Breakthrough Britain

AGE OF OPPORTUNITY

Transforming the lives of older people in poverty

A policy report by the Older Age Working Group
Chaired by Sara McKee

June 2011




THE CENTRE FOR SOCIAL JUSTICE

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CALOUSTE GULBENKIAN FOUNDATION

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About the Centre for Social Justice

The Centre for Social Justice (CSJ) aims to put social justice at the heart of British politics.

Our policy development is rooted in the wisdom of those working to tackle Britain's deepest social problems and the experience of those whose lives have been affected by poverty. Our Working Groups are non-partisan, comprising prominent academics, practitioners and policy makers who have expertise in the relevant fields. We consult nationally and internationally, especially with charities and social enterprises, who are the champions of the welfare society.

In addition to policy development, the CSJ has built an alliance of poverty fighting organisations that reverse social breakdown and transform communities.

We believe that the surest way the Government can reverse social breakdown and poverty is to enable such individuals, communities and voluntary groups to help themselves.

The CSJ was founded by Iain Duncan Smith in 2004, as the fulfilment of a promise made to Janice Dobbie, whose son had recently died from a drug overdose just after he was released from prison.

Executive Director: Gavin Poole

Age of Opportunity: Transforming the lives of older people in poverty

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Preface

The Centre for Social Justice (CSJ) was established in 2004 to find solutions to social breakdown and help transform the lives of people in poverty. In our 2007 report *Breakthrough Britain* we identified five interconnected 'pathways to poverty': family breakdown; educational failure; economic dependency and worklessness; serious personal debt; and drug and alcohol addiction. Such entrenched disadvantage prevents people reaching their personal potential and hinders their playing a full part in our communities. Yet these root causes of poverty cannot be fixed with a wave of a pen or a speech in Westminster; they require a focus on work that changes lives and generates hope. ourhoods would benefit from.

Poverty and social breakdown can affect people at any age, but this review has revealed their tragic impact on older members of our rapidly ageing society. Our first report, *The Forgotten Age*, set out how this took hold across a number of areas and sought to broaden the debate about ageing out from an important but narrow focus on pensions and social care.

This final report from the CSJ Older Age Review, *Age of Opportunity* sets out a path to reform. In it we outline how government, communities, and older people can work together to ensure that later life is an age of opportunity for all. The reforms we propose are, in many cases, rooted in the outstanding work we have encountered both in the UK and abroad. One such example is the Valuing Older People team situated at Manchester City Council, which has pioneered a way to coordinate local groups and services for older people at a neighbourhood level. Another initiative we saw on our visit to the United States – the community development work initiated by the Department of Neighbourhoods in Seattle. In this review we highlight and promote the difference such initiatives make to the lives of older people because we believe they are replicable in other places and in other contexts.

Although the recent changes to the pension system are welcomed, large numbers of older people will still have to rely on means-tested benefits. Many older people are not aware of the options and help available to them, and we believe that it is essential that information should be made more accessible in order for older people to maximise their support.

Older people living on low incomes have to make sacrifices and do without items and services which many of us take for granted. Whether it is a decision to heat their homes at the expense of not eating properly or because of mobility problems they are unable to travel within their communities. There needs to be a major focus of targeting age related benefits towards those who really need them in order for them to be lifted out of poverty.

As a society we also need to think through what type of housing is suitable for older people, and due to our ageing population, whether we have enough decent housing for older people to live. Many of our eldest and most vulnerable people are living in non-decent housing which is unsuitable for their needs, the majority of which is in the private sector. Furthermore, at a time of reduced government expenditure, many older homeowners live in unsuitable properties and have few options available to repair or make necessary adaptations. This is coupled with a cultural reluctance either to move to more suitable accommodation or to use the equity from their property. This needs to begin to change. In this report we outline proposals to overhaul the way that housing repairs and adaptations are administered in this country. We need services are that are more responsive and more preventative.

In this report we also examine social care. Recent political debates have focussed solely on how we as a country are going to fund the provision of care in the future. We have not conducted a technical review of how care can be funded, but rather have focussed on what good care looks like and, therefore, where any increased resources should be channeled. Finally, in many cases the provision of services falls below that which many of us would expect to be a reasonable level due to the rationing of statutory care services. Only by investing in preventative services can many older people be supported to live independent lives for longer.

In publishing this report I would like to thank Sara McKee, Dr Nori Graham and the Older Age Working Group, as well as Paul Langlois and James Mumford at the CSJ, for their efforts.

Only by recognising and responding to these most pressing issues facing the poorest older people, can we ensure they are given an opportunity to live fulfilled lives, and play a part in society.

Gavin Poole
CSJ Executive Director

Members of the CSJ Older Age Working Group

Sara McKee (Chairman)

Sara McKee is Chief Operating Officer of Anchor Trust, the largest not-for-profit provider of housing and care services for older people in England. She was previously Group Commercial Director at A4e. Sara has over 20 years experience in commercial consumer-facing businesses, across a range of sectors including technology, retail, travel, training and employment internationally. Sara is a Fellow of the Royal Society of Arts and a Freeman of the Worshipful Company of Management Consultants.

Dr Nori Graham (Interim Chairman)

Dr Nori Graham is an Honorary Fellow of the Royal College of Psychiatrists and has been awarded an Honorary Doctorate for public services by the Open University. She is Emeritus Consultant in the Psychiatry of Old Age at the Royal Free Hospital. She was, until recently, Mental Health Consultant to Nightingale House. She was the National Chairman of the Alzheimer's Society for England from 1987 to 1994, and Chairman of Alzheimer's Disease International (ADI) from 1996 to 2002. She has recently become a Trustee of Independent Age. She is an Honorary Member of the Association of Contentious Trusts and Probate Specialists. Her most recent publication is: Nori Graham and James Warner *Understanding Alzheimer's Disease and other Dementias*, BMA 2009.

Andrew Harrop

Andrew Harrop is Director of Policy and Public Affairs at Age UK. He leads the charity's Campaigns, Public Affairs and Public Policy departments. Andrew is author of the charity's annual overview of public policy and ageing. He regularly speaks on older people's issues at national conferences and on TV and radio. He has written numerous published reports and

is also co-author of two books *Age Discrimination Handbook* and *Your Rights: Working After 50*. Andrew joined Age Concern England in 2003 and led the charity's policy and influencing on employment and equality, which included successful campaigns to end forced retirement and outlaw age discrimination in goods and services. Previously he was a researcher for the New Policy Institute and a research assistant for Anne Campbell MP.

Roger Davies

Roger Davies is Chief Executive of MHA, a charity providing care homes, housing and support services for 13,500 older people throughout Britain. Annual income is £120 million and its services are delivered by 5,000 staff and enhanced by 5,000 volunteers. MHA seeks to combine professional management, good governance, and financial sustainability in providing older people with a caring service based on Christian principles. Roger began his career in the hospitality sector, firstly in general management and later qualifying as an accountant. From 1989 he has worked in the not-for-profit sector for two top 100 charities and an NHS Hospital Trust. Roger is a non-executive Board Member of English Community Care Association.

Harry Cayton

Harry Cayton has been Chief Executive of the Council for Healthcare Regulatory Excellence since August 2007. He was formerly National Director for Patients & the Public at the Department of Health. From 1992 to 2003 he was Chief Executive of the Alzheimer's Society and from 1981 to 1992 Director of the National Deaf Children's Society. He was chair of the National Information Governance Board for Health and Social Care from 2008-11. He is an advisor to The Health Foundation and to Macmillan Cancer Support, a member of the RCGP Commission on Generalism in Medicine and a trustee of Comic Relief. He was awarded the OBE in 2001 for services to people with dementia. He received the Alzheimer Europe Award in 2004, and was Distinguished Graduate of the University of Ulster 2005. In 2007 he received a Lifetime Achievement Award from the Royal College of Psychiatrists and a Fellowship through Distinction from the Faculty of Public Health.

Stephen Burke

Stephen Burke is Director of United for All Ages, a social enterprise he set up in 2010 with his wife, Denise, to bring older and younger people together to build stronger communities (www.unitedforallages.com). Previously, Stephen was Chief Executive of Counsel and Care, the national charity working with older people, their families and carers to get the best care and support. There he helped raise the profile and influence of Counsel and Care in the debate about the future of care and extended the charity's advice service to reach more older people, their families and carers. Stephen has also been Director of the national childcare charity, Daycare Trust,

where he led the charity's campaign for childcare for all, promoting children's centres in every community and securing substantial new investment. He is a trustee of several national charities including Grandparents Plus, the Older People's Advocacy Alliance and NAAPS.

Richard Furze

Richard Furze is Chief Executive of Friends of the Elderly, a charity which supports older people, particularly those who are physically or mentally frail or isolated. It provides a range of integrated services both in people's own homes and in care homes, some with nursing or dementia specialisms. Friends of the Elderly's vision is that all people in older age should retain independence, dignity, choice and peace of mind. Richard, a chartered accountant by training, has worked in the charitable sector since 1994 and has been heavily involved in strategic and business planning, charity governance and fundraising. Richard is also a trustee of XLP, a Christian charity which works with young people in the London inner city.

Janet Morrison

Janet Morrison joined Independent Age as Chief Executive in March 2007 and has since led a comprehensive transformation of the charity's strategy, service offer and systems. Independent Age is a national older people's charity, working to tackle social poverty, poverty of information and financial need. It does this by providing support to the end of life, tailored to individual needs, delivered via volunteers and a membership community of older people. Janet was previously a founder and Deputy Chief Executive of the National Endowment for Science Technology responsible for Strategy (NESTA), Communications and Policy. Prior to NESTA, Janet was Senior Adviser on UK Policy at the BBC between 1997 and 1999 and before that worked for seven years at the National Council for Voluntary Organisations, where she was Director of Policy and Research. There Janet led work on charity law, the lottery, broadcasting and funding policy. Janet is a Trustee of the Baring Foundation and a Fellow of the Royal Society of Arts.

James Reilly

James Reilly is the Chief Executive of Central London Community Healthcare NHS Trust. He has 25 years of experience in local government, having worked in Brent, Hackney, and Hammersmith and Fulham, primarily in services to adults and also with children's services. His previous role was Director of Community Services for the London Borough of Hammersmith and Fulham and NHS Hammersmith and Fulham, where he was responsible for commissioning community health services for adults, working with GPs, community and acute health services to design integrated services. James is the former Chair of the London Network of Directors of Adult Social Services and Chair of the Adult Social Care Joint Improvement Programme.

He has pioneered extra care sheltered accommodation, providing an alternative to residential care and is a trustee of Standing Together, which tackles domestic violence. Born and educated in Zimbabwe, James has worked in education and community development in Zimbabwe and the Philippines.

Susan Kaye

Susan Kaye is a freelance Consultant, working for clients in areas including recruitment, training and strategic planning. She has a degree in Sociology and Economics at London University and became an Economist followed by a highly successful career in retail with leading UK companies e.g. Marks and Spencer and House of Fraser. She became a consultant in 1995. She is the main carer of her 90 year old father after the death of her mother in 2000. Her aunt is 92 and she also takes a major role in her care.

Donna Payne

Donna Payne is an Assistant Director with Marie Curie Cancer Care. Donna has over 20 years' experience as a nurse caring for people in hospitals and the community. She is part of the charity's Caring Service Executive Team which focuses on providing care to people who are approaching death so they can receive care in the place of their choice. Donna has a degree in health studies and has an interest in helping to improve the support for people whose care is affected by their inability to gain good social care and support in the community. This is often the reason why many healthcare packages fail, resulting in unnecessary admission into hospital.

Dr James Mumford (lead researcher and author)

Dr James Mumford recently received a PhD in ethics at the University of Oxford, having also obtained his undergraduate and Master's degree there. In 2003/4 he was a Henry Fellow at Yale University, studying politics and religion. Whilst a graduate student, James wrote a number of journalistic pieces on addiction, inner-city deprivation and older people in poverty.

Paul Langlois (researcher and co-author)

Paul Langlois read Law at the University of Buckingham before working in finance. Prior to starting work on the Older Age Review, Paul worked on the legacy of *Breakthrough Britain: Serious Personal Debt* and on implementation of the CSJ drug and alcohol addictions policy.

Christian Guy

Christian Guy is Director of Policy at the CSJ. He has led work on a number of CSJ publications including as editor of the 2011 first year report card on the Coalition Government, *Building a Social Recovery?*, author of the 2010 reports *The Forgotten Age* and the *Green Paper on Criminal Justice and Addiction,* and co-author of 2009's prison reform report *Locked Up Potential* with Jonathan Aitken. He led the pre-general election implementation planning for CSJ criminal justice and addiction policy, and was speechwriter to former CSJ Chairman Rt Hon Iain Duncan Smith MP. Christian is Assistant Director of Jonathan Aitken's Westminster Forum. Before joining the CSJ, he worked as a Community Organiser for a partnership of local authorities, police, schools and voluntary sector organisations in Surrey.

The CSJ would also like to thank Harriet Crawford for her editorial support.

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Age UK

Age UK is working for a better later life today and tomorrow. We celebrate ageing and work to create opportunity in later life. And we fight and challenge disadvantage and unfairness to older people wherever we find it.

Every day Age UK is in touch with thousands of people who we support to help themselves and speak up for themselves. We understand the change that is needed to transform later life for the better, and everything we do is aimed at achieving this. We have a positive, forward-looking vision for our ageing society, a world in which older people can flourish. We stand up today for millions of people, but we also speak for the long-term interests of every one of us, so that experiences of ageing grow for each passing generation.

Age UK is proud to contribute to and shape policy at national and local level, to deliver information and services for later life, and to challenge others to join with us in helping those in greatest need around the world.

Calouste Gulbenkian Foundation

The Calouste Gulbenkian Foundation is an international charitable foundation with cultural, educational, social and scientific interests. Based in Lisbon with branches in London and Paris, the Foundation is in a privileged position to support transnational work tackling contemporary issues in Europe. The purpose of the UK Branch in London is to connect and enrich the experiences of individuals, families and communities with a special interest in supporting those who are most disadvantaged. In 2008, the Foundation launched an initiative on ageing and social cohesion. This research study represents the latest development of a wide portfolio of work which we hope will contribute to a growing understanding of the impact of demographic ageing to our society. For more information about the work of the Calouste Gulbenkian Foundation in the UK please visit www.gulbenkian.org.uk

Executive summary

This is the Executive Summary of *Age of Opportunity: Transforming the lives of older people in poverty*. This, the second and final report of the CSJ Older Age Review, offers solutions to the problems we identified in our first report, *The Forgotten Age*. To download the full report, please visit www.centreforsocialjustice.org.uk.

1. A call to action

Life expectancy in Britain has increased dramatically over the last 80 years. This is an achievement that should be celebrated unequivocally as many older people have been able to realise the opportunities a longer life has afforded. Home ownership has reached unprecedented levels and civic participation is widespread.

Yet there is another side of the coin. This review's interim report, *The Forgotten Age*, identified another group of older people in Britain for whom increased life expectancy has not yet afforded greater opportunities. With one in five pensioners living below the poverty line, we analysed the wide range of challenges facing older people in our most deprived communities: stubbornly high levels of social isolation, not helped by poor transport routes particularly in rural areas; the poor housing conditions in which many (and even many homeowners) live; the poor health from which many suffer; the lack of access to good, independent financial advice and a faltering social care system.

We believe, however, that for this group later life does not have to be this way. We believe the challenges identified in *The Forgotten Age* are not insurmountable and that for these individuals later life can be the 'time of gifts' it is for so many others. *Age of Opportunity* focusses on reforms to bring about this change.

Tomorrow's demographic trends are yesterday's news. For years we have been inundated with stark population projections and alerts of an ageing society. By 2024 one in five people will be of pensionable age, and the number of people living with dementia will increase to one million by 2025.[1,2] Yet awareness of the trends has not spurred sufficient action.

1 Office for National Statistics, Ageing in the UK datasets, Table 8: Percentage of the population aged 65 and over
2 King's College London and the London School of Economics, *Dementia UK: The Full Report*, London: Alzheimer's Society, 2007, p1

Worse, an obsession with the demographic projections has led to a neglect of today's pensioner poverty. In our concern about the future we have forgotten about the present – the large number of older people currently living in poverty; with next to no human contact; neglected care needs; in houses which were never designed for them to age in and which they no longer have the income to maintain. They demand our urgent attention now.

2. Dynamic communities

The first priority for any strategy to tackle pensioner poverty must be to re-engage the most isolated older people and build dynamic communities.

Social isolation has received a lot of attention both in the media and in policy discussion. Yet despite widespread acknowledgement of the problem, as a society we are largely failing to tackle it. According to a recent estimate, the extent of loneliness in later life for those aged 65 and over has remained broadly static over the last six decades.[3] Over a million people aged 65 and over report feeling lonely often or always and a similar number feel trapped in their homes.[4, 5]

2.1 Identification and outreach

Social isolation is an aspect of poverty the Government cannot be expected to tackle alone. But we believe that there is a role for the state, namely, to take the lead in identifying and engaging society's most isolated older people. One reason for this is because many are already known to statutory bodies, be they district nurses, social workers or the police. The urgent priority must be for those professionals to link those individuals in with the charities and community groups which can provide the relational support they need.

Case study: Brian and Gladis

Brian, 41, is a photographer who lives in Margate in Kent. Wanting to give something back to society, he was 'matched' by a local befriending charity to Gladis, 88, who lives alone, has no family and is housebound. Before she signed up to the scheme, as she told the CSJ, 'I never went out and had fallen four times in two months.' Initially Brian agreed to take Gladis shopping, since her deteriorating eyesight had made that difficult. Over time the friendship has flourished. Brian now spends around four hours a week with her; opening her post and reading it to her; talking about her memories; fixing things in the house. 'The only person I have is Brian', Gladis told us.

Connecting the most isolated older people to befriending charities is no easy task. But we passionately believe that the new, 'unlikely' friendships these charities can provide are

3 Campaign to End Loneliness, *Safeguarding the Convoy: A call to action from the Campaign to End Loneliness*, Abingdon, Oxfordshire: Age UK, p30

4 Spotlight 2006 survey (unpublished), GfK NOP for Help the Aged, 2006

5 Victor C and Scharf T, *Social Isolation and Loneliness*, (eds) Walker A and Hennessey CH, *Growing Older: Approaches to Quality of Life in Context*, Maidenhead: Open University Press, 2005, cited in Social Exclusion Unit, *A Sure Start to Later Life: Ending Inequalities for Older People*, London: Office of Deputy Prime Minister, 2006, p55

indeed possible. What they require, though, are far more personal referral processes. Merely supplying someone with a phone number of a local charity, or pointing them to a website, is not enough. Instead what we need are the kind of face-to-face introductions by professionals to voluntary sector groups, such as we encountered in one inner-city ward in Manchester.

Case study: Healthy Ardwick, Manchester

Healthy Ardwick is a local charity creating more social opportunities in Manchester's fourth most deprived ward. Its vision is to reach the most isolated older people and to raise expectations of later life. This begins with outreach. 'Until we've knocked on every door we won't know we've gotten to people,' founder and Chair Nick-Carr Brown told the CSJ. But given the fear of crime in the area, credibility on the doorstop is a real hinge factor. For this reason Healthy Ardwick has partnered with the local police so that volunteers accompany Police Community Support Officers as they walk the streets and knock on doors in order for police officers to make face-to-face introductions of older residents to the charity.

Only through such dynamic partnerships between the voluntary and public sector do we stand any chance of reversing social isolation. And in many cases it seems the ignition key is partnership with the police.

Recommendation:
Neighbourhood policing teams should work within their community to identify ways of working with charities to engage extremely isolated older people living in poverty. This will require leadership from their Chief Constables and should become an urgent priority for Police and Crime Commissioners if established or Police Authorities as current structures allow.

2.2 Greater coordination at a local level

As well as more active outreach, any strategy to make later life an age of opportunity for the poorest pensioners also depends upon a far greater level of local coordination between services and charities.

Case study: Valuing Older People 'Networks', Manchester

The Valuing Older People (VOP) team, based at Manchester City Council, was established in 2003 to improve the quality of life for older residents in Manchester. One key way it has sought to achieve this has been by establishing 'networks' at a neighbourhood level, bringing together every kind of agency, charity and community group focussed on older people.

VOP networks, currently covering 17 of Manchester's 32 wards, typically convene on a monthly basis, are facilitated either by a member of the team or by a local stakeholder, and aim to:

- Map the supply of 'provision' for older people (both from services and community groups) and avoid duplication. As well as to work out where there are gaps, the network provides the opportunity for groups to work out precisely what is on offer in a local area.
- Share venues. By using each other's facilities the various groups can increase the number of places older people can go to locally.
- Improve communication. Given the low usage of the internet, often a newsletter is an absolutely crucial means for communication.

On the basis of this model the CSJ recommends that:

Recommendation:
Every local authority, at Chief Executive Office level, should establish VOP teams with urgency in order to establish networks to bring stakeholders together to map provision at a local level.

While VOP teams need to respond to local needs, and therefore vary in terms of their membership, it is also important that central government, preferably the Department for Communities and Local Government, sets clear national objectives to ensure consistency from VOP teams and that combating isolation remains their top priority. We believe that Manchester City Council's VOP team constitutes precisely the kind of replicable, scaleable model we need.

Recommendation:
The VOP team at Manchester City Council should receive a small grant to develop a toolkit for all local authorities to build VOP teams effectively.

2.3 Community development

To re-engage the most isolated older people in society not only requires more active outreach, we also need regenerated communities for them to be linked back into. To such

an end, once again we cannot look solely to the state. Yet, as polling for this review suggests, there is public appetite for local government to have an increased role.

> Over 60 per cent of people polled think local authorities should have a role in encouraging and incentivising neighbourhood initiatives and community projects.
>
> YouGov for the CSJ Older Age Review, May 2011

During the CSJ's visit to Seattle we identified an approach to community development the City Council's Department of Neighbourhoods (DON) has pioneered over the last 20 years. Its approach is based on a conviction that, as founding director Jim Diers told the CSJ:

> 'There's a role for government. There's a role for charities. But there's no substitute for community.'
>
> Jim Diers, founder of the Department of Neighbourhoods, in evidence to the CSJ

There are four main elements to the community development work we saw in Seattle:

- **Neighbourhood Service Centres:** To bring power and services closer to residents the DON has established 'little city halls' across the city. Located in prominent, easily accessible public spaces, people can pay bills, find out information about events and opportunities happening locally, and visit the District Coordinators.
- **Neighbourhood District Coordinators:** Essentially community organisers, District Coordinators are the service centres' 'most cherished resource'. Described as 'overt double agents', they are designed to be the city council's eyes and ears, to build community groups, trouble-shoot residents' difficulties and network across neighbourhoods to organise people so they can take action on what matters to them.
- **Neighbourhood Matching Fund:** The Matching Fund revolves around the idea of a community match, whereby the City Council commits to match financially whatever community groups can generate for specific projects in their neighbourhood, whether physical projects such as renovation of community buildings or community events. The Matching Fund is particularly geared towards lower-income neighbourhoods for the reason that the community match doesn't have to be financial but rather can be volunteer labour or 'sweat equity'.
- **Ageing Your Way neighbourhood gatherings:** Specifically engaging older people, since 2010 King County (in which Seattle is situated) has initiated a number of evening gatherings, hosted at local community centres, to bring together people at or approaching retirement age to develop a vision of a community that would support them as they age. Participants separate into small groups to discuss what kind of a city they would like to live in as they age, before proceeding to imagine local projects which might go some way towards realising that vision.

> "We want to say 'yes'. And we will work with a group until we can get to 'yes'."
>
> Bernie Matsuno, Acting Director, Department of Neighbourhoods, City of Seattle, in evidence to the CSJ

In terms of efforts to develop community at a local level, the CSJ welcomes both the Government's Community Organisers programme – its intention to train 5,000 community organisers, recruited locally by partnering charities – as well as its Community First project, promising to provide £80 million of investment 'to encourage more social action in neighbourhoods of significant deprivation and low social capital.'[6] In terms of implementation, we recommend that both programmes learn the vital cultural lessons of the sustained, mature and highly effective approach to community development pioneered by Seattle's Department of Neighbourhoods.

Recommendation:
Learning from the Neighbourhood Service Centres, community organisers should identify appropriate venues within their communities and draw upon them to connect together local organisations and efforts, particularly via the new VOP teams.

Recommendation:
The key elements of the District Coordinator role – particularly the way it provides a bridge between community and local government – should inform the Government's Community Organisers' programme. Of particular importance is the necessity of community organisers achieving visibility in their local community by being closely attached to community hubs.

Recommendation:
The Community First project should actively encourage and duly make awards to projects initiated by or including older people. The project needs to focus on creating *new* community groups, recognising the level of outreach required to encourage fresh applications from people coming together around a proposed project. Above all we need a shift towards a distinct 'yes' culture among local decision-making structures and whichever bodies award the Community First grants.

Recommendation:
The hosting of Ageing Your Way-type gatherings must be a primary task for VOP teams as they are established. In addition, Community First match-funding should be levered in to support practical projects which emerge from these gatherings.

6 Cabinet Office, *Giving White Paper*, London: The Stationery Office, 2011, p30

2.4 Intergenerational opportunities

John Cairns photography, on behalf of the CSJ

78 per cent of people we polled thought that interacting with older people should be part of a child's educational experience at school.

YouGov for the CSJ Older Age Review, May 2011

It is difficult to underestimate the mutual benefit of intergenerational connections. While intergenerational volunteering takes numerous forms, the outstanding examples we have encountered have involved either older people volunteering in schools – listening to children read; mentoring older students, etc. – or, conversely, younger people putting on pampering sessions and entertainment nights in residential accommodation for older people. Given the extraordinary impact of these kinds of projects, we need to increase the number of such opportunities offered to both older and younger people.

Recommendation:
Local authorities, ideally through VOP teams, should conduct a basic community audit to identify which local schools would be well placed to benefit from older volunteers.

Recommendation:
VOP teams should also identify local residential accommodation for older people (e.g. sheltered housing schemes, Extra Care housing schemes and care homes) which would benefit from visits from schools.

2.5 Transport

Creating dynamic communities in which older people can thrive also depends on making neighbourhoods physically accessible. Reliable and far-reaching local transport networks

become increasingly significant as people get older, with journeys for essential items and social activities sometimes becoming more of a challenge.

Bus travel provides a lifeline for many of the poorest older people who would otherwise be unable to leave their homes. Yet while concessionary bus travel has made a huge difference to some older people, the universal nature of the scheme means that it is poorly targeted. In truth, many people qualify for a bus pass who don't need it.

Recommendation:
The concessionary bus pass should be treated as a taxable benefit. Additional revenue raised by this measure should be placed in a fund administered by an independent agency to pay for other community transport aimed at older people.

Taxis are also of vital importance. Yet while many local councils operate taxi-card schemes offering discount to older people and those with disabilities, some schemes cannot be used for key journeys, such as to the GP, the hospital or day centres.

Recommendation:
Local authority-operated Dial-a-Ride schemes should be broadened to include other essential journeys such as to medical appointments or to day centres.

To help people travel in their communities the Government has signalled its intention to decentralise power to local authorities in order for them to organise their own transport infrastructure and day-to-day transport needs through Local Enterprise Partnerships (LEPs).[7] LEPs will be partnerships between local authorities and businesses, with the Government stating its expectation that business representatives making up half the board and having a prominent business leader in the chair.

Recommendation:
Local authorities establishing LEPs should specifically include representation from older peoples' groups.

3. Managing money and planning for the future

As we identified in *The Forgotten Age*, money is an essential determinant of whether an individual lives in poverty or not.

7 Department for Transport, *Creating Growth, Cutting Carbon – Making Sustainable Local Transport Happen,* London: The Stationary Office Limited, January 2011, p 8

3.1 State pension income and benefits

The proposed introduction of a flat rate pension in 2015/16 will mean that future pensioners will not need to claim for means-tested benefits. Since this flat rate pension will not be available to people who have already retired, existing pensioners will require continued support. Accordingly, although the take-up of core means-tested entitlements like Housing Benefit (HB) has been historically high amongst the older population, a persistent number of people eligible for support with council tax and the Pension Credit Guarantee (PCG) fail to claim them. In 2008/09 non take-up of benefits translated to £3.9 billion going unclaimed by pensioners who were eligible for it.[8]

We found that potentially the most innovative model to increase the take-up of core benefits was a pilot scheme based on paying people PCG automatically, an evaluation of which is due to be published this year. Even though the Government has stated that the pilot will remain an information and data-gathering exercise only, we recommend that:

Recommendation:
If the evaluation of automaticity proves take-up has been significantly boosted, the Government should begin a full roll-out of automation for PCG. Early prioritisation within this should go to people aged 80 and above.

Recommendation:
There should be automatic communication between government agencies so that when someone is in receipt of PCG, their eligibility not to pay council tax or to receive HB is actioned on their behalf.

3.2 Winter Fuel Payment (WFP)

To help with rising energy costs, the Government's central strategy has been to boost income through the WFP, estimated to keep 200,000 households out of fuel poverty each year. Yet when the WFP was first paid, it accounted for over a third of the annual household energy bill. Due to inflation and rising energy prices, the same payment now amounts to less than 20 per cent of the average household energy bill.[9] To address the falling value of the payment, we recommend that:

Recommendation:
The Government should introduce a 'double lock guarantee', whereby WFP is linked to inflation increases or energy price rises, whichever is higher.

8 Department for Work and Pensions, *Income Related Benefits: Estimates of Take-Up in 2008-09*, London: Department for Work and Pensions, 2010, (2009/10 figures delayed by DWP due to new method of calculation. They are due to publish a technical note in summer 2011 and to publish the results for 2009/10 thereafter)

9 House of Commons Environment, Food and Rural Affairs Committee, *Energy efficiency and fuel poverty, Fifth Special Report of Session 2007/08,* London: The Stationery Office Limited, 6 November 2008, p72

Furthermore, to increase the value of the payment, we also recommend that the Government take the difficult but necessary decision to:

Recommendation:
End the universal payment of the WFP to ensure that the poorest receive more support. [10]

Recommendation:
The Government should investigate mechanisms of removing the universality of the WFP in order to increase its effectiveness in fighting fuel poverty for the poorest older people. Within these deliberations, we urge policymakers to ensure that it is spent on what it is designed for – fuel costs or improving homes' energy efficiency.[11]

The savings made by ending the universality of WFP could be used to increase payments to people on the lowest incomes. This would make a substantial difference for older people who currently enter debt to heat their homes, or are forced to live in dangerous cold. In addition, policy-makers need to consider how to ensure that the payment is used for its stated purpose – reducing fuel poverty by reducing energy bills.

3.3 Planning and advice

88 per cent of people we polled thought that financial education should be taught and assessed in schools.[12]

Polling for *The Forgotten Age* found that a third of older people thought that the guidance and support they had received approaching retirement was 'poor' and a third said it was 'adequate'.[13]

Basic financial literacy and effective planning for the future can make a significant difference to the quality of an individual's life in retirement. The value of beginning this early is well-established and should form a compulsory element within the school curriculum. Polling for this review found overwhelming support for financial education being taught and assessed in schools.[14]

For older people on low incomes approaching or having reached retirement, it is also essential that they have easily accessible and clear information in order to maximise their income through accurate independent advice.

10 This recommendation was not endorsed by Working Group Member Andrew Harrop, Director of Policy and Public Affairs at Age UK
11 This recommendation was not endorsed by Working Group Member Andrew Harrop, Director of Policy and Public Affairs at Age UK
12 YouGov, *Older Age*, May 2011
13 YouGov, *Attitudes of People over Retirement age*, June 2010
14 Ibid

We have found that it is the voluntary sector which is able to provide information to people in a personalised and tailored way. We would like to see small community-based voluntary advice services supported by local authorities, and for partnerships between smaller, specialist agencies and larger providers of advice to ensure a broad provision of services that caters for the diversity of older people and their financial circumstances.

Recommendation:
The teaching of financial education should be compulsory in schools and should incorporate planning for later life, including pensions and health insurance.

Recommendation:
People should automatically be offered a free financial health check between the ages of 55 and 60.

Recommendation:
Local authorities should explore the possibility of partnering with different not-for-profit agencies in order to provide information for people on areas such as benefits, housing, care and finance. Furthermore, private sector initiatives to educate both children and adults in personal finance should be encouraged, strengthened and expanded.

4. Housing and homes

Any attempt to tackle pensioner and isolation poverty in Britain must take into account housing, as the condition of the accommodation an older person lives in plays a huge role in determining their experience of later life.

To ensure that suitable housing is available for all older people a preventative strategy must be in place to help older people remain independent for as long as possible. This can be achieved first by improving existing housing stock in order to make homes suitable for people to live in as they age, and secondly by building new stock in order to tackle the chronic shortage of affordable homes purpose-built for older people.

4.1 Existing stock: low-income older home-owners

In 1971 the national level of home ownership was 50 per cent. Today it is over 70 per cent.[15] Yet the majority of these homes were not designed to be grown old in and are now proving unaffordable to repair and maintain for many older people. The result is significant housing poverty among older homeowners especially in the private sector. Currently there are 3.2 million older householders living in non-decent private sector homes.[16]

15 Adams S and Ellison M, *A Perfect Storm: An ageing population, low income home ownership, and decay of older housing*, Nottingham: Care & Repair England, 2010, p6

16 Department for Communities and Local Government, *English House Conditions Survey 2007*, London: Department for Communities and Local Government, 2009

Case study: Mrs Thomas

Mrs Thomas in her home in Leeds

Catherine Thomas (above), 78, lives in Leeds in a home which she owns. Mrs Thomas told the CSJ of the struggles of living by herself in a home she no longer has the income to manage. From the combination of her state pension and a small occupational pension she pays for meals-on-wheels, with little left over. And having exhausted her modest savings on re-wiring, new taps and a new sink, as she told us, 'I'm down to my last £1,000. There will be no more repairs until more money is forthcoming.' Yet bare floorboards and masses of debris (not least, a huge fire risk) revealed a house clearly no longer fit for purpose.

In terms of recent policy, a number of distinct developments have conspired to create what is now 'the perfect storm' facing the poorest older homeowners. Seen in isolation, each of the developments discussed below may seem innocuous; viewed together they constitute a crisis. They are:

- **Loss of Private Sector Renewal (PSR):** In Autumn 2010's spending review the Government withdrew the PSR budget, the major source of national funding for repairs and regeneration of housing in the private sector. This is the first time since 1949 that there has been no central funding for the poorest homeowners.
- **The size of an equity release market:** Despite the development of reputable equity release products to help people release small amounts of equity from their homes, take-up remains low and coverage patchy. A fully competitive and accessible market has yet to emerge.
- **A Disabled Facilities Grant (DFG) system in disarray:** The main state grant given to people to adapt their homes is the DFGs. They are currently means-tested on savings up to £6,000 but disregard equity, so that 70 per cent of grants go to homeowners. Though approximately 40,000 grants are made nationally – 70 per cent of which to older people – the DFG system has become disjointed, complex and inefficient, often resulting in huge delays.
- **Fuel poverty:** Even though increasing the energy efficiency of people's homes is the most realistic way of preventing fuel poverty, successive Governments have not done enough to incentivise people on low incomes to undertake the necessary essential improvements.

In view of these factors we recommend that:

Recommendation:
An integrated system should be established for both disability adaptations and home repair. This system should be clear in terms of entitlement and efficient in terms of delivery. Vital, preventative minor works – i.e. handyperson services, paring down carpets, grab-rails, ramps, or contribution towards disability-related adaptations – should be freely available and universally provided at the local level. (Such a system could thus be free of the current means-testing which makes the system extremely complex to navigate and slow to operate.) Major works, by contrast – whether adaptations such as installing through-floor stair-lifts, house extensions or repairs such as installing new roofs, electrics or heating systems – should increasingly be funded by contributions from homeowners who can afford it, by accessing appropriate amounts of their property's equity.

The creation of such a system depends upon a number of key developments:

First, the significant expansion of the equity release market, underpinned by a cultural 'sea change' in attitudes towards people in later life drawing upon capital to fund lifeline housing repairs. It is tragic that many older people have to live out the last years of their lives in houses falling around them solely because they are trying to preserve the inheritance they pass on to their children. While for some older parents we recognise that this is a genuine choice, we have heard that there are others who may feel forced by convention to sacrifice their health and their living conditions for the sake of bequeathing an asset to their children or family. The cultural aversion to older homeowners using equity release to improve their quality of life and housing needs to be challenged at every level.

Recommendation:
Local authorities should give greater profile to specific products developed to allow low income older homeowners to release equity.

Recommendation:
Given the relative underachievement of the equity release market to date, we believe the Government may need to consider direct market stimulation in order to redress a lack of take up. Such action, which should be a time-limited interim measure, could begin to drive up the competition of product offers, including making interest rates more affordable.

Secondly, the effective administration of any new system for repairs and adaptations will require greater leadership at a local level. Given the well-established connection between health and housing, we believe that the new health and wellbeing boards at local authorities, if legislated upon, could be well placed to deliver this new integrated system. This would also help to protect financially funding for the system, given the proposed ring-fencing of public health grants to local authorities.

Recommendation:
Local authorities' new health and wellbeing boards, if forthcoming, should take responsibility for the delivery of this new integrated system for repairs and adaptations.

Thirdly, any shift from the inefficient system we have today to a new, integrated system will require a proper transition period. For this reason, in terms of repairs, we urge the Government to reconsider the removal of the PSR budget and then to phase out this funding stream as equity release becomes a real alternative.

Recommendation:
As a temporary measure the Government should immediately restore funding for PSR.

And in terms of adaptations, until equity release becomes a viable alternative, in order to make the DFG system more manageable and faster within the current budget, we recommend that:

Recommendation:
The maximum threshold for a Disabled Facilities Grant should be reduced from its current level to the average value of a grant: £6,500.

Furthermore, whilst it might be fair to expect a homeowner of a house worth £200,000 to release equity to fund a through-floor stair-lift worth £10,000 or a new roof worth £15,000, to expect the same from someone whose ex-council flat has halved in value over time may be less practical. We believe extra support for these people will be required.

Recommendation:
The creation of a small emergency and exemptions fund, particularly designed for those with low value equity.

Finally, in terms of fuel poverty, the Green Deal, the Government's new strategy to improve the energy efficiency of people's homes by providing loans for related improvements, has been criticised for being inadequately targeted on the fuel poor, and for being likely to benefit only middle and high income households.[17] Whilst we hear calls from others asking the Government to consider underwriting the costs of this scheme for some low income households, in the current climate this is not feasible. However, we believe that:

Recommendation:
The Government should consider the merits of a fixed rate Green Deal loan for the poorest older homeowners.

4.2 New stock: buildings for the future

At present the housing market in the UK simply doesn't reflect the types of choices older people aspire to. As well the problems with existing stock, there is also serious shortage of new housing

17 House of Commons Library, *Energy Bill [HL] Research Paper 11/36,* 4 May 2011, p9 [accessed via: http://www.parliament.uk/briefingpapers/commons/lib/research/rp2011/RP11-036.pdf, (01/06/11)]

specially designed for older people. Given the demographic projections, building affordable new homes for older people must become a far greater priority for both central and local government.

For central government a key priority should be building affordable housing specifically designed for older people, not least because it also frees up much-needed general needs housing for poorer families. Government can take the lead here both through nationally-determined planning policy and through its distribution of the capital grants still available for new affordable homes.

Recommendation:
A greater proportion of the capital grants the Government makes available to build new affordable homes needs to be allocated to housing specifically designed for older people, whether in the mainstream or specialist sectors. Even in an era of reduced public expenditure there are capital grants available for new housing: how the Government uses these grants is of critical importance.

Recommendation:
Through the 'ground rules' it sets for planning policy, central government needs explicitly to include older people's housing within its priorities. It is vital that the new National Planning Policy Framework takes into special consideration the realities of an ageing population so that, at a local level, all planning authorities who consult it are without any doubt as to what their priorities should be.

At a more local level, we need to move towards a distinct 'yes culture' among planning authorities. Despite the considerable shortage of new housing for older people, local planning authorities often fail to recognise its value, resulting in a cumbersome planning process which paralyses market activity. Without any kind of overall strategy for older people's housing, too many planning authorities treat each application on an isolated, case-by-case basis, with no real understanding of what provision is needed in their locality. To combat this we recommend that:

Recommendation:
All planning authorities should be required to produce an older person's housing strategy based on their assessment of predicted demand in their area.

Despite its clear benefits, owner occupied retirement housing is currently unaffordable for many older owners of (relatively) low value homes. Having heard calls from developers to ease the Section 106 stipulation, we believe that temporarily making retirement housing exempt from the presently required affordability contributions (which essentially seek to secure money and/or a proportion of the development for social use) could be needed in order to change the market in the short term and offer choice. But this contested theory needs testing for outcome and impact.

Recommendation:
An independent impact assessment should be carried out for a proposed pilot of a time-limited period to suspend Section 106 affordability contributions required of retirement developments.

Joyce Catt, right, is a resident of Swan Field Court Extra Care facility

Finally, Extra Care housing holds out great promise for older people with care needs to maintain their independence for as long as possible. Extra Care (essentially, sheltered housing with on-site care facilities) is specifically designed to allow for independent living. Residents live in their own flats and have their own front doors, but care staff, located in the building, are permanently available. Despite the clear benefits of Extra Care housing and the distinct need it caters for, its pace of development has been glacial. At 30,000 units, it constitutes a tiny percentage of accommodation for older people nationally. The CSJ believes that as a country we have not yet realised the potential of Extra Care.

Recommendation:
Councils should take the initiative to bring on-line a greater supply of specialist housing such as Extra Care. In an era of reduced capital expenditure by government, councils need to consider other ways of developing specialist housing products such as offering land and asset transfer arrangements.

5. Transforming care

There is widespread acknowledgement that the social care system in this country is in urgent need of increased financial resources. For the poorest older people underfunding has had two main results:

- Fewer people receiving care, with local authorities restricting the social care they provide to those with the very highest needs;
- Inadequate care for those who are eligible, whether insufficiently short home care packages ('flying visits') or underfunded placements in care homes.

Funding structures are key to the long-term future of care provision in this country. Society at every level – individuals, families, as well as government – needs to ask itself what it is prepared to pay to support an ageing society. Yet while individuals and their families should

not consider housing wealth 'sacrosanct', it is also clear that public investment must keep pace with our ageing society. With the Dilnot Commission on the Funding of Care and Support shortly due to report, it is vital that after a decade of indecision policy-makers respond with conviction and reform. The importance of building a cross-party consensus to map out a strategy to secure a sustainable financial settlement for social care in the coming decades cannot be overstated.

Yet the question of *how* to fund social care is not the only one we face. The often neglected question of *what* to fund is equally important, since funding systems cannot be revised whilst keeping the models of care the same.

In terms of policy, the two objectives of (a) preventing older people from admission to care homes and (b) improving the quality of care homes are usually considered alternatives. We think this assumption should be challenged. Efforts must be focussed simultaneously on maintaining the independence of the frailest older people – through supporting their unpaid carers, providing lower level support and creating integrated, multidisciplinary teams for the most vulnerable – as well recognising that, since the need for care homes is not going to go away, the long-term care sector requires radical reform.

5.1 Unpaid care

> 'Regardless of how little I've slept I have to get up in the morning.'
>
> **A family carer, aged 70, in evidence to the CSJ**

A huge number of people in the UK care, unpaid, for their relatives and loved ones. It is calculated that this group of six million people, of whom 2.8 million are over 50, save the state an estimated £87 billion a year.[18]

Yet while for many caring is a responsibility few would want to give up, there is also evidence that caring takes its toll. The physical dispersal of families, combined with high levels of family breakdown, has led to the increasing intensity of caring roles, with many one-on-one caring relationships becoming increasingly unrelieved and isolated. For this reason far more needs to be done both to identify and to support carers before they reach breaking point.

In terms of identification, GPs have a crucial role to play, given that statistically they the professionals most likely to come into contact with a carer. Currently, however, GPs are incentivised through the Quality Outcomes Framework merely to retain a list of carers. We believe, however, that:

18 Carers UK, ACE National and the University of Leeds, *Valuing carers – Calculating the value of unpaid care*, London: Carers UK, 2007, p3

Recommendation:
There should be much stronger incentives for GPs to identify and refer carers to appropriate support.

In terms of supporting carers, it is of critical importance that the £400 million the Government has recently allocated for respite care actually reaches carers. To facilitate this we believe innovative delivery mechanisms are required on the ground.

Recommendation:
GPs should be allowed to write 'social prescriptions' for respite care directly to carers they identify as overburdened.

But providing more carers with the support they need also depends upon more carers assessments being carried out since, at present, only around seven per cent of all carers have been offered an assessment. To facilitate this change this we recommend that:

Recommendation:
Carers' Centres and agencies other than Social Services should increasingly undertake carers' assessments on behalf of councils.

5.2 Lower level support

The poorest older people with care needs, particularly the 'oldest old', need to be properly empowered to remain independent in their own homes. For this to happen, the trend of councils withdrawing care and support for those with 'low' and 'moderate' needs has to be reversed, depending on a new funding settlement for social care. Yet there is also a distinct need for lower level support to prevent or postpone the onset of care needs in the first place.

We believe this distinct need corresponds to a distinct professional role. The CSJ has long advocated an enhanced role for health visitors at the beginning of life, and thus welcomes the Department of Health's intention to increase the health visitor workforce by 4,200 by 2015. But we believe that health visitors can play just as vital a role in later life. We therefore recommend that:

Recommendation:
Health visiting should be expanded for older people targeted to the areas of most deprivation.

While the role of these health visitors would be multi-faceted – including helping to identify isolated older people and linking them in with befriending agencies – their primary focus

should be advising and supporting older people to maintain healthy lifestyles, given the strong evidence of the connection between diet, nutrition, physical activity and maintaining health in later life.

78 per cent of people would support the introduction of health visitors for older people, funded by the taxpayer.

YouGov for the CSJ Older Age Review, May 2011

5.3 Multidisciplinary care teams

A major consequence of acute health inequality is high rates of unplanned admission to hospital from older people. Since 2005 emergency admissions for those aged 85 and over have risen by 48 per cent.[19] Unhealthy lifestyles, healthcare managed ineffectively in the community, social factors which impact upon an individual's resilience, the fragmentation between health and social care – all these factors conspire to ensure that many older people suffering from chronic conditions are forced to present regularly at accident and emergency departments. During the course of our evidence gathering we have heard from many consultants, therapists and nurses working in secondary care about the prevalence of 'frequent flyers', older people living in poverty who yo-yo in and out of hospital.

Urgently required, therefore, is a more preventative approach to managing the healthcare of this very specific group of older people living in both poverty and ill health.

Recommendation:
The NHS and local authorities should jointly commission preventative care teams to proactively and intensively 'case manage' identified groups of older people living with ill health and at high risk of hospital admission.

Instead of a reactive, disjointed system for dealing with this specific population we need a pro-active and integrated one. Such teams would be multidisciplinary, though GP-led, and would sit alongside the primary care system. And given that many from this group are likely to be receiving social care from their local authority, these teams must be properly integrated with social care, operating under pooled budgets rather than relying on ad hoc 'loose partnership' as in the past.

71 per cent of people would support councils and doctors forming teams, working under a single budget, to manage the care of older people at risk of hospital admission.

YouGov for the CSJ Older Age Review, May 2011

19 Humphries R, *Social care funding and the NHS: An impending crisis?*, London: The King's Fund, March 2011, p10

5.4 Care homes

Given that the need for care homes is not going to go away, there is need for a significant reform to the sector. To begin with, the basic distinction between residential and nursing homes is one which was designed for another era when residential care was often used as a substitute for poor housing or social isolation. Given the dramatically altered profile of people entering long-term care (with residents far frailer and more clinically complex) we recommend that:

Recommendation:
The now out-of-date distinction between residential care homes and care homes with nursing should be removed. The money the NHS makes available to nursing homes should also be allowed to follow the patient into *residential* care to prevent them having to undergo another move into nursing home or hospital.

Secondly, the biggest single failing of long-term care in this country is the frequent difficulty many residents experience in seeing a GP.[20] Care homes are often subject to multiple GPs going (or not going) into care homes, or else GPs who (unrealistically) expect residents to come to them.

> 'People in care homes get substandard health care. It's as simple as that.'
>
> Medical Director of a London primary care trust, in evidence to the CSJ

In terms of delivering primary healthcare in this context, the best arrangement we have seen involves a particular GP or practice being aligned with one specific home and committing to provide regular sessions in the home. The outstanding results Dr Gillie Evans has achieved in The Gables Specialist Nursing Home in Cambridgeshire illustrates this.

Case study: Dr Gillie Evans, The Gables Specialist Nursing Home, Cambridgeshire

'I was ashamed of the quality of care I was providing.' That's the explanation Dr Gillie Evans cited as what motivated her to transform the way her local Peterborough practice has delivered health care for the care home residents in its area. In 2000 Dr Evans went to colleagues in her practice and persuaded them to 'adopt' one local care home each, assigning for herself coverage of the care home not only furthest from the surgery, but also the one with the most clinically complex

20 Centre for Social Justice, *The Forgotten Age: Understanding poverty and social exclusion in later life*, London: Centre for Social Justice, 2010, pp221-222

residents. She took on The Gables, a 55-bed specialist nursing home where the majority of residents have advanced dementia, committing to intensively and proactively case manage this group of people, providing one half-day session a week, held in the home itself, as well as a monthly significant event meeting for staff.

79 per cent of people think that an individual GP should take responsibility for all residents in a care home, allowing all residents to see a GP on a regular basis.

YouGov for the CSJ Older Age Review, May 2011

This model of 'managed care', however, currently remains merely irregular best practice, whether initiated by the care home provider (paying a retainer to a local GP practice) or specifically commissioned by a primary care trust. We think this should change:

Recommendation:
The NHS, through appropriate commissioning bodies, should specifically require GPs to take responsibility for coordinating healthcare in care homes.[21] Single GP practices should be aligned with specific care homes, committing to visit on a regular basis and proactively to 'case manage' the often complex medical conditions of residents.

Transformation of care home culture also depends in large part upon improving the quality of life for those working in the sector. Care home staff are all too often undervalued, demoralised and poorly paid. As well as better pay, we also need to improve the evidence-base around the training which has the maximum impact.

One example of such training is the leadership support programme for care home managers developed by My Home Life (MHL).

Case study: Leadership Support Programmes, My Home Life

MHL is a UK-wide initiative aimed to transform care home culture in the UK. A crucial part of this vision has been the development of a leadership support programme for care home managers, piloted across several local authorities over the last two years. Rather than providing yet another tool kit, or hosting a one-off training day, managers – not only from different care homes but, significantly, from different care home organisations – were invited to a three-hour leadership support group once a month for a period of at least a year. The group was designed to be small – a maximum of 14 managers – and interactive. The facilitator wasn't there to lecture managers; his or her role was to create space and safety for managers to discuss between themselves aspects of the role and then, from there, to gain a deeper understanding of the issues they faced and generate their own solutions. 'We discuss situations on a case-by-case basis,' one manager reported, 'and together we work out together a better way of doing it.' The results of the MHL pilots have been outstanding. The 'refuelling' and solidarity which the support programme has provided have translated into a greater willingness to empower staff to make their own decisions; in turn resulting in better staff retention and improved quality of life for residents.

To allow programmes such as these to become a central part of the 'offer' for managers, we recommend:

Recommendation:
Care home providers should be required to offer independent, regular support and mentoring to managers. Local authority commissioners should reflect that requirement in the fees they pay for care home placements. Leadership support groups for managers should prioritise creating a volunteer-friendly culture in care homes. And in addition a professional body for Social Care Management, potentially in the form of a chartered institute, should be established and charged with ensuring adequate training and development standards within the sector.

21 At the time of writing the proposed transition to GP commissioning is still under negotiation, with recommendations such as the addition of hospital doctors and nurses being considered

Another key aspect of reforming the long-term care sector is the unleashing of greater innovation, creativity and vision for the future. To this end we recommend that:

Recommendation:
Commissioners and regulators together examine the possibilities and conditions in which more person-centred approaches in residential care can thrive.

Two final urgent areas for reform are better regulation and fairer commissioning. At present the national regulator for care homes, the Care Quality Commission (CQC) is in the midst of a significant transition. Despite the introduction in October 2010 of a simplified series of 'essential standards of care' and a commitment 'to look at the care you get rather than at systems and processes,' on the ground a 70 per cent drop in the number of on-site inspections by the CQC has in fact forced providers to revert back to providing more and more paperwork to corroborate processes. [22,23] To change this we recommend that:

Recommendation:
Regulation should in practice change to become risk-based and proportionate ('right-touch') and should focus on the outcomes of care and not merely on the inputs or processes. In terms of inspection, the first and last parameter of whether a care home is providing a good service needs to be user-feedback. Regulators need to be spending far more time actually observing care in action.

But as well as better regulation we also need a fairer commissioning environment. It is of critical importance that any increased public resources are fairly channelled into the care home sector. We therefore recommend that:

Recommendation:
Local authorities should be required to substantiate the fees they pay for (independent) care home places via an agreed 'fair price for care' methodology. This should involve the fundamental disaggregating accommodation costs from care costs.

22 Care Quality Commission, 'Essential standards of quality and safety: How is the new system different?' [accessed via: http://www.cqc.org.uk/usingcareservices/essentialstandardsofqualityandsafety.cfm (13/06/11)]

23 Community Care revealed that the number of on-site visits by inspections dropped from 2,008 from October 2010 to May 2011 from 6,840 over the same period in 2009-10. Pitt V, 'Care Quality Commission visits drop by 70%', Community Care, 3 May 2011 [accessed via: http://www.communitycare.co.uk/Articles/2011/05/03/116741/care-quality-commission-visits-drop-by-70 (09/05/11)]

chapter one
A call to action

Life expectancy has increased dramatically over the last 80 years. This is an achievement that should be celebrated unequivocally. Millions of older people in Britain have been able to realise the opportunities a longer life has afforded. Approximately 70 per cent of older people have taken the opportunity to own their own homes.[1] Millions have been able to enjoy a longer, more active retirement. Many make huge contributions to society, with one 2009 survey estimating that people aged 50 and over form two-thirds of the volunteer workforce and account for nearly 70 per cent of the total number of hours provided by volunteers.[2]

Yet there is another side of the coin. In the interim report of our review which we published in November 2010, *The Forgotten Age: Understanding poverty and social exclusion in later life,* we identified another group of older people in Britain for whom increased life expectancy has not yet afforded greater opportunities. With one in five pensioners living below the poverty line, we analysed the wide range of challenges facing older people in our most deprived communities: stubbornly high levels of social isolation, not helped by poor transport routes particularly in rural areas; the poor housing conditions in which many (even many homeowners) live; the poor health from which many suffer; the lack of access to good, independent financial advice and a faltering social care system.

We believe, however, that for this group of people later life does not have to be this way. We believe the challenges identified in *The Forgotten Age* are not insurmountable and that for these individuals later life can be the 'time of gifts' it is for so many others. Even for those individuals, recently arrived at retirement age, whose entire lives have been spent in poverty, life does not have to be characterised by the realities we identified in *The Forgotten Age*.

Age of Opportunity, the second and final report of the Centre for Social Justice's (CSJ) Older Age Review, focusses on what can be done to bring about this change. In it we set out the urgent action that needs to be taken at all levels to tackle pensioner poverty. This is not a task for government alone; it is one society, families, young people must all take-up.

1 Office for National Statistics, *Focus on Older People,* London: Office for National Statistics, 2004, p5 cited in Centre for Social Justice, *The Forgotten Age: Understanding poverty and social exclusion in later life*, London: Centre for Social Justice, November 2010, p150

2 Volunteering in the Third Age, *The indispensable backbone of voluntary action: measuring and valuing the contribution of older volunteers,* London: Volunteering in the Third Age, 2009, pp5-6

1. The time to act

Tomorrow's demographic trends are yesterday's news. For years we have been inundated with 'startling' population projections and dramatic alerts of the arrival of an ageing society in Britain. We know that by 2024 one in five people will be of pensionable age.[3] We know that a boy born between 2006 and 2008 can expect to live approaching 20 years longer than at the turn of the 1930s.[4] We know that the number of people living with dementia will increase to one million by 2025.[5] However, as of yet sheer awareness of the trends seems not to have spurred sufficient action.

Worse, an obsession with the demographic projections has led to a neglect of *today*'s pensioner poverty. In political discussions sometimes it seems that designing better housing for older people or reforming social care will only become pressing concerns when baby-boomers, with their (more demanding) needs, begin to 'come through' to make up the number of the 'older old'. It is as if we are so concerned about the future we have forgotten about the present – the large number of older people today living in poverty; with next to no human contact; neglected care needs; in houses which were never designed for them to age in and which they no longer have the income to maintain. Pensioner poverty is not awaiting us in some remote future. It demands our urgent attention now.

In our view, any strategy for tackling pensioner poverty must begin with combating social isolation and loneliness.

2. Social isolation and loneliness

Poverty is more than simply the absence of money. Based on mass evidence gathering across the most deprived communities in Britain – and in particular learning from our alliance of 250 grassroots poverty-fighting charities – since 2004 the CSJ has found that poverty in Britain today cannot simply be put down to a lack of income. Poverty is being trapped in a domestic abuse situation with no one to turn to; it is leaving school with no qualifications and unprepared for life; it is a criminal record and little prospect of a job; it is a life wasted by addiction.

In this review we have come up against another devastating aspect of poverty which cannot be reduced to a lack of income. It is the social isolation – or what sociologists prefer to call 'persistent loneliness' – which has become a dominant characteristic of later life in our most deprived communities.

During the course of our evidence gathering we visited many older people whose human contact is limited to just half an hour a week. These individuals we talked to are no 'outliers'

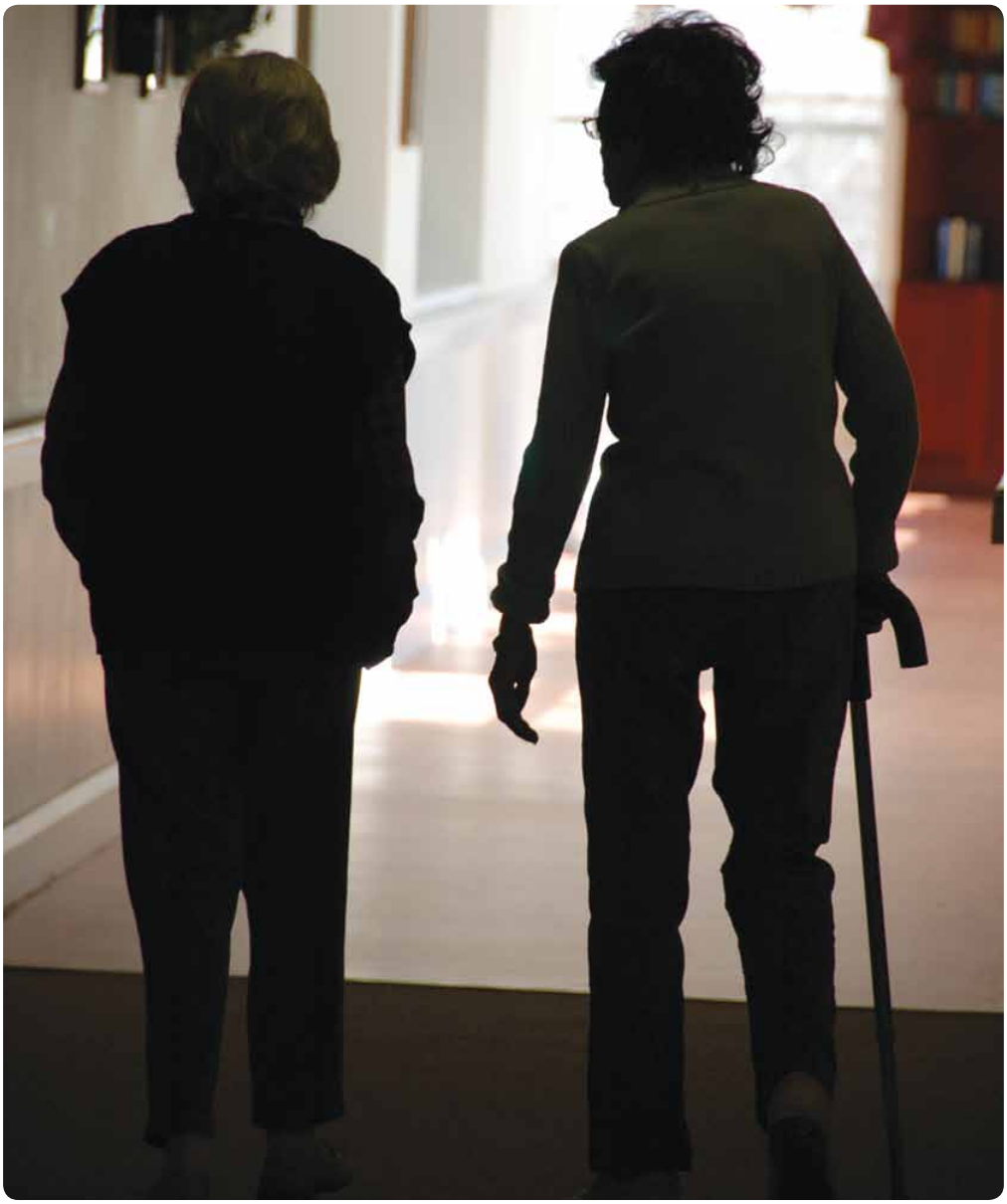
3 Office for National Statistics, Ageing in the UK datasets, Table 8: Percentage of the population aged 65 and over.

4 Office for National Statistics, *Statistical Bulletin: Older People's Day 2010,* Newport: Office for National Statistics, 2010, p3 and Office for National Statistics, English Life Tables No.10. [Accessed via: http://www.statistics.gov.uk/StatBase/Product.asp?vlnk=333&Pos=&ColRank=1&Rank=272 (09/06/11)]

5 Personal Social Services Research Unit at the London School of Economics and the Institute of Psychiatry at King's College London, *Dementia UK: The full report,* London: Alzheimer's Society, 2007, p1

but representatives of a much larger group. Social isolation is profoundly damaging to individuals, the connection between social isolation and poor physical and mental health being so well-established. But above all it constitutes a huge waste of potential: people in our country who have ceased to be members of our community, whose abilities, wisdom and life-experience have ceased to be drawn upon.

The Government is not unaware of such isolation and exclusion as features of poverty. Indeed, the previous Government's Social Exclusion Unit estimated this group to include over a million older people in Britain.[6] But with levels of social isolation thought to have remained broadly static for six decades, this is an aspect of poverty which has eluded successive administrations.



6 Social Exclusion Unit, *A Sure Start to Later Life: Ending Inequalities for Older People,* London: Office of the Deputy Prime Minister, January 2006, p12

For this reason, based on a whole host of inspiring, dynamic models and 'best practice' we have seen, *Age of Opportunity* begins by identifying the steps which can and must be taken at a local level to engage the most isolated older people. Throughout our report, drawing upon case studies, we challenge the kind of defeatism which says that there is nothing either society or government can do to combat entrenched social isolation in later life, which assumes isolation to be simply an expression of people's choices. Because in reality, as we have heard from the most dynamic voluntary groups already working to combat this problem, in most cases isolation in later life issues from a distinct lack of choice; a lack of opportunities for social engagement both across generations and with peers.

3. Structure of the report

In terms of the scope of our review, in *The Forgotten Age* we argued that there is a tendency for the debate about older age to remain narrowly focussed on care and pensions, a tendency accentuated by the bitter, divisive debates about the funding for social care in the run-up to 2010's general election. Our interim report attempted to broaden the debate from one solely about care and pensioners to one focussing on a range of other issues as well: social isolation, housing, exercise, health, transport and access to financial advice.

Accordingly in this report, we have identified solutions and made recommendations across a wide range of issues. Chapter Two focuses on tackling social isolation – the first urgent priority – before proceeding to look at what government and society can do to regenerate communities and make them places, both physically and socially, which are accessible to and inclusive of the poorest older people. Chapter Three then moves on to Money; Chapter Four to Housing and Chapter Five, finally, to the kind of reform in social care we believe to be needed.

chapter two
Dynamic communities

1. Introduction

Social isolation in later life is a problem which has reached epic proportions in the UK. Over the course of this review we met numerous older people whose human contact is limited to just half an hour a week. From the host of charities and professionals consulted, we learnt that these people are not 'outliers', but representative of a vast group. It is estimated that over a million people aged 65 and over report feeling lonely often or always and a similar number who feel trapped in their homes.[1, 2]

Social isolation, or persistent loneliness, is an aspect of social breakdown in the UK which has received a lot of attention, both in the media and in policy discussion. Yet despite widespread acknowledgement of the problem, as a society we are largely failing to tackle it. According to a recent estimate, the extent of loneliness has remained broadly static over the last six decades.[3]

The statistics are alarming:

- More than half of people aged 75 years old and over live alone;
- Half of all older people cite the television as their main form of company;
- In 2006, 500,000 older people spent Christmas Day alone. [4, 5, 6]

As we took care to emphasise in *The Forgotten Age* living alone is not synonymous with loneliness. Many older people who live alone would not describe themselves as lonely. Loneliness is better understood as 'a pain an individual feels when they want companionship but can't have it', a definition adopted from geriatrician and writer on ageing, Dr Bill Thomas, whom the CSJ visited on its trip to the U.S.

1 Spotlight 2006 survey (unpublished), GfK NOP for Help the Aged, 2006
2 Victor C and Scharf T, *Social Isolation and Loneliness*, (eds) Walker A and Hennessey CH, *Growing Older: Approaches to Quality of Life in Context*, Maidenhead: Open University Press, 2005, cited in Social Exclusion Unit, *A Sure Start to Later Life: Ending Inequalities for Older People*, London: Office of Deputy Prime Minister, 2006, p55
3 Campaign to End Loneliness, *Safeguarding the Convoy: A call to action from the Campaign to End Loneliness*, Oxfordshire: Age UK, p30
4 Office for National Statistics, *General Lifestyle Survey 2008*, Table 3.3 (GB), London: Office for National Statistics
5 Help the Aged, *Isolation and Loneliness Policy Statement*, London: Help the Aged, 2008, p6
6 *Christmas Day survey 2007* (unpublished), ICM Research for Help the Aged, 2007

Nevertheless, it is beyond doubt that the prevalence of older people living alone significantly increases the likelihood of loneliness among that group. Whether in a rural or urban context, living alone predisposes many older people in the UK to a situation where they simply do not have the level of personal contact with other people which they desire.

There are different pathways to this social isolation and loneliness in later life. Based on in-depth research in deprived urban communities in Britain, respected sociologist Thomas Scharf identifies two distinct pathways. Some older people's loneliness can be viewed as a chronic condition. 'Being lonely,' Scharf writes, 'typically represents the continuation of longstanding difficult relationships with family members and limited relationships with friends or neighbours.'[7] For others loneliness is more connected to the 'normal' life-course. Later life can often be a period of accumulated loss: the death of a spouse; the loss of a parent (given the inclusion now of more than one generation in the 'older age' bracket); outliving neighbours and friends.

> 'It is time to treat loneliness with as much seriousness as we do other great challenges to health.'[8]
>
> **Campaign to End Loneliness, 2011**

The question we face is this: how can we re-engage isolated and lonely older people back into community? And secondly, is there anything government can do?

We look at five areas in this chapter:

- Identifying extremely isolated older people and developing a hitherto unseen level of active outreach – doing far more to ensure those people are connected in with lifeline befriending services run by the voluntary sector;
- More effective coordination between voluntary groups and statutory bodies at a local level;
- Developing community at a neighbourhood level;
- Investing in and prioritising increasing opportunities for intergenerational contact;
- Improving transport links.

2. Identification and outreach

Social isolation is an aspect of poverty the state cannot be expected to tackle alone. In 2006, the report produced by the previous Government's Social Exclusion Unit, *A Sure Start to Later Life: Ending Inequalities for Older People*, acknowledged that:

7 Scharf T, 'Loneliness: an urban perspective', in *Safeguarding the Convoy: A call to action from the Campaign to End Loneliness*, Oxfordshire: Age UK, 2011, pp31-34

8 Campaign to End Loneliness, *Safeguarding the Convoy: A call to action from the Campaign to End Loneliness*, Oxfordshire: Age UK, 2011, p9

> *'Social isolation and loneliness cannot be solved at national government level alone. Addressing social exclusion amongst the most excluded older people has to be everyone's responsibility.'*[9]

Or, as the newly founded Campaign to End Loneliness put it more recently,

> *'Emotional states cannot be altered by law. You cannot befriend by diktat. There are no Departments of Loneliness, nor should there be.'*[10]

That said, what the state can lead and initiate is work to identify society's most isolated older people. But given how entrenched isolation has become, effective identification is going to require a far more intense level of active outreach than is currently occurring.

Furthermore, simply knowing who are the most isolated is not enough. At present many older people living in extreme isolation are not unknown to statutory bodies, be they district nurses, social workers or the police. Even though many individuals may have 'come onto the radar' (i.e. they are already in the system and may already be in receipt of public services), they could still be described as 'failing in the community'. In other words, those individuals may be in contact with someone; but not the 'someone' who can provide the kind of relational support that such statutory bodies simply cannot.

During the course of evidence gathering, the CSJ went with a palliative care nurse to visit a 72 year-old man living alone in his home in Peckham, South London. Jerry was dying of lung cancer. His tiny flat had recently received a 'deep clean' but was still stark and devoid of furniture. With shortage of breath making even standing difficult, Jerry was forced to spend most of the day sitting where he sleeps: on his bed. Estranged from his children, currently he has no interaction with either immediate or extended family. His contact with neighbours is minimal: one occasionally comes past and agrees to buy Jerry tobacco; but there it ends. 'I more or less plan my life around the box', he told us.

The distinct impression we received from this meeting was that Jerry was someone well served by statutory services. Not only did Jerry receive expert nursing support from his local hospice (when we arrive there was a District Nurse visiting) but he also received meals-on-wheels. Yet, unquestionably, Jerry was living in an extreme state of isolation: the only time during the week when Jerry would venture outside of his house was to spend Tuesdays at the local hospice's day-clinic.

Linking individuals like Jerry in with befriending schemes is no easy task. It is not enough for the involved professional such as a nurse or social worker simply to supply the phone number of a local charity or point the person to a website. Few of us, let alone older people already severely isolated, would simply going to pick up the phone, call a stranger and request 'friendship'.

9 Social Exclusion Unit, *A Sure Start to Later Life: Ending Inequalities for Older People*, London: Office of the Deputy Prime Minister, January 2006, p12

10 Campaign to End Loneliness, *Safeguarding the Convoy: A call to action from the Campaign to End Loneliness*, Oxfordshire: Age UK, 2011, p15

Yet these types of unlikely friendships are indeed possible. In *The Forgotten Age* we acknowledged the unique potential of the voluntary sector to reach people in social isolation.[11] Since our interim report, we encountered two further outstanding examples of charities which have managed (often against all the odds) to provide vital relational support to older people who have become severely isolated. The first is a befriending scheme in Thanet, Kent. The second is a scheme that we visited during our international trip to Holland.

Case study: Good Neighbours Service, Thanet, Kent

For many, coastal Kent is an attractive retirement destination. But for another group of older people life is characterised by a high level of loneliness. The 'Good Neighbours Service', a befriending scheme, was set up in 2009 when a number of local organisations, both statutory and voluntary, came together to identify the most urgent unmet needs in an area classed as one of the most 20 per cent deprived in the country. Feedback from hundreds of questionnaires indicated that persistent loneliness among older people was a serious issue. 'The majority said they were lonely and needed befriending', explained charity lead Bernadette Whitlock. 'A lot of people don't have anybody.'

The Good Neighbours Service matches volunteers to any older person in the vicinity who expresses an interest in a befriending service. 70 per cent of referrals are from Social Services. 'The state is the eyes and ears', Louise, the volunteer coordinator, explained. Social workers, visiting vulnerable people in their own homes, are often the ones to identify isolation and make the initial contact. But Louise is also passionate about the 'hard-to-reach' – those unknown to the state who have, as it were, 'dropped through the net'. To this end she has pioneered a variety of approaches to advertise the service, from dropping leaflets door-to-door to speaking about the Service on a Radio Kent chat-show.

In terms of running an effective befriending service, the challenge is twofold:

- Recruiting volunteers: 'What you have to do is lay down the bare facts,' said Louise, of how she recruits 'good neighbours'. Many people are simply not aware of the extent of isolation among older people. She continued: 'My job is to make it real for people so they are clear about the kind of thing we're asking them to help with.' And Louise actively seeks volunteers, for example setting up stalls in local supermarkets.
- Matching volunteers: Matching 'clients' to volunteers is something of an art form.

The Good Neighbours Service currently has 150 service users currently connected to 80 volunteers. One revealing, albeit tragic, indicator of the scheme's success is the frequency of cases where the volunteer eventually agrees to be registered as the client's 'next of kin.' Another is the fact there have already been cases where volunteers have arranged funerals for people they befriended. 'We're providing a compensatory family in a way,' admited one volunteer we spoke to.

Brian and Gladis

Brian, 41, is a photographer who lives in Margate. He was matched by the Good Neighbours scheme to Gladis, 88, who lived alone, had no family and was housebound. Before Gladis signed up to the scheme, as she told us when we visited her at her home in Margate, 'I never went out and had

11 Centre for Social Justice, *The Forgotten Age: Understanding poverty and social exclusion in later life*, London: Centre for Social Justice, November 2010, pp 110-113

fallen four times in two months.' Initially Brian agreed to take Gladis shopping, since her deteriorating eyesight had made that difficult. Did he find it daunting, befriending a stranger? Brian: 'Well, you get alongside them and get your feet wet and hope they take to you.' Gladis has. 'The only person I have is Brian', she told us. Brian now spends around four hours a week with her; opening her post and reading it to her; talking about her memories; fixing things in the house. 'You get quite close, I suppose,' Brian said, 'It builds over time.'

Case study: 'Buddy-buddy' services, VES, Eindhoven, Holland

Volunteer Emergency Service Eindhoven (VES) is a charity developed as the direct response to a very specific need: the prevalence of many marginalised older people whose only human contact is limited to professionals. VES discovered that a significant number of older people in Eindhoven – particularly those suffering from long-term health conditions and those with psychiatric illness – only interacted regularly with people like social workers, GPs, psychiatrists, nurses and therapist. Their social networks had entirely collapsed, either on account of the nature or longevity of their illness/disability, or as the result of living in extreme isolation for many years.

The problem, as VES Director Luc van Dijck told us, is that 'it is very difficult to move from contact with a professional to friendship with other people.' This is because a relationship with a professional is not genuinely reciprocal. A social worker or community nurse is *paid* to engage with someone. This is part of their job and so, bluntly, their 'tolerance level' is likely to be higher. If someone's only human contact is with professionals, they can get a distorted view of social interaction and may even lose the ability to have real, two-way friendships.

VES meeting with the Working Group in Eindhoven

Luc established VES to match volunteers to the older people in this group. The volunteer acts as a 'buddy', a carefully prescribed role – neither a friend nor a professional but someone in-between whose sole job it is to help that person develop or rediscover their social networks. For example, a volunteer might work with a recently widowed woman to help her rediscover her interests, and then join a related neighbourhood organisation. Volunteers commit to working often with challenging cases. 'When you've had the door slammed in your face by someone with psychiatric illness, often a friend won't come back. But a buddy will,' Luc explained.

The volunteer signs up to spend time with the 'client' for four hours a week for a period of one year. That time period is both a minimum and a maximum: long enough to build a relationship, but not long enough for the client to become dependent on him or her. This, as Luc explained, would defeat the whole purpose of the exercise – to help that person develop a multiplicity of social contacts. In addition, it is important to be realistic when recruiting volunteers: 'if they think they're matched for life, we'd never have any volunteers!'

At present the charity has 320 active volunteers, 200 of whom are working with a long-term buddy-buddy programme. The charity's half dozen staff members focus their efforts on the matching process, receiving referrals of clients from Social Services and then working hard to find a volunteer to buddy with them. 'This year particularly,' Luc told us, 'local government have started to understand the power of the model.' The staff also provide key support for and constant coaching of volunteers, who are often placed in demanding situations with clients which they don't necessarily know how to manage.

The dynamics of befriending services fighting social isolation are unique. Charities like Good Neighbours or VES essentially 'engineer' the introduction of two people who would not have met otherwise (if they would have met otherwise, the older person would not be socially isolated). This unique dynamic makes a befriending charity's matching process hugely important, requiring skilful volunteer coordinators. But another hinge factor is the referral process.

2.1 Revolutionising the referral process: the vital importance of face-to-face introductions

For more isolated older people to benefit from the kind of lifeline relationships which befriending schemes can provide, we need referral processes which are far more personal. Realistically, referrals are far likelier to be effective if they are face-to-face introductions. What we need are the professionals who know the isolated individual but cannot provide the kind of friendship they need and want (e.g. a health visitor or district nurse or social worker) to partner with a befriending charity and together visit that person. It is only by this kind of mutuality between the voluntary sector and public sector that we stand any chance of combating social isolation.

An inspiring model of the face-to-face referral process we are calling for has been developed by Healthy Ardwick, a neighbourhood-based charity the CSJ visited in inner-city Manchester.

Case study: Healthy Ardwick, Manchester

Healthy Ardwick was reconstituted as a members Organisation in 2007 to tackle the root causes of deprivation in Ardwick. One of their first key objectives was to create more social opportunities for older people across Ardwick, a 15,000 person ward (and the fourth most deprived) in Manchester. The vision of Healthy Ardwick's Lifetime 50+ is to reach the most isolated older people and to raise expectations of what later life can be.

Nick Carr-Brown had a very personal reason for helping establish Healthy Ardwick. Formerly an education director at a large national IT company in Staffordshire, in 2007 Nick gave up his job to care for his father. A recent widower, and diagnosed with Alzheimer's, Nick's father had decided to move to Ardwick to spend the last few years of his life with his son and his family. For two years, until his father's death in 2009, Nick was forced to look with fresh eyes at the neighbourhood where he had lived for 25 years. What he discovered was that there was simply nowhere for an 80 year-old to go. 'From a community perspective not much was going on – no accessible local information about activities or groups', he told the Working Group. 'There were, apparently, lots of frontline services, all doing their little bit but having no real impact.'

Healthy Ardwick took a strategic approach to the immense challenge.

- One problem was lack of venues: 'With no venue it is very hard to get anyone involved in the community.' So Healthy Ardwick persuaded local churches and local facilities, such as a recently renovated Edwardian swimming baths, to begin to share each other's space. The vision is for there to be somewhere open at all times for the community and older people to be able to come to. Each Centre was to be within walking distance.
- The second priority was communication: With few older people in the area using the internet, any kind of communication needed to be print-based. So Healthy Ardwick secured the funding to print a newsletter in which local groups could advertise opportunities, events and services. This newsletter is now posted regularly through 6,500 doors, with another 2,500 delivered via schools and community venues in the neighbourhood.

Most importantly, Healthy Ardwick realised that to reach the most isolated, they would have to be proactive. 'Until we've knocked on every door we won't know we've gotten to people,' he told us. Yet gaining credibility on the doorstop is a huge challenge, given the fear of crime in the area. Therefore, Healthy Ardwick has forged a partnership with the local police and crime prevention team. Through the Respect Action Partnership volunteers accompany police officers during Respect Action Weeks, knocking on doors in order for police officers to introduce residents to local activities and initiatives. By association Healthy Ardwick and its activities are seen as reputable and safe.

Smiley

Having been a victim of crime on the Coverdale estate where she lives – mugged, 'flashed' and a victim of anti-social behaviour – Smiley had simply been afraid to venture outside her house. She was supported by a Police Community Support Officer (PCSO) and then introduced to Healthy Ardwick at a Respect event following up on the door-knocking activity. Her relationship with Healthy Ardwick developed gradually: first she started to use Healthy Ardwick's local paying-in facility to South Manchester Credit Union; next, after she had paid her money in each week, she stayed to have tea and talk to members of Healthy Ardwick's staff and volunteering team; she was then introduced to craft and exercise activities, joined in the 'Silver Surfers' club and has participated on days out. Now she has herself become an advocate for the charity, telling other over 50's in the area about the charity's opportunities. 'Smiley was one of many isolated people. We believe that her isolation over a six month period has been broken,' Nick explained; 'but there are so many more Smileys out there'.

In terms of identifying and engaging the most isolated older people, this model shows the difference that a more deliberate approach from neighbourhood policing teams can make. It suggests that partnership between the voluntary sector and the police may prove the ignition key to combating social isolation.

Fear of crime among older people, as we acknowledged in *The Forgotten Age*, is disproportionately high among older people in our most deprived communities.[12] On the ground, this fear often translates into an older person's reluctance to open their front door to anyone except the police. Given this fact, charities such as Healthy Ardwick going house to house with local police may be the only way 'of getting in the door' to offer the most isolated older people a way to re-engage in community.

For this reason we recommend that:

Recommendation:
Neighbourhood policing teams should work within their community to identify ways of working with charities to engage extremely isolated older people living in poverty.

In *The Forgotten Age* we commended the previous Government's introduction of neighbourhood policing and its intention to establish more effective relationships between local police teams and their neighbourhoods.[13] Given the perceived fears of crime among older people, the ability of local teams, particularly PCSOs, to tailor efforts to meet the needs and requirements of their local area is highly valuable. Accordingly, partnership with the voluntary sector – specifically, befriending services – needs to become a core component of PCSOs' job descriptions. This will require leadership of their Chief Constables and should become an urgent priority for Police and Crime Commissioners if they are forthcoming, or Police Authorities as current structures allow.

2.2 Greater coordination at a local level

Partnership between befriending charities and the police needs to be a priority in terms of the initial identification and engagement of older people living in severe isolation and loneliness. Beyond that, however, the far more active level of outreach needed to tackle social isolation will depend upon greater coordination at a local level.

In *The Forgotten Age* we cited our frustrations and those we have heard concerning the previous Government's failure to act upon and implement the 2006 report *A Sure Start to Later Life*.[14] On the basis of strong evidence, the report argued that there were many people living in social exclusion who would benefit from a coordinated effort from local agencies and services to help them reconnect with their communities. Yet at that time there was neither the political will, nor the departmental leadership from the Department for Communities and Local Government (DCLG), to drive through such an agenda.

12 Ibid, pp118-119
13 Ibid, pp121-122
14 Social Exclusion Unit, *A Sure Start to Later Life: Ending Inequalities for Older People*, London: Office of Deputy Prime Minister, 2006

During our evidence gathering the CSJ encountered the work of one pioneering local government team which, we believe, provides precisely the kind of model *The Sure Start to Later Life* report was looking for.

Case study: Valuing Older People 'Networks', Manchester

The Valuing Older People (VOP) team, based at Manchester City Council, was established in 2003. The job it was given was simple and immense: to improve the quality of life of older residents in Manchester. Since then the progress made by the dynamic seven-person team is reflected in the World Health Organisation's designation of Manchester as an 'Age-Friendly City' – the first city in the UK to receive this accolade.

A key way the VOP team set about making Manchester age-friendly was to establish at the most local level possible networks bringing together every kind of agency, charity and community group focussed on older people. At present VOP networks cover 17 of Manchester's 32 wards.

The particular network the Working Group visited is in Ardwick. The person selected to facilitate the group varies by network. In some networks it is a member of the VOP team; in some they are lead by social regeneration programmes and in others by the city's Housing Providers. In Ardwick it is led by the chairman of the charity Healthy Ardwick, Nick Carr-Brown (see previous case study). The network convenes monthly in the basement of the neighbourhood's landmark building – the recently regenerated Edwardian swimming baths.

Around the table at what was the first meeting of this network were representatives of a diverse range of local groups and agencies: a tenants residential association; a housing association; the local Home Improvement Agency (HIA); 'Golden Voices', a choir group for older people; two local churches; Social Services and Healthy Ardwick. Despite many of these groups having worked in the area for a long time, it turned out to be the first time many of them had met each other. 'I hardly need to introduce Care and Repair', began the representative from the HIA. But it turns out she did: the representative from the Residents' Association had never heard of them.

What the VOP network promises to provide is desperately needed communication between different groups. 'All those people around the table can add to the offer for older people,' Nick Carr-Brown told the

CSJ. For example, wanting to build community among older people, Nick's own charity Healthy Ardwick needs to develop a better relationship with Housing Associations in the area, 'Because they know where all the older people are. And so we need some way to get past the bureaucracy and get the social landlord to introduce us to those people.' The network looks set to do that in a number of ways:

- By mapping the supply of 'provision' for older people (both from services and community groups). To avoid duplication, as well as to work out where there are gaps, the Network provides the opportunity for groups to work out precisely what is on offer in Ardwick.
- By sharing venues. By using each other's facilities the various groups can 'bring the buildings alive' and 'run lots of people through them'. For example, as a church committed to embracing community, Coverdale Baptist Church hosts the Credit Union.
- By distributing a newsletter to every house in the ward. Given the low usage of the internet, a newsletter is an absolutely crucial means for communication.

A key reason for the VOP team's success is the strong degree of buy-in from the leadership of Manchester City Council. The VOP team is situated in Public Health Manchester in Manchester City Council. Without that, the danger is that the older people's agenda will simply not get delivered and might get lost over time. Another factor has been the team's commitment to working with older people through the networks, the citywide Forum and a range of issue-specific task groups, all overseen by a board made up entirely of older people from across Manchester.

Members of the VOP team

On the basis of this model, if local authorities want to take seriously the issue of social isolation, the CSJ recommends that:

Recommendation:
Every local authority, at Chief Executive Office level, should have a coordinated, systematic approach to supporting older people in the community, by bringing together local stakeholders to map provision at a local level. VOP teams should be established within all local authorities with urgency in order to establish local networks to bring local stakeholders together to map provision at a local level.

This recommendation, importantly, is not about creating more services at a local level but about improving the communication between them. Accordingly, such a proposal would require:

- Strong 'buy-in' from the local council. Chief Executives and senior councillors at local authorities should take responsibility for establishing VOP teams and holding their delivery to account.
- The local VOP networks should be established at the most local level possible, ideally at a ward level but certainly at a district level.
- The success of these networks will not necessarily depend on new funding but rather upon the willingness of local agencies to 'get around the table'. Where these agencies are local branches of national charities and bodies (such as Care & Repair England) the senior management teams will need to commit to such a vision.
- Public health representatives should be encouraged to take part in these networks.

The attraction of the VOP model is that its networks are designed to respond to local needs, and will thereby vary in terms of their membership (i.e. the organisations of which they are made up). That said, it is also important that central government, preferably DCLG, sets clear national objectives to ensure consistency from VOP teams, and to ensure that combating isolation remains their top priority. We believe that Manchester City Council's VOP team constitutes precisely the kind of replicable, scaleable model we are in need of. To this end we recommend that:

Recommendation:
The VOP team at Manchester City Council should receive a small grant to develop a toolkit to help other local authorities design and develop VOP teams.

3. Community development

3.1 Introduction

Any strategy to combat social isolation among older people must begin with far more active level of outreach to identify the most vulnerable. For this to happen statutory services and voluntary groups need to work together in the kind of new ways we have suggested above. Only through proactive partnership and greater coordination at a local level can we begin to reverse the enduring and significant problem that is persistent loneliness in later life.

But we need to go further. Crucially, what are also desperately needed are regenerated communities and dynamic neighbourhoods.

In *The Forgotten Age* we made a distinction between two closely related but distinct concepts – 'neighbouring' and 'neighbourliness'.[15] Neighbouring, so we said, designates simply the practical informal interactions which occur in any given vicinity. Neighbourliness, by contrast, is a 'thicker' concept, defined by one sociologist as the more 'positive and committed relationship(s) constructed between neighbours.'[16] Having made the distinction, we then stated our intention

15 Centre for Social Justice, *The Forgotten Age: Understanding poverty and social exclusion in later life, London:* Centre for Social Justice, 2010, pp114-115
16 Bulmer M, *Neighbours: the work of Philip Abrams,* Cambridge: Cambridge University Press, 1986, p21, cited in Harris K, *Neighbouring and older people: an enfolding community?* London: Age Concern, 2008, p3

to use this second report to put both neighbouring and neighbourliness back on the social policy agenda.

Regenerating community necessarily involves re-engaging older people. For that to happen, as we have said, we cannot look solely to the state. Nevertheless it does seem that the local government has a role to play, for which there appears to be considerable public appetite. Polling specifically carried out by YouGov for this review found that:

> Over 60 per cent of people polled think local authorities should have a role in encouraging and incentivising neighbourhood initiatives and community projects.
>
> YouGov for the CSJ Older Age Review, May 2011

During the CSJ's international trip to the U.S. we visited Seattle and saw firsthand the approach to community development the City Council's Department of Neighbourhoods has pioneered over the last 20 years. Having seen their work, we recommend that the model, as well as the principles behind it, be used as a basis for a UK strategy. This *general* approach to developing community is what we recommend as a major way of tackling the *specific* issue of the isolation and social exclusion of older people.

3.2 The Seattle model

The Department of Neighbourhoods (the Department) was founded by leading community organiser Jim Diers in 1988. Its mission statement was 'to preserve and enhance Seattle's diverse neighbourhoods, empowering people to make positive contributions in their communities, and bringing government closer to all people, ensuring that it is responsive.' This was based upon a simple conviction that, as Diers put it:

> 'There's a role for government. There's a role for charities. But there's no substitute for community.'
>
> Jim Diers, founder of the Department of Neighbourhoods, in evidence to the CSJ

In essence, the new Department aimed to galvanise community in Seattle's neighbourhoods. This has involved creating *new* community groups as well as to empower existing ones. As Jim Diers told us during our visit to Seattle,

> *'The task has been to take down barriers, to collapse silos and to give permission to people to take matters into their own hands. For too long we have wrongly divided people into two sets: those with strengths – people with real gifts and*

talents – and those with needs, whether at-risk youth, vulnerable older people or disabled clients whom we essentially see as service population. What we have to do instead is to see the strengths everyone has and reintegrate those people into the community.'

For the last 20 years, the Department has tried to implement this vision through a variety of different tools, featured below.

Jim Diers, former Director of Seattle City Council's Department of Neighbourhoods

3.2.1 Neighbourhood service centres

To bring power and services closer to where people live, one of the first things Seattle City Council did was to devolve power from the city hall. This was accomplished by establishing 'little city halls' right across the city. Named 'Neighbourhood Service Centres' (Centres), of which at present there are seven, these are typically located in easily accessible public spaces like leased storefronts or public libraries. The Centres serve a variety of functions – they are places closer to home where residents can:

- **Pay bills:** Customer service representatives assist more than 225,000 residents each year, processing on average $30 million in utility payments. This system provides a way of connecting with poorer older people (who don't pay utility bills on-line), who are often referred from the customer service desk back to District Coordinators (see below);
- **Pay fines:** As most service centres are set up to handle money, they are also able to accept fines for parking and traffic tickets;
- **Process passports;**
- **Find out information:** The Centres also play a crucial role in making information available about community events, community organisations, health services and transport options;
- **Visit the Neighbourhood District Coordinator:** The key purpose of the Centre is to connect different community groups as yet unknown to each other. This is largely the role of the Neighbourhood District Coordinator stationed at the Centre.

One of Seattle City Council's seven Neighbourhood Service Centres the CSJ visited. At these 'Little City Halls' people can pay utility bills and parking fines, as well as apply for passports.

In May 2010 the Coalition's *Programme for Government* announced its intention to create a 'large-scale, 21st Century home-grown English movement of community organising', proposing to 'train a new generation of community organisers and support the creation of neighbourhood groups across the UK, especially in deprived areas.'[17] In February 2011 the £15 million contract to deliver this programme was won by the charity Locality, a nationwide network of 600 community networks. As Locality has emphasised to the CSJ, its vision is for these new community organisers – 500 senior, paid ones and a further 4,500 volunteers – not to be 'parachuted in' to local neighbourhoods but rather to be recruited at a local level via a plethora of local charities across the UK.

The CSJ welcomes the Community Organisers programme. In terms of implementation, we recommend that the programme learns the lessons of the Service Centres. A highly visible community hub, in Seattle's case these 'little city halls', is integral to the success of community organisers' work and their chance of making a real difference to their communities. We therefore recommend that:

Recommendation:
Community organisers should identify appropriate venues within their communities and draw upon them to connect together local organisations and efforts, particularly via the new VOP teams. Such organisers should identify appropriate venues within their communities and use them to connect local organisations and efforts.

3.2.2 Neighbourhood District Coordinator

District Coordinators are essentially community organisers employed directly by Seattle City Council. As Jim Diers explained:

> *'The most cherished resource at any Neighbourhood Service Centre is its coordinator. These Department of Neighbourhood employees are the link between the community and the city government. The coordinators sometimes refer to themselves as being overt double agents.'*[18]

Stan Lock is one coordinator the CSJ met who described himself in exactly these terms:

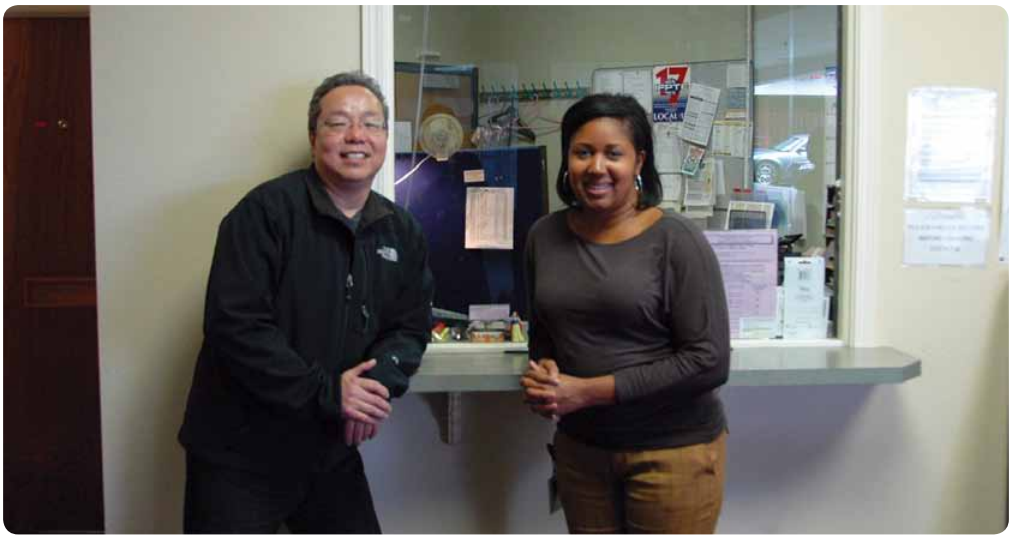
17 McCarthy & Stone, *Housing and Care for an Ageing Population: An Opportunity to Plan for an Ageing Population,* Spring 2011[accessed via: http://www.mccarthyandstone.co.uk/images/stories/pdf-documents/McCarthy-Stone-Policy-Statement.pdf (14/06/11)]
18 Diers J, *Neighbor Power: Building Community the Seattle Way,* Seattle and Washington: The University of Washington Press, 2004, p47

'On the one hand my job is to be the City Council's eyes and ears and to represent City departments to the community. But on the other hand my job is to be on the side of the community, helping people out there to navigate city bureaucracy.'

As a coordinator, Stan performs this 'double agent' role in a number of ways:

- Taking face-to-face meetings with people, referred back from the Service Centre's front desk, who might be experiencing particular difficulty. Stan works as a liaison and trouble-shooter, either putting them in touch with the relevant City Council department; informing them of resources which may be available to them; or linking them in with community groups in their neighbourhood of which they are unaware;
- Building community councils for local neighbourhoods. This will be done by networking across neighbourhoods, identifying leaders (as Stan put it, 'citizens who see a need.') The purpose of the councils is again to organise people so they can take action on issues which matter to them;
- Staffing a District Council that brings a variety of neighbourhood associations together to share information and resources and to work together on common issues;
- Administering and marketing the Neighbourhood Matching Fund (see below).

A good coordinator, Stan told us, has to be a masterful networker, 'very opportunistic', 'ingenious' and 'good at getting people excited about things.' Above all he or she has to know their particular neighbourhoods 'like the back of their hand.'



Stan Lock (far left), one of Seattle's Neighbourhood District Coordinators, who spoke to the CSJ. He stands outside the Neighbourhood Service Centre where he is located.

Given that, in Seattle, the District Coordinator role has been tried, tested and honed over the last 20 year period – thus constituting a mature model – we urge the Government to ensure that:

Recommendation:
The key elements of the District Coordinator role – particularly the way it provides a bridge between community and local government – should inform the Government's Community Organisers programme. Of particular importance is the necessity of community organisers achieving visibility in their local community by being closely attached to community hubs.

One of the tasks of the coordinators is to draw attention to the Neighbourhood Matching Fund, set up to provide neighbourhood groups with council resources for community-driven projects which enhance and strengthen people's own neighbourhoods.

3.2.3 Neighbourhood Matching Fund

The Matching Fund revolves around the idea of the *community match* whereby the Department commits to match financially whatever community groups come up with. However, crucially in the case of low-income neighbourhoods, the community match doesn't have to be financial but rather can be volunteer labour or 'sweat equity' (which the Department values at $20 an hour), donated materials or professional services.

The success of the Fund has been extraordinary. In just over 20 years it has awarded more than $45 million to more than 3,800 projects throughout Seattle, leveraging a community match of $68 million and engaging more than 80,000 volunteers (who have collectively donated over 560,000 hours). The Fund has matched a wide range of projects during this time: the renovation of 'senior centres' (community centres designed particularly for older people); pedestrian improvements; public art; making neighbourhood documentaries and 'oral history' projects; community events; climate action projects; farmers' markets; and neighbourhood parks.

Members of the Working Group visiting Bernie Matsuno, Interim Director of the Department of Neighbourhoods

While some of these projects are physical, others are less tangible – community events or neighbourhood organising. But all of them have to occur within a clear time-period and have a defined goal. The Fund is not designed to sustain ongoing programmes, but rather to bring neighbourhood groups together to initiate their own projects. For this reason, eligibility criteria are kept intentionally loose: the only thing applications must demonstrate is that the intended project has the capacity to build a stronger and healthier community.

With galvanising community as the primary purpose, critical to the success of the Fund is *outreach*. The Department has to be highly proactive. 'They're not looking for us. We're looking for them,' emphasised Garry Owens, a project manager at the Department.

Most groups who come to the Fund have never applied for a grant before, let alone been awarded one. But as Bernie told us:

> "We want to say 'yes'. And we will work with a group until we can get to 'yes'."
>
> Bernie Matsuno, Interim Director, Department of Neighbourhoods, City of Seattle, in evidence to the CSJ

To allow the Department to reach this 'yes', a number of features of the Fund have been developed over the years.

- The Fund has multiple funding streams ('small sparks', small projects and large projects). This helps to lower the barrier to entry and, as Bernie told us, 'to work groups through that continuum.' So a group that successfully implements a Small Sparks project (e.g. receiving $250 to plant trees) can then next time apply for a more ambitious project.
- Multiple funding streams also allow for multiple application tracks. Because there is not one single annual deadline, if the Department feels that a certain group's application isn't good enough, it doesn't have to say a flat 'no' (nor tell them to wait for a year). "The beauty of having multiple application streams is that we can say to a group that applies for a March deadline, 'By July you'll be more ready'."
- A quick turnaround is absolutely crucial. Applications to the Small Sparks Fund, in particular, are processed within one month.
- Finally, community groups applying to the Fund are connected to charities (legally allowed to receive the public money). 'Some groups are not experienced at managing money,' Bernie explained, 'so what we do is to link them in with a larger organisation that will mentor them through the process. For example, we found a local refugee/immigrant group who wanted to apply to the Matching Fund. So we connected them with a charity which helps them manage the project and the funds they receive.' In return for this mentoring 'service', these charities typically receive as a fee five to ten per cent of the Fund award.

Since the CSJ visited Seattle in March 2011, the Government has announced, in its May 2011 White Paper on *Giving*, the Community First project, explicitly referencing the Department of Neighbourhood's work.[19] The Community First project will provide £80 million of investment 'to encourage more social action in neighbourhoods of significant deprivation and low social capital.'[20] The CSJ welcomes this initiative, particularly since the funding looks set to be awarded to community groups on a match-funding basis. Our concern, however, is that a fair balance is struck between match funding awarded to applications from younger people and those from older people. For this reason, we recommend that:

19 Cabinet Office, *Giving White Paper*, London: The Stationery Office, 2011, p29
20 Ibid, p30

Recommendation:
The Community First project actively encourages and duly makes awards to projects initiated by or including older people.

Seattle's Matching Fund model has vital cultural lessons for any approach to developing community. In our view they are:

- A shift towards a distinct 'yes' culture among local decision-making structures and whichever bodies award the Community First grants;
- A focus on creating *new community groups* rather than funding existing ones. This will require the accompanying community organisers to stimulate applications for Match Funding by groups which have never made any application in the past.

3.2.4 'Ageing your Way' neighbourhood gatherings

In terms of specifically engaging older people, since 2010 the County in which Seattle is situated, King County, has commissioned Jim Diers to further the City's Council's work. 'Ageing your Way' gatherings have been hosted across different neighbourhoods in Seattle to bring together people at or approaching retirement age. These gatherings are evening events hosted at local community centres, where diverse groups of 'senior' residents from the local community come together to do two things: develop a vision of a community that would support them as they age and brainstorm concrete projects to support that vision.

Participants separate into small groups around tables first to discuss what kind of a city they would like to live in as they age. Groups are encouraged to illustrate pictorially what such a place would look like, which they then present to the larger group (see photographs below).

Next, people are encouraged to imagine local projects which might go some way towards realising that vision. Again these projects are drawn up before participants present their ideas to the larger group and literally stand behind their graphic illustrations of those ideas. At which point people are encouraged to move around the room to join the projects they are excited by. By the end of the evening a new group has formed, been put in touch

for further contact, and offered a small level of 'technical assistance' to see these projects get off the ground.

In our view, the Ageing Your Way gatherings provide a highly promising mechanism to engage older people in their communities. We therefore recommend that:

Recommendation:
The hosting of Ageing Your Way-type gatherings must be a primary task for VOP teams as they are established. In addition, Community First match-funding should be levered in to support practical projects which emerge from these gatherings.

4. Intergenerational opportunities

Throughout our evidence gathering process, one issue repeatedly brought to our attention was the lack of contact between generation(s) of older people and young people in many parts of Britain today. Intergenerational volunteering needs to become part of the culture in a way it is not at the moment.

John Cairns photography, on behalf of the CSJ

The two projects described below, visited by the CSJ, show how powerful intergenerational contact can be, as much as to the old as to young. The first, The Power of One Volunteer Programme in Seattle, shows the difference older people can make to the lives of school children; the second, *Growing Old Together* in Liverpool shows the difference school children can make to older people.

78 per cent of people we polled thought that interacting with older people should be part of a child's educational experience at school.

YouGov for the CSJ Older Age Review, May 2011

Case study: The Power of One volunteer programme, Seattle

The Power of One volunteer programme was established in 1996 and is a partnership between Shoreline-Lake Forest Park Senior Centre and Shoreline Public Schools. The Programme places volunteers over the age of 55 into schools in the Shoreline district to help elementary, middle and high schools students to read, improve their maths skills and to mentor them.

The Senior Centre set up the programme to answer three distinct questions:

- How can we better integrate with the community?
- How can we place volunteers into school districts?
- How can we reduce social isolation among older people who attend the Centre?

Currently over 60 volunteers currently work in eight local schools. Most work directly with the children, providing the one-on-one interactions not always possible for teachers; others prefer to help teachers prepare for lessons, catalogue material and so forth.

'One of the things I like about the programme', said Director of the Senior Centre Bob Lohmeyer, '[is that] it is not charity from either side's point of view. There is a very specific need, and this programme satisfies it. In terms of the schools, without these volunteers students would go without…'

Ivan Settles and Liz Rosenthal giving evidence to the CSJ

Liz Rosenthal, 78, started volunteering when her husband died. 'What the schools were finding,' she told us, 'is that kids reading to themselves was no good. What really helps them is to read with someone out-loud.' So that's what she does, currently visiting two schools three times a week. This is how she summed up the value of the experience: 'The more you give the more you live.'

Another volunteer on the programme, Ivan Settles, 86, is a retired schoolteacher. Ivan mainly helps with students whose first language is not English. 'I just love it,' he told us; 'what I get out of it is much more than what I put in. It keeps my brain so involved.'

Case study: Growing Old Together Project, Liverpool

Founder John McEvatt is the pastoral head of Year 10 at Parkland High school in Speke, one of the most deprived wards in Liverpool. When both his mother and mother-in-law died of dementia, he decided he wanted to do something in their memory: to try to improve the quality of life of residents in the nursing, residential and sheltered accomodation. At the same time he also wanted to offer more intergenerational opportunities to students in the year group for which he was responsible.

John Cairns photography, on behalf of the CSJ

He began by taking six 14 year-olds from his school into a local sheltered accommodation simply to ask residents what they could do to help. A host of different ideas came out of this initial meeting – providing 'pamper sessions' for tenants; painting nails, doing make-up, hair styling and offering massages. Quiz and entertainment nights were then later added, all proving exceedingly popular with residents. Two years later, the project is now running on a weekly or fortnightly basis in 15 care homes and sheltered housing schemes around East Liverpool.

By creating regular, interactive opportunities that bring together different generations, the Growing Old Together project has broken down the negative preconceptions that often exist between older and younger people. Among students 'the fear of old age seems to have diminished', one participating care home reported, while residents have found that 'it has stimulated them especially with reminiscing.' Another sheltered housing scheme wrote this, 'You should see them with the residents. They are so caring and mix well. They even come to help with Christmas dinner.'

Yet another participating sheltered housing scheme attested to the catalytic impact the project had had: 'the pamper nights have been a great help in motivating the tenants to leave their flat during the winter months... the lounge has never been so busy and the ladies in particular feel pampered and valued.'

Feedback from particular individuals who submitted evidence to the CSJ was similarly ecstatic. 'I really look forward to our Wednesday pamper evenings', Maureen, 88, told the CSJ; 'I normally receive hand massages, manicures and really look forward to the foot spa and pedicure treatment which helps my arthritis immensely'. While a participating student, Kay, 15, wrote this: 'John McEvatt asked me would I go with him to some work with old people. I did and it is the best thing I have ever done. I love my ladies and gents and I think they love me.'

John Cairns photography, on behalf of the CSJ

The above examples clearly demonstrate how mutually beneficial these kinds of intergenerational opportunities can prove. Our concern is with how many more such projects, of both kinds, can be made available to both older people and students. In our view, efforts need to be made on two fronts: first, to increase the opportunities in schools; secondly to find ways of offering greater numbers of older people the opportunity to volunteers in their communities.

4.1 Schools

We also believe that older volunteers constitute a real solution to the urgent challenge of improving literacy in schools. As a recent Ofsted report on literacy rates in the UK candidly stated: 'the underperformance of those from low-income families is very marked, particularly at secondary level.'[21] In the classroom, as The Power of One project above demonstrates, older volunteers can provide a vital role in improving reading levels.

In order to make older volunteers an indispensable part of school culture in the UK, we therefore recommend that:

Recommendation:
Local authorities, ideally through the newly established VOP teams which we have called for, should conduct a basic community audit to identify which local schools would be well placed to benefit from older volunteers. Such volunteers could be especially effective in providing support with basic reading, writing and mathematics programmes within primary schools. They might also have an important part to play in our calls for increased financial education in schools, given their experience of managing money through their working lives.

Recommendation:
On the basis of this first audit of schools, VOP teams should also then identify local residential accommodation for older people (sheltered housing schemes, care homes etc.) which would benefit from visits from schools (such as Parkland High School – see Growing Old Together case study above).

21 Ofsted, *Removing barriers to literacy,* Manchester: Ofsted, January 2011, p4

4.2 Volunteering

To bring about this change in school culture, it is also important to acknowledge the work that needs to be done in order to offer a greater number of older people the opportunity to volunteer. For, as we noted in our discussion of volunteering in *The Forgotten Age*, while people aged 65 and over form almost a third of this country's volunteer workforce, volunteering levels are not as high in lower socio-economic groups.[22] The bi-annual survey also reveals, unsurprisingly, that those living in or vulnerable to social exclusion are less likely to participate in volunteering than those who are not.[23]

> 'There are literally millions of older people with skills and a desire to help. Lots already do help, but there is huge potential to mobilise more.'
>
> An older volunteer, in evidence to the CSJ

Speaking to the CSJ Rachael Bayley, former Director of the UK's Retired Senior Volunteers Programme (RSVP) gave one reason for these lower rates. She said that when RSVP visit socially excluded older people and ask them why they don't volunteer, what is often heard, tragically, is that older people think that they have no skills to offer. The above case studies show how untrue this perception is. To persuade more older people of that fact, however, far more outreach is required. To that end we recommend that:

Recommendation:
Alongside this audit and bridge building work, VOP teams should encourage increased collaboration between older people's organisations and those that focus on children, young people and young families. As well as the clear benefits such partnership would offer to those participating, the exploration of closer working practices and joint funding applications, where appropriate, might offer an added bonus to such organisations in terms of increasing efficiencies, cutting duplication and navigating the choppy waters of reduced public expenditure a little more smoothly.

5. Transport

As we found in *The Forgotten Age*, ageing can make it more challenging to remain mobile and active. Reliable and accessible local transport networks become increasingly significant as people get older when journeys for essential items and social activities can become a challenge.

The transport challenge is often more difficult for older people living in rural communities. The Commission for Rural Communities has found that for people of state pension age and

22 Department for Communities and Local Government, *Citizenship Survey 2008-09*, London: Department for Communities and Local Government, 2009, p15 cited in Centre for Social Justice, *The Forgotten Age: Understanding poverty and social exclusion in later life*, London: Centre for Social Justice, November 2010, p139

23 Ibid

older, almost a quarter lived in rural areas.[24] It is therefore unsurprising that people who live in rural areas spend up to between 20 and 30 per cent more on transport (including motoring costs, public transport and taxis) than those in urban households.[25]

Case study: Ben Clarke

Ben is 82 and lives alone in his own home in Southwark. A former Fleet Street journalist, Ben is a bi-lateral amputee who suffers from a systemic autoimmune disease which has resulted in major operations on his legs. He can only take four or five steps unaided and relies on an electric wheelchair to get around.

'Without transport you can't do anything; transport is the bane of disabled people.'

Since having to give up driving two and a half years ago Ben has been socially isolated, and now only goes out once a week to a day centre run by Little Sisters of the Poor.

Ben relies on taxis to travel within his community as he finds buses unsafe, but even with the services provided, travelling around his community is still far harder than he would like.

One service which is provided by Transport for London is the Dial-a-Ride taxi scheme. Although Ben can use this to pre-book journeys to go shopping or for other activities, the scheme cannot be used for hospital or medical appointments, or be used for transportation to local authority day centres. And with the local authority cutting transport for day centres, Ben is reliant on private taxi operators.

Though there are many taxi operators near him, he has found them to be unreliable and at times the taxis can be very expensive:

'When you call them up and they are a few miles away, they will keep the meter running so by the time they get to me there is £8 on the meter, and the meter is kept running for the time it takes the driver to let the wheelchair access down, so before I actually go anywhere it can be really expensive.'

24 Commission for Rural Communities, *State of the Countryside 2010*, Cheltenham: Commission for Rural Communities, July 2010, p19
25 Ibid, p42

Since the current Government has been in power it has pledged to make the transport network more efficient and to offer better value for money. It has also signalled its intention to decentralise power to local government to organise their transport infrastructure and day-to-day transport needs free from central government diktat.

The CSJ considers that this local approach is the best way for transport solutions to find their way to those most in need. By encouraging citizens to act together to establish the transport solutions in their area, they can make a real impact on the many older people who are socially excluded.

5.1 Transport by bus

Bus travel provides a vital lifeline for many of the poorest older people who would otherwise be unable to leave their homes. Although concessionary bus travel has made a huge difference to millions of older people, the CSJ has also heard that the universal nature of the scheme means that it is poorly targeted and used by many people who qualify for a bus pass but do not rely on its subsidy to remain mobile.

The concessionary bus pass currently costs the taxpayer £1 billion per year with the average pass estimated to be £100 per pensioner.[26] To ensure that this payment is being targeted at those who need it most, we recommend that the concessionary bus pass be treated as a taxable benefit, with older people in receipt of Pension Credit Guarantee (PCG) receiving their pass for free, and those who have sufficient income to be ineligible for PCG to pay a percentage of the cost of the pass in relation to their income tax bracket.

The CSJ would further recommend that the revenue raised be placed in a fund to pay for other community transport schemes such as subsidised taxi services and community buses; we call for this fund to be administered by an independent agency with experience running community transport schemes specifically targeted at older people.

Recommendation:
The concessionary bus pass should be treated as a taxable benefit and the revenue raised placed in a fund administered by an independent agency to pay for other community transport including subsidised taxi schemes and schemes specifically aimed at older people.

5.2 Transport by taxi

We also identified in *The Forgotten Age* that the use of taxis and minicabs is highest among people who live in the lowest income quintile.[27] While some people have no option but to spend money on taxis, many others are unable to do so, either because it is just too expensive, or because some taxi firms are unwilling to provide shorter journeys within their

26 Hansard, *Written answers and statements*, 7 March 2011

27 Department for Transport, *National Travel Survey Table NTS0705:Travel by household income quintile and main mode/mode: Great Britain, 2009*, 29 July 2010 [accessed via: http://www.dft.gov.uk/pgr/statistics/datatablespublications/nts/ (08/06/11)]

communities. These factors can render poorer people, particularly those in rural areas, unable to leave their homes and socially isolated.

In view of this, many local councils operate schemes which offer a discount to older people and those with disabilities to help travel by taxi. During our evidence gathering the CSJ met with Councillors from Westminster City Council to learn about its taxicard scheme. This scheme helps Westminster residents travel by black cabs at a greatly reduced rate if they have a disability or disabilities which prevent them from using public transport. But if such projects are not available in their local area, many older people struggle to travel around their communities.

As recommended above, we would like more subsidised taxi schemes to be established, especially in rural areas, and for further investment to be made into infrastructure, such as taxi card readers, so that a network of taxis is available. But as we note in the case study above, some Dial-a-Ride schemes cannot be used for transport to doctor's or hospital appointments (as an older person would have to arrange transport by the ambulance service via their GP), or for travel to day centres. We would like to see a broadening of the type of journeys which can be made within taxicard schemes so that older people can use these services for travelling to often essential appointments and social activities.

Recommendation:
Local authority-operated Dial-a-Ride schemes should be broadened to include other essential journeys such as to medical appointments or to day centres.

5.3 Community transport

For some of the oldest people in our communities, access to transport plays a pivotal role in either breaking down, or entrenching, social exclusion. Reliable, regular and affordable transport links can be a crucial difference between isolation and loneliness or personal and social wellbeing. One voluntary organisation which is making a life-changing difference to people with mobility problems which the CSJ visited was Community Transport.

Case study: Community Transport

Community Transport is a national charity and social enterprise whose mission is 'to bring people and opportunities together helping to transform lives and build better communities'. They operate 11 transport-related projects in the West Midlands, North West and North East of England which help to keep people supported and included in their communities.

Community Transport covers ten different towns and cities which make up eight per cent of the English population. In 2009 they provided 516,000 passenger trips using a fleet of 100 minibuses which covered over one million miles. They have 70 paid drivers but train over 400 volunteer drivers in any one year. Among the projects they offer are:

Community Transport Passenger Services
The services which they provide include:

- Group transport for voluntary and community groups to ensure that their clients and members are able to access their services such as day care, social clubs and special events;
- Dial-a-ride, shopmobility and car schemes for people who have mobility difficulties;
- 'Demand responsive' services which offer transport by minibus; especially outside of normal public transport hours;
- Partnership services with schools, youth groups and local authorities;
- Tailored transport services for pupils with Special Educational Needs or attending Pupil Referral Units;
- Innovative services to help patients access NHS services.

Hop to the Shops Newcastle

On a visit to Community Transport in Newcastle upon Tyne the CSJ saw the way that this service is helping to change many older people's lives and ensuring they retain independence through a Hop to the Shops service.

The Community Transport bus dropping off older people at a supermarket in Newcastle

The Hop to the Shops service is available to people over the age of 50 who are housebound but want to remain independent and visit the shops to do their shopping. They currently provide 12 shuttle runs every fortnight which helps over 130 older people to get to the shops. Referrals to the service mainly come through Social Services, families, friends and neighbours and they also place leaflets in hospitals and GP waiting rooms.

Older people can book themselves onto a local run where a minibus will pick them up from their home and take them to a local supermarket of their choice. When they're finished shopping they are dropped back home and the driver carries their shopping to their front door; and all they have to pay is £1.50 each way, with free travel for a carer if they have one.

In evidence to the CSJ, Audrey explained what the service meant to her:

> *'I like to remain independent. I can't go on buses because I can't see very well and have arthritis in my hands which makes it difficult to carry my shopping. When I missed a minibus trip due to a hospital appointment I had to do five trips to the supermarket over five days just to get everything I needed as I couldn't carry it all in one go. I don't want to have to rely on family to take me as they have to work and I have to schedule my trips around them. The Community Transport service is a terrific idea.'*

Funding for the service is part provided by Nexus, the passenger transport executive for Tyne and Wear, which pays an hourly rate to help cover the cost of fuel for the minibuses. Their remaining funding is made up from renting space in their depot for storage, and by recycling and selling furniture.

During the visit we met with Steve Orrock. Before working for Community Transport, Steve was a Police Officer in Northumbria and also the Director of a large taxi company with a fleet of over 250 vehicles.

Steve Orrock, Community Transport Services Manager, Newcastle

In May 2010, after having been retired from work for over a year, Steve became involved with Community Transport which offered him an appointment as Passenger Services Manager at the Newcastle Project, Steve told the CSJ:

> *'Many of our customers are physically disabled but want to do everything themselves as they are fiercely independent. There is a huge demand for services and we aim to remain consistent and reliable so that people will continue to use the service; but there is a constant struggle to find where the next money is coming from to continue the service'.*

Mrs J

Mrs J is a lady in her mid seventies who has been a member of the Hop to the Shops scheme for several years and suffers from Chronic Obstructive Pulmonary Disease. Mrs J is unable to walk any distance without getting out of breath and suffers from quite severe chest pains. She therefore requires a door-to-door service to enable her to participate in her once a fortnight shopping trip to the supermarket, where she can stock up with essential items. Mrs J also uses Community Transport to attend regular monthly meetings. Although Mrs J finds taxi fares more affordable than others who use the service, she claims that the quality of service provided by the taxi industry falls way below that provided by Community Transport. On occasions when using taxis, she has had to physically lift her shopping into the back of the taxi whilst the driver sat in his cab. Mrs J has even been left on the main street outside of her house by a taxi driver who refused to help carry her shopping the few feet from the cab to her door.

Another scheme the CSJ is aware of is the Volunteer Driving Scheme operated by the RSVP North East, which uses older volunteers. This scheme provides a transport service to people who need to attend health appointments and collect repeat prescriptions at their local GP surgery, health surgery, clinic or hospital. A volunteer driver uses their own car to collect an individual and take them to their appointment; the driver waits with the individual and then returns them home.

The Government has signalled its intention to decentralise power to local authorities in order for them to organise their transport infrastructure and day to day transport needs through Local Enterprise Partnerships (LEPs).[28] LEPs will be partnerships between local authorities and businesses, with the Government stating its expectation that business representatives make up half the board and have a prominent business leader as the chair. As they establish LEPs, we urge local authorities to include representation from older people's groups to ensure that transport concerns for older people are heard and acted upon.

Recommendation:
Local authorities establishing LEPs should include representation from older people's groups.

Finally we welcome the proposals in the Department for Transport's White Paper for its commitment to community transport projects through the Local Sustainable Transport Fund, and we echo the call for local authorities to partner with organisations, such as Community Transport in Newcastle to enable older people with mobility difficulties to stay active and remain independent.[29]

28 Department for Transport, Creating Growth, Cutting Carbon – Making Sustainable Local Transport Happen, London: The Stationary Office Limited, January 2011, p 8
29 Ibid, p30

chapter three

Managing money and planning for the future

1. Introduction

As we identified in *The Forgotten Age*, rigidly holding to arbitrary definitions of poverty such as income levels and assets – can prove narrow and unhelpful.[1] Unless a broader understanding of poverty is adopted, including such models as the material deprivation indicator below, many older people will simply continue to drift above and below the poverty line without an enduring change in quality of life or opportunities.

Money does, however, remain an essential indicator of whether an individual lives in poverty or not. It is especially pertinent for older people, the majority of whom need to spend more on essentials at a time when disposable income and opportunities to earn more often decrease. People aged 60 and over, for instance, spend more of their money on food and non-alcoholic drinks, and less on eating out and certain leisure activities than younger people.[2]

In 2009/10, almost one in five pensioners (18 per cent) in the UK lived below the income poverty line: 2.1 million before housing costs and 1.8 million after housing costs. The number of older people in poverty before housing costs has reduced by two per cent since 2008/09, but remains unchanged after housing costs.[3] Although this small decrease should be welcomed, there is much that can be done to help the most vulnerable older people maximise their income.

In *The Forgotten Age* the overwhelming majority of the poorer older people we met were reliant on the state pension and other age-related benefits to make ends meet. Yet there is

1 Centre for Social Justice, *The Forgotten Age: Understanding poverty and social exclusion in later life*, London: Centre for Social Justice, November 2010

2 Office for National Statistics, *Family Spending: A report on the 2009 Living Costs and Food Survey*, Newport: Office for National Statistics, 2010, p5

3 Department for Work and Pensions, *Households Below Average Income: An analysis of the income distribution 1994/95 – 2009/10*, London: Department for Work and Pensions, May 2011, p14

an alarming number of older people who are eligible for basic statutory financial support, but do not seek or receive it.

The CSJ considers it essential that not only should older people receive the benefits they are entitled to, but that there should be services available for them to receive good quality financial advice that actively helps them to *maximise* their income. Although there is a wealth of information in the public domain, it is often complex and mistrusted.

We have found a lack of financial advice and guidance for those who needed it most, especially when reaching retirement age; and much financial planning and advice is primarily located online. This is particularly the case for the many utility companies which offer exclusive deals for internet customers and the numerous best buy tables which highlight the most cost-effective lifestyle products. Research by Consumer Focus has shown that people who manage their energy accounts online and receive their bills via email can save an average of £127 per year.[4]

Due to the digital exclusion of many low income older people, they are unable to access these services. This digital divide needs to be addressed. Access to financial advice can make a huge difference to ensuring that older people have the necessary information to help them out of poverty and have a good quality of life.

Further more, the CSJ welcomes the recent addition to the *Family Resources Survey* of indicators of older people suffering 'material deprivation'. This helps to demonstrate that poverty is about much more than an individual's level of income.

Material deprivation

The *Households Below Average Income* report identifies groups in low income with thresholds of 50, 60 and 70 per cent for contemporary median income, together with figures showing groups receiving 50, 60 and 70 per cent below 1998/99 median income held constant in real terms.

In addition, to understand the scale of older age poverty a set of questions were introduced to the *Family Resources Survey* in 2008/09 to ascertain how many older people were going without items considered necessary for a good standard of living. This was prompted by a Department for Work and Pensions (DWP) Working Paper, which identified that the standard questions did not accurately identify the reasons for an older person not having certain items; with pensioners tending to answer questions as 'do not want' as opposed to 'can't afford'.[5] The main reason found for older people lacking these items was due to social isolation, ill health or disability.

Material deprivation uses a set of goods, services and experiences to capture low standards of living. By introducing these indicators the survey should show a much broader understanding of everyday life

4 Mummery H and Cooper G, *Missing the mark: Consumers, energy bills, annual statements and behaviour change*, Consumer Focus, June 2011, p10 [accessed via: http://www.consumerfocus.org.uk/files/2011/06/Missing-the-mark.pdf (07/6/11)]

5 McKay S, *Measuring material deprivation among older people: Methodological study to revise the Family Resources Survey questions*, Norwich: Department for Work and Pensions, 2008 [accessed via: http://research.dwp.gov.uk/asd/asd5/WP54.pdf (02/06/11)]

for many older people and the things they have to do without. Fifteen questions were asked to assess deprivation. Pensioners were given a score between 0 (having all items) and 100 (having none of the items); a threshold of 20 was used to show whether an individual was suffering from material deprivation.

The material deprivation survey showed that amongst the lowest quintile:

- Half of pensioners were not able to take a holiday away from home; the most common reason being ill health or disability;
- A fifth of pensioners would be unable to pay an unexpected expense of £200.

Approximately 900,000 pensioners aged 65 or over were living in material deprivation in 2009/10.[6]

The Forgotten Age also highlighted that huge numbers of people living in fuel poverty. We identified that fuel poverty is a function of three factors: people's income, the cost of energy, and a property's energy efficiency. Only by addressing these issues can people be lifted out of fuel poverty and will we reduce the risk of people falling into fuel poverty.

Despite government initiatives, since 2004 the number of people in fuel poverty has risen from 1.2 million to 4.6 million in 2010.[7] Figures from Citizen's Advice show that of the 2.4 million debt advice queries they received in 2009/10, almost 110,000 were regarding fuel poverty – this was an increase of a third on the previous year.[8] There has been an attempt to confront these factors through supplementing people's income through universal payments, requiring energy companies to offer social support, and by encouraging people to invest in energy improvements for their homes.

2. Money

In order to ensure older people have an income in retirement, the state provides the Basic State Pension (BSP) and supplementary benefits; and in order to help with the cost of energy prices the state provides the Winter Fuel Payment (WFP) as a universal benefit, and energy suppliers are required to offer social price support to their most vulnerable customers.

2.1 Basic state pension

Although we did not conduct a technical review of the BSP in *The Forgotten Age,* we agree with the principle that due to the rising age in life expectancy and an ageing population, people will have to work for longer and the State Pension Age (SPA) has to rise.

The Government's intention to reform the BSP is a welcome step forward in reducing poverty among the most vulnerable older people. We agree that the introduction of a flat

6 Department for Work and Pensions, *National Statistics First Release*, London: Department for Work and Pensions [accessed via: http://statistics.dwp.gov.uk/asd/hbai/hbai2010/pdf_files/first_release_0910.pdf (15/06/11)]

7 Fuel Poverty Advisory Group (for England), *Eighth Annual Report 2009*, London: Department of Energy and Climate Change, July 2010 [accessed via: http://www.decc.gov.uk/assets/decc/what%20we%20do/supporting%20consumers/addressing%20fuel%20poverty/fpag/186-fpag-8-annual-report-2009.pdf (23/05/11)]

8 Citizens Advice Bureau, *Consultation on the Warm Home Discount: Citizens Advice response to the Department of Energy & Climate Change*, London: Citizens Advice Bureau, January 2011, p2

rate pension should simplify the system and help people to receive the income which they are entitled to. It is worth noting that these changes will only apply to people eligible for the BSP from 2015/16, not for those already in retirement. This will create a two tier system which will leave a large number of older people relying on the receipt of PCG, which we explore in more detail below.

2.2 State benefits

Although the take-up of core means-tested entitlements like Housing Benefit (HB) has been historically high amongst the older population, a persistent number of people eligible for additional support such as Council Tax Benefit (CTB) and PCG fail to claim them. In 2008/09 non take-up of benefits translated to:

- Between 180,000 and 350,000 pensioners missing out on PCG;
- Between 220,000 to 380,000 people missing out on HB;
- Between 1.4 million to 1.9 million eligible for but not receiving CTB;
- £3.9 billion going unclaimed by pensioners who were eligible for it.[9]

During evidence gathering we identified four major barriers to the take-up of benefits by older people:

- Lack of awareness of the existence and nature of financial support;
- Not being aware of their entitlement to financial assistance as homeowners, or because they have supplementary sources of income such as a private pension;
- The complexity of benefit applications and the overall process;
- The negative attitudes to receiving benefits.

In *The Forgotten Age*, we found that the most innovative model to increase the take-up of core benefits is based on Automaticity, which aims to achieve higher take-up of PCG.

The preliminary findings for the PCG Automaticity pilot are being published this year and the full report in 2012, but the Government has stated that the pilot will remain an information and data gathering exercise on how information already held by the state can be used more effectively; and that it has no plans to introduce the wholesale application of automatic payments of pension credit.

However, we believe that if the findings of this pilot are encouraging, the Government should use this model for full automation of the PCG system. Although the ultimate goal is full automation for people who retired before the flat rate pension is introduced, we recommend the Government introduces automation for pensioners over the age of 80 as an interim measure to ensure that the oldest and most vulnerable people are maximising their entitlements as much as possible. Alternatively, the Government should remove people

9 Department for Work and Pensions, *Income Related Benefits: Estimates of Take-Up in 2008-09*, London: Department for Work and Pensions, 2010; 2009/10 figures delayed by DWP due to new method of calculation. They are due to publish a technical note in summer 2011 and to publish the results for 2009/10 thereafter.

over the age of 80 from the means testing system of PCG and instead they should receive payment of the flat rate pension.

Recommendation:
If the evaluation of Automaticity proves take up has been significantly boosted, the Government should begin a full roll out of automation for PCG. Early prioritisation within this should go to people aged 80 and above.

As we noted above, the proposed changes to the benefits system through the introduction of a flat rate pension would not help those older people who are currently eligible for PCG but who do not claim it. We consider that the state should do more to ensure that the most vulnerable receive their entitlements and we recommend for there to be automatic communication between government agencies to identify when an older person is eligible for PCG, that they do not have to pay council tax and are eligible for HB, and that this is actioned on their behalf.

Recommendation:
There should be automatic communication between government agencies so that when someone is in receipt of PCG, their eligibility not to pay council tax or to receive HB is actioned on their behalf.

2.3 WFP

To help people pay for their energy costs and reduce fuel poverty, the Government's central strategy to boost income has been the WFP. This is estimated to keep 200,000 households out of fuel poverty each year, and is forecast to cost £2.1 billion for the year 2011/12.[10, 11] The Government has stated that the qualifying age will gradually increase in line with the rise in the women's pension age from 60 in 2010 to 65 by 2020.[12]

In *The Forgotten Age* we made criticisms that the WFP is poorly targeted and often not spent on energy costs as intended. A recent report by the Institute for Fiscal Studies found that households on average only spent 41 per cent of their payment on fuel costs.[13] Furthermore, when the WFP was first paid it accounted for over a third of the annual household energy bill, but due to inflation and rising energy prices, the same payment now amounts to less than 20 per cent of the average household energy bill.[14] These pressures will only increase in view of Scottish Power's intention to increase the price of gas by 19 per cent and electricity by ten per cent, as the other energy suppliers are likely to follow suit. This would add a further

10 100,000 households in England, 200,000 in the UK as a whole. Department for Energy and Climate Change, *The UK Fuel Poverty Strategy, 7th Annual Progress Report 2009*, London: Department of Energy and Climate Change, October 2009, p9

11 Hansard, *Written answers and statements*, 26 April 2011

12 *The Social Security (Equalisation of State Pension age) Regulations 2009*

13 Beatty TKM, Blow L, Crossley TF and O'Dea C, *Cash by any other name? Evidence on labelling from the UK Winter Fuel Payment, Institute for Fiscal Studies Working Paper 10/11*, London: Institute for Fiscal Studies, May 2011, p3 [accessed via: http://www.ifs.org.uk/wps/wp1110.pdf (08/06/11)]

14 House of Commons Environment, Food and Rural Affairs Committee, *Energy efficiency and fuel poverty, Fifth Special Report of Session 2007/08*, London: The Stationery Office Limited, 6 November 2008, p72

£180 to the average household energy bill, which from August 2011 is expected to be £1,162 a year.[15, 16] It is time for bold decision-making and a new approach.

To address the falling value of the payment, we urge the Government to link the falling value of the WFP to inflation or increases in energy prices, whichever is higher, to ensure that older people are receiving the help they need. By introducing a 'double lock guarantee' the Government can ensure that the value of the WFP relative to people's energy bills is not eroded further.

Recommendation:
In order to ensure the WFP retains its relative value for recipients, the CSJ calls on the Government to introduce a 'double lock guarantee', whereby the payment is linked to inflation increases or energy price rises, whichever is higher.

Further to acting on the value of the payment, we also urge the Government to take the difficult but necessary decision to end its universality.[17] Evidence from polling commissioned by this review found that a majority of people agreed that the payment should be means-tested and only given to poorer older people.[18] In *The Forgotten Age* we also found that a significant amount of public money is being spent on many older people, who while grateful for the financial boost it brings each winter, do not rely on the payment to make ends meet.

> A majority of people agreed that the WFP should be means-tested and only given to poorer older people.[19]
>
> **YouGov polling for the CSJ Older Age Review, May 2011**

Furthermore, it is inequitable that those on low incomes receive the same amount as those on the highest incomes. We would like to see the savings made by ending the universality of WFP used to increase payments to people on the lowest incomes. This would make a substantial difference for older people who currently enter debt to heat their homes, or are forced to live in dangerous cold.

In restricting the WFP, the CSJ urges the Government to investigate whether there are some practical mechanisms available whereby the payment could be targeted towards older people on the lowest incomes. We believe a number of options could be considered for the implementation of such a system. The Government could introduce a system whereby:

15 ScottishPower, *ScottishPower Increases Gas And Electricity Prices And Launches The Cheapest Product Currently Available*, 7 June 2011, [accessed via: http://www.scottishpower.com/PressReleases_2183.htm (08/6/11)]
16 uSwitch, *ScottishPower price rise announced,* 7 June 2011, [accessed via: http://www.uswitch.com/news/utilities/scottishpower-price-rise-announced-900000029/ (07/06/11)]
17 This was not endorsed by Working Group Member Andrew Harrop, Director of Policy and Public Affairs at Age UK
18 YouGov, *Older Age*, May 2011
19 Ibid

- A two tier system is operational, where those on the lowest incomes would receive a higher payment. Older people who are not eligible for pension credit would receive a reduced fixed amount, with the savings made being used to pay those who are in receipt of pension credit a greater amount.
- The payment is treated as a taxable benefit: older people would pay tax on the payment according to their level of earned or pension-related income. By administering this levy through the tax system the administrative cost would be reduced and the savings made could be invested in increasing the energy efficiency of homes of people living in fuel poverty.
- Or boldest of all, the payment is means-tested and made payable to people eligible for PCG only. This would ensure that the payment is targeted at those who need it the most, however, the Government must ensure that bureaucracy is kept to a minimum and also increase the take-up of PCG.

As well as modelling alternatives to the WFP's universality, we also urge policy-makers to consider how to ensure that the payment is used for its stated purpose – reducing fuel poverty by reducing energy bills. Whilst ending the universality of the payment would bring a natural reduction of its use for such things as Christmas presents or food shopping (highlighted as common uses in *The Forgotten Age*), the CSJ remains concerned that without a clear incentive or mechanism by which people are required to use it for fuel costs or improving their home's energy efficiency, misspending may continue – even by those on lower incomes.

Recommendation:
The Government should end the universal payment of the WFP to ensure that the poorest receive more support.[20]

Recommendation:
The Government should investigate mechanisms of removing the universality of the WFP in order to increase its effectiveness in fighting fuel poverty for the poorest older people. Within these deliberations, we urge policymakers to ensure that it is spent on what it is designed for – fuel costs or improving homes' energy efficiency.[21]

2.4 Social price support

To help people pay for their energy costs the previous Government introduced a three year voluntary agreement with energy suppliers in April 2008 to provide social price support for the fuel poor, which helped an estimated one million people to a discount or a rebate each year.[22] Despite this, there was confusion amongst energy customers about the very existence of social tariffs. Although suppliers committed to providing greater visibility on their social programmes, the majority of their promotions appeared online, thereby excluding the most isolated older people.

20 This recommendation was not endorsed by Working Group Member Andrew Harrop, Director of Policy and Public Affairs at Age UK
21 This recommendation was not endorsed by Working Group Member Andrew Harrop, Director of Policy and Public Affairs at Age UK
22 Ofgem, *Monitoring suppliers' social programmes 2009-10*, Ofgem, 23 September 2010, p11

Since the voluntary agreement has now expired, a new legal obligation to give a discount on energy bills to vulnerable customers has been confirmed in the recent spending review. This new Warm Home Discount (WHD) scheme is replacing the social tariffs that are being phased out, and requires the 'big six' energy companies to give an annual rebate to its most vulnerable customers of £120. Crucially, this rebate will be automatically paid to people in receipt of PCG and it is expected that two million households will receive the WHD.[23]

While the WHD scheme will ensure that the most vulnerable in receipt of PCG will get assistance with paying their energy bills, the CSJ is concerned that those who do not claim the 'guarantee' element of their pension credit will not get this essential support and more should be done to improve the take-up of PCG as we have called for through Automaticity.

3. Planning and advice

Planning for the future can make a huge difference to the quality of an individual's life in retirement. During our evidence gathering it became clear how confusing the plethora of advice offered to older people can be. Thus to encourage and facilitate early planning, we recommend increased clarity in the information provided to older people and that all the information required for successful planning be provided in one place.

3.1 Early planning

It is never too early to plan and prepare for the financial future. It is essential for children to learn early on how to manage their money and understand age-related financial issues, such as health insurance and pensions, to reduce the risk of poverty in later life. We believe that this process should begin at school; young adults should leave education with a sound knowledge of financial planning. Compulsory financial education in schools was due to be taught from September 2011, but the previous Government was unable to secure the necessary legislative change for reform as a result of time constraints.

We call on the Government to respond to the All Party Parliamentary Group on Financial Education for Young People, which aims for compulsory financial education lessons in schools – such a proposal has already been signed by 219 MPs across all sides of the house.[24]

Recommendation:
The teaching of financial education should be compulsory in schools and should incorporate planning for later life, including pensions and health insurance.

23 Department of Energy and Climate Change, Press release 2010/121a, 02 December 2010 [accessed via: http://www.decc.gov.uk/en/content/cms/news/pn10_121a/pn10_121a.aspx (26/05/11)]

24 Personal Finance Education Group, 'APPG on financial education for younger people' [accessed via: http://www.pfeg.org/curriculum_and_policy/appg_on_financial_education_for_young_people/index.html (02/06/11)]

But financial education should not begin and end in schools. People should be encouraged to improve their financial literacy to assist them with saving for retirement no matter what stage of their lives they are at. An estimated 40 per cent of women and 22 per cent of men aged 56 currently have no private pension wealth.[25]

As the CSJ found in *Breakthrough Britain: Serious Personal Debt*, the quality of education in personal finance needs to be improved significantly.[26] This is an area whereby private sector expertise needs to be realised more effectively in order to improve individuals' (crucially, older individuals') financial capability. We believe that with the support of the private sector, serious personal debt in older age could be reduced. For presently, over half of people aged between 55 and 64 don't think they will be debt free by the time they are 65.[27]

The CSJ is concerned, however, about the current lack of provision of private sector initiatives to help people improve their financial literacy. This is due to be investigated further by the CSJ, following on from their original debt report cited above.

Therefore, we recommend that:

Recommendation:
Private sector initiatives to educate both children and adults in personal finance should be encouraged, strengthened and expanded. This should become a core component of the CSJ's work in its second *Breakthrough Britain* report.

3.2 Later life

As we found in the polling results for *The Forgotten Age*, a third of older people thought that the guidance and support they had received approaching retirement was 'poor' and a third said it was 'adequate'. Just eight per cent said it was 'excellent'.[28] Currently, people receive their Basic State Pension forecast four months before their retirement (although this can be requested earlier). By this time, it is too late to make any necessary alternative arrangements.

To help people who have not planned for their retirement, or who are without the means of avoiding poverty in later life, advice needs to be given to ensure that they are able to achieve as high a quality of life as is achievable. Although we encourage people to seek advice as early as possible regarding their pension and benefit entitlement, we recommend that people undergo a free financial health check between the ages of 55 and 60. This should be offered to people automatically.

25 Hansard, Written answers and statements, 10 March 2011
26 Centre for Social Justice, *Breakthrough Britain: Serious Personal Debt*, London: Centre for Social Justice, July 2007
27 Aviva, The Aviva Real Retirement Report Issue Five, March 2011, p4 [accessed via: http://www.aviva.com/data/media-uploads/news/File/pdf/2011/090311_Aviva_Real_Retirement_Report_issue_five_March_2011.pdf (24/05/11)]
28 YouGov, *Attitudes of People over Retirement age*, June 2010

We propose that these financial health checks be carried out by independent organisations that would provide free information and guidance services on financial matters and the receipt of benefits through a network of volunteers. This could be led by local authorities in partnership with advice providers, as we recommend below.

Recommendation:
We recommend that people be offered a free financial health check between the ages of 55 and 60.

In conjunction with the above, we recommend that people are given an updated copy of *Your Guide to Retirement* by the Money Advice Service (MAS) at the same time as the financial health check. This guide gives independent, impartial advice and information to help people in their retirement. This guide is invaluable to those in employment, but the Working Group has serious concerns about those people who will transition into the pension system from unemployment benefits.

To assist this specific group of older people, we recommend that a tailored financial advice guide should be developed. This guide would be modelled on *Your Guide to Retirement* and developed in consultation with the MAS, the voluntary sector, the private sector and local charities. This would ensure that the content addresses the real issues which people face and covers the assistance available from the voluntary sector.

Recommendation:
A financial advice guide should be developed specifically to assist those people who are moving from working age benefits to retirement age support.

3.3 Money advice service

The CSJ believes that the state can play an important role in providing general generic advice to older people alongside the voluntary sector. Also, crucially, by signposting people to local financial advice providers who can often offer information in a more holistic way than large national providers.

The newly launched Government MAS fulfils this essential role.

Case study: Money Advice Service

In January 2007 the Government asked Otto Thoresen to conduct a review of how best to offer a national generic financial advice service. The *Thoresen Review of Generic Financial Advice*, published in March 2008, identified the need for any national service provided to be 'multi-channel' and accessible via internet, telephone, and through face to face meetings.[29] In the foreword to his report, Mr Thoresen highlighted the importance of providing face-to-face guidance 'through trusted local sources, as it will most likely appeal to the least financially confident'.[30]

29 HM Treasury, *Thoresen Review of generic financial advice: Final report*, London: HM Treasury, March 2008
30 Ibid, p I

In April 2011 the MAS was launched by the Government and replaced the online-only service Money Made Clear, the Government's previous advice service. MAS is an independent organisation funded by a statutory levy on the financial services industry. It provides free, unbiased financial advice online and by telephone; crucially it also offers face-to-face meetings for the first time. Later this year MAS also plans to launch an online financial health check to help people develop a personal action plan for their finances and to budget for the future.

The CSJ welcomes this new 'one-stop-shop' and particularly the face-to-face meetings which have the potential to make such a difference to the most vulnerable older people.

3.4 Voluntary sector advice

Although the state should have a responsibility to provide financial advice to people who need it, such as the older people we are concerned with, it would be highly counter-productive to undermine the excellent work of the voluntary sector. Throughout our evidence gathering it became clear that many older people were unaware of the range of advice available.

As the CSJ reported in *Breakthrough Britain,* the voluntary sector is often able to provide information to people in a particularly personalised and tailored way. Such advice can be especially beneficial for older people's financial planning. Such voluntary sector services are, however, facing a number of barriers:

1. The demand for all types of debt advice outstrips the existing provision;
2. The growth in telephone and web-based debt advice, although very necessary, does not replace the ongoing need for the provision of face-to-face advice;
3. Although small independent advisory organisations provide a personal and professional service which responds to local needs, they seldom experience a level playing field when it comes to local government funding.[31]

To overcome these challenges, we would like to see small community-based debt advice services being supported by local authorities, and for partnerships between smaller, specialist agencies and larger providers of advice; this would ensure a broad provision of services which caters to the diversity of older people and their financial circumstances.

Recommendation:
Local community-based debt advice should be supported by local authorities, and partnerships should be encouraged between smaller, specialist agencies and larger providers of financial advice.

One of the larger national advice services that aims to consolidate all financial information in one place is FirstStop, a free national telephone advice service launched in 2008. It provides a 'one-stop-shop' for information on housing, care and support, finance, and legal rights for older people, their families and carers.

31 Centre for Social Justice, *Breakthrough Britain: Serious Personal Debt*, London: Centre for Social Justice, July 2007, p36

Case study: FirstStop

FirstStop advice service was established in 2008 by Counsel and Care, Elderly Accommodation Council (EAC), Help the Aged and NHFA with seed funding from the Big Lottery Fund. FirstStop is run by the charity EAC, and is funded by the DCLG, who on 9 May 2011 confirmed that funding of £1.5 million would be allocated over two years in 2011/12 and 2012/13.[32]

By working with partner organisations such as County and District Councils, Home Improvement Agencies (HIAs) and older people's groups to create a network of local and national partners, FirstStop strives to develop and sustain the vital services that many older people need. It also has a training programme, delivered by Care & Repair England for the volunteers and professionals who work with older people to inform them about the information available.

When an independent evaluation of FirstStop was undertaken by The Cambridge Centre for Housing and Planning Research it found that FirstStop's innovative use of technology created a seamless experience for users. Since its launch there has been a continual increase in users, exceeding the targets which were agreed with the DCLG.[33] It is providing information to 130,000 older people and their families a year.[34]

Mr H

Mr H contacted FirstStop about his grandmother:

'My grandmother became ill and this caused lots of problems. We had always intended to care for her at home... She went into hospital with an infection and whilst there a stomach ulcer burst so she was in bed for six weeks. The nurses at the hospital said they had done all they could and she needed to go into a nursing home. Because she had been bed ridden she couldn't walk unaided and also had become incontinent.'

Mr H's family needed advice on how to cope with this sudden crisis; the emotional and physical burden of caring for their relative was taking its toll on the family:

'We cared for her for two weeks, my mother who is in her 60s, was looking after her around the clock and I helped, stayed overnight etc. It was exhausting; she needed two people to get her out of bed... We didn't want her to go into care but if we had carried on I think my mother would have had a breakdown, it would have torn the family apart.'

Mr H found the advice from FirstStop invaluable in dealing with the complications and frustrations of funding care, and appreciated being able to talk to someone at length via FirstStop:

'I liked the fact I could ring and speak to someone, I spoke to a chap who was extremely knowledgeable and I didn't feel at all rushed. The first call I made we were on the phone for over an hour. It was really good to do that and then back it up with information from their website. The thing about the website is you can't ask questions... They are such a good source. They are clearly the people to speak to – they are so knowledgeable and the service is free.'

32 Department for Communities and Local Government, 'Government to fund housing advice service for older people', 9 May 2011 [accessed via: http://www.communities.gov.uk/newsstories/housing/1896913 (02/06/11)]

33 Cambridge Centre for Housing and Planning Research, *Evaluation of the FirstStop information and advice service for older people, their families and carers*, University of Cambridge, March 2010 [accessed via: http://www.cchpr.landecon.cam.ac.uk/outputs/detail.asp?OutputID=224 (09/06/11)]

34 Department for Communities and Local Government, 'Government to fund housing advice service for older people', 9 May 2011, [accessed via: http://www.communities.gov.uk/newsstories/communities/1896905 (02/06/11)]

Because of the range of advice provided by many different organisations we believe that there is a role for local authorities to help people access this advice. Advice would thus be delivered locally, to nationally set outcomes; with local authorities advising older people as to how they can spend their money better in their local area. Whilst the technicalities of such a system are beyond the scope of this review, we would urge the Government to explore the possibility of local authorities, operating under a Service Level Agreement or contract, partnering with voluntary sector organisations such as FirstStop, to provide information for people on areas such as benefits, housing, care and financial advice. This would streamline advice provision, and thus assist older people's experiences of financial advice.

Recommendation:
The Government should explore the possibility of local authorities (operating under a Service Level Agreement or contract) to partner with different not for profit agencies in order to provide information for people on areas such as benefits, housing, care and finance.

chapter four
Housing and homes

1. Introduction

> 'Many older people are living in conditions which no one in 2011 would find acceptable.'
>
> **Bill Rollinson, Director of Care & Repair Leeds, in evidence to the CSJ**

Any attempt to tackle pensioner poverty in Britain must take into account the complex and crucial housing issues which the poorest face.

The condition of the accommodation an older person lives in plays a huge role in determining their experience of later life. For everyone, a home is more than a roof. It underpins our sense of identity. And for older people, given that people over 65 spend 80 per cent of their time in their homes (and people over 85, 90 per cent),[1] the nature and condition of the houses they live in could not be more important.

In debates on poverty in an ageing society, the housing question has often been overshadowed by those of pensions and care. Yet any genuinely preventative care strategy – any strategy to help the 'oldest old' remain independent for as long as possible – must focus on housing, given how closely linked the loss of control over an individual's living situation is to psychological health and wellbeing.

Our recommendations in this chapter are subdivided into two areas: first, on improving existing housing stock in order to make homes suitable for people to live in as they age; secondly, on building new stock in order to tackle the chronic shortage of affordable homes purpose-built for older people.

1 Adams S, 'What Role for Housing in Health and Social Care Provision?', *Journal of Integrated Care,* October 2008, p2

2. Existing stock: low-income older home-owners

Case study: Mrs Thomas

Mrs Thomas in her home in Leeds

Catherine Thomas, 78, lives in Leeds in a home which she owns. An ex-teacher, she has lived alone since being widowed in her 20s. She has no children and, herself the only child of an only child, no immediate family. When we visited her, Mrs Thomas spoke of the struggles of living by herself in a home she no longer has the income to manage. From the combination of her state pension and a small occupational pension she pays for meals-on-wheels. She has little left over. And having exhausted her modest savings on re-wiring, new taps and a new sink, as she told us, 'I'm down to my last £1,000. There will be no more repairs until more money is forthcoming.' While the bare floorboards and masses of debris (not least, a huge fire risk) revealed a house clearly no longer fit for purpose, Mrs Thomas was adamant that she didn't want to move, nor even contemplate residential care.

Mrs Thomas's situation is not a one-off. She typifies the entirely new social phenomenon we highlighted in *The Forgotten Age*: the coincidence of increased longevity with far higher levels of home ownership.

In 1971 the national level of home ownership was 50 per cent. Today it is over 70 per cent.[2] In large part due to the 'right to buy' policy (with 1.2 million homes sold to former social renters during the 1980s) and unprecedented access to mortgages for lower income groups, older people now occupy 30 per cent of all homes. Yet the majority of these homes

2 Adams S and Ellison M, *A Perfect Storm: An ageing population, low income home ownership, and decay of older housing,* Nottingham: Care & Repair England, 2010, p6

were not designed to be grown old in; and they are now proving unaffordable to repair and maintain.

The result is significant housing poverty among older homeowners. Dry rot, threadbare carpets, rotten windows, leaky roofs, unsafe electrics, old boilers – these all contribute to a house being designated 'non-decent'. As we noted in *The Forgotten Age*, whereas housing standards in the socially rented sector have dramatically improved in the last decade, the same cannot be said of housing standards in the private sector. Currently 84 per cent (3.2 million) of older householders living in non-decent homes live in private sector housing.[3]

The odd one out: while housing standards in the public sector have improved in recent years, private sector housing lags behind.

2.1 The current crisis

In terms of recent policy, a number of distinct developments have conspired to create what is now 'the perfect storm' facing the poorest older homeowners. Seen in isolation, each of the developments discussed below may seem innocuous; viewed together they constitute a crisis.

2.1.1 Loss of private sector renewal

As part of its deficit reduction programme, in autumn 2010's spending review the Government withdrew the Private Sector Renewal (PSR) budget, the major source of national funding for repairs and regeneration of housing in the private sector. Declining from £317 million in 2010/11 to zero since April 2011, this is the first time since 1949 that there has been no central funding for the poorest homeowners. On the ground, the CSJ witnessed firsthand the impact that this has had. Visiting Care & Repair Leeds, the city's main HIA (see case study), we heard about the forthcoming termination of its Home Maintenance Service following Leeds City Council's loss of PSR funding. This

3 Department for Communities and Local Government, *English House Conditions Survey 2007*, London: Department for Communities and Local Government, 2009

service has supported 3,600 of the poorest homeowners in Leeds over the last ten years, carrying out urgent repairs to homes (up to £1,000 worth of work), improving homes' safety and security, reducing hazards, repairing heating systems and improving energy conservation.

2.1.2 The size of an equity release market

The Government has withdrawn this central funding for the improvement of private sector housing in a context where there is currently no real alternative to state subsidies. For even though there are approximately one million older people entitled to pension credit who have properties worth at least £100,000 at present there are few suitable products to draw upon that equity to carry out essential repairs'.[4] In *The Forgotten Age* we explored some of the reasons for this:

- A profound cultural reluctance among older people (often sustained by their families) to consider reducing the inheritance they pass on to family members;
- A reduction in social lending and the cessation of low cost equity release schemes for low income groups (allowing them to access small amounts of their capital);
- A mistrust of equity release products following high profile cases in the early 1990s when, with house prices falling, older people lost their homes when their equity release debt exceeded the value of their property;
- A concern that withdrawing equity as regular income will jeopardise means-tested benefit entitlements.

2.1.3 A Disabled Facilities Grant system in disarray

If repairs are about making a home 'decent', habitable and offering some degree of thermal comfort, adaptations are about making a home accessible for disabled people (and half of all people aged 75 and over are estimated to have a longstanding limiting illness). Adaptations include installing a stairlift, level-access bathrooms and room extensions.

A through floor stairlift

4 Terry R and Gibson R, *Can equity release help older homeowners improve their quality of life?*, York: Joseph Rowntree Foundation, 2010, p1

The main state grant for adaptations is the Disabled Facilities Grant (DFGs), currently administered by local housing authorities. DFGs are currently means-tested on savings up to £6,000 but disregard equity, so that 70 per cent of grants go to homeowners.[5] Introduced in 1990, the aim of a DFG is to adapt a building, up to a current limit of £30,000, to enable a disabled person to live there independently. Though approximately 40,000 grants are made nationally – 70 per cent of which to older people – the truth is that the DFG system has become a disjointed, complex and inefficient beast.[6]

The case study below offers an example of the human cost of the system's inefficiency.

Case study: The Ansari family

Raheem Ansari, 22 (below), is trying to keep his family together. He has been the main breadwinner since his father, 67, had a serious stroke three years ago. Raheem's family – his mother, father, sister and niece – share a small house owned by his father.

Raheem Ansari and his mother at home in Leeds

When the CSJ visited him, Raheem's father, Mr Ansari, was in a hospital bed set up in the kitchen. This makeshift arrangement had been ongoing for 18 months. The 'kitchen' had been moved to the (damp) cellar, where we found Mr Ansari's daughter feeding her newborn baby.

This impasse had been reached because of a disagreement with the Council, ongoing at the time of our visit. Mr Ansari had been assessed as eligible for a DFG. Yet the council's 'preferred scheme' (at a cost of £20,000) proposed the installation of a through-floor lift to enable Mr Ansari to access his upstairs bedroom (Mrs Ansari lifted her husband for months after his hospitalisation but has consequently damaged her back). However, the only space where a lift could be put in (given the miniscule size of the steep staircase) was in the middle of the house's sole living room.

Unsurprisingly, installing this lift was not the solution the family favoured. Putting in such a major installation to the only family room was felt to be severely disruptive to family life. Whenever Mr Ansari wanted to get up and down to his bedroom there would have been disruption to whatever was going on to the heart of the home, shared not just by his wife but by three generations of his family.

5 Foundations, '*Policy Bulletin: Disabled Facilities Grant – Survey findings October 2009*' [accessed via: http://www.foundations.uk.com/previewnewsletter?ref=68 (20/06/11)]

6 Department for Communities and Local Government, *Disabled Facilities Grant Programme: The Government's proposals to improve programme delivery*, London: Department for Communities and Local Government, 2007, p10

The alternative solution devised by a local HIA was to build a small extension onto the back of the house, where there is currently vacant space. This solution has been rejected by the council because it costs £28,000, £8,000 more than the council's solution (though £2,000 less than the nationally-set £30,000 DFG limit).

Mr Ansari in his hospital bed in the kitchen

The problems with the DFG system which we identified in *The Forgotten Age* – the huge delays; the cumbersome process necessarily involving Occupational Therapist assessment; the removal of ring-fencing and concomitant dropping of the requirement for local councils to match the central government DFG allocation 60:40 – have only intensified since we published our interim report in November 2010. For while autumn 2010's spending review retained the DFG funding source (at £169 million annually), other budget decreases (such as PSR) are likely to increase local pressure upon DFG budgets.[7] More recently, the Government has admitted that delays are in effect simply a way of managing demand. A DCLG report published in February 2011 acknowledged that the total amount of money required to cover DFGs for all of those 'theoretically eligible under the current rules' is £1.9 billion, more than ten times the annual budget.[8]

2.1.4 Fuel poor homes

During our evidence gathering we heard about people living in fuel poverty and the need for them to improve the energy efficiency of their homes. As well as the proposals in Chapter Three, we believe that increasing the energy efficiency of people's homes is the most realistic way that people can be taken out of fuel poverty in the long term. The group is

7 Department for Communities and Local Government, *Spending Review 2010: Equality Impact Assessment, Funding for Private Sector Renewal*, London: Department for Communities and Local Government, December 2010, p1

8 Department for Communities and Local Government, *Disabled Facilities Grant allocation methodology and means test: Final report*, London: Department for Communities and Local Government, 2011

concerned, however, that successive Governments have not done enough to incentivise people on low incomes to undertake essential improvements to the energy efficiency of their homes.

A recent report, *The Health Impacts of Cold Homes and Fuel Poverty*, found that:

- Countries which have energy efficient homes suffer less excess winter deaths;
- Cold housing increases the likelihood of suffering an accident or fall at home;
- Older people in cold housing suffer from increased mental and physical health and have higher mortality rates.[9]

2.2 Existing stock: a path to reform

2.2.1 A simple system for adaptations and repairs

The convergence of these various developments has precipitated a crisis. There is therefore an urgent need for major reform to the way that both disability-related housing adaptations and home repairs are funded and administered. In the recommendations which follow we try to chart a path to such reform.

Before outlining specific recommendations, it is important to explain two overarching principles:

1. We believe equity release should be established in the mainstream so that people can release capital to ensure they have a suitable home to live in. In the coming years we should begin to move towards equity release as the default system for those who have been fortunate enough to own a property;
2. We need greater clarity about what the state will pay for in terms of adaptations and repairs.

In broad terms, our central recommendation is that:

Recommendation:
An integrated system should be established for both disability adaptations and home repair. This system should be clear in terms of entitlement and efficient in terms of delivery, hinging upon a central distinction between minor and major 'interventions'. In terms of both repair and adaptations, vital, preventative minor works – i.e. handyperson services, paring down carpets, grab-rails, ramps, or contribution towards disability-related adaptations – should be freely available and universally provided at the local level. (Such a system could thus be free of the current means-testing which makes the system extremely complex to navigate and slow to operate.) Major works, by contrast – whether adaptations such as installing through-floor stair-lifts, room extensions or repairs such as installing new roofs, electrics or heating systems – should increasingly be funded by contributions from homeowners who can afford it, by accessing appropriate amounts of their property's equity.

The creation of such a system would depend upon a number of key developments which we outline in the following sections. They are: (1) the expansion of the equity release market; (2) greater leadership at a local level, with one body responsible for managing the system

9 Marmot Review Team for Friends of the Earth, *The Health Impacts of Cold Homes and Fuel Poverty*, London: Friends of the Earth, May 2011, p9

and working with HIAs to do so; (3) a carefully-managed transitional period which ensures that the most vulnerable homeowners are not left behind; (4) the development of insurance products; and (5) the creation of an ongoing, carefully prescribed exemptions fund.

2.2.2 Expanding the equity release market

Economic and demographic factors have, in our view, made it unsustainable to give extensive subsidy for either adaptations or repair to those with high value property. However, the clear alternative to public subsidy – i.e. people being able to draw upon capital from their homes – is not a viable option for many low income homeowners because the way that equity release is currently constituted is often inadequate and unattractive.

There is lively debate about the reasons for poor rates of equity release take-up in Britain. Some people we have met cite a cultural aversion within families for older people to access equity in a property whose mortgage has now been paid off; others argue that providers of equity release products cannot be trusted; yet others criticise features of individual products like high interest rates (this is particularly significant for the poorest homeowners).

In recent years various attempts have been made to overcome the obstacles to equity release we cited in *The Forgotten Age*. Safe Home Income Plans (SHIP) has been launched as a direct response to the growing need for consumer protection. Representing 90 per cent of providers in the equity release market in terms of volume, SHIP's members include the leading providers of lifetime mortgages and home reversion plans. Furthermore, certain charities have developed products specifically designed to allow older homeowners to extract small amounts of equity from their properties. The most prominent of these products we encountered are highlighted below.

Case study: The Home Improvement Trust's Houseproud scheme

The Home Improvement Trust (HIT) is a not-for-profit organisation established in 1997 with the support of what is now DCLG. The HIT works with over 100 local councils, as well as their HIAs, to make it possible for low income, older homeowners to release equity from their homes in order to undertake essential repairs, improvements, and adaptations.

As Houseproud is a partnership, local 'on the ground' assistance is provided by the council and/or their HIA. Thus, after consultation with a local case worker, if an older homeowner then chooses equity release, the HIT sets out the various loan options; arranges a property valuation; selects a trusted Financial Services Authority-regulated loan provider (who will provide loans as small as £3,000 and will also offer a no-repossession guarantee and no negative equity guarantee); and once all legal work has been completed then arranges payments to contractors upon completion of the work.

Under the Houseproud scheme three sorts of loans are available:

- Capital and Interest Repayment Loan: Equivalent to a straightforward mortgage, under this option a client's monthly repayments cover both the interest and part of the original amount borrowed (the capital).
- Lifetime Interest-Only Loan: With this loan a client continues to make monthly interest payments until the property is sold. When that happens, however, only the actual amount borrowed (e.g. the original £10,000) is repaid.
- No Service Loan: Under this option a client isn't required to make any regular payments. Instead the amount borrowed and the accumulated interest is repaid when the property is sold.

As they told the CSJ, the HIT explicitly provides information in accordance with FSA stipulations showing the cost of a 'no service loan'. This is because of the way that interest compounds under this loan type. However, the decision to proceed or not is always determined by the client and their financial circumstances. Depending on the length of the time before the property is sold, this inevitably erodes the remaining equity in the property as compounded interest (at current interest rates of 5.74 per cent) means that the loan size roughly doubles every ten years.

Although not government backed the HIT's Houseproud scheme dovetails into government policy by introducing finance from the private sector. Support for the scheme comes under 'localism' because local councils promote the product. For those older people in receipt of either income support or pension credits and using equity release to fund 'essential works' the DWP may subsidise the monthly interest payments on the loan. With interest rates currently charged at around five per cent, the DWP may contribute up to 3.63 per cent (and, though it has not been officially stated, there is an expectation that DWP may pay more if/when interest rates rise).

Debbie

The windows and doors of Debbie's house were wooden, single-glazed and rotting. Prompted by an advert about the Houseproud scheme she saw on the bus, Debbie, 60, contacted the HIT and, after discussing options with a council case worker and her family, she selected the Interest Only Loan option. Being in receipt of pension credit and with the type of repair she needed deemed 'essential', Debbie was eligible for assistance on her monthly interest payments from the DWP. When the loan process was completed, builders (supervised on-site by the council technical officer) replaced and fitted UPVC double glazed windows and doors.

Case study: Joseph Rowntree Foundation's Home Cash Plan

In *The Forgotten Age* we referenced the Joseph Rowntree Foundation's (JRF) innovative work on equity release for older home-owners who may be 'cash-poor, asset-rich'. Since our interim report the CSJ has consulted the JRF and others involved in the pilots and heard how one equity release provider, Just Retirement, stepped forward and undertook to:

1. Develop the new product using no public subsidy;
2. Create a product allowing older people to draw small amounts of capital (a minimum initial drawdown of £5,000 – but subsequent payments can be as low as £2,000 – with a maximum facility of £30,000), and to do so 'as and when' (rather than at pre-determined points, in order to comply with pension credit rules).

Under the Home Cash Plan, instead of ongoing monthly repayments of capital/interest, interest is 'rolled-up' and taken off the property when it is sold (with interest compounding at about seven per cent) together with the total amount that has been drawn. The Home Cash Plan was developed in consultation with the DWP to ensure that the product has little or no adverse effects on benefit entitlements, in particular pension credit.

Just Retirement's Home Cash Plan has been piloted in partnership with three local authorities in England: Kensington and Chelsea, Islington, and Maidstone Borough Council. Just Retirement Solutions provides financial advisers to talk to interested homeowners about their circumstances and to assess whether equity release is the right option – including checking benefits and considering all other options, such as downsizing. This advice has to be objective, is provided with no obligation, and an administration fee is only charged if an equity release plan is subsequently taken out. JRF is undertaking an independent assessment of the success of the plan. Interim findings will be available by autumn 2011.

Yet despite the development of these products over a number of years, reports of their take-up remain low and their coverage patchy. A fully competitive and accessible market is yet to emerge as only minimal volumes of low income older homeowners have drawn upon such schemes.

Accordingly, any future expectation that older homeowners be required to release capital to fund major adaptations and significant repairs depends upon the development of a proper equity release market, to run alongside the revamped universal system for minor adaptations and repairs we have called for.

Any kind of reform must begin with a challenge at all levels to the cultural aversion to older homeowners using equity release to improve their quality of life and housing.

> The majority of people the CSJ polled believe that homeowners should make a contribution towards essential adaptations to allow them to continue to live at home.
>
> YouGov polling for the CSJ Older Age Review, May 2011

The 'aversion' to reducing one's asset, as we found throughout our evidence gathering, is expressed by many older homeowners but often sustained by their families. 'It's appalling,' one HIA Director told the Working Group. "People think of their parent's houses as their legacy. They think, 'You're spending our legacy.'" And tragically, these decisions are often taken at the expense of their parent's health.

The wider expansion of equity release products (by government and others) needs to be underpinned by a cultural 'sea change' in society's attitude towards people in later life drawing upon capital to fund lifeline housing repairs. 'Mum and Dad's care needs to come first', as someone put it to us. It may sound strange to say, but we need to encourage in society a more consumerist attitude towards later life. It is tragic that many older people have to live out the last years of their lives in houses falling around them solely because they are trying to preserve the inheritance they pass on to their children. While for some older parents we recognise that this is a genuine choice, we have heard that there are others who may feel forced by convention to sacrifice their health and their living conditions for the sake of bequeathing an asset to their children or family. As housing expert Janet Sutherland told the Working Group,

> *'A lot of what we need to do is to change people's attitudes. Instead of thinking that the capital they have built up is completely sacrosanct and can't be touched, we actually need to be a bit more relaxed about our thinking.'*

Underpinned by this broader cultural sea change, we recommend that:

Recommendation:
The Government gives greater profile to specific products developed to allow low income older homeowners to release equity. Each local authority should increase its promotion of a range of existing and future equity release solutions.

Recommendation:
Given the relative underachievement of the market to date, we believe the Government may need to consider direct market stimulation in order to redress a lack of take up. Such action, which should be a time-limited interim measure, could begin to drive up the competition of product offers, including making interest rates more affordable.

2.2.3 New local leadership

We have mentioned above that the problem with the DFG system is not only money but process. 'The system is an utter mess', as one private sector building contractor told the CSJ. It can take months for a lifeline adaptation to be installed into someone's property. Delays in assessment and the lack of joined-up working between local housing authorities which commission work and the HIAs which often project-manage it – all of this adds time. In addition, we have cited concerns that DFG funding, now devoid of a ring-fence at a local level, is not reaching those older people for whom it was intended.

To combat this problem it is crucial that greater leadership is taken at a local level for the effective administration of any new system for repairs and adaptations. Given the well-established connection between health and housing, we therefore recommend that:

Recommendation:
Local councils' new health and wellbeing boards, if forthcoming, should take responsibility for the delivery of this new integrated system for repairs and adaptations.

The shift of responsibility for this new system away from housing authorities (located, in two-tier authorities, at district level) to health and wellbeing boards at upper-tier and unitary local authorities could have a number of beneficial consequences. The new integrated system for repairs and adaptations would be:

- **Financially protected:** in its November 2010 public health White Paper, *Healthy People, Healthy Lives*, the Government announced its intention to transfer the public health functions of Primary Care Trusts (PCTs) to upper-tier and unitary local authorities. Crucially, under current plans, the budgets allocated by central government to these new health and wellbeing boards would be ring-fenced, demonstrating that even in an era of localism some political priorities are important enough to protect at a local level.[10] Making a new, integrated DFG/repairs system a primary responsibility for health and wellbeing boards would thus involve restoring the ring-fence on DFGs and thereby protecting its budget.
- **Consolidated:** during our evidence gathering we have heard that some upper-tier local authorities are already planning to consolidate the DFG system. One county council shared with us its plans to persuade district councils to relinquish their current administration of DFGs. With the multiple districts in that county receiving

10 HM Government, *Healthy Lives, Healthy People: Our Strategy for Public Health in England*, London: The Stationery Office, 2010, p8

a combined number of 900 DFG applications annually, the county council believes it can improve both efficiency and timescales if one county-wide team deals with that end-end process. If the DFG system was enlarged to include delivery of minor repairs as well as minor adaptations, making that system the responsibility of health and wellbeing boards would achieve exactly this kind of consolidation.

- **Faster:** with a system streamlined into minor repairs and adaptations (provided free) and major ones (funded by equity release), health and wellbeing boards should be expected to turn around the former far quicker (i.e. within a four week period). Though decisions on actual delivery would be discretionary at a local level, it would be hoped that the new boards would turn to HIAs such as Care & Repair due to the person-centred approach which the CSJ witnessed on a visit to Leeds.

Case study: Care & Repair Leeds

Care & Repair Leeds, the city's HIA (est. 1986) reaches approximately 13,500 low income older homeowners a year. 'The general assumption that the poor only live in social housing is a fallacy', Director Bill Rollinson told the CSJ on its visit to Leeds; '70 per cent of older people live in private sector housing and many poor older people live in very poor housing which may be cold, damp, unsafe and completely inadequate for disabled people.'

The 'home improvement' Care & Repair offers and organises has nothing to do with extending the conservatory 'to let in a bit more light', nor with changing the carpet schemes to fit in with a new colour scheme. The kinds of services they provide – a handyperson service; a home maintenance service (mentioned above) to put roofs on currently 'uninhabitable' houses; a disability adaptations scheme; a falls prevention service; a housing choices service; a project targeting the city's 19,000 back-to-back houses (with their punishingly steep stair cases and narrow door-frames) – in many cases make the difference between an older person coping and not coping at home. In Rollinson's view, 'Home Improvement Agencies' should really be named 'Independent Living Agencies.'

Care & Repair Leeds is a charity and exhibits many of the traits of a dynamic charity: case workers who go the extra mile, becoming relentless advocates of their clients' best interests; always starting off with the person's needs rather than charging in and imposing pre-ordained solutions; always on the lookout for how they can link that person in with other services.

Much of the work they carry out is genuinely preventative. For example, one client the CSJ interviewed, Mrs Archibald, 74 (pictured) lives in a back-to-house with its notoriously steep double staircase. Before coming into contact with Care & Repair, at huge risk of injury, Mrs Archibald was forced to clamber up (and then slide down) the stairs on all fours. Disinclined to move into more suitable accommodation ('I like it here. I've been here for donkey's ages') all Care & Repair did was to fit grab-rails on her staircases. Yet, as Mrs Archibald told us, 'I wouldn't still be here if it weren't for them.'

Another key aspect of their work is to act as a trusted intermediary. Before she was contacted by Care & Repair, Joan's house was unsafe – in need of re-wiring and new gas piping – and in a serious state of disrepair. Care & Repair supplied her with a list of 'approved providers' for the £5,000 worth of work required, and then reviewed the quotes she was given. As she told us,

'Care & Repair have been marvellous. I can't speak too highly of them. When you're elderly you're vulnerable to cowboy builders. One man arrived at my doorstep and said he'd returned to cut my trees as I'd asked. As there are no trees on my property I knew it was a complete scam. But were I senile I would have believed and paid him.'

Abul, a case worker at Care & Repair, speaks of the squalor in which many older homeowners live. Despite the number of people Care & Repair reaches annually, he believes that it barely scratches the surface of need. 'There are so many more people we can help', he insisted; 'but we barely advertise because we have so much work on… when you're allocating money and making policy you need to see the real side.'

Before Care & Repair fitted these grab-rails Mrs Archibald was forced to climb up and slide down her staircase on all fours

2.2.4 The importance of the transition period

Alongside expanding the equity release market and greater leadership at a local level, a third 'deal-breaker' for any new system of repairs and adaptations is the importance of a transition period. A great deal of consideration needs to go in to how we make the shift from the inefficient system we have today to any new, more integrated system.

For this reason, in terms of repairs, we urge the Government to reconsider the removal of the PSR budget during autumn 2010's spending review and look at ways to phase out this scheme whilst phasing in new alternatives in the form of equity release. In the Equality Impact Assessment which accompanied this cut, DCLG cited this justification: 'It is the view of the Government that owner occupiers are primarily responsible for the upkeep of their own properties.'[11] While in principle we agree that those fortunate enough to own their own houses should be expected to make a contribution towards renovation of those properties, for the Government to make this argument at a time when the equity release alternative is virtually non-existent has consequences that could adversely impact the lives of many older vulnerable members of our society.

In a similar way, to address the lack of options presently available to people, and to ensure the safety and health of many vulnerable older people, we recommend that:

11 Department for Communities and Local Government, *Spending Review 2010: Equality Impact Assessment, Funding for Private Sector Renewal*, London: Department for Communities and Local Government, 2010, p1

Recommendation:
As a temporary measure the Government should immediately restore funding for PSR. This funding stream should then be phased out gradually in line with the expansion of a proper equity release market for low income homeowners giving them the real choice of safely drawing upon their capital to fund major repairs and adaptations.

Secondly, in terms of disability adaptations, we have highlighted the chronic inefficiency of the current DFG system and quoted the DCLG's recent acknowledgment that the annual budget of £169 million would need to be ten times larger simply to cover everyone 'theoretically eligible under the current rules.' For this reason we believe that in the future any workable, more responsive system should involve a universal, non-means tested state contribution for adaptations – whether ramps or minor works or via a contribution to more major works – while major adaptations are increasingly funded by homeowners able to withdraw small or large amounts of capital from their homes where it is fair for them to do so. Given this aspiration, however, the importance of a transition period is again crucial. While we transition towards such a system, in the immediate future, to make the DFG system more manageable and faster within the current budget, we recommend that:

Recommendation:
The maximum threshold for a means-tested DFG should be reduced from its current level to the average value of a grant: £6,500.[12] As equity release becomes more of a genuine and mainstream option (allowing homeowners to withdraw even small amounts of money for adaptations) DFGs should be reduced down further to the universal contribution level, which should be determined on the basis of extensive consultation by the Government.

2.2.5 The development of insurance products

As we have stated before, we are publishing this review ahead of the eagerly anticipated findings of the Dilnot Commission on the Funding of Care and Support, established by the current Government upon its arrival in office. We have said that on the basis of the findings of this Commission, it is vital that the Government takes its once-in-a-generation opportunity to reform the care system in this country. Though the report has not yet been published, from what Dilnot and others have already indicated, many expect that the Commission will propose some sort of insurance scheme which is, at its extreme ends, government backed.

The proposal we have outlined above – the creation of a single system according to which, for both adaptations and repairs, minor works are universally provided while major works are funded through equity release – needs to be put in the context of the likely Dilnot proposals. If the Commission does recommend a 'cap' on care spending, so that if an individual incurs 'catastrophic' costs (of say £50,000) the state will step in to help them financially, any major disability-related adaptations which an older homeowner releases equity to pay for (e.g. £30,000 room extension) could conceivably be 'counted' as a care cost. Thus while an asset-

12 Adams S and Ellison M, *Time to Adapt – Home adaptations for older people: The increase in need and future of state provision*, Nottingham: Care & Repair England, September 2009, p8

rich individual might release equity in the present, they would do so in the knowledge that they might have to pay less towards their care costs later on.

2.2.6 An exemptions fund

A crucial priority in the establishment of any new system of repairs and adaptations needs to be continued financial support for those unable to make any contribution to required work on their property.

To recall, we are proposing a two-tier system where minor works – both in terms of adaptations and repair – are universally available free of means-testing. This will ensure that a system is faster, more responsive in making those small key, preventative interventions which our evidence gathering suggests make such a difference to older people's lives. In terms of the poorest homeowners and tenants, then, this service will be free to them because it is free to all.

In terms of important major works, however, we propose that these (both repair and adaptations) should increasingly be funded by equity release. In terms of adaptations at least, this would involve a change to DFG system so that it takes into account a person's equity as it (currently) does their savings.

In thinking through this proposal, however, many have brought to our attention the special case of homeowners of low value homes. Therefore, whilst it might be fair to expect a homeowner of a house worth £200,000 to release equity to fund a house extension worth £20,000 or a new roof worth £15,000, to expect the same from someone whose ex-council flat has halved in value since the recent recession seems impractical.

In light of this concern, we therefore recommend:

Recommendation:
The creation of a small emergency and exemptions fund, particularly designed for those with low value homes.

This would ensure that the poorest homeowners would not be left behind by a current system and that policy is alert to the effects upon the poorest of any potential shifts in housing prices and inevitable regional variance in property values.

2.2.7 Improving energy efficiency

The previous Government's strategy to increase energy efficiency since 2001 was the Warm Front scheme, which has provided grants to help people in receipt of certain income related benefits and whose homes are poorly insulated and in need of heating and insulation improvements to improve their fuel efficiency. Although the scheme and its predecessor scheme have been allocated more than £2.6 billion, it has been criticised for being inadequately targeted on the fuel poor.[13] Funding for the Warm Front scheme is being

13 House of Commons Library, *Energy Bill [HL] Research Paper 11/36*, 4 May 2011, p9 [accessed via: http://www.parliament.uk/briefingpapers/commons/lib/research/rp2011/RP11-036.pdf (01/06/11)]

phased out over the next two years to be replaced with the Green Deal, the Government's new strategy to improve the energy efficiency of people's homes.

The Green Deal is aimed at enabling householders to improve energy efficiency in their homes by helping them to fund major energy investments through a 'pay-as-you-save' scheme and is expected to be available to customers in 2012. A third party provides the funding by way of an interest-bearing loan against the property for the improvements, which the household repays through the reductions in their energy bills. The 'golden rule' of the scheme is that the cost of the installation payments should not exceed the savings on a household's energy bill for the life of the loan, which can be as long as 25 years.

However, the CSJ has heard concerns that the Green Deal will benefit only middle and high income households and not those in fuel poverty – people who under-heat their homes will not see as much benefit as those who use too much energy. Furthermore, because the interest rate for the loan is not fixed, if interest rates rise then any savings to be made could be wiped out. This 'golden rule' could also fail due to unforeseen circumstances such as the death of a partner, which would then mean repayment of the loan on a reduced income.

The CSJ considers that the Government should offer incentives to people who could take advantage of the Green Deal to make it into a real long-term strategy which can have a positive impact on people living in fuel poverty. To help take away some of the uncertainty and increase the uptake of the Green Deal, the Government should consider promoting a fixed rate loan in order for older people on low incomes to have the certainty to enable them to budget for the future costs. We would also like to see a benefit check, which was part of the Warm Front scheme, reintroduced to ensure that all older people applying for a loan are receiving all the benefits they are entitled to.

Recommendation:
We recommend that the Government considers promoting a flat rate interest bearing Green Deal loan. We also suggest that people who apply for Green Deal loans should automatically be referred to a provider who offers benefit checks to ensure that they are receiving the support they are entitled to.

In addition to the Green Deal, the Energy Company Obligation is a new strategy due to begin in 2012 which targets people in fuel poverty, the vulnerable and people who are living in 'hard to treat properties', (i.e. properties with solid walls). Whilst we welcome the emphasis on targeting those most in need, details for this obligation have not been announced; the current Minister of State for Energy and Climate Change has stated 'I fully expect a far greater level of resource to be brought to bear on the fuel-poor than was previously the case under the carbon emissions reduction target or Warm Front'.[14]

We believe that in order to make a real difference to people's homes, the Government should prioritise and facilitate increasing homes' energy efficiency.

14 House of Commons debates, *Energy Company Obligation,* 19 May 2011 [accessed via:http://www.theyworkforyou.com/debates/?id=2011-05-19b.477.5 (02/06/11)]

3. New stock: building for the future

At present the housing market in the UK simply doesn't reflect the types of choices older people aspire to. As well as the huge number of problems with existing stock, there is a serious shortage of new housing specially designed for older people, whether 'specialist' or 'non-specialist' (for definitions see below). Given the demographic projections, the glacial pace of new development of housing particularly suited for older people suggests that, as a country, we are sleeping walking into an ageing society. Even in today's challenging economic climate, building affordable new homes for older people must become a far greater priority for both central and local government, if policymakers are serious about securing Britain's social and economic future.

We are well aware of the national shortage of housing in this country. But there is also recognition that housing designed for older people is particularly scarce. The National Housing Federation (NHF) has argued in its recent *Breaking the Mould* report:

> *'Local authorities, housing providers and other local place-shapers have been working to address the issues presented by our changing demographics, but progress has not been able to keep pace with the increasing needs of the population. The pace of change in demand and need has constantly outstripped the changes in the volume and design of housing and services.'*[15]

As the NHF goes on to say, what we urgently need in this country is a diverse housing market for older people. In simple terms this means lots more of everything (i.e. a variety of different types of housing). The recommendations which follow identify ways in which we as a society can make a concerted effort to build more of both specialist and non-specialist housing for older people, and respond to the pressures of our ageing population.

In terms of definitions, 'specialist' housing we describe in the box below. By 'non-specialist', however, we refer to mainstream housing which has been specifically designed with older people in mind. It will be accessible; located in a desirable position; built according to Lifetime Standards (e.g. entrance-level bedrooms, space for convenient movement in hallways, rooms and through doorways, potential for future provision of grab rails) and perhaps also incorporating the key design features set out by the well-respected 2009 Housing our Ageing Population Panel for Innovation report:[16]

- Generous internal space standards;
- Windows which allow plenty of light;
- Adaptability and care ready design;
- Shared facilities for residents to meet;
- Energy efficiency and sustainable design.

15 National Housing Federation, *Breaking the Mould: Re-visioning older people's housing*, London: National Housing Federation, 2011, p7

16 Homes and Communities Agency, *Housing our Ageing Population Panel for Innovation*, London: Department for Communities and Local Government, 2008, p38-9

What is 'specialist' housing?

1. **Sheltered housing – 407,000 units nationally**
   In terms of provision, 'sheltered housing' dominates the specialist housing sector. Sheltered housing expanded greatly during the 1960s to 1980s. Today, however, as we acknowledged in *The Forgotten Age,* much of it is in poor condition and inappropriate for older people to live in. Half of the stock is over 30 years old, half include bedsits and much is considered hard to let.[17]

2. **Retirement housing – 106,000 units nationally**
   While sheltered housing has typically been rented, retirement housing is typically purchased on a lease-hold basis and found in specially designed blocks of apartments which have communal facilities, house managers and other networks of support integrated within them. Though these blocks of apartments are designed specifically for older people, they are typically located in city centres so as to avoid 'ghettoisation'.

3. **Extra Care Housing – 30,000 units nationally**
   Extra Care is sheltered housing with on-site care facilities. where everyone has their own front door. Despite the great outcomes reported by residents, both owners and tenants, the total amount of stock is minimal.

3.1 The use of the state grants

In an era of reduced government expenditure, it is clear that we need to look increasingly to the independent sector to provide new housing. The capital grants Government has allocated for new affordable homes has significantly diminished, and so how the remaining £4.5 billion is used is of vital importance.

The Homes and Community Agency (HCA), responsible for administering the National Affordable Housing Programme, allocates capital grants mainly to housing associations in partnership with local authorities to develop housing to be made available at social rents. During the last spending review period (2008-11) the HCA distributed £513 million to build approximately 9,000 new units of specialist housing for older people.[18] However, given the total size of the National Affordable Housing Programme over that period (£8.4 billion) we do not think that was enough. As many experts emphasise, spending on new homes specifically designed for older people not only enables greater choices for older people; it also frees up much-needed family housing.

For this reason, our recommendation is that, over this current spending review period:

Recommendation:
A greater proportion of the capital grants the Government makes available to build new affordable homes needs to be allocated to housing specifically designed for older people, whether in the mainstream or specialist sectors.

17 Homes and Communities Agency, *Vulnerable and Older People Advisory Group,* London: Homes and Communities Agency, 2010, p22
18 Homes and Communities Agency, *Vulnerable and Older People Advisory Group*, London: Homes and Community Agency, 2010, p34

So far in 2011 the HCA has given little indication of what proportion of its funding it intends to make available for housing specifically designed for older people. In our view it is crucial that government takes a strong lead in prioritising the development of purpose-built housing for older people.

3.2 Towards a 'yes culture': reform of the planning system

Despite the considerable shortage of new housing for older people and its clear benefits reported, throughout our evidence gathering we have heard that at a local level planning authorities (essentially the 'gate-keepers' of development) often fail to recognise its value. The CSJ has heard from both social landlords and commercial outfits of councils' frequent hostility towards them, and the cumbersome planning processes which paralyse market activity.

For example, in evidence to the CSJ, McCarthy & Stone, provider of 70 per cent of private retirement housing in the UK, said that over half of its developments are only permitted on appeal because agreement could not be struck with the local planners first time round.[19] Without any kind of overall strategy for older people's housing, too many planning authorities treat each application on an isolated, case-by-case basis, with no real understanding of what provision is needed in their locality.

Compounding this problem, in two-tier authorities there is often a lack of communication between planning departments (located at bottom-tier authorities) and the Adult Social Services departments (located at upper-tier) typically more aware of the need for new types of specialist housing for older people. One County Councillor with a portfolio for adult social care told the Working Group:

> *'We [the County] have all the cost pressure and statutory responsibility. They [the Districts] have the planning permission.'*

What is urgently required, therefore, is a shift towards a real 'yes culture' among planning authorities. Central government needs to prioritise new homes purpose-built for older people through the way it allocates grants. But so too does local government. And it should start by facilitating a far less prohibitive planning process.

In terms of making steps to change this culture, we recommend first that:

Recommendation:
Through the 'ground rules' it sets for planning policy, central government needs explicitly to include older people's housing within its priorities.

Since the Government took office in May 2010, national housing policy has been determined in large part by its distinctly localist agenda. The Government wishes increasingly to devolve decision-making, on housing as well as other key issues, to a more local level. To this end a major review of current planning policy has been commissioned, to form the basis of a single National Planning Policy Framework (NPPF). This review, set to be published in the summer

19 McCarthy & Stone, Policy Statement: *Housing and Care for an Ageing Population: An Opportunity to Plan for an Ageing Population*, Spring 2011 [accessed via: http://www.mccarthyandstone.co.uk/images/stories/pdf-documents/McCarthy-Stone-Policy-Statement.pdf (14/06/11)]

of 2011, promises to reduce tomes of planning regulations down to a 'concise', 'user-friendly' and 'accessible' framework which will then constitute the main vehicle through which central government 'nudges' local planning priorities.

Given its likely influence, the NPPF needs to makes explicit reference to housing for older people. It is vital that the Framework takes into special consideration the realities of an ageing population so that, at a local level, all planning authorities who consult it are without any doubt as to what their priorities should be.

In terms of planning policy, national recognition is not all that is needed. Above all it is vital that local planning authorities gauge both the benefits of specialist housing as well as the demand for it. Only then will we start to see more developments, in prime locations, of the kind of new homes which are so desperately needed.

To galvanise planning authorities into action, the CSJ recommends that:

Recommendation:
All planning authorities should be required to produce an older person's housing strategy based on their assessment of predicted demand in their area.

At present, providers of specialist housing report that it is far easier to obtain planning permission for a particular site when the requisite council has developed local intelligence on the needs of its area. Requiring local planning authorities to have an older person's strategy is one way of increasing this awareness, given that at present only an estimated half of all planning authorities have specific strategies for older people.

3.3 'Last time buyers': making retirement homes affordable

As we noted in *The Forgotten Age*, despite the often negative public perception of specialist or retirement housing, older people actually living in this type of accommodation report its clear benefits. They include:

- Dedicated on-site support;
- More plentiful social networks;
- A safer environment;
- Readily available repairs and maintenance.

At present, however, this type of suitable housing is unaffordable for many older owners with (relatively) low equity, the current values of their homes being less than the 'asking price' of an apartment in specialist accommodation. (Between 2007 and 2010 the average value of the previous dwelling of older homeowners moving into McCarthy & Stone retirement apartments was just under £220,000.)[20] For example, say an older couple wished to sell an

20 Ball M, Blanchette R, Nanda A and Wyatt P, *Housing markets and independence in old age: expanding the opportunities*, Reading: Henley Business School, 2011, p28

ex-council flat, outside of the South East, currently valued at £60,000, even if they owned it outright they would still not have sufficient equity to buy a retirement apartment.

As Professor Michael Ball of the University of Reading noted in his recent report, *Housing markets and independence in old age: expanding the opportunities:*

> *'Millions of elderly homeowners who have saved, purchased and paid off mortgages are ineligible for owner occupied retirement housing because for them it is unaffordable.'*[21]

In his report Professor Ball blames this problem on the minimal amount of retirement housing in the UK. Not only are there only 106,000 units of retirement housing (representing only two per cent of the total number of homes for those aged 65 and over) but the pace of development is currently very slow – approximately only 4,400 units are brought on-line a year. [22, 23] It is this lack of supply which keeps prices high and prevents 'millions more of the elderly to contemplate this as a lifestyle.'[24] The key question, therefore, is how the supply of retirement housing can be increased, so that poorer homeowners can enjoy the benefits enjoyed by their wealthier counterparts.

Having heard calls from developers to ease the Section 106 stipulation, we believe that temporarily making retirement housing exempt from the presently required affordability contributions (which essentially seek to secure money and/or a proportion of the development for social use) could be needed in order to change the market in the short term and offer choice. But this contested theory needs investigating for likely outcome and impact. Therefore, as part of a package to offer more choice and affordability for older people, we recommend:

Recommendation:
An independent impact assessment should be carried out for a proposed pilot of a time-limited period to suspend Section 106 affordability contributions required of retirement developments.

This would assess two things: first, whether such a suspension would encourage and deliver more developments and new builds as providers claim; secondly, the projected take-up of older people in such circumstances.

3.4 Extra Care housing

Throughout our evidence gathering for this review, the CSJ has seen firsthand the promise Extra Care housing holds for older people with care needs to maintain their independence for as long as possible. Extra Care (essentially, sheltered housing with on-site care facilities) is specifically designed to allow for independent living. Residents live in their own flats and have their own front doors. But care staff, located in the building, are available 24 hours a day. And not only is care always on hand; it can also be 'flexed' – available as and when someone needs it.

21 Ibid, p29
22 Ibid, p4
23 Ibid, p5
24 Ibid, p5

The promise of Extra Care: a facility with care on-site, yet with your own front door

Residents from a number of Extra Care facilities we visited across the country spoke of the distinct benefits of this form of specialist housing. For example, Olive, 80, moved into Cullum Road Extra Care scheme, Bury St Edmunds ten years ago. Recently widowed, Olive had been in hospital for a year and her daughter was struggling to look after her at home. 'I couldn't believe the size of the room', she told the CSJ on its visit to Suffolk. 'I was able to take my furniture with me.'

Furthermore, again anecdotally, we also heard of the real alternative Extra Care can be for those struggling to cope with the onset of care in general needs housing. After his wife suffered a stroke, and dealing with the onset of care needs himself, Dick and his wife moved into Pantiles House, an Extra Care facility in Wimbledon run by Housing 21. With the extra support the facility provides, Richard has actually seen his wife's care needs decrease. At their previous home she had been in receipt of a care package of 7.5 hours a week; now it has gone down to 4.5 hours. 'Without this place and the way it's run I'd be up the creek', he told us.

Despite the clear benefits of Extra Care housing and the distinct need it caters for, its pace of development, as Richard Humphries, senior fellow of the King's Fund, told the CSJ, has been 'glacial'. At 30,000 units, it constitutes a tiny percentage of the specialist housing in this country. The CSJ believes that as a country we have not yet delivered upon the promise of Extra Care.

To make Extra Care a real choice for far more people, we don't just need a more efficient planning system. Our recommendation is that:

Recommendation:
Councils need to take the initiative to bring on-line a greater supply of specialist housing such as Extra Care. In an era of reduced capital expenditure by government, councils need to consider other ways of developing specialist housing products such as offering land and asset transfer arrangements.

We encountered an example of this kind of proactive lead in the commissioning strategy developed by Hertfordshire County Council since (HCC) 2007.

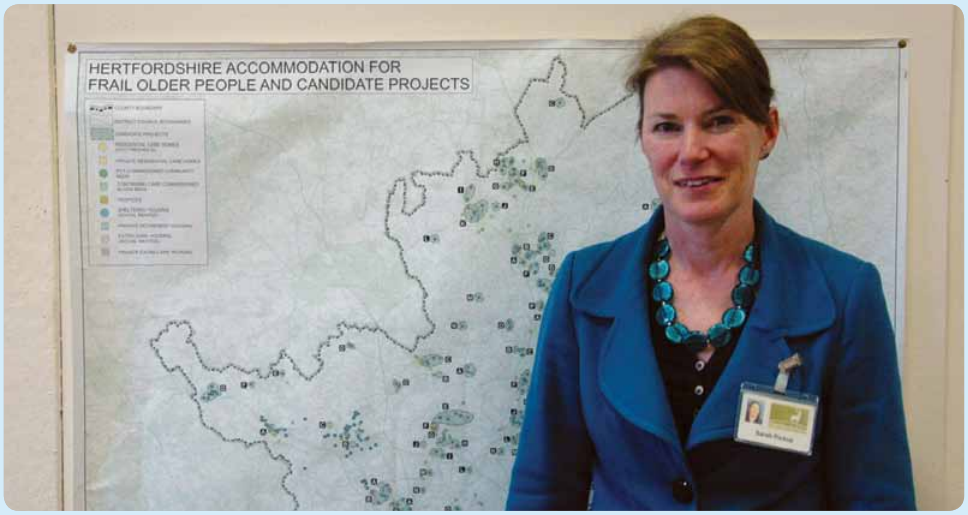
Case study: Hertfordshire County Council

In 2007 HCC embarked on a programme to increase the range of accommodation it could offer to older people in the County with care needs. In large part the vision was to remodel sheltered housing (in plentiful supply in the County, but increasingly inappropriate for the frailest older people) into Extra Care housing.

'Strategic commissioning is really important,' Adult Social Services Director Sarah Pickup told the CSJ, 'The market won't just provide the kind of care facilities we need. We wouldn't have Extra Care housing as an option for people if the Council hadn't pushed for it.'

There were a number of stages to the County's programme: mapping supply and demand based on demographic projections; bringing providers around the table to discuss the Council's intentions and work out where development could occur; identifying sites coming forward (through the planning system) for residential development as a result of affordable housing commitments; and finally, making strategic investments.

One site targeted by the County's programme was Bircherley Court, a sheltered housing scheme in Hertford town centre. Riversmead Housing Association (who owns and manages the scheme and is a member of Network Housing Group) had plans to redevelop the scheme, and through their participation in the Council's area programme board, recognised the need for Extra Care housing. As a result, Riversmead invested £7 million to completely redevelop the scheme as an Extra Care housing complex. Work went ahead and the new Bircherley Court now includes 60 remodelled flats with improved accessibility, ten new flats, wider corridors for wheelchair access, wet rooms and improved communal areas based off a central, double height, glazed atrium. The County Council commissions and pays for the 24/7 on-site Goldsborough Home Care teams and allocation of a flat is made via a multi-agency panel based on priority of need.



Sarah Pickup, Adult Services Director, Hertfordshire County Council

Hilda, 80, lives in one of Bircherley's 70 apartments. When her husband died, Hilda found herself extremely isolated in a rural part of the County. 'All I saw was woods and trees. I didn't see anybody', she told us. Consequently, what she most appreciates about Bircherley Court is its location. Situated in the middle of Hertford town centre, 'it's easy to get out and around town.' She enjoys living in the heart of the town: 'I see so much! I just look out the window.' And she also boasts about the flexibility of the care she receives. Rather than being subject to a stringent rota, she is able to choose what time in the morning her carers come in. 'They'll do anything for you. I didn't realise there were such lovely people in the world.'

Joyce Catt, right, is a resident of Swan Field Court Extra Care facility

Another part of Hertford's strategy has been to develop new facilities specifically designed for people with living dementia. Swan Field Court is a smaller Extra Care scheme the County developed through Welwyn Garden City Housing Association four years ago. Staff have been specially trained to work with dementia; door sensors have been fitted, though it is not a secure unit. In terms of actual care, residents require only four to ten hours a week. But the environment is a safe one, with the 'insurance policy' of more care if needed. One resident we met, Joyce Catt, moved from a residential care into Swan Field two years ago. 'Don't tell anyone, but I'm really happy', she told the CSJ.

chapter five
Transforming care

1. Introduction

The time of writing (June 2011) coincides with a profoundly important time for social care policy. The Law Commission reported last month, calling among other things for nationally enshrined eligibility criteria for social care as well as a move to make social care assessments portable (across various councils). The Commission on the Funding of Care and Support, chaired by Andrew Dilnot, is also due to report next month. With the Law Commission concerned about *clarity* (in terms of eligibility for social care) and the Dilnot Commission with *money*, we share the widespread hope that their joint findings will form the basis of legislation to reform a broken system. As we argued in *The Forgotten Age*, after a 'decade of indecision', it is vital that this Government does not miss its opportunity to reform the system of social care funding in this country.[1]

For despite the extra £2 billion allocated for social care by 2010's spending review, there remains widespread acknowledgement that the social care system in this country is in urgent need of increased financial resources. AGE UK recently stated that 'care and support in later life has reached financial breaking point'.[2] A recent report from the King's Fund demonstrated that over the past five years, while spending for services for people with learning disabilities has risen by 20 per cent and for those with physical disabilities has risen by 14 per cent, spending for older people (at around £9 billion annually) has increased by less than three per cent.[3] 'For older people', the King's Fund concludes, 'the trend towards a decline in spending... defies demography.'[4] Even Andrew Dilnot has agreed that 'What we have at the moment is a nightmare. There must be more resources – both public and private'.[5]

For the poorest older people, inadequate funding has resulted in two main outcomes:

- **Fewer people receiving care.** Councils have severely tightened their eligibility criteria, in effect restricting their support only to older people with the most intense care needs. In

1 Centre for Social Justice, *The Forgotten Age: Understanding poverty and social exclusion in later life*, London: Centre for Social Justice, 2010, p184
2 Age UK, *Care in crisis: causes and solutions*, London: Age UK, 2011, p1
3 Humphries R, *Social care funding and the NHS: An impending crisis?*, London: The King's Fund, 2011, p4
4 Ibid, p6
5 Andrew Dilnot speaking at SAGA Care Crisis Seminar, 7 June 2011

2005 half of all councils provided support to people assessed as having 'moderate' needs, but in 2011 the figure has fallen to 18 per cent.[6] As Richard Humphries (author of the recent King's Fund report) told the CSJ, this rationing of care has undermined any kind of preventative agenda which would seek to help older people to live independently in their own homes. 'The whole system has become skewed to the high-need side of the spectrum,' he argued.

- **Often inadequate care for those who are eligible.** Councils are struggling to provide sufficient care for older people they have assessed as eligible. In terms of home care, councils have had increasingly to commission shorter slots from care workers visiting people in their own homes. As we noted in *The Forgotten Age*, these so-called 'flying visits' ensure that the care many older people receive is often task-oriented, impersonal and insufficient to help them maintain independence. Secondly, in terms of residential care, as sector expert William Laing has recently acknowledged, 'councils continue to pay unrealistically low care home fees'.[7] In Section 4.7 we propose a way that a fairer price for care could be achieved. The effect of this underfunding, again as we examined in *The Forgotten Age*, has been poor quality across many care homes. Understaffing situations and low pay have led to high turnover rates and low morale, both of which detrimentally impact residents.

The CSJ agrees that funding structures are key to the long-term future of care provision in this country. We believe that society at every level – individuals, families as well as government – needs to ask itself what it is prepared to pay to support an ageing population. As we have argued in Chapter Four of this report, we do not believe that housing wealth should be considered 'sacrosanct'. We believe that homeowners, supported by their families, should not be impeded from drawing upon housing wealth to improve their quality of later life. That may be to improve their housing conditions, as we set out in Chapter Four, but it may also be to pay for care. This must be balanced with the recognition that more public investment will be required just to keep pace with our ageing society, especially true if recent home ownership trends continue to suggest property capital will be reduced in the decades to come.

Yet the question of *how* to fund social care is not the only one we face. In this chapter our preoccupation is with the equally important question of *what* to fund. For it seems clear that the funding systems cannot be revised whilst keeping the models of care the same. As the King's Fund recently argued, '[it] is not simply a matter of injecting additional resources into an unchanged system.'[8]

In terms of social care policy, the two objectives of (a) preventing older people from admission to care homes and (b) improving the quality of care homes are usually considered alternatives. Most people think it's either one or the other. Thus the systematic problems which plague the care home sector (and which we explored in *The Forgotten Age*) have often been neglected because policy attention has focussed predominantly on how to support older people to stay in their own homes.[9] Further, there is sometimes an unstated

6 Age UK, *Care in crisis: causes and solutions,* London: Age UK, 2011, p1
7 Quoted in *Community Care*, 7 April 2011, p23
8 Humphries R, *Social care funding and the NHS: An impending crisis?,* London: The King's Fund, March 2011, p16
9 Centre for Social Justice, *The Forgotten Age: Understanding poverty and social exclusion in later life*, London: Centre for Social Justice, 2010, pp213-226

assumption that if you improve care homes you will stimulate demand for them and thus undermine any kind of preventative care strategy. This is what, speaking to the CSJ, Dr Bill Thomas, a geriatrician and founder of the Green House model (see below), named 'the woodwork effect': namely, that if you significantly improve care homes, people will come out of the 'woodwork' and seek admission.

We think the assumption that investing in prevention and improving care homes are mutually exclusive aims should be challenged. In the set of policy recommendations which follow in this chapter we propose ways to secure the independence of the frailest older people living in poverty, by providing greater support to their unpaid carers, by greater investment in lower level support and via the establishment of integrated care teams. Yet we also recognise that the need for care homes is not going to go away. We therefore urge improvement of quality in the sector and outline what some of that improvement may look like.

2. Unpaid care

> 'Regardless of how little I've slept I have to get up in the morning.'
>
> **A family carer, aged 70, in evidence to the CSJ**

A huge number of people in the UK care, unpaid, for their relatives and loved ones. Six million people care for their spouses, partners, parents, siblings and friends, saving the state an estimated £87 billion a year.[10]

Yet as we acknowledged in *The Forgotten Age*, while for many caring is a responsibility few would want to give up, there is also evidence that caring takes its toll:

- Carers are more than twice as likely to suffer from poor physical and mental health compared to people without caring responsibilities.[11]
- 72 per cent of carers are financially worse off as a result of becoming carers.[12]

The most alarming trend we identified in *The Forgotten Age* was the increasing intensity of caring roles. Growing numbers of people are providing 50 or more hours of care a week.[13] The physical dispersal of families, combined with high levels of family breakdown, has led to many one-on-one caring relationships becoming increasingly unrelieved and isolated. Often members of both the extended and immediate family are simply not at hand to absorb the impact of an older person's increasing care needs.

10 Carers UK, ACE National and the University of Leeds, *Valuing carers – Calculating the value of unpaid care,* London: Carers UK, 2007, p3
11 Office of National Statistics, Census 2001
12 Carers UK, *Real change, not short change: Time to deliver for carers,* London: Carers UK, 2007, p10
13 Centre for Social Justice, *The Forgotten Age: Understanding poverty and social exclusion in later life,* London: Centre for Social Justice, 2010, pp189-191

For example, an occupational therapist at a major London hospital spoke to the CSJ of occasions when an older carer has collapsed and called an ambulance. But when the ambulance crew arrives it finds the carer and 'cared-for' living in so isolated a situation that there is no other option but to put the 'cared-for' into the ambulance along with the carer. In turn the hospital will then be forced to admit the cared-for person, even though at that point they are not in need of medical treatment. Such a scenario is not only indicative of the isolation of many caring relationships; it also constitutes a waste of public money.

In terms of the policy direction, the Government's approach to carers has been marked by a high degree of continuity with that of the previous Government. In November 2010 the Department of Health published a 'refresh' of the Labour Government's June 2008 Carers Strategy. Five key outcomes are at the heart of this strategy:

1. Carers should live healthy lives and retain their physical and mental health;
2. Carers should not be financially disadvantaged by their caring role;
3. Carers should be treated as expert partners by health and social care professionals;
4. Carers should have a life outside of caring;
5. Young carers should not be taking on inappropriate levels of caring responsibilities.[14]

To support this vision, £400 million has been allocated over a four-year period to fund, via the NHS, respite care for carers. In addition the Government committed £6 million to provide training for GPs to better assess carers' needs.

We welcome the steps the Government has taken both to identify and to support carers. Yet on both fronts we have concerns about the delivery of these good intentions. The recommendations which follow focus on how we can best ensure that the twin goals of identifying and supporting carers are most likely to be realised.

2.1 Identifying carers

The Forgotten Age highlighted the significant challenge in identifying carers. So too has the Government, opening *Recognised, valued and supported* with the acknowledgement that:

> *'A significant number of people with caring responsibilities do not readily identify themselves as carers. They understandably see themselves primarily as a parent, spouse, son, daughter, partner, friend or neighbour.'*[15]

This is a particular problem for older carers, of whom there are estimated 2.8 million in the UK.[16] Talking to the CSJ about her role at City & Hackney Carers Centre in London, Aysegul Dirik spoke of older carers 'often having a mindset that they battle on and don't need much support'. As a result, many carers only come onto the radar during a crisis.

14 Cross-Government publication, *Recognised, valued and supported: Next steps for the Carers Strategy*, London: Department of Health, 2010
15 Ibid p8
16 This is 'people over 50 providing unpaid care in the UK', as cited by Age UK, Agenda for Later Life 2011: Public policy and an Ageing Society, London: Age UK, 2011, p46

Any preventative strategy therefore largely depends upon identifying carers before they reach breaking point. This means, as Aysegul put it, that 'professionals need to be on the lookout.'

Statistically, the professional most likely to come into contact with a carer is the GP given that taking a spouse, friend or parent to the doctor is typically a core task for carers. Yet currently, GPs are incentivised merely to retain a register for carers. Three Quality Outcomes Framework (QOF) points are rewarded to GP practices for simply keeping a list, and one which might well remain small and dormant (i.e. where nothing is done with the information). Indeed, many Carers' Centres assert that a large number of GPs local to those centres successfully claim the three QOF points without making any carer referrals to Carers' Centres.[17]

The CSJ thus recommends that:

Recommendation:
There should be much stronger incentives for GPs to identify and refer carers to appropriate support. The QOF should measure outcomes rather than processes, with GPs being rewarded not simply for retaining a register but for referring carers for assessments or for writing prescriptions for ad hoc respite care (see below).

2.2 Supporting carers

The Government's pledge of £400 million to fund respite care for carers is a positive step. It is vital that overburdened carers get a break to prevent reaching crisis point. Yet as we reported in *The Forgotten Age*, the last time the Government committed a significant amount of funding for respite care, only a small proportion of that money actually reached carers.[18]

After the 2008 Carers' strategy announced £150 million for respite care, two carers' charities – Crossroads Care and the Princess Royal Trust for Carers – requested spending data under the Freedom of Information Act. What they found was that in the first year only 23 per cent (and in the second, 25 per cent) of the money received by PCTs specifically for respite care actually went to carers. The money was simply spent elsewhere.

This cannot happen again. What is urgently required are mechanisms at a local level to enable carers to access the money allocated by central government to local health commissioners (whether PCTs or GP consortia). The GP social prescription model below is an example of one such mechanism. On the basis of this successful pilot we recommend that:

Recommendation:
GPs should be allowed to write 'social prescriptions' for respite care directly to carers they identify as overburdened.

17 The Princess Royal Trust for Carers, *Response to HM Government's Call for Evidence for 'Refreshing the National Carers Strategy'*, Woodford Green: The Princess Royal Trust for Carers, p11

18 Centre for Social Justice, *The Forgotten Age: Understanding poverty and social exclusion in later life*, London: Centre for Social Justice, 2010, p194

Case study: GP Carers Prescription Service, Yaxley surgery, Cambridgeshire

In 2010 Cambridgeshire PCT and Crossroads Cambridgeshire, one of the largest local providers of respite care in the country, decided to pilot a scheme to help GPs look out for carers. They also wanted it to be a scheme which would allow GPs actually *to do something* for the carers they encounter rather than merely taking down their details and making the offer of further advice. So working closely with Cambridgeshire Primary Care Trust, Crossroads developed a 'social prescription' mechanism to allow local GPs directly to prescribe short breaks for people they have identified as carers.

Dr Chris Grant is the senior partner of Yaxley clinic, where Margaret Randall (in-from-left) and Pat Batey (far right) have received social prescriptions for respite care

On a visit to Cambridgeshire, the CSJ interviewed Dr Chris Grant, senior partner of the Yaxley centre, one of the 23 local practices to have participated in the scheme during the last year. 'As GPs we're in a good position to recognise the stresses and strains which arise for carers. We see carers when they bring their 'cared-fors' to see us.' Previously, though, all Dr Grant and his partners were required to do was to compile a carers' register. 'But what do you do with it? Now (with the social prescription) we've now got a real resource we can attach to it.'

The process is simple: instead of filling out a prescription for medication, the GP fills out a prescription for respite care; rather than faxing that prescription to the pharmacy, the surgery then faxes it to Crossroads, who then quickly contact the carer and arrange the respite, at present up to three short breaks within a period of a month.

Margaret Randall is one carer who has benefited from the scheme. Six years ago her husband David, now 73, suffered a stroke. The impact of the couple's lives has been huge. Unsteady on his feet, no longer able to read and write, and suffering irregular sleeping patterns, life is 'full-on', as Margaret put it. 'It's regardless of how little I've slept I have to get up in the morning.' Since the stroke Margaret has received very little support until, during one of David's appointments, the Randalls' GP identified Margaret as an ideal potential recipient of the new scheme. Three short breaks were promptly prescribed, to be taken over the course of the month. Naturally, the form respite care takes varies significantly. What Margaret most needed was, first, some time to herself at home to catch up on paperwork and to relax; and secondly, a chance to visit her family since David 'gets fidgety' when they go together. So Crossroads arranged for a respite carer to, in this case, take the 'cared-for' person out of the house, taking David on a day-visits to the town he was brought up in.

The Yaxley GP surgery, Cambridgeshire has worked hard to embed carer's issues into the surgery's

In terms of how he would evaluate the one-year pilot, Dr Grant was eager to acknowledge the difference it has made. 'While we like to think that, as a practice, we're proactive in supporting carers [the prescription scheme] has definitely made us more alert to [carers'] situations which could lead to breakdown.' This was exactly the scheme's purpose: to embed carer support solutions into everyday surgery practice. The joint aspiration of Cambridgeshire GPs and Crossroads is to develop a way of working that is quick, responsive and allows the people who need respite care to get it. And they also wanted something which can be genuinely preventative. 'We want to be able to offer things in advance', Dr Grant concluded.

Finally, throughout our evidence gathering we found that one of the reasons that approximately only seven per cent of all carers in this country have been offered an assessment (458,000 in 2009/10) is because the assessment is often carried out solely by Social Services departments.[19] Yet, as the Law Commission recently acknowledged, local authorities are in fact allowed by law to authorise others (such as service users, carers, health professionals, and advocates) to undertake carers assessments.[20] For example, in the London Borough of Barking and Dagenham, the council has successfully delegated assessment to the local Princess Royal Trust for Carers centre. The process put in place is simple and efficient: the Carers' centre completes the council's assessment form with the carer, forms an action plan and then loads both onto the local authority's database, at which stage the council is notified. Thus, while the council makes the ultimate decision as to what services the carer gets, the whole process is dramatically accelerated.

According to Barking and Dagenham Carers' Centre, this arrangement has resulted in huge benefits for carers:

- **More carers get assessed:** All those carers the local authority come into contact with are referred to the Carers' Centre for assessment, as well as all the other carers that come into contact with the Carers' Centre – i.e. those self-referred, by friends and health professionals.

19 NHS Information Centre, *Community Care Statistics 2009-10, Social Services Activity Report,* London: NHS Information Centre, 2011, p63
20 The Law Commission, *Adult Social Care,* London: The Stationery Office, 2011, para. 5.122, p54

- **Increased openness:** Carers feel more open to discuss their situation.
- **More relentless advocacy:** The Carers' Centre can better advocate on behalf of services for the carer because they have done the needs assessment.
- **A quicker process:** The Carers' Centre contacts the carer within 48 hours of referral to arrange a home visit for the assessment and then usually visit within two weeks.

Unsurprisingly, during the period of time in which they have worked closely with the local Carer's Centre, the number of assessments Barking and Dagenham has carried out has increased by 50 per cent.

To facilitate a greater number of assessments, we therefore recommend that:

Recommendation:
Carers' Centres and agencies other than Social Services should increasingly be encouraged to undertake carers' assessments on behalf of councils. This would ensure unnecessary duplication is avoided whereby by a Carers' Centre takes a carer's details and then requires Social Services to do the same. Instead, Social Services should work more flexibly and, where possible, 'sign off' assessments conducted by Carers' Centres.

3. Care at home

As we argued in *The Forgotten Age*, the overriding policy direction in recent years has been to help older people remain independent in their own homes, i.e. to prevent or postpone admission into residential care. In reality, though, this strategy has too often served to consign many of the most vulnerable older people with care needs (particularly the widowed or single 'oldest old') to a life without the support they need in their own homes.

As we argued above, this lack of support is inextricably linked to the present funding crisis. Both the tightening of eligibility criteria by councils (leading to the withdrawal of care packages for older people with 'low' and 'moderate' needs) as well as the insufficient support received by those who are assessed as eligible can be traced back to a lack of funding. The upshot, as many have told us during our evidence gathering, is the undermining of any kind of preventative agenda. With funding for support for minor *but vital* daily tasks having been withdrawn, and with home care packages all too often reduced to 'flying visits' by overstretched home care workers, so the argument runs, the onset of greater care needs becomes inevitable.

3.1 Personalisation

Notwithstanding the funding crisis, in recent years hope for reform of the social care provided to older people in their own homes has largely been pinned upon personalisation. Giving personal budgets (ideally through direct payments) to those deemed eligible for social care empowers people with care needs to choose how to support themselves. The assumption is that a more consumer-driven market (in effect making people their own

commissioners) will drive quality through the system, resulting in the survival of good home care services and the demise of poor ones.

Personalisation is a policy shift which has achieved cross-party consensus, with the current Government taking up where the previous Government left off. In its White Paper on social care in November 2010 the Government stated its intention for all in receipt of social care to be on personal budgets by April 2013.[21] As a policy shift, the CSJ unequivocally welcomes personalisation. Personalisation, we believe, should be the key that unlocks the system for the benefit of the poorest older people, with statutory bodies able to assess and fund flexible packages tailored to suit the individual. Yet in terms of implementation, while take-up of personal budgets among adults with learning or physical disabilities has been high, currently only ten per cent of older adults eligible for social care receive personal budgets. Additionally, the self-empowerment which personalisation promises has been compromised by budgets being restricted only to those with the most critical needs, and, as we stated in *The Forgotten Age*, there is a real fear that the budgets older people receive will be rendered 'toothless', insufficient to buy the kind of quality services they need.[22]

For this reason, any prospect of increased resources for social care, depending on which conclusions of the Dilnot Commission the Government decides to enact, need to be channelled towards lower level support for those currently deemed ineligible by councils, as well as better, more personalised support for those with significant care packages.

3.2 The need for lower level support

As well as providing social care, increasingly through personal budgets, to older people with lower level needs, through our evidence gathering we have also heard of the distinct need for support which is even more 'upstream' or preventative. Above all this support needs to be focussed on helping older people to maintain good health in older age which will help to postpone or prevent altogether the onset of care needs in the first place.

One way we believe that this support could be delivered is through an enhanced role for health visitors for older people.

The CSJ has long advocated an enhanced role for health visitors. In *Breakthrough Britain* we first recommended that health visiting be expanded to prevent dysfunction in very young children's cognitive and emotional development, and that health visitors should be specifically aligned with facilities at the heart of communities.[23] In two subsequent reports, *The Next*

21 Department of Health, *A Vision for Adult Social Care: Capable Communities and Active Citizens*, London: The Department of Health, p19

22 Centre for Social Justice, *The Forgotten Age: Understanding poverty and social exclusion in later life,* London: Centre for Social Justice, 2010, p204

23 Centre for Social Justice, *Breakthrough Britain: Ending the costs of social breakdown,* London: Social Justice Policy Group, July 2007

Generation and *Couldn't Care Less*, we repeated our call that the Government takes steps to check the national decline of health visiting.[24, 25]

Having made the case that government prioritise a preventative and supportive home visiting service, we welcome the Department of Health (DOH)'s announcement in February 2011 of a four-year Health visiting implementation plan.[26] The DOH has committed to:

- Increase the health visitor workforce by 4,200 by 2015;
- Coordinate a national recruitment drive to increase the numbers of health visitors; attracting more people to train to join the profession, as well as encouraging former health visitors back into practice;
- Closely align health visitors with Sure Start centres.

We welcome this investment in health visiting – and its vital focus on supporting families and the early years of a child's life. Yet throughout our evidence gathering for this review we have also come to realise the vital importance of health visitors at the other end of life. One particularly impressive team of health visitors we encountered was in the London Borough of Croydon.

Case study: Health Visiting for Older People (HVOP) team, Croydon

The HVOP team was initiated 14 years ago by a group of GP commissioners who identified an unmet need for lower level support among vulnerable isolated older people in the London Borough of Croydon. Currently the small, ten-person team has contact with an astonishing 4,600 older people a year.

The POP bus aims to proactively search out people who need advice in areas such as the High Street in North End, Croydon

24 Centre for Social Justice, *The Next Generation: A policy report from the Early Years Commission*, London: Centre for Social Justice, 2008

25 Centre for Social Justice, *Couldn't Care Less: A policy report from the Children in Care Working Group*, London: Centre for Social Justice, September 2008

26 Department of Health, *Health visitor implementation plan 2011-15: a call to action*, London: Department of Health, 2011

'I have never felt as effective as I do in this job', Clinical Team Leader, Gill Vincent-Clayden told the CSJ. 'We will get a call from the GP telling us that a lady is not coping at home, starting to have falls. And we will do anything and everything to maintain their independence.' Sometimes these are major things, involving referring on to Occupational Therapists for community equipment and home adaptations. But most of the time the team helps people to bring about 'simple little changes which make a huge difference'.

Gill spoke for example of the devastating impact someone's loss of confidence can have. 'People will stop going out because of one fall.' The HVOP's job is to restore confidence, by talking through issues, by giving a vision to people of what can be possible and by helping people to take risks. All of this is provided through visits to people in their own home for a defined period of time.

But the HVOP team doesn't only undertake one-on-one visits to people's own homes. They actively reach out to a greater number of older people via participation in a Partnership for Older People (POP) service, originally funded by the DOH's 2006-09 POP pilot scheme but now jointly funded by NHS Croydon and Croydon Council. Following a widely advertised timetable, the service travels around the borough and offers key services to older people living in the community. By making the service accessible to the community in areas like the high street, supermarkets car-parks, social clubs and community events the service can proactively targets anyone over the age of 50 who mightn't otherwise present themselves at their GP surgery or other health or social care services.

By having a broad range of professionals at each venue and linking with a broader virtual team across primary and secondary healthcare services, social services and the voluntary sector, the service is able to offer a truly holistic approach to promote independence, health and well-being for older people with a focus on local priorities for health and social services. The service addresses health promotion, screening and management of long term conditions, covering issues such as diet, exercise, mental well-being, smoking cessation, diabetes, stroke, cancer and falls prevention, and it directly provides some services such blood pressure-, hearing-, and medication-reviews and replacement of walking stick ferrules. The team also address a wide range of other issues such as welfare benefits, help in the home, assistive technologies, transport, leisure, social participation and support for carers. When the CSJ visited the POP bus at a High Street venue there was a representative from Age UK, a health visitor, a NHS pharmacist and a representative from Crossroads Care.

The POP service therefore offers a valuable personalised service for older people who may have multiple health and/or social care issues who either do not present themselves to their GPs or other services or who may be in need of a different approach to their care. Using this service they can discuss their issues all in one place and not feel as though they are being rushed in and out the door.

David Chapman, employed by NHS Croydon as the Lead Pharmacist for the POP Service, told us 'Our approach tends to result in people really opening up to us, and indeed often to themselves, which then gives us an opportunity to help them achieve better outcomes'. One of the most common things they hear is people saying, 'Oh, I have lots of problems, but I didn't want to bother the GP about them'. For those people, as Chapman said, 'We can help them develop a plan that makes best use of health and social care services. Most often it's about providing information and education and motivating them to put the plan into action themselves, but sometimes we may need to act on their behalf to ensure that their needs are addressed appropriately'.

Our recommendation, therefore, is that:

Recommendation:
Health visiting should now be expanded for the poorest older people and targeted in areas of most deprivation.

While the role of these health visitors would be multi-faceted – including helping to identify isolated older people and linking them in with befriending agencies in the way we identified in Chapter Two – we believe their primary focus should be advising and supporting older people to maintain healthy lifestyles.

In *The Forgotten Age* we emphasised the vital importance of nutrition, diet and remaining active in later life. We cited evidence showing that physical activity is associated with: lower risks of cognitive impairment, Alzheimer's disease and dementia of any type; preventing falls through improved balance and strength; the reduction of the incidence of low-level disability.[27] Despite this, as we argued, there is also evidence many people are failing to engage in recommended levels of physical activity and exercise. The most recent figures highlight that only 39 per cent of men and 29 per cent of women aged 16 and over hit the recommended mark.[28] Furthermore, participation in exercise severely declines as individuals get older. We believe that the kind of personalised, committed and professional support which health visitors can offer could play a vital role in reversing this trend.

78 per cent of people we polled would support the introduction of health visitors for older people, funded by the taxpayer.

YouGov for the CSJ Older Age Review, May 2011

Contact could be made either through GP surgeries for home visits or via innovative service provision models such as Croydon's POP bus. This service should be overseen by the new health and wellbeing boards at local authorities if legislated upon, given that health visiting should fall within a public health remit.

3.3. Multidisciplinary care teams

Acute health inequalities in the UK are well documented. Even in 2011 it remains the case that the higher a person's social position, the better their health is likely to be. Despite concerted efforts to tackle health inequalities over the last decade, as the Government's November

27 Laurin et al, 'Physical Activity and Risk of Cognitive Impairment and Dementia in Elderly Persons', *Archives of Neurology,* 2001, Issue 58, pp498-504; Feder et al, 'Preventing osteoporosis, falls, and fractures among elderly people', *British Medical Journal,* 199 318:1695; Council of Scientific Affairs, 'Exercise Programs for the Elderly', *Journal of the American Medical Association*, 1984, 252 (4) pp544-6

28 The Health and Social Care Information Centre, *Statistics on obesity, physical activity and diet: England 2010*, Leeds: The Health and Social Care Information Centre, 2010, p25

2010 public health White Paper candidly acknowledged, 'Health inequalities between rich and poor have been getting progressively worse.'[29]

Health inequalities are apparent not only between different regions of the country but even between neighbouring wards. Sir Michael Marmot's landmark 2010 review of health inequalities notes that life expectancy in Tottenham Green, one of London's poorer wards, is 17 years shorter than in a ward only a few miles away in Kensington and Chelsea.[30] And even more startling than differences in overall life expectancy are differences in *healthy, disability-free* life expectancy. So while the average difference between richest and poorest in terms of life expectancy is seven years, the average difference in healthy, disability-free life expectancy is a staggering 17 years.[31] As Marmot bluntly put it, 'People in poorer areas not only die sooner, but they will also spend more of their shorter lives with a disability.'[32]

A major contributory factor to acute health inequality is unhealthy lifestyles. Smoking, obesity, lack of physical activity and poor nutrition – very often the underlying causes of chronic disease – all typically follow the social gradient. Yet while developing a strategy to tackle life-style driven ill health is an urgent priority, it is also true that health inequality cannot be completely explained by contrasting lifestyles between the richest and the poorest. Often, allied to unhealthy lifestyles over a lifespan is the additional problem of poor healthcare in deprived areas. Despite outstanding counter-examples, primary care in many of England's most deprived wards is not as developed as in other areas.[33]

In terms of poorer older people, two further issues compound this problem:

- **Lower resilience:** some of the social factors we explored in Chapter Two – social isolation, the absence of a family carer, poorly developed social networks and fewer choices due to straightened financial circumstances – directly affect an older person's ability to cope with the onset of chronic conditions such as Chronic Obstructive Pulmonary Disease or diabetes;
- **Lack of integration between health and social care:** with multiple conditions likely to precipitate care needs, many poorer older people will be eligible for and/or in receipt of social care. However, as we emphasised in *The Forgotten Age*, in many places health and Social Services do not work well together, thereby making a multi-entry system even more difficult to navigate.

On the ground, a major consequence of acute health inequality is high rates of unplanned admission to hospital from older people. Nationally, since 2005 emergency admissions for those aged 85 and over have risen by 48 per cent.[34] Healthcare experts acknowledge that the poorest will make up a large part of this increase. As Dr Geraint Lewis, pioneer of the

29 HM Government, *Healthy Lives, Healthy People: Our strategy for public health in England*, London: The Stationery Office, 2010, p2
30 The Marmot Review, Fair Society, Healthy Lives: *Strategic Review of Health Inequalities in England Post-2010*, London: The Marmot Review, February 2010, p29
31 Ibid, p10
32 Ibid
33 The King's Fund, *Improving the quality of care in general practice: Report of an independent inquiry commissioned by The King's Fund,* London: The King's Fund, p4
34 Humphries R, *Social care funding and the NHS,* London: The King's Fund, March 2011, p10

Virtual Ward model examined below and current Senior Fellow at the Nuffield Trust, told the CSJ, 'unplanned hospital admission is clearly associated with higher deprivation'. All the factors mentioned above – unhealthy lifestyles, healthcare managed ineffectively in the community, social factors which impact upon an individual's resilience, the fragmentation between health and social care – conspire to ensure that many older people suffering from chronic conditions are forced to present regularly at accident and emergency departments. During the course of our evidence gathering we have heard from many consultants, therapists and nurses working in secondary care about the prevalence of 'frequent flyers', older people living in poverty who yo-yo in and out of hospital.

What we therefore require is a genuinely preventative approach to managing the healthcare of this very specific group of older people living in both poverty and ill health. And given that many from this group are likely to be receiving social care from their local authority, any preventative approach to healthcare must be properly integrated with social care. The CSJ therefore proposes that:

Recommendation:
The NHS and local authorities jointly commission preventative care teams to proactively and intensively 'case manage' identified groups of older people living with ill-health and at high risk of hospital admission.

Instead of a reactive, disjointed system for dealing with this specific population we need a pro-active and integrated one. Such teams would be multidisciplinary (though GP-led – see below), and would sit alongside the primary care system. Thus patients' usual GPs would 'release' them onto these teams – i.e. the teams would take full charge of coordinating the healthcare of that individual for a discreet period of time while they are at major risk of hospital admission – and then receive them back, just as GPs do vis-à-vis hospital consultants.

71 per cent of people polled would support councils and doctors forming teams, working under a single budget, to manage the care of older people at risk of hospital admission.

YouGov for CSJ Older Age Review, May 2011

It is not our intention in what follows to be overly prescriptive: the case study we provide below, of Wandsworth PCT's recent 'virtual' ward pilot is just one example of such a multidisciplinary team. Yet in presenting that case study, and in fleshing out the model, it is clear that such teams would have a small number of *defining features*: they need to be (1) community-based, (2) preventative, (3) multidisciplinary but GP-led; and (4) fully integrated between health and social care.

3.3.1 Defining feature one – 'community-based'

Once it is agreed that a sea-change is needed in how the healthcare of older people living in poverty and ill health is managed, the next question is, where is the best place to do that.

One answer might be to manage those people's conditions more effectively in hospital, i.e. to create an enhanced, multidisciplinary service in a secondary care context to ensure this group of people gets better treatment. Yet this seems undesirable for a number of reasons.

First, it is well known that many older people tend to decline when in hospital. As Dr Seth Rankin, lead-clinician of Wandsworth PCT's Virtual Ward model, told the CSJ 'hospital is for older people very often a brutalising experience' (see box below).

Secondly, in terms of health policy, the 'elephant in the room' is that with an ageing population we simply cannot afford to be offering this kind of an enhanced service to this group of people *in hospital.* The hotel and accommodation costs of hospitals – the accumulated cost of land, buildings, catering and supporting people (all on top of the cost of the care being providing) – are simply punishing. Yet at present spending on secondary care is not only by far the largest item of NHS's annual expenditure (at 45 per cent), but spend on hospitals has actually been increasing over the last three years as a proportion of the overall spend, according to the National Audit Office report.[35] That trend is simply unsustainable.

The reality of how hospital-centric our health system has become, and the fact that the current levels of spend on secondary care are unsustainable, is an issue only the boldest politicians will address. Yet speaking to the CSJ, Richard Humphries, senior fellow at the King's Fund, said this:

> *'Since 1945, treating lots and lots of people has become a badge of virtue for hospitals, and payment by results has encouraged hospitals to treat more and more people. But actually we need to turn that round so we start measuring how many people we are allowing to live healthy and independent lives without recourse to hospital admission.'*

Policymakers are now waking up to this reality. In November 2010's public health White Paper the Government recognised 'the domination of our attention and spending on secondary care'.[36] Yet at present there seems to be no real strategy to turn the tide and reweight resources away from secondary care. Creating a greater number of multidisciplinary teams is one way of doing this, since those teams are designed intensively to 'case manage' patients away from a hospital context and thus 'virtually.' Ideally the group of professionals who comprise the team, aided by technology, discuss the patient remotely and decide upon the treatment plan for that person, with the nurses on the team then doing the bulk of the home visiting.

3.3.2 Defining feature two – 'preventative'

The first question any new model faces is obviously that of who gets access to it. In this case, if these teams are really to be preventative, their 'referral stream' cannot be left entirely up to individual GPs to pick and choose. Instead, predictive risk models should be employed.

35 National Audit Office, *Department of Health: Health Resource Allocation, Briefing for the House of Commons Health Select Committee,* London: National Audit Office, 2010, p16

36 HM Government, *Healthy Lives, Healthy People: Our strategy for public health in England,* London: The Stationery Office, 2010, p12

The whole aim of these multidisciplinary care teams is to avoid hospital admission for the poorest older people. And therefore a crucial part of this proposal is accurately to target those people before they are in need of hospital admission. It is not beneficial to those people, nor cost effective, to admit them onto the team's case-load right before they are about to be admitted to hospital anyway. The medical intervention – being brought under the remit of the team – needs to be 'upstream'. In other words, the case-finding aspect of the teams is vital if they to be genuinely preventative.

Predictive risk models, developed for the NHS over the last ten years, are becoming an increasingly important way of identifying people likely to be admitted to hospital in the future. They do this by taking medically-based facts about people's health histories (a 2006 ruling by the Patient Information Advisory Group found that such models do not compromise patient confidentiality because of the sophisticated way they can render the data pseudonymous) and then using it to predict risk of hospital admission. Having given risk scores to large groups of people, the models thereby deliver to commissioners a cohort of people to actively follow up with and case manage.

Evidence suggests that predictive risk models such as the Patients at Risk of Re-hospitalisation (PARR) and the Combined Model (outlined below) stand a better chance than health professionals do of accurately identifying which people will be at risk of hospital admission in 12 month's time. Dr Geraint Lewis, who has helped pioneer the development and clinical use of predictive risk models, explained their purpose to the CSJ in this way: 'The point of predictive models is to put names and faces on next year's likely emergency hospital admissions.'

Case-finding tools based on predictive risk models developed for the NHS[37]

PARR model
This model was built using a ten per cent sample of Hospital Episode Statistics data together with variables from the national census. The model can be downloaded and run free of charge by any NHS organisation.

Combined Model
A disadvantage of PARR is that it is unable to make any predictions about the vast majority of the population who have not had a recent hospital admission. The Combined Model thus runs on a combination of hospital data and GP data. The Combined Model is able to generate a risk score for every member of a registered population that reflects their risk of having an unplanned hospital admission in the next 12 months.

Specifically in terms of health inequality, the attraction of using predictive models to select the cohort of older people to be case managed by multidisciplinary teams is that you are no longer reliant on the GP spotting those people. Many of the poorest older people who have little contact with GPs, won't typically seek help soon enough and are

37 The Nuffield Trust, *Predictive risk and health care: an overview,* London: The Nuffield Trust, March 2011, p8

likely to end up in accident and emergency, *are* likely to be flagged by the risk models. In addition, predictive risk models can intentionally feed in poverty metrics such as the Index of Multiple Deprivation.

3.3.3 Defining feature three – multidisciplinary but GP-led

The key to the success of these teams is their multidisciplinary nature. All of the parties instrumental in good clinical treatment need to be brought together around the patient: GPs, nurses, therapists (occupational therapists, physiotherapists, speech therapists), social workers to manage the care packages, psychiatrists and secondary care specialists.

These teams, as in a hospital, would regularly review the patient in question and together generate a treatment plan. The bulk of the direct face-to-face contact with the patient would then be from the nurses, on home-visits. Yet given the complexity of the medical conditions of those patients on the teams, it is vital that the teams receive strong leadership from GPs. There could be a number of ways of doing this: GPs tasked with this role could be full-time, running multiple teams (each team covering around 25 to 30 people); or otherwise GPs could be commissioned to work part-time on one of these teams, and the rest of the time in ordinary general practice.

3.3.4 Defining feature four – fully integrated

There is currently a huge appetite for increased integration between health and social care. Both health professionals and politicians have come to realise that, despite repeated attempts for 40 years, the 'Berlin Wall' separating the NHS and councils' Social Services departments has not been felled.

Calls for integration come first and foremost from professionals working within the sector. In March 2011 the King's Fund argued that 'the case for a much closer alignment of health and social care resources is overwhelming'.[38] In April 2011, in an article boldly entitled, 'A glimpse of the future of healthcare', the British Medical Journal profiled the successful merger in Torbay between the PCT and Social Services Department, highlighting that since its 2005 integration Torbay now boasts the lowest rate of emergency admissions in south west England.[39] But policymakers have also begun to cotton on to the benefits, both for patients and for budgets, of integration. Thus the Government took office in May 2010 promising to 'break down barriers between health and social care funding to incentivise preventative action', and in April 2011 the Prime Minister spoke with renewed vigour about the need to 'heal the divide between health and social care.'[40, 41]

In recommending that GPs and local authorities jointly commission these multidisciplinary teams (to case manage select groups of older people living in poverty and severe ill health) we are adding our voice to these calls for integration. For since many of the older people likely to be case managed by these multidisciplinary teams will also be in receipt of social

38 Humphries R, *Social care funding and the NHS: An Impending Crisis,* London: The King's Fund, March 2011, p17
39 Davies P, 'A glimpse of the future of healthcare', *British Medical Journal,* 2 April 2011, Volume 342, pp738-9
40 Cabinet Office, *The Coalition: Our Programme for Government,* London: The Stationery Office, May 2010, p30
41 BBC Radio 4, *Today,* Tuesday 19 April

care packages, the teams need to be fully integrated between health and social care. Yet what should this integration look like?

In truth, the 'loose partnership' approach to integration has manifestly failed: the history of the last two decades (since the Community Care Act of 1990) has been of small initiatives around integration never mainstreamed – here and there a Social Services department which has forged a good working relationship with its neighbouring NHS Trust; a plethora of positively-evaluated pilots never scaled up. Therefore, unless these teams operate under an integrated management structure (including both medical professionals and social workers) and with a pooled budget, it is hard to see how the aim of helping poorer older people to cope with long-term conditions will realised. In order for scale to be achieved attention has to be given to more systematic governance of these arrangements.

Case study: Wandsworth's 'Virtual Wards' pilot

Since 2008 Wandsworth PCT has been piloting a 'Virtual Ward' scheme to replicate the multidisciplinary approach of a hospital ward *but in the community.* Four virtual wards have been proactively case-managing a group of patients (typically 30 patients per team) identified as being at risk of hospital admission.

'As a society I don't think we've quite acknowledged what hospital can be like for older people', Dr Seth Rankin, clinical lead for the pilot, told the CSJ. 'Hospitals are absolutely essential but it is not always the best place to be – even when unwell. Taking an 80 year-old out of their home and clothes and putting them on a gurney in a busy hospital can be a brutalising experience. And we know that hospitals can be dangerous places in terms of infection.'

Despite that, the health system in this country remains very hospital-centric. 'No doctor will ever get into real trouble for admitting patients to hospital,' Dr Rankin argued; 'Often as soon as anything gets complicated – medically or socially – people are transferred to hospital.' In addition, with GP home-visited having declined in recent years, primary care has become a largely office-based system, favouring of course ambulant patients. For patients with long-term chronic conditions all too often calling '999' has been the only option.

Dr Seth Rankin has developed the Wandsworth's virtual wards since 2008

Wandsworth's virtual wards were established to put a stop to this. 'A lot of the time there's no reason that the little old lady waiting on a gurney in hospital can't be at home,' Dr Rankin explained. 'But ultimately, to keep people out of hospital you need more robust community services.' Historically, however, community services have suffered from a lack of access to medical support. 'In recent times GPs have been less intimately involved with their community nursing teams – it's been the really important missing dynamic.' Thus a full-time GP has been employed to work on each virtual ward, alongside two community matrons, a team of district nurses and a ward clerk. Why is GP involvement so crucial? 'Well, how does a ward work in hospital?' Dr Rankin countered. 'Doctors are essential for a fully multidisciplinary team approach in any healthcare system but have been less involved in community services than they should be. They are a vital element of any hospital ward where they provide diagnoses and treatment plans and clinical support in the patient's ongoing care.' Similarly, in the virtual ward it is the GP who chairs the weekly multidisciplinary meeting – attended by all the 'allies' to keep people at home (therapists, social workers, palliative care professionals); who takes the responsibility necessary for other professionals to feel safe referring complex patients to the team; and who support the community nurses (and the rest of the team) with any clinical uncertainty and training needs.

Community services have also been blighted by a lack of integration, not just between health and Social Services but also between different parts of the health service. In the past, as Dr Rankin explained, 'community systems have all been there. But since they haven't been integrated in a way that is always easily accessible, sometimes the only option has been for GPs to admit their patients to hospital.' The virtual ward was designed specifically to combat this problem. 'Every agency that can help is in that room', Dr Rankin explained; 'the ethos is that the buck stops with them.' There is no other professional whom they can refer on to. Functionally, too, the idea has been to 'put the band back together'. Thus the ward clerk personally knows each of their 'allies'; has each of their mobile phone numbers; and has remote LOG-INS to the computer systems of General Practice, Secondary Care and Social Services.

The success of the Wandsworth pilot has led to Wandsworth PCT's decision to redesign its entire community services on a community ward model utilising all the best aspects of the virtual ward pilots. 'Cost-effective medicine is about picking up patients on the upward slope of need. And that's what we have done', Dr Rankin explained. Patients are happier, because they are receiving more intensive care. Nurses are happier, because they can actually get hold of a GP. Local GPs are happier, because the group of patients with long-term chronic conditions that could take up a substantial degree of their time are receiving enhanced support. And hospitals are happier, because they are seeing less 'frequent flyers'.

Speaking of the future, Dr Rankin was optimistic about the potential move to GP commissioning in the health service: 'It's a massive opportunity. There isn't an agile, robust, safe system to care for people at home, and GPs know we need it. It's what the entire health economy is looking for.'

Colin

Colin, 69, suffered a stroke in 2009. Already partially-sighted, and suffering from diabetes, the stroke affected Colin's balance so that he began to fall regularly. Without other services, and having recently been left by his wife, Colin had to call out ambulances on a regular basis.

Colin came into contact with the virtual ward both on account of his predictive risk scores and having being referred by a GP. That GP undertook an initial visit to Colin's house. A 'dishevelled flat', broken fridge and dirty dishes revealed someone 'not coping at all well'. Worse, due to his partial sight, Colin was taking the wrong amount of insulin.

The virtual ward's 'intervention' started with an in-depth look at Colin's circumstances in 'the round'. From this came a plan to sort out his medication, co-ordinate nurse input and sort out his living conditions (i.e. fixing smoke-alarms and ensuring the front door was no longer left open). When he felt unwell, moreover, Colin was directed towards the virtual ward clerk rather than hospital. Offering this more intensive support, Colin was prevented from hospital admission and was able to remain independent in his own home.

4. Care homes

4.1 Introduction

In terms of care, the policy direction in recent years has been clear: older people should be able to live in their own homes for as long as possible rather than be admitted into 'institutional' care (i.e. a residential or nursing home). Despite the large number of older people in long-term care (approximately 400,000 people, of whom 250,000 are supported by the state), the policy debate has revolved around finding alternatives to (rather than reforming and improving) care homes.[42] In short, the question of how to make the 'staying put' option more realistic has eclipsed the necessary focus on how conditions and quality of life in care homes can be improved.

As shown by our recommendation in the previous section concerning preventative care teams targeted to those older people at risk of admission to hospital and/or long-term care, the CSJ fully supports a radical overhaul of 'community care'. Care for older people in their own homes needs to become more preventative and more effective. If it does not, the state faces huge problems in future years.

Yet it is also crucial that the care home sector is not neglected. The demographic projections around dementia alone (a 46 per cent increase to a total of one million people with dementia in the UK by 2025) mean that there will always be a need for a large number of older people to be looked after in an intense care setting.[43] In reality, care homes are already in the process of becoming dementia homes, with approximately 64 per cent of residents of both care and nursing homes living with dementia.[44] Though in future it may well be possible for many more of the frailest older people to be cared for outside of long-term residential settings – through, for example, the greater provision of Extra Care housing or telecare – it is unrealistic to think that the need for the most intensive support which care homes provide will dramatically decline.

Furthermore, insofar as there has been a debate about long-term care in recent years, that debate has been narrowly restricted to one about funding. That of course is a crucial issue, given:

- Care home providers' complaints about chronic underfunding by local authorities (the largest purchaser of long-term care);

42 Humphries R, *Social care funding and the NHS: An impending crisis*, London: The King's Fund, March 2011, p5

43 Personal Social Services Research Unit at the London School of Economics and the Institute of Psychiatry at King's College London, *Dementia UK: The full report*, London: Alzheimer's Society, 2007, Figure 3.2, p24

44 Blood I, International Longevity Centre, *Equality and Diversity and Older People*, London: Joseph Rowntree Foundation, October 2010, p16

- Local authorities' respective complaints of the pressure on their budgets exerted by older residents who started off as self-payers but have exhausted their assets (i.e. sold the family home) and been thrown upon the state;
- The often unacknowledged fact that, as one County Councillor with the portfolio for Social Care told the CSJ 'the elephant in the room is that self-payers hugely subsidise state-supported residents'.

While we eagerly await the findings of the Dilnot commission on the Funding of Care and Support, this preoccupation at a policy level with *how* to fund the system has again smothered a serious discussion of *what* it is which should be funded. Which models of care do we want to invest in once we have decided how we are going to pay for it? What kind of care homes do we want and do we need?

In short, the older men and women who currently live in long-term care are, as we reported in our interim review, among the frailest and neediest people in the country. They are a huge group of people – over three times the number of hospital patients.[45] Improving their quality of life is a task we cannot neglect by simply longing that they could be cared for in a different setting. Just because the rejuvenation of residential care is an unfashionable subject does not mean that it is an unnecessary one.

4.2 The (out-of-date) distinction between residential and nursing homes

In *The Forgotten Age* we drew attention to just how artificial the basic distinction between residential and nursing homes has become.[46] This was a distinction designed for another era: when state-supported older people in residential care were not generally as frail as they are now; and when admission particularly to residential care was often used as a substitute for poor housing or social isolation.

As we found throughout our evidence gathering, times have changed. The profile of people entering long-term care has altered dramatically over the last 20 years. Older people are coming into long-term care at a much later stage (nationally, the average age of a resident is 85); their length of stay is much shorter (on average less than 18 months); and, importantly, there is considerable overlap between the needs of occupants of residential care and the needs of nursing home occupants. Just as older people who would in the past have been cared for in NHS Long-Stay Geriatric hospitals now find themselves in nursing homes, so too those who would have been in nursing homes are now in residential homes.

Despite the fact that occupants of residential homes are increasingly coming to resemble their peers in nursing homes, the system has failed to adapt to this new situation. Not only does regulation maintain the distinction between 'care homes' and 'care homes with nursing'. More importantly, the NHS restricts its financial contribution to the sector – the weekly Registered

45 Average daily number of occupied beds in the NHS is approximately 120,000 (*Average Daily Available and Occupied Beds Time series*, Unify2 Data Collection – KH03, London: The Department of Health, 2011

46 Centre for Social Justice, *The Forgotten Age: Understanding poverty and social exclusion in later life*, London: Centre for Social Justice, 2010, pp217-8

Nurse Care Contribution (RNCC) – to nursing homes. This currently causes a number of negative consequences, as has been argued by others:

- It limits 'the ability of residential care homes to continue to meet their residents' health needs';
- It increases the likelihood of a resident having to undergo a second traumatic move (this time from their residential home on to a nursing home) should their needs deteriorate;
- It particularly discriminates against the large group of those in *residential* homes suffering from dementia (estimated to be over 50 per cent of residents). Just because they haven't moved into a nursing home shouldn't disqualify them from health money.[47]

Our first recommendation, therefore, is that:

Recommendation:
The now out-of-date distinction between residential care homes and care homes with nursing should be removed. The money the NHS makes available to the sector (the weekly RNCC) should no longer be restricted to care homes with nursing. Instead it should be allowed to 'follow the patient', i.e. to be allocated to those individuals in residential care who condition significantly deteriorates. Receiving additional NHS funding for nursing will not only prevent a subsequent move to a new nursing home but may also prevent (and thus offset the cost of) hospital admission.

For this funding contribution for nursing to be allocated to (what are now classified as) residential homes it would need to be decoupled from the requirement to directly fund *on-site* nurses. (Since it would be unrealistic to expect residential homes to put in place a full 24/7 nursing team). Therefore, any proposal to remove the basic distinction between residential and nursing homes is, necessarily, a proposal fundamentally to reassess the role of nurses in long-term care settings. Nurses, rather than being required to be constantly on-site (with a role – so we have often heard – overwhelmed by bureaucracy), need instead to be free to oversee and empower non-nursing staff (i.e. care workers) to deliver good care. Throughout our evidence gathering we have heard that many tasks which only nurses are allowed to perform in nursing homes – most notably, dispensing medication – in residential homes are frequently and successfully undertaken by non-nursing staff.

Therefore, we recommend that the RNCC money should be able to be used by any care home to fund whatever that home thinks most likely deliver more intensive care for its increasingly dependent residents. This could be to increase staffing numbers or to fund greater training for staff in dementia.

In making this radical recommendation, we are not a lone voice. Speaking to the CSJ since our interim report, Dr Finbarr Martin, President of the British Geriatric Society, said this: 'the distinction between care homes with nursing and those without nursing is spurious. We should get rid of it.' And in consultation with the CSJ, Sharon Blackburn, a former nurse and

47 Wild D, Szczepura A and Nelson S, *Residential care home workforce development: The rhetoric and reality of meeting older residents' future care needs*, London: Joseph Rowntree Foundation, 2010, p7

now Policy Director of the National Care Forum, stressed the need to reassess the role of nurses:

> *'The role of the nurse in long-term care needs to change. Currently the role of the nurse is so task-focussed that often the full extent of their knowledge and skills is not realised. The old model of saying you need x amount of nurses per shift is over. It's not just about numbers. It's about encouraging nurses to retain accountability whilst delegating to appropriately trained care staff. This will require innovation and effective leadership.'*

4.3 Doctors for residents: medical input into care homes

Jonathan is 99 years old and is a resident of a nursing home in North London. He requires intensive coverage from care home staff and would be described as a clinically-complex case. Yet, when the CSJ visited him, he reported not having seen a GP in two years. He spoke angrily of 'the disgusting neglect of old people when they want a doctor', and his daughter talked of her disbelief that a care home resident such as her father simply cannot access good, regular NHS healthcare outside of hospital.

> Nearly seven out of ten care home residents do not get a regular planned medical review by their GP. [48]

In *The Forgotten Age* we argued that the biggest single failing of long-term care in this country is the frequent difficulty many residents experience in seeing a GP.[49] Notwithstanding significant exceptions, the system is in disarray, a judgment brought to our attention not only by the many care home residents, staff and managers we interviewed but also confirmed by GPs and other medical professionals who spoke to the Working Group. For example, the medical director of one London PCT spoke of GPs' typical reluctance to visit residents in care homes, fearing the 'clinical iceberg' they anticipate finding there. 'The work very quickly becomes fire-fighting', he admitted. Another medical director told the Working Group, 'People in care homes get substandard health care. It's as simple as that.' And Dr Martyn Wake, PCT medical director pointed to the low priority that care home residents received at a commissioning level.

> *'There is little incentive for GPs to attend specially to the needs of care home residents, even though more often than not this is a group of people who are more dependent on regular and intensive medical care to maintain good health.'*

On the ground, this low prioritisation of care home residents by primary care plays out in a number of highly unsatisfactory scenarios:

48 Royal College of Physicians, Response to *'Liberating the NHS: Transparency in Outcomes'*, October 2010 [accessed via: http://www.rcplondon.ac.uk/sites/default/files/rcp-outcomes-response-oct-2010.pdf (09/06/11)]

49 Centre for Social Justice, *The Forgotten Age: Understanding poverty and social exclusion in later life*, London: Centre for Social Justice, 2010, p221-222

- In some cases GPs refuse to visit the care home at all, instead insisting that staff bring a resident to attend an appointment at the surgery like any other patient in the community. This requirement is hugely challenging for typically immobile residents and, in addition, deprives the home of staff for long periods of time.
- If GPs do visit the care home, often each resident will have a different GP and thus the care home is subject to a plethora of different GPs coming in at different times and too irregularly to properly and proactively manage the often complex medical needs of those residents.
- Finally, some care homes have completely given up on the system and instead decided to pay a retainer to one GP practice (who are often already being paid per capita for having those residents on their practice lists) to come into the home regularly. But, as the Chief Executive of one not-for-profit care home told the CSJ 'We don't think we should have to pay for GPs. It is a scandal that GPs charge care homes to look after residents.'

The reasons for poor primary health coverage of care homes are historical. While there are exceptions (with some primary care trusts having attempted to commission adequate medical care for care homes) in general, as one PCT medical director told the CSJ, 'the responsibility for care home residents' primary health care has always been a grey area.' Following the closure of the NHS long-stay geriatric hospitals since the Community Care Act of 1990, independent nursing and care homes basically inherited this population of the most clinically complex older people for whom, in terms of curative medicine, little more could be done. Whereas in the long-stay hospitals this group of older people received ward rounds and clinical support, now they were in the community but *minus the on-site doctors*. Unsurprisingly, the consequence has been high levels of emergency admission to hospital. This is a lamentable outcome for residents, given the danger of hospital in terms of infection, the trauma of the hospital experience for older people, and the fact that many, if they are at the end of their lives, will be denied the opportunity to die in what has become their home. But it is also a lamentable outcome for the state given, as we have noted in Section 3.3.1 above, the huge expense of secondary care.

In view of this urgent situation, the CSJ makes this recommendation:

Recommendation:
The NHS, through appropriate commissioning bodies, should specifically require GPs to take responsibility for coordinating healthcare in care homes. The current system – where multiple GPs go (or don't go) into care homes, or else expect residents to come to them – should be replaced by one where single GP practices are aligned with specific care homes, committing to visit on a regular basis and proactively to 'case manage' the often complex medical conditions of residents.

During our evidence gathering we have found that, in terms of delivering primary healthcare in this context, the best arrangement involves a particular GP or practice being aligned with one specific home and committing to provide regular sessions in the home. Dr Gillie Evans' relationship with The Gables specialist nursing home in Cambridgeshire is one example of this.

Case study: Dr Gillie Evans, The Gables Specialist Nursing Home, Cambridgeshire

'I was ashamed of the quality of care I was providing.' That's the explanation Dr Gillie Evans cites as what motivated her to transform the way her local Peterborough practice has delivered health care for the care home residents in its area. 'Previously, the work we were doing in that context was merely fire-fighting', she told the CSJ. 'I was convinced we could do better.' And so in 2000 Dr Evans went to colleagues in her practice and persuaded them to 'adopt' one local care home each. To show them she meant business, Dr Evans had to assign herself coverage of the care home not only furthest from the surgery, but also the one with the most clinically complex residents. She took on The Gables, a 55-bed specialist nursing home where the majority of residents have advanced dementia. What she committed to do was intensively and proactively to case manage this group of people, providing one half-day session a week, held in the home itself, as well as a monthly significant event meeting for staff. On the CSJ's visit to the Gables we were able to sit in on both of these sessions.

Weekly patient consultation

Dr Evans' weekly visit to The Gables begins with an extended meeting with The Gables' senior nurse, Sally Jakes. The meeting is held in the hairdresser's salon on account of its secure phone-line which (bypassing the switchboard and thus protecting patient confidentiality) allows Dr Evans to plug in her computer and review her patients' practice notes remotely. 'Having the information at your fingertips is a key part of being able to operate well in this context,' Dr Evans explained. Dr Evans and Nurse Jakes, whom regular contact has afforded the time to forge a good working relationship, started to talk through residents on a case-by-case basis. They discussed acute and long-term medical problems and changes in behaviour which may signal underlying pain, infection or distress. Medication is considered, recent changes reviewed and adjustments made as required. This generates action plans going forward. After this discussion has come to the end, Nurse Jakes then proceeded to take Dr Evans round the home to review selected patients.

The medical conditions of many residents in this home, Dr Evans explained, are highly complex. 'It takes every piece of training and experience I have to make some of the decisions I make.' But one benefit of this 'managed care' approach is being able to deal with a resident's behaviour, if presenting a challenge to manage, via behavioural techniques rather than opting for what in many homes is the default option of sedation. 'If you're not reviewing people regularly, it's harder to stop medication', Dr Evans explained. 'It's easy to press on a button a computer saying 'MEDICATION REVIEW DONE' and leave it at that.'

According to Nurse Jakes, the benefit of such regular contact with a GP has been incalculable. In particular she explained how good palliative care hinges upon the regular presence of a GP and advance care planning. When residents reach the end-of-life stage, it's only an experienced clinician, who knows the skills of the team, who has the authority to say that a resident can stay in the home and thus die in the place with people who know and can meet their needs best. Dr Evans is at hand to oversee the management of residents' medication by syringe-drivers in the terminal stage. Nurse Jakes was frank: 'We'd never have managed syringe drivers without Dr Evans here regularly. If residents become bubbly, breathless or are in pain, we don't have to ship them off to hospital'.

'Significant event' meetings

In addition to the weekly ward-round, Dr Evans also holds a monthly summit for staff members. Open to any nurse or carer at the Gables, attendance at these 'significant event' meetings is completely voluntary. Yet the 9 a.m. meeting the CSJ attended was packed: care staff, nurses and the activity coordinator all in attendance, with freshly baked cookies to perk up the night-staff who have stayed on for the meeting. The agenda is loose – the only non-negotiable being a commitment to discuss the death of any resident who has died over the last month – and the purpose of the meeting is for members of staff to be able to bring up and work through with Dr Evans any difficult issues relating either to specific residents or the home in general. It provides peer and professional support and has been the driver for the development of many practical tools and positive changes.

The morning we attended started with Walter, who had passed away a fortnight previously. 'There were long periods where he was drowsy', one carer told Dr Evans. 'He became less and less interested in his eating and drinking, and was losing weight fast.' The staff proceeded to discuss how they managed Walter's syringe-drivers; how Walter's family had responded; and how, after Walter died, they (the staff) had taken him out of his night wear and dressed him in the yellow-T-Shirt and blue jeans he was more accustomed to wearing – a practice which had apparently stunned the undertakers who collected him. It was unusual, the undertakers reported, to pick up a deceased care home resident who had had such care and attention after death. 'We did see him well to the end,' a nurse concluded.

Next on the agenda were the concerns staff are experiencing about weight-loss among residents. The staff had been dispensing fortified milkshakes on the advice of a senior dietician, but this had proved too rich for some residents. It was agreed at the meeting to continue fortifying as many meals and drinks as possible using milk powder, extra butter and cheese and especially double cream and to continue close monitoring of residents' weights. The meeting then closed on a positive note with the minutes to be reviewed at the meeting next month.

As shown by this case study, for residents the main benefit of this enhanced primary care model is continuity of care, i.e. seeing the same doctor twice. But it is also clear that this way of working hugely benefits care home staff, whether the manager, nurses or carers. This is a point Dr Finbarr Martin emphasised in his representation to the CSJ:

> *'If GPs rush in and out of care homes, they don't come to see that staff in a care home do indeed have the potential to improve care.'*

Dr Martin cited the Gold Standards Framework (GSF), the highly successful palliative care programme, as an example of how, with greater input from medical professionals, 'care home staff have to be considered part of the solution rather than an obstacle to improving care homes.' Dr Martin spoke of having worked in numerous care homes he wouldn't describe as 'remarkable', yet for whom sustained contact with a single group of medical practitioners (in this case implementing the GSF) had brought the best out of staff. 'What the GSF has highlighted is the general principle of managed care. But we don't have to conceive of that only in terms of the last year of life.'

79 per cent of people think that an individual GP should take responsibility for all residents in a care home, allowing all residents to see a GP on a regular basis

YouGov for the CSJ Older Age Review, May 2011

At present, however, this model of 'managed care' remains merely irregular best practice, whether initiated by the care home provider (paying a retainer to a local GP practice) or by the PCT through the commissioning of a Locally Enhanced Service (LES) for a specific care home. Dr Evans, for instance, is not reimbursed for the session she spends in the home. Yet, as demonstrated by our poll, there is wide public support for this 'best practice' to become

the mandated way that the NHS manages patient care in care homes rather than relying on the goodwill of extraordinary individual GPs like Dr Evans or the responsible activity of a particular group of commissioners. Naturally, as residents may wish, there must be a choice to maintain contact with their former GP, as long as that GP is committed to providing the medical attention they require.

4.4 Investment in staff

In *The Forgotten Age* we drew attention to some of the major workforce issues in the residential care sector.[50] From interviews with many care workers the picture which emerged was of a dedicated workforce undervalued, demoralised and poorly paid – the majority at or around the minimum wage. A constant complaint we heard was that carer workers could typically get paid more stacking shelves in the local supermarket. Yet, as Kerry Allen, a 27 year-old care worker at Abbey Park nursing home in Coventry put it, 'If everyone went off stacking shelves for the same money, who would care for these people?'

One of the key factors to retain staff, and to improve their experience of residential care, is the level of training and development provided to them. We need a far more professionalised sector, with care workers who feel more confident and empowered to work with the client-group particular to the sector.

To this end, the first task we face is to improve the evidence base around what works in terms of staff training and development. Speaking to the CSJ, Martin Green, Chief Executive of the English Community Care Association, warned,

> *'Training has been the 'false god' of the twentieth and twenty-first century. Billions have been wasted on training which has made not one jot of difference to outcomes to service users.'*

Therefore, as Green emphasises, what we require is a solid evidence-base around what kind of training has the maximum impact in terms of staff satisfaction (reflected in rates of staff turnover) and the experience of residents.

One example we encountered of the kind of training which does have an impact is the leadership support programme for care home managers developed by My Home Life (MHL), a regeneration movement for the residential sector. Experts all agree that critical to the delivery of quality outcomes for older people is the leadership and professionalism of care home managers. This is a hugely demanding role: brokering between the needs of the residents, the demands of council commissioners and the concerns of management; helping staff to deal with the deaths of residents – these are all core tasks for managers. Yet in many parts of the country care managers feel isolated in this role. The MHL pilot has focussed specifically on tackling this problem.

50 Centre for Social Justice, *The Forgotten Age: Understanding poverty and social exclusion in later life*, London: Centre for Social Justice, 2010, pp218-221

Case-study: Leadership Support Programmes, My Home Life

MHL is a UK-wide initiative aimed to transform care home culture in the UK. A crucial part of this vision has been the development of a leadership support programme for care home managers, piloted across five local authorities (Wiltshire, Essex Bristol, Derbyshire and Yorkshire) over the last two years, which has now expanded to incorporate a further six counties and six London councils.

The programme is based on the premise that any kind of care home reform needs to begin with the care home manager. As Tom Owen, himself a former care home practitioner, seconded from AGE UK to help set up MHL, explained:

> *'Care home managers take on a world of pressures. They have so many unseen roles. At any one time they are business managers running the day-to-day operations, advocates for residents, counsellors for relatives, a primary contact-point for external parties, and liaisons between the home's owners, regulators and commissioners. That's why there are high rates of burnout in the manager's position… Care home managers need to fix their own oxygen masks first.'*

MHL's leadership support programme was designed to help managers 'fix their own oxygen masks first.' From the beginning MHL were adamant that they didn't want to reproduce yet another tool-kit, nor to host another one-off training day. Instead, managers – not only from different care homes but, significantly, from different care home organisations – were invited to a three-hour leadership support group once a month for a period of at least a year. The group was designed to be small – a maximum of 14 managers – and interactive. The facilitator wasn't there to lecture managers; his or her role was to create space and safety for managers to discuss between themselves aspects of the role and then, from there, to gain a deeper understanding of the issues they faced and generate their own solutions. 'We discuss situations on a case-by-case basis,' one manager reported, 'and together we work out together a better way of doing it.'

At a feedback session from the programme's most recent graduates, the CSJ heard of its outstanding results. Managers spoke of the isolation they had experienced – 'the sense that you can't speak to anyone'; and how the programme had, often for the first time, enabled them to be honest about the pressures of the role. They spoke of how operating from a place of fear had sometimes translated into a 'command and control' attitude towards staff; and how the programme, by helping them to rebuild confidence, had in turn enabled them to empower their staff to make decisions for themselves. Where the 'dreaded staff meeting' had once been poorly attended, now it was a 'full house', one manager reported. "Seeing the full circle of chairs, one colleague asked me, 'What have you done? Bribed them?'"

Managers also spoke of more objective indicators of quality improvement. 'It had been a very difficult time for me as a person,' one manager admitted; 'I thought I should quit my job because I was so stressed, and because I was stressed I acted aggressively.' The combination of high staff turnover and safeguarding issues in her home had led to an expensive and unfortunate over-reliance on agency staff. But after a year on the MHL programme, the home's owner had come to her asking why staff were staying put and why disciplinary hearings had ceased. The programme has demonstrated the value, indeed the critical need for independent support and coaching for managers to cope with the stresses that they face and improve the quality of life of their residents, relatives and staff.

Such initiatives are of vital importance. For this reason, we recommend that:

Recommendation:
Care home providers should be required to offer independent, regular support and mentoring to managers. Local authority commissioners should require this support and reflect that requirement in the fees they pay for care home placements.

In addition to this, we also believe that more must be done to make Social Care management a recognised and respected profession, which attracts more and more high quality candidates into the sector. We therefore recommend that:

Recommendation:
Central government should strongly encourage and support the establishment of a professional body for Social Care Management, potentially in the form of a chartered institute, charged among others things with ensuring adequate training and development standards within the sector.

Clearly providers, through their various representative bodies, must have a key role in delivering this, as should the Social Care Institute for Excellence (with their mandate to improve quality in the sector) and Skills for Care (with their responsibilities for shaping the Health and Social Care Diploma system).

> 'It would be nice if the outside world came in here.'
>
> 99 year-old nursing home resident, in evidence to the CSJ

Finally, in *The Forgotten Age* we highlighted the problem of isolation which affects many care homes. Managers and staff we interviewed spoke of the declining regularity of visits from friends and family; others told us of residents who had no visitors at all. Yet, as we argued, with homes often understaffed and care workers often overstretched, there is a desperate need for 'the outside world' to be let in to homes. As one manager told us, 'more than anything what we need is volunteers who will build one-to-one relationships with residents.'

The Growing Old Together project in Liverpool, profiled in Chapter Two, provides one example of the kind of volunteer-led, intergenerational solution to the isolation of residents. Yet while there are fantastic examples of volunteer-groups going into care homes to do the kind of vital relationship-building work which staff cannot, there are also many homes in the country which, intentionally or non-intentionally, shut out exactly the kind of groups they need. Either volunteers are disincentivised from visiting in because of being bureaucratically treated, or homes are worried that volunteers will substitute for staff and so operate a 'no volunteers policy.'

In light of this, and given what we have said about the pivotal role of leadership from care home managers, we recommend that:

Recommendation:
Care homes need to develop a greater culture of outward engagement. The leadership support groups for managers which we are calling for should prioritise creating a volunteer-friendly culture in care homes. They need, for example, to link in to the community audit we have called for in Chapter Two, whereby VOP teams work to connect schools with care homes and sheltered housing schemes in their area.

4.5 Vision for the future

If, as we have argued, the need for care homes is not simply going to go away, it is crucial that we properly plan for the future. As well as removing the arbitrary distinction between residential homes and nursing homes, better managing the healthcare of residents, investing in staff and managerial leadership, we also need innovation, creativity and vision to be released into the sector.

The case study below is of a new model of nursing care the CSJ encountered on its visit to the United States in February 2011. In our view the Green House model challenges the defeatism in some circles about the long-term prospect of radically improving long-term care. We think that it holds out an aspiration of what can be achieved in this sector.

Case study: The Green House Project, United States

Not many people can say they've invented a completely new form of nursing care. In February 2011, on its visit to the United States, the CSJ met someone who can lay claim to this. Dr Bill Thomas has devised a radically new model of nursing care – facilities known as 'Green Houses' – as a result of a profound personal experience.

Dr Bill Thomas meeting with the CSJ during its visit to New York

Returning from Harvard Medical School, Dr Thomas had gone to work as a doctor in a local nursing home in his native upstate New York. He found himself appalled by how quickly he came to tolerate the institutionalisation of the American nursing home culture which, as he saw it, disempowered and degraded older people. 'Older people represent an important part of the wealth of our nation and we have been squandering that wealth', he told the CSJ. Convinced that there had to be a new way of doing it, he decided that non-profit organisations were best placed to drive change in the sector by developing best practice. Starting with a blank sheet of paper, he returned to first principles: if he or someone he loved had substantial nursing care needs, what kind of care would he want, and where would he want it provided?

First of all, Dr Thomas decided, it's important to be realistic. As he told us, 'society carries a fantasy that we're all going to be surrounded by family members in our old age.' The Green House model is predicated on the fact that this will not always be the case. Green Houses are fundamentally places where 'small groups of unrelated individuals can choose to come together and share the rhythm of daily life.'

The novelty of the model, as witnessed by the CSJ on its visit to one Green House in Albany, New York, lies partly in the design features of the facilities and partly in their staffing ethos.

Design features

First, Green Houses are much smaller than traditional nursing homes. A Green House is a self-contained facility for only ten to 12 residents. Secondly, Green Houses are specifically designed to be far more homely than nursing homes. So, no clinical-looking corridors – instead each resident's room is built off a central lounge; and no hidden-away underground kitchens; rather, as the photograph below displays, the kitchen is part of the open-planned central lounge, complete with long dining tables on which residents eat together.

A Green House is designed to be open-planned, with a kitchen as part of the home rather than hidden away in the basement

Staffing ethos

Yet, as Dr Thomas told us, 'fundamentally the place doesn't matter. What matters is the type of care and support someone receives.' Being a care worker has traditionally been a very low prestige job, Thomas argued; it has traditionally be devalued, with no career structures and a steeply hierarchical system. 'The critical thing to change has been to train and empower staff. We've wanted to move decision-making as close to the residents as we can. As employers and managers in the past, we haven't listened to the very people who know the residents the best.' In addition, Dr Thomas's aim was for all direct caregivers to become dementia experts.

To make this vision a reality Dr Thomas again had to start from scratch. First of all he needed a new nomenclature, replacing the baggage-laden 'care worker' with the exotic-sounding 'Shahbaz' (pl. Shahbazim – Persian for 'falcon', Dr Thomas invented a myth whereby the falcons defended the interests of the people against the king.) In a Green House Shahbazim are multi-tasking staff members empowered to run the home from top to bottom. They are the ones to decide how to make life more amenable for the residents; they cook the food themselves and then eat with the residents. On our visit, the first noticeable thing about the Shahbazim was that they are dressed in their own clothes – the whole idea being break down the professional gulf between staff and residents.

Stanley Radzyminski, resident of the Green House Albany

We talked to Teresa, a nurse who works in the Green House. 'I far prefer working here than in the nursing home where I do night-shifts', she told us. Another key change is the staff-to-resident ratios. For each home there are always two Shahbazim on duty, meaning a staff-resident ratio of 1:5 or, maximum, 1:6.

In terms of older people's experience of the new model, the residents we interviewed in Albany are hugely enthusiastic. Marion, 97, moved into the Green House when it opened a little over a year ago. A former resident of a number of different care facilities, Marion was adamant: 'This is the best. When they built these they did a wonderful thing.' Stanley Radzyminski, a World War Two veteran aged 90, concurred: 'It's the building', he told us. 'But it's the people. The people are the best.'

In Albany we found that staff were as positive as residents about the Green House model. When Northeast Health built these Green Houses a year ago and moved the population of their nursing homes into them, the part of the transition management were most worried about was staff buy-in.[51] 'Staff were as doubting and cynical as they come', confessed Laurie Mante, manager of the project. However, surveyed a year later, 99 per cent of staff said they far preferred working in Green Houses: the atmosphere was more relaxed; they felt they knew the residents far better; and they liked how they could really follow the residents' rhythm of life.

Current progress

The first Green House opened in the year 2000, and there are currently around 1,000 older people living in approximately 100 Green Houses spread across nearly 30 states. Yet Green Houses are not a distinct corporation with Dr Thomas as CEO. Rather the Green House model is one which various providers can franchise, as Northeast Health have done in Albany. Crucially, the Green House model is explicitly designed for the very poorest, with the majority of residents nationally being state-supported. Which means, as Dr Thomas said, that the Green House model 'can't be one cent more expensive than the nursing homes which Medicare reimburse.' Nevertheless, Dr Thomas was confident that, even in an era of funding constraints, the Green House model can still start to tackle some of the chronic problems in the institutional care sector. As he concluded, 'To solve these problems you don't need a major discovery in nuclear physics'.

51 Northeast Health is one of the region's largest not-for-profit networks of healthcare, supportive housing and community services

To allow for this kind of innovation, we therefore recommend that:

Recommendation:
Commissioners and regulators should examine together the possibilities and conditions in which more person-centred approaches in residential care can thrive. Regulation needs actively to accommodate rather than prevent the kind of innovation that new models present.

4.6 Transforming regulation

In *The Forgotten Age* we cited some of the frequently-heard complaints about regulation in the care home sector.[52] From many quarters we have heard that the handing over of regulation to a national 'super' regulator in 2002 – currently the Care Quality Commission (CQC) – has led to the growth of policies, regulations and procedures imposed by people very few of whom have real experience of making care homes work. This has led to two distinct problems:

- First, care home staff often feel compelled to 'document their every move'. In one home we visited, every single conversation between a member of staff and a resident has to be 'logged', a process which, unsurprisingly, deters interaction between staff and residents.
- Secondly, when inspectors do come into the home, so we have heard, all too often they spend their (limited) time looking at the wrong things. Inspection can very quickly become a box-ticking exercise rather than an opportunity to observe care in action and to talk to residents' about their experience of the home.

At the time of writing, the CQC is in the midst of a significant transition. On one (policy) level, the 'direction of travel' has seemed promising. CQC's introduction in October 2010 of a simplified series of 'essential standards of care' seems to signify a shift to a more outcome-focussed approach and a commitment 'to look at the care you get rather than at systems and processes.'[53]

On the ground, however, there has been a different story. As Martin Green told the CSJ, 'The CQC has moved from process to outcomes in their rhetoric. But they certainly haven't moved from that in the culture of their inspectors.' Worse, a Freedom of Information request by Community Care in May 2011 revealed that despite increasing the fees it charges providers, there has been a 70 per cent drop in the number of on-site inspections by the CQC.[54] Yet rather than reducing bureaucracy, fewer inspections in fact force providers to revert back to providing more and more paperwork to corroborate processes, the very thing which the new essential standards were supposed to supplant.

In view of this we recommend that:

52 Centre for Social Justice, *The Forgotten Age: Understanding poverty and social exclusion in later life*, London: Centre for Social Justice, 2010, pp225-6

53 Care Quality Commission, 'Essential standards of quality and safety: How is the new system different?' [accessed via: http://www.cqc.org.uk/usingcareservices/essentialstandardsofqualityandsafety.cfm (13/06/11)]

54 Community Care revealed that the number of on-site visits by inspections dropped from 2,008 from October 2010 to May 2011 from 6,840 over the same period in 2009-10. Pitt V, 'Care Quality Commission visits drop by 70%', Community Care, 3 May 2011 [accessed via: http://www.communitycare.co.uk/Articles/2011/05/03/116741/care-quality-commission-visits-drop-by-70 (09/05/11)]

Recommendation:
Regulation should in practice change to become risk-based and proportionate ('right-touch') and should focus on the outcomes of care and not merely on the inputs or processes. In terms of inspection, the first and last parameter of whether a care home is providing a good service needs to be user-feedback: what residents say about the homes in which they live. Regulators need to be spending far more time actually observing care in action.

Secondly, one consequence of poor regulation has been *more* regulation. In many parts of the country local authorities are spending their precious adult social care budgets on yet more inspections. What this duplication signifies was emphasised by Martin Green in his submission to the CSJ,

> *'When I ask Adult Social Services directors why are they doing their own additional inspections at a time when they're strapped for cash, they say, 'Because CQC is useless and we don't trust them.' That's the reality. And as a provider, the more time and energy you spend responding to these overlaying bureaucracies, the less time and energy you've got to deliver outcomes and care.'*

Even further, having last year scrapped the star-rating system popular with the public, the CQC are currently considering licensing yet more organisations to operate a replacement 'excellence scheme.' This would signal yet further duplication.[55] To avoid duplication across the CQC and local authorities, there should be one agreed set of standards.

Finally, throughout our evidence gathering we have also heard many care home providers complain bitterly about the downward drive on prices and local authorities manipulating their purchasing power (as the largest purchasers of long-term care). The Dilnot Commission has expressed its commitment to find a way for 'increased resources' to be allocated to adult social care. It is imperative that these resources are distributed in an equitable way. And therefore we recommend that the regulator needs to inspect commissioning (i.e. local authorities' reimbursement policies) as well as the provision of care.

4.7 Transparency in funding

Finally, in *The Forgotten Age* we cited the complaints of care homes providers about significant underfunding by local authorities and of the failure to compare like with like when considering the finances of care home placements versus home care.[56] In a panel of care home managers hosted by the CSJ, one manager spoke of his local council pushing him to accept one resident. When he refused on the grounds that the price they were offered was simply insufficient to provide quality care for that resident, he told by the council representative:

> *'You'd better accept it. Six or seven of us (councils) are working as a cartel to fix mother.'*

55 Care Quality Commission, 'Care Quality Commission launches consultation on excellence in social care', Press Release, 9 May 2011 [accessed via: www.cqc.org.uk//newsandevents/pressreleases (09/05/11)]

56 Centre for Social Justice, *The Forgotten Age: Understanding poverty and social exclusion in later life*, London: The Centre for Social Justice, pp214-15

It is widely agreed that this problem cannot be solved apart with increased funding reaching the system. As we have said in the introduction we share in the expectation that the Government will be able to act upon proposals generated by the Dilnot Commission and provide a long-term, realistic funding settlement for social care. Yet in this review, as we have stated, our concern has been with how additional funding (however generated) *will be channelled*. Our recommendation, therefore, is that:

Recommendation:
Local authorities should be required to substantiate the fees they pay for care home places via an agreed 'fair price for care' methodology. This should involve disaggregating accommodation costs from care costs.

Such a change would go some way to tackling a major analogy in the care system in this country which tends to confuse service users, commissioners and policy makers. The anomaly is this: if an older person stays in their own home or goes to live in a specialist housing scheme such as an Extra Care facility, the cost of their accommodation remains separated from the cost of the care they receive. For those without means, the funding streams are differentiated, with the accommodation cost be funded through Housing Benefit while the (home) care is paid for by social service. Yet the moment that person then moves on into a care home accommodation and care costs are automatically merged (and payable in full by councils as one all inclusive fee).

Our hope is that such a reform would go some way to achieving is to place residential care in a continuum with other housing offers. By disaggregating the accommodation and care costs in this way, *where* a person receives care would become a matter of choice, with the government promoting that choice rather than impeding it through the way that payment mechanisms are currently structured.

List of recommendations

1. Neighbourhood policing teams should work within their community to identify ways of working with charities to engage extremely isolated older people living in poverty.

2. Every local authority, at Chief Executive Office level, should have a coordinated, systematic approach to supporting older people in the community, by bringing together local stakeholders to map provision at a local level. VOP teams should be established within all local authorities with urgency in order to establish local networks to bring local stakeholders together to map provision at a local level.

3. The VOP team at Manchester City Council should receive a small grant to develop a toolkit to help other local authorities design and develop VOP teams.

4. Community organisers should identify appropriate venues within their communities and draw upon them to connect together local organisations and efforts, particularly via the new VOP teams. Such organisers should identify appropriate venues within their communities and draw upon them to connect local organisations and efforts.

5. The key elements of the District Coordinator role – particularly the way it provides a bridge between community and local government – should inform the Government's Community Organisers' programme. Of particular importance is the necessity of community organisers achieving visibility in their local community by being closely attached to community hubs.

6. The Community First project actively encourages and duly makes awards to projects initiated by or including older people.

7. The hosting of Ageing Your Way-type gatherings must be a primary task for VOP teams as they are established. In addition, Community First match-funding should be levered in to support practical projects which emerge from these gatherings.

8. Local authorities, ideally through the newly established VOP teams which we have called for, should conduct a basic community audit to identify which local schools would be well placed to benefit from older volunteers. Such volunteers could be especially effective in providing support with basic reading, writing and mathematics programmes within primary schools. They might also have an important part to play in our calls for

increased financial education in schools, given their experience of managing money through their working lives.

9. VOP teams should also then identify local residential accommodation for older people (sheltered housing schemes, care homes etc.) which would benefit from visits from schools.

10. VOP teams should encourage increased collaboration between older people's organisations and those that focus on children, young people and young families. As well as the clear benefits such partnership would offer to those participating, the exploration of closer working practices and joint funding applications, where appropriate, might offer an added bonus to such organisations in terms of increasing efficiencies, cutting duplication and navigating the choppy waters of reduced public expenditure a little more smoothly.

11. The concessionary bus pass should be treated as a taxable benefit and the revenue raised placed in a fund administered by an independent agency to pay for other community transport including subsidised taxi schemes and schemes specifically aimed at older people.

12. Local authority operated Dial-a-Ride schemes should be broadened to include other essential journeys such as to medical appointments or day centres.

13. Local authorities establishing LEPs should include representation from older people's groups.

14. If the evaluation of Automaticity proves take up has been significantly boosted, the Government should begin a full roll out of automation for PCG. Early prioritisation within this should go to people aged 80 and above.

15. There should be automatic communication between government agencies so that when someone is in receipt of PCG, their eligibility not to pay council tax or to receive HB is actioned on their behalf.

16. In order to ensure the WFP retains its relative value for recipients, the CSJ calls on the Government to introduce a 'double lock guarantee', whereby the payment is linked to inflation increases or energy price rises, whichever is higher.

17. The Government should end the universal payment of the WFP to ensure that the poorest receive more support.[1]

18. The Government should investigate mechanisms of removing the universality of the WFP in order to increase its effectiveness in fighting fuel poverty for the poorest older people. Within these deliberations, we urge policymakers to ensure that it is spent on what it is designed for – fuel costs or improving homes' energy efficiency. [2]

1 This recommendation was not endorsed by Working Group Member Andrew Harrop, Director of Policy and Public Affairs at Age UK
2 This recommendation was not endorsed by Working Group Member Andrew Harrop, Director of Policy and Public Affairs at Age UK

19. The teaching of financial education should be compulsory in schools and should incorporate planning for later life, including pensions and health insurance.

20. Private sector initiatives to educate both children and adults in personal finance should be encouraged, strengthened and expanded.

21. We recommend that people be offered a free financial health check between the ages of 55 and 60.

22. A financial advice guide should be developed specifically to assist those people who are moving from working age benefits to retirement age support.

23. Local community-based debt advice should be supported by local authorities, and partnerships should be encouraged between smaller, specialist agencies and larger providers of financial advice.

24. The Government should explore the possibility of local authorities (operating under a Service Level Agreement or contract) to partner with different not for profit agencies in order to provide information for people on areas such as benefits, housing, care and finance.

25. An integrated system should be established for both disability adaptations and home repair. This system should be clear in terms of entitlement and efficient in terms of delivery, hinging upon a central distinction between minor and major 'interventions'. In terms of both repair and adaptations, vital, preventative minor works – i.e. handyperson services, paring down carpets, grab-rails, ramps, or contribution towards disability-related adaptations – should be freely available and universally provided at the local level. (Such a system could thus be free of the current means-testing which makes the system extremely complex to navigate and slow to operate.) Major works, by contrast – whether adaptations such as installing through-floor stair-lifts, room extensions or repairs such as installing new roofs, electrics or heating systems – should increasingly be funded by contributions from homeowners who can afford it, by accessing appropriate amounts of their property's equity.

26. The Government gives greater profile to specific products developed to allow low income older homeowners to release equity. Each local authority should increase its promotion of a range of existing and future equity release solutions.

27. Given the relative underachievement of the market to date, we believe the Government may need to consider direct market stimulation in order to redress a lack of take up. Such action, which should be a time-limited interim measure, could begin to drive up the competition of product offers, including making interest rates more affordable.

28. Local authorities' new health and wellbeing boards, if forthcoming, should take responsibility for the delivery of this new integrated system for repairs and adaptations.

29. As a temporary measure the Government should immediately restore funding for PSR. This funding stream should then be phased out gradually in line with the expansion of a

proper equity release market for low income homeowners giving them the real choice of safely drawing upon their capital to fund major repairs and adaptations.

30. As a temporary measure, until the equity release market has been properly expanded, the maximum threshold for a means-tested Disabled Facilities Grant should be reduced from its current level to the average value of a grant: £6,500.[3]

31. The creation of a small emergency and exemptions fund, particularly designed for those with low value equity (say, less than £100,000).

32. We recommend that the Government considers promoting a flat rate interest bearing Green Deal loan. We also suggest that people who apply for Green Deal loans should automatically be referred to a provider who offers benefit checks to ensure that they are receiving the support they are entitled to.

33. A greater proportion of the capital grants the Government makes available to build new affordable homes needs to be allocated to housing specifically designed for older people, whether in the mainstream or specialist sectors.

34. Through the 'ground rules' it sets for planning policy, central government needs explicitly to include older people's housing within its priorities.

35. All planning authorities should be required to produce an older person's housing strategy based on their assessment of predicted demand in their area.

36. An independent impact assessment should be carried out for a proposed pilot of a time-limited period to suspend Section 106 affordability contributions required of retirement developments.

37. Councils need to take the initiative to bring on-line a greater supply of specialist housing such as Extra Care. In an era of reduced capital expenditure by government, councils need to consider other ways of developing specialist housing products such as offering land and asset transfer arrangements.

38. There should be much stronger incentives for GPs to identify and refer carers to appropriate support. The QOF should measure outcomes rather than processes, with GPs being rewarded not simply for retaining a register but for referring carers for assessments or for writing prescriptions for ad hoc respite care (see below).

39. GPs should be allowed to write 'social prescriptions' for respite care directly to carers they identify as overburdened.

40. Carers' Centres and agencies other than Social Services should increasingly be encouraged to undertake carers' assessments on behalf of councils. This would ensure

3 Adams S and Ellison M, *Time to Adapt – Home adaptations for older people: The increase in need and future of state provision*, Nottingham: Care & Repair England, September 2009, p8

unnecessary duplication is avoided whereby by a Carers' Centre takes a carer's details and then requires Social Services to do the same. Instead, Social Services should work more flexibly and, where possible, 'sign off' assessments conducted by Carers' Centres.

41. Health visiting should now be expanded for the poorest older people and targeted in areas of most deprivation.

42. The NHS and local authorities jointly commission preventative care teams to proactively and intensively 'case manage' identified groups of older people living with ill-health and at high risk of hospital admission.

43. The now out-of-date distinction between residential care homes and care homes with nursing should be removed. The money the NHS makes available to the sector (the weekly RNCC) should no longer be restricted to care homes with nursing. Instead it should be allowed to 'follow the patient', i.e. to be allocated to those individuals in residential care who condition significantly deteriorates. Receiving additional NHS funding for nursing will not only prevent a subsequent move to a new nursing home but may also prevent (and thus offset the cost of) hospital admission.

44. The NHS, through appropriate commissioning bodies, should specifically require GPs to take responsibility for coordinating healthcare in care homes. The current system – where multiple GPs go (or don't go) into care homes, or else expect residents to come to them – should be replaced by one where single GP practices are aligned with specific care homes, committing to visit on a regular basis and proactively to 'case manage' the often complex medical conditions of residents.

45. Care home providers should be required to offer independent, regular support and mentoring to managers. Local authority commissioners should require this support and reflect that requirement in the fees they pay for care home placements.

46. Central government should strongly encourage and support the establishment of a professional body for Social Care Management, potentially in the form of a chartered institute, charged among others things with ensuring adequate training and development standards within the sector.

47. Care homes need to develop a greater culture of outward engagement. The leadership support groups for managers which we are calling for should prioritise creating a volunteer-friendly culture in care homes. There is a need, for example, to link in to the community audit we have called for, whereby VOP teams work to connect schools with care homes and sheltered housing schemes in their area.

48. Commissioners and regulators should examine together the possibilities and conditions in which more person-centred approaches in residential care can thrive. Regulation needs actively to accommodate rather than prevent the kind of innovation that new models present.

49. Regulation should in practice change to become risk-based and proportionate ('right-touch') and should focus on the outcomes of care and not merely on the inputs or processes. In terms of inspection, the first and last parameter of whether a care home is providing a good service needs to be user-feedback: what residents say about the homes in which they live. Regulators need to be spending far more time actually observing care in action.

50. Local authorities should be required to substantiate the fees they pay for care home places via an agreed 'fair price for care' methodology. This should involve disaggregating accommodation costs from care costs.

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