratively *with private developers and registered providers to boost housing supply*	**Upskilling our staff** *to better support our residents with specific training on mental health, dementia and domestic abuse*	**Regenerating existing estates** *to improve and increase affordable housing provision*

While Thurrock currently has a relatively young population, the older populace is projected to increase significantly in future years, with the Housing Strategy estimating that an estimated 3,400 new homes will be needed by 2031 to accommodate the growth. The council want to support older people to live as healthily and independently as possible by providing suitable, innovative and aspirational homes to meet a range of lifestyle and health needs.

The Housing strategy set out the following aspirations:

- Deliver tailored and needs led services to all residents
- Provide high quality council housing
- Enhance the quality of housing in the private sector
- Deliver value for money with high levels of customer satisfaction
- Empower residents to make informed choice with access to advice and support
- Support our residents through prevention and early intervention to sustain their homes and avoid crisis
- Support residents to maintain and improve their independence

- Create employment pathways and support residents to access these.
- Boost the housing market delivering new affordable homes to meet local need
- Increase housing supply, working collaboratively with the private sector
- Enhance local communities through estate regeneration
- Ensure the sustainability of our homes to meet residents needs now and in the future.

The Council plans to make better use of existing adapted properties while supporting residents in need of new home aids and adaptations as well as rolling out some sheltered housing services to those in general needs and private sector housing to increase independence. Through providing innovative and aspirational housing for older people, it hoped that older people could be supported to move into move suitable accommodation and downsize, freeing up family housing. It also aims to support the borough's most vulnerable residents by embedding safeguarding into the housing team and continuing to offer free home security equipment to residents of sheltered housing.

The Council is reviewing its supply of extra-care housing to identify requirements for further schemes. Bruyns Court in South Ockendon is Thurrock's first older adult housing scheme built with HAPPI design principles, and uses general needs housing as a template but with an emphasis on creating community and creating for physical needs of people in this age group. Progress is also being made at Calcutta Road, the Council's second HAPPI scheme. The Council is also aspiring to apply HAPPI principles to other housing schemes with the view to build adaptable homes that will support people throughout their lives. All new supported accommodation will meet REACH standards and the Council are working with Thurrock Coalition to better understand the needs of disabled and older people to inform the design of future schemes. The council aspires to greater independence and wellbeing for the borough's older adults now and into the future; increasing choice, availability and quality within the housing market is a key step in achieving this goal and it aspires to ensure specialist support for older people with dementia through training and awareness building.

3.4 ICT

The "Connected Thurrock" Digital strategy intends to work collaboratively with the private sector and government to complement these ambitions by ensuring that Thurrock is properly positioned to take advantage of all of the opportunities that are available to a vibrant 21st century community. Further information is available on the Council's website, but its main aims are to:

- Ensure people have access to world class broadband wherever they need it
- Quality of life is enhanced through smart technologies
- Promoting and enabling digital inclusion across the entire community

The strategic vision is for Thurrock to become a 'smart place', using digital technologies to enhance service delivery and wellbeing, to reduce costs and resource consumption, and to also engage more effectively and actively with citizens. This strategy is relevant for older people who are a key user group for smart technology such as telecare, additionally older people may benefit from but may not be active users of digital technologies currently (as discussed in Chapter four).

3.5 Health and Communities

3.5.1 Stronger Together

The Stronger Together programme was developed to bring together a range of complementary initiatives working with the Council's Community Development Team, Thurrock CVS and Ngage. The programme operates on five principles:

1. Place based – this recognises that it is in neighbourhoods that everything comes together. Work needs to happen at a neighbourhood level in order to connect people to the place where they live.
2. Focus on strengths – this way of thinking focuses on 'what is strong; not what is wrong?' This could be individual strengths, neighbourhood strengths, assets to be used etc.
3. Citizen-led – the programme is committed to working in a way that puts communities in the driving seat. Citizen action is more durable and sustainable than professional intervention.
4. Relationship building – the programme builds on the strengths of the informal associations and networks that make up the fabric of community life.
5. Social justice – the programme ensure an inclusive approach is at the heart of community building

Within Thurrock there are efforts to coordinate and build connections across and between initiatives including Local Area Coordination (LAC), Asset Based Community Development (ABCD), Community Organisers and Time banking. Local Area Coordination began in July 2013 in Thurrock and is an innovative approach to supporting people who are vulnerable to identify and pursue their vision for a good life, to strengthen the capacity of communities and to make services more personal, flexible and accountable, (63) and ABCD is an approach to building more connected, less isolated communities. Thurrock is committed to a strengths based approach to community development, which means that value is placed upon the assets and contribution that a community can contribute to designing its own opportunities. In terms of older people there is great deal to be gained from a person's life experience and skills should they choose to volunteer or invest within their community, and within Thurrock there are some examples where this has been facilitated as in Animate and University of the Third Age.

Clearly, the entire Stronger Together programme is extremely relevant for the older population and helping them to feel part of a community, have a voice, and build relationships within their neighbourhood, will potentially have a significant impact upon their physical and mental health

3.5.2 For Thurrock In Thurrock

*For Thurrock In Thurroc*k is the joint strategic health and care service transformation programme between the Council's Health and Adult Social Care functions and NHS Thurrock CCG that proposes new models of integrated health and care that places greater emphasis on neighbourhood based care in communities. It includes plans to develop four Integrated Medical Centres across the borough in Grays, Tilbury, Purfleet and Corringham. It also includes a new model of care *Better Care Together Thurrock* which encompasses significantly increasing the capacity and capability of Primary Care using a mixed skill clinical workforce centred around locality based networks of GP surgeries, a

suite of projects to improve the diagnosis and clinical management of long term health conditions, and proposals to integrate health and care community services including new *Wellbeing Teams* and *Community Led Support Teams* based from our locality community hubs.

A new *Thurrock Integrated Care Alliance* of all major health and care providers has signed an MOU which commits stakeholders to working in collaboration to integrate commissioning and delivery of care on a single health and care systems basis, together with a new outcomes framework to support transformation. This approach aims to prevent avoidable demand on the most expensive elements of the system; namely unplanned hospital admissions and entry to residential care by intervening earlier to improve the health and wellbeing of the population.

3.5.3 Sustainability and Transformation Partnerships

Thurrock is part of mid and South Essex Sustainability and Transformation Partnership (STP), a new transformation programme for NHS services across Thurrock, Basildon and Brentwood, Castlepoint and Rochford, Southend-on-Sea and mid Essex. It has already developed a programme of hospital transformation between the three District General Hospitals including developing specialist centres for stroke, cardio-vascular disease, cancer and elective care on different hospital sites. A new STP Primary Care Strategy is replicating plans developed for Primary Care transformation as part of *Better Care Together Thurrock* across the entire STP footprint

All of these initiatives should have a major positive impact on the health and wellbeing of older residents, seeking to intervene earlier to prevent serious health events, promote independence, address the wider determinants of health including social isolation and loneliness, and bring simplified, easier to access, higher quality health and care services closer to home.

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Chapter 4: The health and wellbeing of Thurrock's older population

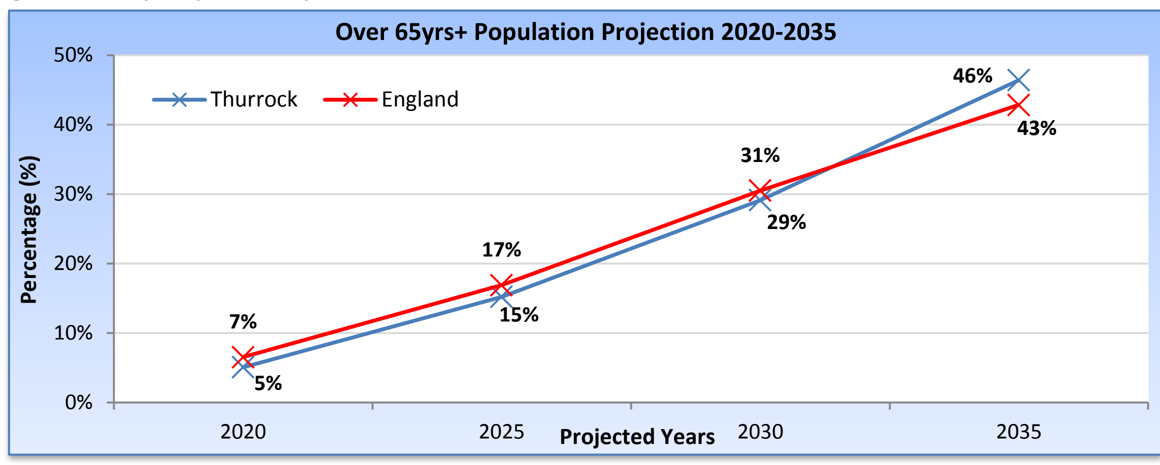
Key Points

- There are 23,700 people aged 65+ in Thurrock (2017), and this is set to increase at a faster rate than the England average.
- 'Older People' should not be treated as one population group, as they have different characteristics. Thurrock's main segments according to MOSAIC classifications are 'Solo Retirees' and 'Classic Grandparents'.
- Thurrock's 65+ population are not uniformly distributed across the borough, with proportionally more households in wards such as Stanford East & Corringham Town.
- There are key pockets of deprivation in older people – generally to the south and west of the borough.
- Hypertension is the most common diagnosed long term condition in older people in Thurrock, with a rate of 432 per 1,000 people aged 65+. However it is known that there are a number of as yet undiagnosed patients with long term conditions, many of whom will be aged 65+. These are patients who are at high risk of an emergency hospital admission if they are not receiving appropriate care.
- Our data indicates we are likely to see an increase in older people unable to undertake at least one self-care activity by themselves (a 58.8% increase by 2035), and in older people reporting they cannot undertake at least one mobility activity by themselves (a 61.9% increase by 2035). These growth rates indicate a likely increase in demand for future adult social care services.
- It is estimated that the number of adults aged 65+ years in Thurrock estimated to have a fall is set to increase from 6,245 in 2017 to 9,759 by 2035 – an increase of 56.3%.
- The number of older people likely to have dementia is predicted to increase by 1,147 (75.2%) between 2017 and 2035.
- There were 12,173 A&E attendances by those aged 65+ in 2017/18. The cost of A&E attendances increased by 12.7% in the last year.
- There were 19,747 emergency admissions for Ambulatory Sensitive Care Conditions in 2017/18 – which could have been prevented with better-managed care.
- The main reasons for Delayed Transfers of Care were "Waiting further NHS Non-Acute Care" and "Awaiting Care Package in Own Home".
- 45% of Thurrock residents over the age of 75 years have no access to a car or van, which is the highest proportion of its geographical neighbours and is above the national average.
- Some of our most vulnerable residents do not perceive themselves as being able to get to all the places they wish to - the Adult Social Care survey found this to be the case for 14.9% of respondents.
- There are some wards in Thurrock where up to 39% of the population aged 65+ live alone.
- 13.3% of Thurrock residents have either never used the internet or have not used it in the last three months, and national data indicates this is more likely to be the case in older people.
- There are some Adult Social Care service users who may perceive themselves to be socially isolated - 14.0% of Thurrock's social care service users do not feel they have enough social contact with people, and a further 4.2% reported that they feel socially isolated.

4.1 Thurrock Population

It is known that nationally the population is living longer, albeit not necessarily healthier, lives. Those aged 65+ are the highest users of Adult Social Care services and are also more likely to develop multiple long term conditions, which results in increased demand for specialist housing, health and social care services with fewer working age people that can be taxed to pay for this increased demand. Within Thurrock, the over 65yrs+ population is estimated at **23,700** (2017), accounting for 14% of the whole population. It is projected to grow by 5% by 2020, and potentially by 46% by 2035 (see below for percentage growth)

Figure 9 Over 65yrs Population Projection

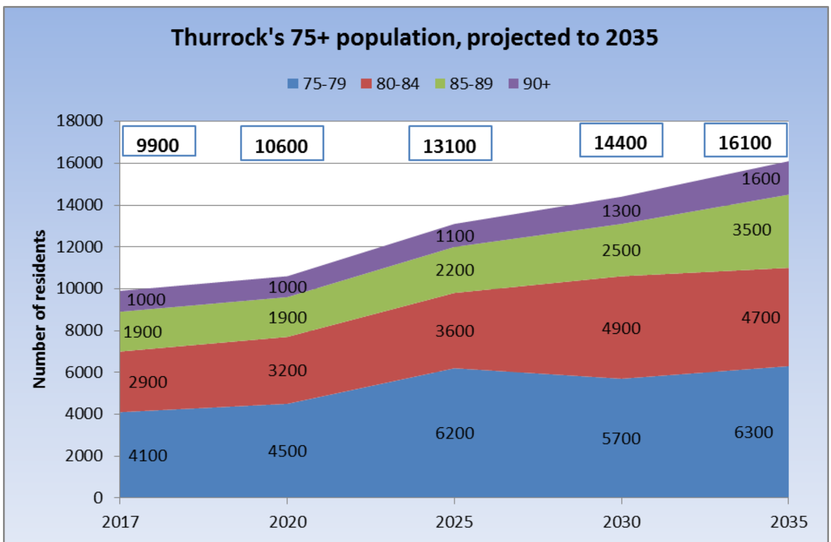


Source: ONS Projection Populations 2016

Quantifying this, the local 65+ population is expected to increase to 25,100 (5% increase) by 2020 and 27,900 by 2025. *[Note that these estimates do not incorporate planned housing and regeneration development within the borough as accurate numbers and timelines are not yet known. The true rate of growth will be even higher once these are accounted for].*

When breaking this projected increase down, there is a larger percentage increase in some of the older age groups within the 65+ population. As a whole, the 75+ population increases by 7.1% and 32.3% by 2020 and 2025 respectively, but this data indicates a higher percentage increase in those aged 75-79 years by 2025 (51.2% since 2017)

Figure 10: Thurrock's 75+ population, projected to 2035



Source: ONS Population Projections 2016

Implications

Applying these population estimates to the SHMA projections described in Chapter Two, the implication of this increase in population for Thurrock in terms of specialist housing is that for the aged over 75 population, there will be a requirement for:

By 2020:

- *87.5 additional sheltered housing units*
- *14 additional enhanced sheltered housing units*
- *17.5 additional extra care units*

By 2025:

- *400 additional sheltered housing units*
- *64 additional enhanced sheltered housing units*
- *80 additional extra care units*

By 2030:

- *563 additional sheltered housing units*
- *90 additional enhanced sheltered housing units*
- *113 additional extra care units*

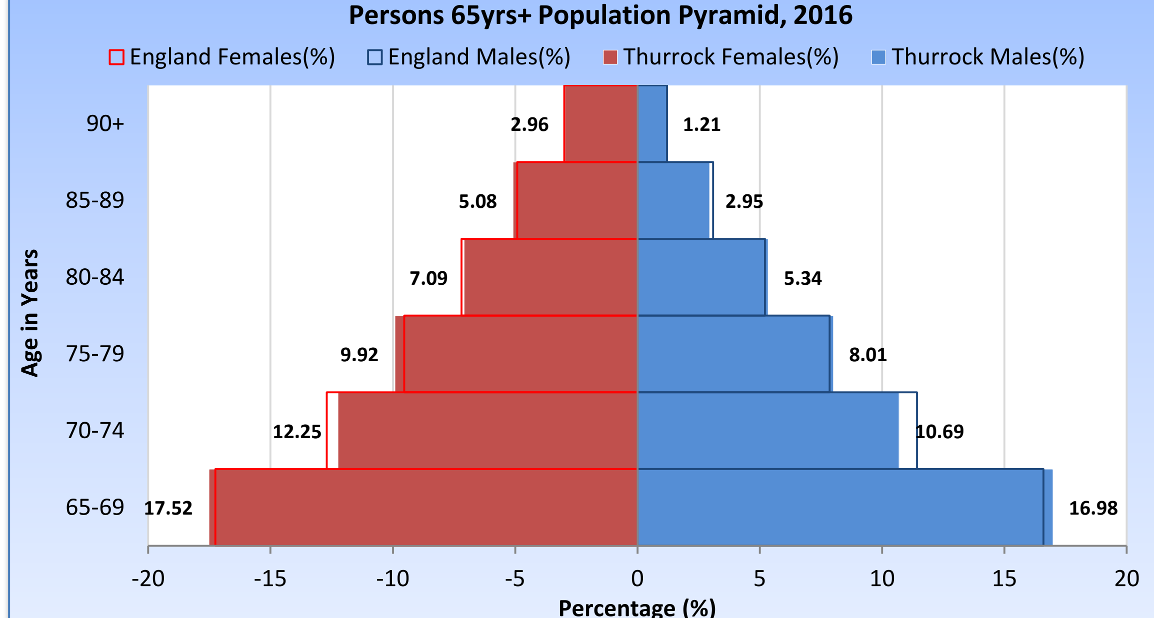
These figures should be used with some caution however. Notwithstanding that these are for the 75 plus population only, as described in Chapter Two, there are significant unknowns in terms of how the housing and health needs of older people will change, how these needs could be met with assistive technology and other aids, the impact of potential medical advances, changes in retirement ages, and differences between the current and future older people's in terms of social and political attitudes and preferences for housing types. Additionally but importantly, there may be inward and outward movement of older people in/out of Thurrock which will also impact upon demand as will the delivery mechanism of any new homes, such as whether they are limited to certain age ranges or population groups or open to all.

It is also important to note that a range of products may comprise each category of sheltered housing, enhanced sheltered housing and extra care and as discussed in Chapter two, one size does not fit all. Bespoke specialist housing should be co-designed with older people to meet the spectrum of needs indicated by these projections.

The stage of development of the local plan for Thurrock means that specific targets for the numbers of specialist homes to be built have not yet been developed.

Looking at the age/gender distribution within the current 65+ population, in Thurrock there is a higher percentage of 65-69yrs (34.7% combined) compared to England as a whole, whereas 70-74 yr. olds is slightly lower.

Figure 11 Thurrock Population 65yrs+



Source: ONS Population Estimates (Sept 18 Release)

4.1.1 Segmentation of the Older Population

Mosaic is a consumer classification system used to help us better understand the make-up of our community and how best to communicate with them by looking at where they are, who they are and what they want. The Mosaic groups in the table below relate to older people and show the most common characteristics associated with each group. We use this to demonstrate that 'older people' are not one heterogeneous group, and that we must plan accordingly for a wide range of needs.

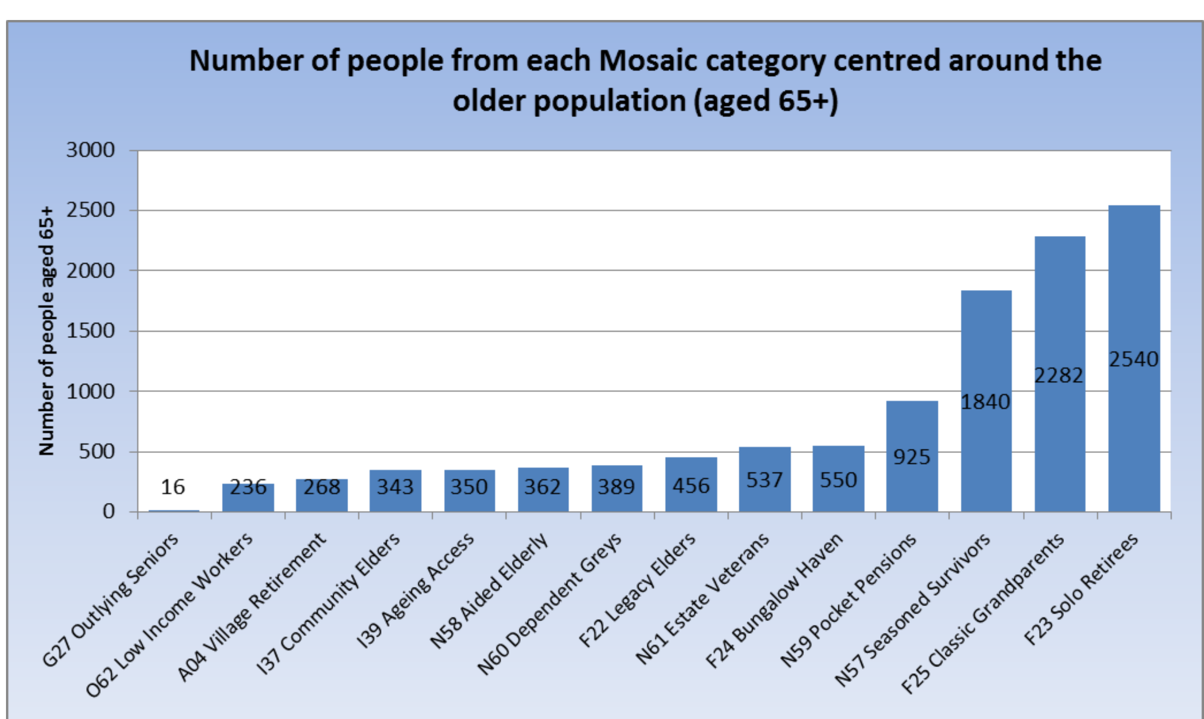
Figure 12: Explanation of Mosaic population groups

A04	Village Retirement	Retired couples and singles	Larger village location	Like to be self-sufficient	Enjoy UK holidays	Most likely to play cricket and golf	Often prefer post for communications
F22	Legacy Elders	Oldest average age of 78	Mostly living alone	Own comfortable homes outright	Final salary pensions	Low technology knowledge	Broadsheet readers
F23	Solo Retirees	Elderly singles	Small private pension	Long length of residence	Own a suburban semi or terrace	Keep bills down by turning things off	Don't like new technology
F24	Bungalow Haven	Elderly couples and singles	Own their bungalow outright	Neighbourhoods of elderly people	May research online	Like buying in store	Pre-pay mobiles, low spend
F25	Classic Grandparents	Elderly couples	Traditional views	Not good with new technology	Most likely to have a basic mobile	Long length of residence	Own value suburban semis and terraces
G27	Outlying Seniors	Aged 60+	Low cost housing	Out of the way locations	Low income	Shop locally	Dislike being contacted by marketers
I37	Community Elders	Older households	Own city terraces and semis	Have lived there 20 years	Some adult children at home	Multicultural neighbourhoods	Respond to direct mail charity appeals
I39	Ageing Access	Average age 63	Often living alone	Most are homeowners	Modest income	1 or 2 bed flats and terraces	Pleasant inner suburbs
N57	Seasoned Survivors	Very elderly	Most are living alone	Longest length of residence (29 years)	Modest income	Own mostly 2 or 3 bed terraces	Retired from routine / semi-skilled jobs
N58	Aided Elderly	Developments for the elderly	Mostly purpose built flats	Most own, others rent	Majority are living alone	Have income additional to state pension	Least likely to own a mobile phone
N59	Pocket Pensions	Retired and mostly living alone	1 or 2 bedroom small homes	Rented from social landlords	Low incomes	Prefer contact by landline phone	Visit bank branch
N60	Dependent Greys	Ageing singles	Vulnerable to poor health	1 bedroom socially rented units	Disabled parking permits	Low income	City location
N61	Estate Veterans	Average age 75	Often living alone	Long term social renters of current home	Living on estates with some deprivation	Low income	Can get left behind by technology
O62	Low Income Workers	Older households	Renting low cost semi and terraces	Social landlords	Longer length of residence	Areas with low levels of employment	2 or 3 bedrooms

Source: MOSAIC

The chart below shows us the number of households in Thurrock in each of the older population segments, and it can be seen that the highest number of households aged 65+ came from the 'Solo retirees' mosaic group (2540). The lowest number were in the 'outlying seniors' group (16).

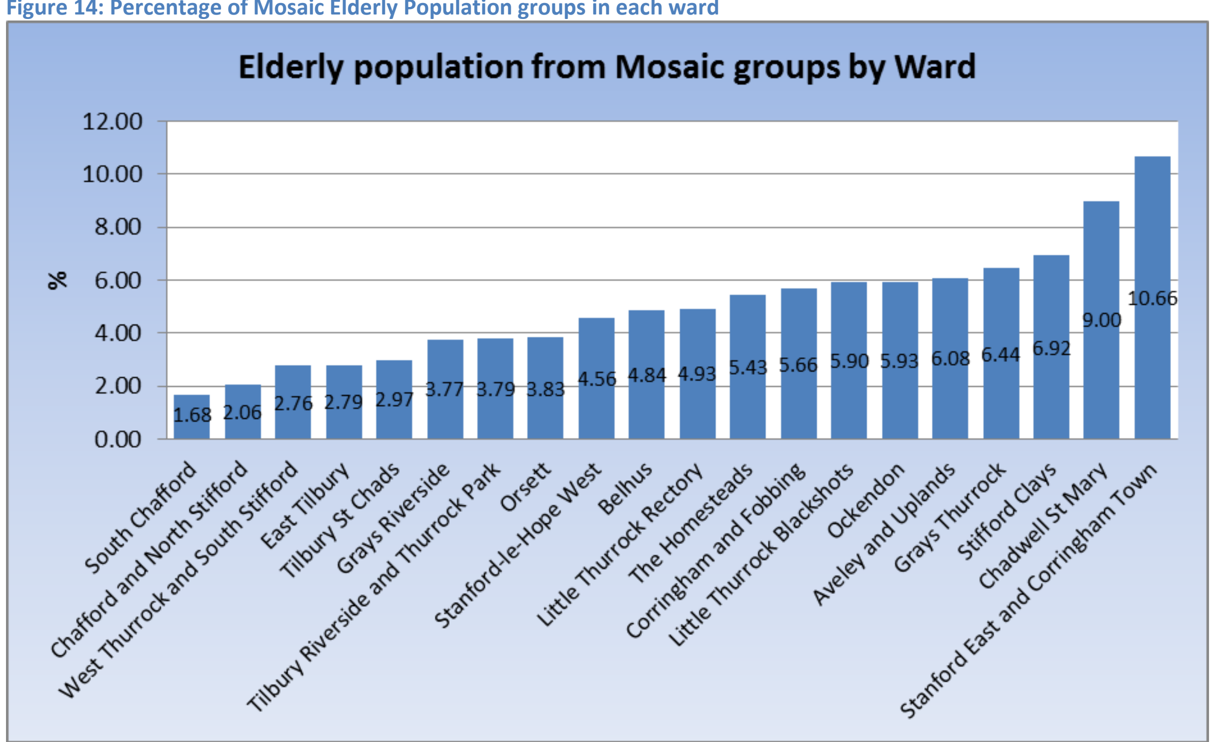
Figure 13: Number of Thurrock households per older population segment



Source: MOSAIC

The elderly population from Mosaic groups varies widely with South Chafford having just over 1.6% of the Mosaic group population and Stanford East and Corringham Town having over 10%.

Figure 14: Percentage of Mosaic Elderly Population groups in each ward



Source: MOSAIC

We know that these population groups will not be uniformly distributed across the borough – for example, we know that Grays Riverside contains a large number of community elders, even though the figure above shows that proportionally speaking, they only contain a small percentage of older people in Thurrock.

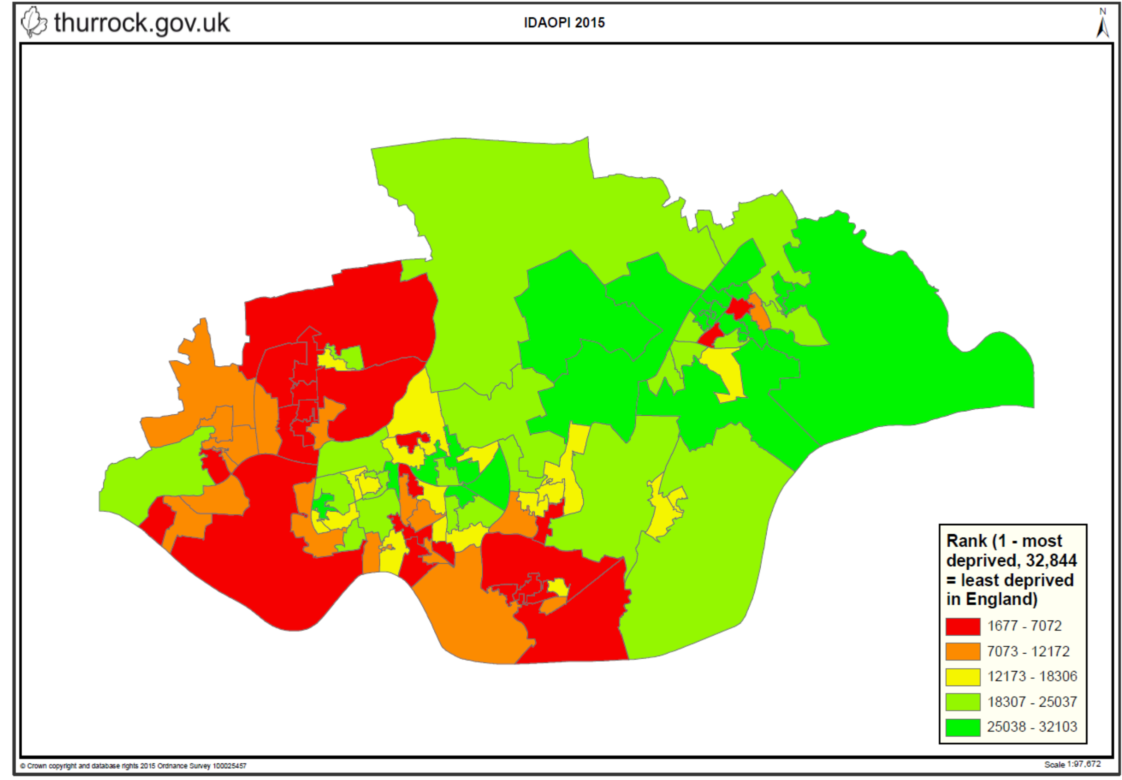
Implications

The information above shows that “older people” are not one category, and have differing living circumstances, preferences and needs. In Thurrock, our three biggest segments are Solo Retirees, Classic Grandparents and Seasoned Survivors. These population groups appear to generally own some sort of property already and have modest amounts of incomes; however we don’t know if they will have taken steps to already adapt their homes for future needs. This could be something to consider promoting. The Mosaic characteristics also suggest that many of them might not be confident with new technologies, which is something to consider if telecare / telehealth options are used or if digital technologies are otherwise used within new homes.

4.2 Deprivation

Deprivation can be measured using the Income Deprivation Affecting Older People Index (IDAOPI), which is calculated based on the percentage of older people living in income-deprived households. Every Lower Super Output Area (LSOA) in England is ranked on this, and the map below shows the variation across Thurrock – it can be seen that the majority of LSOAs on the east side of the borough have comparatively low levels of deprivation in older people, and that some LSOAs to the west and south are in the most deprived quintile in the country. The impact of this is discussed below.

Figure 15: Income Deprivation Affecting Older People by LSOA, 2015



Source: Department of Communities and Local Government

a. Fuel Poverty

There are 3 important elements in determining whether a household is fuel poor:

- household Income
- household energy requirements
- fuel prices

The official definition of fuel poverty is determined by application of the Low Income High Costs (LIHC) indicator. Under the LIHC indicator, a household is considered to be fuel poor if:

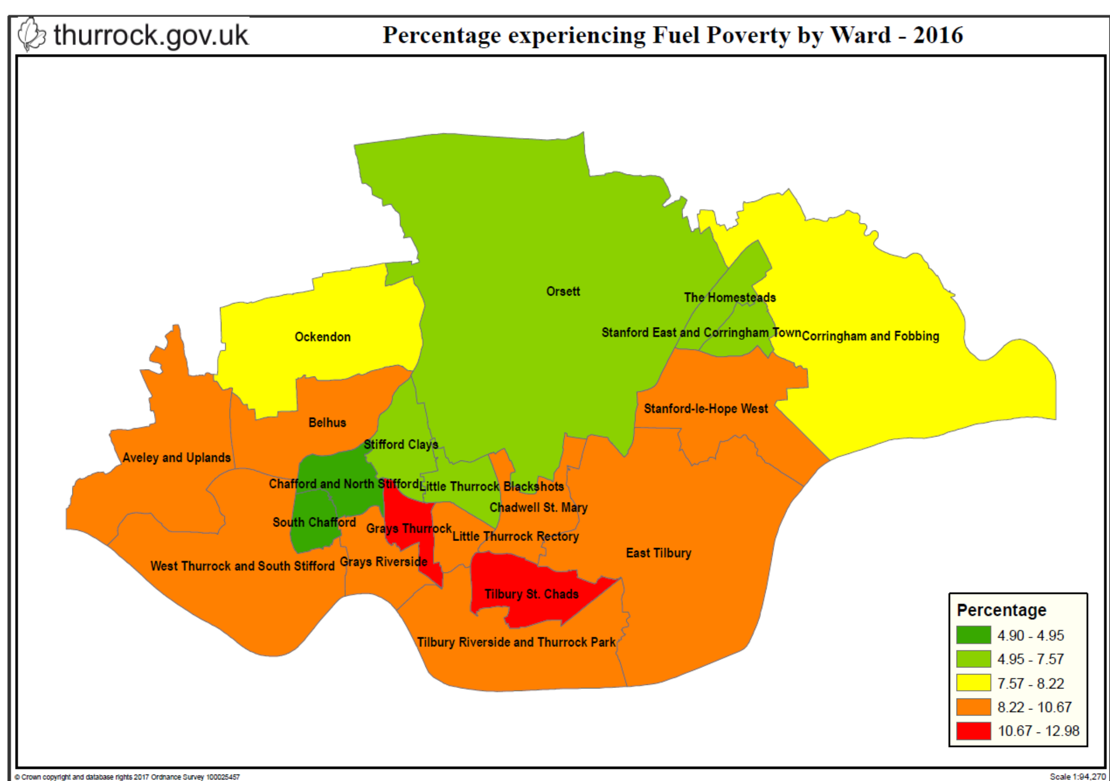
- they have required fuel costs that are above average (the national median level)
- were they to spend that amount, they would be left with a residual income below the official poverty line (64)

As of 2016, 5638 households in Thurrock were estimated to be in fuel poverty, which is 8.6%. This is below the national average of 11.1%. There is an increased risk of these households not being able to adequately heat their homes and we know that older people are much more likely to be affected by a cold home. However this proportion varies across the borough, with wards such as Tilbury St Chads and Grays Thurrock having more of their households in fuel poverty, and the two Chafford wards having the least.

There is therefore a need to ensure that homes are modified, or arrangements are made, to enable older people to be able to adequately heat their homes, with particular consideration to those wards where the proportion of homes in fuel poverty is higher.

There is evidence to suggest that warmth and energy efficiency can lead to improvements in general health, respiratory health and mental health, particularly in those with existing chronic respiratory disease. (25) This is particularly relevant to older people who we know are more likely to have chronic respiratory disease and other comorbidities, and struggle to keep their homes warm for either financial or maintenance reasons, however there is evidence to show that older people can be unaware of energy efficiency programmes and schemes they could benefit from (see chapter 2). For Thurrock this means there is a need to consider how to improve knowledge of benefits available and existing support services.

Figure 16: Percentage of Households in Fuel Poverty by ward, 2016



Source: Department for Business, Energy and Industrial Strategy

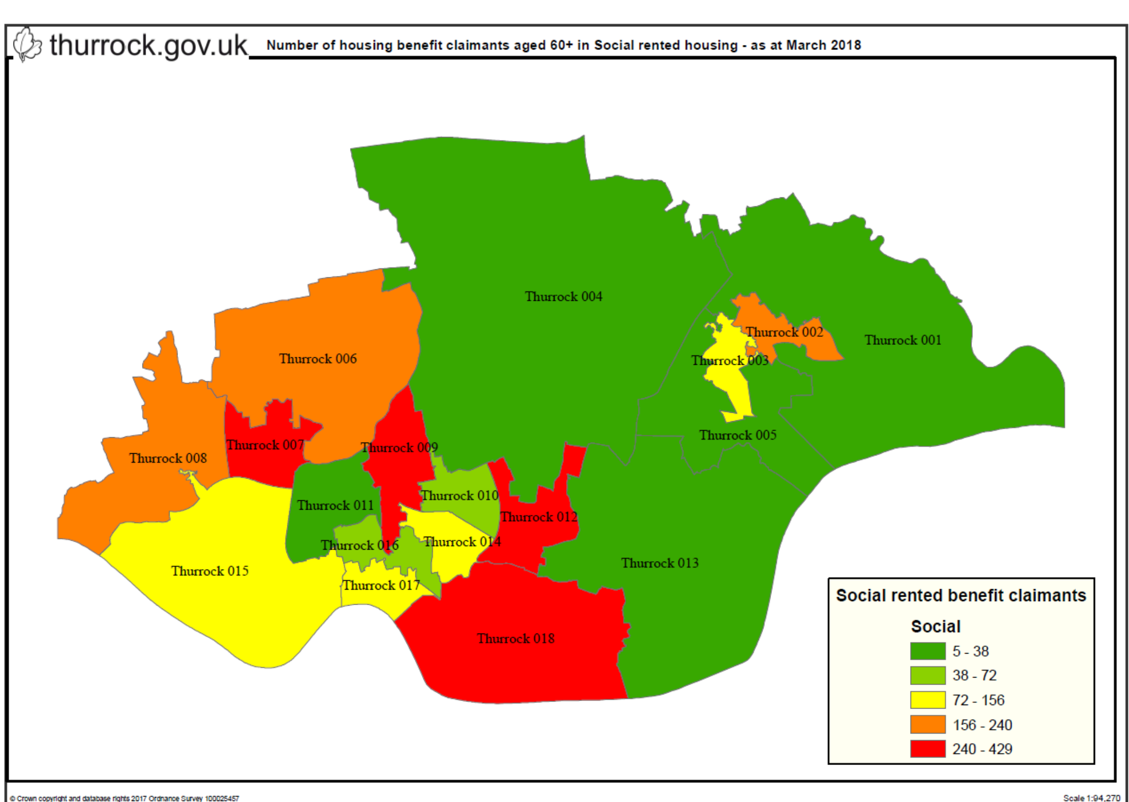
b. Housing Benefit Claimants

Thurrock also has a number of older people who claim Housing Benefit – and are therefore likely to be on low income. The majority of those claiming housing benefits aged 60+ are in social rented housing – this accounted for 3,002 claimants in March 2018.There were also 468 claimants in private rented accommodation. The majority of older claimants were in fact over 70 years old [2069].

The most common type of benefit claimed was Pension Credit (1724 claims), followed by Standard case – including savings credit only (1344 claims).

Distribution of housing benefit claimants aged 60+ varies across Thurrock. The map below shows the number of housing benefit claimants aged 60+ who are in social rented housing. The areas with the highest number of people (Red) are Stifford Clays, Belhus, Tilbury Riverside and Thurrock Park and Tilbury St Chads. The majority of these are also areas that have the highest percentage of people aged 65+ living alone or have higher levels of deprivation.

Figure 17: Housing Benefit Claimants in Social Rented Housing, March 2018



Source: Department for Work and Pensions

Implications

The information above shows that Thurrock has pockets of older residents living in poverty. Deprivation is strongly associated with poorer health outcomes, and there is the added impact of the inverse-care law – which demonstrates that those in greatest need of good quality healthcare are least likely to receive it. This also impacts on ability to afford a home and to adequately run it – the data on fuel poverty above indicates that 5,638 households may be in this position.

Section 1 portrays the link between housing and health, and the maps above showing variation within the borough highlight the areas to target to support residents to improve housing quality (see section on Well Homes) or apply for relevant grants from central government. Evidence suggests that knowledge of relevant services and grants may be lacking which indicates a need to improve the quality and /or availability of information to Thurrock Residents.

The information above also highlights the need to support residents to maintain employment pre-retirement, and support them to save for their retirement years.

c. Lifestyles

It is well-documented that if we can improve certain lifestyle choices, we can prevent onset of ill-health. This is true at any age, although the younger the person, the longer they will see the benefits for. Data on Adult Smoking Habits in England (65), shows that nationally, the smoking prevalence amongst older people is 8.1%, which is lower than for the adult population as a whole (16.4%). In Thurrock, we do not have an estimate of smoking prevalence in older people, but we have data on the age of those accessing smoking cessation support provided by Thurrock Healthy Lifestyles Service.

The most recent data for Smoking Cessation services indicates that:

- 94 of the 671 smokers accessing cessation support in 2017/18 were aged 65+ [14.0%]
- 55 of the 398 smokers accessing cessation support between April – September 2018 were aged 65+ [13.8%]. Data from this partial year indicates a larger number of smokers accessing cessation support should be seen in 2018/19.

The team also deliver NHS Health Checks for those aged 40-74 years who are not diagnosed with a pre-existing long term condition. The most recent data for NHS Health Checks indicates that:

- 212 of the 1,997 NHS Health Checks undertaken in 2017/18 were to those aged 65-74 [10.6%]
- 164 of the 1,125 NHS Health Checks undertaken between April-July 2018 were to those aged 65-74 [14.6%]. Data from this partial year indicates a larger number of NHS Health Checks should be completed in 2018/19.

Implications

The information above shows that older people account for 14% of smokers accessing support. Whilst it appears proportional to the population distribution within Thurrock (older people make up 14% of the Thurrock population as a whole), this service is for adults only. Take up of NHS Health Checks appears proportionally low when considering the proportion of residents in the 40-74 age group; however it is expected that higher numbers of younger adults would take up this offer – due to the fact that it is more likely residents aged 65+ will already have a long term health condition and therefore not be eligible.

Work programmes are already underway to improve uptake of both these services overall – for example, social marketing research was commissioned to identify the best ways to target NHS Health Checks towards those with undiagnosed long term conditions, and there is an amount of targeted smoking cessation activity in train with practices.

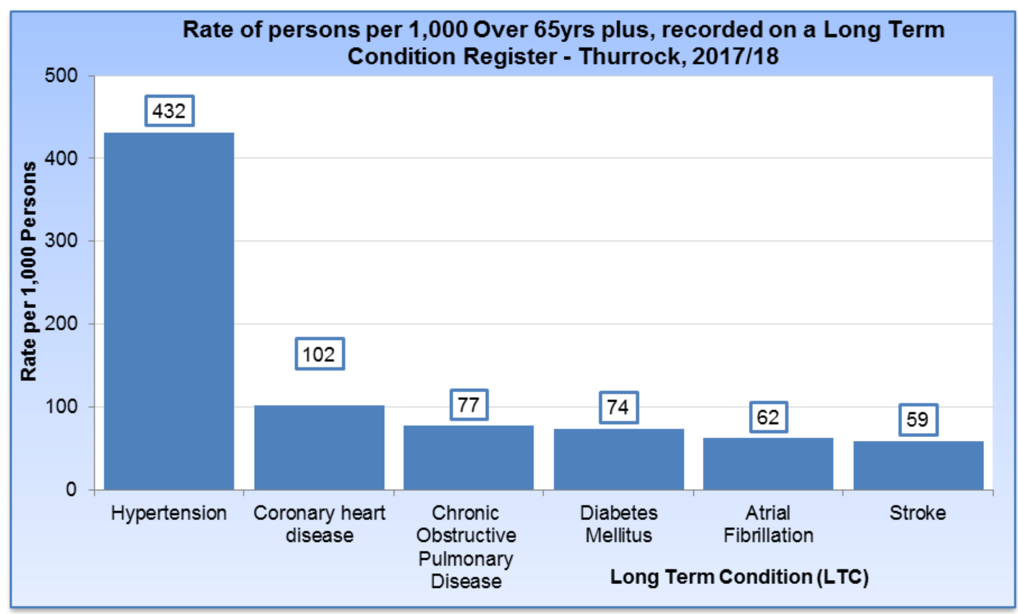
However this could be complemented with the continued support of Making Every Contact Count amongst front line staff, including housing staff, widespread use of community groups and hubs to increase service promotion and awareness of the consequences of not improving lifestyles.

4.6 Long Term Conditions

A King's Fund (66) report states long-term conditions are more prevalent in older people (58% of people over 60yrs compared to 14% under 40yrs) and in more deprived groups (people in the poorest social class have a 60% higher prevalence than those in the richest social class and 30% more severity of disease). People with long-term conditions now account for about 50% of all GP appointments, 64% of all outpatient appointments and over 70% of all inpatient bed days.

Within Thurrock, Hypertension is the highest diagnosed condition for over 65 year olds, with a rate of 432 per 1,000 persons, with Stroke being the lowest with a rate of 59 persons per 1,000.

Figure 18 Over 65yrs recorded on a Long Term Condition Register



Source: Systm One Reporting 2017/18

Whilst we know older people are more likely to have multiple Long Term Conditions, the chart above shows each condition separately, therefore some patients will be on more than one register.

4.6.1 Undiagnosed long term conditions

Modelling work by Public Health England and stated within the Thurrock Annual Public Health Report 2016 indicates that there are a large number of patients who have long term health conditions who are not yet diagnosed and therefore not receiving any form of treatment. Whilst numbers are not available for 65+ only, we suspect some of the undiagnosed LTC patients will be older adults.

Implications

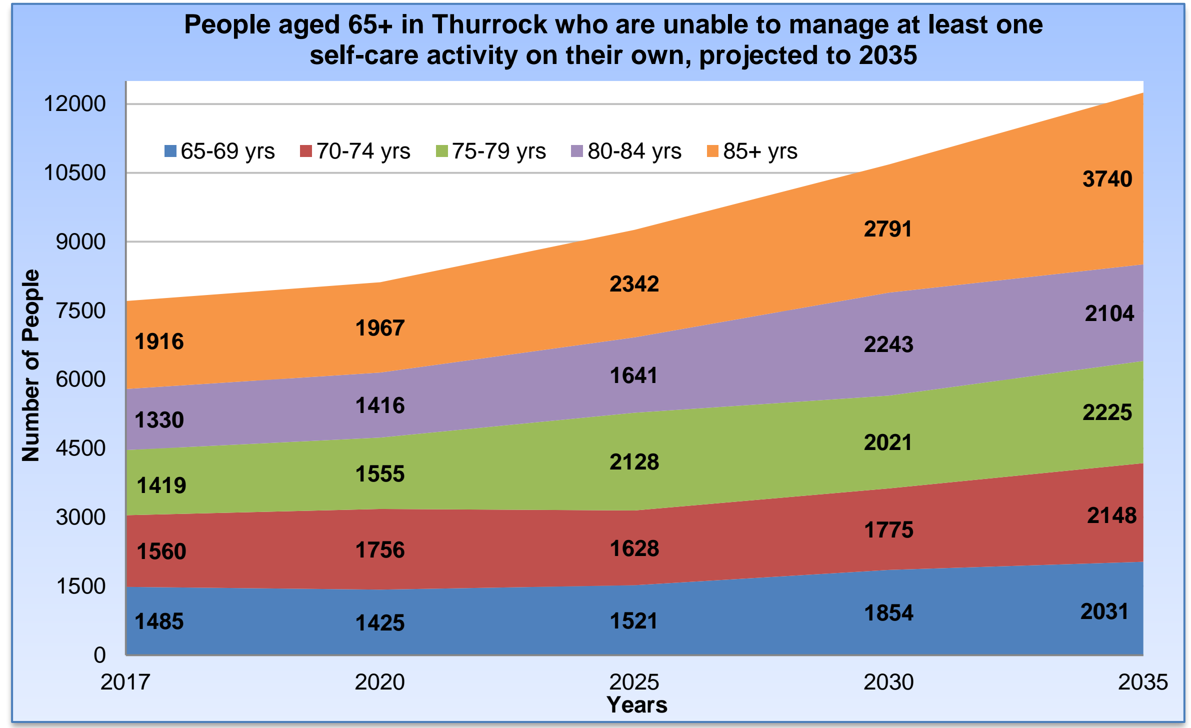
The information above shows that older people are more likely to have long term conditions – either diagnosed or undiagnosed. This highlights the importance of a) preventative interventions such as smoking cessation and weight management services to support all adults to reduce the likelihood of developing long term conditions, b) diagnostic interventions such as NHS Health Checks and Hypertension detection programmes which aim to diagnose early before conditions worsen, and c) increasing the holistic treatment offer of care for patients with more than one long term condition.

Whilst there are a number of programmes in place already to address all of the above, more could be done to embed them within the Housing work programme – e.g. using communal sheltered housing complexes to host long term condition detection interventions, training more staff in Making Every Contact Count and ensuring housing improvement programmes such as Well Homes (see later section) adequately identify and refer patients to relevant health services.

4.7 The impact of long term conditions on daily living

It is known that approximately 70% of health and social care budgets are spent on treating those with long term conditions, and that older people are more likely to develop them. These conditions can have a debilitating effect on people's ability to care for themselves, resulting in reliance on Adult Social Care support. A recent study by researchers at Newcastle University (67) estimated that the number of adults in England aged 85+ needing 24 hour care is set to nearly double in the next 20 years, and that the number of those aged 65+ requiring 24 hour care will increase by a third. Locally we also expect to see an increase in those requiring Adult Social Care support in some way - the figure below shows the estimated increase in people over 65 years who cannot undertake at least one self-care activity alone and therefore will be requiring support from Adult Social Care. Whilst the total number in 2017 was 7,710, this is projected to increase to 12,248 by 2035, which is an increase of 58.86%. The largest increase is seen in the 85+ year age group, which sees an increase of 95.20% between 2017 and 2035.

Figure 19 Over 65yrs unable to manage at least one self-care activity

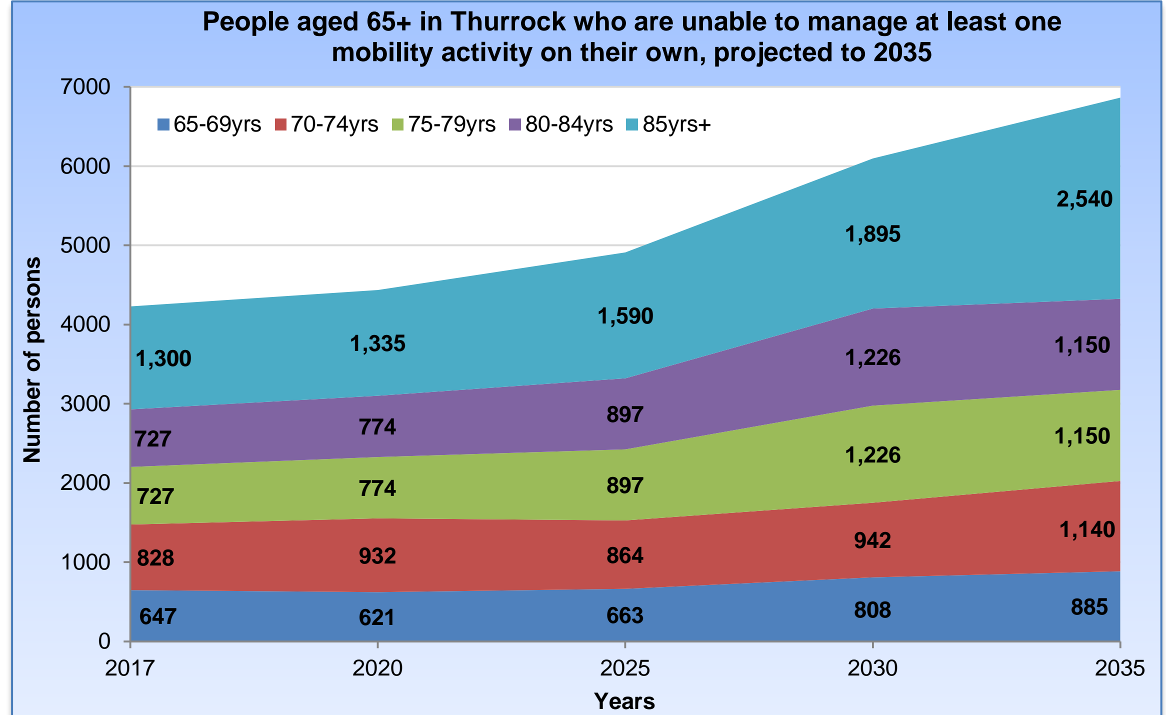


Source: POPPI 2018

As people become older, factors such as decreasing mobility and illnesses relating to old age sometimes mean that their accommodation is no longer suitable without some support or adaptation. Some people decide to 'stay put' in their current home, while others move into specialist accommodation for older people. Those with mobility problems can find it hard to get to the shops to buy food or to the post office to pay bills and top up pre-payment cards for gas and electricity.

Decreased mobility can have a debilitating effect on people's ability to care for themselves, resulting in reliance on Housing and Adult Social Care support. The figure below shows the estimated increase in people over 65 years who cannot undertake even one mobility activity alone and therefore will be requiring support from Adult Social Care. Whilst the total number in 2017 was 4,201, this is projected to increase to 6,801 by 2035, which is an increase of 61.89%. The largest increase is seen in the 85+ year age group, which sees an increase of 95.38% between 2017 and 2035. Residents in their 80s are already the largest users of residential care, so without effective intervention to mitigate this trend of decreased mobility, the need for residential care is likely to increase substantially.

Figure 20 Over 65yrs unable to manage one mobility activity



Source: POPPI 2018

Implications

The information above shows that there could be up to 4,538 more older people who are unable to manage at least one self-care activity alone by 2035, and 2,600 more struggling with increased mobility issues – indicating an increased demand for social care support. Whilst one solution to this could be to provide more residential and nursing home accommodation, this is not sustainable, and would not promote independence nor align with the wishes of residents asked about their future home.

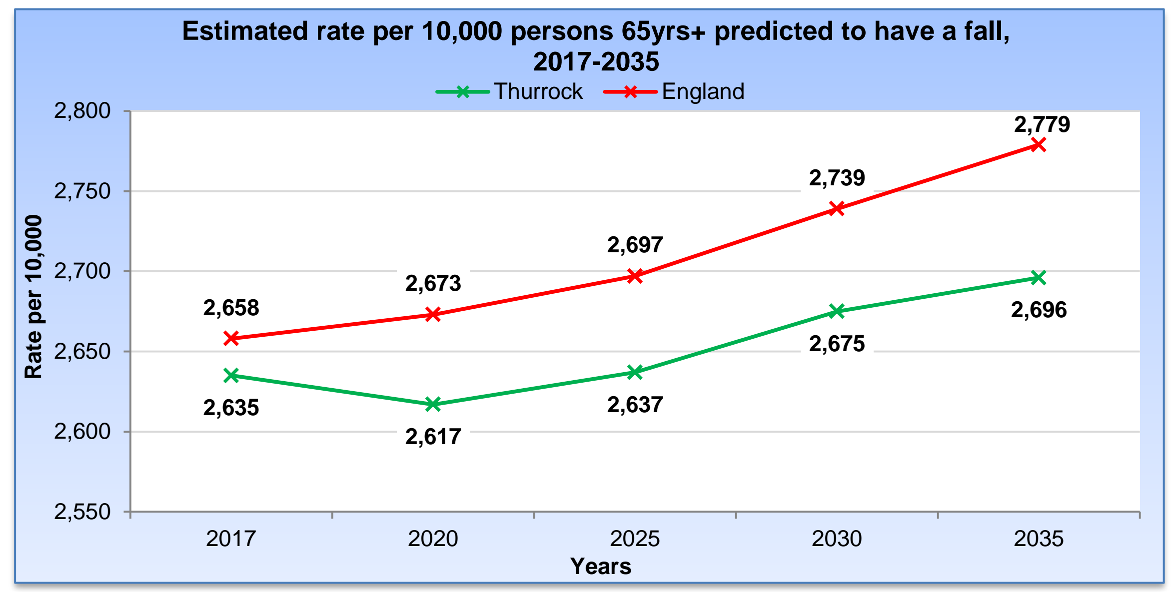
This indicates a need to support residents to access telecare or housing adaptation support at an early stage, to increase the likelihood they can remain independent in their own homes. There is also a need to ensure accommodation for older people is located close to community amenities and green space with safe walking routes to access these to encourage older people to remain mobile rather than to discourage it.

4.8 Falls

Falls are common in older people and are the leading cause of injury related admissions to hospital in people of 65 years and over, accounting for about 14% of emergency admissions and 4% of all hospital admissions in this age group. (68)

Within Thurrock it is estimated that by 2020 a rate of 2,617 per 10,000 persons are predicted to have a fall. By 2035 it is estimated to increase by 2.31% (2,696 per 10,000 persons)

Figure 21 Over 65yrs predicted to have a fall 2017-2035



Source: POPPI 2018

Converting these rates to absolute numbers, it is estimated that the number of adults aged 65+ years in Thurrock estimated to have a fall is set to increase from 6,245 in 2017 to 9,759 by 2035 – an increase of 56.3%.

The rate of patients who have attended A&E with a fall related injury[d] varies across the borough. Ash Tree Surgery has the highest rate of 9.8 compared to Purfleet Care Centre with 1.2 per 1,000 persons. This could be due to genuine differences in occurrences of falls which are severe enough to warrant an A&E attendance, or it could be due to differences in ability to access GP support.

The costs associated with each fall can give an indication of their severity. The table below shows the differing cost of falls in 2017/18 per locality, with Corringham having the highest costs of £51,580 and Tilbury the lowest with £12,379. However, population size alone does not account for the differing costs - when population size is taken into account, it can be seen that whilst Corringham has the highest cost, it does not have the largest number of people aged 65+, meaning the approximate cost per person of a fall is higher. Tilbury conversely has the lowest cost per person in terms of falls. This is also reflected in GP level variation – Hassengate MC (Corringham) has the highest cost and Medic House (Tilbury) the lowest.

[d] Mede Analytics indicators for fall related injuries used – Laceration, Contusion/abrasion, Soft tissue inflammation, Head injury, Dislocation/fracture/joint injury/amputation, Sprain/ligament injury, Muscle/tendon injury

Table 1 Approximate cost per person - A&E related fall injury

Locality	Over 65yrs+ Pop	Total Falls Costs	Approx. per Person
Corringham	3,887	£51,580	£13.27
Grays	8,989	£46,254	£5.15
South Ockendon	4,798	£14,100	£2.94
Tilbury	5,551	£12,379	£2.23

Source Mede Analytics 2017/18

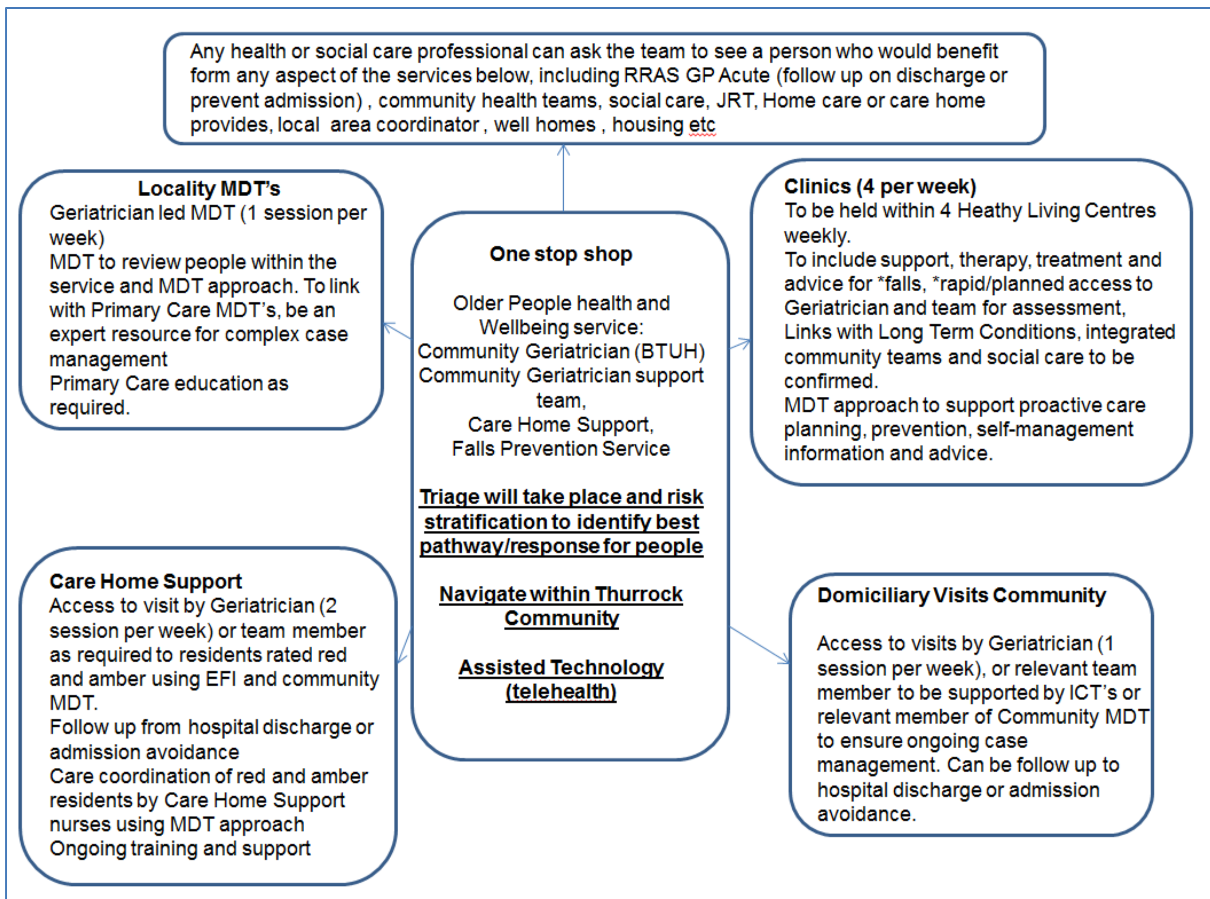
In 2017/18 there were 287 admission spells for Thurrock patients to BTUH with a recorded fall. The total cost of these was £1,344,620, with an average cost per spell of £4,685.
The wider impact of these falls to the longer term health and social care system is vast - one estimate from et al. (69) indicates that the long term care costs resulting from a fall could be as much as £29,479 per person. **Applying this to the Thurrock estimated number of falls (rather than just hospital activity presented above would give long term care costs of £184,096, 355 for the 6,245 older adults estimated to have fallen in 2017, and costs of £287,685,561 for the 9,759 adults estimated to fall in 2035.** Falls prevention approaches can therefore provide a large return on investment - this can be seen through the activity to date from the Well Homes service in terms of the Category 1 Hazards they have removed to date (see section on 5.4.1 Private Housing).

Thurrock has been operating a falls prevention service run by NELFT which is part of the **Older Adults Health and Wellbeing Service**, which would support care and residential homes with the aim to reduce the need for a hospital admission and improve quality of care. The team consisted of a number of roles, including:

- Pharmacist
- Consultant Geriatrician
- Dementia Nurse
- Physical Nurse
- Health Care Assistant
- Physiotherapist
- Assistant Practitioner

A more detailed outline of the service can be seen in the figure overleaf

Figure 22: Older People's Health and Wellbeing Service



Source: Thurrock CCG

There are several elements to the service:

1) Geriatrician-led falls clinic. This is for any patient referred for falls with a medical need, and occurs once a week. In addition to this, there are two geriatrician rapid access clinics where patients are asked about falls as part of their Comprehensive Geriatric Assessment. If a patient requires therapy intervention, the therapist could see them at their home.
2) Home Therapy. The therapy team is made up of a physiotherapist, OT and Assistant Practitioner, and they complete a full falls assessment at the patient's home to include a home hazard check. Patients are educated about falls and given prescribed exercises. Equipment is ordered if the assessment identifies a need. The aim is to see all patients within 15 working days of referral.
3) Falls Group. This is a 12 week programme, with patients being given exercises to complete between sessions. These patients are also offered home-based medication reviews by the pharmacist, in order to help reduce the number of patients who are not compliant with their medication.
4) Care Home Support. In 2017/18, the team were supporting over 500 patients in care homes, offering several dedicated MDT sessions per week. The offer includes the work of the mental health nurse in increasing diagnoses of 'unspecified dementia', completion of medication reviews by the pharmacist in the care home setting, and environmental audits of each care

home and relevant advice/training to staff and care home managers supplied as required. The service is also hoping to trial some gait analysis technology in order to increase the amount of proactive interventions they can deliver.

5) Stakeholder Education. This element involves educating wider professionals such as GPs, sheltered housing staff and ICTs. The trust also carried out the *Significant Seven* training package for care home staff which involved use of a tool to identify patients showing signs of deterioration and to then support development of the appropriate management plan.

Implications

The charts above indicate that the rate of falls is set to increase. This means that, without effective interventions to prevent falls, the number of people requiring long term care, or residential care is likely to increase which is contrary to what older people want and which will also be costly to the system. Evidence suggests that minor home adaptations are effective and cost effective for preventing falls and injuries (see chapter 2) and falls prevention services are also effective and can provide a large return on investment. We need to explore how the local falls prevention offer can mitigate this projected increase in the rate of falls.

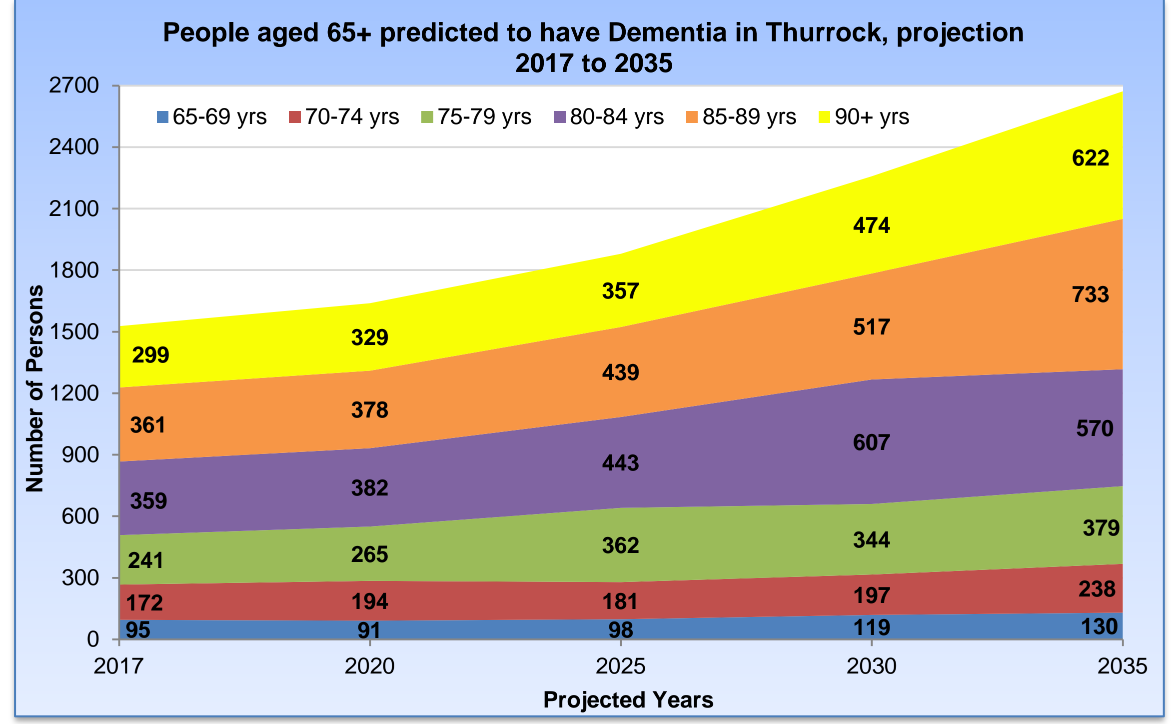
The data also indicates that the cost per person of falls is not uniformly distributed across the borough. This could mean that, in the areas where there is a higher cost per fall, that either more people within that population are falling, or that the falls that are occurring are more severe, or both. Falls prevention services should consider this distribution when targeting interventions.

4.9 Mental Health

4.9.1Dementia

Dementia prevalence is known to increase with age. The graph below shows the estimated number of people aged 65+ with dementia could increase from 1,526 in 2017 to 2,673 in 2035 – an increase of 75.16%. The largest two proportional increases are seen in the 80-84 year olds (103.05%) and 90+ year (108.03%) age groups, which as mentioned previously, are age groups who are already high users of adult social care services. It is worth bearing in mind that the figures below will include some people with dementia who have not received a formal diagnosis, and therefore not receiving care.

Figure 23 Over 65yrs predicted to have Dementia



Source: POPPI 2018

Within Thurrock the prevalence of patients with a diagnosis of dementia ranges across the borough, from St Clements Health Centre (HC) with 0.1% to Chadwell Medical Centre with 1.8%. This could be due to genuine differences in underlying prevalence of this condition between different practice populations and/or differences between GP practices' ability to identify and diagnose this condition in their patients.

Implications

The charts above show that Thurrock can expect to see a large increase in the number of older people with dementia, and that it might not be uniform across the borough. This shows the need for investment into ensuring communities are perceived to be dementia-friendly –further evidence on this can be seen in Chapter Two.

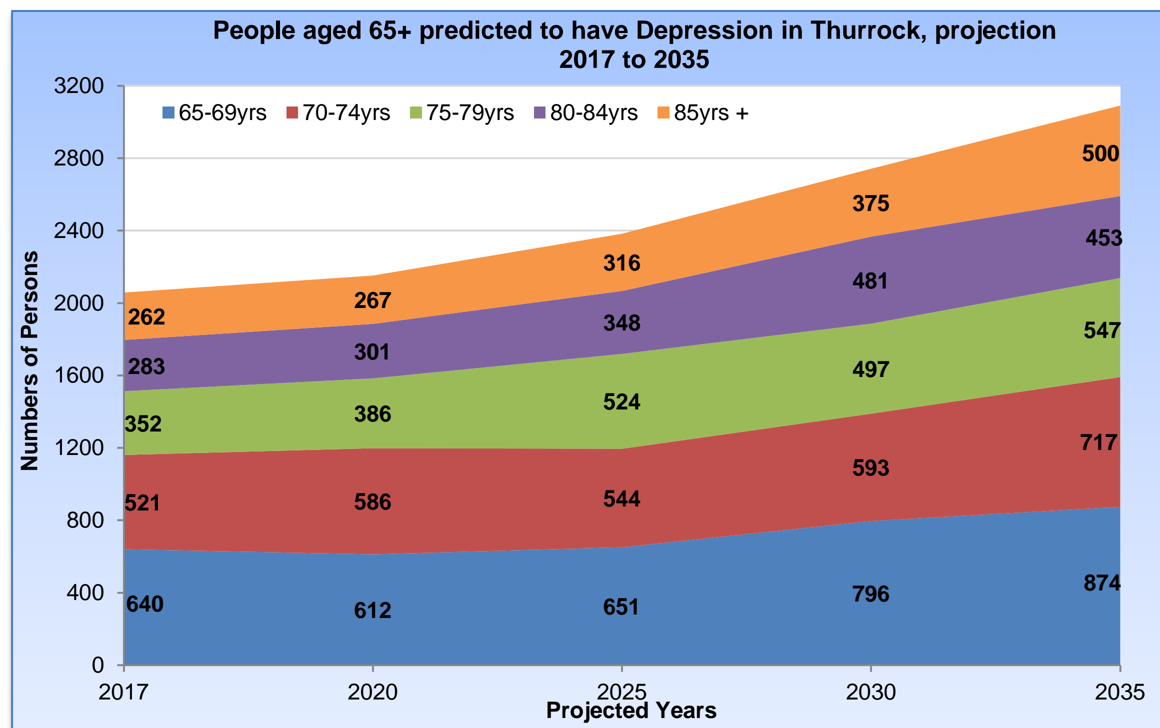
4.9.2Depression

According to Age UK, (70) more than 2 million people in England over the age of 75 live alone, and more than a million older people say they go for over a month without speaking to a friend, neighbour or family member. Whatever the cause, it's shockingly easy to be left feeling alone and vulnerable, which can lead to depression and a serious decline in physical health and wellbeing.

Risk of depression increases with age. Depression affects around **22%** of men and **28%** of women aged 65 years and over and up to 40% in those aged 85+ (71) yet it is estimated that **85%** of older people with depression receive no help at all from the NHS. (72)

The graph below shows the estimated number of people aged 65+ with depression could increase from 2,057 in 2017 to 2,742 in 2035 – an increase of 50.22%. The largest two proportional increases are seen in the 80-84 year olds (60.07%) and 85+ year (90.84%) age groups, which as mentioned previously, are age groups who are already high users of adult social care services. It is worth bearing in mind that the figures below will include some people with depression who have not received a formal diagnosis, and are therefore not receiving care.

Figure 24 Over 65yrs predicted to have Depression



Source: POPPI 2018

Implications

The charts above show that Thurrock can expect to see a large increase in the number of older people with depression and that it might not all be diagnosed and treated appropriately. The impact of depression on the wider health and social care system is huge – information from the 2018 Thurrock Mental Health Joint Strategic Needs Assessment found that between 12-18% of all NHS spend on long term conditions is related to poor mental health, and the presence of poor mental health increases the average cost of NHS service use by each person with a long-term condition from approximately £3,910 to £5,670 a year.

Applying this to the expected increased number of older people with depression locally by 2035, using the assumption that 46% of those with a mental health condition also have a physical health condition, this would mean 315 of these additional older people could cost an additional £1,760 each per year in additional treatment costs.

There are already a number of initiatives underway to improve the diagnosis of depression in the adult population as a whole, including the cleansing of GP registers to identify patients likely to have a diagnosis but not accurately recorded as such, the implementation of depression screening in primary care for patients with Diabetes, and the use of practice level data on IAPT referral activity to drive referrals to treatment services. However more could be done to embed depression screening into the day job of more front line staff (e.g. housing officers) and those professionals who see older people regularly.

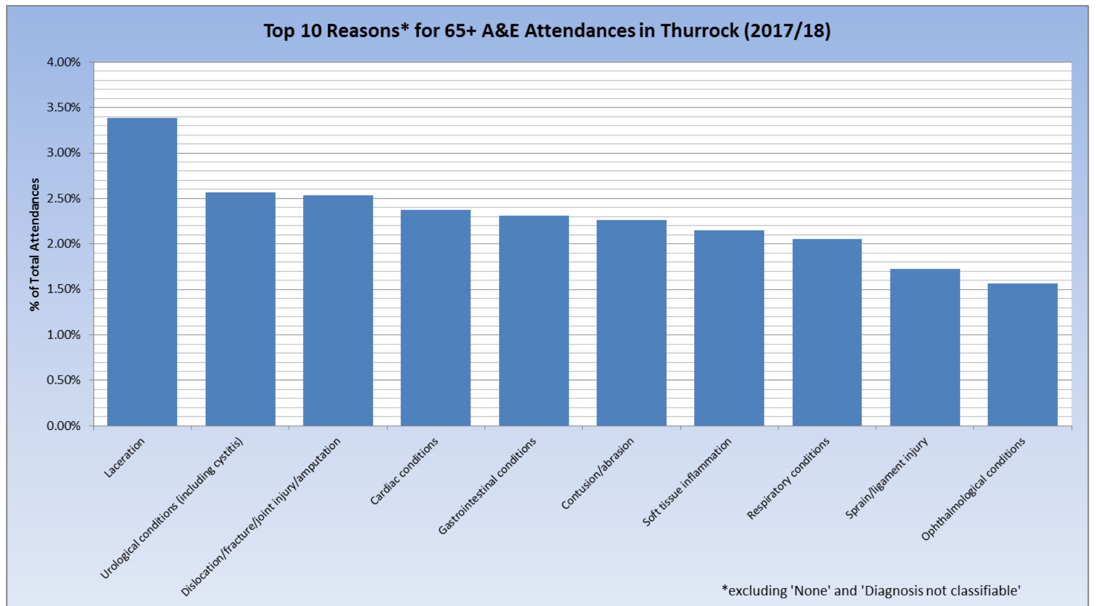
Work is also commencing in Thurrock to develop new, more integrated and holistic models of care for treating common mental health disorders, linking traditional clinical

4.10 Secondary Healthcare Use

4.10.1 A & E

In 2017/18 there were 12,173 A&E attendances for people aged 65+ in Thurrock, with the most popular diagnoses at admission being '*none*' (65.31%) and *'diagnosis not classifiable'* (3.84 This suggests both on-going hospital coding issues, and potentially a cohort of older patients accessing A&E attendances were from people needing advice only; something that can and should be provided in Primary Care, and indicates ongoing issues with the populations ability and/or willingness to access local GP surgeries in a timely way. Where a reason was recorded, the largest proportion of attendances was for '*lacerations*' (3.38%). The top ten reasons are shown in the chart below (excluding the proportion of those where a diagnosis was not known).

Figure 25: Most common reasons for A&E attendances for those aged 65+ in Thurrock, 2017/18



Source: Hospital Episode Statistics

Although Thurrock has a high volume of attendances for which the reason is uncoded, nationally there was much better coding of A&E attendances, with a lower proportion of attendances (42.9%) having an unknown diagnosis, which means it is likely to be a more representative picture of reasons for people attending. National data for the same time period indicated that cardiac and respiratory conditions accounted for 6% of attendances each, and that attendances for dislocation/fracture/joint injury/amputation accounted for almost 5%, so it is likely that there more attendances locally for these reasons than were coded as such.

Overall A&E attendances in Thurrock for 65+ remained relatively stable with a small increase of 134 attendances between 2016/17 (12,039) and 2017/18 (12,173). However the cost increased from £1,545,024 in 2016/17 to £1,740,997 in 2017/18 – an increase of 12.7%. This could signify an increase in the complexity of patients attending A&E. Caution should be taken around this conclusion however due to the high proportion of attendances without a reason recorded.

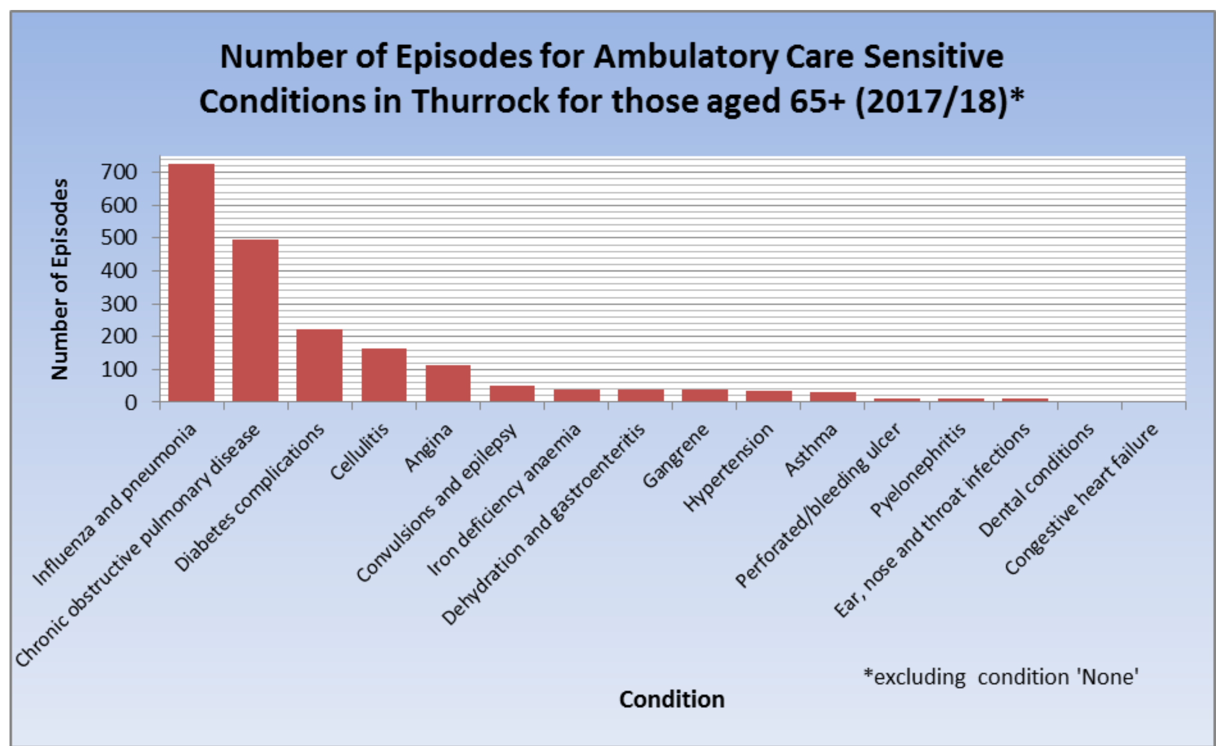
Implications

This information tells us that we don't have the full picture of patients attending A&E aged 65+. However we can make an inference that some of the reasons they are attending for are largely preventable, or could be treated in primary care if the facilities were available. This was quantified in the 2016 Annual Public Health Report, which found that 77% of A&E attendances for all ages fell into this category. This highlights the importance of the current work underway to improve access to primary care – including expanding opening hours and increasing the primary care workforce, improving the quality of primary care given – including incentivising GPs through the Stretched QOF programme which pays GPs to treat more unwell patients, and to detect undiagnosed long term conditions at earlier opportunities (as outlined earlier in the report). The data earlier in the report profiling the increased projected number of falls also underpins the need to continue with evidence-based falls prevention approaches in order to reduce the numbers needing to access A&E for care.

4.10.2 Hospital admissions for ACSCs

In 2017/18 there were 19,747 inpatient episodes of Ambulatory Care Sensitive Conditions (ACSC) for adults aged 65+ in Thurrock. This represents the number of inpatient episodes that could potentially have been avoided if a chronic condition was managed better in primary care. The most common "condition" was 'none' which accounted for 17,755 (90%) episodes. Besides 'none', there are 16 named categories of ASC with the most common being 'influenza and pneumonia' (725) followed by COPD (497), Diabetes (221), Cellulitis (165) and Angina (113). The rest of the conditions account for less than 1% of episodes. The distribution can be seen in the figure below.

Figure 26: Ambulatory Care Sensitive Condition admissions 2017/18, Thurrock patients aged 65+



Source: Hospital Episode Statistics

<u>Implications</u>
This shows us that the top two causes for ambulatory care sensitive conditions – i.e. those largely preventable with better healthcare, are respiratory-based, and therefore could be influenced by work to improve housing quality (see sections on Well Homes and Transforming Homes). In addition, continuing to embed Making Every Contact Count principles across the wider front line workforce is key to earlier prevention or detection of conditions which could be managed within primary care and should not lead to an admission.
This also underlines the importance of promoting healthy lifestyle interventions such as smoking cessation, and encouraging older adults to receive their free flu jab during winter months.

4.10.3 Delayed Transfers of Care

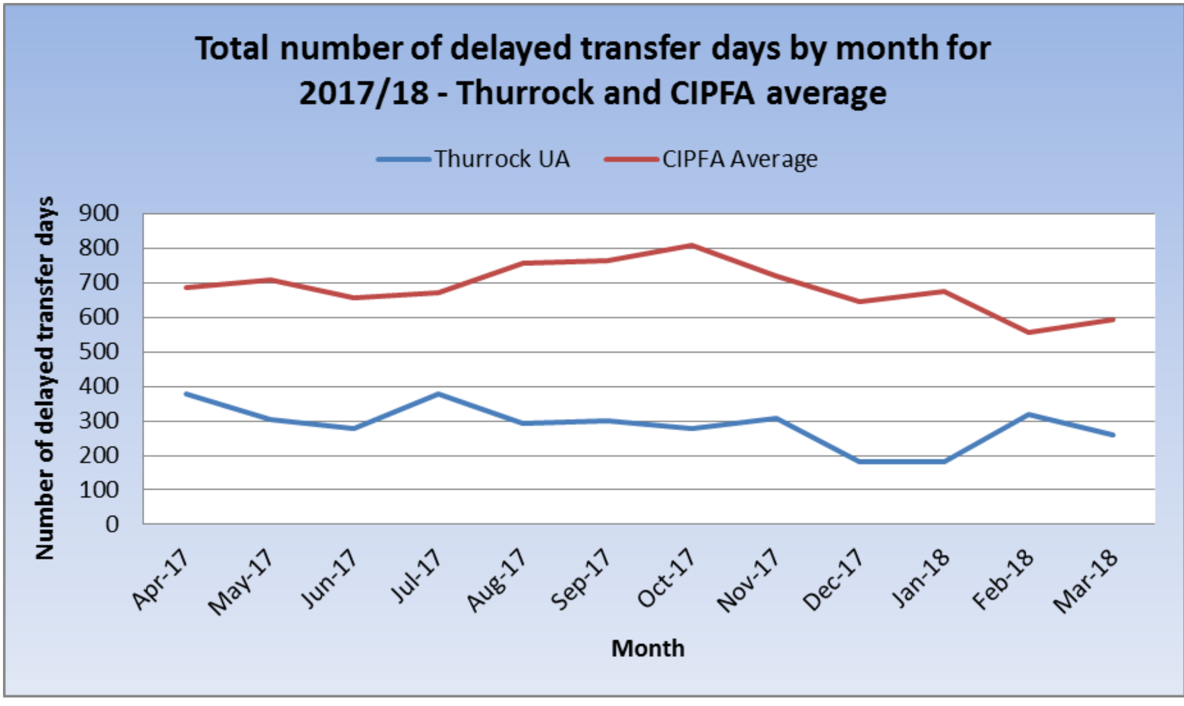
As per the section above on hospital activity, patients aged 65+ are high users of hospital services. Reducing how long older people stay in hospitals can have benefits for patients, hospitals and reduce demand for adult social care. However discharging people from hospital relies on there being a suitable home environment which is equipped to meet their recovery and support needs - whether this is their own home or a type of specialist accommodation.

NHS England reports monthly statistics on "delayed days", which essentially count the number of days when patients who were medically fit for discharge could not vacate their hospital bed.

In 2017/18 there were 3,451 "delayed days" in Thurrock, which is a reduction from the number in 2016/17 (4,255). The latest data available at the time of writing this report was for April-June 2018, during which there were 385 delayed days in total. Comparing this to the same time period during the last two years, this is lower than the April-June period in both years.

Compared to its CIPFA comparators, Thurrock has low levels of delayed transfer of care activity. The chart below shows monthly delayed days for Thurrock and the CIPFA average, and it can be seen that Thurrock has consistently lower days overall than other areas.

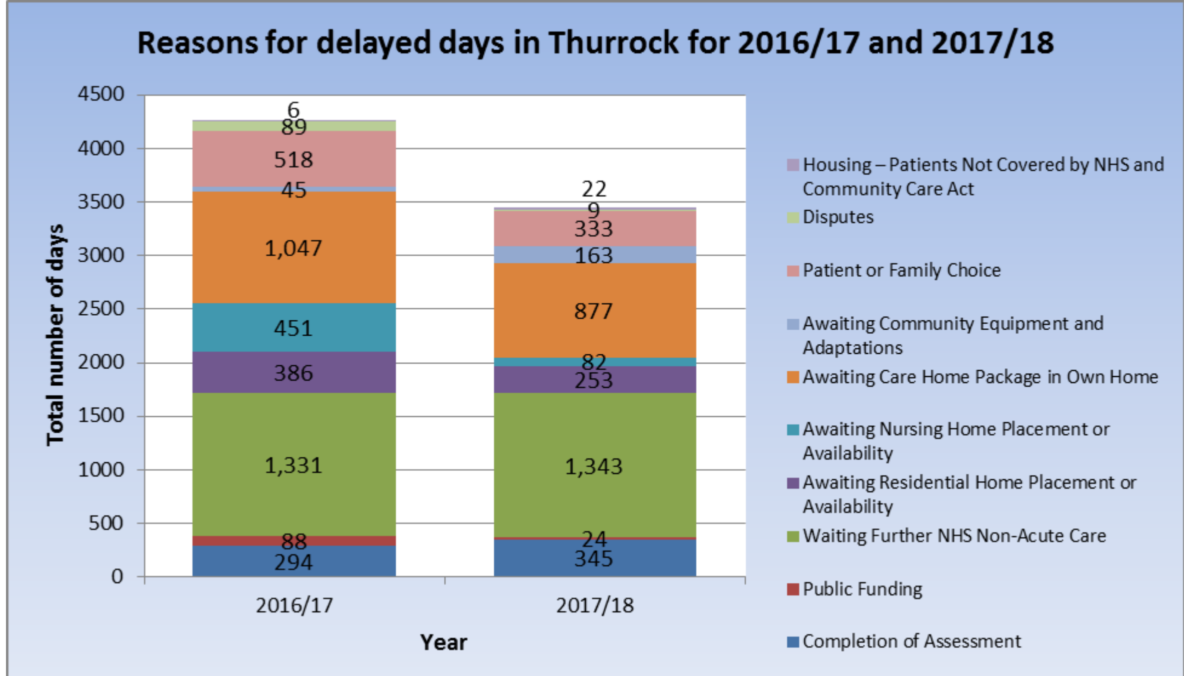
Figure 27: Delayed Days 2017/18 - Thurrock and CIPFA comparators



Source: NHS England

The chart below details the reasons given for delayed days in 2016/17 and 2017/18. The main reasons for delayed days are "Waiting further NHS Non-Acute Care" and "Awaiting Care Package in Own Home". However it can be seen that "Awaiting Community Equipment and Adaptations" accounted for 45 delayed days in 2016/17 but 163 days in 2017/18 - corresponding to 163 days. "Housing - patients not covered by NHS and Community Care Act" is listed as accounting for 6 days in 2016/17 and 22 days in 2017/18.

Figure 28: Reasons for Delayed Days in Thurrock, 2016/17 and 2017/18



Source: NHS England

Implications

The two charts above tell us that whilst Thurrock has decreasing levels of delayed transfers of care, there are some delays caused by lack of equipment or a housing issue which have not decreased over time. This means there could be patients in a hospital bed who are well and could be discharged home if the correct equipment or adaptations were available, and consequently compounding the demand on the healthcare system unnecessarily.

Whilst the delays due to awaiting community equipment and adaptations could be due to either the NHS or Adult Social Care, it is something that should be monitored and could be unpicked further. Further information on the main types of equipment and adaptations accessed by Thurrock residents can be seen in the section on Housing Adaptations.

4.11 Community Connectivity

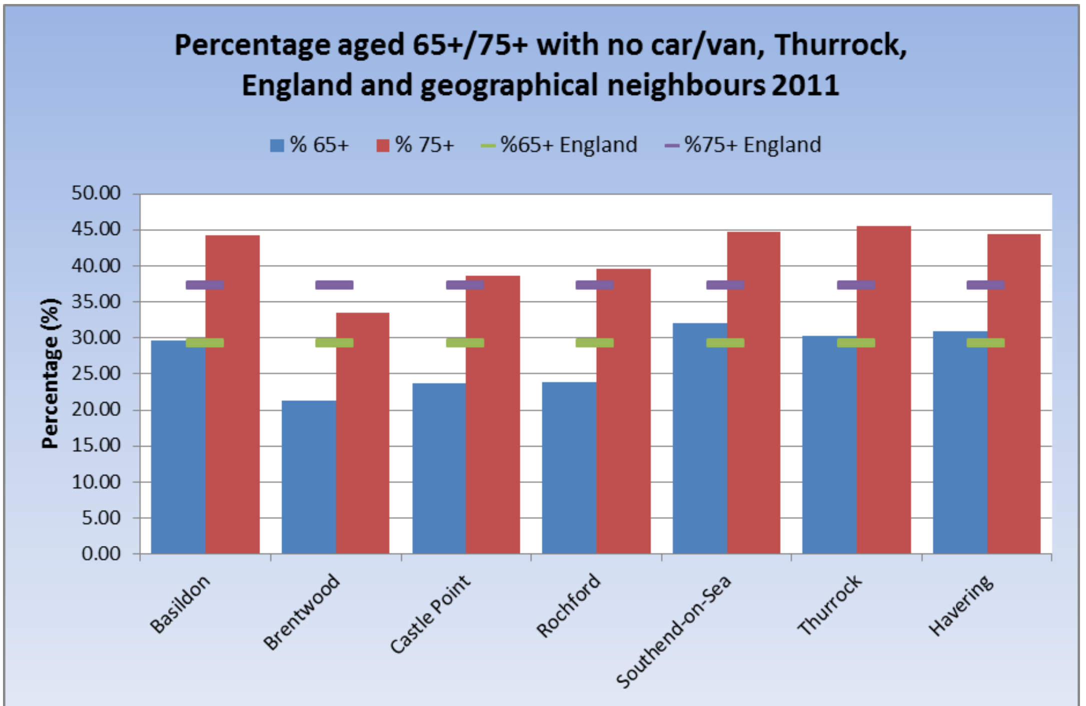
As discussed in Chapter two, feeling 'connected' in the community is vital to well-being, whether this be in terms of physical place or virtually, for the elderly this connection may be even more crucial. Connectivity to the community is therefore a key factor on the effect of quality of life for the elderly.

4.11.1 Physical Connectivity – Ability to access car/van

Thurrock has almost 6000 residents aged 65+ where there is no car or van in the household. Over 45% of those aged 75+ have no car or van leading to the potential for isolation. For over 65's this percentage is just over 30%. Comparatively, Thurrock has a similar percentage of those aged 65+

with no access to a car/van to England, but a higher proportion aged 75+ with no access than England (England average is 37%).

Figure 29: Older people with no access to a car/van, 2011



Source: NOMIS

The 2011 Census details that there were 3987 people aged 65+ in Thurrock who live in one person households where there is no car or van. This varies across the borough, with areas such as Stanford East and Corringham with highest numbers of one person households aged 65+ with no car or van. However there could be several reasons including affluence in areas such as Chafford Hundred and Orsett, so they may be able to afford to run a car more easily. Public transport may also play a part; as described in Chapter two, public transport is seen as an essential age –friendly feature and some elderly people may not feel the need to run a car if the transport links in their area are sufficient for their needs.

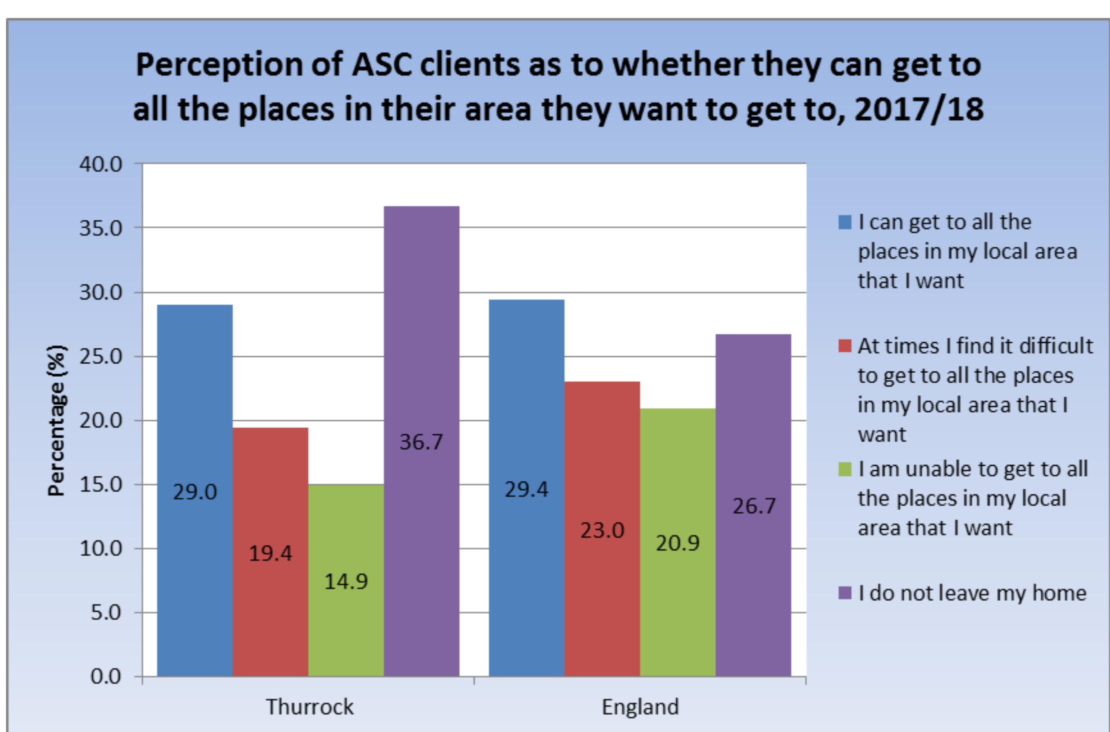
Implications

This chart highlights that there are a higher proportion of residents aged 75+ in Thurrock who are unable to access a car/van than nationally. The evidence shows that whilst older people walk more, their risk of falling increases. This finding emphasises the importance of designing places which have age friendly features such as safe pedestrian routes with resting places and no hazards, and providing homes in locations where facilities can be easily accessed; and for those parts of the borough with higher numbers of lone-person households with no car/van, ensuring that community facilities can be reached by public transport.

4.11.2 Perceived accessibility

Lack of access to a car/van might not be the only reason older people might not access facilities in their local area. The Adult Social Care survey found that 36.7% of respondents stated that they do not generally leave their home, and another 14.9% felt that they were unable to get to all the places they wanted to. Whilst the reasons were not given, this highlights the importance of a) ensuring the home is safe and fit for purpose if many older people are not leaving it regularly, and b) looking at ways to support people to leave their homes if they should want to. It might be that provision of telecare equipment (e.g. pendant alarms) or support with accessing appropriate public transport may facilitate this group of older people to access the places they wish to; however it might be that more research is required to understand the reasons in more detail.

Figure 30: Perceived accessibility for ASC clients, 2017/18

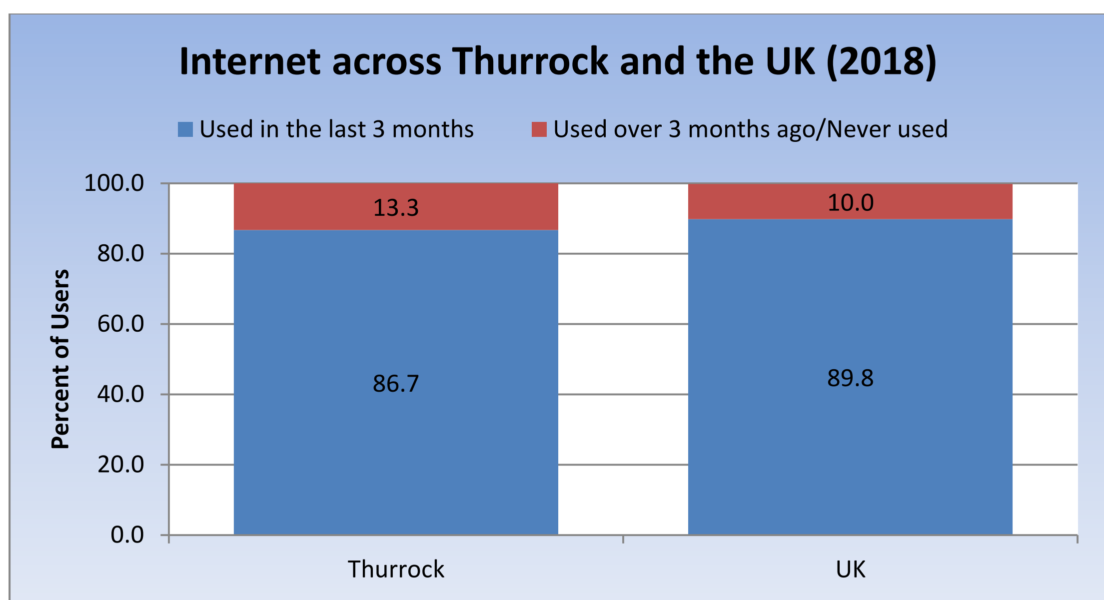


Source: Adult Social Care Service User Survey, 2017/18

4.11.3 Digital Connectivity

A growing amount of social contact is undertaken via the internet – this could be via emails, websites or apps such as WhatsApp. This can offer the opportunity to facilitate and enable contact with others and has the potential to increase connectivity and reduce risk of loneliness. When compared to the UK, Thurrock has a slightly lower percentage of users who have used the internet recently. In Thurrock, 86.7% of 16+ residents have used the internet in the last three months while the figure is 89.8% for the whole of the UK. However, despite the small difference, it is clear that a very large proportion of Thurrock residents are regular internet users.

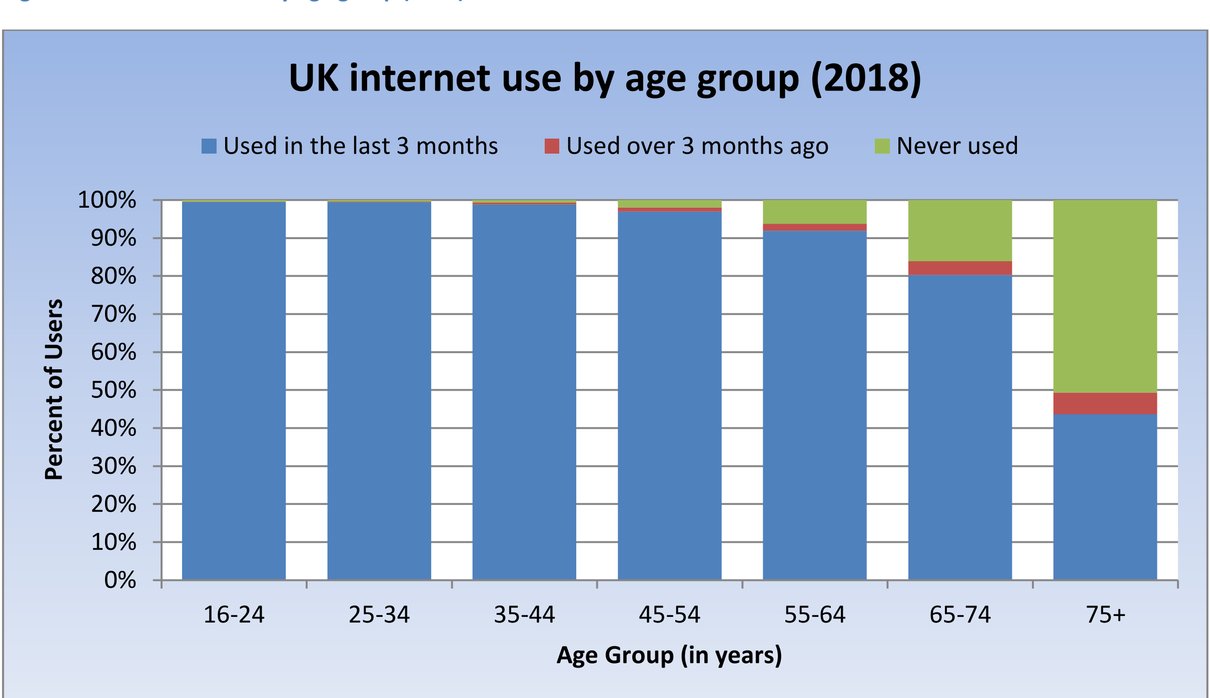
Figure 31: Internet usage within the last 3 months, Thurrock/UK (2018)



Source: ONS: Internet Users 2018

Nearly all adults between 16 and 44 have used the internet in the past three months. Usage begins to drop off in the 45-54 age range and then continues to drop as age increases with the most dramatic fall occurring between the 65-74 group and those aged 75+ - over half (50.6%) of those aged 75+ have 'never used' the internet and a further 5.7% use it very infrequently (over 3 months ago). This shows a clear pattern that that internet usage decreases with age and that older people in the UK are less likely to use the internet than younger groups.

Figure 32: UK internet use by age group (2018)



Source: ONS: Internet Users 2018

There has undoubtedly been growth in internet usage in the last decade with regular (daily or almost daily) users increasing from 72% in 2011 to 82% in 2016. However, data shows that only 74% of regular internet users rate their ability as good or excellent and 77% have basic digital skills. This suggests a skills gap amongst internet users as 5-8% use the internet regularly but do not have good digital skills. There is an even larger gap when it comes to critical literacy on the internet (the ability to distinguish accuracy or bias on a website) which is only high amongst 62% of internet users.

Implications

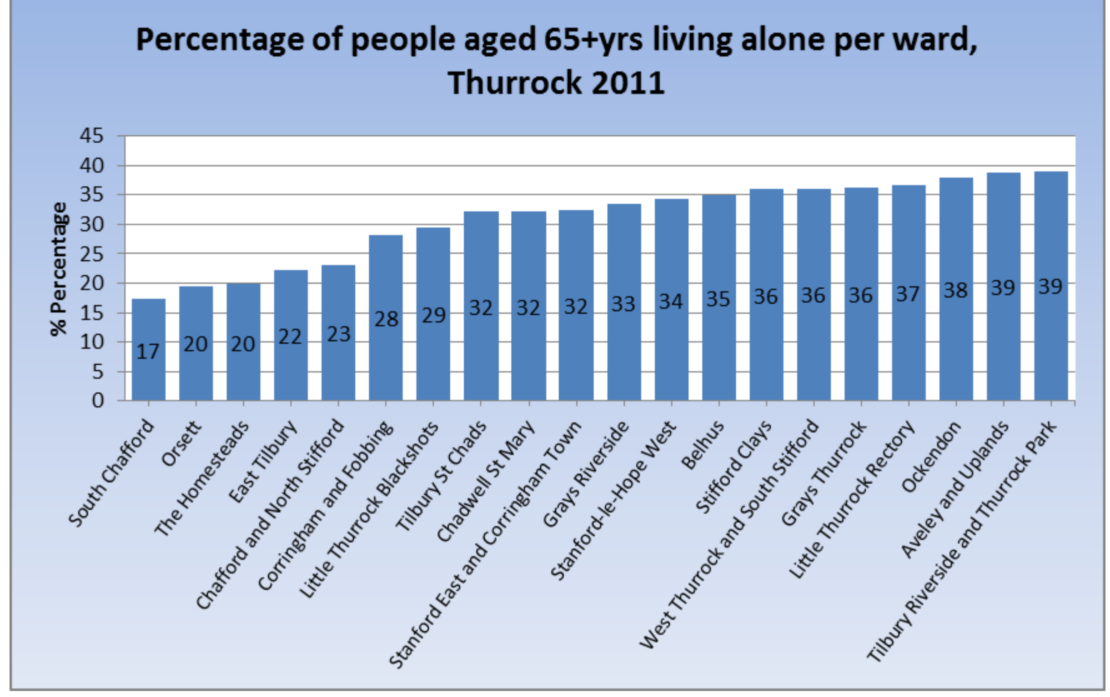
The charts above indicate that Thurrock has a slightly higher proportion of adults who do not use the internet, and that they are likely to be older adults (if the national assumptions on usage by age are applied). Evidence suggests that digital connectivity can bring benefits to older people. Triangulating this with the segmentation data on our older population groups, it is likely that we will have some residents who may benefit from support with using new technologies via education and training. This should also be considered when promoting new telecare and telehealth solutions.

It also shows however that we are likely to have large numbers of "younger older people" who are confident using the internet, so we can continue to use those as assets in supporting others to do so – e.g. via the community hubs.

4.11.4 Social Isolation and Loneliness

Living alone is one risk factor for social isolation and loneliness. Amongst our older population, the percentage of those aged 65+ who live alone ranges by ward, from 17% in South Chafford, to 39% in Aveley and Uplands and Tilbury Riverside and Thurrock Park.

Figure 33: Percentage of older people living alone per ward, 2011



Source: Census 2011

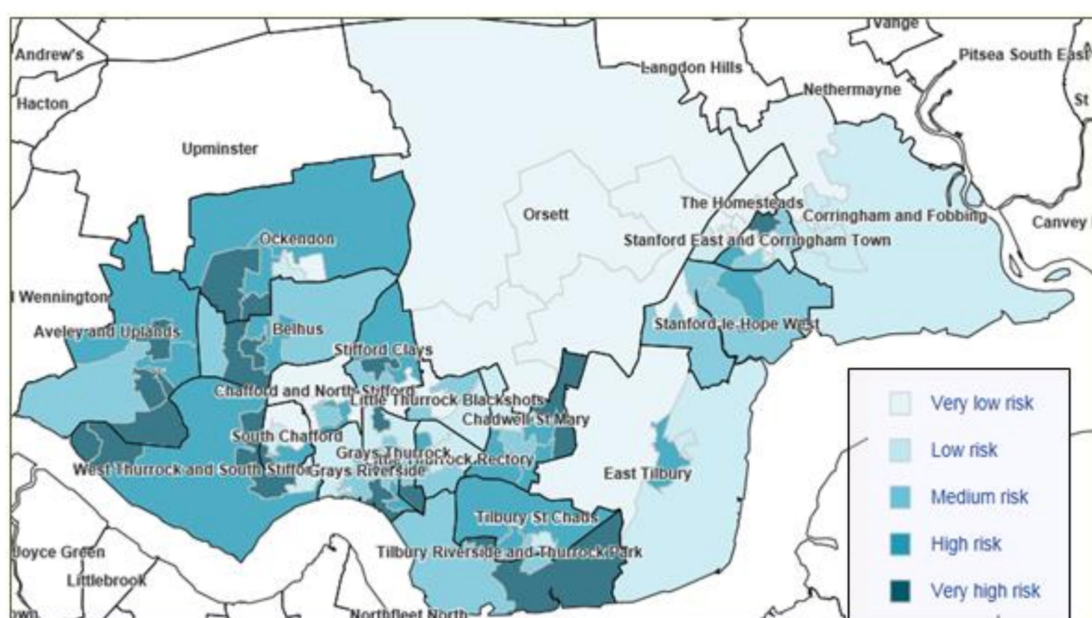
Age UK produced data showing the relative risk of loneliness across Thurrock based on the Census 2011 figures for the following factors:

- marital status
- self-reported health status
- age
- household size

These four factors predict around 20% of the loneliness observed amongst older people 65 and over as represented in the English Longitudinal Study of Ageing (ELSA). Looking at this data at ward level, the wards with the highest odds of being lonely in the elderly are Aveley and Uplands and 'Tilbury Riverside and Thurrock Park' (-3.5 and -3.51), which as mentioned above, have the highest proportions of older adults living alone. The Homesteads and Orsett wards have the least likely odds (-4.36 and -4.26), which is despite Orsett having the highest number of 'legacy elders' and 'outlying seniors'.

The two wards identified above as having high risk of loneliness do both host Community Hubs, which are often accessed by older people for a range of activities.

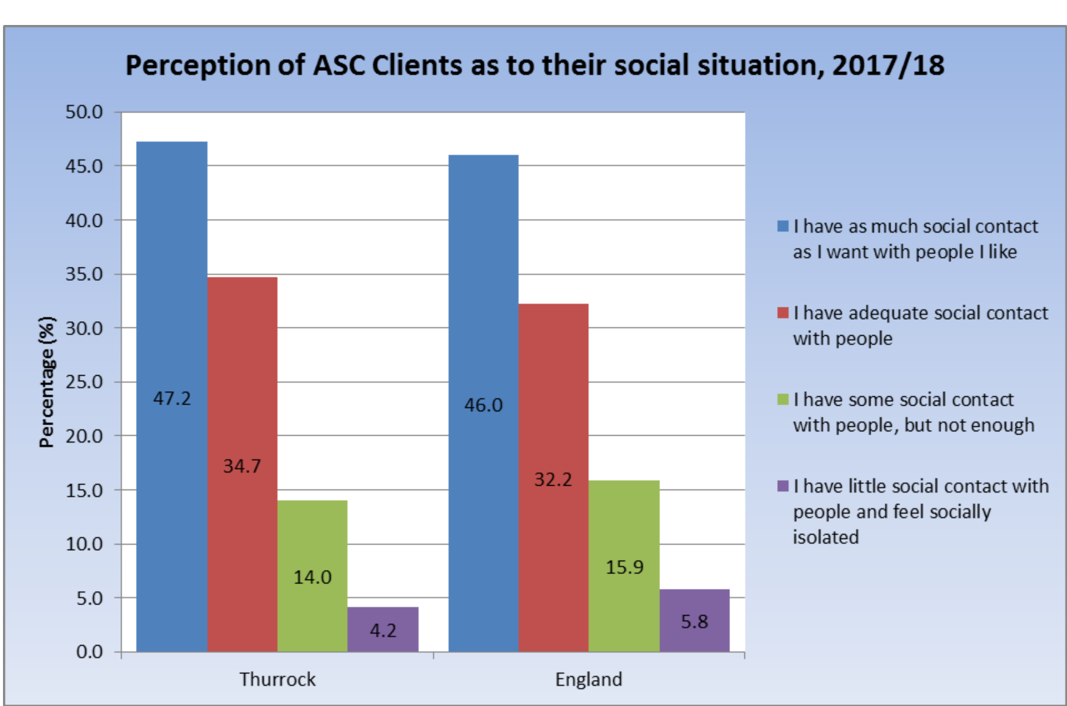
Figure 34: Risk of Loneliness as calculated by Age UK, 2016



Source: Age UK

Another group at high risk of feeling socially isolated are those in receipt of Adult Social Care services. Findings from the latest service user survey indicate that 14.0% of Thurrock's social care service users do not feel they have enough social contact with people, and a further 4.2% reported that they feel socially isolated. These are slightly lower percentages than the national average (see figure below).

Figure 35: Perception of ASC clients as to their social situation, 2017/18



Source: Adult Social Care Service User Survey, 2017/18

Thurrock operates a social prescribing service enabling GPs to refer patients for non-medical needs. Data from the service in the last 9 months indicates they saw approximately 130 patients aged 60-90 years out of 700 in total, with varied reasons for referral. The service often finds that, upon further discussions, the initial reason for referral might lead to wider issues being unpicked such as social isolation. The social prescribers could signpost to local clubs, befrienders and activities, but lack of personal mobility, the location of their homes and limited access to public transport can prevent them becoming engaged in their local community.

The service says:

"We have met elderly patients living independently in privately owned homes, privately rented and council accommodation. Family homes are no longer appropriate, spouses, immediate neighbours and friends might have died and children and extended family do not necessarily live locally. Housing, decreased mobility and ill health contribute to social isolation and low mood. They would benefit from purposeful activities and clubs but they are not always accessible. "

Implications

The charts above indicate that Thurrock has a cohort of Adult Social Care service users who perceive that they do not have as much social contact as they like, and that there is variation across the borough in terms of potential risk of social isolation and loneliness. Thurrock's approach to community development in terms of local area coordination, social prescribing and community hubs are vital in promoting social contact and reducing the risk of loneliness particularly amongst these higher risk groups. The case studies in Chapter Two outline some examples of housing developments that incorporate elements of social spaces and facilities which could reduce the likelihood of loneliness in older age.

CHAPTER 5: Current Housing Provision in Thurrock

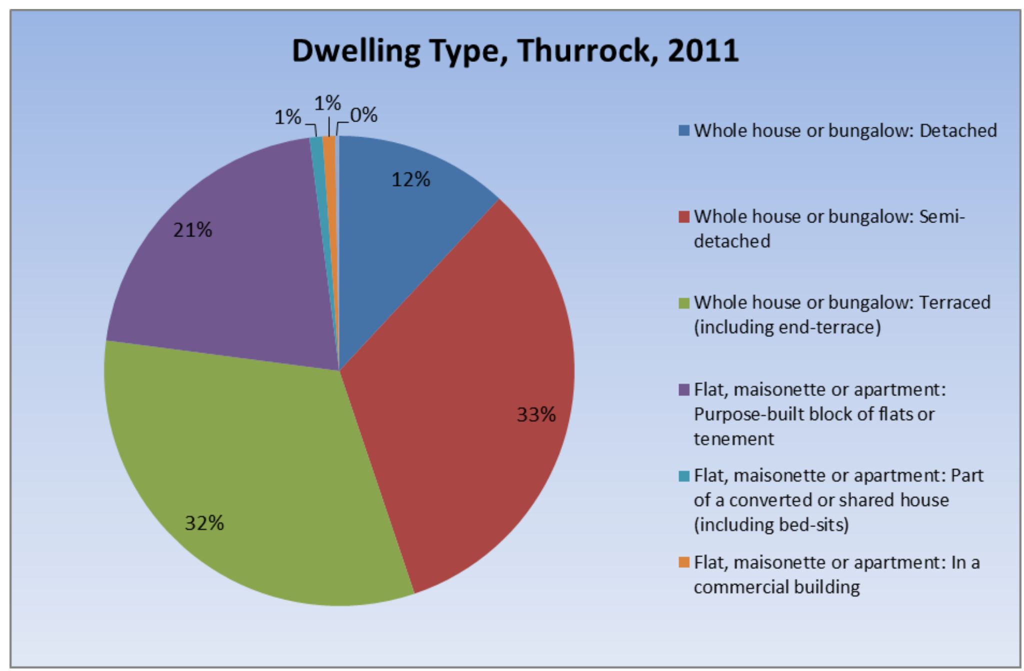
Key Points

- The majority of housing in Thurrock is houses/bungalows, with 77% in this category and 23% as flats.
- Housing types differ across the borough, with wards such as Corringham and Fobbing containing 95% houses/bungalows, whereas in wards such as Grays Riverside, flats make up more than half of the properties.
- 63.8% of housing stock is owner-occupied, though as above this ranges per ward – with wards such as Corringham and Fobbing with nearly 90% of homes owned, but in wards such as Tilbury Riverside and Thurrock Park, this is around 45%.
- The average house price in Thurrock is £275,000 (2017); although the variation between house prices in West Thurrock and in Orsett is £156,750.
- The average price for flats has increased by 500% in the last 20 years, which is faster than the price rise for houses.
- In terms of affordability, the ratio between median house price and earnings in Thurrock is 9.32 (2017) which is higher than the national average of 7.8.
- 5.6% of dwellings in Thurrock can be classified as overcrowded.
- There is specialist housing provision available in the borough for older people – including care homes, sheltered housing and extra care homes.
- Work has been underway to improve housing quality – 7800+ Council-owned homes have been transformed under the Transforming Homes programme, and 2,111 people in private housing have been reached via the Well Homes programme, resulting in estimated savings of £1.5m in the last three years.
- The Council and NELFT have both provided a number of adaptations and telecare packages – the most common types of larger adaptations provided are shower adaptations and stair lifts. Other types of telecare provided include pendant alarms
- 8.7% of Adult Social Care service users surveyed said that their house either met some or none of their needs – which could indicate an unmet need for telecare or adaptations.

5.1 Housing Types and Tenures

The most recent data supplied by the Housing Team in Thurrock Council indicates that we have approximately 70,000 dwellings in the borough. The 2011 Census gives a breakdown of dwelling types: 77% could be classified as whole houses or bungalows, and 23% as flats, maisonettes or apartments. This distribution can be seen in the chart below.

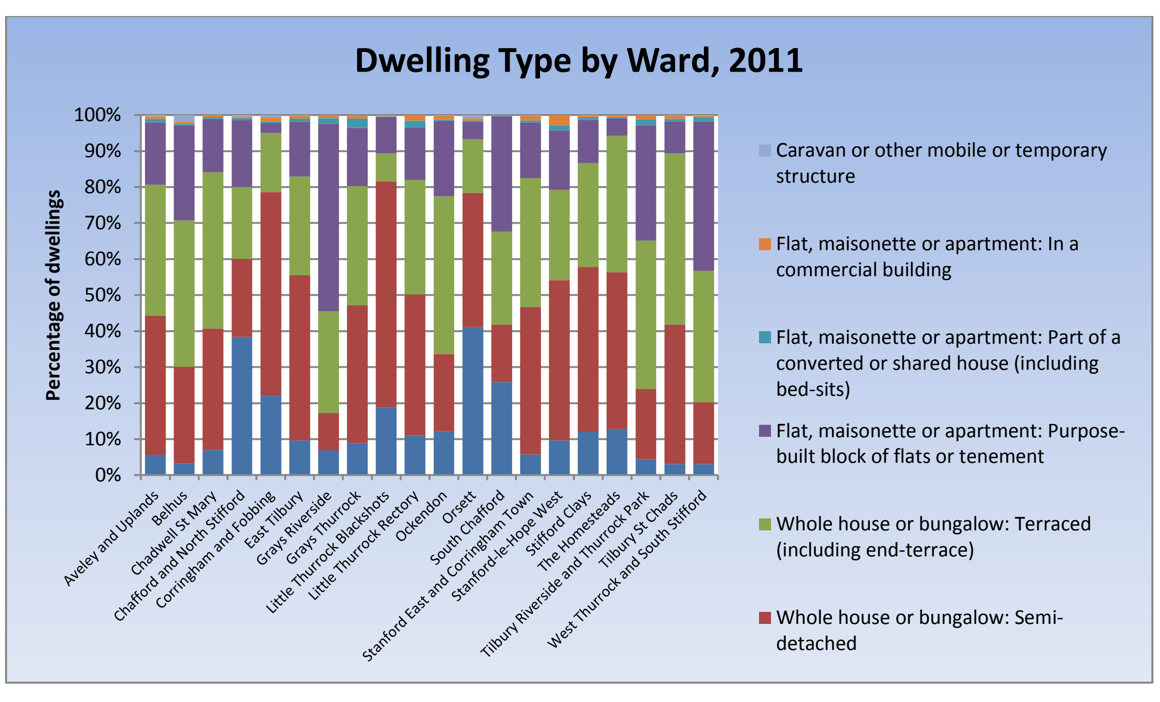
Figure 36: Dwelling types in Thurrock, 2011



Source: Census, ONS

This distribution of dwelling types is not uniform across the borough. The chart below shows this at ward level, and it can be seen that wards such as Corringham and Fobbing, and The Homesteads have high proportions of detached dwellings, whilst Grays Riverside has more than 50% of its dwellings classified as flats. It should be noted that this data is from 2011 and as such might not represent the current distribution accounting for properties built since then.

Figure 37: Dwelling type by ward, 2011



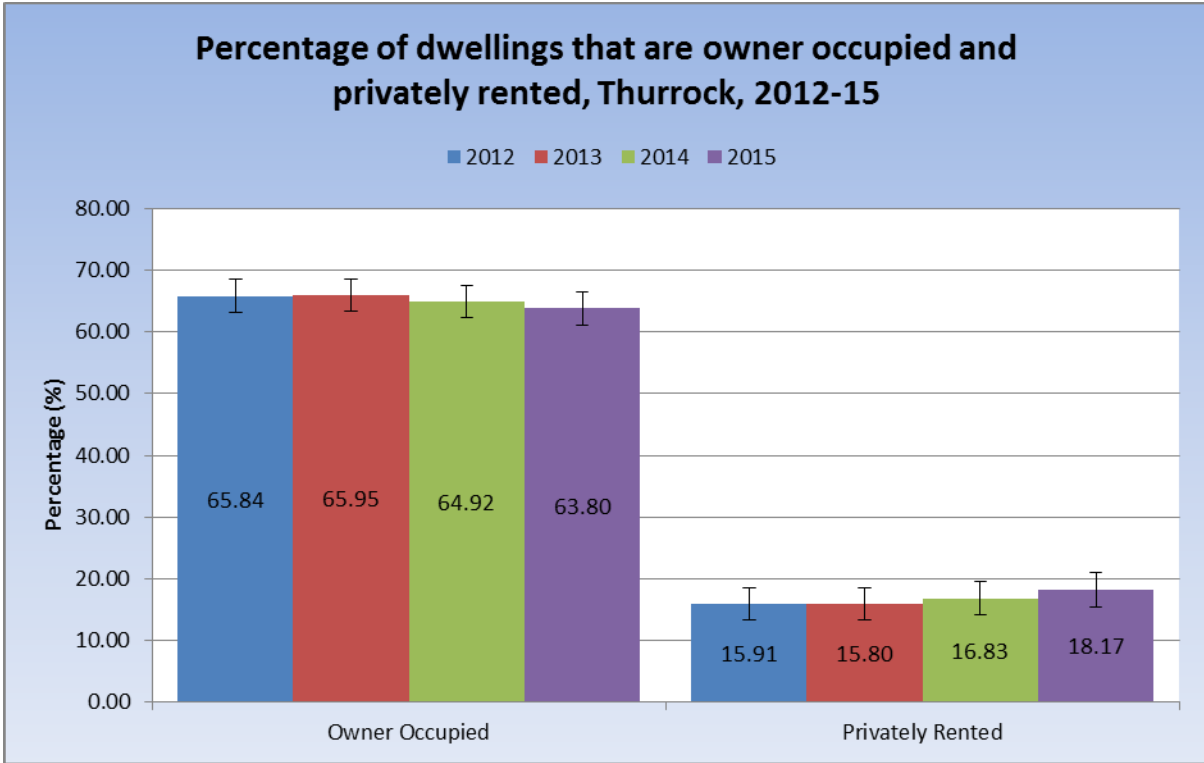
Source: Census, ONS

The majority of housing stock in Thurrock is owner-occupied, with estimates from 2015 approximating that 63.8% of dwellings in the borough were owner-occupied. The private rented sector was estimated to account for 18.2% of dwellings in 2015. Whilst estimates were not available within the same dataset for the social rented sector, the Census 2011 found social renters to account for 18.4% of Thurrock's stock, which is broadly in line with the 18.03% of dwellings unaccounted for in the chart below.

This data might help us to understand the need for different tenure types for specialist housing for older people in future. National evidence suggests that there are not enough specialist homes available to buy which may be one barrier for older people in moving home.

It can also be seen in the chart below that whilst owner-occupancy appears to have reduced and private rented appear to have increased, this cannot be viewed as significant due to the reliability of the data.

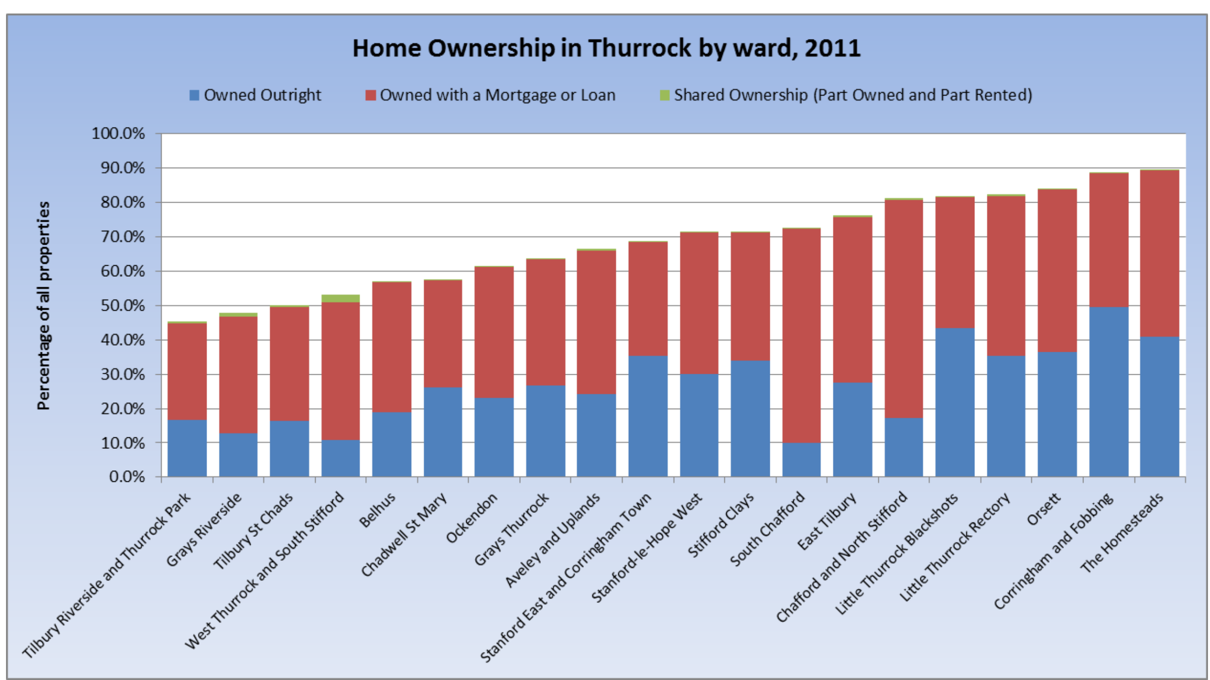
Figure 38: Owner occupied / privately rented dwellings, 2012-15



Source: Sub-national dwelling stock by tenure estimates, ONS

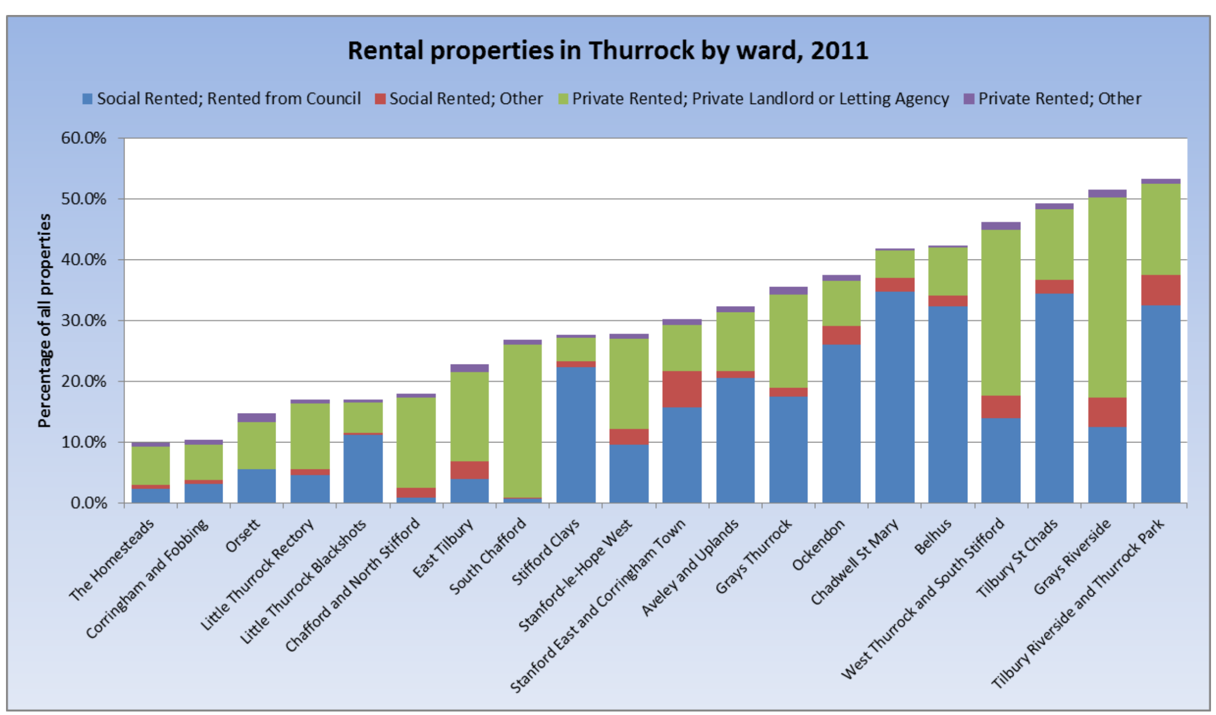
However we know there is a large amount of variation within Thurrock. The two charts below show the proportion of properties that were owned and rented within each ward – it can be seen that in wards such as Corringham and Fobbing and The Homesteads, almost 90% of homes were either owned outright or owned with a mortgage, but in wards such as Tilbury Riverside and Thurrock Park, this figure was just under 45%. In the second chart, it can be seen that there is a variation in the type of rental – for example, wards such as the two Tilbury wards have higher proportions of Council properties, whilst wards like Grays Riverside have large proportions of rented properties, but the majority come from a private landlord (33%).

Figure 39: Home Ownership by ward, 2011



Source: Census, ONS

Figure 40: Rental properties by ward, 2011



Source: Census, ONS

Implications

The charts above indicate that the majority of homes are owner-occupied, although there is widespread variation in the borough. This should be considered in strategic planning decisions on provision for older people's housing.

A high level of home ownership could also mean a number of older people in homes they have lived in for some time, and therefore the responsibility for adapting these for future needs would lie with the individual. Evidence shows that it is cost-effective to adapt a home in order to prevent falls, or onward admission to residential care because a person cannot live independently, equally delays in receiving adaptation can negatively affect the effectiveness of that adaptation. The data above suggests that support for and access to adaptations within Thurrock should be reviewed to ensure that owner-occupiers in need as well as rental tenants are accessing the necessary adaptations.

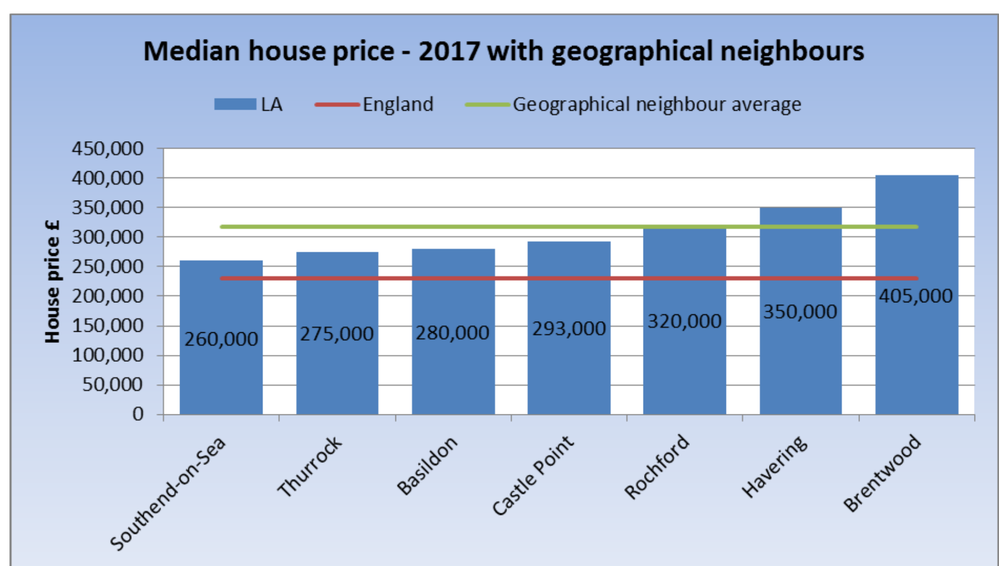
Additionally, this data may assist in identifying the need for the proportion of homes by tenure that are built in the future, particularly in terms of specialist homes, where the lack of options to buy a property may act as a barrier to moving for existing owner-occupiers. A range of homes for older people, of different tenures, are likely to be required.

5.2 Affordability of Current Stock

5.2.1 Current House Prices

In 2017 the average cost of a property in Thurrock was £275,000, which is higher than the national average (£230,000) but lower than the majority of our geographical neighbours, with only Southend having a lower median house price than Thurrock [see chart below]. It should be noted that the percentage increase from 2013-17 in median house price was 59.6% in Thurrock, which was more than double the increase seen nationally (24%).

Figure 41: Median House Price, Thurrock and Neighbouring LAs, 2017

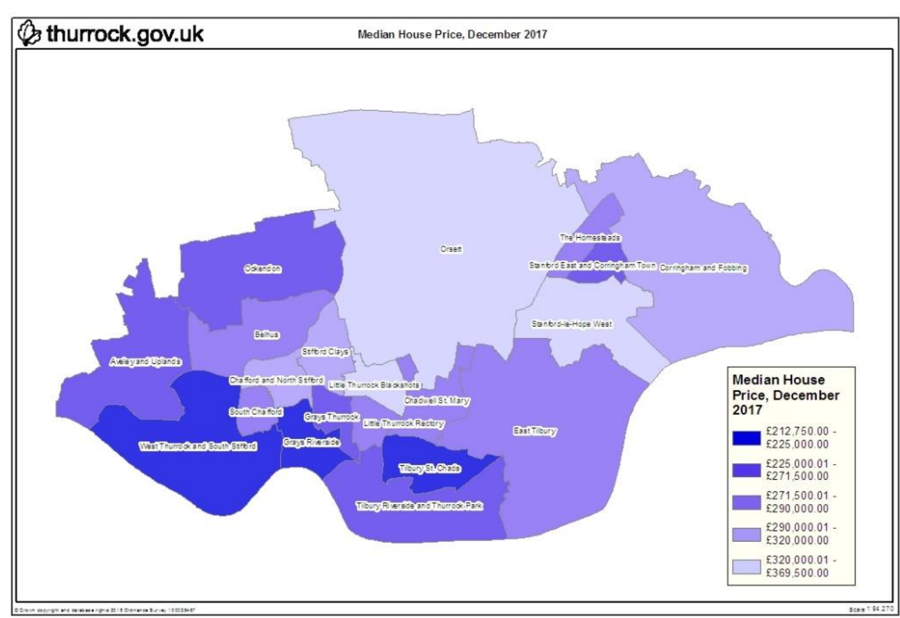


Source: House Price Statistics for Small Areas, ONS

As with the median house price, the same pattern can be seen when looking at the lower quartile house price, in that Thurrock again has the second lowest (£224,000) of its geographical neighbours, and that it is higher than the England average (£151,000). It should be noted that the percentage increase from 2013-17 in lower quartile house price was 60% in Thurrock, which was more than three times the increase seen nationally (18.1%) and is consistent with the rate of change in median house price.

House prices also vary within Thurrock – in December 2017 the median house price ranged from £212,750 in West Thurrock, to £369,500 in Orsett. This can be seen in the map below.

Figure 42: Median House Price by ward, December 2017

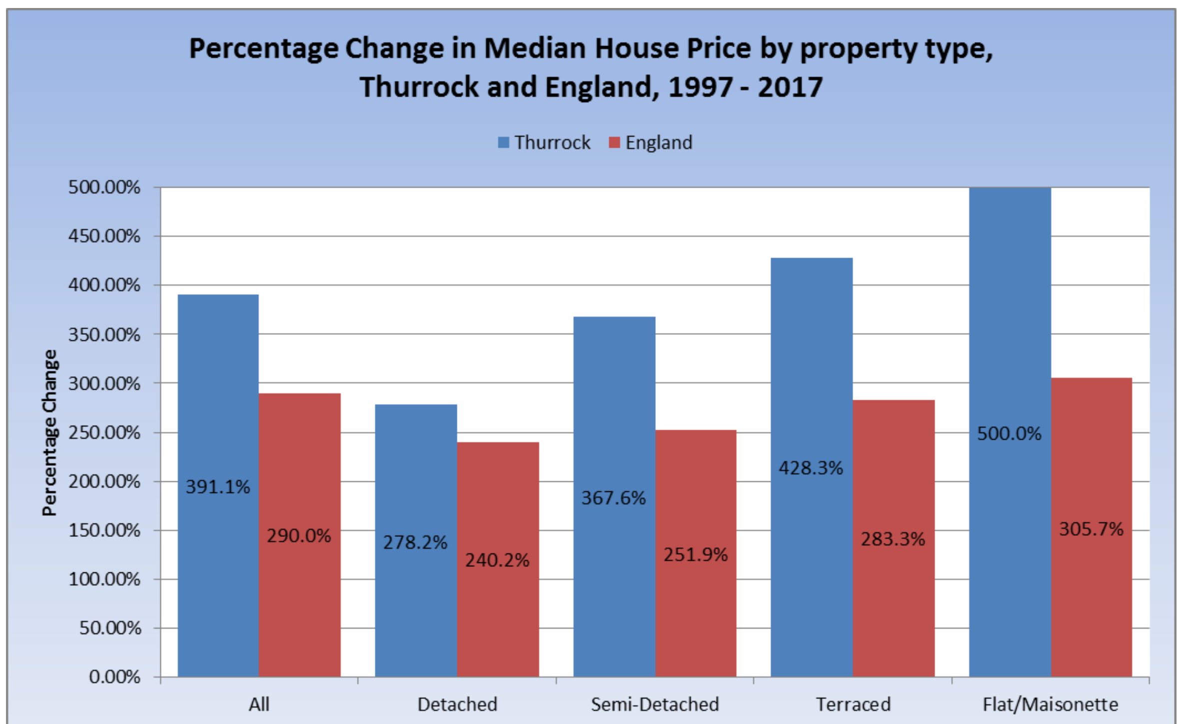


Source: House Price Statistics for Small Areas, ONS

5.2.2 Affordability by type of dwelling

It should be noted that the analyses above look at the median house price for all types of dwelling, thereby disguising variation by property type. Analysis of the change in median house prices by different type of property indicates that whilst the growth rate in Thurrock is above the England average for all types, the median price for flats and maisonettes has increased by 500% locally compared to 305.7% nationally, and for terraced properties has increased by 428.3% compared to 283.3%.

Figure 43: Percentage change in median house price by property type, Thurrock and England, 1997 to 2017



Source: House Price Statistics for Small Areas, Office for National Statistics

Figure 40 shows there are wards such as Grays Riverside and West Thurrock and South Stifford with high proportions of their dwellings as flats. This should be considered alongside Figure 42, which shows these areas to be comparatively more 'affordable' than other parts of the borough. So it might be that the 'affordability' of these areas will reduce in the future at a faster rate than other parts of the borough.

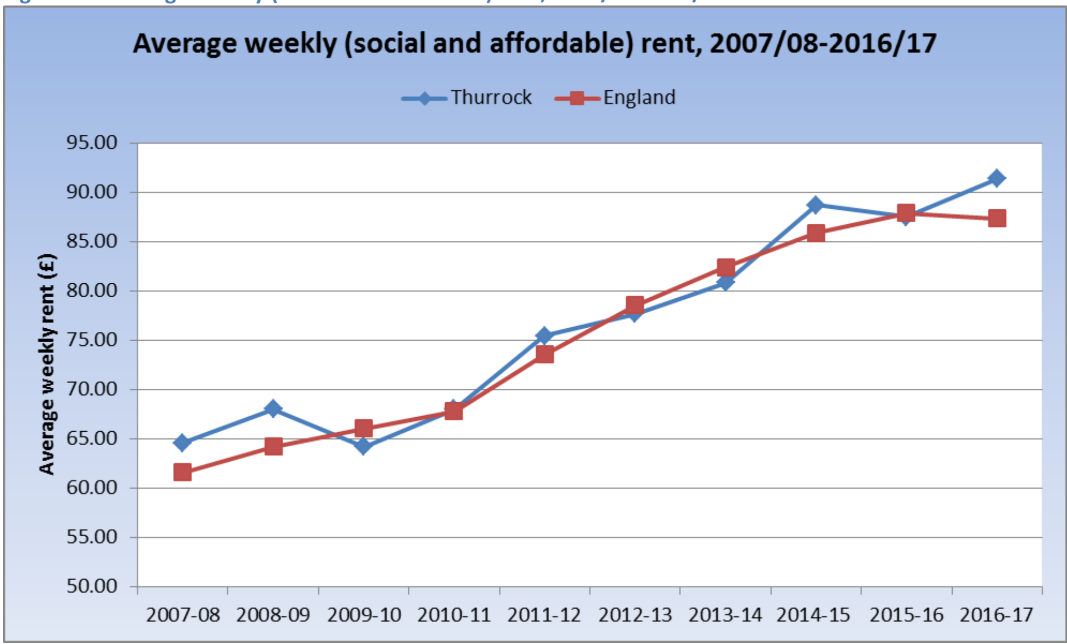
5.2.3 Affordability in rental properties

Whilst the charts above depict the increase in house prices and their impact on affordability, it can also be seen that rental prices have increased over the last ten years. Rents in Thurrock remain higher than England's, perhaps unsurprisingly as rent charged is likely to be associated with the capital value of property (rental yield) and hence the size of mortgage required by a private sector landlord to acquire it. The growth in private sector rent is largely in line with England's which suggests that rental yield from property in Thurrock is falling.

The first figure below shows social and affordable rent in Thurrock and England, and it shows that Thurrock's average weekly rent has increased from £64.58 in 2007/08, to £91.43 in 2016/17 – an

increase of 41.6%. Nationally, social rents have increased at approximately the same rate (41.77%) although social rent nationally is cheaper than in Thurrock (£61.62 in 2007/08 and £87.36 in 2016/17).

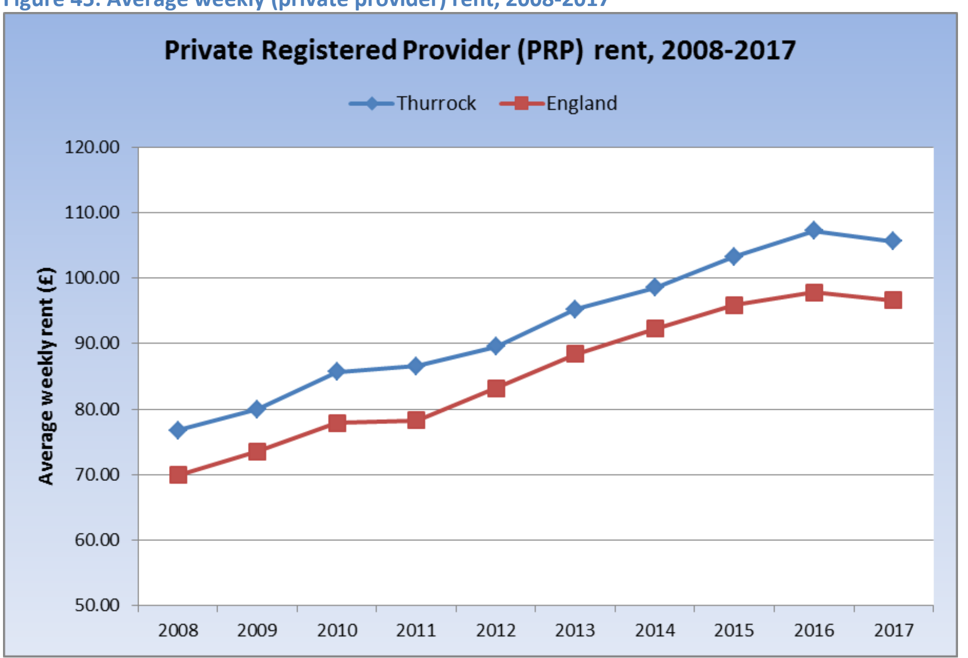
Figure 44: Average weekly (social and affordable) rent, 2007/08-2016/17



Source: Ministry of Housing, Communities and Local Government

Looking at the private rental provider rents, a similar pattern can be seen to the social rent data shown above - in 2017 the average weekly rent in Thurrock was £105.60, having increased by 37.57% from 2008 where it was £76.76. Nationally rent increased by 38.09% from £69.96 to £96.61 in the same time period.

Figure 45: Average weekly (private provider) rent, 2008-2017



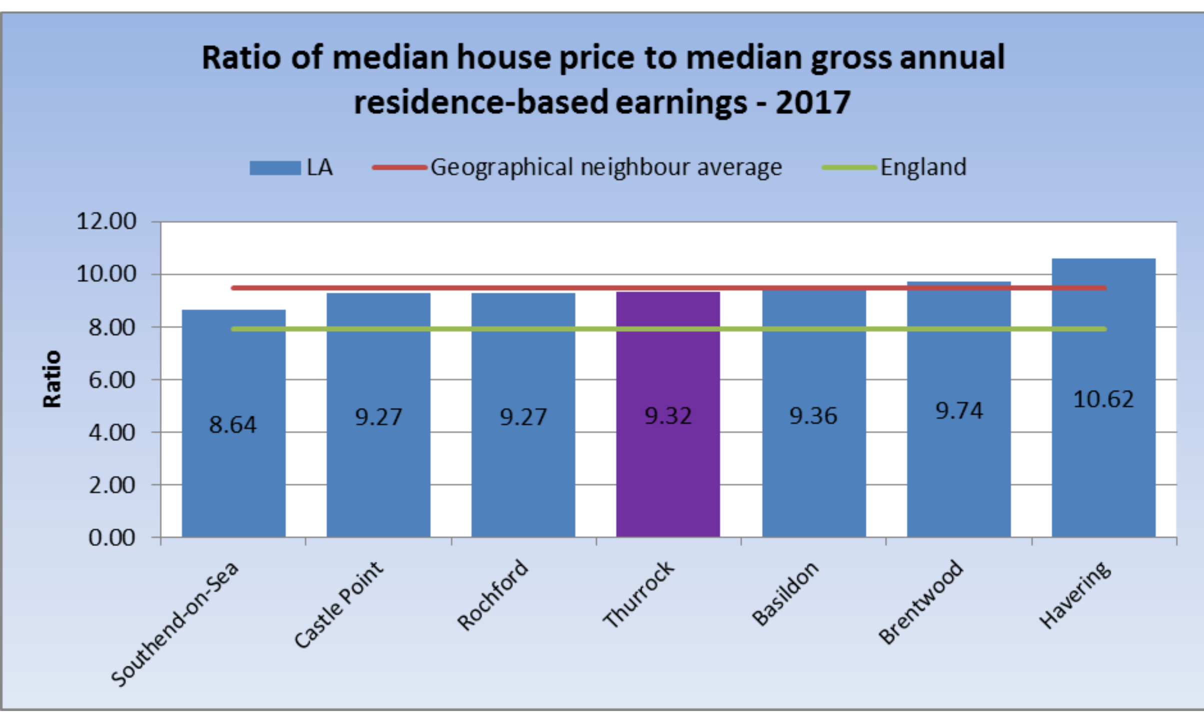
Source: Ministry of Housing, Communities and Local Government

5.2.4 Affordability compared to Earnings

The median house price paid for residential property in England and Wales increased by 259% between 1997 and 2016, in this same time period earnings only increased by 68% - meaning that housing affordability has worsened in all local authority districts over the last 2 decades. By dividing the house price for an area by its earnings, a ratio can be produced which serves as an indicator of relative affordability. A higher ratio indicates that on average, it is less affordable for a resident to purchase a house in their local authority district. The housing affordability ratio in England and Wales increased from 3.6 in 1997, to 7.8 by 2017, which means that on average, full time workers could expect to pay 7.8 times their annual workplace-based earnings on purchasing a home.

In Thurrock, this ratio is even higher than the national average, with the average home costing 9.32 times their annual earnings in 2017. This has increased by 56.9% in the last five years, which is a faster rate than the national average. The 2017 ratio is lower than that of Havering however; which has a ratio of 10.62 – likely because of its situation within Greater London. Thurrock's position when compared to geographical neighbours can be seen below. Incidentally, Thurrock has the highest median house price: earnings ratio of its CIPFA comparators.

Figure 46: Ratio of Median House Price: Earnings - Thurrock and geographical neighbours, 2017



Source: House Price Statistics for Small Areas and Annual Survey of Hours and Earnings, ONS

When looking at the lower quartile house price: earnings ratio, Thurrock looks relatively more affordable than most of its geographical neighbours with a ratio of 10.2, making it the second most affordable. However the ratio has increased by 52.7% over the last five years, which as with the median house price: earnings ratio, is a faster rate than the national average (10.5%).

Figure 47: Ratio of lower quartile house price: earnings - Thurrock and geographical neighbours, 2017

Ratio of lower quartile house price to lower quartile gross annual residence-based earnings - 2017

LA | Geographical neigbour average | England

Ratio

14.00
12.00
10.00
8.00
6.00
4.00
2.00
0.00

Southend-on-Sea	Thurrock	Basildon	Brentwood	Castle Point	Rochford	Havering
8.85	10.20	10.39	11.08	11.47	12.12	12.63

Source: House Price Statistics for Small Areas and Annual Survey of Hours and Earnings, ONS

Implications

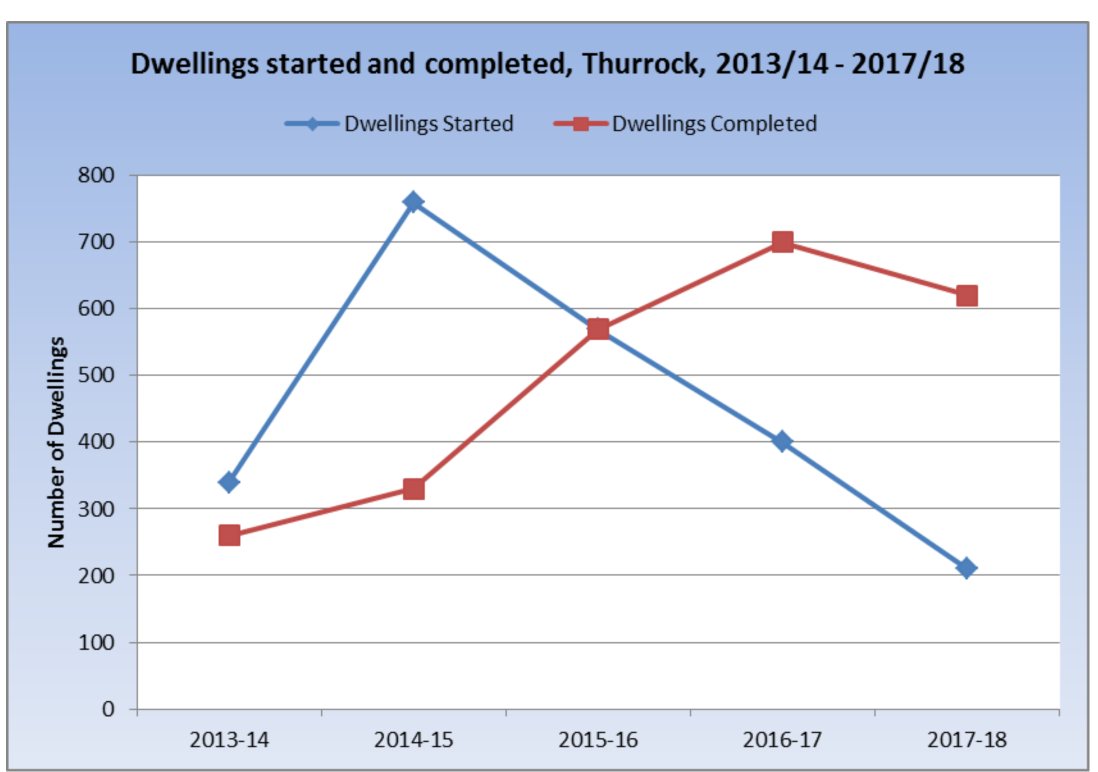
The charts above indicate that whilst Thurrock could be seen as more 'affordable' than its geographical neighbours, the recent trends in both house prices and rents indicate this will not continue to be the case – particularly in flats. However as Thurrock is still more 'affordable' than London, it remains an attractive prospect for families moving from the capital, thereby potentially reducing the housing stock available for Thurrock residents. For older people who bought their property over a decade ago, these data are likely to be good news as they are likely to have benefited from significant capital appreciation of their house at a time of enjoying historically low interest rates on their mortgage. Should they choose to move, the capital that they have amassed could provide considerable choice in retirement.

Conversely, for older people who do not own their own home, the opposite is true. Rents have risen at a faster rate than income in all sectors, making housing more unaffordable. If this trend were to continue, this will present future affordability to challenges in the future, particularly as younger older people's incomes drop as they come to retire. There is a need to explore the issue of affordability in greater depth in order to identify potential ways to alleviate this, or at the very least identify ways of mitigating the impact of this issue. Housing affordability is a complex issue that is a product of land value, house building supply, supply of properties in the private and local authority rented sector, interest rates, access to mortgage finance, mortgage application terms, income and taxation. A dedicated JSNA product on housing affordability in the borough is planned for 2019.

5.3 Housing Supply

In 2017/18 there were 210 dwellings started, of which 200 (95.2%) were Private Enterprises and the remaining 10 from Housing Associations. During the same year, 620 dwellings were completed, with 380 (61.3%) coming from Private Enterprises and the remaining 240 (38.7%) from Housing Associations. Looking at start and completion activity over the last five years, it can be seen that the number of new dwellings started per year has decreased since 2014/15 from a peak of 760 to 210 in 2017/18 – which is a decrease of 72.4% in four years. The number of dwellings completed per year increased from 260 in 2013/14 to a peak of 700 in 2016/17 (a 169.2% increase in four years) although this figure decreased in 2017/18.

Figure 48: Dwellings started and completed in Thurrock, 2013/14 - 2017/18



Source: Table 253, www.gov.uk

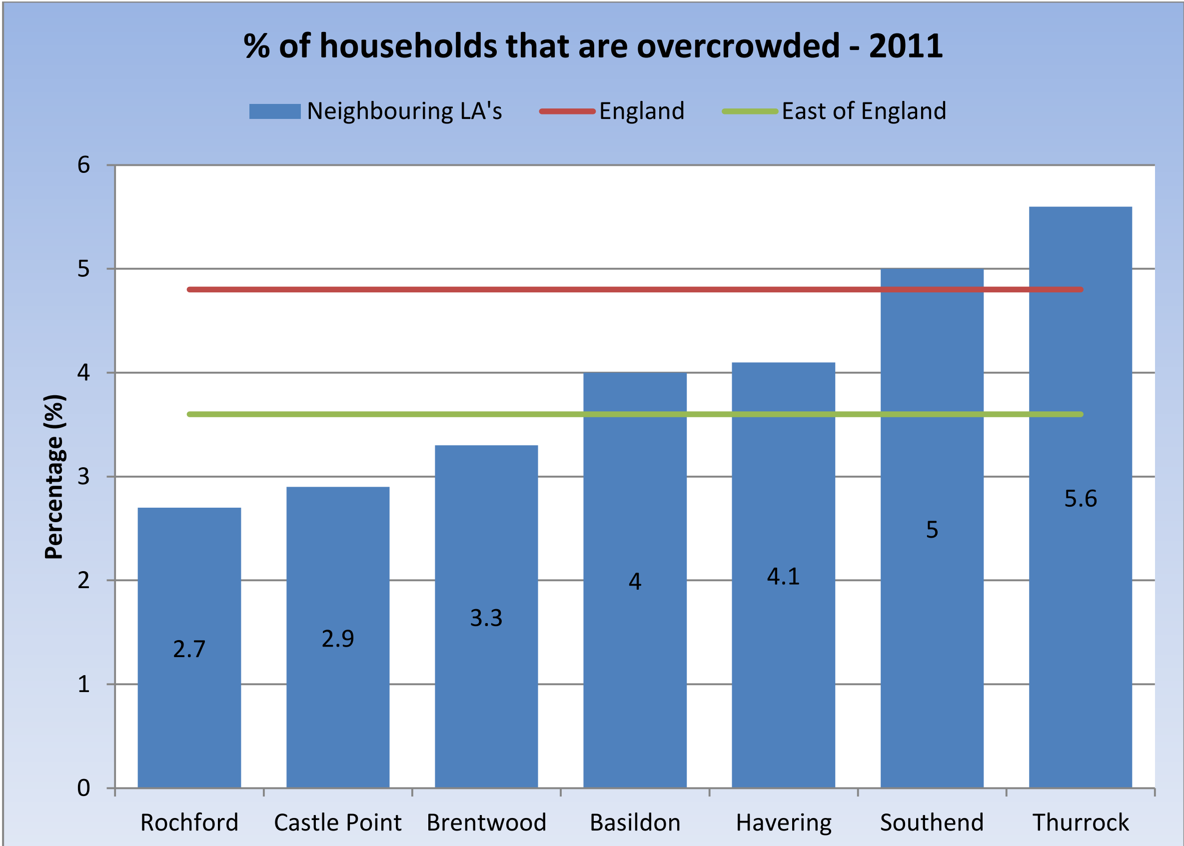
The decrease in number of dwellings started is likely to be explained by the dwindling supply of brownfield sites for building, and the lack of release of greenbelt land, which means that there are insufficient sites currently on which to build. This trend is likely to continue going forwards until greenbelt land is released and additional sites therefore become available. Clearly the number of completions will likely largely mirror the number of dwellings started albeit with a time lag however we know that the market is increasingly becoming dominated by volume house builders which tends to result in a lack of diversity of homes; this can have the result of making homes more difficult to sell and often results in building work slowing down as house builders lack urgency to push through to completion.

5.3.1 Overcrowding

Overcrowded households can be used as a proxy measure for whether supply is meeting demand. In the Census data, the housing occupancy rating provides a measure of whether a household's

accommodation is overcrowded or ‘under occupied’. An occupancy rating of -1 implies that a household has one fewer room/bedroom than required, whereas +1 implies that they have one more room/bedroom than the standard requirement.

Figure 49: Percentage of households that have an occupancy rating of -1 or lower, 2011



Source: Fingertips

Figure 49 shows the percentage of households in Thurrock and surrounding areas that are classed as overcrowded. It shows that Thurrock has the highest percentage of its surrounding areas having 5.6% of households overcrowded, which is significantly higher than England. Whilst the chart above shows all ages, this is pertinent to older people as some of these will be older people who are unable to afford to live elsewhere, and others will be the older people of the future – who are the cohort we need to plan for

.

Implications

The charts above indicate that the number of houses completed has been increasing; however the number that has been started each year has been decreasing – meaning the number of new houses completed in the next few years may not meet demand, and are unlikely to meet the needs identified in the Local Plan.

We also know from the data that Thurrock has more overcrowded households than its geographical areas, meaning these are households who could be in much poorer health, which could be compounded in those with existing long term conditions or older people.

National evidence suggests that many older people are likely to under-occupy, particularly owner-occupiers. Whilst modelling the impact of downsizing on overcrowding is very complex it is likely that downsizing will have the result of freeing up larger family homes which may in turn have an impact on overcrowding.

The Council should continue to explore strategies to increase the proportion of houses started that are completed, such as encouraging a diverse range of house builders, and also provide support to improve quality of homes identified as overcrowded to mitigate the risk of poorer health outcomes. Additionally, the Council should develop a strategy for encouraging downsizing in those older people who either wish to move or whom may be undecided, building on the existing downsizing incentive schemes and incorporating other 'pull factors' (see Chapter 7).

5.4 Quality of Current Housing Provision

Council Properties

The Council is currently part-way through a home improvement programme called Transforming Homes, which aims to bring all Council homes beyond the Decent Homes Standard. The programme covers:

- kitchens that are over 20 years old
- bathrooms that are over 30 years old
- boilers that are over 15 years old
- electrics that are over 25 years old
- windows that are either over 30 years or are single-glazed
- roofs that are over 40 or 50 years old, depending on type

The work also aims to maximize energy efficiency and eradicate damp and mould.

The Council had improved over 7,800 homes as of March 2018, with the intention for all to be completed by 2021.

Implications

Whilst this improvement programme is just aimed at residents in Council homes, this will improve the quality and mitigate the risks of ill-health associated with housing (as evidenced in section 1) for a large number of residents. Data shown earlier in the report indicated there were 3,002 residents in Council housing aged 60+ claiming housing benefits, so this is likely to improve health and reduce health service usage in the future for this cohort.

5.4.1 Private Housing

The Council has commissioned a *Well Homes* project over the past three years aiming to support residents in the private sector to live healthily in their homes by addressing home hazards and promoting health, wellbeing and independence. The service is considered to be an innovative and integrated approach as health determinants have been considered broadly with signposting to services such as, but not limited to grants to improve energy efficiency including home insulation and boiler replacement, together with employment support, debt management and lifestyle modification.

The project has so far focussed on older people, people with long term or mental health conditions, and people on low incomes, although it operates on an open access basis. Evaluation for the project between August 2016 - August 2017 reported positive outcomes:

- 910 people were reached, of which 246 (27%) were aged 60+. This resulted in 470 homes being improved.
- 879 hazards were removed, estimating savings to the NHS and society of **£1,542,455**[e].
- 203 boilers were installed by *Warm Zones*
- Thurrock Lifestyle Solutions (handyman service) carried out 152 jobs, the majority of which were fitting PIR security lights.
- Essex Country Fire and Rescue Service also conducted 736 visits during this year, installing smoke alarms, removing trip and fall hazards and conducting fire risk assessments and oven cleaning where needed.

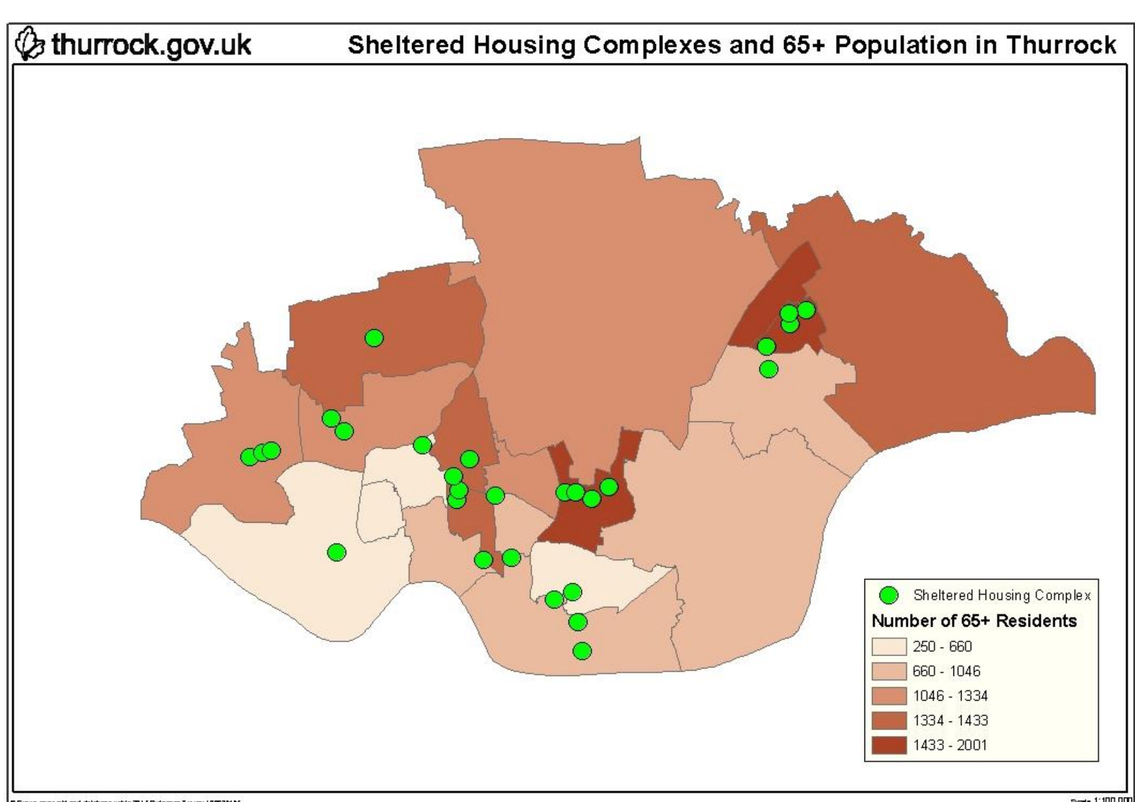
To date a total of 2111 people have been reached over the three years that Well Homes has been running and due to its success two additional schemes are being piloted in the upcoming year, one of which is focussed around supporting *Well Homes* residents in Tilbury locality with long term conditions to better manage their illnesses from their home setting as part of the *Healthier Together* campaign. Autumn 2018 will also see Well Homes being re-launched as an in-house service with a further evaluation of this arrangement planned for the following summer.

[e] Calculated using the Building Research Establishment Housing Health Costs Calculator

5.5 Specialist Housing Provision for Older People

The Council offers some specialist accommodation in the form of Sheltered Housing, which is targeted towards older people who require some support to continue living independently. There are currently 1,240 properties owned by the Council across the borough, with the locations mapped as below. It can be seen that there are several complexes in the areas with the older residents.

Figure 50: Locations of Sheltered Housing Complexes and Older Population



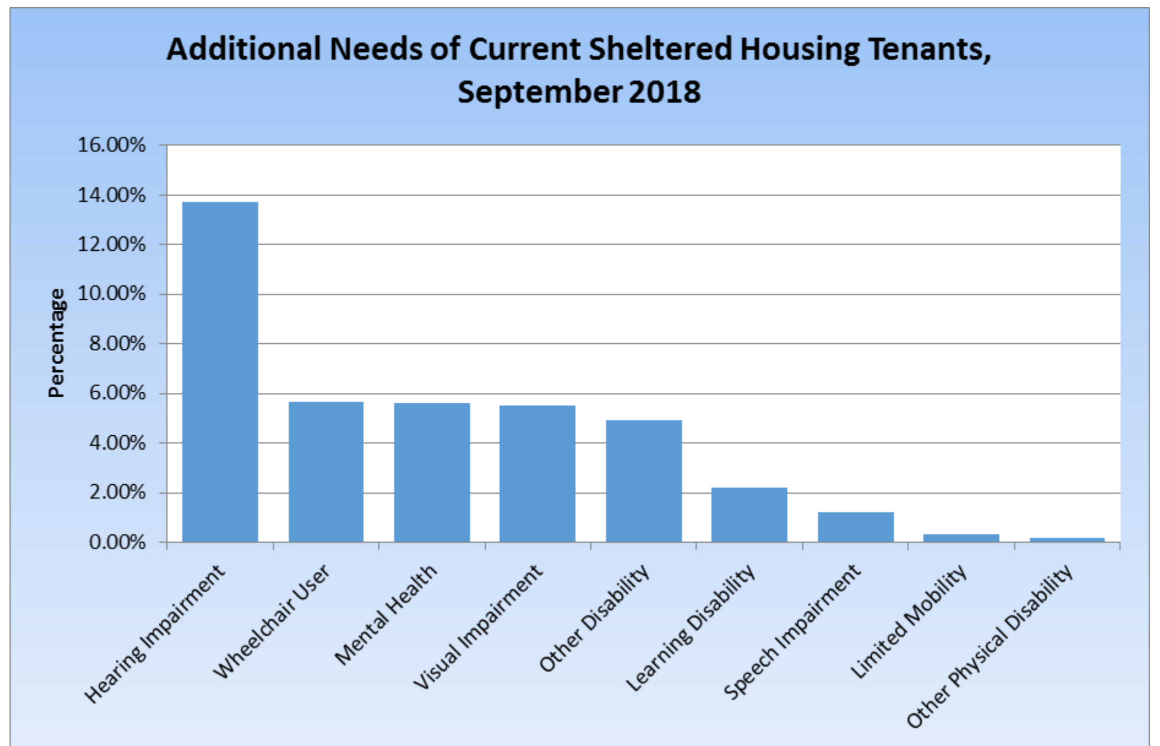
Source: ONS and Thurrock Council

The eligibility criteria for Sheltered Housing as published on the Council's website are that you must:

- be 60 years-old or older, or 55 to 59 and getting a high-level personal independent payment (PIP) – married couples will qualify when 1 partner has reached the qualifying age
- need housing-related support
- be single or a couple without children
- be a tenant of Thurrock Council or housing association properties

The average age of the current 1,217 tenants is 72.6 years, although this does range per complex. The main reported additional need is hearing impairment, with 167 (13.7%) experiencing one. The other types of needs are shown in the figure below.

Figure 51: Additional needs of current sheltered housing tenants, September 2018



Source: Thurrock Council

There are currently 1177 applicants on the housing register who are eligible to bid for sheltered housing, however this does not necessarily mean that these applicants wish to move to sheltered housing. Since November 2017, the Council have advertised 135 properties in sheltered housing, receiving a total of 952 bids. This averages out at 7.05 bids per property, however the median is 6 bids per property. This implies that there is unmet demand for council owned sheltered housing although the level of this demand is unclear from these figures.

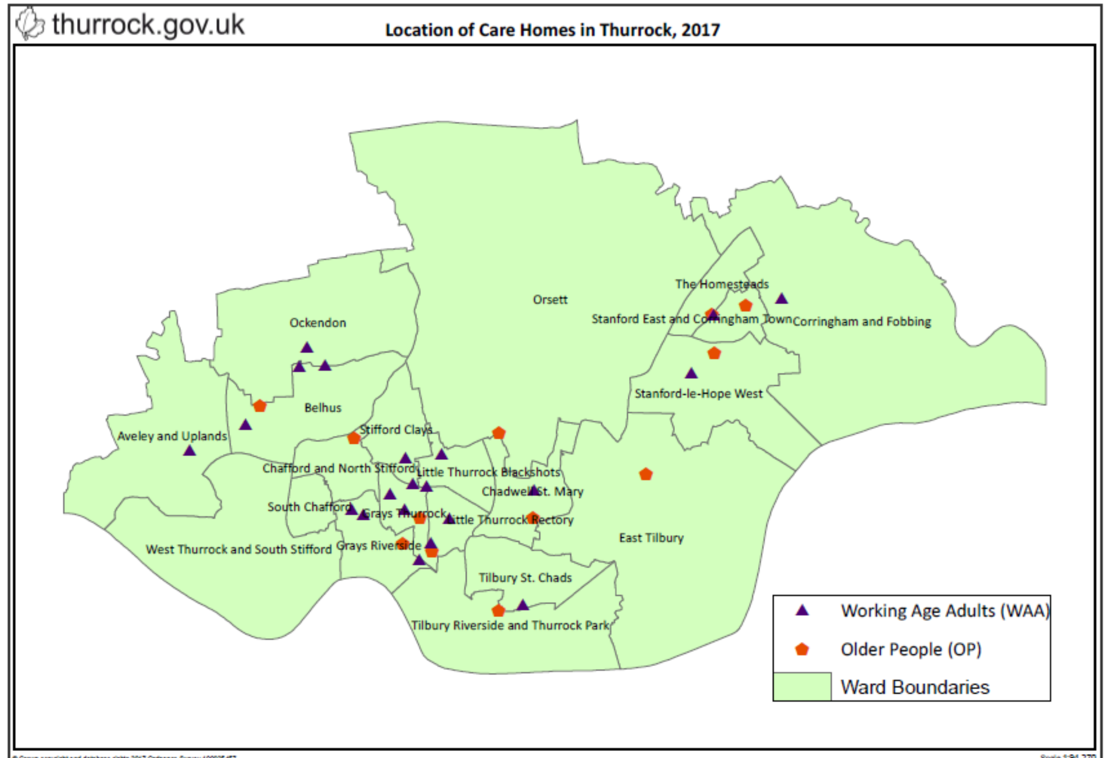
In addition to Council owned sheltered housing, there are two private age exclusive developments totalling 32 properties (18 leasehold and 14 socially rented), and four private retirement housing developments totalling 176 properties of which 146 are leasehold properties and 30 socially rented.

There is also Extra Care Housing available in Thurrock, with the Council operating one scheme in Piggs Corner (Grays) where tenants can rent properties, and a private scheme at Elizabeth Gardens (Grays) where tenants can either rent or buy their properties. Extra Care Housing is also designed for older people, but more specifically for those who require at least 7 hours a week of care. The development at Piggs Corner contains 89 flats and there are 65 properties at Elizabeth Gardens. The latest information from our Adult Social Care team indicates that there are 6 applicants waiting for a place in Extra Care Housing currently, meaning there is a level of unmet demand for these properties.

Thurrock Council also operates one residential home – Collins House in Corringham, which has 45 rooms. There are a number of other care homes in the borough run by private providers – these can be seen in the map below. There is a proposal to build another site at Whiteacres. This will provide a range of homes for older people needing care from small easy to maintain flats designed for frail

elderly people, to retirement living for those who wish to downsize to a care ready environment, including potentially a mix of one and two bedroom dwellings for rent. This an opportunity both to address the growing demand for residential care, and to invest in innovation in care, and so to set new higher standards for residential provision in the Borough which will be a mixture of specialist and more general older people's housing.

Figure 52: Care Home locations in Thurrock, 2017



Source: Thurrock Council

5.6 Housing Adaptations

The Council undertake adaptations to their stock where needs are identified. The table below lists the types of adaptations recorded on the Council's system. It can be seen that the most common type of adaptation completed was a shower, followed by stair lifts. It should be noted that some were just categorised by the room (kitchen/bathroom) so it is unclear exactly what was adapted within the room.

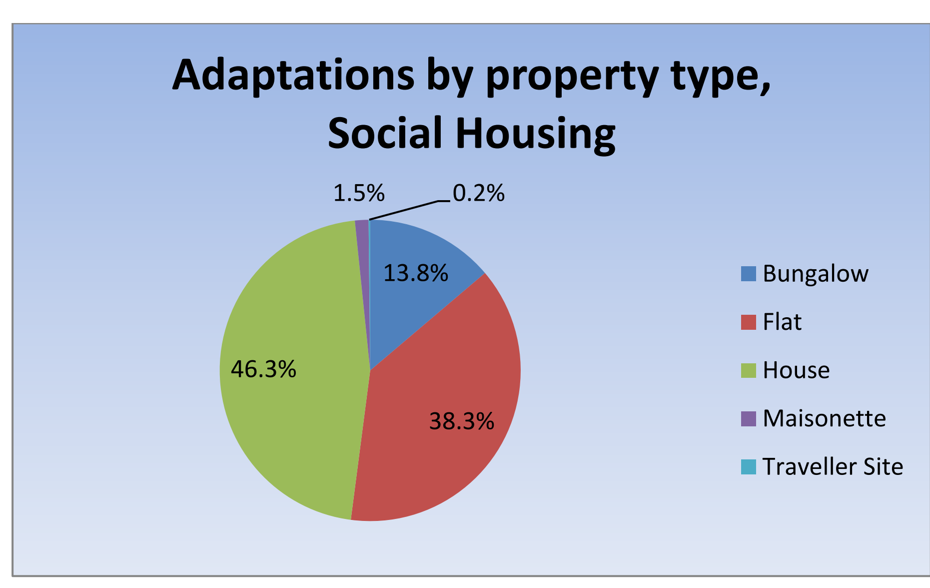
Table 2: Adaptations to Social Housing in Thurrock by type

Adaptation Type	Number of Properties
Graded Floor Shower	455
Over Bath Shower	227
Low Step Shower	200
Stair Lift or Step Lift	102
Minor Adaptations	52
Ramp	45
Kitchen	19
Bathroom	18
Ceiling Track Hoist	14
Closomat Specialist WC	14
Conversion or Extension of Existing Building	11
Through Floor Lift	7
Additional WC	2
Grand Total	**1166**

Source: Thurrock Council

Although the date range for this data is unknown, this data indicates that the most common adaptation is a graded floor shower. This suggests that these residents have mobility issues which are affecting their ability to undertake activities of daily living, be it independently or with help. This data gives an indication of the important features to consider when building homes which are appropriate across the life-course such as the flexibility to include a graded floor shower without major works and at relatively low cost. Almost half of the adaptations were made to houses (46.3%) with a large number of those being terraced houses rather than detached or semi-detached. Adaptations to flats made up the next largest number, with more of these being low rise than high rise buildings. The types can be seen in the figure below.

Figure 53: Adaptations to Social Housing by property type

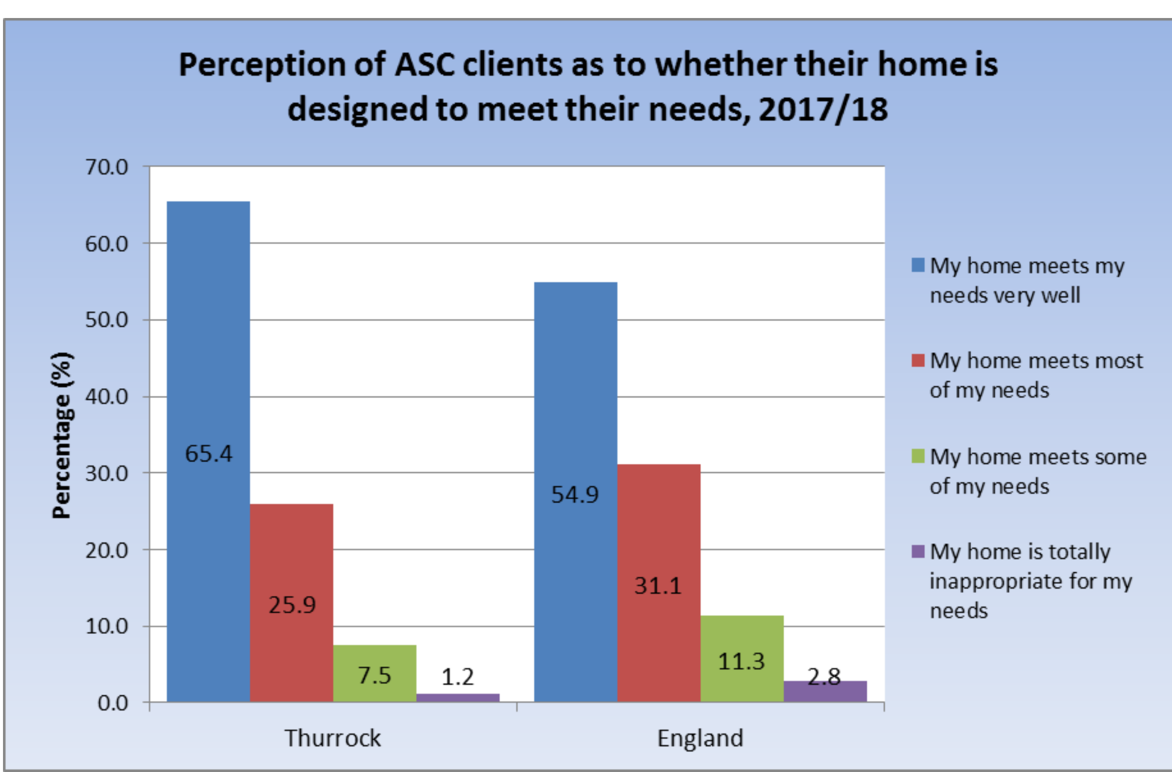


Source: Thurrock Council

This may indicate that houses are less suitable than other housing types for people with care needs and require more adaptations, or it may indicate that more people live in houses compared to other property types which would reflect broadly the type of housing in the borough and these residents either cannot or do not wish to move. However, evidence of the effectiveness of housing adaptations indicates that adaptations can prevent falls and injuries, which may in turn help prevent or delay the need for residential care (see chapter 2 and chapter 4).

The Adult Social Care Service User survey collects the views of current service users as to whether they feel their current home is designed to meet their needs. Looking at the most recent data, 91.3% of Thurrock social care users feel that their home meets all or most of their needs, which is very positive as the aim is to keep people safe and well in their own homes for longer. There are however 7.5% of respondents who felt their home only meets some of their needs, indicating there could be unmet need for adaptations, and 1.2% feel the home is totally inappropriate, indicating a potential need for alternative accommodation. These results do compare favourably to England however, where only 86% of social care users feel their home meets all or most of their needs.

Figure 54: Perception of ASC clients regarding their home, 2017/18



Source: Adult Social Care Service User Survey, 2017/18

5.6.1 Telecare

Adult Social Care provides a range of equipment and home adaptation solutions for residents with eligible care and support needs, either in isolation or part of wider support arrangements. These systems are useful for a wide range of people, including those:

- who may be frail or have a fear of falling
- with health conditions that can be monitored for their well-being

– with cognitive or learning impairments who require prompting messages and monitoring of safety
– with sensory impairments

This is delivered through a number of teams and services, working with both housing and health partners. Tech enabled care solutions are explored through the main care and support need assessment process, undertaken by various teams within ASC. There is a standard offer of Telecare solutions available, which have been identified as core items that can meet the predominant needs and outcomes identified. However, these are not limited and bespoke solutions are explored where required. Supply and install is supported through partnership with housing Careline and external provider, Red Alert.

Specialist Equipment and minor adaptations is supported through shared service agreement with Essex County Council and a number of health partners (several CCGs). The Integrated Community Equipment Service (ICES) is provided by both health and social care to allow the frail, elderly and physically disabled to live independently in their home and facilitate discharge from hospital. In 2017/18 it delivered 157,000 items for 53,430 customers within the areas of Essex County Council (ECC) and Thurrock Council, and is currently delivered by Essex Cares. The equipment available through this service ranges from simple daily living aids to assist service users to bathe and toilet themselves or assist with their mobility, to more complex equipment designed to facilitate nursing care, such as profiling beds and hoists.

Minor adaptations (anything below cost of £1000) are also delivered through the ICES arrangement, and items such as grab rails to permanent half steps, door widening are inclusive. The approach for the ICES is one where items are defined as standard or non-standard stock. Standard stock is for the most part, determined by volume and identified commissioning intentions of partners, enabling realisation of procurement benefits from the open market. Non-standard items are determined by individually assessed need, and enables bespoke support options to be considered for individual needs and outcomes. Sensory support options are also delivered through the ICES approach.

Major home adaptations (above £1000) are assessed and supported via ASC, and delivered via the Disabled Facilities Grant or housing adaptation services. The range of solutions include ramped access, to property extensions, and is determined by specific need and reasonable and practicable options determined by property design and structure.

Home healthcare equipment is also supplied by Essex Equipment Services (ECL) via NELFT. This ranges from equipment such as hand rails, concrete ‘half-steps’ or bath lifts. They also supply telecare equipment across Essex. Information from NELFT suggests that these are most often supplied to support recuperation post-surgery or relating to end of life care. Data from July and August 2018 shows that 155 items were dispatched to Thurrock residents, with a total cost of £641.87 – making an average cost of £4.14 per item. Adding the technician cost to the item costs gives a total of £2,751.78 (giving an average cost of £17.75 for the item cost and technician time). It is unknown by the authors of this report whether this is cost-effective when compared to other providers – however it will certainly be less expensive than keeping people in hospital or residential care unnecessarily.

Evidence shows that telecare can help maintain functional status (27) and promote independence. (28) and is also likely to be cost effective. There is a large amount of work underway within the Council looking to embed technology enabled care[f] in its future approaches to Adult Social Care. There is some pilot work happening in Tilbury and Chadwell locality, aligned with the roll out of the new approach to Social Care via the implementation of Community-led Support teams and Wellbeing teams. It is also forming part of the 'Connected Thurrock' Digital Strategy *Connected* Place theme. This pilot aims to:

- Raise community awareness of telecare and telehealth equipment/devices/apps
- Encourage the take up of appropriate technology enabled care to support vulnerable people to be safe, independent and connected both within their homes and outside
- Support carers through greater use of technology enabled care
- Combat loneliness through connecting isolated people to the wider community and family and friends
- Encourage greater digital health literacy
- Prevent, reduce or delay the need for social care or acute health interventions (i.e. through falls preventions, swift hospital discharge etc.)

Implications

The Council provides a range of adaptations and telecare for residents. There is evidence that adaptations and telecare are both effective and potentially cost effective as they can help to maintain function and independence, reducing the need for care services or residential care. However evidence from local residents indicates that there may be barriers to accessing these services (see Chapter 7). The data available on uptake and cost of these services at the time of producing this report is patchy, and moving forwards, the Council should seek to ensure that the adaptations and telecare offer is evaluated fully to ensure they are being accessed, and are effective for those in greatest need.

Additionally, we know from national level evidence that the design of a home can impact upon the need for adaptations and telecare, the ease with which adaptations and telecare can be installed, and subsequently the cost to provide these. Moving forwards, consideration to the design of new homes should be given to make them appropriate and flexible across the life course, and where telecare and adaptations are required these can be easily and cheaply installed (see Chapter 2).

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[f] TEC is an umbrella term that includes assistive, adaptive, and rehabilitative devices for people with disabilities while also including the process used in selecting, locating, and using them

CHAPTER 6: Attracting people in older age to alternative or new housing

Key Points:

- The older adult market is very diverse with very diverse wants, though there are some common desires and reasons for wanting to move such meeting care needs, reducing maintenance and reducing running costs
- Barriers to moving may be physical, emotional or financial and by addressing these we may make it more attractive and easier for older people to move
- The key barrier to moving is the lack of suitable and attractive options; however many older people also find the process of moving difficult and costly.
- It is also important to attract residents with 'pull' factors before they are forced to move due to 'push' factors so that they have the opportunity to make the best choice for themselves.
- Housing options should be aesthetically attractive as well as functional
- Downsizing schemes offering financial incentives offered by the council have shown limited uptake; these should be complemented with additional 'pull' factors.

6.1 National residents views

The older adult market is very diverse; some older people are interested in moving to smaller properties, some don't intend to move and some even want to upsize to a larger property. As older adults become a larger proportion of the population, it is important to consider their housing needs as well as taking into account their own desires and opinions relating to their homes. The HAPPI3 report, (71) which was published in 2016, explores how older people can be given more control over the management and delivery of services and access to a wider range of housing choices. The report emphasizes that there is a need to offer older adults more autonomy, choice and control over their housing.

Specialist housing for older adults is far more popular elsewhere in the world than it is in Britain. Only 1% of Britons live in specialist retirement homes while the number is 17% in the USA and 13% in Australia and New Zealand; (71) this suggests that this type of housing is desirable but there may be a cultural element that is restricting its appeal in the UK. The following section considers the results of surveys and reports on the thoughts of older UK residents regarding moving house and the elements that make homes attractive as well as some of the reasons they may not move.

6.1.1 Types of Houses/Why move?

According to a 2017 report by the National House Building Council (NHBC) and the University of Cambridge Centre for Housing & Planning Research, (72) two-bedroom homes were the most common choice for about half of those who had moved into smaller properties, this was followed by three-bedrooms which accounted for about a quarter of moves. This shows an appetite for smaller

homes amongst older adults; and in fact, for those over 55 who moved into new-build homes, 39% had fewer bedrooms than their previous home. However, it is important to remember that not all older adults who are considering moving want a smaller home. The NHBC report also revealed that four-bedroom homes were desirable amongst the over-55s for the extra space, which allows for hobbies or friends and family to stay over. There is also a large proportion of those 55 and over who do not want to move at all.

The common estimate is that between a quarter and a third of older people are interested in moving, this represents just under 3 million people in all. (73) Again, though, it is important not to assume that all older adults want the same thing, two bedroom homes are a popular option amongst many in this age group, but other housing types are also of interest. Demos research shows about a quarter of those who want to move are interested in specialist retirement housing, either the downsizer retirement type or the extra care type. (73) Perhaps surprisingly, the results of the NHBC report found that flats were viewed favourably for the ease of maintenance and security, which allows for longer trips away (72) while those surveyed in Bedfordshire did not view flats favourably and instead expressed a clear preference for bungalows. Residents of a Park Home site responded favourably to their 'specialist' mobile homes, which were designed with older adults in mind. The attractiveness of park homes was down to a few factors including the picturesque location, the single story 'bungalow-like' layout, an independent lifestyle and the sense of community. (74)

In terms of tenure, the HAPPI 3 report as well as Demos research found that older adults want to remain homeowners, buying their homes instead of leasing even after downsizing. (71) (73) This finding is echoed amongst Bedfordshire residents who expressed a preference for ownership of 'care ready' property in mainstream housing as opposed to an age-segregated development like a retirement village or extra-care scheme. (74)

The reasons for moving, or wanting to move, are as diverse as the types of homes wanted. United for All Ages said that, of those making enquiries to their website about moving: 38% give family reasons (death of a partner, moving closer to family); 33% say they have care, health or mobility needs; 24% want to reduce their running costs/maintenance bills; 19% want to release capital; and 10% are planning in advance of retirement. (73) The NHBC report found that the top four most important elements were: easier maintenance, reduced running/maintenance costs, property is more suited to growing older, and a garden that is easier to manage. (72) This was echoed by research for HAPPI3 which found the most important things for those who have or want to downsize are reducing maintenance (most important) and bills. (71) NHBC participants also mentioned that clarity over future expenditure was important for them to plan and feel confident that a move would be financially sensible for them. (72) Older Bedfordshire residents laid out that their main reason for moving was in order to 'right-size' or to move into a home that was more appropriate for them in their current and future life-stages in terms of size and accessibility. However, the main driver to actually making a move was the quality of the available options and features such as access to amenities and transport, property design/size and tenure and costs. Releasing equity did not feature amongst the drivers for moving to a smaller home. (74)

There is a gap between those who say they want to move and those who actually follow through. While the Bedfordshire survey revealed some of the drivers to moving, the study of housing for

older people explored the barriers to moving. Concerns that prevented older adults from moving home fell into three overarching categories: physical, emotional and financial. Some of the barriers expressed by this group were that moving was too difficult and costly and therefore “not worth it”. Also that there was no property available with the light and space desired, they were all too small, overpriced or had ‘strings attached’. Finally, though they knew that moving was the best option for them, some residents felt too emotionally attached to their family homes to go through with a move. (73)

6.1.2 What might help?

According to HAPPI3, many older adults do not engage with, or are in denial about, the dangers of growing older and only move after a crisis. This reduces the opportunity to consider options and make the best choice. (71) Many older adults who do move often wish they had done so sooner, often “five to 10 years earlier”.[3] With knowledge of older adult preferences as well as barriers, the reports also explored options that might assist or encourage older adults to overcome those barriers and move sooner.

Many of the people surveyed mentioned the difficulty and bother of moving and implied that they would be more inclined to do so if there were services or packages that offered guidance and assistance through the most challenging aspects of moving. (72) ‘Smooth move’ services, like the one offered by McCarthy and Stone, which assist with packing, selling and storing belongings as well as closing utilities, etc. ‘incentive to move’ schemes by accredited providers could fulfil this need. (73) There are also programs such as *Support to Relocate* and *Move On* offered by local authorities or housing associations that provide similar support. However, there was an expression that still more support and incentives are needed when moving, i.e. stamp duty tax relief and good independent advice. (71)

The NHBC report emphasized that housing for older adults is as much a challenge for marketing as it is for supply. Marketing to the over 55s would benefit from emphasizing nearby GP/NHS facilities and ease of transport into town instead of things usually marketed to families such as school catchment areas. The flexibility and adaptability of new homes should also be highlighted. It was clear that age stereotyping new-builds as ‘family’ or ‘starter’ homes and marketing as such made older adults feel excluded from that market and that agents and developers should provide marketing material emphasizing how these new-builds could meet the needs of older people. (72)

Providing they types of homes that older adults find desirable is one thing, but extra features and conscious design can make a home go from adequate to attractive. The HAPPI3 report recommends building in ‘local’ locations and applying HAPPI principles to affordable senior housing. (71) These steps would make senior housing part of the community instead of an afterthought. Technology also has a role to play in making senior housing both attractive and enjoyable and is also the reason some schemes are already attractive. This includes fast broadband, which can improve Skype and other communication, as well as cheaper and better control over personal environments (i.e. temperature). (71) These features may be upgrades from previous housing and have the potential to improve quality of life after a move. Generally, older adults wished there was a bit more emphasis on aesthetics as well as the functionality of senior housing; they want the move to be aspirational

instead of sad. (73) No one will be tempted to move to a home that's worse as well as smaller, so good design is vital if we want people to be proactive about finding a more suitable home; particularly as we spend more time at home as we get older. (73)

6.1.3 Local Residents Views

As part of this report, the Public Health team sought to obtain thoughts and preferences of Thurrock residents. This was done through a survey and conversations with residents. A range of questions were formulated to include:

- The respondent's current housing situation and how well this meets their needs.
- What is important to the respondent in terms of the building in which they live
- What is important to the respondent in terms of the place in which they live
- What the barriers and enablers are to moving home in older age
- How older people could be supported to start planning for older age sooner.

A full evaluation report is included in Appendix 2.

In summary, the local survey reflects evidence from elsewhere – 'national views', that increasing the stock of attractive and appropriate homes could increase the number of people willing to move as the top barrier to moving was the 'availability of suitable properties' and the top option that would encourage people to move was 'greater availability of preferred housing'. The local survey supports the view that older people want to remain home owners with 30% stating that they would consider buying their own specialist property, although interestingly 30% also said they would consider renting a specialist property.

In terms of the reasons for moving, Thurrock residents agreed that the most common reason for wanting to move was care needs. Important features for a new home identified nationally were reflected locally with low maintenance, reduced running/maintenance costs, and level access highlighted.

The local engagement also supports the national evidence that the process of moving is difficult and costly and that incentive to move schemes may be beneficial; as it looks as though there is a desire for general assistance with moving as the proportion of respondents saying they would be encouraged to move by 'Advice', 'Financial help' and 'Practical help' as being similar (17%, 16%, 14%).

Results of our survey showed that just under half of respondents said that they would consider moving (47%), with an additional 24% stating that they would "maybe" consider moving which is slightly higher than national evidence. Despite this, the local survey showed that less than half (44%) of respondents over 60 years old have started planning for their future housing needs (albeit 22% of respondents said they already live in specialist accommodation). However, just over a third of respondents have not yet started to plan. It also appears there might be a call for better information/advice (evidenced by the 17% of people that say advice/guidance might help them plan towards meeting their future housing needs, and another question showed that some people did not think they had enough information as to what their options are).

As with the national evidence, a large proportion of people do not want to move at all. Of concern to local residents was finding out about local support services and the reliance on the internet for disseminating information. Residents commented that they often seemed to find out about services 'by chance'. Residents expressed a desire for face to face opportunities to speak to staff about their needs. Additionally, residents were concerned about the cost of services, such as adaptations and how long these took to receive.

In terms of place, it appears as if residents view the connectivity of their home as important, evidenced by them ranking 'close to family/friends' and 'close to town/facilities' as important. Through the conversations with residents, a sense of community emerged as a strong theme that was important to them and feeling that neighbours were looking out for one another.

6.2 Current Downsizing Activity

Councils often offer incentives to encourage downsizing amongst older residents. Thurrock Council currently offers an incentive to existing Council housing tenants who wish to downsize from their existing property, both in terms of a financial payment (currently up to £1,000) and support arranging removals services. Further information on this can be found on the Council's website: Downsizing Scheme.

The table below shows a summary of the downsizing requests received by the Council to date.

Table 3: Downsizing activity of existing Council tenants, 2015/16-date

Year	Number of requests received	Average Number of bedrooms	Average number of bedrooms released	Payments issued by the Council
2015/16	77	Not known	Not known	£58,825
2016/17	51	Not known	Not known	£36,651
2017/18	82	2.89	1.47	£55,589
2018/19 (to date)	28	2.65	1.35	£22,527

Source: Thurrock Council

National data indicates that the proportion of older people who under-occupy in socially rented properties is typically quite low (around 19% compared to 68% of owner-occupiers (56)), however analysis of this data suggests that the take up of the offer of removals support is still very limited.

The Council also runs a *Right Size* scheme aimed at older owner-occupiers who are happy to move into Council-owned accommodation for older people (e.g. sheltered, extra care or HAPPI) and lease their homes to the Council on a fixed-term basis. The scheme is open to residents meeting the following criteria:

- Aged over 60 or 55-59 with a disability
- Requiring sheltered, extra care or HAPPI accommodation
- Downsizing from a larger property – at least 2 bedrooms
- Willing to sign up a minimum 5 year lease with the Council

Details on this scheme are set out in the Housing Allocations Policy: Rightsizing Scheme. However the interest in this scheme appears to be very limited, with only one homeowner taking up this offer since the pilot launched in 2017.

This supports the residents view both nationally and locally, that there needs to be a range of pull factors to encourage older people to move, and no one size fits all.

CHAPTER 7: Summary of Key Findings and Recommendations

At the outset of this report, it was stated that there were four key questions that were to be answered. The answers to these questions are summarised below.

What impact will demographic change have on the needs for new and existing housing stock across all tenures in the next 20 years?

Within Thurrock, the over 65yrs+ population is currently estimated at 23,700 (2017) and is projected to grow by 5% by 2020, and potentially by 46% by 2035. This equates to an additional 10,900 older people by 2035 albeit caution should be exercised with this projection**.** This population increase means that there will need to be a larger number of properties in Thurrock which are suitable for older people, be it mainstream housing or specialist housing. This broadly resonates with the current Housing Strategy (2015-2020) for Thurrock which proposed to build 1,000 new homes over the next five years (to 2020).

The proportion of new homes which should be mainstream homes or specialist homes is influenced by a multitude of factors, not least the personal preferences and wishes of the individuals involved. The survey undertaken as part of this report indicated that changing care needs were the most common reason for moving or considering moving, and our analysis tells us that by 2035 there is likely to be:

- An additional 2,600 older people who cannot undertake at least one mobility activity by themselves
- An additional 4,538 older people who are unable to undertake at least one self-care activity by themselves.
- An increase of 2.3% in falls
- An additional 1,147 people with dementia
- An increase in long term conditions which research suggests impacts upon the ability of an individual to self-care.

This means that there will be a larger group of people in Thurrock in the future who require support from health and social care services in order to manage their health and activities of daily living. Demand for health and social care services will be greater, and supply of services will need to increase, or the model of provision of these services will need to change if these needs are to be met. Thurrock is currently developing four integrated medical centres, and piloting an accountable care organisation in Tilbury as a new model of care to integrate services in order to reduce demand, increase capacity and improve patient outcomes, partially in response to the anticipated population projections.

The Thurrock Housing Strategy 2015-2020 plans to support older people to live independently and healthily by providing suitable, innovative and aspirational homes, and there are currently 1240 council owned sheltered housing properties across the borough, 176 privately owned retirement properties across four complexes (of which 146 are leasehold properties), 32 age exclusive

properties across 2 complexes (including 18 leasehold) and two extra-care developments containing a total of 154 properties. However, given the anticipated increase in population, and increase in people with health and social care needs, it is likely therefore that there will be a need for further specialist housing to accommodate the increase in the older population. Modelling the demand for specialist housing in the future is incredibly difficult due to the multiple influences on housing demand and supply, personal preferences and uncertainty about the future. The current older population is likely to be different to older people in future - retirement ages changes, medical advances, and different social and political attitudes may affect housing needs and preferences, additionally society is more mobile now and more likely to travel and less likely to stay in or around the place of birth or close to family members. National modelling work has indicated that the demand for specialist housing may increase by anywhere between 35-70%.

That being said, even with an increase in supply in specialist housing there would not be capacity for every older person to live in a specialist home, and neither would all older people wish to, or indeed have a need to. In fact we know that the majority of older people want to remain living in their current mainstream home. This means that existing mainstream stock needs to be made suitable for older people, and mainstream stock built going forwards needs to be developed with the whole life course in mind.

Existing stock can be unsuitable, unsafe, unhealthy and insecure for older people. More than 5,600 households in Thurrock are estimated to be in fuel poverty and a local survey of social care users indicated that 7.5% of social care users felt that their home only met some of their needs which indicates a potential unmet need for changes to their home. The latter is supported by engagement work for this report in which 16% of respondents indicated that their home was not appropriate for them in terms safety and security, 15% in terms of proximity to health and leisure facilities, 14% in terms of accessibility, 12% in terms of size and social networks, and 10% in terms of their ability to cope and also quality of life, and 14% in terms of accessibility. Notwithstanding the small sample size of this survey, this suggests that a sizeable proportion of people in Thurrock are living in a home which is either not suitable now, or which they predict will become unsuitable as they age and this will have a negative impact on their health. There therefore needs to be appropriate support in place to mitigate these negatives.

Within Thurrock, initiatives such as Well Homes (for private housing) and the Transforming Homes programme (for Council housing) have tackled aspects of ensuring homes are suitable and the Well Homes programme has been evaluated recently to show positive outputs. Options to develop this project further are currently being explored.

Housing adaptations and telecare are also provided for Thurrock residents and a pilot is currently underway in Tilbury and Chadwell as part of the new approach to social care and Connected Thurrock Digital Strategy, to increase knowledge and take up of telecare. Evidence suggests that housing adaptations and telecare are effective and potentially cost effective mechanisms to increase the independence of older people living in their own homes, and they can be acceptable to the older population. There are however gaps in the evidence in specific user groups and in the UK context, in the terms of cost effectiveness, additionally residents views collected as part of this report indicated that there may be barriers to accessing these, for example in terms of waiting time and cost and also

some older people may not know what options are available. This means that evaluation of local initiatives, including the Tilbury and Chadwell pilot are required to demonstrate how these may be effective, cost effective, accessible, equitable and relevant to the older population in Thurrock.

High Level Recommendation:

Ensure that all older people who wish to stay in their own home are supported to do so, for as long as possible, by providing appropriate and accessible information and services to meet needs identified.

Key Questions:

- How can information about support services be made more readily available, particularly for older people who cannot or do not use the internet?
- Are there any other effective and cost effective services or schemes which can support people to healthily stay put? What does the Council/and partners offer and are there any gaps?
- Is the local falls prevention service effective? How can we prevent the rate of falls increasing in the future?
- How affordable and what are the waiting times for adaptations? How is the Disabled Facilities Grant used and does this meet the needs of the population?

Existing Assets to build upon:

- Stronger together
- Community hubs and libraries
- Tilbury and Chadwell telecare pilot
- Council commissioned services such as Exercise on Referral/ Walking for Health
- Existing social prescribing programme
- By Your Side (home from hospital service)
- Existing Well Homes Service
- Thurrock U3A

For new housing, the vision for Thurrock is to have a life course approach to ageing which includes ensuring that all new homes built are appropriate across the life course. Homes which are appropriate across the life-course are more easily adaptable and have features already which enable healthier ageing in place, such as good lighting and adequate ventilation. Despite the recent changes to building regulations to partially incorporate lifetime home standards, these remain largely optional; indeed in Thurrock these are not currently part of mandatory policy. This means there is currently little obligation or incentive for developers to build homes with these features.

Thurrock's current Housing Strategy (2015-2020) states that 100% of new council properties will be built to the lifetime homes standard and London space standards however it is unclear how many have actually incorporated these standards to date. Arguably limiting to only council properties does not go far enough. The ten HAPPI principles are widely regarded as the gold standard for not only housing for older people, but for all housing. These are not currently incorporated in plans for new homes as standard, although they are encouraged. To enable older people to age healthier in their current homes going forwards, all mainstream homes should be built which incorporate age friendly and life-course features such as those outlined by HAPPI and this should be reflected in the local plan.

High Level Recommendation:

Explore the impact of mainstreaming HAPPI design principles into planning guidance within the Local Plan.

Key Questions:

- Why is affordability of housing an issue in Thurrock? How can it be alleviated and mitigated?
- What will the impact of this high level recommendation be on encouraging new home building?
- How should new developments best be quality assured during the design and building process?

Existing Assets to build upon:

- Active By Design
- Secure by Design
- Health Impact Assessment expertise within Public Health Team
- Council's Planning and Advisory Group

What types of housing do our elderly population want and what are the impacts of choosing to move to a home more suitable for later life?

Older people are not a homogenous group and should not be treated as such and it is therefore important to ensure that more suitable housing is defined by the older person and is specific to the older person's needs and preferences, rather than being a generic definition. The wishes of older people and personal choice should be respected; and evidence from both national level surveys and local engagement indicates that the majority of older people wish to remain in their current home and as stated previously, services such as adaptations and telecare should be available to support people to do this. From the mosaic analysis in chapter 2 we know that within 'older people' the three biggest segments in Thurrock are *Solo Retirees*, *Classic Grandparents* and *Seasoned Survivors*. They are likely to own their own home which may present an issue with us knowing if any adaptations are needed or have already been made. The Mosaic characteristics suggest that many of these households may not be confident with technology which may need to be considered if

options such as telecare/telehealth are to be used or if digital technologies are otherwise used in new homes.

We know that there is a high level of home ownership in Thurrock and evidence from the local engagement exercise indicates that 30% of residents would consider buying a specialist property and 30% would consider renting a specialist property (although these residents may not be mutually exclusive). However, in Thurrock, the bulk of sheltered housing is council owned (1240 properties); there are only 146 retirement properties and 18 age exclusive properties which are leasehold properties. This demonstrates that whilst there is interest in specialist housing; potentially there are not enough properties of the correct tenure. The Council and developers need to ensure that the tenure of future specialist housing matches preferences; certainly the national evidence indicates a shortage of specialist homes that are available to buy; and also that some older people are averse to leasehold properties which can also act as a barrier.

Evidence from our local engagement indicated that the most important property features are low maintenance or being easy to maintain and having own garden or some outside space. Accessible features and at least one space bedroom were also rated as important. Being close to friends and family and being close to a town centre were rated as the most important features of the area.

It has not been possible to quantify the impact of choosing to move to a more suitable home in later life on the individual (if that more suitable home is deemed to be specialist housing) because the evidence of effectiveness of specialist housing is very limited. Whilst there is some evidence from the literature of positive outcomes associated with Housing with Care, which can improve quality of life, promote health improvement and reduce social isolation, few studies have been conducted on other types of specialist housing. Scrutiny of schemes in other areas and the available literature tells us that there is no 'best practice' in terms of a model of housing which works for older people, as this is very much dependent upon the needs of the population who will be living there. This means that there is no specific model that Thurrock can exactly replicate to realise the same effects. There are some common themes which emerge however in successful case study models such as autonomy and control over living environment being very important and these can be applied to any new schemes to enable a wide offer of options to a diverse market of older adults. National guidance suggests that housing for older people should be co-produced with older people. For Thurrock, this means that there is a need to design and develop bespoke specialist housing alongside and in partnership with local residents which takes into account the themes evident from successful schemes elsewhere.

High Level Recommendation:

With older people as active participants, develop and build a range of bespoke specialist housing for older people and ensure the need for these specialist homes are reflected in the local plan.

Key Questions:

- What are the best ways to involve older people throughout this process?
- How can we better predict the number and type of specialist homes we need in Thurrock?
- How can developers be incentivised to build specialist homes?

Existing Assets to build upon:

- Opportunities for engagement through Thurrock Over Fifties Forum and Older People's Parliament.
- Thurrock U3A
- Women's Institute

More attractive specialist housing may have a benefit in terms of freeing up some family homes for younger families. Whilst the issue of under-occupancy and overcrowding is hugely complex and the quantitative impact of downsizing is uncertain, we know that almost 68% of owner occupiers over the age of 65 nationally under-occupy and whilst the majority of these will wish to stay in their current home, if those that are undecided can be encouraged to move to a smaller property, this would have some impact on freeing up larger family homes.

When considering a move to move suitable housing, what would make the option attractive to our elderly population?

A key action within Thurrock's Housing strategy is to create attractive housing options for older people that encourage independence and wellbeing. Evidence from national and local public engagement work suggests that a key pull factor is the availability of suitable and attractive properties and for older people to have a greater awareness of these options.

Around 25% of older people nationally, and 47 % of older people surveyed locally, express that they would consider moving in the future. An additional 24% of older people locally indicated that they would "maybe" consider moving. Given the sizeable proportion of residents who are unsure, potentially many of these could be encouraged to move if the options available were suitably attractive and potential barriers were removed.

A key barrier is the lack of suitable properties as discussed previously in this section, however other barriers to moving identified through both local and national surveys include cost of moving, lack of

information on the options, practicalities of moving, not wanting to leave current home due to sentimental reasons, risk of losing existing support networks or a wish to retain the equity in the property.

Evidence suggests that downsizing, for many, will not free up finances as is often one of the main benefits promoted to encourage older people to move. Additionally in Thurrock, the Council offers downsizing payments to Council tenants which has had some uptake, however a rightsizing scheme implemented in 2017 aimed at owner-occupiers has not been successful in attracting applicants since its inception in 2017. This means that there needs to be greater 'pull' factors which encourage people to move.

Moving forward there should be appropriate support with the planning and moving process for people who do wish to move, and to encourage those who may be open to but undecided about moving, information about housing options and awareness of the assistance with planning and moving available should be provided.

Evidence from surveys indicates that older people need to be encouraged to start to plan for their older age sooner and more advice and guidance on housing options may be a way to do this. More in depth resident engagement work needs to be undertaken to look into practical solutions to tackle these issues further. Additionally, there is further work that needs to be undertaken to identify issues around affordability of this housing.

What impact does housing have on health and how can we enhance the positives and mitigate against the negatives? And how can we ensure they are better understood by those affected

It is widely accepted that housing can have a significant impact on health in terms of excess winter deaths and cold related ill health, indoor air quality, mental health including loneliness and social exclusion, falls, and demand and access to health services. Additionally, we know that the wider public realm can also have a significant impact, for example on social isolation and physical activity levels.

As discussed previously in this section, we know that housing can have a negative influence on health and wellbeing if it is unsuitable, unsafe, insecure and unhealthy, and these negative influences can be mitigated through provision of focused services. This report only considers services which directly impact upon the home itself and there would be value in exploring other services in greater depth such as home-sharing.

Housing Operations functions could be better engaged to affect health positively through encouraging and enabling a healthier lifestyle For example, we know that, in Thurrock, there is a high rate of people with hypertension, with substantial numbers who have not yet been diagnosed, many of whom will be aged over 65. If not identified and managed appropriately these patients may be at risk of an emergency hospital admission. Housing provides a vehicle with which to try and impact upon these conditions and outcome - in terms of identifying conditions earlier, enabling people to better manage these conditions possibly limiting further deterioration, and also by

preventing these conditions arising, or delaying the onset of these conditions through a healthier lifestyle, better access to services and increased social capital and integration.   Health improvement work could be complemented with the continued support of Making Every Contact Count amongst front line staff, including housing staff, widespread use of community groups and hubs to increase service promotion and awareness of the consequences of not improving lifestyles for example.

We know that older people are much more likely to have long term conditions and whilst there are a number of programmes in place already, more could be done to embed them within the Housing work programme, for example, using communal sheltered housing complexes to host long term condition detection interventions, training more staff in Making Every Contact Count and ensuring housing improvement programmes such as Well Homes adequately identify and refer patients to relevant health services. We also know that, in Thurrock, mental health problems such as depression are set to increase in the future and the presence of poor mental health increases the average cost of NHS service use by each person with a long-term condition from approximately £3,910 to £5,670 a year.   This indicates more could be done to embed depression screening into the day job of more front line staff (e.g. housing officers) who may have access to older people who would be hard to reach by other professionals and there would be benefit in improving pathways between mental health services and Housing. In addition, by building developments that encourage community cohesion and reduce the risk of isolation, we could reduce the risk of developing depression.

We know that more appropriate housing is likely to result in savings to the NHS. We know in Thurrock that many emergency admissions of older people could have been prevented with better managed care, and nearly 5% of all delayed transfers of care are due to awaiting community equipment and adaptations. For Thurrock, this mean that there needs to be integration of housing into NHS pathways to ensure a holistic provision of services is provided, and also that the home is routinely seen as a place in which health promoting activities can be actioned.

Alongside enhancing the positives directly through appropriate housing, wider place making elements are also extremely important and can have a huge impact. The Housing strategy states that it will consider green space requirements for new council properties, however there is a need for further steps to be taken to ensure wider place-making elements are included and across all new properties.   There are two aspects to this; firstly in terms of developing healthy places for all, and ensuring that residents of a place have opportunities for active travel, enabling healthy eating and having access to appropriate healthcare for example.   The principles set out in the NHS Healthy New Towns Programme provide a good standard upon which to base planning guidance in this regard. This is important because keeping people healthy throughout the life course has an impact on how healthy a person is in older age. The second aspect is incorporating age-friendly features into a healthy place. We know that just under half of all residents in Thurrock aged over 75 have no access to a car or van which may mean that they have difficulty getting around, and 39% of older people live alone which may be a risk factor for loneliness or social isolation. This emphasises the importance of giving due attention to the wider place making agenda. Evidence from around the world indicates that there are specific considerations with regards to transport, green space, community, safety and crime prevention, work and volunteering and the digital environment that may impact on the lifestyle and health of an older person and how active and valued they feel within

a community. Whether building new mainstream housing with life-course features, or new specialist housing, it should be a key feature of the local plan that particular importance is placed upon the wider public realm with regards to these features.

High Level Recommendation:

Ensure that healthy place making principles, such as those outlined by the NHS Healthy New Towns Programme, and age friendly features, are incorporated in the design process of all new homes in the Local Plan, whether mainstream homes or specialist homes.

Key Questions:

- How can we ensure that these principles are being adhered to in new place planning and design?
- How can we ensure that Dementia Friendly Communities are developed?

Existing Assets:

- Strong relationship between Public Health and Place team
- Stronger Together (including Local Area Coordinators and Time banking for example)
- For Thurrock in Thurrock / ACO work
- Micro-enterprises programme
- Community hubs and libraries
- Thurrock Coalition
- Thurrock Adult Community College
- Housing and Planning Advisory Group
- Health Impacts Assessment expertise within Public Health Team

To ensure these issues are better understood by those affected, we need to ensure that awareness and communication with older people is improved; evidence suggests that older people do not know what is available to them, and there is a concern that if they do not use the internet as is the case with just over 13% of Thurrock residents, that there is a risk that they will miss out on help and support. Within the context of the Council's digital strategy, this indicates that there is a need to enhance the existing methods of face to face communication such as through volunteer hubs utilising the skills of "younger older people" who are confident in using the internet, then considering whether there is a need to provide training specifically to older people to improve their competence and confidence in using the internet.

1. Recommendations

This section outlines some specific recommendations and key questions which may help contribute towards the high level recommendations presented in Chapter 7.

1. Ensure that all older people who wish to stay in their own home are supported to do so, for as long as possible, by providing appropriate and accessible information and services to meet needs identified.

Recommendation	Rationale	Section of the report
1a) Produce a single directory identifying the range of support services available to older people across the local authority, NHS and voluntary sector, including adaptations, telecare and home help.	• Feedback from residents identified that they were not aware of what support was available and the process for accessing these	6
1b) In line with the digital strategy, increase the ability and confidence of older people to use technology.	• Feedback from local residents indicates that they feel they miss out on support if they cannot access the internet. • MOSAIC data shows we have large numbers of older population segments who may not be confident in using technology – so we need to make it easier to use	4, 6
1c) As part of the strategic vision of 'Connected Thurrock' and the possibilities for future houses to be built with appropriate technologies embedded within them, undertake a detailed evaluation of existing/proposed telecare and adaptations services to ensure these are fit for purpose, equitable, effective and cost effective for Thurrock	• There is a Council strategic work stream around keeping people independent at home • Evidence that it is acceptable to older people and also cost-effective • Data we have got on our current uptake • The sheer cost of a residential care/nursing home care package • MOSAIC data shows we have lots of older population segments who may not be confident using technology – so we need to make easier to use and access	2, 4, 5
1d) Continue with the Well Homes scheme and consider whether this offer could be expanded to include an annual winter health check for the home and input into making the home more energy efficient.	• The savings it has shown so far • The reach it has had so far • There are pockets of deprivation in the borough which will impact upon the ability to afford a home and adequately run in • There are inequalities within the borough in terms of fuel poverty	4, 5
1e) Consider implementing depression screening in housing staff	• Projections indicate that by 2035, there may be a 50.2% increase in the number of people with depression. • Housing staff are seeing older people on a regular basis • Housing staff already deliver *Making Every Contact Count* (MECC) which is an approach to healthcare that encourages all those who have contact with the public to talk about their health and wellbeing.	4, 5
1f) Develop better pathways between EPUT and Housing teams in supporting the increased number of older people with MH issues.	• The number of older people with mental health issues such as depression, dementia or psychotic disorders is set to increase in future years. • 12-18% of all NHS spend on long term conditions is related to poor mental health	4

Key Questions	Relevant Information	Section of the report that this can be found
How can information about support services be made more readily available, particularly for older people who cannot or do not use the internet?	• Feedback from residents identified that they were not aware of what was available and the process for accessing these • 13.3% of Thurrock residents have either never accessed the internet or not done so within the last three months. • Evidence from literature and from local views suggests that the emphasis on digital communications can result in older people feeling isolated and unable to control their own personal effects fully (e.g. finances) • Thurrock Council's digital strategy aims to promote and enable digital inclusion across the entire community.	2, 3, 4, 6
Are there any other effective and cost effective services or schemes which can support people to healthily stay put? What does the Council/and partners offer and are there any gaps?	• Outside the scope of this report, however some evidence from elsewhere that for example, home sharing schemes can have a positive impact upon older people and their ability to live independently for longer. There are some schemes available in Thurrock currently such as the home from hospital and home-sharing schemes.	2
Is the local falls prevention service effective? How can we prevent the rate of falls increasing in the future?	• The rate of falls is predicted to increase • We know that falls prevention services are generally cost-effective	4
How affordable and what are the waiting times for adaptations? How is the Disabled Facilities Grant used and does this meet the needs of the population?	• Local residents views suggest that residents wait long times to receive adaptations; and another group of residents feel that they are unaffordable. • Many local older people are owner-occupiers who may not be eligible for support to adapt their home. • Evidence suggests that long waiting times can reduce the effectiveness of adaptations. • The data in this report is patchy, so we do not have the full picture.	5, 6

2. Explore the impact of mainstreaming HAPPI design principles into planning guidance within the Local Plan.

Recommendation	Rationale	Section of the report that this can be found
2a) Develop an older persons housing strategy	• There is a lack of detail in the current housing strategy 2015-2020 relating to older people's housing • The older people's population are not a homogenous group and require a specific and detailed action plan; evidence suggests that many local authorities do not have such a plan.	2, 3
2b) Ensure there is buy in to HAPPI principles across the Council and the potential for this to be incorporated into planning guidance is considered.	• Most people want to continue living in their own home, so housing needs to be appropriate across the life course. • HAPPI principles are considered to be an exemplar for all housing, including both specialist housing and mainstream housing.	2

Key Questions	Relevant Information	Section of the report that this can be found
Why is affordability of housing an issue in Thurrock? How can it be alleviated and mitigated?	• The median house price is 9.2 times the average annual wage, and there are a number of residents claiming housing benefit; however it is outside the scope of this report to investigate this to the extent that is needed.	4, 5
What will be the impact of this high level recommendation on encouraging new home building?	• If plans and policies are not financially viable, developers will not come to Thurrock to build homes	
How should new developments best be quality assured during the design and building process?	• Building inspections check for compliance with building regulations at stages during the house build; there is a need for similar checks that the building work complies with HAPPI and other design principles.	

3. With older people as active participants, develop and build a range of bespoke specialist housing for older people and ensure the need for these specialist homes are reflected in the local plan.

Recommendation	Rationale	Section of the report that this can be found
3a) Co-Design and build a bespoke range of specialist housing for older people with older people. The foundations for this should be based on evidence of what has been successful elsewhere however the design should be tailored towards what the target group of older people in Thurrock specifically need.	• Local and national residents' views suggest that a key barrier to moving is a lack of suitable properties. • Evidence from published literature indicates that the effective housing solutions involve older people their design. • Encouraging some older people to downsize may have the benefit of freeing up some larger family homes.	6, 2
3b) Undertake some focused additional public engagement on specific issues relating to specialist housing planning for housing in older age and the process of moving home. This may be as part of programmes such as "Your Place, Your Voice" or as separate exercises depending upon the topic and target group.	• National residents' views indicate that there may be value in designing services which tackle barriers to moving. • Questions raised through the local resident engagement suggests there would be value in exploring these issues in more depth.	6
3c) Consider developing a package of support for people in terms of moving to include: help with removals, negotiating with energy suppliers, redirecting mail, selling unwanted goods, dealing with administrative and legal issues and post move support (subject to outcome of action 3b)	• National and local residents views indicated that that may be value in designing services which tackle barriers to moving • There is an offer to council tenants currently; however this is not available to owner-occupiers or those privately renting.	6
3d) Develop the quality and accessibility of advice on housing options available to residents.	• Local and national residents' views indicate that people do not know what is available to them or how to find this information.	6
3e) Develop the relationship between sheltered housing and public health	• Sheltered Housing complexes are distributed all over the borough, with halls in the areas with the older people. • There is an opportunity to improve these relationships as Sheltered Housing are reviewing their data collection requirements, plus they often have capacity to host PH events etc. in communal areas	5
3f) Produce a separate product seeking to identify the need for older people's mental health specialist accommodation	• Growing number of older people plus adults likely to have Mental Health crises • Market position currently unknown – recent Market position statement did not drill down into this in much detail • Other work has shown fragmentation of Mental Health and Housing pathways • This is not within the scope of this report.	4

Key Questions	Relevant Information	Section of the report that this can be found
What is the best way to involve older people throughout the process?	• Evidence from published literature indicates that the effective housing solutions involve older people their design. • Engagement work needs to be relevant, effective, timely and sustainable throughout the project.	2
How can developers be incentivised to build specialist homes?	• Evidence suggests that developers can be put off specialist housing due to the long lead in times, risk of being unable to sell and uncertainty in the market. • Additionally there is some uncertainty pertaining to planning guidance	

4. Ensure that healthy place making principles, such as those outlined by the NHS Healthy New Towns Programme, and age friendly features, are incorporated in the design process of all new homes in the Local Plan, whether mainstream homes or specialist homes.

Recommendation	Rationale	Section of the report that this can be found
4a) Ensure that healthy place principles such as those outlined in the NHS Healthy New Towns Programme are embedded in place-making policy. This could be achieved by taking forward the draft interim planning guidance developed by the Public health and place team.	• There are a number of older adults at risk of loneliness (e.g. there are a number of lone older person households, many who cannot access a car/van, and there are 2,057 older adults we estimate to have depression currently • ASC survey findings – some residents say they are feeling socially isolated and can't get to all the places they want to • Recognition of certain areas in Thurrock with lower accessibility	2, 4
4b) Ensure that age friendly principles are embedded in place-making policy.	• Evidence from literature suggests that there are a number of place-making factors which can impact upon a person's health and wellbeing.	2

Key Questions	Relevant Information	Section of the report that this can be found
How can we ensure that these principles are being adhered to in new place planning and design?	• There needs to be appropriate checks throughout the process to ensure that places are being designed in accordance with these principles.	2, 4
How can we ensure that Dementia Friendly Communities are developed?	• The estimated number of people aged 65+ with dementia could increase from 1,526 in 2017 to 2,673 in 2035 • A key element affecting quality of life for someone with dementia is where they live	2, 4

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CHAPTER 9: Glossary of terms

Age exclusive housing: Schemes or developments that cater exclusively for older people, usually incorporate design features helpful to older people, and may have communal facilities such as a residents' lounge, guest suite and shared garden, but do not provide any regular on-site support to residents.

Almshouse: Independent local charitable trusts that provide affordable housing for older people in need. Most are for older people living in a specific geographical area or connected with a particular trade. They are administered by a body of voluntary Trustees.

Assisted Living: A name initially introduced from the United States to describe a form of 'housing with care' designed for older people, and now adopted by a number of housing developers for both the private and rental markets. There is no single definition though they tend to function in a similar way to *Extra Care Housing* with some offering *Close Care Housing* services.

Care Home: A residential setting where a number of older people live, usually in single rooms, and have access to on-site care services. Since April 2002 all homes in England, Scotland and Wales are known as 'care homes', but are registered to provide different levels of care.

- All homes provide meals and staff on call at all times.
- A home registered simply as a **care home** will provide personal care only - help with washing, dressing and giving medication.
- A home registered as a **care home with nursing** will provide the same personal care but also have a qualified nurse on duty twenty-four hours a day to carry out nursing tasks. These homes are for people who are physically or mentally frail or people who need regular attention from a nurse.
- Some homes, registered either for personal care or nursing care, can be registered for a specific care need, for example dementia or terminal illness.
- Dual registered homes no longer exist, but homes registered for nursing care may accept people who just have personal care needs but who may need nursing care in the future.

Close Care Housing: Close Care schemes are a relatively new concept and consist of independent flats or bungalows built on the same site as a care home. Residents often have some services (such as cleaning) included in their service charge and other services can be purchased from the care home. Close care schemes can either be rented or purchased. Purchasers may receive a guarantee that the management will buy back the property if they enter the care home.

Cohousing: Cohousing communities are created and run by their residents. Each household has a self-contained, private home but residents come together to manage their community and share activities. Cohousing is a way of combating the alienation and isolation many experience today, recreating the neighbourly support of the past. This can happen anywhere, in an existing street or starting a new community using empty homes or building new.

Downsizing: Moving to a property which is either smaller or of lower monetary value or both.

Enhanced Sheltered Housing: Provides residents with the independence of having their own front door and self-contained flat whilst also having access to some on-site support service. Most developments will have scheme manager (warden) and alarm systems in the

property, there may also be some personal care and home help services that can be arranged by the management.

Extra Care Housing: Housing designed with the needs of frailer older people in mind and with varying levels of care and support available on site. People who live in Extra Care Housing have their own self-contained homes, their own front doors and a legal right to occupy the property. Extra Care Housing is also known as very sheltered housing, assisted living, or simply as 'housing with care'. It comes in many built forms, including blocks of flats, bungalow estates and retirement villages. In addition to the communal facilities often found in sheltered housing (residents' lounge, guest suite, laundry), Extra Care often includes a restaurant or dining room, health & fitness facilities, hobby rooms and even computer rooms. Domestic support and personal care are available, usually provided by on-site staff. Properties can be rented, owned or part owned/part rented. Most providers set eligibility criteria, which prospective residents have to meet.

Homeshare: In Homeshare, someone who needs a small amount of help to live independently in their own home is matched with someone who has a housing need and can provide support or companionship. Homeshare schemes arrange the matching process between the 'Householder', who typically owns their home but has developed some support needs or has become isolated or anxious about living alone, with the 'Homesharer', typically a younger student or key public service worker who cannot afford housing. Usually no rent is charged, but the household bills are shared, and in return the Homesharer will help out around the house, for example by cooking meals, running errands, shopping trips and providing company.

HAPPI (Housing our Ageing Population: Panel for Innovation): A panel established in 2009 born out of the Lifetime Homes, Lifetime Neighbourhoods: a national strategy for housing (2008), aiming to identify the reform needed to ensure that new build specialised housing meets the needs and aspirations of the older population in the future.

Lifetime Homes Standards: 16 design criteria for new homes including parking, potential for entrance level bed space, glazing and window handle heights that can be universally applied to new homes at minimal cost. The purpose of these is to ensure that general needs housing meets the existing and changing needs of diverse households.

Nursing Home: Apart from in Northern Ireland where it is still used, the term *nursing home* has been replaced by *care home with nursing* in the UK. Homes where nursing is not provided, formerly known as *residential care homes*, are now generally referred to simply as *care homes*. A home registered for nursing will provide personal care (help with washing, dressing and giving medication), and will also have a qualified nurse on duty twenty-four hours a day to carry out nursing tasks. These homes are for people who are physically or mentally frail or people who need regular attention from a nurse.

Overcrowding: originally defined in the Housing Act 1985 as wherever two or more persons, aged ten and over of opposite sexes and not living together as husband and wife have to sleep in the same room. However this is recognised by the Government as not being a 'generous' standard as it enables kitchens and livings rooms, in theory to be classed as a bedroom, and there is no limit on the number of people of the same sex who could sleep in the same room.

Park Home: Park homes are residential mobile homes, some resembling bungalows and others closer to traditional caravans. Park homes can be bought at relatively low prices. Although you usually buy your Park Home, you have to pay the site owner a rent for the pitch on which your home is installed and for maintenance of the communal areas. All privately owned sites must be licensed by the local authority.

Residential Care Home: Apart from in Northern Ireland where it is still used, *residential care homes* are now generally referred to simply as *care homes.* And what used to be

called *nursing homes* are now called *care homes with nursing*. A care home is a residential setting where a number of older people live, usually in single rooms, and have access to on-site care services. A home registered simply as a care home will provide personal care only - help with washing, dressing and giving medication. Some care homes are registered to meet a specific care need, for example dementia or terminal illness.

Retirement Housing: (Also called *Sheltered Housing*) Housing developments in which residents have their own flat or bungalow in a block, or on a small estate, where all the other residents are older people (usually over 55). With a few exceptions, all developments (or 'schemes') provide independent, self-contained homes with their own front doors. Properties in most schemes are designed to make life a little easier for older people - with features like raised electric sockets, lowered worktops, walk-in showers, and so on. Some will usually be designed to accommodate wheelchair users. And they are usually linked to an emergency alarm service (sometimes called 'community alarm service') to call help if needed. Many schemes also have their own 'manager' or 'warden', either living on-site or nearby, whose job is to manage the scheme and help arrange any services residents need. Managed schemes will also usually have some shared or communal facilities such as a lounge for residents to meet, a laundry, a guest flat and a garden.

Retirement Village: Lacking any clear or official definition, but essentially anything from an estate to a full village-sized development of bungalows, flats or houses, intended for occupation by older people. Some retirement villages include a care home alongside independent living and assisted living properties, and most of the larger ones include leisure and hobby facilities as well as restaurants, shops, hairdressing salon, etc.

Sheltered Housing: See: *Retirement Housing*

Telecare: Different alarm systems are available for your home, some of which can let a family member, friend, neighbour, nurse or warden (if you're in sheltered housing) know by phone when there's something wrong. These include:

- a personal alarm, where you raise the alert by pressing a button that you keep on you at all times; it's usually on a small wristband or a pendant that you wear around your neck
- motion sensors, which make accidents and falls less likely by automatically switching on your bathroom or hallway lights at night when you get out of bed
- sensors which raise the alarm that something is wrong such as pressure mats on mattresses that can tell if the person has not made it back into bed, or a sensor on a door that can tell if it's open or closed.

Tenure: describes the legal status under which people have the right to occupy their accommodation; the most common forms are home ownership and renting. (75)

Under-occupancy: is where a household lives in a property which is larger than its needs. It is often defined in terms of excess bedrooms**.** (76)

Warden: The job title of the person responsible for managing a sheltered or retirement housing scheme - now more commonly known as a Scheme Manager or House Manager.

Some housing schemes have a resident warden / scheme manager and a 24 hour service, others have visiting and part time wardens. Over the last few years there have been many changes to the warden’s duties, which can vary considerably between schemes. Most wardens are now expected to:

- Manage the scheme
- Build up a relationship with older people living in their schemes; giving residents information on availability and access to services and encouraging them to ask for additional support from statutory and voluntary organizations when appropriate.
- Summon help in an emergency.

Appendix 1. Literature Review of Best Practice for Specialist Housing

Evidence of Best Practice for Specialist Housing

As the older adult market is very diverse, so should be the models of housing available to them. However, there is more variety in the types of housing for older people internationally than in the UK, which has mostly focused on residential care homes and traditional sheltered housing until recently. Some options available for older people internationally include:

Cohousing: *Cohousing communities are created and run by their residents. Each household has a self-contained, private home but residents come together to manage their community and share activities. Cohousing is a way of combating the alienation and isolation many experience today, recreating the 'neighbourly support of the past'. This can happen anywhere, in an existing street or starting a new community using empty homes or building new.*

Garden Suites: *A specialist version of a "tiny house", designed with features specifically for older persons. A garden suite is a self-contained living area usually located on the grounds of a single-family home. Suites can be detached or attached to the other dwelling. Garden suites are also known as 'granny pods' or can be understood in the UK as a 'granny annex'.*

Intergenerational Housing: *Developments that house older people as well as younger people and families to create a dynamic community. Some schemes have 'buddy programs' which match older residents to younger ones for mutually beneficial social relationships as well as practical help for the older person.*

While places like the USA, Australia, and mainland Europe have embraced more innovative solutions for older adult housing, the UK has made a shift towards new types of schemes. The recent trend in senior housing in the UK has been towards models that promote and extend independence, which include models such as Sheltered/Retirement Housing and Extra-Care. There are no official definitions for these models of housing which makes it difficult to evaluate and compare schemes, as the service provision is not necessarily consistent across the market. However, for the purpose of this report, we will be using the following definitions:

Sheltered/ Retirement Housing/Villages: *Housing developments in which residents have their own flat or bungalow in a block, or on a small estate, where all the other residents are older people (usually over 55). With a few exceptions, all developments (or 'schemes') provide independent, self-contained homes with their own front doors. Properties in most schemes are designed to make life a little easier for older people - with features like raised electric sockets, lowered worktops, walk-in showers, and so on. Some will usually be designed to accommodate wheelchair users. And they are usually linked to an emergency alarm service (sometimes called 'community alarm service') to call help if needed. Many schemes also have their own 'manager' or 'warden', either living on-site or nearby, whose job is to manage the scheme and help arrange any services residents need. Managed schemes will also usually have some shared or communal facilities such as a lounge for residents to meet, a laundry, a guest flat and a garden.*

Extra-Care: *Schemes with self-contained specialist housing units (whether rented, private purchase leasehold, or shared ownership), a care team on site providing 24-hour care, seven days a week, and access to communal facilities, such as a restaurant or activities room.*

These models differ only subtly and are often referred to with the blanket term 'housing with care'. Unfortunately, at present, evidence for the effectiveness of specific schemes at

improving particular elements of health and wellbeing of residents is scarce. The formal evaluations that have taken place are all of extra-care and retirement schemes. However, as stated above, these terms do not describe a standard service, and as such there are no official definitions. The common definitions do not specify the level of care provided or the degree of dependency of residents, and these can vary widely between schemes. This has implications for costs and charges and makes direct comparisons between extra care housing schemes, and between extra care housing schemes and care homes or home care, difficult. One scheme, therefore, cannot be said to be typical or representative of extra care housing in general.

As the evidence for particular schemes is extremely limited, the available evidence will be reported in an outcomes based approach. Nineteen papers and reports were reviewed and measures for the following outcomes were collated to create a picture of extra-care's effectiveness for each:

- Social Isolation/ Loneliness
- Quality of Life
- Health Improvement
- Use of Health Services
- Cost Effectiveness

Isolation / Loneliness

According to Age UK, over 2 million people in England over the age of 75 live alone and over half of those say they sometimes go over a month without speaking to a friend, neighbour or family member. (77) The health and wellbeing consequences of loneliness and isolation in old age are increasingly being recognized. Loneliness and social isolation are distinct phenomenon; social isolation is an objective lack of contacts and interactions between a person and a social network while loneliness is a subjective negative experience, the discrepancy between the level of social connectedness a person desires and what they perceive they have. The increased likelihood of seven-year mortality is 26% for loneliness, 29% for social isolation and 32% for living alone.

Some 14-17% of adults over 65 are lonely. Social isolation and the subjective experience of loneliness can increase the risk of poor health outcomes, including anxiety, depression, suicide, sleep problems, cognitive decline and premature mortality. (78) Older adults may be especially vulnerable due to decreased financial and social resources, reduced mobility, changing family structures and bereavement. (79) Loneliness is also associated with more GP visits, longer hospital stays and higher odds of rehospitalisation. (80)

Some research has suggested that loneliness is common amongst residents of retirement housing[g] in England. (81) Mechanisms behind the adverse health effects of loneliness include changes in health behaviour such as diet, alcohol, smoking, stress, likelihood of

[g] In the UK, retirement housing is also known as sheltered housing. These are developments in which all residents are older people (usually 55+). Schemes may vary in size but all are comprised of private self-contained homes with individual front doors. Designs of homes are conscious of the needs of older people (walk-in showers, lower cabinets, etc.). Schemes often have some communal facilities and a manager (or warden) who arranges services.

seeking emotional support, immune and cardiovascular system changes and worsened sleep along with consequent metabolic, hormonal and neurological changes. Potentially modifiable risk factors include living alone, social isolation and where one lives; building structures, local amenities and neighbourliness all have an impact. (78) In order to make new housing options for older adults both attractive and beneficial to wellbeing, schemes should look to encourage meaningful social contact amongst residents as well as providing for maintenance of relationships outside of the development. (41) Many housing schemes attempt to achieve this through organized groups and activities, communal spaces, and guest suites for family and friends.

Results of a recent systematic review (39 studies: 3 RCTs, 34 observational studies, and two genetic studies) support claims that social relationships are positively associated with cognitive function (82) and another review (27 studies: 22 cross sectional studies, 3 prospective/longitudinal and 2 intervention studies) showed some evidence that social support was positively associated with leisure time physical activity. (83)

A 2006 review of housing with care[h] by Croucher et al. (40) concluded that there is evidence that housing with care offers opportunities for relationships and social support. This is supported by a 2009 study by Callaghan et al. (41) that looked at the social climate of 15 new-build extra-care housing schemes at six and twelve months after opening using questionnaires and interviews with residents. Most residents in the study were classified as having 'good' levels of social wellbeing; 90% of the sample had made new friends since moving to the scheme. Self-perception of residents' social life was associated with participation in activities; those who attended more events were more likely to rate their own social life as being 'good' or 'as good as it could be'. Results at 12-months found that social activities and communal facilities were important for developing new friendships.

However, both Croucher and Callaghan found evidence that there are some groups in particular that may not experience the social benefits of extra care housing. Both identify marginalized groups within schemes, particularly those who are very frail or with cognitive and/or physical impairments. Callaghan also found that social isolation and loneliness were reported by a small number of residents who were also more likely to be in poorer health and receiving care. Additionally, men in smaller schemes were more likely than women to report 'severe lack of social support'. This finding is supported by Evans and Vallelly (45) who also found that male residents were more likely to report loneliness. Overall, all studies concluded that older residents or those with some level of disability were less positive about their social wellbeing than healthier residents.

Fromm et al. (42) surveyed 71 residents from three US cohousing communities,[i] this is the only model in this review that does not fall under 'housing with care'. Respondents' weekly conversations with neighbours improved from two to 8–11 hours per week in the cohousing compared with previous residences. All residents felt able to ask neighbours for help with

[h] In this review, 'housing with care' refers to models where the 'housing component' allows older people to be tenants, owners or leaseholders, with private living space that is theirs and theirs alone, and where the 'care component' is flexible and can address a spectrum of care needs from very low to very high dependency levels that might formerly have resulted in admission to residential care. Thus the models support the concept of 'ageing in place'.

[i] Cohousing is a form of grouped housing designed and managed by those who reside within it. (more detail in case study #1)

tasks when unwell, compared with 40% in previous residences. While these are encouraging results, increasing social interaction may not be sufficient to prevent loneliness as loneliness is only weakly correlated with social isolation. (78) However another element of cohousing, autonomy, may moderate the effects of social isolation on loneliness as a feeling of ownership of one's environment contributes to a sense of social belonging. This effect is supported by a study by Knight et al. (43) which randomised care home residents to groups that either have collective input versus no control into the design of their communal living space. The group with input and control had increased social identification, psychological comfort, quality of life, physical well-being as well as interacting more and using communal spaces more frequently.

To address loneliness more directly, a study conducted by the International Longevity Centre UK (ILC) (44) explored independence, loneliness and quality of life in seven retirement villages with extra care across England. The sample of 201 residents were in generally good health and were financially well off as the villages were all 'luxury' models. The survey measured loneliness using a Three-Item Loneliness Scale and found that only 3.8% of residents reported the highest levels of loneliness while 64.2% were not lonely. However the study did find that 1 in 5 residents did report feeling lonely some of the time. This supports the theory that retirement housing can be socially beneficial for residents, though this study cannot say whether any improvement has occurred since it did not measure loneliness before entering the villages. In order to make a comparison with community dwelling older adults, the study created a comparison group using similar respondents from the English Longitudinal Study of Ageing (ELSA). Average scores on the 3-9 loneliness scale (lower scores being less lonely) were more favorable amongst retirement housing residents (3.73) than community dwelling older adults (4.37).

Finally, Callaghan concludes that communal facilities at the studied schemes, in particular restaurants and shops, are important for facilitating residents' social well-being, especially for helping friendships to develop. These facilities can also bring people from the local community into the scheme, which may increase residents' opportunities for social interaction and provide a link to the wider community. Social activities are valued by residents and help friendships to develop, but a wide variety need to be available to appeal to men, women and different age groups. (41) The evidence suggests the implementation of socially facilitating designs, like communal facilities, within the older adult housing market can improve social outcomes for residents.

Quality of Life

Quality of life (QOL) is a complex and multifaceted concept, it is defined by the World Health Organization as the following:

"…an individual's perception of their position in life in the context of the culture and value systems in which they live and in relation to their goals, expectations, standards and concerns. It is a broad ranging concept affected in a complex way by the person's physical health, psychological state, personal beliefs, social relationships and their relationship to salient features of their environment." (84)

As housing is an important element of an individual's life, it is reasonable to think that it may have an impact on their overall QOL either positively or negatively. A number of studies have found that assisted living environments can provide improved QOL for residents if they

effectively address the following factors: facilitation of individual choice and control, individualized care and social environment. (47)

Only the Baumker study and the ILC study attempted to 'measure' QOL, though other studies use residents' statements of satisfaction and general positivity as indications of good or improved quality of life.

The 2006 review by Croucher et al. (40) concludes that, for many older people, housing with care offers a combination of independence and security which contribute to residents' perception of improved QOL when compared to their previous homes.

The Baumker et al. (46) evaluation of an extra care scheme in Bradford found an improvement in self-reported quality of life according to the CASP-19[j] (with an additional QOL question) amongst all residents after six months living in the Rowanberries development. The mean score before moving was 4.2 while six-months later the mean was 3.1[k]; the improvement in mean QOL score was determined to be statistically significant ($p<0.005$) even though the sample size ($n=22$) was small. Most residents (54.5%) selected '*alright*' (the middle option) to describe their quality of life in their previous home, though a shocking 13.6% believed their QOL before moving was '*so bad, it could not be worse'*. At follow-up the largest proportion (40.9%) reported '*good*' and no residents indicated the lowest two categories.

Though the sample size of the Baumker study was small, its results are supported by other research. A review of research on housing for older adults in Australia (47) concluded that many residents of a number of retirement housing schemes reported improved QOL with particular reference to the physical and social environments as well as home maintenance and health support. However as this was a review of a number of studies, the measurement tool for QOL was not specified.

The ILC study (44) used both the CASP-19 and the Older People's Quality of Life Questionnaire (OPQOL) to measure quality of life. This study did not use a modified CASP-19 as the Baumker study did so the responses were interpreted on a 0-57 scale with higher scores indicating higher QOL. The mean score amongst residents was 43.73 while the most frequent score was 51; these results indicate that residents enjoy an overall high QOL. This is supported by the OPQOL scores, which are rated on a 0-65 scale; the average score was 55.92 and the most frequent score was 65, the highest possible score. The element which stood out as having the greatest effect on QOL was having 'control over living situation', those with greater control felt they had a better QOL. Using two measures of QOL strengthens the results of this study, though the sample is still an unrepresentative one. The ELSA comparison found that the retirement village residents reported better QOL (47.73) than those living in the community (41.23).

Quality of life is a difficult thing to measure, but it is particularly difficult to measure for a change comparison since that would require people being assessed before they move and it would be difficult to find people at the stage before moving. Two of the studies included here

[j] A validated QOL scale for older adults which asks individuals to rate a series of statements covering control, autonomy, pleasure and self-realization on a four-point scale resulting in an overall score to represent QOL

[k] Lower scores indicate better self-perceived quality of life

have attempted to get around this problem by a recall survey and a matched sample. There are limitations for both methods as recall can be unreliable and matched samples may differ in important ways from the study sample. However, these at least give an idea of the difference between extra-care/retirement villages and community living. The results from these studies are encouraging that housing with care can provide better QOL for older adults when compared to living in standard homes.

Health Improvement

It is often the case that health deteriorates with age and older people can find themselves with one or multiple conditions that reduce their ability to carry out daily activities. Generally, someone over the age of 65 might be considered an older person. However, it is not easy to apply a strict definition because people can biologically age at different rates so, for example, someone aged 75 may be healthier than someone aged 60. Instead of simply age, frailty has a bigger impact on their likelihood to require care and support. (85)

Frailty is a term used to describe those at highest risk of adverse outcomes such as falls, disability, and admission to hospital or the need for long-term care. (86) According to the NHS, 14% of adults in England over the age of 60 are considered frail. (85) Frailty is linked with poor mobility and difficulty accomplishing tasks of daily living; it also results in large increases in the health cost for care settings such as inpatient, outpatient and nursing homes. (85) General frailty can be exacerbated by long-term conditions such as heart disease and COPD. In England, 75% of adults aged 75 and older have more than one long-term condition. (86)

Between 2007 and 2014 the numbers of A&E attendances by people aged 60 or over increased by two-thirds; in order to ensure that the NHS is able to cope with the increasing demand for resources as well as changing patient needs, support for older adults outside the health service needs to improve. (86) There is some evidence that retirement or extra care housing schemes can improve the health and frailty status of older adults.

It is complicated to understand the impact on health from older adult housing schemes as each scheme draws its residents from different populations and has different entry requirements; therefore a study needs to have assessed each resident at entry or have a matched population of community dwelling adults (though this has its limitations) to use for comparison.

Netten et al. (48) conducted a study for the Department of Health evaluating 19 extra care housing schemes in England involving over 800 residents. This study found that the average resident of an extra care scheme was frailer than the population of older adults living in the community; over 50% of residents were unable to use stairs, go outdoors or wash without some assistance while this was the case for only 11% of the matched sample of community dwelling older adults. Over 40% of the residents which were followed up at six months and 18 months after moving in had improved physical functioning according to the Barthel Index[l]. However, after 30 months 47% of residents had deteriorated physical functioning, though this could be due to the generally frailer condition of residents overall. At 30 months, 14% of residents had improved cognitive function compared to only 6% who had deteriorated. Another study measured the impact of an extra care wellbeing service on 162 new extra

[l] Measures people's capacity to take part in normal activities of daily living

care housing residents with a control group of people living in their own homes in the community. After 12 months, 19% of the extra care group had improved to a ‘resilient’ state from ‘pre-frail’ at baseline. (52) This study examines the results of a particular program rather than the extra-care environment itself though it may suggest that the extra care environment is a good place to implement further support.

Mortality levels in the extra care housing were much lower than would be expected based on modelling for care-homes. The predictions for a similar cohort within a care home setting were that 50% of residents aged 65+ would have died within 32 months, however in the participating extra-care schemes, 32% of 65+ residents died over the study period, much lower than predicted.

Kneale et al. (49) found a significant proportion of those who enter extra care housing with care needs will go on to have health improvements that lead to a reduction in falls and care packages. The study also found that compared to those aged 80+ living in the community with domiciliary care, those in extra care housing are less likely to enter institutional care (8% after five years compared to 19%).

These results are mirrored by Kingston et al.’s investigation of a retirement community which revealed that the self-reported health of residents did not change dramatically while a matched sample of community dwelling older adults’ health declined over the same period. This suggests that retirement housing can play a role in maintaining health status for older adults. This could be due to a number of elements of specialist housing including 24-hour care availability and age appropriate design.

Retirement housing residents also perceive their accommodation to be beneficial. Over half of residents interviewed by a 2004 survey believed that their accommodation helped to promote good health and that their own health was good/very good.

Use of Health Services

The pressure on the NHS is likely to increase as the population ages. People aged 65+ account for 37.96% of hospital admissions in Thurrock; the 2016 Thurrock Annual Public Health Report (87) showed that many of these admissions are unnecessary or could be avoided with proper management within the community or appropriate and safe home environments. Preventing falls and other domestic injuries could be achieved with appropriate and adaptable homes. Extra-care schemes are designed with independence and accessibility at their core and there is evidence that they can be successful in reducing health service use by their residents.

The 2004 report published by ORB (50) found that while more residents (21%) received inpatient care than those aged 75+ in the general population (17%), the average number of nights spent in hospital was 7.4 compared to the average 17 nights spent by the general population of 75+ older adults. Knowing that an older person has suitable accommodation to return to and support to recover will allow hospital staff to discharge patients sooner, freeing up beds and reducing costs. (50) There were also fewer overnight hospital stays as residents found it easier to return home since moving into an extra care scheme. Fifty-four percent of scheme residents did not require any outpatient treatment and 13% did not require a GP visit over the study year.

The study of Rowanberries in Bradford found that health care costs were 50% lower due to better health enjoyed by residents since moving in to the scheme; these saving were mostly through a reduction in intensity of nursing consultations as well as fewer hospital visits and lower proportion of residents using acute services. (46)

Extra Care housing can be a good alternative to placement in residential care. A case study of extra care housing schemes in East Sussex observed that 63% of residents would have been placed in residential care if they were not living in extra care; the study also found that 94% of residents were appropriately placed. This indicates that there is a significant portion of residential care residents who would be better placed in extra care. (53)

An evaluation by Aston University measured the impact of an ExtraCare Charitable Trust's Well-being Service on 162 new extra care housing residents with a control group of people living in their own homes on the community. Planned GP visits fell by 46% among the intervention group versus no change among control participants; planned hospital admissions fell by 31% versus no change among control participants. There was no difference in unplanned visits between the two groups. (52)

Extra-care presents an opportunity to relieve pressure on the health care system by supporting older adults to receive support that will keep them out of hospital and to provide appropriate homes for them to return to after inpatient care. Reduced use and reduced intensity of use of GPs and hospitals may be due to better management of conditions with the support of scheme-provided care. While there was no difference in unplanned hospital visits and, in fact, inpatient procedures were more numerous amongst the extra-care population than the community dwelling control groups, the evidence shows that extra-care actually frees up hospital beds by reducing the length of stays.

Cost Effectiveness

A key reason for the government's recent push for extra-care housing over more traditional residential care settings is the potential for cost savings associated with extended independence and resultant lesser care needs. However, it is important to understand the true cost differences, including whether or not there is actually some cost shunting where the cost burden remains the same or higher but is paid by a different agency (i.e. health to social care). As with other outcomes, it is difficult to generalize about the cost effectiveness of 'extra-care' as a whole since the service provision across schemes can differ widely. A number of studies have been conducted to try to answer the question: is extra-care cost effective? However, each study has had different comparators and when it comes to housing with care, cost-effectiveness can be complex. For example, a housing scheme may actually cost more while producing better outcomes making the cost per-outcome lower but the overall cost higher. The acceptability of costs is not a readily available reference so the true 'cost effectiveness' may actually differ from area to area based on the available funds and the willingness to pay for certain outcomes. These studies compare extra care housing to previous residence, residential care and to the opportunity cost.

One study by Baumker et al. (51) conducted a comparative cost and outcome analysis between extra-care and a residential care home. This study, trying to acknowledge the variability within the extra care market, found that the probability that extra care is more cost-effective than residential care is 76%. Over a six-month period, the cost savings of £902 per

resident per week were in favour of extra care over residential. This study also analysed costs in relation to physical and cognitive outcomes. The mean score on the Barthel Index[m] was practically the same for both groups at baseline (13.94 compared with 13.89 for the care homes group, p = 0.898). At the six-month follow-up stage the scores were 14.22 for extra care and 13.51 for the care homes group. Thus, there had been a marginal improvement in extra care residents' abilities (0.28) and a decline amongst those in residential care homes (–0.37), on average, extra care residents had better outcomes than care home residents over the six months. In terms of cognitive functioning, the extra care group remained stable whilst the care homes group showed some slight deterioration. Combining the cost analysis with the health improvement analysis resulted in an estimated £1,406 savings for the extra care group over six months per additional point gained on the Barthel Index.

A very small evaluation of an extra care housing scheme in Bradford (46) looked at a sample of 22 residents to determine whether their weekly expenditure was higher or lower after moving to the scheme. While the costs of accommodation and social care went up, on average, the cost of healthcare decreased. However, this decrease was not enough to make a saving in the extra care scheme. On average, residents' cost per week increased by £91. The main limitation of this study is that the residents in the sample lived in a variety of previous accommodation so there is no straightforward comparison between two housing options.

A recent report from Demos (54) has attempted to quantify the social value of sheltered housing. The value approximation is a sum of the following: reduced inpatient stays, reduced care costs of falls prevented, reduced cost of hip fractured prevented, reduced health service use due to reduced loneliness. Based on these costs, the total estimate of national savings from sheltered housing is £486 million per year.

A case study by East Sussex County Council which looked at the business case for extra care housing (53) concluded that the cost of extra care housing was on average half the gross cost of alternative placements in residential or nursing care. This study also calculated that, based on the contributions by the council, return on capital investment would be between 1.5 and 3.3 years.

In the Aston University study, (52) NHS costs for the intervention group reduced by 38% compared to control participants over 12 months, resulting in a saving of £1,115 per person per year. The cost reduction was most significant for residents who were assessed as being frail, decreasing from £3,374 to £1,588 on average per person per year.

Long-term, the evidence suggests that housing with care is cost-effective but the picture is complex. While extra-care improves health and reduces health care system usage, it is reasonable to expect that it would reduce the cost to the public purse; however, the cost to the individual may be higher than it would be in a private residence. In these cases, higher costs are associated with better outcomes so the increased price may be worthwhile if the individual can afford it; but those in the worst health are also generally the least wealthy. The variability across studies in terms of comparison groups and scheme details makes it difficult to draw conclusions but the evidence is encouraging.

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[m] Normally, a higher score on the Barthel Index indicates greater independence but to simplify interpretation the scoring was reversed

Appendix 2. Public Engagement Evaluation Report

Older People's Housing and Health Public Engagement – Evaluation Report

1. Introduction

As part the process of developing the Annual Public Health Report (APHR) 2018, the Public Health team sought to obtain thoughts and preferences of Thurrock residents. A range of questions were formulated to include:

- The respondent's current housing situation and how well this meets their needs.
- What is important to the respondent in terms of the building in which they live
- What is important to the respondent in terms of the place in which they live
- What the barriers and enablers are to moving home in older age
- How older people could be supported to start planning for older age sooner.

This report will analyse all comments, data and feedback from the public submitted in response to a 4 week consultation around Older People's Housing and Health in Thurrock.

The consultation was open to all ages because older people and people approaching older age, (who are the future older population) will have views on this subject. The information gathered was used to input into the Annual Public Health Report for 2018 and will provide a basis on which to engage with the public further in regards to the recommendations proposed.

2. Methodology

A questionnaire was developed by the APHR working group (consisting of colleagues from Public Health, Housing, Planning, Adult Social Care and Communications) and approved by the Council Communications Team, Director of Public Health and Assistant Director of Housing prior to circulation. In addition to the pre-determined responses there were also opportunities for comments to be added.

The survey ran from 7th September 2018- 5th October 2018 with the short timeframe due to deadlines for presenting the report at Housing Overview and Scrutiny Committee before the end of the calendar year. The survey was primarily available online, however paper surveys were also made available and actively distributed via the sheltered housing team, Thurrock Over Fifties Forum events, residents forum and each of the six community hubs to try and ensure the consultation was inclusive of those who may not be able to access the internet. The online survey was accessible via the Thurrock Council Portal and was cascaded via several online routes such as social media, council internal communications, housing newsletters, the CCG and CVS to name a few. In addition to the survey, opportunities were taken to have discussions with local residents on the above issues through attendance at Thurrock Over Fifties Forum Conference, Thurrock Over Fifties Forum October meeting and Purfleet September residents meeting. These conversations started with discussions on what was most important in terms of a) the building or house, and b) the place in which they live however often expanded to cover other pertinent points.

3. Responses - survey

There were a total of 116 responses to the survey. The sample size is not known due to the way in which the survey was distributed. The responses and analysis to the key questions can be found below.

3.1 Demographics of respondents

The breakdown of response by age and gender are shown in Chart 1 and 2. It can be seen that the majority of responses were from female residents aged over 60 years. Over a quarter (26%) of our respondents currently live in Grays and over half (53%) own their own home with no mortgage (another 13% own their home with a mortgage).

Chart 1. The age of respondents to the survey

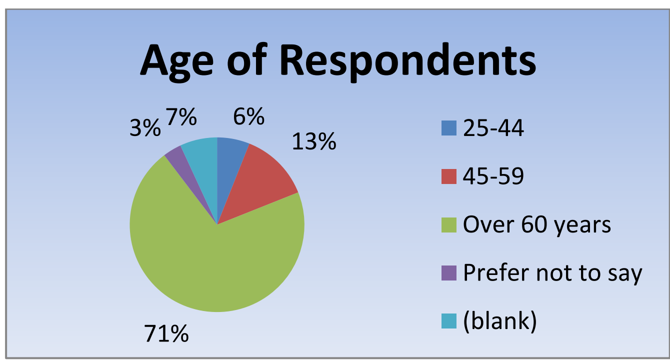


Chart 2. The gender of respondents to the survey

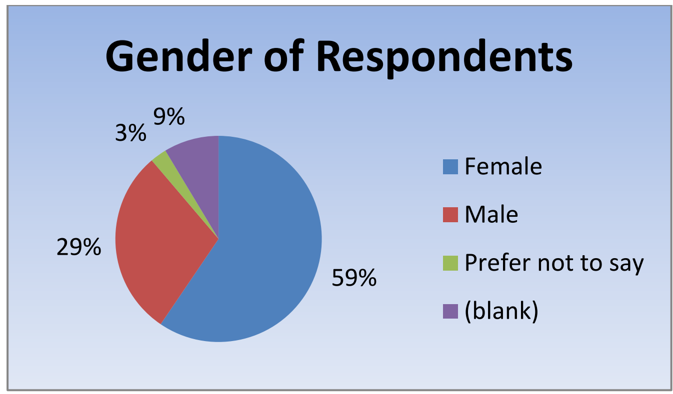


Chart 3. Where respondents to the survey live

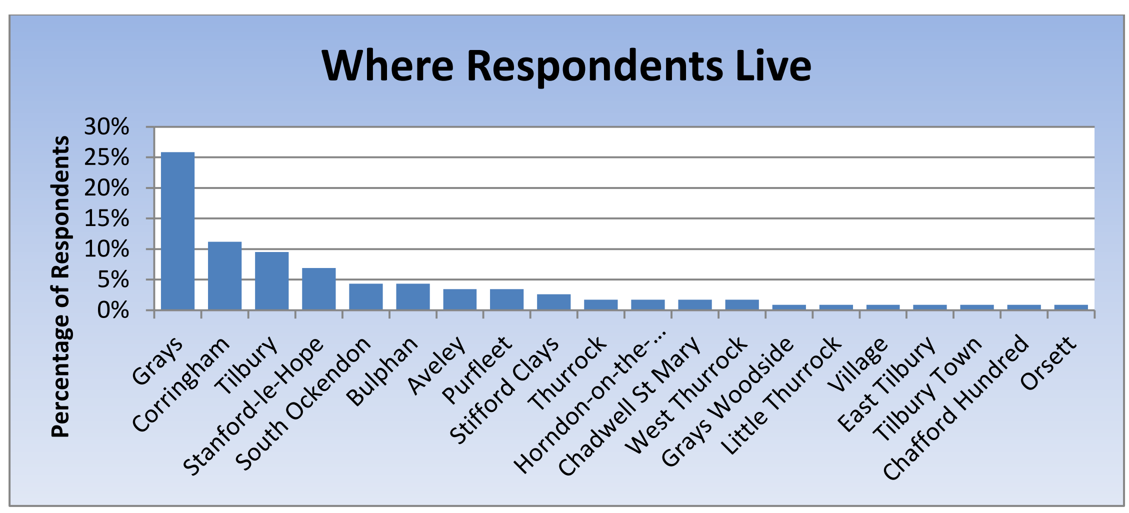
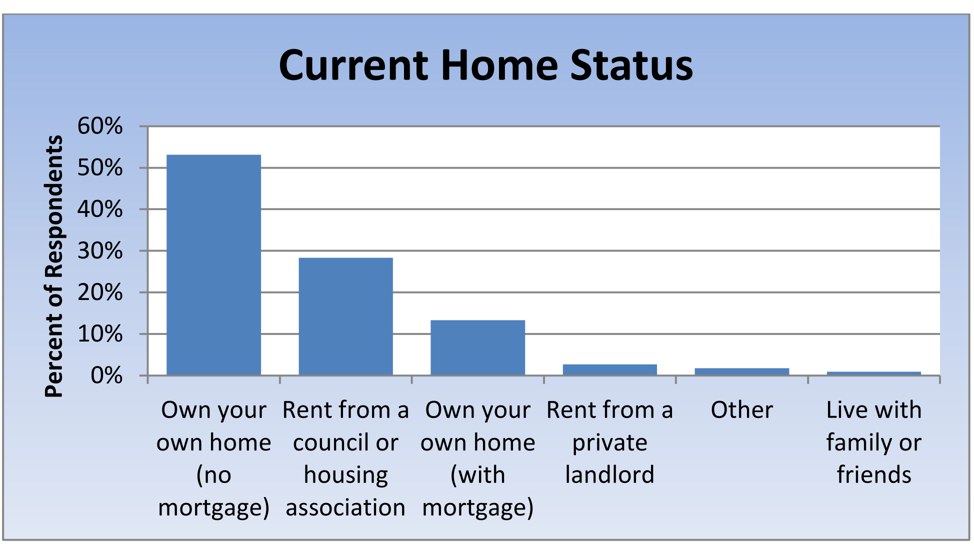


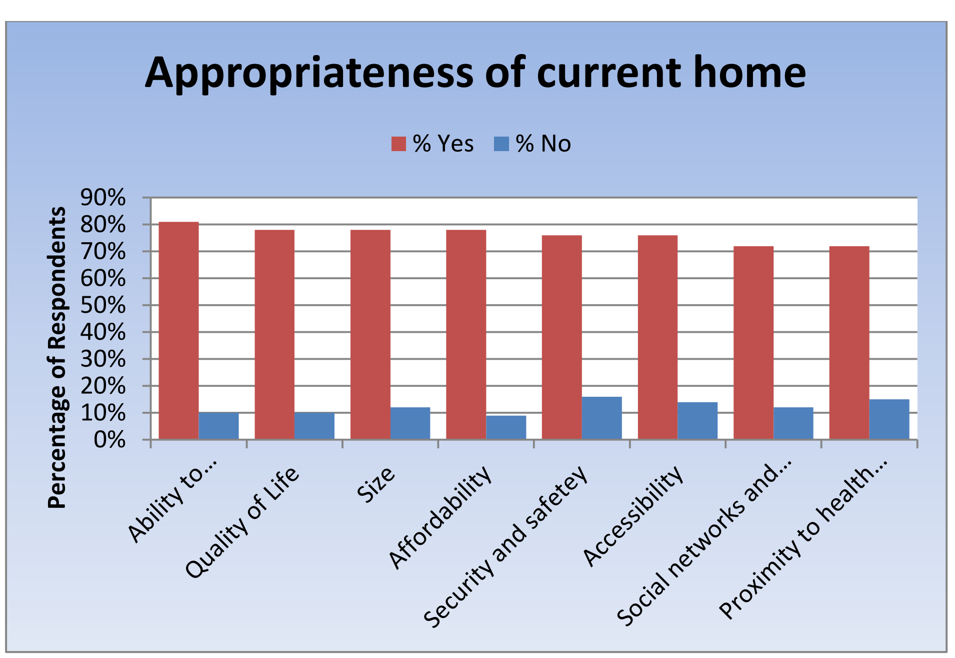
Chart 4. Respondents' tenure status



<u>3.2 Appropriateness of current home</u>

Chart 5 shows the appropriateness of the respondents' current homes in terms of specific factors. For each of the factors listed, between 9% and 15% of respondents felt that their current home was not appropriate for them for that specific factor.

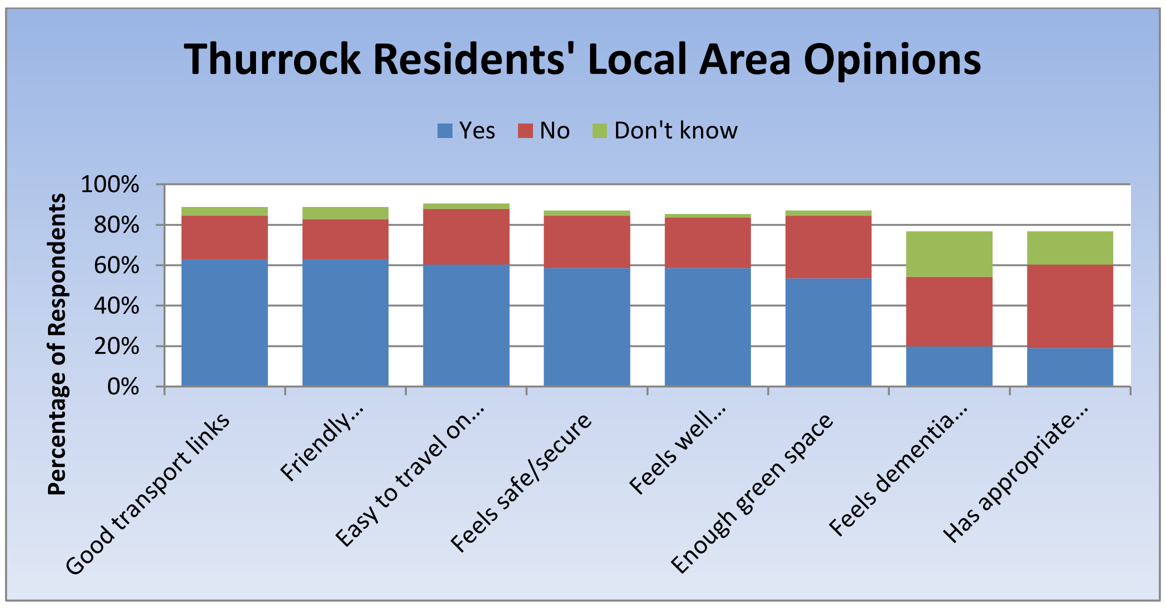
Chart 5. How appropriate respondents felt their current home is in terms of specific factors.



3.3 Opinions about local area

Chart 6 shows respondents' views on whether the area they currently live in was appropriate in terms of several features. The chart shows that many respondents feel that the place they live is not dementia/age friendly and does not have appropriate housing options for older people.

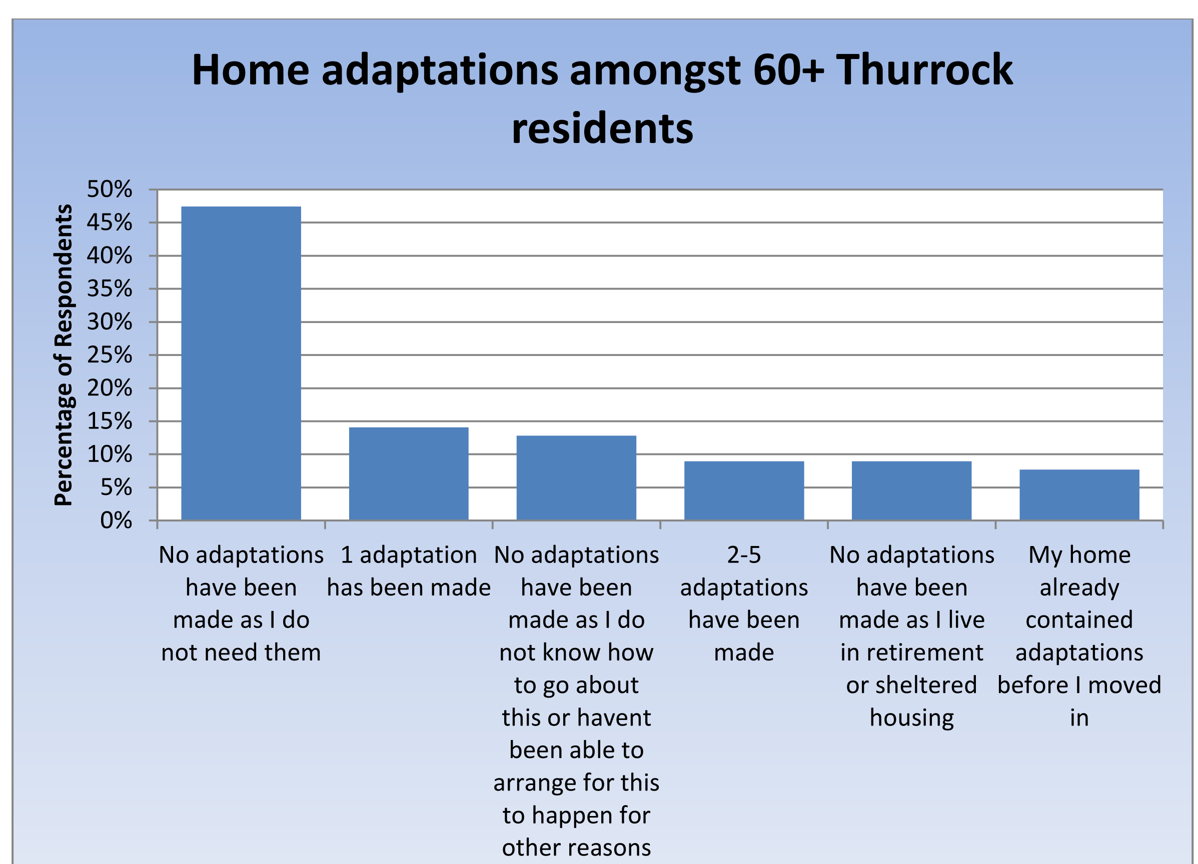
Chart 6. Respondent's views on how appropriate the area in which they currently live in terms of eight defined features.



3.4 Home adaptations (only for 60+)

Of those respondents aged 60 plus, just under half (47%) did not have any adaptations as they do not need them while 31% have either made at least one adaptation or their house already contained them when they moved in.

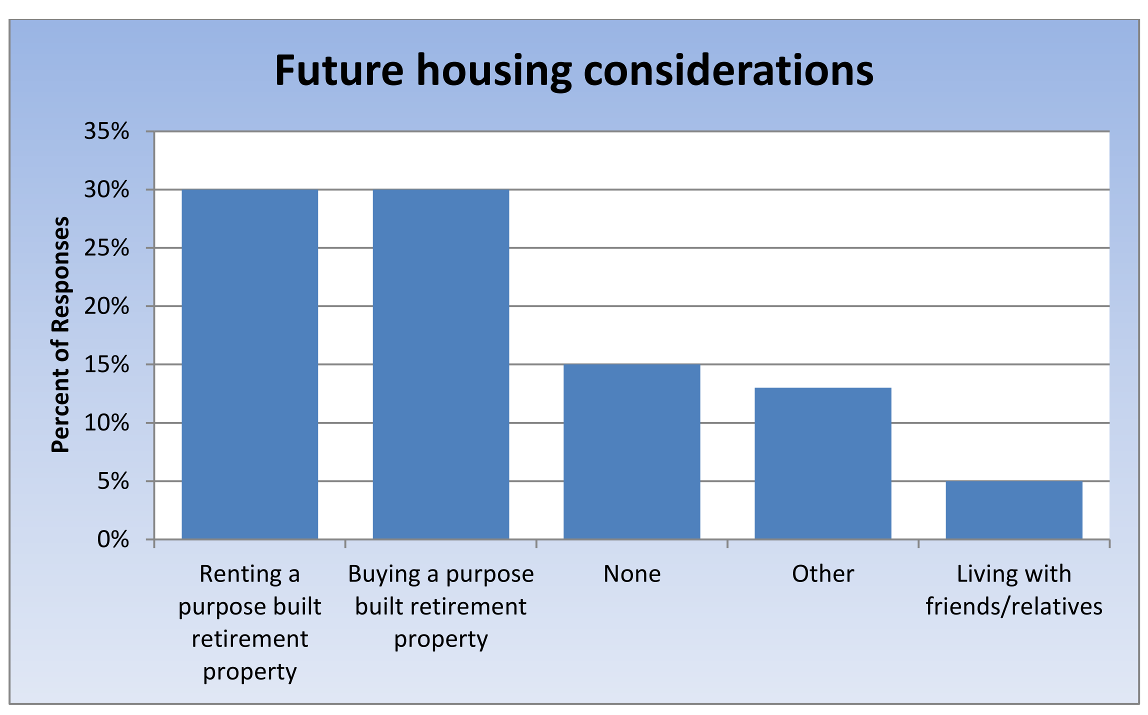
Chart 7. The number of home adaptations amongst the age 60 plus respondents.



3.5 Future housing considerations

Chart 7 shows the type of property that respondents would consider moving to in future. There is equal interest in both buying and renting a purpose built retirement property (both 30%). These options gained double the responses of the next most popular option, 'None' (%15) indicating that purpose built retirement properties are a particularly popular option.

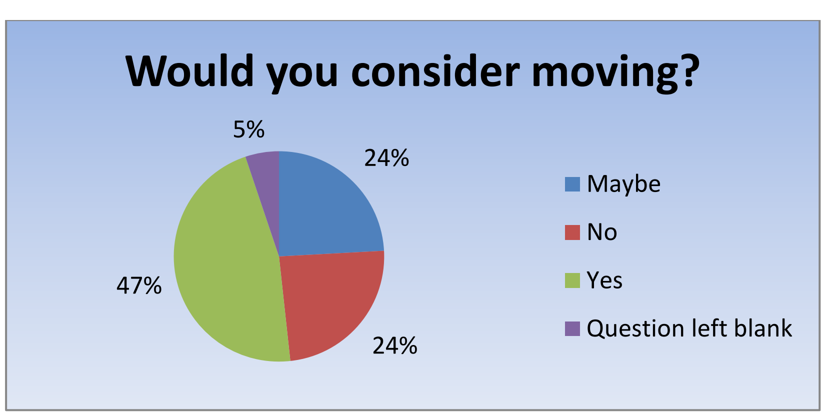
Chart 7. The types of property that respondents would consider



3.6 Would you consider moving?

Just under half of respondents said that they would consider moving (47%), with an additional 24% stating that they would "maybe" consider moving.

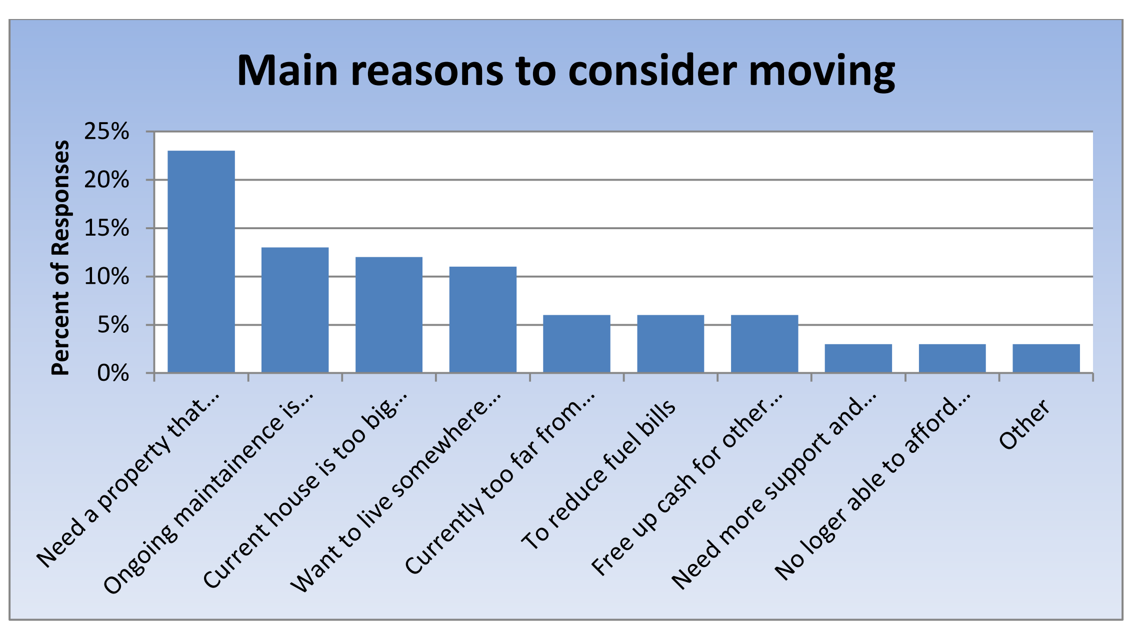
Chart 8. Respondents' attitudes towards moving.



3.7 Main reasons to consider moving

The most commonly cited reason for considering moving was a need for a property which suited the respondents needs better. Ongoing maintenance, the house being too big and wanting to live somewhere different were also common reasons.

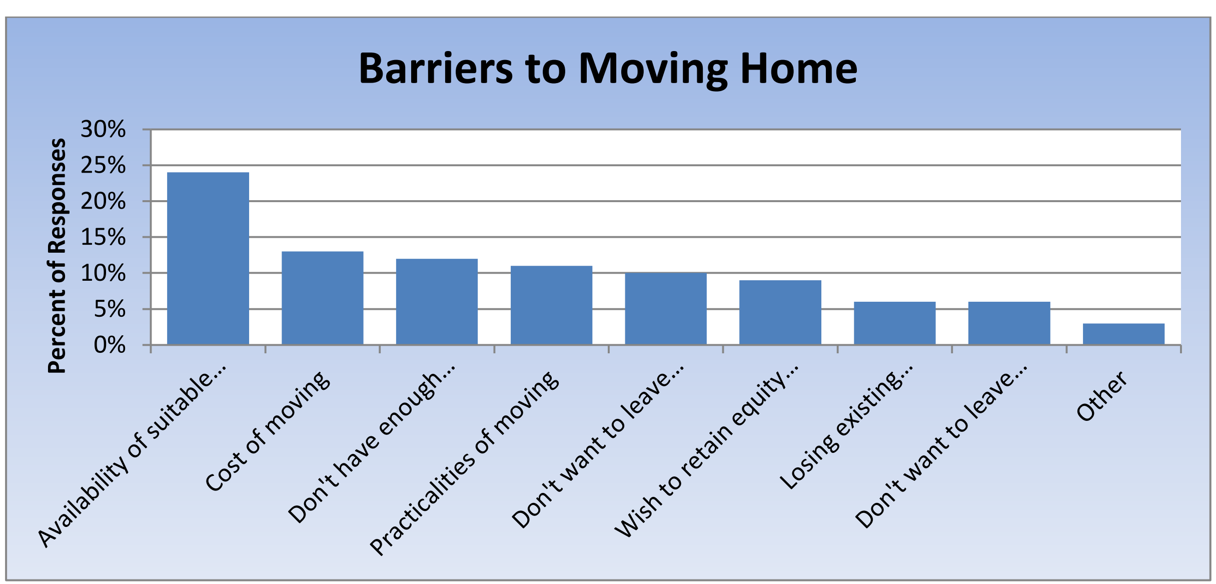
Chart 9. The main reasons that would lead respondents to consider moving



3.8 Barriers to moving

Almost a quarter (24%) of respondents felt that the availability of suitable properties was a barrier to moving. The second largest concern was the cost of moving. 16% of respondents did not want to leave their current home (for both sentimental and practical reasons)

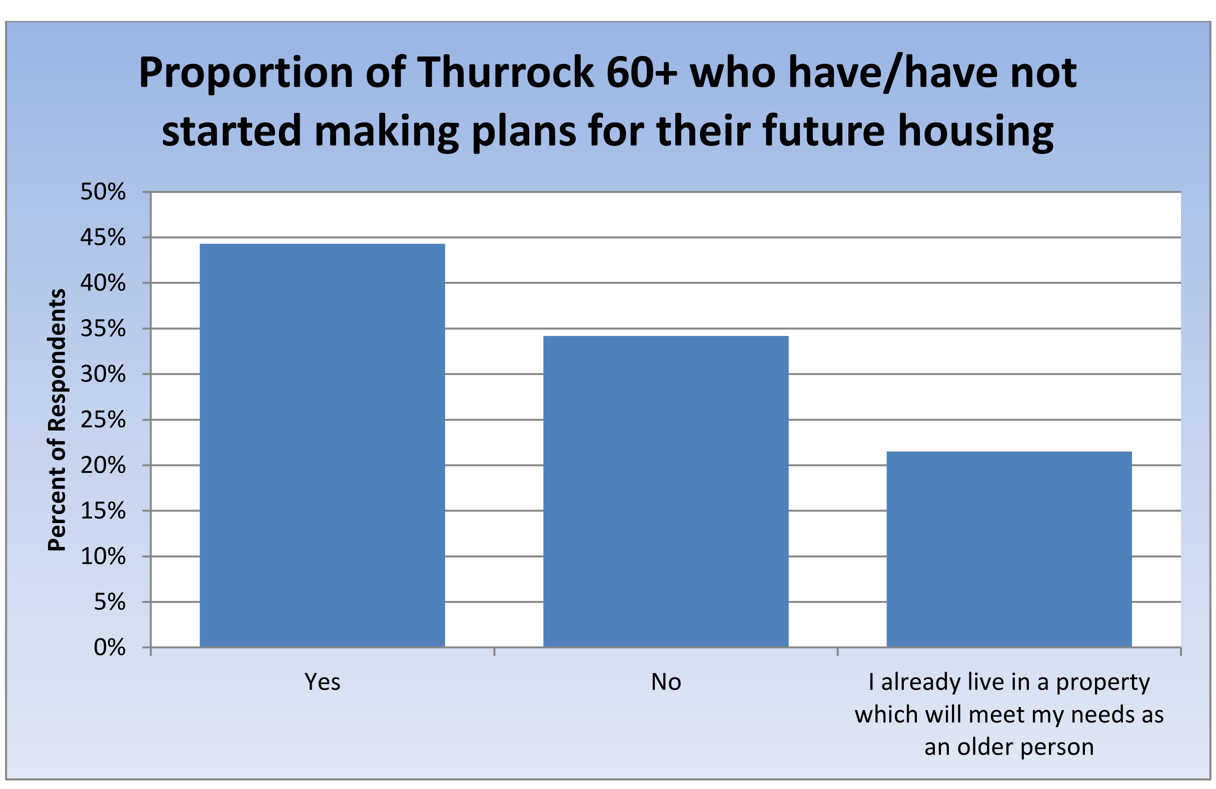
Chart 10. The main barriers to moving home identified by respondents.



3.9 Have you started to plan?

Less than half (44%) of respondents over 60 years old have started planning for their future housing needs and 22% are already in age appropriate accommodation. This means that over a third (34%) of 60+ respondents have not yet started to plan for their future housing needs.

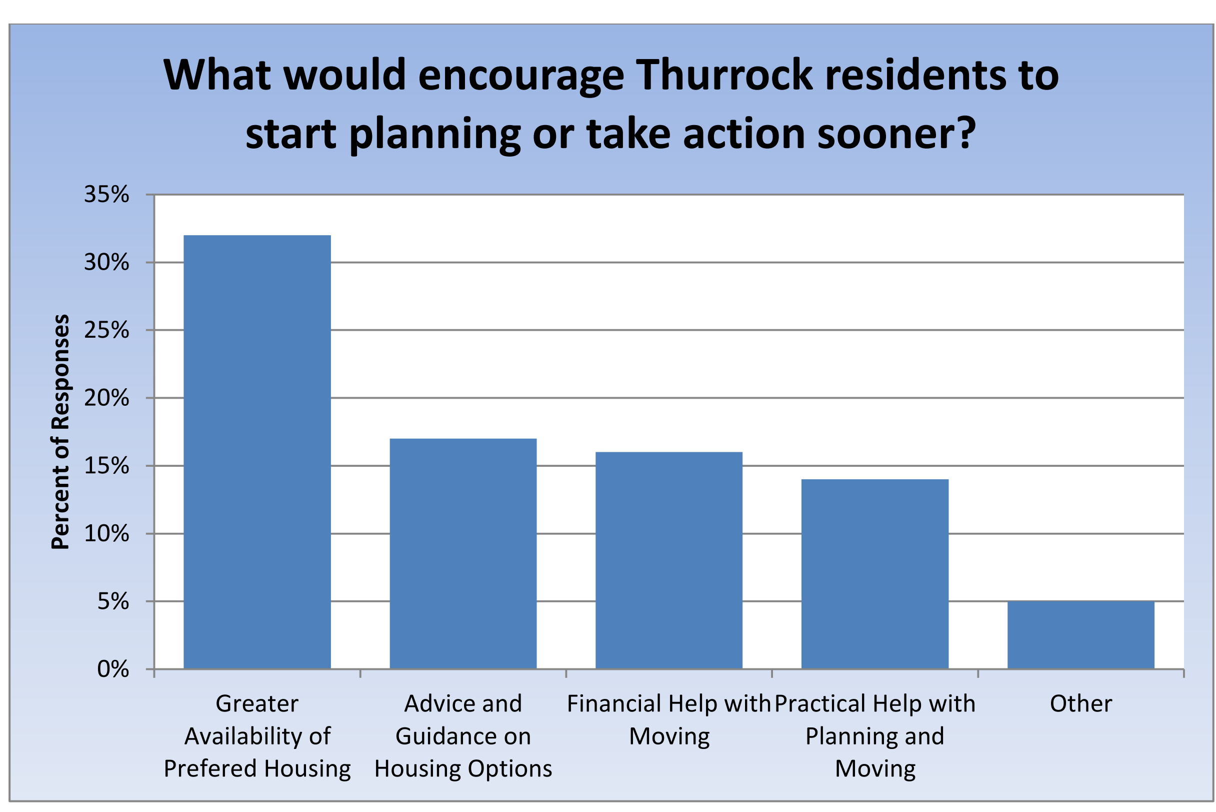
Chart 11. The proportion of respondents aged 60 and over who have started to make plans with regards to their future housing.



3.10 What would encourage people to plan/ take action sooner?

Over a third of respondents (32%) felt that greater availability of preferred housing would encourage them to take action sooner. However, advice and guidance on housing options, financial help with moving and practice help with planning and moving would also be of benefit.

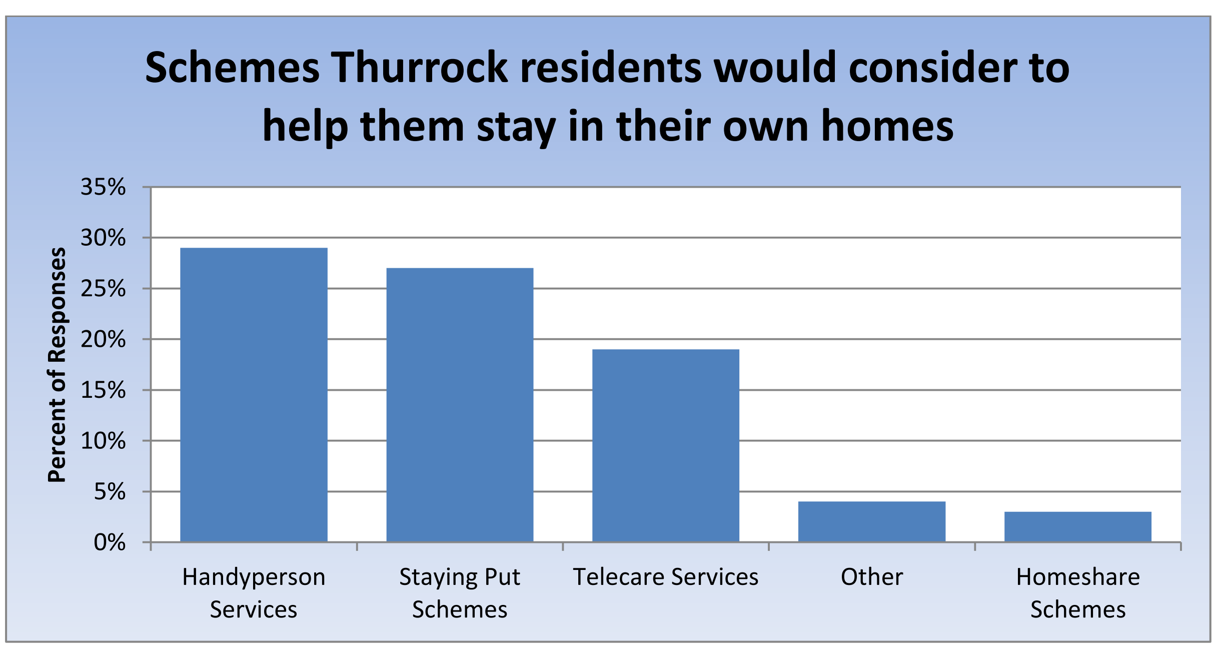
Chart 12. The factors which would encourage respondents to start planning or taking action sooner.



3.11 What schemes would people consider to help them stay in their home?

Schemes that respondents would consider to help them stay in their home are shown in chart 13. Handyperson services would be considered by 29% of respondents and Staying Put schemes by 27% of respondents. Telecare would also be considered however home sharing schemes were less favourable.

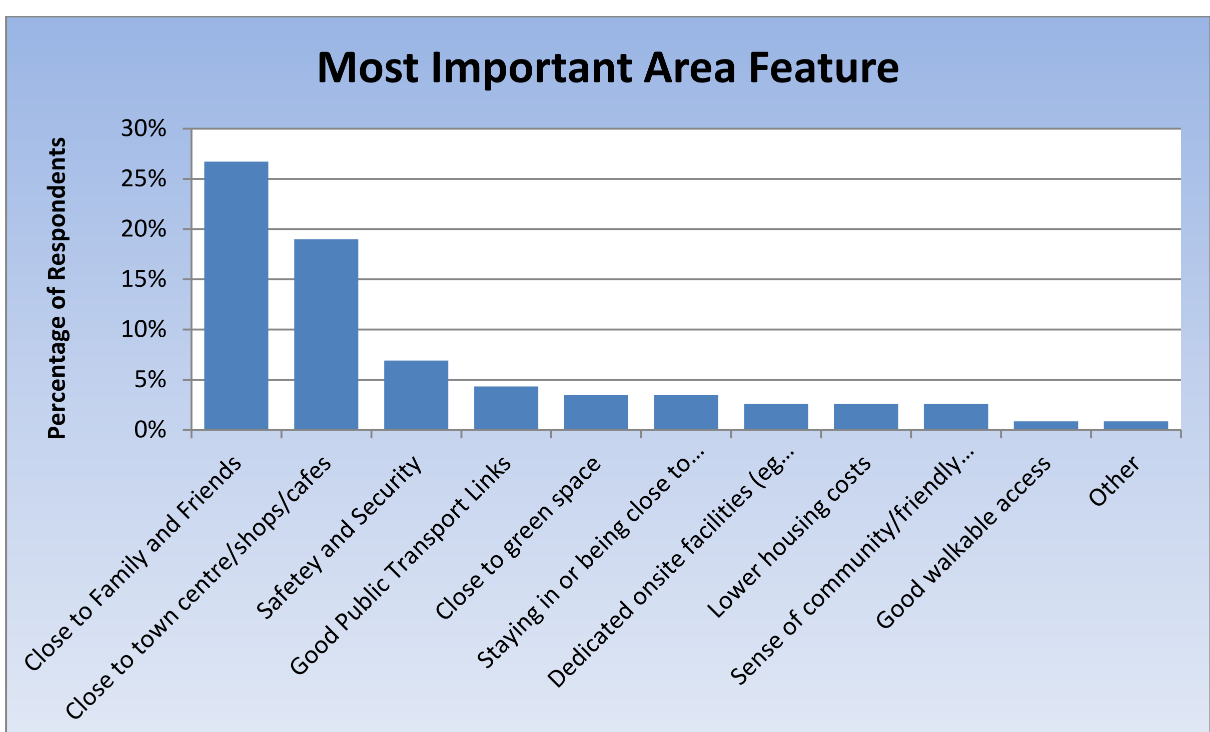
Chart 13. The schemes which respondents would consider to help them stay in their own homes.



3.12 Most important area features

Chart 14 shows the proportion of respondents selecting each area feature as their top priority. Being close to family and friends was the most attractive feature for 27% of respondents, and being close to a town centre, shops and cafes was important for 19% of respondents.

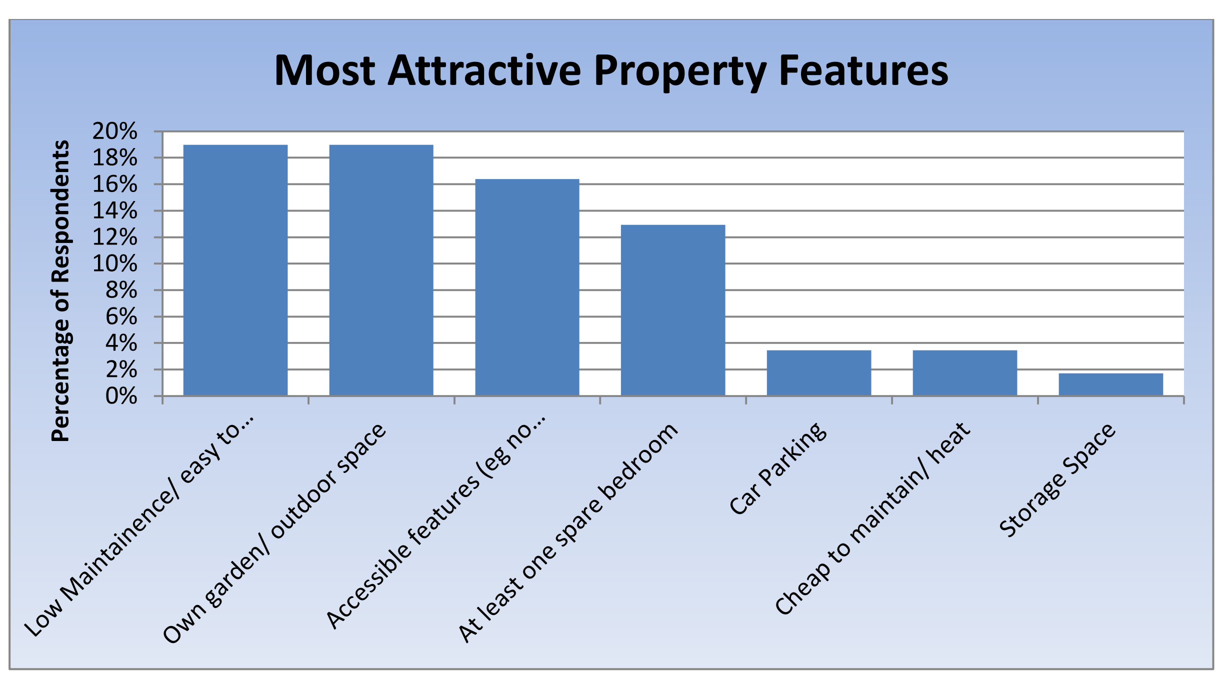
Chart 14. The area feature ranked first in terms of preference by respondents.



3.13 Most attractive Housing Features

Chart 15 shows the proportion of respondents selecting each property feature as the most important. Low maintenance/easy to maintain, and having outdoor space/own garden were the most attractive features, with accessible features and a spare bedroom also highly rated.

Chart 15. The property feature ranked first in terms of preference by respondents.



Themes

It appears as if residents view the connectivity of their home as important, evidenced by them ranking 'close to family/friends' and 'close to town/facilities' as the two most important features of an area. One respondent also noted a lack of decent public transport in their current area as a reason to move. An area being appropriate for wheelchairs and mobility scooters was a concern expressed in free-text responses. Combining these responses creates a good picture of the kind of areas that are attractive to older adults, with the proximity of friends and family as well as the ability to easily access and navigate community amenities being key. Another aspect of 'connectivity' that we did not include as a survey option but was expressed in the free-text was internet access.

It also appears there might be a call for better information/advice, evidenced by the 17% of people that say advice/guidance might help them plan towards meeting their future housing needs, and the barriers to moving question showed that 12% of people did not think they had enough information as to what their options are. Some free-text responses support the need for better and more accessible information about what is available. One respondent said that when they were considering their future options they were not made aware of Elizabeth Gardens (one of the borough's extra-care facilities) but they would have purchased accommodation there had they known about it. Another respondent said that they were reluctant to move because they were concerned that somewhere else may not offer quality of life. There is a clear demand for more comprehensive information about what is available and what can be offered by each option. It also may be that the delivery of available information should be reviewed to reach a wider audience. It looks as though there is a desire for general assistance with moving as the proportion of respondents saying they would be encouraged to move by 'Advice', 'Financial help' and 'Practical help' as being similar (17%, 16%, and 14%).

Financial issues came up in free-text responses with 'cost for my family' and the expense of renting an 'OAP flat' being mentioned as barriers and 'can't afford' entered in response to

future housing considerations, ‘cost of moving’ was the second most popular response to ‘barriers to moving’.

This survey found 34% of 60+ respondents have not started planning for their future housing needs, and free-text responses revealed that many would only consider their future when it was ‘necessary’ or they ‘became immobile’.

This survey provides evidence that increasing the stock of attractive and appropriate homes could lead to more house moves as the top barrier to moving was the ‘availability of suitable properties’ and the top option that would encourage people to move was ‘greater availability of preferred housing’. It is interesting that both renting and owning received the same proportion of responses as 66% of respondents currently own their own home. A preference for bungalows was expressed in the free-text of the survey, though one respondent who already lives in a bungalow expressed concern that it was becoming difficult to keep up with the ongoing maintenance. This is a reminder that this housing style, popular for its accessibility, does not address all the housing issues for older adults.

3 Responses – discussions with local residents

There were several themes which emerged during face to face conversations with residents. These are summarized below.

4.1 What is most important in terms of the building you live in?

Level Access

Level access was a strong theme emerged across all conversations. Many respondents felt that this was crucial in maintaining independence in the home. Respondents noted that it is only once mobility is an issue that steps and curbs are particularly noted. Of specific note was the reference from several people of the need for wet rooms and the difficulty in getting these installed.

Finances

Finance emerged as a strong theme with several residents commenting that they recognized that they needed adaptations however having received quotes for this work they felt that they could not afford these adaptations.

Respondents were also very worried about the costs of maintaining their homes including upkeep of gardens and handyperson services were welcomed however costs were mentioned as an issue.

Other

Other comments related to being able to park close to the house, being able to get outside during the snow when there is no-one to clear the path to the house, and lack of space for storing mobility scooters.

4.2 What is most important in terms of the place you live in?

A Sense of Community

A very strong theme mentioned by all residents as being very important was feeling part of a community. Many felt that a sense of community did not seem to exist and there was little interaction with neighbours. They felt that people should look out for one another and check in from time to time on vulnerable neighbours but this was not their experience. Organised activities and groups were often the only way to get social interaction.

Physical presence of amenities

Many residents mentioned that they struggled to use or did not have access to the internet, and felt that they missed out on information because of this. It also meant that they had to rely on family members to undertake some tasks for them e.g. online banking, which made them feel less independent and could be an invasion of privacy. Residents wanted more face to face contact with services and to be able to visit a post office, or shop etc. in person rather than accessing services online.

Other

Other issues mentioned were access to parking in town centres which was close to facilities, good public transport links and crime. It was also mentioned that the opportunity to speak to people directly about their views and needs in relation to housing and place would be preferable.

4 Reflection upon the public engagement exercise

Despite extensive efforts to promote the survey link via different routes, and the availability of paper versions, there were a small numbers of responses to the survey which mean that it is difficult to draw firm conclusions from them. However, these survey results enable comparison with data from national surveys and provide a local baseline platform from which to explore specific issues further.

Whilst small in number and informal, the conversations with residents provided a rich source of information which enhances the understanding of the survey results, albeit there is some discrepancy between the two sources, for example, costs of maintaining a home were a strong theme in the conversations but this was not highlighted by the survey. Small numbers across both engagement methods, combined with the way in which the survey was distributed and forum in which conversations took place may mean that the sample was not representative of the older people's population of Thurrock.

This suggests that there would be value in further engagement work on specific issues to explore these areas further. However, it is unlikely that a survey is the best vehicle to do this, so it is proposed that face to face methods, such as focus groups are used going forwards which will enable older people to put their views into their own words and enable greater depth of exploration into issues. It is likely that the survey was too long and was impacted upon by there being a number of other consultations being run by the Council at the same time. Additionally, there may have been a view that the survey was only relevant for older people. There needed to be greater encouragement or incentive to complete the survey, with more availability for non-online methods.