

Breakthrough
Britain

The Forgotten Age

Understanding poverty and social exclusion in later life

An Interim Report by the
Older Age Working Group

Chaired by Sara McKee

November 2010

THE CENTRE FOR
SOCIAL
JUSTICE

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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

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Preface

The Centre for Social Justice (CSJ) was established to find and promote solutions to social breakdown in the UK. 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. These are the key drivers of social breakdown and disadvantage in Britain today. The findings of that report demonstrate how poverty cannot be measured on income alone. Social problems have deep and long-term causes that must also be confronted. This is foundational to everything we do at the CSJ.

We have already noted in *Breakthrough Britain*, and in our work on early intervention, how important it is to support people in their earliest years. But the needs of our oldest people are equally important if we are serious about reversing social breakdown and tackling poverty. And as this interim report makes clear, quick fixes don’t work. To alleviate poverty in older age effectively, just as with poverty at any age, the only viable course is to combat the roots as well as the symptoms. The ‘pathways to poverty’ we identified in *Breakthrough Britain* all extend into older age. For example, the scars of a drug or alcohol addiction will be worn throughout older age in terms of finances and health; the breakdown of a family creates a fragmentation of a potential care and support system for its oldest members; a lifetime of economic dependency translates to a lack of stability and security that will only worsen as an individual’s housing and health demands increase.

Poverty and social exclusion in later life remain unacceptably high for a society as relatively prosperous as ours. One in five pensioners in the UK lives below the official poverty line and bearing in mind the narrow and arbitrary nature of this measurement, there are many more older people whose quality of life is far too low. As this report shows, the clearest example of this less quantifiable disadvantage is older people’s experience of loneliness and exclusion. And for those in Britain’s poorest communities, such disadvantage is an urgent reality: on average people in these areas live shorter lives than those from more affluent neighbourhoods. What is at stake is life, not simply quality of life. Our society is also ageing rapidly: by the year 2024 one in five people will be of pensionable age. This phenomenon will bring with it new social and economic pressures. Unless these are handled promptly and efficiently, pensioner poverty and social exclusion in later life are likely to worsen.

We also have to recognise that older people have for too long been a ‘political football’ in Westminster. This has to change. Care and pensions – the traditional flashpoints of the older age debate – are indeed important

areas and reform is essential if we are to ensure the wellbeing of older people. However, as our society continues to age, the range of challenges continues to extend. Accordingly, this review considers several other ways to improve the lives of this ever-growing section of society, from better housing to better neighbouring, from exercise to digital inclusion. This review's Working Group also encountered a worrying and prevalent 'planning apathy' amongst those they had spoken to. This must be confronted; the foundations for a fulfilling and healthy older age must be laid early.

In all of this, however, we should also be quick to celebrate older age and the opportunities it can afford. Retirement years can be among life's most fulfilling and older people have a huge amount to offer society. For example, they already constitute the fibre of our volunteer workforce. And there are both economic and social benefits to making people's later lives vibrant and valuable, as this review makes clear. This will form a central theme of the strategy we will outline next year.

This is a two-part review. Here we present the nature and scale of the challenge our new Government faces if it is to tackle poverty and social exclusion in later life. In publishing this report I would like to thank Sara McKee and the Working Group, as well as Christian Guy, Paul Langlois and James Mumford at the CSJ, for their efforts. The second report, to be published next year, will set out a reform agenda based on this analysis. We are fully aware of the extreme public expenditure pressures that the next years entail, and the review will take these adverse circumstances into account. But let us be clear, our current economic context means it is even more important that we get this right once and for all.

Gavin Poole

Executive Director, the Centre for Social Justice

Chairman's Foreword

It has been a great privilege to work with such a distinguished group of specialists focusing on poverty and social exclusion in Older Age, and to lead this increasingly important area of policy which is so often kicked into the long grass.

Debates about ageing in the UK tend to focus on the negative aspects of life in retirement, and it is true that our living for longer presents challenges to individuals and policy-makers. However, our Group determined from the review's outset that older age is something to celebrate and enjoy. Additionally, we should also remember that older people are not a homogenous group. With increasing numbers of people living well beyond 100 and retirement beginning when people are in their sixties, the "older generation" actually encompasses an extremely wide age range.

The astounding statistics on demographic change in the UK have been well-debated. Less apparent is how public services and wider society must evolve to face these new realities. The responsibility we have to tackle the challenges posed by our ageing population is not simply to future generations. Today, in every community, in every part of the country, the extremes of life in old age are being experienced: loneliness, isolation, poverty, boredom and fear. These are not the experiences of all older people. But they are the experiences of too many and, unchecked, will be the experiences of many, many more.

We need to celebrate old age. In doing so we must find better ways of ensuring the wisdom and experience gleaned by individuals over decades is not allowed to go to waste. In taking evidence, the Working Group heard of many examples of older people who were enjoying life, playing active parts in their communities and making a contribution. But they were the exception rather than the rule. For too many, it seems, older age brings harder challenges than ever before, and fewer resources with which to meet them.

In a period when politicians are stressing the interconnectedness of individuals in society, as well as our mutual responsibilities to support communities, it is crucial to ensure older people are empowered to play their part, and are themselves served and respected in return.

The timing of this report could not be more apposite. Individuals, organisations and the state have experienced a paradigm shift. The financial realities caused by the economic crisis mean maintaining public funding for services, including those for older people, at pre-recession levels is not an option. Yet we also know that even maintaining the status quo would have meant declines in funding in real terms as the number of older people and their longevity increases.

The swift and decisive action to tackle the deficit must be weighed against the unintended consequences that are already resulting from recent cuts. For example, it was clear from the evidence submitted to our review that short-term pressures to save money in one budget can lead to massive budgetary impacts elsewhere.

However, this report is an attempt to step back from the important but ultimately limited debate about public funding. Too often the debate about older age focuses on care and pensions – and in particular, the State's contribution to both. The diversity and challenges of our ageing society means this is inadequate. Almost every Whitehall department touches issues of relevance to older people and responsibilities at a local level span a variety of local authority departments as well as health, housing and the voluntary sector.

In gathering evidence, we have attempted to understand how we can access the innate value to society of ensuring older people are able to continue to play an active part, even when facing significant care needs. With growing discussion of the concept of the Big Society, it is clear that such a society cannot be achieved unless it is a society in which older people feature strongly.

We are at a tipping point. There is growing and ever-more heated debate about whether the baby-boomers “owe” the rest of society; whether their property wealth and relatively secure lives have been at the expense of younger generations. But such divisive debate is flawed. Not all baby-boomers are sitting on huge amounts of equity and while many may have higher aspirations than their parents' generation, they are not immune from declining property values and poorer-than-expected investment performance.

Most importantly, our report shows there are disturbing numbers of older people living in poverty and social exclusion. We cannot afford, financially or morally, to let this situation continue. We must not allow complex and circular discussions to obscure the most urgent issues of the day. This report will outline the various areas of older people's lives that need addressing, by State and society, if we are to lift struggling older people out of the poverty they do not deserve.

In our report we criticise Westminster for using older people's issues as a ‘political football’. We make no apologies for doing so. What I am heartened by, however, is the fact that politicians are finally recognising these issues are worthy of real debate and the pre-general election jostling this year is evolving into serious discussion of the issues.

I hope this interim report provides a positive contribution to that debate and helps demonstrate the importance of moving swiftly from discussion into action. Our second report, to be published in 2011, will outline an agenda for facing such challenges.

I would like to thank our lead researcher at the Centre for Social Justice, Christian Guy, for his tireless effort in pulling together the many strands of evidence into this report. My thanks also go to Paul Langlois and James Mumford in the same regard. And, of course, I would like to thank all the

members of the Working Group, as well as those who gave evidence, for so generously giving their invaluable time and expertise.

Sara McKee

Chairman, Older Age Working Group

Members of the 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.



Andrew Harrop

Andrew Harrop is Director of Policy and Public Affairs at Age UK, the new force combining Age Concern and Help the Aged. 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 on employment and equality and was then Head of Policy from 2006 to 2009.



Roger Davies

Roger Davies is Chief Executive of MHA Care Group, a charity providing care homes, housing and support services for 12,500 older people throughout Britain. Annual income is £120m. 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 also 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 1981-1992 Director of the National Deaf Children's Society. He is chair of the National Information Governance Board for Health and Social Care, Co-Chair of National Voices, an advisor to The Health Foundation and to Macmillan Cancer Support 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.



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Stephen Burke

Stephen Burke 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, from March 2005 to November 2010. 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. Previously Stephen was Director of the national childcare charity Daycare Trust from 2000. He led the charity's campaign for childcare for all, promoting children's centres in every community and securing substantial new investment. In November 2010 Stephen moved home to the north east Norfolk coast where he and his wife are setting up United for All Ages, a social enterprise bringing older and younger people together.



Richard Furze

Richard Furze began work in the voluntary sector in 1994 with the Shaftesbury Society, which specialises in supporting people with a disability as well as in church development work, before moving to Friends of the Elderly in 2001, first as Finance Director and then as CEO, developing and running the centenary celebrations in 2004/05. In both charities Richard has been heavily involved in strategic and business planning as well as in matters of charity governance and fundraising.



Janet Morrison

Janet Morrison joined IndependentAge as Chief Executive in March 2007 and has since led a comprehensive strategy review for the charity. Independent Age is a national charity, working to enable older people to lead independent and fulfilling lives via volunteer led befriending services and grant making. She was previously a founder and Deputy Chief Executive of NESTA - the National Endowment for Science Technology. 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 NCVO - the National Council for Voluntary Organisations, where she was Director of Policy and Research. Janet is a Trustee of the Baring Foundation and a Fellow of the Royal Society of Arts.



James Reilly

James Reilly is Director of Community Services for the London Borough of Hammersmith and Fulham. He is responsible for Adult Social Care, Regeneration, Housing and Voluntary Sector Support. He has led a number of partnerships with statutory, voluntary and private sector partners to develop local services which have been commended by the Audit Commission. He was the Chair of the London region Association of Directors of Adult Social Services and co-chair of the ADASS Older People's Network. He was a member of the National Task Force on the Future of Social Work. James has worked with social services in Hackney and Brent and in the NHS, Voluntary Sector and undertaken 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 Retailing with leading UK companies e.g. Marks and Spencer and House of Fraser. She became a consultant in 1995. She is his main carer of her 90 year old father after the death of her mother in 2000. Her aunt is 91 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.


Caroline Glendinning *Adviser*

Caroline Glendinning is Research Director (Adults, Older People and Carers), Social Policy Research Unit, University of York. She leads SPRU's DH-funded research programme on Choice and Change across the Lifecourse; was involved in the national evaluation of the Individual Budget Pilot Projects and a linked study of the impact of IBs on carers; and has led a major evaluation of the longer-term impacts of home care reablement services. Caroline is also interested in comparative research in social policy and is currently contributing to two studies of reforms to long-term care and home care across Europe. Caroline is a Trustee of the Thalidomide Trust and is currently Chair of the UK Social Policy Association.


Christian Guy *lead author and researcher*

Christian Guy is the Policy Group Manager at the CSJ. As well as this he holds responsibility for criminal justice, addictions and older age policy work. He was the senior researcher and co-author of *Locked Up Potential*, our recent prison reform review. He is also the Assistant Director of Jonathan Aitken's Westminster Forum. Before joining the CSJ he worked as a Community Development Officer for a partnership of local authorities, police, schools and voluntary sector organisations in Surrey, as well as undertaking a 12 month political internship in East London. He read Politics and International Relations at the University of Reading.

Paul Langlois *researcher and co-author*


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



James Mumford *researcher and co-author*

James Mumford was studying for a PhD in ethics at the University of Oxford before joining the CSJ, having 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.

The CSJ would like to thank Lizzie Davidson, for her excellent editorial and research support, as well as Mario Ambrosi and Tony Bridger for their work on chapter four.

Executive Summary

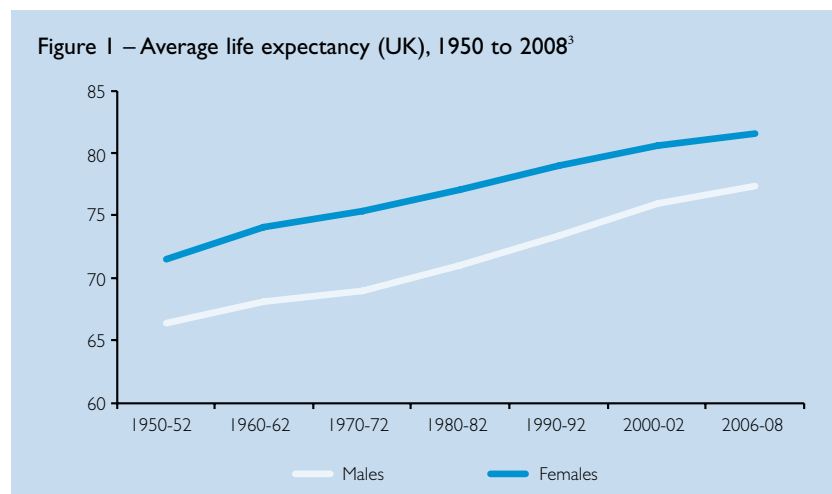
This is the Executive Summary of the Centre for Social Justice's (CSJ) Older Age review interim report. To download the full report, please visit www.centreforsocialjustice.org.uk.

1. INTRODUCTION

1.1 Celebrating Older Age

We should celebrate the fact that we are all living longer. Recorded life expectancy rates have increased significantly in the last 80 years, such that a boy born in the UK between 2006 and 2008 could expect to live to the age of 78 years and a girl 82 years, approaching 20 years longer than at the turn of the 1930s.¹ One in four boys will now live to 100 and as many as one in three girls are expected to do the same.²

The rate of life expectancy increase has been particularly striking since 1950, as the following table demonstrates.



- 1 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>
- 2 Speech by the Secretary of State for Work and Pensions, Rt. Hon Iain Duncan-Smith MP, Reinigorating Pensions, Thursday, 24 June 2010
- 3 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>

These progressive demographic changes reflect significant developments in public health and awareness, overall national and personal prosperity and access to ever more sophisticated healthcare. Additionally, for many people their retirement years bring new found levels of financial and social freedom, as well as increased choice; for example, over 55 year olds control 80 per cent of the nation's wealth and account for 40 per cent of the UK's annual consumer spending.⁴ Overall, then, our developed society is, in general and comparative terms, a better one in which to grow old than many others around the world.

Furthermore, given such improvements, hundreds of thousands of older people across the nation have the opportunity to make an integral contribution to community life. They are so often the heartbeat of our country's civic participation, volunteering and social action, formally and informally. These trends and social traits – which continue to improve the quality of life for millions of older people in our communities – are to be respected, welcomed and championed.



CSJ Policy Group Manager Christian Guy talks to a resident of the Norton House Care Home, Westminster

1.2 An Ageing Society

Whilst old age is a clear cause for celebration, it is also crucial to recognise that Britain's rapidly ageing society offers a number of serious short and long term challenges. These must be recognised and tackled.

The most serious of these challenges is our projected demographic pattern. The UK's population is projected to increase rapidly in the coming years, and, particularly relevantly, become older overall. This constitutes the most serious social policy issue in decades. Unless action

is taken to accommodate these changes there will be significant pressure on age-related public services – such as the state pension and benefit system, healthcare and social care provision – and a serious impact on workforce growth.

Between now and 2033 the median age in the UK will rise from 39.3 years to 42.2 years⁵ and the gap between the number of under 16 year olds and people of pensionable age (taking into account the planned pension age rise), will widen rapidly. By the year 2024 one in five people will be of pensionable age:⁶ a 32 per cent increase. More pertinently, many individuals within the pensioner population will be living for much longer by 2033.

⁴ HM Government, *Building a society for all ages*, London: The Stationery Office, 2010, p14

⁵ Office for National Statistics, *Statistical Bulletin: National population projections, 2008-based*, Newport: Office for National Statistics, 2009, p4

⁶ Office for National Statistics, *Ageing in the UK datasets*, Table 8: Percentage of the population aged 65 and over

1.3. A ‘Political Football’

What is also true is that our older population has been one of the largest ‘political footballs’ in Westminster for too long. The treatment of older people’s issues during our recent general election, for example, disappointed many. And those who suffer most as a consequence of this behaviour are not the politicians and policy-makers who engage in and fuel it, but older people themselves.

In view of the urgent economic pressures and projected demographic changes Britain faces, and given the public anger about the recent undignified squabbling over social care, this simply must change. Older people, both in evidence to this review and more broadly, are demanding more from those who hold public office, and of those who seek it.

A newly founded and broadly welcomed atmosphere of political coalition and consensus does offer justifiable hope that reasoned and responsible debate will ensue. It is the intention of this CSJ Working Group, both in this interim report and through our recommendations to follow, to make a useful contribution towards achieving that aspiration.

1.4 Broadening the Debate

There is a tendency for the debate about older age to remain narrowly focused on care and pensions. The emerging diversities and challenges of our ageing society suggest that this sort of response is inadequate, and it is vital that policy-makers engage in the much broader debate about ageing. One only needs to look at the cross-department division within central and local government, as well as other core local public services, to grasp the sheer range of ageing issues. Direct responsibility for old age-related policy falls across a multiplicity of Whitehall teams within several arms of government including the Department for Work and Pensions (DWP); the Department for Communities and Local Government (DCLG); the Department for Health; and the Department for Transport. At a local level the responsibility is spread across Social Services; benefit offices; local authority housing teams and associations; PCTs, Hospitals; and the commissioned voluntary sector. One can add to this list decisions made by other departments which affect us all, whether old or young, such as HM Treasury; the Home Office; and the Ministry of Justice.

Too often older people are grouped into one or two interest cohorts as if life fundamentally narrows at 60 or 65. Ask almost any older person what matters to them, however, and it will become clear that this assumption is

“At 70 years old you can be confined to a wheelchair with rapidly deteriorating health or you can be running for President of the United States. We have to start making room for that diversity.”

A housing professional, in evidence to the CSJ

“You wouldn’t sweep 10 year olds and 50 year olds into the same group, so why do we continually see that happening with people of pensionable age?”

A social care professional, in evidence to the CSJ

misguided. This naive habit disregards the diversity of issues within every stage of later life, and leads to inappropriate ‘one size fits all’ public policy. So whilst there is an urgent need for social care and pension reforms, Britain must also initiate a broader conversation about both the wider life experiences of people above pensionable age, and the issues that matter to them.

1.5 Older Age Poverty and Social Exclusion

MARY

At the time of her referral to a local charity in 1995, Mary, 82, had only a small weekly income from her state pension. She was in desperate need of a new bed, mattress and bedding. She needed help with her utility bills. Mary rents a house on a deprived council estate in north London and is now in receipt of housing benefit and council tax benefit. Her neighbours have moved away, her husband died 20 years ago and she has no contact with other family members. She has become increasingly isolated and depressed. Mary feels she has no one to call on for help or company. She lacks confidence and the means to socialise. Her faithful dog, which was her only reason to go out daily, died in 2008. For a long time now her only social contact has been a local taxi driver who collects her pension and takes her food shopping. Mary rarely leaves the house; she has become frail and nervous of the outside world, and is fearful of the crime she often describes as rife in her area.

The CSJ was established to put social justice at the heart of British politics, and to find and promote solutions to deep rooted poverty. Accordingly, it works for people society has left behind, like Mary.

1.5.1 THE POVERTY LINE

One in five pensioners in the UK lives below the poverty line:⁷ 2.3 million before housing costs and 1.8 million after housing costs. This equates to £206 disposable income a week after housing costs for a couple and £119 a week for a single person.⁸ Comparably to 1998, it should be noted, this does represent a reduction of 0.5 million pensioners in poverty before housing costs, and 1.1 million after housing costs. We welcome this progress.

Regrettably, though, it should also be noted that much less progress has been made in helping those pensioners in more severe and persistent poverty. For instance, the number of pensioners living below 50 per cent of median income is currently 1.1 million after housing costs, rising back towards 1999/00 levels of

⁷ Defined by Government as below 60 per cent of contemporary median net disposable income

⁸ Department for Work and Pensions, *Households Below Average Income: An analysis of the income distribution 1994/95 – 2008/09*, London: Department for Work and Pensions, p22

1.3 million (after falling to 0.9 million between 2004 and 2006).⁹ What is more, poverty remains disproportionately high in many ethnic minority communities.

This illustrates, as the CSJ has argued in previous publications, that there is a problem with rigidly holding to arbitrary definitions of poverty which prove narrow and unhelpful. The previous Government, for example, was often too quick to base its strategy for poverty reduction solely on income levels. This regularly resulted in changes to benefit levels and tax credits alone, which in turn led to quick fixes and technical claims that demonstrated how a certain number of people within a targeted group had been lifted out of poverty. But as the longer term figures show, unless a broader understanding of poverty is adopted such targeted groups will simply continue to drift above and below the line without an enduring change in quality of life or opportunities.

This review, therefore, aims for a broader analysis. We have identified several key indicators which help clarify our concentration on the poorest older people. Although far from exhaustive characteristics, the most common are outlined below and help build a basic personal profile by which this review is guided.

1.5.2 GUIDING CHARACTERISTICS: MONEY

The overwhelming majority of older people we refer to in this review do not possess sufficient assets (savings, pensions or investments) to release capital for a higher quality of life. Consequently many are reliant on the state pension and other age-related benefits to make ends meet. Most commonly these benefits comprise Housing Benefit; Pension Credit Guarantee and Council Tax benefit. Many within our targeted group claim a combination of these benefits: for example 1.1 million people receiving Housing Benefit do so on a passported basis by way of also receiving Pension Credit (Guarantee Credit).¹⁰ However, as we outline, there also remains an alarming number of older people who are eligible for basic statutory financial support but who do not receive it.



1.5.3 GUIDING CHARACTERISTICS: HOUSING

Although almost two-thirds of pensioners living below the income poverty line are outright home owners and a third rent,¹¹ the majority of the poorest older people we have encountered through meetings or submissions have very little or no asset and savings base at all. They therefore have no option to release sufficient capital or finance. What is more, many of the poorest older people we have met live in more socially deprived urban areas where social housing tends to dominate local housing provision.

⁹ Ibid, p12

¹⁰ Department for Work and Pensions, *First Release: DWP Quarterly Statistical Summary: Additional Table 6*, London: Department for Work and Pensions, 2010

¹¹ Department for Work and Pensions, *Households Below Average Income: An Analysis of the Income Distribution 1994/95 – 2008/09*, London: Department for Work and Pensions, 2010, p168

We also recognise that as well as tenants with very low assets there exists a proportion of homeowners who have to make significant mortgage repayments well into their retirement, or who have low asset value in their property due to the nature of their locality or the property's poor state of repair. Added to this there are a number of older people who live in deprived or very isolated rural settings where unique pressures can entrench poverty. There are also older people, some of whom we have encountered, who have a low quality of life and who could improve it by accessing capital but choose not to. In addition we have heard and fully share the concerns of those who have given evidence to our review about homelessness in old age. We will respond to these concerns.

1.5.4 GUIDING CHARACTERISTICS: LONELINESS AND SOCIAL EXCLUSION

Research demonstrates that loneliness is felt particularly acutely by those above pensionable age: almost one in ten people aged 65 and over report regularly or always feeling lonely.¹² This is often triggered by a loss of social networks and companions – features commonly associated with later life. In poorer communities it has been a particularly debilitating theme.

Many older people show characteristics of social exclusion. In particular, those over 80 years old, those who have never been married or who have experienced family breakdown, and those who live on low incomes.¹³ Evidence presented by the previous Government found that of those people (20 per cent of all older people) living on low income approximately 15 per cent experience severe exclusion; of those renting (almost 20 per cent of all older people) approximately 20 per cent will do so.¹⁴ There remains a huge amount left to achieve in lifting people out of this, and recognising the root causes – such as social breakdown – is crucial to succeeding.

“When you reach this age having a bit of money matters more than ever. The older we get the more important it is to try to eat well and stay warm. That starts with money.”

Elderly community project member in evidence to the CSJ

2. MONEY

2.1 Money Matters

Although as we have noted pensioner poverty should be defined in broader terms than income and an individual's assets, money is absolutely vital in determining whether an individual lives in poverty or not. And money becomes particularly pertinent for older people, the majority of whom tend to need to spend more on essentials at a time when disposable income and the opportunities to earn

- 12 Social Exclusion Unit, *A Sure Start to Later Life*, London: Office of the Deputy Prime Minister, 2006, p55
- 13 The English Longitudinal Study of Ageing, *Retirement, Health and relationships of older people in England* (Wave 2), London: ELSA, 2006, p297
- 14 Social Exclusion Unit, *A Sure Start to Later Life*, London: Office of the Deputy Prime Minister, 2006, p21

more often decrease. For example, people aged 60 and over spend more of their money on food, drinks and energy, and less on clothes, transport and certain leisure activities than younger people.¹⁵ It should also be noted that these necessary spending patterns have rendered many older people some of the most vulnerable in society during the recent recession.

2.2 The Recent Recession

The Working Group has been acutely aware that our review is being conducted in the context of deep rooted economic uncertainty and severe pressure on public finances. The recent recession, as one of the deepest in our history, meant that the majority of Britons experienced personal financial pressure to some extent during it; however, evidence leaves us in no doubt that older members of society have been some of the hardest hit.

There is evidence that poorer older people have been cutting back drastically on important household expenditure – meaning for example that one in five pensioners has been forced to cut back on food and approximately four in ten have reduced their use of electricity and gas.¹⁶ As well as the rising cost of living, some older people have suffered intensely as a result of the dramatic fall in interest rates.

2.3 The State Pension

Unsurprisingly the state pension is a lifeline for many of our poorest older people. Figures published by the Office for National Statistics (ONS) reveal that the Basic State Pension (BSP), with minimum income guarantee or Pension Credit, is the sole means of support for a third of pensioners in the UK.

The pension was originally designed as a safety net to prevent older people from slipping into poverty. Nowadays, the costs of living, and the level of income required to live well, mean that the pension is not enough on its own to support an older person's lifestyle (hence frequent reliance on Pension Credits and other benefits). The seismic demographic change ahead, policy-makers predict, will only intensify these issues. Plans are being made to adapt the state pension system accordingly; for example, the DWP calculates that by 2050 the BSP should amount to twice as much in real terms as in the year 2012.¹⁷ Moreover, reforms are in motion to address the numbers of people receiving the full BSP, so that by this year an estimated 75 per cent of women will receive the full BSP,¹⁸ and by 2050 95 per cent of both men and women will receive the full BSP. Additionally, the 2010 Comprehensive Spending Review

15 Office for National Statistics, *Family Expenditure, 2009 edition*, Newport: Office for National Statistics, 2010, p115

16 Age Concern and Help the Aged (now Age UK), *Economy in crisis, Coping with the crunch: the consequences of the recession for older people*, London: Age Concern and Help the Aged, 2009, p1

17 Office of National Statistics, *Analysis of impact of pensions legislation*, June 2009, accessed via: <http://www.statistics.gov.uk/pdfdir/ptrends0609.pdf>, p2

18 Pensions Act 2007

confirmed that State Pension Age will be equalised on November 2018, and the pension age for men and women will then be raised to 66 by April 2020. And although details remain unclear, we welcome the new Government's decision to investigate a 'citizen's pension'.

It is not in the remit or the capacity of this review to recommend extensively on the technicalities of pension reform. That said, we strongly emphasise the need to consider pensions in the broader context of working, saving and retirement. We hope very much that policy will travel in the direction of persuading those of working age to plan ahead for their retirement, as well as truly 'making work pay' so that saving is possible and effective, even for those on the lowest incomes. The continual pressure on the pensions system will only be properly alleviated when social breakdown is reversed and fewer people are entering older age in poverty, ill-prepared for living without any earnings.

2.4 Benefits

A significant proportion of weekly income for people of pensionable age is drawn from benefits. In total, approximately 2.6 million pensioners are in receipt of Pension Credit (in the form of either the Guarantee Credit or Savings Credit stream); approximately 1.5 million receive Housing Benefit; and 2.5 million receive Council Tax Benefit.¹⁹

But although the receipt of benefits provides a vital source of income for many, the non-take up of the benefits remains very worrying. In 2008/09 this non take-up translated to between 180,000 and 350,000 pensioners missing out on Pension Credit (Guarantee); between 220,000 to 380,000 people for Housing Benefit; and between 1.4 million to 1.9 million eligible but not receiving Council Tax Benefit. In total this resulted in as much as £3.9 billion going unclaimed by pensioners who were eligible to receive assistance.²⁰

The Working Group established four key reasons which act as barriers to a higher take-up of benefits: a lack of awareness of the existence and nature of financial support; older people believing they were not entitled to financial support; the bizarre complexity of the benefit process; and the stigma some older people assign to claiming benefits.

“These past six years have been a devastating period for the fuel poor.”

Fuel Poverty Advisory Group (England), Annual Report 2010²¹

2.5 Fuel Poverty

Poverty and inadequate housing are particularly dangerous in the winter. Simply keeping warm in the colder weather can be a challenge for many vulnerable older people. Since 2001 the number of households in England living

¹⁹ Department for Work and Pensions, *Income Related Benefits: Estimates of Take-Up in 2008-09*, London: Department for Work and Pensions, 2010

²⁰ Ibid.

²¹ Fuel Poverty Advisory Group (for England), *Eighth Annual Report*, London: Department of Energy and Climate Change, 2010, p3

in fuel poverty has increased from 1.2 million to 4.6 million.²² This represents a doubling of households living in fuel poverty across all age groups, but overwhelmingly households in fuel poverty are living in low income – the majority are economically inactive – and are headed by an older person.²³

Undeniably the previous Government oversaw early and substantial progress in reducing the number of households living in fuel poverty. Yet despite allocating more than £20 billion to eradicating fuel poverty since the turn of the millennium,²⁴ its programmes have invited some heavy criticism – including from the official Fuel Poverty Advisory Group which has summarised many of them as ‘inadequate’.²⁵ Furthermore, due to European Union regulation, its universal nature means the Winter Fuel Payment is poorly targeted – for example in 2007/08 payments were made to approximately 100,000 households with an annual net income of more than £100,000 and a number to households with an income of over £200,000.²⁶ Incredibly, the payment goes to more than 63,000 expatriates living on the European continent – including such climates as Spain, Cyprus and Portugal – at an estimated annual cost of £14 million.²⁷

The new Government has an opportunity to build a coherent fuel poverty strategy which learns the lessons of the past. It should take full advantage of it.

2.6 Patchy Access to Advice

The Working Group has also heard concerns expressed by many people about the patchy nature of financial guidance and support for poorer people approaching older age. This is concerning given its central role in alleviating poverty.

Whilst there are many excellent employer schemes which provide detailed assistance – both before and after retirement – as well as a number of very successful voluntary sector initiatives run by organisations such as Age UK and Counsel and Care, our review has heard that there are numerous poorer older people who simply fail to access sound guidance and advice about later life. It is also true to say that many of the concerns older people have in relation to advice and guidance, or the need to access it, are triggered by bereavement or failing health.

This apparent lack of support or guidance was borne out by results of the internet-based public polling this review commissioned. According to a third of the older people we polled, the support and guidance they received

22 Fuel Poverty Advisory Group (for England), *Eighth Annual Report*, London: Department of Energy and Climate Change, 2010, p4

23 Department of Energy and Climate Change, *Annual Report on Fuel Poverty Statistics 2009*, London: Department of Energy and Climate Change, pp.30-3

24 Department of Energy and Climate Change, *The UK Fuel Poverty Strategy: 7th Annual Progress Report*, London: Department of Energy and Climate Change, 2009, p5

25 Fuel Poverty Advisory Group (for England), *Seventh Annual Report*, London: Department of Energy and Climate Change, 2008, p2

26 Hansard, *Written answers and statements*, 10 March 2010, (Before Housing Costs)

27 The Times, *Winter fuel bonanza for 64,000 expats in Europe*, 16 February 2010

According to a third of the older people we polled the support and guidance they received approaching retirement was ‘poor’.

approaching retirement was ‘poor’. Another third said it was ‘adequate’. Just eight per cent described the assistance they received as ‘excellent’.²⁸

During the course of our review the Working Group also heard many concerns about financial abuse of older people. Although our review’s primary focus is on pensioners living in financial and social poverty we could not ignore the opportunity to highlight the tragic nature of

the financial abuse of too many vulnerable older people, an issue which is too often overlooked by policy-makers and can, of course, cause poverty.

A recent survey published by Help the Aged and Barclays revealed that 70 per cent of older people are targeted by financial scams each month, and almost four in ten older people fear they would be unable to spot a scam if they were approached.²⁹ Furthermore, shocking figures collated by the awareness group, Think Jessica, found that for one particular scam 22,000 victims replied to a ‘mail shot’ in one day, and sent a total £500,000 in response.³⁰ It is time this scandalous targeting of vulnerable older people was tackled forcefully.

52 per cent of people we polled said they didn’t give much thought to growing older (in terms of income, accommodation and lifestyle).

YouGov poll for the CSJ Older Age review

2.7 Personal Planning

Whilst we need to provide helpful information for those at the point of serious need – whether caused by care requirements, the loss of a partner or other unplanned circumstances – the Working Group must also emphasise the importance of encouraging personal responsibility and thoughtful planning for later life.

We have been struck both anecdotally and through research, by how little personal planning many older people undertook in younger life. Although much of the debate about older age planning tends to focus less on pensioners in poverty and more on such issues as maximising pension pots, managing savings and releasing capital amassed in assets such as property, we recognise the role that it has in preventing pensioner poverty, or in alleviating it – even in view of the unique challenges presented by life on a low income.

We have encountered a dangerous cultural apathy towards planning for older age, particularly regarding finance. We also consulted many people in the earlier stages of working life who readily dismissed retirement, or even pension planning, as something to delay thinking about until much later in life. And according to recent research there is an alarming lack of savings

28 YouGov, *Attitudes of People over Retirement age*, June 2010

29 The Daily Telegraph, *Majority of pensioners are targeted by scams every month, charity warns*, 16 September 2008

30 Accessed via: <http://www.thinkjessica.com/>, 15 July 2010

provision amongst the group of people approaching later life.³¹ These findings were further substantiated by our review's polling. In terms of income, accommodation and lifestyle, over half of the respondents said they didn't give much thought to growing old. Only one in ten said they planned as comprehensively as possible for later life. This kind of ratio was consistently reflected throughout our consultation process.

3. COMMUNITY AND LIFESTYLE

3.1 Community

3.1.1 SOCIAL BREAKDOWN

The CSJ has identified five common pathways to poverty prevalent in our poorest areas. They cause and entrench poverty. They are family breakdown, educational failure, economic dependency and worklessness, debt and addiction to drugs and alcohol. Many such areas are also characterised by high crime rates, anti-social behaviour and static local authority housing which stifles social mobility.

These communities are intense beacons of health inequality, low life expectancy rates and poor physical and mental wellbeing. It is clear that the nature of an individual's community has a profound impact on the nature of an individual's lifestyle and choices. For example: a child growing up in a community where family life is often dysfunctional, worklessness is intergenerational, school standards are poor and crime is fuelled by drugs and alcohol, will find it much more difficult to break away from these factors. This, of course, significantly impacts the quality of life in older age.

3.1.2 THE PHYSICAL ENVIRONMENT

As well as social dynamics, the physical nature of communities is important to overall quality of life and well-being. Whilst this is true across all age groups, our review is acutely aware of this relevance for older people. Although many older people are self-sustaining in later life, it is also true that because many experience a reduction in physical and mental capability, as well as self-confidence, basic neighbourhood facilities become pivotal in helping to remain active and independent. This means, for example, that pavements must be properly maintained, public toilets accessible and benches available.

31 Aviva, *The Real Retirement Report – Issue Two*, Aviva, 2010, p8



3.1.3 LONELINESS, ISOLATION AND SOCIAL EXCLUSION

Although the majority of older people maintain healthy relationships and vibrant social networks, there is a group who experience persistent loneliness, isolation and severe social exclusion. The tragedy of loneliness in older age is often triggered by the death of a spouse or by the common experience of being alone in later life. More than half of people aged 75 years old and over live alone;³² half of all older people cite the television as their main form of

company;³³ and thousands face loneliness at key points during the year when others are surrounded by friends and family – in 2006, for example, 500,000 older people spent Christmas day alone.³⁴

Such factors are deeply damaging. Recent research from the United States, for instance, found that people with adequate social relationships live for longer than those with negative social relationships.³⁵ This is comparable with the impact of smoking cessation, and equates to a more significant impact on mortality risks than common factors like a lack of exercise and obesity.

There are pockets of excellent practice – mainly led by the voluntary sector – which are responding to these problems. Yet in policy terms, reforms to tackle loneliness, isolation and social exclusion have been lukewarm, with the Government largely failing to act on the implementation of its *Sure Start to Later Life* report.³⁶

We also recognise the role of neighbouring and neighbourliness, often neglected in social policy, as another way of tackling these problems.

“When we first came here I wouldn’t have dreamt of locking a door, or even shutting it. Now almost nobody over 60 would think of going into town by themselves at night. I think we have a policeman but I don’t think he is ever there.”

A rural pensioner, in evidence to CSJ

3.1.4 CRIME

While there has been an overall reduction in crime over the last ten years, crime figures still remain high and 66 per cent of people still feel crime is increasing nationally.³⁷ Even though a minority of older people have themselves been victims of crime, we heard an enormous amount of evidence that older people are concerned about crime and

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- 32 Office for National Statistics, *General Lifestyle Survey 2008*, Table 3.3 (GB), London: Office for National Statistics, 2010
 - 33 Help the Aged, *Isolation and Loneliness Policy Statement*, London: Help the Aged, 2008, p6
 - 34 *Christmas Day survey 2007* (unpublished), ICM Research for Help the Aged, 2007
 - 35 Holt-Lunstad J; Smith TB; Layton JB; *Social Relationships and Mortality Risk: A Meta-analytic Review*; published in PLoS Med 7, 2010 accessed via: <http://www.plosmedicine.org/article/info%3Adoi%2F10.1371%2Fjournal.pmed.1000316#aff1>
 - 36 Social Exclusion Unit, *A Sure Start to Later Life*, London: Social Exclusion Unit, 2006
 - 37 Home Office, *Crime in England and Wales 2009-10*, London: Home Office, 2010, p7

fear victimisation. They are also more likely than any other age group to feel that there has been an increase in national crime.³⁸

Crime disproportionately affects our poorest communities, and since a large proportion of pensioners living in poverty and social exclusion live in these areas it is imperative that this be addressed, both short and long term. One key problem to tackle is older people's lack of confidence in their local police. One BCS study showed that on average just over 55 per cent of older people agreed that their local police and council are dealing with Anti-Social Behaviour and crime issues.³⁹ Whilst we commend neighbourhood policing and welcome the new Government's pledge to further improve policing and crime fighting, many of the principles outlined in the CSJ's report *A Force to Be Reckoned With*⁴⁰ remain as crucial as ever to improving public safety.

3.1.5 TRANSPORT

Since ageing often decreases mobility, it is extremely important that reliable, safe and accessible transport networks are available. As people age, they increasingly make journeys to shop for essentials such as food or to access vital services. Poor access to transport can therefore seriously and negatively impact on the lives of the poorest and most vulnerable older people, often increasing the risk of social isolation. This has proven a particular problem in rural areas during the course of our review.

*'13 per cent of people living in rural areas in their later years report poor access to a range of basic services, including GPs, dentists, hospitals, post offices and local shops. Those on low income and those aged over 80 are significantly more likely to report poor access.'*⁴¹

Nearly a quarter of older people live in rural areas, and nearly four in ten rural households do not have access to a supermarket within two and a half miles.⁴² What is more, the percentage of rural households within five miles from a hospital is 55 per cent, compared to 97 per cent of those living in urban households.⁴³ Related to this, those living in rural areas can spend between 20 and 30 per cent more on transport (that is, public transport, taxis and motoring costs) than those from urban communities.

The Working Group particularly focused on buses and taxis. Regarding buses, we heard that the free transport passes available to those of pensionable age has had a highly positive impact. Since the introduction of free concessionary travel, the number of over 60s who have taken up the concessionary bus fares

38 Ibid, p123

39 Ibid, p136

40 The Centre for Social Justice, *A Force to Be Reckoned With*, London: Centre for Social Justice, 2009

41 HM Government, *Building a society for all ages*, London: The Stationary Office, July 2009, p46

42 Commission for Rural Communities, *State of the Countryside 2010*, Cheltenham: Commission for Rural Communities, July 2010, p30

43 Ibid.

has risen from 49 per cent in 1998/2000 to 76 per cent in 2009.⁴⁴ We will look further at whether reliability and regularity of bus services could be improved, with a view to extending what are clearly very popular bus services to all older people, even in rural areas.

Taxis can be prohibitively expensive for many older people and what is more, some companies will refuse to take older people the very short distances they need to go. We heard of some commendable schemes, run by local authorities, which go some way to countering this by offering greatly reduced rates for pensioners who have disabilities that prevent them from using public transport. The option of being driven somewhere can completely change an older person's quality of life; for instance, visiting the GP and collecting repeat prescriptions becomes instantly more manageable.

It is clear that the quality of, and level of access to, transport can either break down or entrench social exclusion. And while improvements have been made in many areas, the Working Group believes that transport is an area that will continually need attention and improvement.

3.2 Lifestyle

The Working Group investigated the lifestyles of poorer older people in an effort to understand which factors can lead to a positive experience of ageing, and which do not. It emerged as we visited poorer communities that the following themes were handled unsatisfactorily:

“Social justice is a matter of life and death. It affects the way people live, their consequent chance of illness, and their risk of premature death.”

World Health Organisation, Commission on Social Determinants of Health⁴⁵

3.2.1 HEALTH

We were very struck by evidence of unacceptable health inequality in the UK. There is an undeniably strong link between social breakdown and poor health. The circumstances in which people are born, grow up, and age determine the quality of health of those individuals dramatically. The Government's *Strategic Review of Health Inequalities in England post-2010*⁴⁶ found that members of the nation's poorest communities die an average of seven years before members of the wealthiest. While the average life expectancy in the UK is continually on the rise, shocking findings by the National Audit Office (NAO) reveal that the gap in life expectancy between the richest and the poorest is widening.⁴⁷ And, of course, life expectancy is not the only measure

44 Department of Transport, *National Travel Survey Table NTS0619: Take-up of concessionary fare schemes by area type: Great Britain, 1998/00 to 2009*, 29 July 2010, <http://www.dft.gov.uk/pgr/statistics/datatablespublications/nts/>

45 World Health Organisation, *Closing the gap in a generation: health equity through action on the social determinants of health*, Geneva: World Health Organisation, 2008

46 The Marmot Review, *Fair Society, Healthy Lives: Strategic Review of Health Inequalities in England post-2010*, London: The Marmot Review, 2010

47 National Audit Office, *Tackling inequalities in life expectancy in areas with the worst health and deprivation*, London: The Stationery Office, 2010, p8

of ill health: people in our poorest communities can expect to live longer with a disability.

With a view to investigating this, the Working Group decided to look at three core themes: diet, alcohol and exercise.

Diet

Despite considerable public health promotion, figures suggest that older people are far more likely to be overweight and obese than younger people. Within that, men are more likely to be overweight than women. This is a considerable issue within the general health and ageing debate. As well as this, malnutrition presents a pressing health problem for poorer older people.

The physical process of ageing demands a healthy diet for energy, strength, immunity, resilience and a well-functioning digestive system. Quite apart from this, malnutrition can seriously damage organ systems, reduce recovery rates from illness and accelerate cognitive and functional decline. While the importance of a well balanced and substantive diet is now well understood, levels of malnutrition amongst our older people remain stubbornly high: one recent study calculated the number of malnourished older people at three million.⁴⁸ Furthermore, a recent survey found just under a third of care home residents were malnourished.⁴⁹

The previous Government published a Nutrition Action Plan to help tackle this.⁵⁰ It also established an independent Nutrition Action Plan Delivery Board (NAPDB) to monitor progress on these commitments. Its initial report, published in February of this year, was less than glowing about the first year of implementation.⁵¹ In its core conclusions the NADPB concluded that there remains a significant problem of malnutrition across society including in places where there is a duty of care on professional staff, and much more needs to be done to reverse this. We have heard very similar analysis during our review.

Alcohol

While the Working Group recognises that the majority of the population have a responsible attitude towards alcohol, the CSJ's 2007 report *Breakthrough Britain* demonstrated that abuse of alcohol is a growing problem in too many households and communities – particularly in our poorest areas.⁵² The human and financial costs of this are extremely high. Whilst behaviours such as binge drinking are not associated with the older age group, the Working Group

48 BAPEN, *Combating Malnutrition: Recommendations for Action*, Redditch: BAPEN, 2010, p1

49 BAPEN, *Nutrition Screening Survey in the UK in 2007*, Redditch: BAPEN, 2008, p2

50 Department of Health, *Improving Nutritional Care: a joint Action Plan from the Department of Health and Nutrition Summit stakeholders*, London: Department of Health, 2007

51 Nutrition Action Plan Delivery Board, *Nutrition Action Plan Delivery Board: End of Year Progress Report*, London: Nutrition Action Plan Delivery Board, 2009

52 Centre for Social Justice, *Breakthrough Britain – Volume four: Towards Recovery*, Leeds: Centre for Social Justice, 2007

is concerned to note a small but persistent level of hazardous and harmful drinking amongst those 65 years old and over.

Older people have some of the highest rates of alcohol-related hospital admissions each year, and people aged 65 and over are the most likely age group to drink every day. Moreover, these alarming figures do not even take into account the casual but unhealthy levels of alcohol consumption that are likely to be occurring amongst older people, especially those living alone or in social exclusion.

Exercise and Physical Activity

Regular physical exercise is good for everybody, but the medical benefits for older people in particular have been highlighted by a wealth of international research. The effects on mental health are overwhelmingly positive; an enormous amount of research has shown that physical activity is associated with lower risks of cognitive impairment, Alzheimer's disease and dementia of any type.

Exercise also unlocks an enormous range of physical benefits, from preventing osteoporosis (by increasing bone mass, density and strength) and falls themselves through improving balance and strength, to reducing the otherwise very real risk of coronary heart disease. Participation in exercise and physical activity is also particularly important for older people given that

many spend the majority of their time at home, and can therefore engage less in general activity and the often more energised pattern of younger life.

We have encountered disappointing levels of physical activity within our older population. There are also clear links between inactivity and deprivation. Building on this, our discussions fully corroborated studies which have identified specific factors that often prevent older people engaging in physical activity.⁵³ We support initiatives to encourage older people's physical activity and we will seek to explore possible community-based models that are cost-effective and productive.



“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

3.2.2 VOLUNTEERING

The Working Group considers volunteering to be one of the major opportunities offered by older age that ought to be promoted. It has benefits for the individual, as well as being highly positive for society and fitting in with the Government's Big Society agenda. It is clear that older people are absolutely crucial to the success of volunteer

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See, for example, Finch H, *Physical Activity 'At Our Age': Qualitative Research Among People Over the Age of 50*, London: Health Education Authority, 1997, p42; and Rai DK and Finch H, *Physical Activity 'From Our Point of View'*, London: Health Education Authority, 1997, p41

projects. A recent report found that many older volunteers were integral to such fields as Social Services, health, culture and environment. It found that:

- People aged 50 and over formed two-thirds of the volunteer workforce and nearly 70 per cent of the total number of hours provided by volunteers;
- Those aged 65 formed almost a third of the volunteer workforce.⁵⁴

However, as we have taken evidence about poorer communities, volunteering levels appear to fall. As the *Citizenship Survey* reveals, formal and informal volunteering is higher in the higher socio-economic groups. Those in routine occupations, who are unemployed or have never worked are much less likely to take part in formal volunteering, and informal volunteering, than those in higher and lower managerial positions and professions.⁵⁵

In this review, we identify four key barriers to volunteering facing older people: a lack of confidence; a lack of awareness about available volunteering options; a lack of access to safe transport and money; and a cultural problem of risk averseness, bureaucracy and perceived restrictions from insurance policies.

3.2.3 DIGITAL EXCLUSION

It is estimated that 17 million people in the UK still do not use computers or the internet,⁵⁶ and this is a particular challenge for older people. Yet again, there is a clear link between missed opportunity and social deprivation, with half of all those without internet within the official DE socio-economic group.⁵⁷

Digital exclusion precludes the possibility of older people benefiting from such things as information and access to discounted energy tariffs, free financial advice, free communication with friends and family, further learning and hobbies, and online shopping. On the whole, then, we see digital inclusion as life-enhancing, and while we recognize that there are barriers to overcome (which we highlight), our review wholeheartedly encourages it. To this end, we are looking for models of good practice that reduce digital exclusion.

54 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, p6

55 Department for Communities and Local Government, *Citizenship Survey: 2008-09*, London: Department for Communities and Local Government, 2009, p15

56 HM Government, *Delivering Digital Inclusion: an action plan for consultation*, London: HM Government, 2008, p9

57 Department for Communities and Local Government, *Understanding Digital Exclusion*, London: Department for Communities and Local Government, October 2008, pp26-7

4 HOUSING

4.1 Housing and Older People: More than a Roof

The importance of housing reaches far beyond the basic physical shelter that a roof provides. Housing design, conditions and standards have a significant bearing on an individual's overall wellbeing. Our findings prove that this is particularly true for older people.

Furthermore, our rapidly ageing society has sobering implications for national housing policy: half of the predicted housing growth by 2026 will be driven by households headed by individuals aged 65 and over, and there will be a further 2.4 million older households in England.⁵⁸ Added to this, the 75 and over age group is growing at a faster rate than younger age groups – so much so that it is expected that the number of older disabled people will double by 2041.⁵⁹

4.2 Low Income Homeowners

Contrary to popular assumptions, two thirds of older people living below the poverty line either own their own homes outright or are paying a mortgage. Additionally, according to research highlighted by this review a significant minority are entering older age with considerable mortgage debt: of the 12 per cent of 65 to 74 year olds with a mortgage, the average outstanding balance is £51,000. For those aged 75 and over it is £31,000.⁶⁰ Such a burden can be utterly debilitating for those on a very low income.

4.3 Selling Up?

Linked to this, the debate about selling homes in later life is one of the most sensitive and emotive topics the Working Group has engaged with. In its evidence gathering and discussions the Working Group has heard a passionate defence of people's right to keep their home in order to maintain community roots and eventually pass on as much of its value as possible to loved ones. But we have also heard a challenge to this, largely based on the argument that an individual's largest asset should not be exempt when unlocking the resources needed to live comfortably in retirement or pay for the very high costs of residential care. This challenge also tends to cite current economic pressures and ever-decreasing public funds. The fears of those unwilling to sell their homes are clearly real and understandable, and yet the challenges made to that position seem pragmatic and responsible.

58 Department for Communities and Local Government, *Lifetime Homes, Lifetime Neighbourhoods*, London: Department for Communities and Local Government, 2008, p20

59 Ibid.

60 Aviva, *The Aviva Real Retirement Report – Issue Two*, Aviva, 2010, p15

Equity release schemes can offer a positive option to some such older people keen to release capital from their home and improve their quality of life. That said they can also limit an individual's ability to respond to new or progressing care needs should they seek sheltered housing, extra care facilities or wish to move to a lower maintenance property. And while the present system provides free residential care for those with very few assets or low savings – largely non-home owners or people with a family member still living in the property – it does not for those who have sought to save as much as possible. This, so it is felt by many, disincentivises saving and penalises people who have saved for their retirement. We recognise the anger many people feel about this.

4.4 Housing Standards and Design

4.4.1 HOUSING STANDARDS

Undoubtedly, the previous Government's decent homes standard has driven up housing quality in the socially rented sector. However, there is still a huge amount more to be achieved in improving housing standards for all older people. We have heard that despite improvements in the social sector, very real concerns remain about the condition of many properties belonging to home owners and those rented in the private sector. This is relevant to our review given the number of older people below the income poverty line who are in such housing.⁶¹ Despite progress, more than a third of all homes were classified non-decent in 2008, including almost half of privately rented properties and a quarter of housing association properties.⁶²

Furthermore, recent evaluation of the decent homes initiative – published by both the National Audit Office and the Public Accounts Committee – has questioned its overall efficacy, its recorded value for money and the previous Government's overall management of the programme.

4.4.2 HOUSING DESIGN: LIFETIME HOMES AND COMMUNITY

The development and intended expansion of the Lifetime Homes concept is a welcome first step towards meeting longer-term housing design needs. Yet, while commendable progress has been made in rolling out the commitment for such homes – through, for example, the innovative 2004 *London Plan*⁶³ – a significant amount of work remains in order to build on good intentions. Not all new homes, of course, are built to Lifetime Homes standard. Furthermore, new homes only account for a tiny proportion of the overall housing stock. DCLG's aspiration to ensure that all public sector housing is built to Lifetime

61 Department for Work and Pensions, *Households Below Average Income: An Analysis of the Income Distribution 1994/95 – 2008/09*, London: Department for Work and Pensions, 2010, p168

62 Department for Communities and Local Government, *English housing Survey: Headline Report 2008-09*, London: Department for Communities and Local Government, 2010, p32

63 Mayor of London, *The London Plan: Spatial Development Strategy for Greater London, Consolidated with Alterations since 2004*, London: Greater London Authority, 2008

Homes Standards from 2011 is to be welcomed, but while these levels will be mandatory for public sector housing, private developers are not subject to such a target.

In relation to this, however, we also heard about a lack of engagement with older people and the wider community about housing design and planning. This failure, so our evidence gathering suggested, too often produces buildings and environments that do not reflect older people's diverse needs and preferences, or that are divorced from the wider community to which they belong.

4.5 Adaptations and Improvements

During our evidence gathering it was frequently stated that many older people want to remain in their own homes for as long as possible. However, due to declining personal mobility and inflexible household design, maintaining the necessary independence to do so can be extremely difficult as people age. For instance men in the UK can expect to live their last 7.2 years with a disability, and for women the average is 9.4 years.⁶⁴

There are currently three quarters of a million people over 65 that need specially adapted accommodation and whose quality of life would seriously deteriorate if they were to have a fall.⁶⁵ Research has shown that:

- For people over 65 years old, approximately one in three (3.4 million) people, will suffer a fall each year, costing the NHS an estimated £4.6 million a day, or £1.7 billion a year;⁶⁶
- The principal cause of injury leading to a hospital admission or death for people over 65 is due to the person falling;⁶⁷
- And of those who suffer a hip fracture, half will never regain the mobility they had previously and 20 per cent of people will die within three months.⁶⁸

In responding to this level of need, the provision of assistive equipment can have a hugely beneficial impact on maintaining or improving an older person's quality of life. Yet, as an Audit Commission report recently revealed, low importance is attached to such equipment. This is in spite of mass research

64 Office for National Statistics, *Statistical Bulletin: Health expectancy at birth and at age 65 in the United Kingdom, 2005-2007*, London: Office for National Statistics, 2010, p2

65 Department for Communities and Local Government, *Housing in England 2006/07: A report based on the 2006/07 Survey of English Housing, carried out by the National Centre for Social Research*, London: Department for Communities and Local Government, 2008, p48

66 Age UK, *Falls in the over 65s cost NHS £4.6 million a day*, 21 June 2010, accessed via: <http://www.ageuk.org.uk/latest-press/archive/falls-over-65s-cost-nhs/?paging=false>

67 Ibid, p6

68 Todd, CJ, Freeman, CJ, Camilleri-Ferrante C. Et al, Differences in mortality after fracture of hip: the East Anglian audit, April 1995, *British Medical Journal* 310:904, accessed via: http://www.bmj.com/content/310/6984/904.abstract?ijkey=7d50d316e62036ed3f7069825e34906e2b9324dc&keytype=tf_ipsecsha

finding it provides good outcomes and reduced costs. On this the report stated that:

“If a drug was discovered with a similar cost-profile, it would be hailed as the wonder-drug of the age.”⁶⁹

4.5.1 HELP BEFORE IT’S TOO LATE

Although adaptations and improvements in the home provide an invaluable service to many older people, we have seen and heard how the present system is too bureaucratic and complex. It is often beset by long delays. A report by *Care & Repair*, which looked at the nature of these delays, concluded that:

“The result is human misery. Older people are facing the undignified situation of living, sleeping and eating in a single room with a commode in the corner, of being washed down standing in a child’s paddling pool in their kitchen or crawling up the stairs on their hands and knees. Professionals who want to support disabled people find themselves debating whether a person has a social or a medical need to bathe (able to offer help with the latter but not the former) in the face of inadequate budgets and rationing of provision.”⁷⁰

4.6 Sheltered and Retirement Housing

If and when older people decide to move from their previous home, many have much higher expectations of retirement housing than previous generations. This, so it has appeared during our review, is especially true across all areas of policy for many of the so-called ‘baby boomers’. We have seen how the low-level support provided by retirement housing can help older people stay independent for longer, as well as stave off the need for more expensive stays in hospitals or nursing homes.

Where the benefits of such housing are clear, particularly the increased security and peace of mind such accommodation can offer, the likely reduction in funding of the Supporting People programme – which appears to have highly impressive cost benefit analysis⁷¹ – has been identified as a major factor that will impact on the quality and availability of such facilities for people with low and



Residents of The Village, Barkingside sheltered housing

⁶⁹ Ibid p64

⁷⁰ Adams, S. & Ellison, M, *Time to Adapt: Home adaptations for older people: The increase in need and future of state provision*, Nottingham: Care & Repair, 2009, p6

⁷¹ Department for Communities and Local Government, *Research into the financial benefits of the Supporting People programme*, London: Department for Communities and Local Government, 2008, p105

“Three words best sum up the older homeless: invisible, hidden and isolated.”⁷²

mid range incomes. This is especially true in terms of the provision of onsite wardens. There are other concerns about the provision of, and access to, such housing which we highlight in the chapter.

4.7 Older People and Homelessness

Although the total number of older homeless people is small in comparison to the general older population, they are among the most disadvantaged members of society. Older homeless people often have multiple difficulties including severe mental health issues and substance abuse problems – which are clearly often the common underlying causes of their homelessness.

Every year the specialist membership body Homeless Link – with which we have consulted – conducts a national survey of needs and provision services for homeless people. In its latest survey, its findings suggested that although there has been an increasing demand of services from older homeless people, support projects catering for this group have been closing.⁷³

To help homeless people move into more permanent housing, resettlement services are vital. However, due to the lack of suitable medium and long term accommodation, homeless people can become trapped in temporary housing, and prevented from rebuilding their lives. Research carried out by the Salvation Army, for example, echoed our anecdotal evidence when it found 47 per cent of their clients in residential facilities unable to move on due to the lack of social housing stock available. They are forced to remain in a temporary setting,⁷⁴ which puts them at a higher risk of becoming institutionalised and therefore it is much harder to resettle into permanent accommodation.

5. CARE

In recent years political debates about older age have all too often been restricted to the question of how to fund social care, with unfortunate consequences. First, older people end up being portrayed solely as a problem society has to pay for. Second, discussion about how we are to pay for care has eclipsed a broader discussion about what kind of care system we want in the first place.

Although the debate about ageing should widen beyond care and pensions, it is also clear that social care is a very real concern for older people. Approximately 2.5 million older people in the UK have a care need⁷⁵ and

72 Shadow Secretary of State for Health Paul Burstow (now of Minister of State for Care Services, Department of Health), speaking at a Westminster Hall Debate on Homelessness on 27 January 2004

73 Homeless Link, Survey of Needs & Provision 2010: *Services for homeless single people and couples in England, March 2010*, London: Homeless Link, p32

74 The Salvation Army, *A home for all?: Homelessness policy challenges for Labour's third term*, London: The Salvation Army, p6

75 Wanless, Sir Derek, *Securing Good Care for Older People: Taking a Long-term view*, London: The King's Fund, 2006, p30-31

almost half of those aged 75 and over have a disability.⁷⁶ How to provide social care in an ageing society is a subject that must be reasoned with sensibly and sensitively. It is time to end the patterns of party political point-scoring witnessed in recent years.

5.1 Social Care

Social care encompasses the range of services which support people to maintain their independence or help them to live with disability or ill health. It includes personal care, practical help and social support. These types of care can be provided across a range of venues: in a person's own home (usually referred to as domiciliary or home care); at community venues such as day care centres; and in care homes, whether residential or nursing.

Unlike health care in England and Wales, social care is strictly means-tested by the majority of local authorities. Care support is provided only for those with the highest needs and the lowest means. In terms of financial eligibility for residential care, for example, currently an individual must have assets less than £23,250 in England to qualify for local authority placement into a care home.

“Unpaid care for disabled, sick or older people is the bedrock of community care in the UK.”⁷⁷

Carers UK

5.2 Unpaid Care

There are approximately six million unpaid carers in the UK,⁷⁸ twice the number of paid NHS staff and the social care workforce combined.⁷⁹ There are important variations among this dedicated group of people. 1.5 million are themselves over 60,⁸⁰ 60 per cent are women,⁸¹ and there are particularly high instances of caring in some black, minority and ethnic communities (twice as many Pakistani women, for example, are carers compared to the national average).⁸²

We have seen during our evidence gathering how for many engaged in it caring is a source of great joy and a responsibility few would want to exchange. However, there is also extensive evidence that, inevitably, caring takes its toll. Carers who provide a significant amount of care for sick or disabled family members are more than twice as likely to suffer from poor health compared

76 Office for National Statistics, *National Lifestyle Survey 2008* -Table 7.2, 2010, Newport: Office for National Statistics

77 Carers UK, *Tipping Point for Care: time for a new social contract*, London: Carers UK, 2010, p3

78 2001 Census Standard Tables, Crown Copyright 2003: ONS, GRO(Scotland) and NISRA

79 Carers UK, *Tipping Point for Care: time for a new social contract*, London: Carers UK, 2010, p3

80 Carers UK/Sheffield Hallam University, *Older Carers in the UK*, 2005, p2

81 The NHS Information Centre for health and social care, *Survey of Carers in Households in England 2009/10*, Provisional Results, p2

82 The Princess Royal Trust for Carers & Crossroads Caring for Carers, 2009, *Putting People First without putting carers second*, London: The Princess Royal Trust for Carers & Crossroads Caring for Carers, p10

to people without caring responsibilities⁸³ and in a recent survey 59 per cent of carers had given up paid work to care.⁸⁴

Perhaps the most alarming trend we have encountered is the increasing intensity of caring roles. Growing numbers of people are providing 50 hours care or more a week.⁸⁵ Both the physical dispersal of families and high levels of family breakdown have led to 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.

Caring will always remain the prerogative of families and loved ones. Yet, not least because the annual value of this care is estimated at £87 billion,⁸⁶ policy-makers have a responsibility to support carers and strengthen families. All too often this has not happened. While in recent years there has been increasing awareness about the core challenges carers face, there has been a failure of those in government to lead the necessary reform and support in response. For instance, even considering the present economic reality, the main financial benefit for carers, Carer's Allowance, is (at £53.90 a week) low by international standards. And even though it has been recognised as absolutely vital in terms of sustaining care, respite care remains an undervalued and underutilised resource.

Furthermore it is predicted that we will have soon reached the tipping point for unpaid care, with the number of older people needing care projected to outstrip the number of working-age family members available to supply it. It is predicted that by 2041 there will be a shortfall of 250,000 intense carers.⁸⁷

5.3 State Provision of Care

In 2008/09 1.2 million people aged 65 and over received services from their local authority (68 per cent of all adult Social Services clients).⁸⁸

Even taking what people think of as the three core social care costs – home care, residential care and nursing care – we can see that although the people supported in long-term care (i.e. residential and nursing) are a minority, they account for £5 billion of the total £7 billion budget. Figures 2 and 3 below show the comparison.

Residential care may be the right choice for those older people with the highest intensity needs. Yet it is expensive (the average cost of a single room is

83 Office of National Statistics, Census 2001

84 The Princess Royal Trust for Carers, *Carers and finance survey*, London: The Princess Royal Trust for Carers, 2010, p5

85 The NHS Information Centre for health and social care, *Surveys of Carers in households 2009/10 – Provisional Results*, p2

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

87 Pickard, L, *Informal Care for Older People Provided by their Adult Children: Projects of Supply and Demand to 2041 in England, Report to the Strategy Unit (Cabinet Office) and the Department of Health*, PSSRU Discussion Paper 2515, London: Personal Social Services Research Unit, 2008, p12

88 NHS Information Centre, *Community Care Statistics 2008-9: Social Services Activity Report, England*, London: NHS Information Centre: 2010, p4

£25,220 a year for residential care and £35,256 for nursing)⁸⁹ and most people would prefer to be supported in their own homes. Despite this, in the main local authorities' service models still remain weighted towards residential care.

Figure 2 – Older people receiving council services: number of people nationally⁹⁰

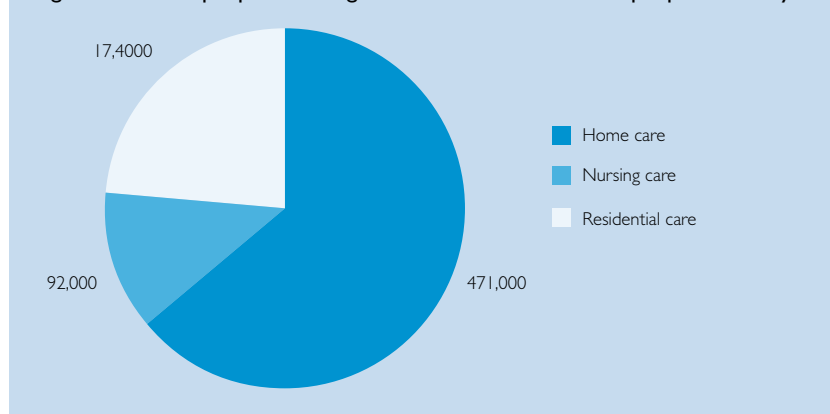
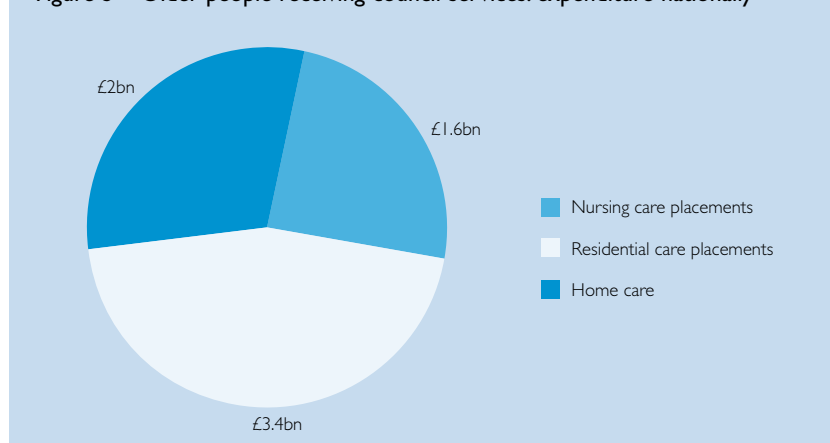


Figure 3 – Older people receiving council services: expenditure nationally⁹¹



The Working Group identified four crucial issues in state-provided social care:

5.3.1 PREVENTION

Preventative care services are those that prevent or delay higher-dependency situations among older people, such as day-care, aids and adaptations to the home, reablement services and telecare products. Preventative social care is absolutely crucial as

“People are failing in the community but no one notices.”

Consultant Geriatrician, in evidence to the CSJ

89 Calculated from Laing and Buisson, *Care of Elderly People: UK Market Survey 2009*, London: Laing & Buisson, 2009, p193

90 NHS Information Centre, *Community Care Statistics 2008-9: Social Services Activity Report, England*, London: NHS Information Centre: 2010, p29

91 Local Government Association and Association of Directors of Adult Social Services, *Report on Adults' Social Services Expenditure 2008-2009*, Leeds: York Consulting, 2009, p24

we adjust to our ageing society. Yet, despite this, we have frequently seen and heard how both central and local government often seem unwilling to match rhetoric on prevention with delivery.

5.3.2 PERSONALISATION

Personalisation, whether through direct payments or personal budgets, has been welcomed by many. Yet the roll-out of this agenda has been slower among older people than those who are younger or disabled. Even if take-up does improve there are legitimate concerns, particularly from charities working with older people living in poverty, that so-called ‘DIY care’ may simply be an unrealistic expectation for the most frail and socially excluded older people. Moreover, while some support currently exists to help people use their budgets, the fear is that the impending public expenditure cuts will mean a phasing out of that support as the realities of austerity take hold.

“Why should I spend millions on preventative services such as telecare if all the savings will be in health”

Adult Social Services Director, in evidence to the CSJ

5.3.3 LACK OF INTEGRATION

Despite much discussion and many well-intentioned initiatives a lack of integration between health care and social care teams still remains a defining feature of the current system. Local government and health authorities are still largely independent agencies, managing separate teams and driven by different incentives. The consequence is that all too often older people fall between the cracks, with hospital regularly the hub of this breakdown.

5.3.4 RATIONING

In recent years local councils have been forced to contain their budgets and tighten eligibility assessments for a range of care services. In many areas this has been achieved by raising the thresholds of need eligibility so only those with the highest needs have access to services. Such severe rationing undermines the preventative work most likely to ease the social and economic pressures on care and health services, as well as increasing the levels of unmet care needs among the most vulnerable older people.

5.4 Care at Home

The direction of travel in terms of older-age related policy has been largely uncontested in recent years: people should be supported to live independently in their own homes for as long as possible. How realistic this ‘staying-put’ option is depends largely on the availability and quality of domiciliary care; yet since 1994 the overall proportion of people receiving domiciliary care

has halved and remains low by international standards.⁹² As well as this, the intensity of home care packages has increased.

And although we recognise the passion and dedication of many domiciliary care workers, the inconsistency of home care quality was a constant concern raised during our evidence gathering. The most frequently heard complaint in relation to this was the restrictive brevity of home care visits.

The frequency of these so-called ‘flying visits’ is due, so we have heard, not only to an inadequate level of accountability in domiciliary care (compared to more intense supervision in residential care settings). It is also driven by councils responding to cost pressures through commissioning practices, either directly paying for 15 minute slots or simply not factoring in travel time for care workers. A 15 minute visit is typically not long enough to provide high quality personal care, as we have seen all too often during this review.

There is also evidence that the care home workforce – which has a high annual turnover – is highly demoralised and badly paid.⁹³

“They’re in and out of the door in ten seconds.”

Jerry, 61, in evidence to the CSJ

5.5 Care Homes

There are currently 419,000 residents of UK care homes,⁹⁴ of whom approximately 95 per cent are older people. Despite policy drives to keep people in their own homes for longer, and despite the care home population having decreased in recent years, the combined number of people in nursing or residential care homes still remains over two and a half times the number of hospital beds in the UK.⁹⁵

A common picture which emerged during the course of our evidence gathering was of state-funded providers struggling to cope with a downward pressure on their budgets exerted by overstretched Social Services departments. In both nursing and residential care the typical resident is far frailer and older than even ten years ago; the average length of stay is shorter (under two years); and a higher proportion of both residential and nursing care residents suffer from dementia. Whereas in the past older people might have entered long-term care pre-emptively – to prepare for a higher dependency situation, because they felt isolated in the community or even as



Norton House Care Home Manager
Felicia Imafidon with a resident

⁹² Wanless, Sir Derek, *Securing Good Care for Older People*, London: The King's Fund, 2006, p52

⁹³ At 22 per cent in 2010 according to Skills for Care, *The state of the adult social care workforce in England 2010*, London: Skills for Care, 2010, p102

⁹⁴ Laing and Buisson, 'Occupied places in April 2009', *Care of Elderly People: UK Market Survey 2009*, p3

⁹⁵ 158,319, as of 29 June 2010. Department of Health, *Average daily number of available and occupied beds by sector, England, 2009-10, 'All ward types'*, London: Department of Health, 2010

“It’s back-breaking work. I think people deserve more.”

Care home manager, in evidence to the CSJ

an alternative for poor housing – overwhelmingly today’s residents really do need 24/7 care.

5.5.1 CARE HOME WORKERS

From our interviews with many care workers, as well as care home nurses and managers, the picture which emerged was of a dedicated workforce largely underpaid, undervalued and demoralised.

The market rate for care workers in the UK is extremely low. Many receive minimum wage or close to it. Yet even more concerning than low pay is the current reported level of understaffing. We have heard that with no statutory agreement on minimal staffing levels too many care home providers seek to cut corners on staff numbers. Though it is difficult to identify a responsible universal ratio – given the danger of such arbitrary lines – it is widely acknowledged that the 1:7 – 1:10 ratio we typically encountered is inadequate. What it leads to is the overburdening of existing staff, increasingly task-oriented work and the increasing likelihood of residents’ needs being neglected.

“All too often you simply have to dump people. You just turn on their TV and rush off to attend to someone else.”

A care home worker, in evidence to the CSJ

5.5.2 HEALTH CARE IN CARE HOMES

“People in care homes get substandard health care. It’s as simple as that.”

Medical Director of a London PCT, in evidence to 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.”

Non-profit nursing home provider Chief Executive, in evidence to the CSJ

The lack of medical presence in care homes was the biggest theme which emerged from our evidence gathering on care. Across the country many residents are unable to access basic health services which would be far more easily available if they still lived in the community.

At present care home coverage is not built into GP contracts; there is little incentive for doctors to go into residential or nursing homes. Consequently, care homes typically face a choice between paying a retainer to one local practice or subjecting themselves to a plethora of different doctors with highly variable commitments in response to call-outs. Unsurprisingly, care homes opting for the former report the best health outcomes and lowest rates of hospital admission. Yet many care homes simply cannot afford this option, while others feel it is unacceptable that they are expected to pay for health services which are intended to be free at the point of use.

Historically, the most clinically complex and frailest older people were looked after in NHS Long-stay Geriatric hospitals. With the closure of these

since the late 1970s independent nursing home providers essentially inherited this population, but now minus the doctors. The major consequence of poor primary health coverage has been services typically defaulting to hospital admission when an emergency arises. Among other things this reverses improvements seen in palliative care nationally, with too many residents dying in hospital rather than in the care homes in which they live.

“It would be nice if the outside world came in here.”

99 year-old nursing home resident, in evidence to the CSJ

5.5.3 ISOLATION

Many older people in care homes across the UK feel increasingly ostracised from the community. In many places the declining regularity of visits from friends and family mean that overstretched staff are residents’ only point of personal contact. Notwithstanding significant exceptions, particularly in rural areas, care home managers lament low levels of volunteering in British care homes. In many places the most pressing need – volunteers who will commit to build one-on-one relationships with care home residents – is simply not being met.

6. A NEW STRATEGY

This interim report has attempted to serve two purposes. The first has been to celebrate, respect and champion older age. In many ways our latter years can be the most rewarding and fulfilling period of life. And our rapidly progressing average life expectancy rates are the mark of an increasingly advanced society. But the second purpose of this interim report has been to set out the reality of life for some of our society’s poorest older people. Today in Britain there is a group of older people simply being left behind despite the efforts of policy-makers and the work of some inspirational families, individuals and local organisations. This group of people on the margins of society – some of whom we have met during the review – is a shameful anomaly in a nation as relatively prosperous as ours.

Furthermore, as we have undertaken this analysis three overlapping themes have emerged. These will form the basis of our deliberations about the proposed recommendations in the second report. Within this it has also become apparent that many of the issues outlined in this report are caused, linked or heightened by the experience of loss. This loss, so it seems, is often driven by a number of common factors. For example we have seen how many of the decisions, difficulties and even opportunities older people face at some stage are caused by such things as a need to leave employment, the death of a partner, the loss of relationships, a lack of self-confidence or diminishing physical and mental capacity.

And it is in encountering these events – some of life’s most trying moments – where older people are likely to face decisions across all the chapter areas we have included in this report, and accordingly make a transition into a different

quality of life. In this regard what is also abundantly clear has been the extent to which poverty, social breakdown and loneliness both fuel and exacerbate the intensity of these experiences. Building on these foundational points the Group has identified the following three themes which will shape our second report. We hope they lay the foundations for a new strategy that tackles older age poverty, within the context of a rapidly ageing society and an economically challenging environment.

6.1 Celebrating Older Age Within Society

Older people are at the heart of much civic participation and social action within our communities, and deservedly they command considerable respect from the majority of people across society. However, despite the fact that there is much to be proud of in how older people are honoured, as well as choose to engage within society, we have encountered a number of issues that hinder the full realisation of potential in both cases.

Our second and final report, therefore, will begin by setting out a range of policy recommendations to ensure we do more to respect, celebrate and utilise older age within society – particularly in our poorest areas. This section will include recommendations for and about individuals, families, social networks, communities and government. Where appropriate it will tackle directly the recurring issues of regulation and risk aversion across each of the chapter areas we have included in this interim paper.

6.2 Personal Planning and Informed Choice

Perhaps the most commonly recurring theme across each of the chapter areas has been personal planning. Its importance, and regrettably often its absence, has become abundantly clear to members of the review. Repeatedly throughout this report, whether in the field of personal finance, lifestyle, housing or care needs, we encountered an unevenness of planning.



Within this analysis and conclusion, members of our review have also been quick to identify a failure of others integral to personal planning to provide and encourage accessible information for older people, particularly those vulnerable to social and digital exclusion. We have found that the inaccessibility of information and a subsequent lack of informed choice are commonly driven by a number of factors including the absence of provision, the complexity of certain systems and digital exclusion – often caused by poverty or an inability to use technology.

Linked to these failures, and often caused by them, we have also encountered too many older people forced to make crucial life-altering decisions at crisis point. Where informed and encouraged planning would have prepared individuals for decisions about such things as the organisation of their money, whether they would prefer to move house or make adaptations to their existing property as they age, or in taking decisions about the nature of the care they might need (or indeed how it will be paid for), we have instead heard about the pressure of a rushed commitment driven by such pressures as deteriorating health or the death of a partner. A debate about a new culture of planning – both at an individual and corporate level – would help to ease the trauma of such moments. We will make recommendations about such cultural and practical changes in our forthcoming report.

6.3 Public Sector Provision and General Services

The third overlapping theme derived from our interim report is the provision of public and core services within communities, such as welfare benefits, health and social care, transport and social housing, as well as the utilisation of the voluntary sector in meeting the needs of individuals and communities.

In doing so it has become clear that although most provision is led by well-intentioned and dedicated people – most of whom have chosen to work with older people through passion not financial reward – many are struggling to meet demand and provide the desired high quality delivery for older people, particularly under the current intensity of reducing budgets.

Furthermore, many such services have grown accustomed to so-called ‘silo-working’ and independence. This has, as we have highlighted in our report, often undermined the strategy for preventative working in social care for example. For although there has been near universal agreement about the value of preventative interventions, there has been a regular failure of the core services required for their delivery to work in a genuinely collaborative manner. For instance: where have the structural and financial incentives been for a social care team to invest its resources in programmes that reap financial rewards in budgets other than its own? And given the extraordinary rationing by local authorities in recent years, and its likely continuation, it is difficult to envisage how prevention will be a realised goal without radical systemic reform.

Our second report will also recognise the pioneering work of many in the voluntary sector. So many projects working with older people and making a difference – particularly in poorer areas – are led by innovative charities. Yet as we have also discovered, and as the CSJ has highlighted in many previous reports, these organisations often face a daily battle simply to stay afloat. Several have even reported how they believe it would be easier (though not easy) to secure funding were they charities focused on children or young people.

6.4 Unintended Consequences

Further to these three themes, review members have regularly expressed their concerns that the rate of change in public service provision in order to make short-term financial savings, runs the risk of significant unintended consequences for individuals and the public purse. For example in relation to care, if it is recognised that systemic change is needed – and there appears to be cross-party consensus that the current system is broken – it is important to protect good preventative services until that change can be implemented properly. Yet as we have noted there is currently little incentive to fund low-level services which prevent the need for more costly services at a later date if the financial saving is in a budget controlled elsewhere. Similarly, altering eligibility to achieve short-term cuts to the public funding of residential and in-home care before the introduction of a new funding regime runs the risk of many older people missing out on vital services.

In publishing policy recommendations and considering the impact of their implementation within our second report, the Working Group aims to avoid falling into the trap of instigating unintended consequences. As far as is possible our agenda for reform will promote a shared vision and practice across many of the agencies, organisations and individuals to which it relates.

CHAPTER ONE

Introduction

Chapter Findings: Summary

- We should celebrate the fact people are living longer.
- Many older people are making indispensable contributions to community life and national wellbeing.
- That said, we must also come to terms with Britain's ageing society.
- Older people have been a 'political football' for too long. Many are disappointed when important debates such as how to fund social care are hijacked by political point-scoring. In addition, the preoccupation of public debate with the cost of social care risks characterising older people as a problem society has to pay for.
- The frequent and narrow categorisation of older people of multiple generations (e.g. conflating a 65 year old with a 95 year old) is naïve and leads to inappropriate 'one size fits all' public policy.
- We have perceived a societal and cultural imbalance between provisions for older people and provisions for younger people.
- Approximately one in five older people lives below the poverty line in the UK. And while pensioner poverty has been reduced overall, the very poorest continue to be let down.
- As with all CSJ publications this review will focus on the poorest older people and those trapped in social breakdown and exclusion.

1.1 Old Age: A Cause for Celebration

We should celebrate the fact that we are all living longer. Older age – for the purpose of this review ranging from pensionable age to over 100 years old – is something to respect, welcome and enjoy. As this interim report will outline, older age is something an increasing proportion of the population will experience, and for the majority of us in Britain, it will prove a generally positive period of our lives.

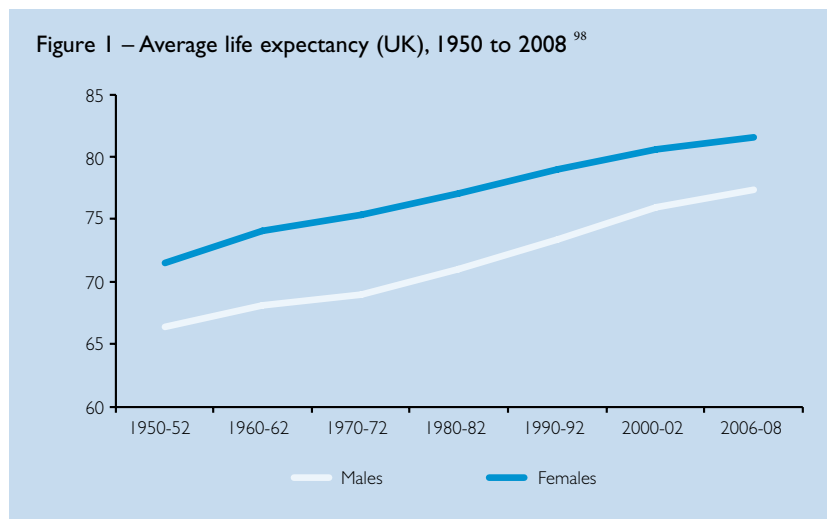
Above all this review aims to celebrate and champion old age

1.1.1 LIVING FOR LONGER

Life expectancy rates have increased significantly in the last 80 years. A boy born in the UK can now expect to live to 78 years old and a girl 82 years.⁹⁶ This compares to 59 years for a boy and 63 years for a girl born between 1930 and

⁹⁶ Office for National Statistics, *Statistical Bulletin: Life expectancy at birth and at age 65 by local areas in the United Kingdom, 2007-09*, Newport: Office for National Statistics, October 2010, p1

1932.⁹⁷ The rate of life expectancy increase has been particularly significant since 1950 as the following table demonstrates.



More than 13.6 million people aged 60 years old or above live in the UK.⁹⁹ Within this, 1.4 million people are between the ages of 80 and 85 and approximately 11,000 are aged 100 or older – a figure projected to rise to more than 87,000 by 2034.¹⁰⁰ Such progressive demographic changes reflect significant developments in public health and awareness, overall prosperity and access to decent healthcare.



1.1.2 OLDER PEOPLE WITHIN SOCIETY

For many their retirement years bring new found levels of financial and personal freedom, and increased choice. Research shows, for example, that over 55 year olds control 80 per cent of the nation's wealth and account for 40 per cent of the UK's annual consumer spending.¹⁰¹

There have also been significant improvements in quality of life for the majority of older people, such as greater freedom to travel and more opportunities to exercise and stay active.

Older people make a rich contribution to our communities in a number of ways. People over 50 make up the majority of carers in our country¹⁰² and

⁹⁷ Office for National Statistics, *News Release: Life Expectancy at birth*, Newport: Office for National Statistics, 2009, 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>.

⁹⁸ Office for National Statistics, *Statistical Bulletin: Life expectancy at birth and at age 65 by local areas in the United Kingdom, 2007-09*, Newport: Office for National Statistics, October 2010, p1

⁹⁹ Office for National Statistics, *Statistical Bulletin: National population projections, 2008-based* (Current datasets), Newport: Office for National Statistics, 2009

¹⁰⁰ Office for National Statistics, *Statistical Bulletin: Older People's Day 2010*, Newport: Office for National Statistics, 2010, p1

¹⁰¹ HM Government, *Building a society for all ages*, London: The Stationery Office, 2010, p14

¹⁰² Ibid.

grandparents do so much to enable parents to stay in work while their children are young. And more people aged between 65 and 74 years old engage in formal volunteering as a proportion of their age group than any other group of people.¹⁰³

Figure 2 – Percentage of people engaged in regular formal and informal volunteering (England), by age¹⁰⁴

Age Group	Formal Volunteering	Informal Volunteering
65-74	30 per cent	38 per cent
75 and over	20 per cent	32 per cent

Citizenship Survey results show that many older people strongly feel they belong to their local neighbourhood. 88 per cent of 65 to 74 year olds said that they strongly felt they belonged to their area, as did 87 per cent of those aged 75 and over. Of interest, this compared to a national average across all ages of 77 per cent, and was higher than the 68 per cent of those aged 25 to 34 years old.¹⁰⁵ Results were also similar across the older population in terms of general satisfaction with their local area.¹⁰⁶

There are many other indicators, some of which we highlight during this report, which demonstrate how growing older can be thoroughly enjoyed, not just endured. This now has to be our vision for *all* older people.

1.2 Underlying Principles

It is important to outline both the guiding principles which shape our policy development process and key considerations which frame the content.

1.2.1 THE CSJ POLICY DEVELOPMENT PROCESS

Transformative, Empowering Policy

The Centre for Social Justice (CSJ) is fundamentally ambitious about the reversal of poverty through individual and societal transformation. Through its policy work it aims to find and promote solutions to Britain's most intractable social problems. Its



L-R: Working group members Roger Davies, Dr Nori Graham and Harry Cayton, in an evidence-gathering session.

¹⁰³ Department for Communities and Local Government, *2008-09 Citizenship Survey*, July 2009, London: Department for Communities and Local Government, 2010, pp6-8

¹⁰⁴ Ibid.

¹⁰⁵ Department for Communities and Local Government, *Citizenship Survey: April – December 2009 England*, 2010, London: Department for Communities and Local Government, 2010, p41

¹⁰⁶ Ibid., p42

values are outcome-driven and transcend the political spectrum. It aims to reverse poverty, to promote prevention instead of cure; independence over maintenance; the importance of individual dignity; the fulfilment of personal and relational potential; and strong local communities with a vibrant voluntary sector at their heart.

Experience-Led, Evidence-Based Policy

Shaped by these core values, the CSJ asks only two things of its expert Working Groups. The first requirement is that they listen more often than they talk. The Rt Hon Iain Duncan Smith MP was moved to establish the CSJ not by persuasive experts or detached debate, but by seeing the reality of poverty and listening to those trapped in it. Not one of the 700 plus policy recommendations published by the CSJ since 2005 can be traced back to the ivory towers of Westminster. They have emerged through visits to communities and hearings with professionals the length and breadth of the country and further afield. It is only by such grassroots and grounded gathering of evidence that the true nature and scale of the issues will become clear.

The second requirement of any CSJ Working Group is that they present the reality as they find it without any restrictions. There are no positional constraints on the recommendations of those commissioned to develop policy. In simple terms, if emerging recommendations are experience-led, evidence-based, positively transformational and realistic, they will be promoted.

1.3 Underlying Considerations

Building on this it became apparent that several key considerations should be raised about the nature of policy-making and older people. These observations act as principled lessons for our work.

1.3.1 THE HISTORICAL AND POLICY CONTEXTS

On the Agenda: An International Perspective

The World Health Organisation (WHO) has been leading the debate about global ageing and international policy responses during recent years. Through its widely acclaimed *Active Ageing* agenda it has collated evidence and arguments for embedding crucial factors such as exercise, activity and good health within ageing society strategies. We investigate active ageing from a domestic perspective throughout the report, and in particular, in chapter three.

In addition to this, the WHO has undertaken significant work on the concept of Age-Friendly Communities, outlining the essential nature of certain environmental provision for people of all ages, as well as the global situation within selected major cities. We consider these factors throughout the report.

On the Agenda: the Domestic Context

As our chapters on money and care illustrate, older people and related systems of support have been integral to central government policy-making for more than a century.

In terms of pensions, key landmarks within this period include the 1908 Old Age Pensions Act which introduced the first non-contributory general old age pension; Sir William Beveridge's *Social Insurance and Allied Services* report published in 1942; the introduction of a contributory state pension in the 1946 National Insurance Act; Margaret Thatcher's decision to remove the link between state pension increases and average earnings; and Gordon Brown's move to remove tax credits for pension funds on company dividends.

Care and support for older people has also long been on the agenda of central government. The National Assistance Act of 1948 established local residential accommodation for older and disabled people on a statutory footing; the introduction of Attendance Allowance in 1971 offered special financial support for disabled older people; the 1990 Community Care Act mandated local authorities as care managers and promoted flexible domiciliary care; and the publication of two social care related White Papers in 2006 and 2010 sought to instigate system-wide reforms.

More broadly still, through the introduction of free eye tests, free TV Licences for those aged 75 and over and free bus travel, along with the introduction of pensioner-specific payments like the Winter Fuel Allowance in 1997, politicians have vigorously sought to provide for older members of society.

That said it is the field of social care and the related one of health care sector which has received the most public and political attention. In recent years much has been promised in the field of social care but, as we note below, recent political debates have been conducted far from impressively at times. Many of those who followed deliberations in the recourse to the recent General Election, for example, feel let down. The Working Group considers care services in chapter five, but here it is used to highlight a detrimental trait of policy-makers: treating old people as a 'political football'.

The 'Political Football'

At the commencement of this review in the spring of 2010, amidst deep rooted economic and political uncertainty, Britain moved towards a General Election which would go on to redraw our political landscape. It seemed that virtually every politician, of both the Left and the Right of the British political system, called for a 'new politics' and hailed a need for real change. Landmark television debates sparked fresh engagement from many disinterested voters, and a late flurry of electoral roll registrations suggested a higher than average turnout was to be expected.

Yet the reality for many older people was more of the same tired party politics on social care. Despite such promising developments and the excellent work of expert organisations including Age UK, Counsel and Care and the

King's Fund – who all repeatedly attempted to lift elder care debates above party political bickering and forge a broad political consensus (which existed in part but was wholly overshadowed by what followed), there was little in the way of 'new politics'. The Parties' approaches to the debates about older people, and in particular the system through which they receive care, were too often hijacked in the pursuit of a good headline.

This was perhaps never clearer than when the important deliberations about social care system funding, fuelled by the imminent publication of the previous Government's long-awaited White Paper,¹⁰⁷ descended into the rhetoric of the 'Death Tax' and subsequent refusals to engage in further discussions about policy unless certain funding options were ruled out:

'Cross-party deal on elderly care in tatters after three parties engage in row live on TV'

The Daily Telegraph, 14 February 2010¹⁰⁸

'Political debate on care descends into acrimony.'

Community Care, 4 March 2010¹⁰⁹

Whatever the rights and wrongs of the proposed policies at that time, we have heard the disappointment and criticisms of many in the field, including numerous older people, about the tendency for such important issues – which deserve mature and measured debate – to fall foul of petty political point-scoring.

“At 70 years old you can be confined to a wheelchair with rapidly deteriorating health or you can be running for President of the United States. We have to start making room for that diversity.”

A housing professional, in evidence to the CSJ

In view of the urgent economic pressures and projected demographic changes Britain faces, and given the public anger about often undignified social care squabbling during the recent General Election, this simply has to change. Older people, both in evidence to this review and more broadly, are demanding more from those who hold public office and those who seek it.

It is the intention of this CSJ Working Group, both in this interim report and through our recommendations to follow, to make a useful contribution in achieving that aspiration.

A Broader Focus: Beyond Care and Pensions

Further to a need for greater maturity in elder care policy development, it is vital that policy-makers engage in a broader debate about ageing. One only needs

107 HM Government, *Building the National Care Service*, London: The Stationery Office, 2010

108 Accessed via: <http://www.telegraph.co.uk/health/elderhealth/7237531/Cross-party-deal-on-elderly-care-in-tatters-after-three-parties-engage-in-row-live-on-TV.html>, 25 May 2010

109 Accessed via: <http://www.communitycare.co.uk/Articles/2010/03/04/113803/political-debate-on-care-descends-into-acrimony.htm>, 25 May 2010

to look at the cross-department division within central and local government, as well as other core local public services, to grasp the sheer diversity of ageing issues. Direct responsibility for older age-related policy falls across a multiplicity of Whitehall teams within several arms of government including the Department for Work and Pensions (DWP); the Department for Communities and Local Government (DCLG); the Department for Health; and the Department for Transport. At a local level the responsibility is spread across Social Services; benefit offices; local authority housing teams and associations; PCTs; Hospitals; and the commissioned voluntary sector. One can add to this list decisions made by other departments which affect us all, whether old or young, such as HM Treasury; the Home Office; and the Ministry of Justice.

This should be no revelation to us yet too often older people are siphoned off into just one or two issue groups as if life fundamentally narrows at 60 or 65. Ask almost any older person what matters to them, however, and it will become clear that this is simply misguided. This was most recently demonstrated by Age UK's pre-General Election survey of 2010 which revealed that older people care about similar issues as younger people, and to a similar extent.

So whilst there is an urgent need for social care and pension reforms, Britain must also initiate a broader conversation about the wider life experiences of people above pensionable age and the issues that matter to them. As members of the Working Group listened to many such people, it became clear that our review's contribution would be most effective if it took on such a challenge.

Furthermore, in grounding the public policy debate about ageing in care systems and economics alone, we also risk sending a debilitating message to older people. They are too frequently, even if subconsciously, characterised solely as a problem society has to look after and pay for. Instead, we must celebrate and cater for the different stages of ageing, as well as recognise the unique contribution older people make in society.



Early evidence gathering session with
The British Society of Gerontology

“You wouldn't sweep 10 year olds and 50 year olds into the same group, so why do we continually see that happening with people of pensionable age?”

A social care professional, in evidence to the CSJ

A Broader Focus: The Diversity of Ageing

Another fundamental feature of policy-making has been a narrow categorisation of multiple generations of pensioners as one group with one need. This disregards the differing experiences of ageing and leads to inappropriate 'one size fits all' public policy. Our review will seek to break out of this habit and consider the totality of ageing and the many nuances within it.

1.3.2 THE SOCIETAL IMBALANCE

Our review has heard, consistently, about a cultural imbalance between provisions for older people and provisions for younger people – regularly

“There’s no doubt that if we were a project for young people funding would be much easier to find and secure. But our society is geared towards young people.”

A pensioners’ community project leader, in evidence to the CSJ

appearing to favour the latter significantly. Several outstanding projects visited by Working Group members informed our review about the relentless struggle for public funding in this regard.

In addition to this concern there is a broader public consciousness issue – often played out in national and local media coverage. From our anecdotal evidence gathering it has become apparent that, despite the proportion of the UK population aged 16 years or younger dropping below the proportion over state pension age for the first time in 2007,¹¹⁰ concerns about older people can be overlooked.

This manifests itself in a number of ways. For example, members of the public are frequently and rightly reminded of the scandal of widespread youth unemployment – almost one million so-called NEETs¹¹¹ are seemingly drifting into residual adult worklessness and state dependency¹¹² – but it is striking on consideration how little we hear about the equally appalling epidemic of loneliness among our pensioner population. Furthermore, the excellent aspirations underpinning the Sure Start initiative to support our most vulnerable families are to be commended (whatever the inadequacies of the scheme’s subsequent implementation),¹¹³ but many are right to call for an equivalent holistic and coordinated effort for the poorest and most vulnerable of our elderly population. This concern was recognised by the previous Government in its ambitious report *A Sure Start to Later Life*,¹¹⁴ but as we explore later in this report, there remains a significant amount to be done to make progress on its intentions.

Rightly, significant effort is exerted to ensure our children and young people are given the best start in life. Yet this need not be at the expense of older people. How a society values, cares for and supports its youngest members and its oldest should be one of the most significant markers of its compassion and decency. Many of those who gave evidence to our review argued that Britain has, in certain ways, failed to strike this important balance for some time now. Although we have a rapidly ageing population, Britain was often characterised as a young person’s arena. The Working Group recognises the unique value of our children and young people, but we will also strive to use this review to speak up for those who feel frustrated by a perceived imbalance. This imbalance undermines older people and undervalues those seeking to support them.

110 Office for National Statistics, *Social Trends No. 39 - 2009 edition*, Newport: Office for National Statistics, 2009. p1

111 Those aged between 16 and 24 years old who are not in education, employment or training.

112 Office for National Statistics, *Labour market statistics: 2010*, Newport: Office for National Statistics, 2010, p38 (941,000)

113 See for example The Centre for Social Justice, *Green Paper on the Family*, London: The Centre for Social Justice, 2010

114 Social Exclusion Unit, *A Sure Start to Later Life*, London: Office of the Deputy Prime Minister, 2006

1.3.3 OUR AGEING SOCIETY: A DEMOGRAPHIC URGENCY

Whilst old age is a clear cause for celebration, Britain's ageing society offers a number of serious short and long term challenges which must be recognised and discussed.

“An ageing society is no longer on the horizon, it is here with us today.”

The DWP¹¹⁵

The most Serious Challenge

The most serious challenge is our projected demographic pattern. The UK's population is projected to increase rapidly in the coming years, and of particular relevance become older overall. This presents the most significant challenge for social policy in decades. Unless action is taken these changes will place real pressure on age-related public finances – such as the state pension, healthcare and social care provision – and impact on workforce growth.

Growing and Growing Older

In its sobering *Population Projection Bulletin*, the Office for National Statistics (ONS) lays out the degree to which our population will not only expand, but age overall. It projects that the UK population will increase by approximately 10 million people over a 25 year period: from 61.4 million in 2008 (latest figures available) to 71.6 million in 2033.¹¹⁶ Based on calculated trends, 55 per cent of such an increase will be attributed a natural increase (more births than deaths), and 45 per cent attributed to estimated net migration.^{117 118}

As the population is projected to increase, it is also expected to age. According to the ONS the median age in the UK will rise from 39.3 years to 42.2 years between 2008 and 2033,¹¹⁹ and the gap between the number of under 16 year olds and people of pensionable age (taking account for the planned pension age rise) will widen rapidly. The result of which means that by the year 2024 one in five people will be of pensionable age.¹²⁰

Figure 3 – Projected UK population by age bracket, 2008 – 2033 (millions)¹²¹

Ages	2008	2023	2033
Under 16 years old	11.5	12.6	12.8
Pensionable age	11.8	13.4	15.6

115 Accessed via: <http://www.dwp.gov.uk/policy/ageing-society/>, 26 May 2010

116 Office for National Statistics, *Statistical Bulletin: National population projections, 2008-based*, Newport: Office for National Statistics, 2009, p1

117 Ibid., p2

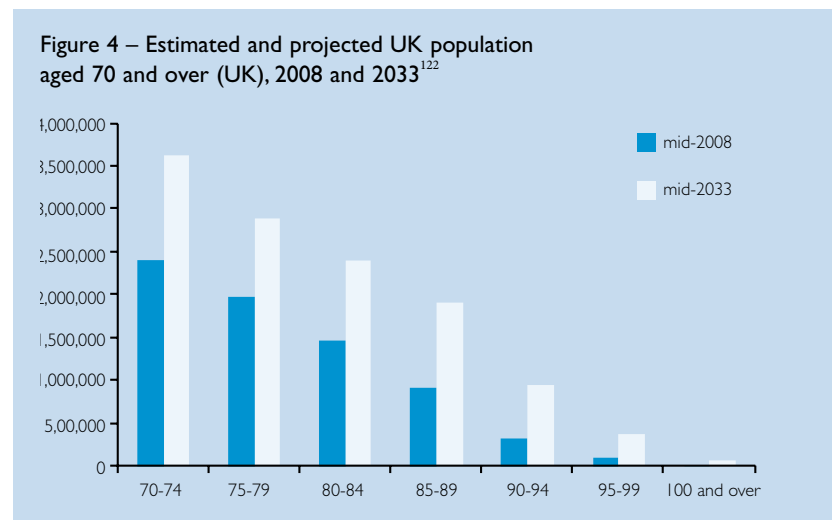
118 This net migration projection will likely be subject to review as a result of the proposed change in policy under the UK's new Coalition Government.

119 Office for National Statistics, *Statistical Bulletin: National population projections, 2008-based*, Newport: Office for National Statistics, 2009, p4

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

121 Office for National Statistics, *Statistical Bulletin: National population projections, 2008-based*, Newport: Office for National Statistics, 2009, p3

More pertinently, as the following chart demonstrates, by 2033 many individuals within the pensioner population – which will have increased by 32 per cent according to the figures above – will be living for longer.



What is also clear is that although people are living for longer, there is evidence they are increasingly spending longer in poor health. Whilst life expectancy rates and periods of good health are increasing,¹²³ work undertaken by the ONS demonstrates that healthy life expectancy has not matched the pace of increase and has therefore lowered the average period spent in favourable health.¹²⁴

Economic Pressures and Workforce Changes

It is also right to recognise that such societal trends, and their implications, could have a wide-reaching economic impact. Economic pressures will be heightened as the projected rise of the number of people over the current pension age will not be matched relatively by the number of adults below this age. Furthermore, not only will the working age population fail to increase relative to the pensionable age population, but the working age population will also become older. The ONS reports that although in 2008 the number of working aged individuals under the age of 40 years old exceeded those over 40 by 1.5 million, by 2033 this will have reversed to result in the latter outnumbering the former by 1.4 million.¹²⁵ This makes clear the need to adapt the employment rate and workforce exit ages.

In its 2010 report *Under Pressure* the Audit Commission highlighted further implications of an ageing society, particularly the challenges it presents to local

¹²² Ibid., p5.

¹²³ Technically referred to as Healthy Life Expectancy (HLE).

¹²⁴ Office for National Statistics, *Healthy Life Expectancy: Living Longer, more years in poor health*, accessed via: <http://www.statistics.gov.uk/cci/nugget.asp?id=2159>, 27 May 2010

¹²⁵ Office for National Statistics, *Statistical Bulletin: National population projections, 2008-based*, Newport: Office for National Statistics, 2009, p5

authorities and councils.¹²⁶ As well as outlining how our changing demographic situation presents an opportunity by making the most of the widespread yet still underutilised contribution of older people in communities, it also reported that such developments will increase the cost of responding to a variety of age-related health conditions. Using dementia as an example, by highlighting estimates contained in the 2009 *National Dementia Strategy*,¹²⁷ the report noted that the number of cases of dementia is projected to double in the next 30 years and its costs could virtually treble: from an annual £17 billion to £50 billion.¹²⁸

The projected economic implications for social care are also deeply sobering. In a recent report the Personal Social Services Research Unit (PSSRU) concluded that public spending would need to increase by 90 per cent in real terms between now and 2026 simply in order to match the current population projections outlined by the ONS and maintain the current care on offer.¹²⁹ Yet, as is universally recognised, the current social care system is already broken. Furthermore, as the PSSRU outlines, if our present means-testing and self-funding trends continue (the likelihood of which is likely to be subject to review under the new social care commission), private spending or self-financing will have to increase at an even faster rate than public spending.

With appropriate action these consequences can be avoided, but the immediate economic framework within which such action must be taken is now extremely pressurised.

Population projections suggest that public spending will have to virtually double by 2026 to match the current care offer.

Responding to the Challenge

Two early observations have struck the Working Group about the ageing society. The first is that there is, thankfully, significant consensus about the nature and scale of the challenge that confronts us all. In our positive discussions with senior civil servants, academics, professionals, and employers there has been little disagreement about the nature of the demographic trends and what they broadly mean for society. This unity of analysis must be seized upon to produce the strongest and most effective response possible.

The second observation, which was previously noted by reports such as the Audit Commission's *Don't stop me now*,¹³⁰ is that although key stakeholders recognise the scale of the challenge there has yet to be serious and widespread action in response to it – particularly at the local level. In 2008 just a third of councils were well prepared for an ageing population while 27 per cent focused

126 Audit Commission, *Under Pressure: Tackling the financial challenge for councils of an ageing population*, London: Audit Commission, 2010

127 Department of Health, *National Dementia Strategy*, London: Department of Health, 2009

128 Audit Commission, *Under Pressure: Tackling the financial challenge for councils of an ageing population*, London: Audit Commission, 2010, p10

129 Personal Social Services Research Unit, *Analysing the Costs and Benefits of Social Care Funding Arrangements in England*, London: Personal Social Services Research Unit, 2009, p48

130 Audit Commission, *Don't stop me now: preparing for an ageing population*, London: Audit Commission, 2008

solely on social care, making no other provision for older people.¹³¹ This is an analysis with which we broadly still concur. While there are some encouraging indications that councils and central government departments are now moving from agreement to action, and taking a broader approach to supporting older age, much more work needs to be done to ensure that policy-makers at every level are working together to meet these challenges.

1.3.4 BRITAIN'S BROKEN ECONOMIC FRAMEWORK

The impact of the trends outlined above would be a cause for discomfort in times of international economic certainty and prolific domestic growth. In our present economic circumstances, therefore, they should be a stark cause for concern.

Whilst the majority of us are likely to suffer to some extent in the coming years of economic austerity, it has been argued in many of our evidence sessions that it is our older people who could be hit the hardest.

During our evidence gathering it has become apparent that, in relation to social care at least, this enforced mass scaling back has been happening at local authority level for some time. Funding within the social care needs framework, in which people are assessed within the *Fair Access to Care Services* (FACS) bands of Low, Moderate, Substantial or Critical, is becoming increasingly high-end allocated. In 2008 the Audit Commission found that most councils focus on the needs of a minority who need higher levels of social care.¹³² This was a conclusion that the Care Quality Commission (CQC) substantiated in its 2010 report *The state of health care and adult social care in England*:

'72 per cent of councils have chosen to focus their funding for social care solely on people whose needs are substantial or critical. As criteria are tightened, increasing numbers of people become ineligible for public funding'.¹³³

Consequently this drift is also impacting service delivery at a local level. Several of the community projects we visited during the review, such as day clubs, informed us about their growing funding pressures. They regularly referred to the drift of statutory services away from prevention work. In almost every discussion hosted with key social care professionals, local authority officials and older people in receipt of social care, this has been identified as a factor for our review's consideration.

Whilst current economic pressures are unavoidable and difficult public expenditure decisions lie ahead, policy-makers should give an assurance that they will not duck the brave, radical and necessary reforms required in this

131 Ibid., p21

132 Audit Commission, *Don't stop me now: Preparing for an ageing population*, London: Audit Commission, 2008

133 Care Quality Commission, *The state of health care and adult social care in England*, London: The Care Quality Commission, 2010, p15

field. These are not decisions for another day. Failure to act now will see Britain sleepwalking into a demographic and societal minefield.

1.3.5 THE LOW STANDING OF PARLIAMENT

Although the deep rooted mistrust of politicians and our parliamentary system is not directly related to this review, nor its consequences exclusive to one section of society, its damaging impact on older people's willingness to respect and engage with future reform has been raised by some in evidence to our review. Given the pressing nature of the challenges outlined above, significant and perhaps deeply controversial decisions may be required. These decisions, and the motivations behind them, will need to command the respect of society and those whom they will impact. In view of the anger and disappointment felt about recent events in Parliament the Working Group registers its concern that unless rapid and comprehensive action is taken to begin the restoration of public trust in the political process, the legacy of the recent scandal will be a deeply damaging one.

“You just can't trust politicians. They've all got their hands in the till.”

Elderly lunch club member in evidence to the CSJ

1.4 The Poorest: Our Lens

1.4.1 MORE THAN MONEY: WHAT WE MEAN BY POVERTY

One in five pensioners in the UK lives below the poverty line.¹³⁴ Comparably to 1998/99 this represents a reduction of 0.5 million pensioners in poverty before housing costs, and 1.1 million after housing costs (arguably the more reliable of the two measures given the regional diversity of housing costs and variability of people's housing).¹³⁵ This is to be welcomed.

Regrettably, it should also be noted that less progress has been made in helping pensioners in more severe poverty. The number of pensioners living below 50 per cent of median income is currently 1.1 million after housing costs, rising back towards 1999/00 levels of 1.3 million (after falling to 0.9 million between 2004 and 2006).¹³⁶ The Working Group believes the new Coalition Government simply has to do better than this for the very poorest older people in society.

According to official figures one in five UK pensioners (2.3 million people) lives in poverty.

Yet, as the CSJ has argued in its previous work, there is a problem with such arbitrary definitions of poverty: they can prove narrow and misleading. As chapter two identifies, the previous Government was often too quick to base its strategy for poverty reduction

¹³⁴ Defined as below 60 per cent of contemporary median net disposable income

¹³⁵ Department for Work and Pensions, *First Release: Households below average income statistics*, London: Department for Work and Pensions, 2010, p1

¹³⁶ Ibid., p12

solely on increasing income levels. During its period in office such an approach resulted in an obsession with changes to benefit levels and tax credits alone, which in turn led to quick fixes and technical claims about how a certain number of people within a targeted group had been lifted out of poverty.

One only needs to study the recent history of child poverty, to see how flawed this model is in reality. The number of children living in poverty as defined by the previous Government fell between 1998/99 and 2004/05 as income-related measures made their impact, but began rising again soon after when the narrowness of the strategy became clear. Take the example of

a child with a heroin-addicted parent living below the 60 per cent poverty line. Increasing household income through the tax or benefit systems could quite quickly and technically move that household, and child, above the poverty line. But unless the heroin dependency is tackled alongside providing an increased income, the addiction will continue to entrench household poverty.

By identifying the core drivers of social breakdown the CSJ has attempted to redefine the debate about poverty. Although some progress has been made in recent years, particularly in the theory and understanding of social

exclusion, there remains much to be done. This is particularly true in the case of older people.



An early Working Group meeting discussing issues for the review

1.4.2 POVERTY, SOCIAL EXCLUSION AND THIS REVIEW

In view of these considerations our review seeks to work within a broader concept of poverty than the median income measurement, important as it is as a place to begin. Informed by the Working Group's expertise and our evidence gathering process several key indicators bring definition to our concentration

on the poorest older people. Although far from conclusive characteristics, the most common are outlined below and provide a typical personal profile by which this review is guided.

Approximately 1.3 million people over 65 years old claim Housing Benefit¹³⁷

Common Profile Characteristics: Income

Without external financial assistance almost all of the group of people we are concentrating on would be below the income-related poverty line. As it stands, the overwhelming majority do not possess sufficient assets (namely savings, pensions or investments) to release capital for a higher quality of life and consequently are reliant on the State Pension and other age-related benefits to make ends meet. Most commonly these benefits comprise Housing Benefit; Pension Credit Guarantee and Council Tax benefit. Many within our targeted group claim a combination of these benefits: for example

¹³⁷ Department for Work and Pensions, *First Release: DWP Quarterly Statistical Summary: Additional Table 8a*, London: Department for Work and Pensions, 2010

1.1 million people receive Housing Benefit on a passported basis by way of also receiving Pension Credit (Guarantee Credit).¹³⁸ Furthermore, as chapter two outlines, there are significant numbers of older people eligible for statutory financial support who do not claim it for several reasons. Many of these people live in deep levels of poverty.

Common Profile Characteristics: Housing

Whilst DWP figures show that just under two thirds of pensioners living below the income poverty line are outright home owners and a third rent,¹³⁹ the majority of the poorest older people we have encountered through meetings or submissions have very little or no asset and savings base at all – and therefore have no option to release capital or finance. Furthermore, as Professor Thomas Scharf et al concluded in the report *Growing older in socially deprived areas*,¹⁴⁰ many of the poorest older people live in socially deprived urban areas where social housing tends to dominate local housing provision. Therefore, although it is unnecessary to establish strict criteria for our review, it will be primarily focused on the group of people who fall into these housing categories.

However, we recognise that as well as tenants with very low assets there is a proportion of homeowners who have to make significant mortgage repayments well into their retirement, or who have low asset value in their property due to the nature of their locality or the property's poor state of repair. We also recognise that a number of older people live in deprived or very isolated rural settings where unique pressures can entrench poverty. There are also older people, some of whom we have encountered, who have a low quality of life and who could improve it by accessing capital but choose not to. In addition we have heard and fully share the concerns of those who have given evidence to our review about marginalisation and homelessness in later life; we will respond to these concerns.

Common Profile Characteristics: Loneliness and Social Exclusion

The Working Group has also encountered the stubborn and tragic realities of loneliness and social exclusion, which can be particularly acute for the poorest older people.

Loneliness

We all experience loneliness at some stage, no matter our age or social situation. Yet research demonstrates that loneliness is felt particularly acutely by those above pensionable age: almost one in ten people aged 65 and over

138 Department for Work and Pensions, *First Release: DWP Quarterly Statistical Summary: Additional Table 6*, London: Department for Work and Pensions, 2010

139 Department for Work and Pensions, *Households Below Average Income: An Analysis of the Income Distribution 1994/95 – 2008/09*, London: Department for Work and Pensions, 2010, p168

140 Scharf et al, *Growing older in socially deprived areas: social exclusion in later life*, London: Help the Aged, 2002

report feeling regularly or always lonely.¹⁴¹ It is often triggered by a loss of social networks and companions – features more likely experienced in later life. And as we have looked closely at the group of older people which we are predominantly focusing on, loneliness has been a debilitating theme. On this and associated subjects the Working Group will link its efforts closely to those of the CSJ Mental Health review, running concurrently to ours.

Social Exclusion

‘(social exclusion is)...a shorthand term for what can happen when people or areas suffer from a combination of linked problems such as unemployment, poor skills, low income, poor housing, high crime, bad health and family breakdown.’

Preventing Social Exclusion, Social Exclusion Unit report¹⁴²

Many poorer older people experience broader social exclusion. Evidence presented by the previous Government found that of the 20 per cent of older people living on low income approximately 15 per cent experience severe exclusion. Despite the rhetoric and well intentioned efforts of the previous Government to tackle social exclusion across the generations, there remains a huge amount left to achieve in lifting people out of it and recognising the root causes – such as social breakdown – is crucial to succeeding.

Mary, who lives as we describe below, is representative of this group, even though she receives excellent support from a charity.

MARY

At the time of her referral to a local charity in 1995, Mary, 82, had a only a small weekly income from her state pension. She was in desperate need of a new bed, mattress and bedding. She needed help with her utility bills. Mary rents a house on a deprived council estate in north London and is now in receipt of housing benefit and council tax benefit. Her neighbours have moved away, her husband died 20 years ago and she has no contact with other family members. She has become increasingly isolated and depressed. Mary feels she has no one to call on for help or company. She lacks confidence and means to socialise. Her faithful dog, which was her only reason to go out daily, died in 2008. For a long time her only social contact now has been a local taxi driver who collects her pension and takes her food shopping. Mary rarely leaves the house; she has become frail and nervous of the outside world, and is fearful of the crime she often describes as rife in her area.

141 Social Exclusion Unit, *A Sure Start to Later Life*, London: Office of the Deputy Prime Minister, 2006, p55

142 Social Exclusion Unit, *Preventing Social Exclusion*, London: The Stationery Office, 2001, p11

1.5 Core Review Themes

The ageing debate in British politics has been too narrowly focused on social care, what it costs and how we pay for it in the future. We recognise that older age is far more nuanced than many realise and that there are unique challenges for the poorest older people in society. In view of this four themes will shape this interim report.

1.5.1 MONEY

The next chapter of this interim report considers money. Although the Working Group is clear in its belief that poverty has to be measured in broader terms than income, money is clearly highly influential in determining whether an individual lives in poverty or not. During our evidence gathering income-related issues have been raised time and again and it is right that we look at these points. We will therefore make broad consideration of the state pension; age-related benefits and fuel poverty. In considering money, however, the Group believes it would be a missed opportunity to focus on income alone. In view of this, the chapter will also make consideration of often neglected issues like personal financial planning and advice.

1.5.2 COMMUNITY AND LIFESTYLE

In chapter three we consider Community and Lifestyle. During our evidence gathering the Group heard many submissions about several important themes which fall within this category. This chapter will therefore look at a number of issues including diet, health and exercise; the impact of crime; and neighbourliness and social networks.

1.5.3 HOUSING

In chapter four the Working Group has decided to investigate the fundamental yet regularly overlooked issue of housing for older people. In our early discussions several leading organisations were critical of the previous Government's failure to consider and consult as fully as it should have on housing policy. This is a mistake the Working Group will aim to avoid by putting housing policy at the heart of reform for older people. We will therefore consider the importance of personal planning; promoting independence and informed choice; and the variety of housing models presently available in our communities. We will also investigate the scandal of older age homelessness.

1.5.4 CARE

The fifth chapter will consider contact with unpaid and formal care services, so often triggered by personal bereavement or deteriorating health. Given the highly technical and comprehensively costed scoping work undertaken by

organisations like the King's Fund¹⁴³ in recent years, as well as the forthcoming work of the social care commission, the Working Group has decided its contribution to the debate should involve stepping back from such detailed economic analysis to make broader observations and recommendations. As well as a general assessment of social care we also want to consider the important issues relating to unpaid carers; the nature, challenges and scale of integration between social care and health care teams – including hospital admissions and discharges; and finally long-term care.

1.6 More of the Same is not an Option

In many ways we cannot continue to maintain the *status quo*. There remains much to do to ensure that the quality of old age for the poorest pensioners in our society is improved. Such is the purpose of our review.

Furthermore, given such stark economic and demographic pressures, the Working Group is clear that there is no more time for political squabbling and naive generalisations about old age. Policy-makers should instead develop a broader and more grounded understanding about ageing. Whilst the present economic crisis offers a more significant opportunity for individuals, families and communities to play an even more crucial role in building a better future for us all, it also demands that there should be adequate support to enable them to do so. The Working Group hopes its review is a useful contribution to an already energised debate. There is no time to waste.

143 See for example The King's Fund, *Securing Good Care for Older People: Taking a long-term view*, London: The King's Fund, 2006; The King's Fund, *Securing good care for more people: options for reform*, London: The King's Fund, 2010

CHAPTER TWO

Money

Chapter Findings: Summary

- Poverty cannot simply be measured by the level of income an individual receives. That said, a persistent number of older people struggle to make ends meet, especially those who have no private income and are fully dependent on state-based financial assistance.
- Pensioner poverty, whilst reduced under the previous Government, is still a real issue for many. Severe pensioner poverty remains stubborn and largely unimproved.
- Currently one third of pensioners rely solely on the Basic State Pension and income guarantee or Pension Credit as their sole means of support in older age.
- Many of the poorest older people in society are still not receiving all of the benefits they are entitled to. In 2008-09 entitlements worth a total of £3.9 billion went unclaimed by older people who were eligible. Raising awareness and encouraging older people to claim what they are entitled to would greatly increase many older people's quality of life.
- Due to the rising cost of fuel and other factors such as living in homes with poor insulation, more than a third of people over 60 years old stay or live in one heated room of their home to save money.
- Much more needs to be done to help people plan for later life so that they have a reasonable level of income for a healthy and fulfilling retirement. A recent survey has shown that of people aged over 55 and approaching retirement, almost one in four people have less than £2,000 savings and one in three has savings of under £10,000.

2.1 Pensioner Poverty in the UK

2.1.1 MONEY MATTERS

Money becomes particularly crucial for older people as the majority tend to spend more on essentials like food at a time when disposable income and the opportunities to earn more often decrease. On average people aged 60 and over spend approximately 15 per cent of their budget on food and non-alcoholic drinks, compared to less than ten per cent for those below 30 years old. Older people also tend to spend less than younger people on clothes, transport and certain leisure activities.¹⁴⁴ As section 2.2.1 highlights these necessary spending



An older age Parliamentary roundtable hosted by Penny Mordaunt MP facilitated a useful discussion with MPs

144 Office for National Statistics, *Family Expenditure, 2009 edition*, Newport: Office for National Statistics, 2010, p115

“When you reach this age having a bit of money matters more than ever. The older we get the more important it is to try to eat well and stay warm. That starts with money.”

Elderly community project member in evidence to the CSJ

55 per cent of the pensioners in social housing that we polled identified a lack of money as a reason for missing out on the things they want to do.

YouGov poll for the CSJ Older Age review¹⁴⁵

patterns have rendered many older people even more vulnerable than other sections of society during our recent recession.

2.1.2 THE SCALE AND NATURE OF PENSIONER POVERTY

Low Income and Poverty

Using the traditional (if on its own inadequate) definition of poverty we can derive certain trends and characteristics about the nature of poverty amongst older generations. Despite the highlighted frailties of this measurement, we note that financial pensioner poverty has declined significantly during the last decade. Pensioners are now less likely to be in financial poverty than the majority of non-pensioners after housing costs, as Figure 5 demonstrates. Only working-age couples without children are less likely to be in poverty than those over pensionable age. Whilst this is an encouraging development for pensioners, it should be noted that several other groups in society have recently moved in the opposite direction.

As demonstrated below for example, the proportion of working age couples in poverty has increased, as has the percentage of single people without children.

Figure 5 – Percentage of individuals (UK) in low income (below 60 per cent median income) After Housing Costs, 2003/04 to 2008/09¹⁴⁶



¹⁴⁵ YouGov, *Attitudes of People over Retirement Age*, June 2010

¹⁴⁶ Department for Work and Pensions, *Households Below Average Income: An analysis of the income distribution 1994/95 – 2008/09*, Table 3.7ts, London: Department for Work and Pensions, 2010, p56

In weekly terms pensioner couples in low income live on £206 after housing costs and a single pensioner, £119 a week.¹⁴⁷ For the 1.1 million pensioners who live in more severe poverty, as defined by 50 per cent median income, it is considerably less still.¹⁴⁸

It is also alarming that poverty remains disproportionately high in some of our ethnic minority communities. Research from the DWP indicates Pakistani, Bangladeshi and other Asian groups are more likely to live in income poverty than White groups. Shockingly, 49 per cent of all Pakistani and Bangladeshi pensioners live below the income poverty line, as do 31 per cent of Indian pensioners and 30 per cent of Black pensioners. This compares to 17 per cent of White pensioners.¹⁴⁹

In setting the context of the Working Group's consideration of money it is also worth noting, as is outlined in section 2.4.1, that many pensioners derive a significant proportion of their income from the state. And the proportion of state sourced income increases as an individual grows older. Furthermore, there is a significant minority of people of pensionable age who have no private income, and are fully dependent on state-based financial assistance (also section 2.3.4).

The reality of living on a low income is deeply challenging for individuals or families of any age, but as section 2.1.1 outlined, it can be particularly difficult for older people. In a 2002 report Professor Thomas Scharf et al uncovered how a third of pensioners in poverty fell behind in their payment of household bills, and a quarter had needed to borrow money to meet the basic cost of living – including from high interest door-step lenders. Almost half of those engaged in the study who were living in poverty had gone without buying clothes in the previous year, a third had foregone buying shoes, almost a quarter had sacrificed going out, one in five had gone without heating and telephoning friends or family, and 15 per cent reported they went without food. Perhaps unsurprisingly, two-thirds of the people in the study who reported a (very) low quality of life were living in poverty.¹⁵⁰

These findings were further supported by the third wave of the English Longitudinal Study of Ageing (ESLA) study. This study proved that as well as their level of physical functioning, an individual's income level is significantly correlated with well-being and quality of life.¹⁵¹

Social Breakdown, Social Exclusion and Poverty

Informed by extensive evidence gathering in Britain's poorest communities, the CSJ has long argued that the causes and catalysts of poverty are broader

147 Department for Work and Pensions, *Households Below Average Income: An analysis of the income distribution 1994/95 – 2008/09*, London: Department for Work and Pensions, May 2010, p22

148 Ibid.

149 Ibid., p154

150 Scharf et al, *Growing older in socially deprived areas: social exclusion in later life*, London: Help the Aged, 2002, pp32-37

151 English Longitudinal Study of Ageing, *Living in the 21st Century: older people in England: THE 2006 ENGLISH LONGITUDINAL STUDY OF AGEING (Wave 3)*, London: Institute of Fiscal Studies, 2008, p148

than the absence of money. In identifying five common drivers of poverty – referred to in previous CSJ publications as pathways to poverty – these causes have been outlined. They are: family breakdown; intergenerational worklessness and economic dependency; educational failure; serious personal debt; and addiction to drugs and alcohol. These interconnected pathways to poverty characterise life in too many of our most deprived areas and entrench social breakdown, as well as social exclusion.

Before moving briefly to outline the nature of social breakdown in relation to older people – which increases the likelihood of poverty – it is important to seek to understand the scale of it. Although by nature it is difficult to determine the true prevalence of the problem – in that those socially excluded from society are harder to identify – work has been undertaken in an attempt to do so.

Research undertaken by the previous Government's Social Exclusion Unit in its 2006 report *A Sure Start to Later Life*¹⁵², which built on the analysis of ELSA, identified that seven per cent of older people were severely excluded, a further 13 per cent were significantly excluded, and almost 30 per cent experienced just one form of social exclusion.¹⁵³ We are pleased that half of our older population is not socially excluded, and that a third is only marginally excluded. Yet there remains a significant number – more than two million people – detached from their communities and the rest of society. In our travelling to meet older people and those who work alongside them we could find no one who disputed the broad accuracy of these figures. In fact we encountered many who suggested, albeit anecdotally, that they were probably underestimates in reality.

It was also clear that key common causes of social breakdown impacted *older* people in our most deprived communities, as well as younger people. Although the death of a partner was the most common reason for an older person living alone, we met a number of people who were living alone as a result of a divorce or relationship breakdown at an earlier stage of life. Given that UK divorce rates remain high, as does overall family breakdown, this is only likely to continue. In addition, a number of community project workers explained how divorce and separation were increasingly causes of loneliness and isolation amongst some of the older people they know.

We also met older people who moved between unemployment and low income employment for a significant proportion of their working lives. We encountered older people who felt intimidated by truanting pupils and the anti-social behaviour many engaged in. We also took evidence from housing experts who knew of older ex-offenders or substance abusers. These trends are the early and emerging consequences of deep social breakdown. Unless reversed, they will become even more common in the near future.

This anecdotal analysis concurs with the work of others including the

152 Social Exclusion Unit, *A Sure Start to Later Life*, London: Office of the Deputy Prime Minister, 2006

153 Exclusion was measured against specific indicators, such as relationships, cultural activities and civic participation

seminal ESLS study and *A Sure Start to Later Life*. Such work identifies the core factors linked to the risk of an older person living in poverty. Based on seven dimensions of social exclusion – social relations; cultural activities; civic participation; basic services; neighbourhood; financial products; and material consumption – typical personal profiles were collated. Common profile features for those excluded across these dimensions included having no educational qualifications, experiencing unemployment and being in receipt of benefits; living in a deprived area; living in rented accommodation; and living alone.¹⁵⁴

In line with this the third ELSA report, *Living in the 21st Century: older people in England*, identified certain social risk factors that increased the likelihood of an individual living in poverty. Such risk factors included the loss of a partner (particularly significant for divorced, separated or widowed women); leaving the labour force; and having low levels of education.¹⁵⁵

Social exclusion, often fuelled by social breakdown, should force policy-makers who are intent on tackling pensioner poverty to look in broader terms than income.

2.1.3 TACKLING PENSIONER POVERTY: THE RECENT HISTORICAL CONTEXT

The Previous Government

Under the previous Government the number of pensioners living in income poverty fell significantly: from 2.9 million in 1998 to 1.8 million in 2009 (After Housing Costs).¹⁵⁶ Credit must be given for this welcome change which has been largely delivered by the introduction of Pension Credit and entitlements like the Winter Fuel Payment (see section 2.5.2). Yet, despite the rhetoric of successive governments, and although this reduction has been hailed as one of the previous Government's great legacies, much less was achieved for those in deeper poverty. This group is much harder to lift above an arbitrary poverty line.

Severe pensioner poverty was much less reduced during the course of the previous administration and remains largely unaddressed: the number of pensioners living below 50 per cent of median income is currently 1.1 million after housing costs, rising back towards 1999/00 levels of 1.3 million.¹⁵⁷

“...I believe that we in Britain can – even amidst the pressures and insecurities of globalisation – become the first country of this era to...eradicate pensioner poverty”

Gordon Brown, Labour party conference speech, 2003

154 Social Exclusion Unit, *A Sure Start to Later Life*, London: Office of the Deputy Prime Minister, 2006, p20

155 English Longitudinal Study of Ageing, *Living in the 21st Century: older people in England: THE 2006 ENGLISH LONGITUDINAL STUDY OF AGEING (Wave 3)*, London: Institute of Fiscal Studies, 2008, pp126-128

156 Department for Work and Pensions, *Households Below Average Income: An analysis of the income distribution 1994/95 – 2008/09*, London: Department for Work and Pensions, 2010, p160

157 Ibid.

Figure 6 – Number of pensioners (millions) living in income poverty (below 60 per cent and 50 per cent median income, After Housing Costs) 1998/99 to 2008/09 (UK)

Year	Below 60 per cent median income	Below 50 per cent median income	All pensioners
1998/99	2.9	1.4	10.3
1999/00	2.8	1.3	10.3
2000/01	2.7	1.2	10.3
2001/02	2.7	1.2	10.4
2002/03	2.5	1.1	10.5
2003/04	2.2	1.0	10.5
2004/05	1.9	0.9	10.7
2005/06	1.8	0.9	10.8
2006/07	2.1	1.1	10.9
2007/08	2.0	1.1	11.1
2008/09	1.8	1.1	11.3

Further to these trends it is also important to note, in line with the analysis offered by Mervyn Kohler of Age UK in his recent representation to the Work and Pensions Select Committee,¹⁵⁸ that there is a significant number of pensioners who fall very close to the 60 per cent poverty line and as we have seen, not only in relation to pensioners but also children and lone parents, it is quite simple to move these clustered groups above or below it through small variations in welfare payments and tax credits.

The new Government simply has to do better to protect and improve the quality of life for our poorest older people – however difficult that will be in our present economic circumstances.

¹⁵⁸ House of Commons Work and Pensions Select Committee, *Tackling Pensioner Poverty*, London: The Stationery Office, 2009

Persistent Pensioner Poverty

Official figures reveal the extent of persistent and prolonged pensioner income poverty. Between 2004 and 2007 approximately one in ten pensioners was living below average income for three of those four years (After Housing Costs).¹⁵⁹ Independent research by the ELSA (a panel survey) suggests persistent pensioner poverty is more deeply rooted still.

According to the ELSA data collated during three waves of research, people above the state pension age experienced higher income poverty persistence than those aged between 50 and state pension age. ELSA found that of the pensioners living in income poverty in 2002/03, approximately 55 per cent remained there three years later. Furthermore, half of that group was still living in income poverty in the third wave of research in 2006/07. ELSA concluded that persistent pensioner poverty showed 'little sign of declining over time for individuals aged above the state pension age'.¹⁶⁰ This was also broadly the conclusion of the Institute for Fiscal Studies (IFS) in its analysis of the previous Government's strategy to reduce pensioner poverty.¹⁶¹



Photograph provided by Karis Neighbour Scheme, Birmingham

2.2 The Impact of the Recession on Older People

The Working Group is acutely aware that our review is being conducted in the context of deep rooted economic uncertainty and severe pressure on public finances. The recent recession was one of the deepest in our history and although the majority of readers are likely to have experienced some personal financial pressure, evidence suggests older members of society have been some of the hardest hit.

“I find I’m spending much more than usual on the basics every week. It’s hard on my income and I’m forced to cut back on things I would have normally afforded. It’s worrying for the future.”

A lunch club pensioner in evidence to the CSJ

2.2.1 THE IMMEDIATE IMPACT

Making Ends Meet: Living Costs and Inflation

Although the state pension has increased at a faster rate than inflation during the last decade¹⁶² many people of pensionable age are struggling to make ends meet. For instance, according to recent polling commissioned by Age UK 42

159 Department for Work and Pensions, *Households Below Average Income: An analysis of the income distribution 1994/95 – 2008/09*, London: Department for Work and Pensions, May 2010, p187

160 English Longitudinal Study of Ageing, *Living in the 21st Century: older people in England: THE 2006 ENGLISH LONGITUDINAL STUDY OF AGEING (Wave 3)*, London: Institute of Fiscal Studies, 2008, pp125-126

161 The Institute for Fiscal Studies, *Pensioner Poverty over the next decade: What role for tax and benefit reform?* London: Institute for Fiscal Studies, 2007

162 Aviva, *The Aviva Real Retirement Report*, Aviva, 2010, p6

per cent of people in retirement are struggling to afford essential items and the same percentage are cutting back on socialising – a key determinant of an older person's quality of life. One in five pensioners has been forced to cut back on food and approximately four in ten have reduced their use of electricity and gas.¹⁶³

Research has demonstrated that on average during the recession rising inflation rates have hit pensioner households harder than other groups in society. Periodic work published by the *Alliance Trust* throughout the downturn found that, until very recently, people aged 75 and over had experienced the highest inflation rates in comparison to others:

*'In the whole of 2009 on we found that the inflation rate facing the over 75s was 42 per cent higher than the official rate of inflation, as measured by the Consumer Prices Index.'*¹⁶⁴

This is driven by the fact that older people spend more of their income on essentials like food and utility bills. Although the price of such goods has decreased in recent months, they had risen by as much as 25 per cent and 77 per cent respectively between 2005 and 2009.¹⁶⁵ This compares to discretionary goods like clothing or audio visual products which continue to fall in price and constitute a greater proportion of expenditure among young groups.

Making Ends Meet: Interest Rate Falls

Many older people have also been hit hard by a significant loss of income from savings and investments, as interest rates have sunk to very low levels. As the House of Commons Work and Pensions Select Committee reported in 2009 the sharp fall in interest rates from 5.75 per cent in July 2007 to 0.5 per cent in March 2009 (the present level) has rendered many pensioners much worse off each week.¹⁶⁶ In its recent *Real Retirement Report* Aviva highlighted how income from the average savings pot – given as £11,590 – could have fallen from £41 a month in January 2000 to just £3 in December 2009.¹⁶⁷

Whilst the poorest pensioners are unlikely to be significantly impacted by the interest rate drop, and its impact for savings income, the Working Group does recognise that for many this recession has placed significant strain on monthly outgoings.

163 Age Concern and Help the Aged (now Age UK), *Economy in crisis, Coping with the crunch: the consequences of the recession for older people*, London: Age Concern and Help the Aged, 2009, p1

164 Alliance Trust, *Inflation and Age*, Dundee: Alliance Trust, 2010, p1

165 Aviva, *The Aviva Real Retirement Report*, Aviva, 2010, p4

166 House of Commons Work and Pensions Select Committee, *Tackling Pensioner Poverty*, London: The Stationery Office, 2009, p65

167 Aviva, *The Aviva Real Retirement Report*, Aviva, 2010, p7

2.2.2 THE LONGER-TERM IMPACT

Older Workers

Despite our review's concentration on many older people above pensionable age who do not work – by nature of focusing on poverty and social exclusion – the Working Group considers it important to acknowledge the impact of the recession on older people in work who are approaching retirement age, or retirement.

While evidence suggests that older workers have not suffered disproportionately during this recent economic crisis,¹⁶⁸ the latest unemployment statistics do reveal that the number of unemployed people aged 50 and over has increased from 259,000 to 387,000 between August 2008 and August 2010. Equally as concerning, the number of people within this group who have been unemployed for over 12 months has reached 165,000, up from 96,000 since August 2008.¹⁶⁹ As the table below demonstrates, many more people between the ages of 55 and 64 are looking for work as a result of the recession.

Figure 7 – Jobseeker's Allowance caseload, February 2008 to February 2010¹⁷⁰

Date	Claimants aged 55-59 (thousands)	Claimants aged 60-64 (thousands)
February 2008	53.82	6.93
February 2009	91.78	18.27
February 2010	95.69	16.80

Organisations like Age UK have been quick to highlight the unique concerns and challenges those in work aged over 50 experience during a recession. In its report *Coping with the crunch* Age UK presented academic and anecdotal evidence about the fears of many older workers. It found that 60 per cent of older workers believe the current economic climate will force them to work for longer than planned, it revealed that a third of older workers feared they would be a greater risk of redundancy than others if their employer needed to make cuts, and it discovered that twice as many people aged 50+ have reduced the amount they are saving and paying into pensions as have increased it.¹⁷¹

¹⁶⁸ See for example Government Equalities Office, *Monitoring the impact of the recession on various demographic groups*, London: Government Equalities Office, 2009

¹⁶⁹ Office for National Statistics, *Statistical Bulletin Labour market statistics*, Table 9(2) Unemployment by age and duration, October 2010

¹⁷⁰ Department for Work and Pensions, *JobSeeker's Allowance Caseload (Thousands): Time Series by Age of claimant*, accessed via http://83.244.183.180/100pc/jsa/ccdate/cnage/a_carate_r_ccdate_c_cnage.html, 17 June 2010

¹⁷¹ Age Concern and Help the Aged (now Age UK), *Economy in crisis, Coping with the crunch: the consequences of the recession for older people*, London: Age Concern and Help the Aged, 2009, p1

As well as older workers having to take pay cuts or redundancy – both of which can severely impact retirement planning – there is evidence that people over 50 find it very difficult to re-enter the workforce once they are unemployed.

Publications from organisations ranging from *PRIME*¹⁷² to the *TUC*¹⁷³ have drawn attention to this. And evidence contained in the second wave of ELSA, published before the recession, has found that unemployed men aged between 50 and 64 years old had only a one in four chance of being in work two years later, for women of the same age it was approximately one in five.¹⁷⁴ Unsurprisingly, as the most recent ELSA report found, the longer an individual in that cohort remains out of work, the harder it becomes to re-enter work: with each year that passes men are approximately 25 per cent less likely to re-enter the labour market.¹⁷⁵

In view of many recent reports about previously successful unemployed individuals like Kevin Forbes (who applied for 4,700 jobs and received only two interviews) encountering a seemingly impenetrable job market, the Working Group will monitor the Government's efforts to help older workers who do wish to re-enter employment.



Photograph provided by Karis Neighbour Scheme, Birmingham

The Recession And The Poverty Line

It is important to note, if somewhat counter-intuitively, that the recent recession may in fact reduce pensioner poverty on a technical measure. Such a fact would undermine the use of an arbitrary income-based poverty line as the guide to strategy and target-setting.

According to figures presented by the Institute for Fiscal Studies (IFS), relative pensioner poverty¹⁷⁶ fell by more than 15 per cent in each of the last recessions, albeit from much higher starting points than current levels, as those on fixed incomes like pensions and benefits caught up with average income – which tended to stall or decrease – thus reducing the poverty threshold.¹⁷⁷ Given the possibility of this happening again it will be important to keep these technical points in mind when new poverty figures emerge, and the Working Group urges responsible usage of the pensioner poverty figures in this context.

¹⁷² PRIME, *Older people hit harder by the recession than youth*, London: PRIME, 2009

¹⁷³ TUC, *Older workers and the recession – taking account of the long-term consequences*, London: TUC, 2009

¹⁷⁴ English Longitudinal Study of Ageing, *Retirement, health and relationships of the older population in England: THE 2004 ENGLISH LONGITUDINAL STUDY OF AGEING (Wave 2)*, London: Institute of Fiscal Studies, 2006, p48

¹⁷⁵ English Longitudinal Study of Ageing, *Living in the 21st Century: older people in England: THE 2006 ENGLISH LONGITUDINAL STUDY OF AGEING (Wave 3)*, London: Institute of Fiscal Studies, 2008, p38

¹⁷⁶ Based on median income.

¹⁷⁷ Institute for Fiscal Studies, *Living Standards During Previous Recessions*, London: Institute for Fiscal Studies, 2009, p14 and 32.

2.3 THE STATE PENSION

2.3.1 THE BASIC STATE PENSION (BSP)

Alongside an energised debate about the future of social care, pension reform has fuelled much of the recent discussion about older age. Accordingly, we recognise that detailed work has already been undertaken, most notably through the 2004 *Turner Report* and Lord Hutton's ongoing review. In view of this, and our review's remit, we will concentrate on the BSP, rather than a review of pensions. We will use this section to give context to our considerations on money as well as to make general observations about the BSP and its future.

As this chapter outlines, the BSP provides a lifeline income to many older people on low income. In view of the highly technical nature of the debate this review will only consider core themes and issues. Members will explore whether there is a necessity to commission a further technical CSJ review of the BSP before publishing final recommendations.

2.3.2 HISTORY AND PURPOSE OF THE BSP

Pensions have long been a focus for public policy. Before 1942, the Old Age Pensions Act 1908 introduced a means-tested non-contributory pensions system, and the first contributory benefit scheme was established through the Widows, Orphans and Old Age Contributory Pensions Act 1925. This scheme was not universal in coverage and only applicable to low-wage and manual workers.

The current BSP is rooted in the 1942 Beveridge Report.¹⁷⁸ This report laid the foundations for the introduction of a universal state pension, which was then established through the National Insurance Act of 1946. In return for weekly contributions, defined benefits were paid to different groups of people within society including: people in retirement; widows; the sick; and the unemployed. In setting this context it is also crucial to note that this pension system was *not* designed to provide people with a high replacement income, but instead to act as a safety net against disadvantage and destitution.

However, as the Beveridge Report made no provision for those already in older age a 'pay-as-you-go' system was introduced. Through National Insurance (NI) contributions, the entitlement level was set at the current need of existing pensioners, and not as Beveridge envisaged related to an individual's future pension requirement.

During the subsequent 60 years politicians and policy-makers have altered and amended the BSP so that it resembles very little of what was originally proposed. One of the biggest changes was the removal of the BSP's link to national average earnings, to link it to inflation as measured by the Retail Prices Index. In recognition of the opportunity to do better still, the new

¹⁷⁸ Beveridge, Sir William, *Report of the Interdepartmental committee on social insurance and allied services*, London: His Majesty's Stationery Office, 1942

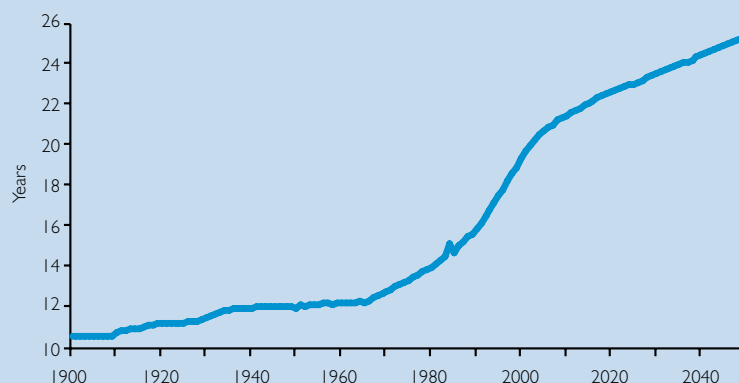
Government has introduced the ‘triple lock guarantee’ system, which will annually increase the BSP by the higher of earnings inflation, prices inflation or 2.5 per cent.¹⁷⁹

2.3.3 THE BSP TODAY

There is now very little relation between how much income a pensioner receives and the total amount of NI contributions they have made. NI rates are effectively set according to overall government budgetary strategy, rather than a calculation of how much pensions obligations will cost in the future.

Importantly, the original Beveridge model assumed the eradication of poverty in old age could be achieved by setting a minimum income subsistence level that pensions should not fall below. However, as incomes have risen over time, so too naturally has the necessary level of minimum standard. This has, in effect, meant some of the poorest pensioners in our communities have become trapped in poverty – despite their eligibility for various forms of supplementary income. As it became clear that it was unsustainable to provide an acceptable subsistence level to all pensioners, additional sources of means-tested benefits were introduced, such as Pension Credit (see section 2.4), to help the poorest older people.

Figure 8 – Life Expectancy at age 65, 1900 to 2050¹⁸⁰



One of the major challenges policy-makers face in sustaining the BSP is the ongoing and projected rise in life expectancy. Between 1930 and 1932 life expectancy at birth for a boy was 59 years and a girl 63 years; but figures show that between the years 2007 and 2009, this had risen to 78 years for a boy and

¹⁷⁹ Speech by the Secretary of State for Work and Pensions, Rt. Hon Iain Duncan-Smith MP, *Reinvigorating Pensions*, Thursday, 24 June 2010

¹⁸⁰ Office for National Statistics, *Population Trends 2008*, www.statistics.gov.uk

82 years for a girl.¹⁸¹ So the pension system must now support people for an average of between 12.7 to 21.9 years. In addition in 1951, many men working manual jobs would have died before they could even claim the new basic state pension.¹⁸²

Added to this rapid increase in life expectancy has been the monetary increase of the BSP in comparison to its introduction. In its first year (1948), the BSP amounted to £1 6s per week (or £1.30 in new money, which is equivalent to about £34.72 in April 2009 prices). This is just 36 per cent of what a single pensioner receives today.¹⁸³

2.3.4 LIVING ON THE BSP

If an individual has been credited with sufficient qualifying years of NI contributions during their working life they will receive the BSP at the full rate: currently £97.65 per week for a single person and £156.15 per week for a couple. However, because the BSP falls below the basic income support threshold many older people qualify for additional income support. This most often constitutes the means-tested Pension Credit Guarantee (PCG), which increases weekly income to £132.60 for a single person and £202.40 for a couple.¹⁸⁴

Such support is the only lifeline for a number of people. The BSP with minimum income guarantee or Pension Credit is the sole means of support for a third of pensioners in the UK. Figures also show, that single women are more likely to rely solely on the BSP than men or couples, with 42 per cent of women, 31 per cent of men and 19 per cent of couples solely relying on the BSP.¹⁸⁵

2.3.5 WOMEN AND THE BSP

Historically men have spent their working lives in employment and consequently have qualified for a full BSP entitlement. Many women, on the other hand, typically spent a shorter period of time in the labour market in order to fulfil caring and parenting roles. This resulted in fewer NI qualifying years. Because the BSP was paid on a pro-rata basis this meant that a large proportion of women who choose to take breaks from work to care for children or relatives were penalised.

181 Office for National Statistics, *News Release: Life Expectancy at birth*, Newport: Office for National Statistics, 2009, 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>; and Office for National Statistics, *Statistical Bulletin: Life expectancy at birth and at age 65 by local areas in the United Kingdom, 2007-09*, Newport: Office for National Statistics, 2010, p1

182 Public Sector Pensions Commission, *Reforming Public Sector Pensions: Solutions to a growing challenge*, London: Institute of Directors, 2010, p8

183 Bozio A, Crawford R, and Tetlow G, *The history of state pensions in the UK: 1948 to 2010, 2010*, London: Institute for Fiscal Studies, p13

184 Accessed via: www.direct.gov.uk on 20 August 2010

185 Office for National Statistics, *Social Trends No.40*, Newport: Office for National Statistics, 2010, p109 and 118

Even though far more women now spend a substantial proportion of working age in employment there still remains a significant number of female pensioners who do not qualify for a full BSP. In September 2008, for example, a third of female pensioners (2.3 million) received 60 per cent of the full BSP or less, compared with just two per cent of male pensioners (0.1 million).¹⁸⁶ As might be expected, therefore, single women are the largest group of pensioners receiving the Pension Credit Guarantee, with 1.3 million women recipients in August 2008.¹⁸⁷

2.3.6 THE FUTURE OF THE BSP

As we have made clear, the scope of the BSP and its many technical elements mean it is not within our remit or capacity to review it extensively, nor to make specific recommendations. That said we do have several summary observations.

Policy-makers are clearly aware that predicted demographic changes mean an increase in pension costs and sizes. As referenced, the DWP calculates that by 2050 the BSP should amount to twice as much in real terms as in the year 2012.¹⁸⁸ Moreover, reforms which came into effect at the start of the year address the numbers of people receiving the full BSP, so that at estimated 75 per cent of women who reach state retirement age this year will receive the full BSP, and by 2050 95 per cent of both men and women will receive the full BSP.¹⁸⁹ This is in contrast to the situation before these reforms where only around 35 per cent of women were entitled to the full BSP.¹⁹⁰ This builds on the aforementioned introduction of the ‘triple lock guarantee’ system, announced in June 2010. In tandem with these changes, there are set to be multiple reviews over the coming years about the position of the State Pension and Default Retirement Ages. This includes confirmation in the 2010 Comprehensive Spending Review that State Pension Age will be equalised on November 2018, and the pension age for men and women will then be raised to 66 by April 2020.

Shortly after 2010’s Comprehensive Spending Review the Government also appeared to favour the introduction of a ‘citizen’s pension’. According to reports at the time of publication, such an arrangement would significantly increase the basic pension rate and remove the means-tested top up system. Whilst, of course, details remain far from clear, the Working Group welcomes the Government’s decision to investigate such a model. In welcoming it, though, crucial questions arise. Such questions include projections about how many people currently receiving income above the proposed flat rate, as topped up

186 Office of National Statistics, *Analysis of impact of pensions legislation*, June 2009, accessed via: <http://www.statistics.gov.uk/pdfdir/ptrends0609.pdf>

187 Office for National Statistics, *Pension Trends*, June 23 2009, accessed via: <http://www.statistics.gov.uk/cci/nugget.asp?id=2239>

188 Office of National Statistics, *Analysis of impact of pensions legislation*, June 2009, accessed via: <http://www.statistics.gov.uk/pdfdir/ptrends0609.pdf>, p2

189 Pensions Act 2007

190 Hansard, *House of Commons written answers*, 5 March 2008

by their qualifying through NI contributions, will lose out. There is also the fundamental debate about whether such a model is affordable. We will monitor developments closely and respond, if able, in our second report.

Such developments and debate are to be commended. However, the CSJ strongly believes that in order to reform and improve the BSP system to meet our pressing demographic changes, pension policy-makers must coordinate their efforts as part of broader action to tackle poverty in later life. It will ultimately prove unsustainable to rely solely on adaptations to the state pension system – or the benefit system – to fit the changing needs of the nation and fight poverty. While sensible reform should be a feature of state pension policy, what is also required is a permanent overhaul of attitudes and incentives towards working, saving and retiring. Only this would reduce both the demand for constant adaptation of the BSP and the dependence many people have on it.

To this end, we wholeheartedly encourage a move to individuals working longer where it is feasible and appropriate. Additionally we hope that this Government's commitment to welfare reform will indeed 'make work pay', so that during their working lives the people who have for too long been trapped in benefits and poverty have greater scope to plan and save for their futures, instead of having to rely so heavily and precariously on the BSP. To this aim the CSJ has made an unpublished submission in response to the DWP's *21st Century Welfare* review. We also broadly welcome schemes such as NEST which aim to work alongside these changes and encourage even the nation's very poorest to save for their later years. It must, however, maintain an appropriate degree of flexibility to support those on low incomes who are unable to make arbitrarily appointed contributions. Ultimately, we hope that low-cost pension schemes like NEST will make saving easier and retirement planning more effective.



CSJ researcher James Mumford visiting a lunch club for older people

2.4 State Benefits

2.4.1 AN ESSENTIAL SOURCE OF INCOME

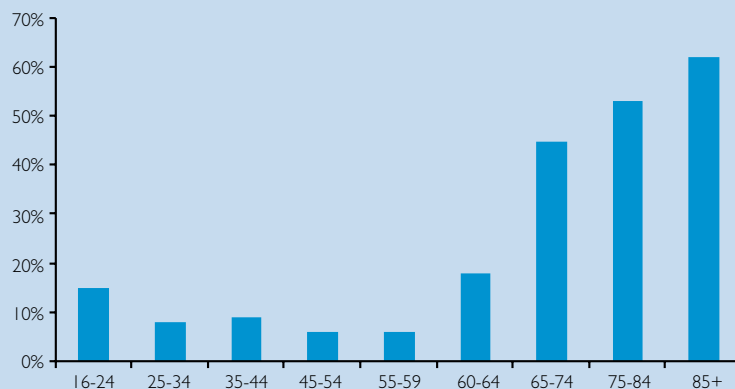
Although benefits provide a financial lifeline for people of all ages, they become particularly important for older people as the following chart demonstrates.

Furthermore, 30 per cent of pensioners receive at least one income related benefit, such as Housing Benefit, Council Tax Benefit or Pension Credit.¹⁹¹

In total, approximately 2.6 million pensioners are in receipt of Pension Credit (in the form of either the Guarantee Credit or Savings Credit stream);

¹⁹¹ Department for Work and Pensions, *The Pensioners' Income Series 2008-09*, London: Department for Work and Pensions, 2010, p8

Figure 9 – Percentage of total weekly household income sourced from the State, by age of household head (UK)¹⁹²



approximately 1.5 million receive Housing Benefit; and 2.5 million receive Council Tax Benefit.¹⁹³ And as one would imagine, significant amounts of public expenditure are allocated to providing this support: the bill for 2008/09 was more than £14 billion on the aforementioned benefit streams alone.¹⁹⁴ Added to these entitlements, almost half of those aged 75 and over have a limiting longstanding illness¹⁹⁵ and 2.8 million older people cannot manage one or more self-care activity.¹⁹⁶ Many older people rely on disability-related benefits to meet the associated and additional costs of living. Approximately one fifth of pensioners

receive a form of disability benefit – mainly in the form of Attendance Allowance and Disability Living Allowance – and the average weekly receipt is £66.¹⁹⁷

The overwhelming majority of pensioners we met during the review who received some of these benefits hailed them as invaluable. We have heard that this is particularly true for older people in receipt of Attendance Allowance, many of whom are enabled through it to purchase some additional private care. This is particularly helpful in view of current social care rationing (see section 5.5.1).

In reassessing public spending commitments the new Government should be extremely careful to ensure that lifeline payments such as these are not fatally reduced for those who most need them.

“Without the additional income from Attendance Allowance, many disabled older people would struggle financially and experience greater social exclusion by being unable to participate in social relationships or contribute to the costs of these.”

Social care academic, in evidence to the CSJ

¹⁹² Department for Work and Pensions, *Family Resources Survey United Kingdom 2009-09*, London: Department for Work and Pensions, 2010, p23

¹⁹³ Department for Work and Pensions, *Income Related Benefits: Estimates of Take-Up in 2008-09*, London: Department for Work and Pensions, 2010

¹⁹⁴ Ibid.

¹⁹⁵ Office for National Statistics, *National Lifestyle Survey 2008* -Table 7.2, 2010, Newport: Office for National Statistics

¹⁹⁶ National Housing Federation, *In your lifetime*, London: National Housing Federation, p11

¹⁹⁷ Ibid., p36

2.4.2 GUARANTEED INCOME AND THE POVERTY LINE

The Working Group notes the criticism of many, including the House of Commons Work and Pensions Select Committee,¹⁹⁸ that although the package of benefits to guarantee minimum income for single pensioners lifts them above the income poverty line, the package for pensioner couples does not. It falls short. The current levels compare as the following table highlights:

Figure 10 – Pension Credit (Guarantee) and the poverty line¹⁹⁹

Year	Pension Credit guarantee level (single)	60 per cent median income amount (single)	Pension Credit guarantee level (couple)	60 per cent median income amount (couple)
2008/09	£132.60	£119	£202.40	£206

Given that the recession has lowered the 60 per cent median income line, and although certain lump sum payments may boost income enough to lift pensioner couples above it, there are many couples who will remain in income poverty in the short and long term. Under the previous Government there was a penalisation of working age couples in the tax and benefits system,²⁰⁰ and the new Coalition Government should monitor this issue very carefully to ensure it doesn't preside over a similarly damaging penalty for couples of pensionable age.

Pension Credits are a lifeline for many we have met during this process. However, during our evidence gathering it has also been argued that the introduction of means-tested benefit to guarantee a certain level of income has proven a disincentive for people on lower incomes to save for their retirement. Given that the state pays the difference between the BSP of £97.65 and the PCG of £132.60 for a single individual it has been argued that there is little incentive for them to save unless in order to save enough to rise above means-testing altogether, which is unlikely if they are earning a low income. So although the introduction of PCG has lifted significant numbers of pensioners out of relative poverty, we have also heard that it has discouraged

“Means-testing...reduces rational incentives to save for many people”

Work and Pensions Committee, *Tackling Pensioner Poverty*²⁰¹

198 House of Commons Work and Pensions Select Committee, *Tackling Pensioner Poverty*, London: The Stationery Office, 2009, p32

199 Ibid.

200 See for example Centre for Social Justice, *Green Paper on the Family*, London: Centre for Social Justice, 2010.

201 House of Commons Work and Pensions Committee, *Tackling Pensioner Poverty: Fifth Report of Session 2008-09 Volume 1*. July 2009, London: The Stationery Office, p27



future pensioners from saving for their retirement in the knowledge that the state will support them to the £132.60 limit.

2.4.3 NON TAKE-UP OF BENEFITS

In view of the support these benefits provide to very many pensioners across the country, there remains a serious concern about the large numbers of pensioners still failing to claim their means-tested entitlements.

As the following table demonstrates non take-up of such benefits by pensioners has been a persistent problem in recent years.

Figure 11 – Percentage of non take-up ranges as a percentage of overall entitled recipients, core means-tested benefits (GB) ²⁰²

Year	Pension Credit (Guarantee)	Housing Benefit	Council Tax Benefit
1993-94	n/a	7 – 13 per cent	24 – 33 per cent
1996-97	n/a	1 – 12 per cent	20 – 32 per cent
1999-00	n/a	7 – 15 per cent	30 – 64 per cent
2002-03	n/a	10 – 17 per cent	38 – 44 per cent
2004-05	19 – 30 per cent	12 – 18 per cent	42 – 47 per cent
2007-08	19 – 28 per cent	12 – 19 per cent	40 – 47 per cent
2008-09	17 – 29 per cent	13 – 20 per cent	36 – 44 per cent

In 2008/09 this non take-up translated to between 180,000 and 350,000 pensioners missing out on Pension Credit (Guarantee); between 220,000 to 380,000 people missing out on Housing Benefit; and between 1.4 million to 1.9 million eligible for but not receiving Council Tax Benefit. In total this resulted in as much as £3.9 billion going unclaimed by pensioners who were eligible for it. ²⁰³

Although the take up of core means-tested entitlements like Housing Benefit has been historically high, a persistent number of people eligible for payments like Council Tax Benefit and Pension Credit simply do not claim them.

²⁰² Department for Work and Pensions, *Income Related Benefits: Estimates of Take-Up in 2008-09*, London: Department for Work and Pensions, 2010

²⁰³ Ibid.

The Impact of Non-Take Up

In times of severe economic pressure whilst this non-take up might provide welcome relief for those in charge of public expenditure it is a reality which must be changed. Non take-up leaves many pensioners below the poverty line.

Figure 12 – Percentage of pensioners entitled to Pension Credit (Guarantee) living below the 60 per cent median income line (GB) ²⁰⁴

Year/category			Before Housing Cost (BHC)	After Housing Costs (AHC)
Pensioners (all family types)	Entitled	2007-08	75	74
	Not Receiving	2008-09	77	75
	Entitled	2007-08	38	38
	Receiving	2008-09	33	32

There is a similar scenario for those entitled to both Housing Benefit and Council Tax Benefit.

Figure 13 – Percentage of pensioners entitled to Housing Benefit living below the 60 per cent median income line (GB) ²⁰⁵

Year/category			Before Housing Cost (BHC)	After Housing Costs (AHC)
Pensioners	Entitled	2007-08	51	66
	Not Receiving	2008-09	47	62
	Entitled	2007-08	13	27
	Receiving	2008-09	10	23

²⁰⁴ Ibid., p72

²⁰⁵ Ibid., p94

Figure 14 – Percentage of pensioners entitled to Council Tax Benefit living below the 60 per cent median income line (GB) ²⁰⁶

Year/category			Before Housing Cost (BHC)	After Housing Costs (AHC)
Pensioners	Entitled	2007-08	48	37
	Not Receiving	2008-09	47	38
	Entitled Receiving	2007-08	30	28
		2008-09	25	22

The Reasons for Non Take-Up

‘The system is opaque, repetitive and almost impossible to use for anyone with physical or mental disabilities. For many elderly people, they find the forms impossible to complete without help, which may not be available to them. This is a major factor in the low take-up.’

A carer, in evidence to the CSJ

Four key reasons have been identified by the Working Group as major barriers to higher take-up. Unsurprisingly these concur with those highlighted by other organisations such as Age UK.

First, we have taken evidence from a number of sources about a lack of awareness of the existence and nature of financial support for older people. The Working Group welcomes initiatives like the Money Made Clear programme’s *Your Guide to Retirement* publication, but remains concerned at the varied implementation and accessibility of such schemes.

‘Approximately one in ten of the pensioners we polled said they had no idea what support they were entitled to. More than half said they only had a basic understanding about it.’

YouGov poll for the CSJ Older Age review ²⁰⁷

Second, many older people don’t think they are entitled to any or much financial assistance as homeowners, or if there have supplementary sources of

²⁰⁶ Ibid., p121.

²⁰⁷ YouGov, *Attitudes of People over Retirement Age*, June 2010.

income such as a private pension. We met one person living in isolated rural poverty who assumed because he had some assets he would have to get rid of everything, or claim dishonestly:

'I could get rid of all my money and go to the state and say I'm destitute, but how do I get rid of all the capital in order to go to the Government? If you own something you don't like giving it away. I don't want to cheat the system.'

Third is the complexity of benefit applications and the overall process. We regularly heard that without an ability to deploy 'box-ticking' phrases or a willingness to over-emphasise need, people are often unsuccessful in their claims. It seems this is particularly true for disability benefits.

'The application process is hugely cumbersome – there are pages and pages to fill out. You also need to know how to phrase things to stand the best chance of success. It is a system set up to say no. We help where we can but there are lots of older people who just give up.'

Older persons' support worker, in evidence to the CSJ

The fourth key hurdle in attempting to increase take-up of benefits is found in the attitudes of some older people. For many who have spent the majority of their lives getting by, and who view state benefits with a degree of disdain, it can be extremely difficult to encourage applications. During the review we met one pensioner who told us he was happy living on a low income:

'My quality of life may be poor but at least I'm free to keep it poor.'

These factors are linked and often operate in a combination of ways. An individual who experiences the loss of their partner and an associated reduction in income may be more likely to claim than someone who can manage without. Another person might have come to a decision to apply for support but encounter the complexity of the process and decide not to pursue it any further.

Acting On Non Take-Up

Both the previous Government and the new Government committed to piloting measures to increase the take-up of core benefits. In the Working Group's view the most innovative model under evaluation is based on Automaticity. The current Automaticity pilot, aimed at achieving higher take-up of Pension Credit, has targeted 2,000 pensioners who have been identified by the DWP and receive automatic payments for 12 weeks based on an estimated entitlement assessment. During the 12 weeks those in receipt of payment are encouraged, by letter, to apply for formal Pension

Credit on a long-term basis. However, it is important that this pilot learns the lessons of rolling out previous initiatives like Direct Payments. It must recognise the important nuances within the process such as the literacy and language barriers of some people receiving the letters. Whilst also the pilot's evaluation period seems unnecessarily lengthy, the Working Group welcomes this approach to tackling the persistent and unacceptable problem of non take-up of benefits for pensioners in or vulnerable to poverty. We look forward to seeing the preliminary findings published in 2011 and the full report in 2012.

In considering action to tackle non-take up of benefits the Working Group also welcomes the conclusions of the House of Commons Work and Pensions Committee's 2009 report on pensioner poverty.²⁰⁸ In particular the Committee was correct to conclude that the voluntary sector could be utilised more effectively in the fight against non take-up, particularly given that many charities within it have specialist experience in reaching older people in need. We encountered one such example of a voluntary sector organisation in central London, called Advocacy Plus, which was making a significant difference through financial advice.

Advocacy Plus

Advocacy Plus provides trained advocates to support older people in Westminster express choices which enhance their quality of life.

Advocacy Plus currently reaches 350 clients a year, all of who are experiencing severe deprivation in relation to their housing, their income, physical and mental health, dementia or other factors. Over 70 per cent of their clients live in the one third most deprived wards in relation to both the Index of Multiple Deprivation and the Income Deprivation Affecting Older People Index. Over 60 per cent of their clients have a disability; 45 per cent are from black and minority ethnic (BME) communities; more than 1 in 3 are over 80 years old; and more than three quarters live alone.

'Our vision is to empower all older people to express choices about matters affecting their everyday lives and so achieve a better quality of life.'

Janice Webster, Advocacy Plus, London Operations Manager

Case study: Linda

Age Concern referred Linda, aged 89 and with fluctuating mental capacity, to Advocacy Plus. She had cancelled her care package for weekly shopping support as she was unable to afford her community care charge. Their advocate gained Linda's trust and found her to be confused, partially sighted and unable to shop or cook.

On her behalf, the advocate negotiated a better care package, including support with domestic duties, personal care and shopping services and a financial assessment which revealed an overcharge in her care bill. Linda was referred for an occupational therapy assessment for supportive aids in her home and to a befriending service.

The advocate who recently visited Linda stated:

208 House of Commons Work and Pensions Select Committee, *Tackling Pensioner Poverty*, London: The Stationery Office, 2009, p37.

'Firstly, she looked fabulous – so although there are still access problems with Carewatch she is obviously receiving enough care, she had even had her hair cut and her flat was spotless even in the inside of her cupboards! She said 'when we first met I was at my wits end'. I was so amazed at just how much she was able to remember and interestingly, what she had been able to hang on to as memories – good associations, she chatted about hospital, described her stroke, the nursing home, the Care Manager, her eye sight and hearing problems!'

Advocacy services prove invaluable for many older people to get their voices heard and to help them through often confusing benefits packages and services.

'Working at Advocacy Plus, I know I am making a real difference to someone's life. People come to us at the end of their tether. No-one is prepared to listen. I have the time to listen explore the issues with them and try to find a way to resolve the root causes of the problem.'

Advocate for Advocacy Plus

2.5 Fighting the Winter: Fuel Poverty

2.5.1 THE WINTER PERIOD

This review was commissioned in the midst of one of the most severe UK winters on record, and the coldest since 1978/79. With an average UK temperature of 1.5 °C between December 2009 and February 2010,²⁰⁹ heavy snowfall and extremely low overnight temperatures, people of all ages had to strive to stay warm, healthy and safe. These winter challenges are rendered all the more acute as we get older and have less money, however, meaning many older people – some of whom we have met during our review – experience extreme vulnerability during the winter months. It is no exaggeration that for some older people living on a low income the winter months are not simply a period to endure, they are a fight for survival.

Annual winter death statistics reveal the extent of this reality. Although excess winter mortality is in the main caused by an increase in respiratory and circulatory diseases and not by low temperatures, figures do demonstrate the disproportionate danger of winter in comparison to the other seasonal periods. In 2008/09 there were 36,700 excess winter deaths, 33,330 of which were people aged 65 years old and above, 18,100 of which were people aged 85 and above. This represents a 49 per cent increase on the previous year.²¹⁰

2.5.2 FUEL POVERTY

In view of the challenge the winter months present to so many older people on a low income and in social exclusion, the Working Group has concluded that it must look at the fuel poverty strategy – a key component of the previous

209 Met Office, Coldest UK winter for over 30 years, 1 March 2010, accessed via: <http://www.metoffice.gov.uk/corporate/pressoffice/2010/pr20100301.html>, 25 June 2010

210 Office for National Statistics, Statistical Bulletin – *Excess winter mortality in England and Wales: 2008/09 (provisional) and 2007/08 (final)*, Newport: Office for National Statistics, 2010, p6

“These past 6 years have been a devastating period for the fuel poor.”

Fuel Poverty Advisory Group (England), Annual Report 2010²¹¹

Government’s approach to keeping people healthy during the colder months.

What Is Fuel Poverty?

Any household that needs to spend at least 10 per cent of its income on fuel to maintain an adequate level of warmth is considered to be in fuel poverty. It is caused by three factors:

- Low household income – in 2008/09 there were approximately 13 million people living below the poverty line;²¹²
- The cost of energy – since 2004 energy prices have outstripped increases in inflation and income;
- Many homes continue to have low quality energy efficient infrastructure – despite progress as measured by the Standard Assessment Procedure (SAP) initiative.

“Average modelled fuel expenditure has increased between 2003 and 2007 by over 60 per cent, from £694 in 2003 rising to £1,138 in 2007. Average incomes have also risen, but only by around 18 per cent...”

Annual fuel poverty statistics 2009²¹³

These factors, particularly the soaring cost of energy, have resulted in high levels of fuel poverty during the last decade.

To its credit the previous Government set highly ambitious targets to abolish it: by this year (2010) in England it pledged to ensure that no vulnerable household was living in fuel poverty, and by 2016 it pledged to have eradicated fuel poverty altogether. Concurrently the devolved administrations in Wales, Scotland and Northern Ireland were set working to individual targets that would mean UK fuel poverty was eradicated entirely by 2016. As a result of extremely high energy prices in relation to income increases, as well as a number of questionable government programmes, the 2010 target has been missed and the 2016 target is also extremely unlikely to be met.

36 per cent of people aged 60 or over in Great Britain sometimes stay or live in just one heated room of their home to save money.²¹⁴

Who Lives in Fuel Poverty?

Since 2001 the number of households in England living in fuel poverty has increased from 1.2 million to 4.6 million.²¹⁵ This represents a doubling of households living in fuel poverty across

211 Fuel Poverty Advisory Group (for England), *Eighth Annual Report*, London: Department of Energy and Climate Change, 2010, p3

212 Department for Work and Pensions, *Households Below Average Income – and analysis of the income distribution 1994/95 – 2008/09*, London: Department for Work and Pensions, 2010, p48

213 Department of Energy and Climate Change, *Annual Report on Fuel Poverty Statistics 2009*, London: Department of Energy and Climate Change, p36

214 ICM, *Winter Fuel Bills survey for Help the Aged*, October 2008.

215 Fuel Poverty Advisory Group (for England), *Eighth Annual Report*, London: Department of Energy and Climate Change, 2010, p4

all age groups. According to the slightly less recent UK statistics, approximately 16 per cent of UK households live in fuel poverty.²¹⁶

Overwhelmingly households in fuel poverty are living on low income – the majority are economically inactive – and are headed by an older person. For example in England the majority of fuel poor households are found within the lowest three income deciles – an increase between 2003 and 2007 of 1.4 million (from 1.2 million to 2.6 million).²¹⁷ However, despite this concentration at the bottom of the income scale, rising fuel prices are beginning to drag more households towards fuel poverty as income increases fail to keep pace. Given rising fuel prices, public sector pay freezes and reduced welfare expenditure commitments outlined in the Coalition Government's 2010 Budget, as well as increased unemployment as a result of the recession, the number of households in fuel poverty is highly likely to increase – including within higher income brackets.

Added to this, although the number of households in fuel poverty doubled across every age group between 2003 and 2007, households headed by someone over 60 years old account for approximately half of all households in fuel poverty. Now, one in five households headed by someone over 60 years old is fuel poor. Furthermore, a quarter of all fuel poor households have at least one occupant aged 75 or over.²¹⁸



Dr Nori Graham visiting a lunch club for older people in Huddersfield

*Tackling Fuel Poverty: a Failing Strategy?*²¹⁹

Undeniably the previous Government oversaw early and substantial progress in reducing the number of households living in fuel poverty. By any standards one must commend its more than halving the total of fuel poor households within five years of entering office. Yet despite allocating more than £20 billion to eradicating fuel poverty since the turn of the millennium,²²⁰ there has been a regression towards the levels which it inherited in 1997, as the table above demonstrates. Furthermore, the previous Government's programmes have come in for some heavy criticism – including from the official Fuel Poverty Advisory Group which has summarised them as 'inadequate'.²²¹

In view of these considerations the Working Group makes several observations about the recent fuel poverty strategy. In doing so we acknowledge

²¹⁶ Department of Energy and Climate Change, *Annual Report on Fuel Poverty Statistics 2009*, London: Department of Energy and Climate Change, p6

²¹⁷ Ibid., p34

²¹⁸ Ibid., pp30 -33

²¹⁹ As responsibility for tackling fuel poverty is devolved to the National Assemblies of Scotland, Wales and Northern Ireland we will be analysing the work ongoing in England only (although there is some overlap on certain schemes).

²²⁰ Department of Energy and Climate Change, *The UK Fuel Poverty Strategy: 7th Annual Progress Report*, London: Department of Energy and Climate Change, 2009, p5

²²¹ Fuel Poverty Advisory Group (for England), *Seventh Annual Report*, London: Department of Energy and Climate Change, 2008, p2

that we are unable to explore the issues in an ideal level of detail for the purpose of a workable remit.

Income Measures: the Winter Fuel Payment

Other than attempting to undertake wider action to increase the income of fuel poor households, or those vulnerable to becoming fuel poor, through general benefits and credits, the central pillar of the previous Government's direct strategy to boost the income of those in fuel poverty has been the Winter Fuel Payment.

The Winter Fuel Payment, which equates to £200 for households with someone aged 60 to 79 and £400 for households with someone aged 80 or over, was paid to more than 12.3 million people throughout the UK in 2008/09.²²² Since its introduction more than £18.9 billion has been allocated to it.²²³ To its credit it is estimated that present Winter Fuel Payments keep approximately 200,000 households out of fuel poverty every year.²²⁴ This success is of course to be welcomed. In recognising this, however, the Working Group has also taken evidence which argues that more could be done to utilise the payments in the most effective way.

The Working Group supports the criticism of many who highlight the universality of the payment as its biggest flaw. Whilst the Working Group recognises there are complexities and associated expenditure in means-testing payments, it seems wasteful that many people who do not need the money receive it automatically.

'It goes on Christmas presents for the family.'

A Grandmother in evidence to the CSJ

'My Gran says it buys her some nicer food for a while. I think she'd be willing to lose it if more of the money could go to poorer pensioners, because she doesn't really need it.'

A Grandson in evidence to the CSJ

Alongside the significant anecdotal evidence we have received about the Winter Fuel Payment, we cite two statistical examples of its inadequately targeted use. First, there are a number of people on a high income who receive the payment in the UK. Latest estimates show that in 2007/08 Winter Fuel Payments were

222 Department of Energy and Climate Change, *The UK Fuel Poverty Strategy: 7th Annual Progress Report*, London: Department of Energy and Climate Change, 2009, p23

223 Hansard, *House of Commons written answers*, October 2007; Department for Work and Pensions, *Annual Report by the Secretary of State for Work and Pensions on the Social Fund 2007/2008*, Norwich: The Stationery Office, 2008; Department for Work and Pensions, *Annual Report by the Secretary of State for Work and Pensions on the Social Fund 2008/2009*, Norwich: The Stationery Office, 2009

224 Hansard, *Written answers and statements*, 22 February 2010

made to approximately 100,000 households with an annual net income of more than £100,000 and a number to households with an income of over £200,000.²²⁵ Second, annual figures reveal that the Winter Fuel Payment goes to more than 63,000 expatriates living on the European continent – including in Spain, Cyprus and Portugal – to help heat their homes in the winter months at an estimated annual cost of £14 million.²²⁶

We also recognise the concerns of those unhappy that government is unable to ensure the money is actually spent on heating an individual's home. It may be fair to assert that this is caused by a lack of clarity about its purpose. As the quotations above suggest there are those who use it as a winter cash bonus because they simply don't need it, and those who use it to improve their general quality of life.

Undoubtedly for many people it has been a popular lump sum winter payment, and has helped in the effort to reduce the number of fuel poor households. Yet, for the reasons outlined above, the Working Group is concerned about its application in the future. First, it has suffered from a lack of clarity about its purpose. Second, if its main rationale is to reduce fuel poverty then it is ineffectively targeted as a universal, unconditional payment. Establishing clarity about these points is of particular importance given the current economic climate, the significant pressures on public spending, and the forthcoming cuts.

Energy Efficiency Measures: Warm Front

Although unable to comment on the entirety of energy efficient initiatives introduced in recent years, the Working Group has chosen to look briefly at several schemes which have been drawn to its attention during our evidence gathering process.

The Warm Front Scheme, which provides grants and household adaptations, was established to assist eligible homes in becoming more energy efficient and to beat fuel poverty. Since its inception Warm Front has been allocated more than £1.8 billion of public expenditure²²⁷ but remains the subject to considerable public criticism in several important areas. Recently, the House of Commons Public Accounts Committee concluded that the lack of clarity as to whether the scheme was primarily focused on reducing fuel poverty or simply improving the energy efficiency of households had impaired its ability to deliver value for taxpayers' money. Consequently, despite recommending five years earlier that Warm Front should urgently improve its targeting to ensure that those who are fuel poor benefit from the scheme, the Committee again found it was inadequately targeted:

225 Hansard, *Written answers and statements*, 10 March 2010, (Before Housing Costs)

226 The Times, *Winter fuel bonanza for 64,000 expats in Europe*, 16 February 2010.

227 House of Commons Public Accounts Committee, *The Warm Front Scheme*, London: The Stationery Office, 2009, p1.

*'The Scheme continues to be poorly targeted despite some changes to the eligibility criteria. Nearly 75 per cent of households entitled to a grant are unlikely to be in fuel poverty, whilst the Scheme is only available to 35 per cent of all those households likely to be in fuel poverty, partly because the eligibility criteria include receipt of non-means tested benefits. In addition, the Scheme does not prioritise those with the most energy inefficient accommodation. Between June 2005 and March 2008, £34 million was paid to households whose properties were already energy efficient, representing about 18 per cent of those assisted in that period. Some £15.4 million was spent on providing energy efficient light bulbs, tank jackets and draught proofing, which have limited impact on overall energy efficiency, and are also unlikely on their own to lift households out of fuel poverty.'*²²⁸

Furthermore, as the Committee also highlighted, the scheme's static maximum grant allocation levels between 2005 and 2009 coupled with increased labour and service costs meant that many households were priced out of applying for an award, or completing an application. During that period approximately 6,000 households withdrew their application and 1,400 chose less expensive work. As the Committee points out these factors can exclude people in low income and poverty.²²⁹

We welcome the increase of the maximum grant levels and commend the scheme for assisting more than 635,000 households to achieve annual energy bill savings of up to £300. Yet, as both the House of Commons Public Accounts Committee report and the National Audit Office evaluation of the scheme²³⁰ highlight, the Warm Front Scheme has wasted a considerable opportunity to lift thousands of people out of fuel poverty in recent years and delivery value for public money – even if it has furthered the energy efficiency of many homes. During our discussions about fuel poverty we could find no-one who disagreed with this analysis.

Energy Efficiency Measures: Decent Homes

Another core strategy for reducing fuel poverty under the previous Government was the Decent Homes Standard (also see section 4.7), which has made some progress in improving the quality of housing stock in the social sector. As the Fuel Poverty Advisory Group has noted in its latest annual report,²³¹ applying the Standard has reduced by half the number of social sector homes with inadequate thermal comfort. However, as the same report argues, concerns remain about the nature of the targets for thermal comfort. These are concerns

228 Ibid.

229 Ibid.

230 National Audit Office, *The Warm Front Scheme*, London: The Stationery Office, 2009.

231 Fuel Poverty Advisory Group (for England), *Seventh Annual Report*, London: Department of Energy and Climate Change, 2008

about the Decent Homes Standard we have heard from other sources during our evidence gathering.

Energy Efficiency Measures: Community Energy Saving Programme (CESP)

During its evidence gathering the Working Group visited the Walsall CESP, led in partnership by Centrica and the local authority. CESP – an energy saving initiative targeting the lowest 10 per cent of areas as measured by the Indices of Multiple Deprivation – is an obligation placed on energy the largest energy providers to reduce carbon emissions across 90,000 households by four million tonnes and lower the costs of energy in the most deprived communities.

We recognise there are important improvements to be made to CESP after its evaluation. These include issues raised by the Fuel Poverty Advisory Group about customers carrying the burden of the programme's long term funding²³² and points about its delivery at the local level. That said, the Working Group welcomes phase one of the initiative as an innovative and promising effort to lift some of the most vulnerable households out of fuel poverty. The Working Group also recognises, however, that as with such initiatives there will be challenges in planning its scalability.

“They did the work quickly and people have been impressed with the scheme. I’m hoping to notice a real difference when the cold months come along.”

A retired social housing tenant, CSJ CESP Walsall visit

CESP Walsall

As a result of CESP in Walsall (a partnership between Centrica, Walsall Housing Group and Walsall Council):

- 136 properties will have external wall insulation installed;
- 136 new central heating systems and boiler controls will be installed;
- 136 properties will have their loft insulation inspected and improved if necessary;
- Up to 136 home energy audits will be completed.

Energy Prices

It is clear that any provider of an essential commodity like energy should recognise it has a social responsibility to offer an appropriate arrangement for the least able to pay. Alongside this the Working Group has heard the concerns of many older people on a low income who are extremely anxious about the current and future cost of energy. In view of these points the CSJ welcomes the fact that since 2008 energy suppliers have agreed to invest in to reducing the cost of energy for the poorest customers. By 2011 this agreement will have

232 Ibid., p14

resulted in more than £425 million invested in programmes such as social tariffs, which now benefit over one million homes.²³³

Yet, as well as hearing about the benefits of social tariffs and the progress they have made in helping many households meet the cost of energy, we have heard two common criticisms from customers and experts which merit reference here.

First, we have heard that there remains confusion amongst energy customers about the very existence of social tariffs. A number of older people we met who could be eligible were unsure whether they were on a social tariff, or even what a social tariff is. Although suppliers recently committed to provide greater visibility of their offers on social programmes, the Working Group was disappointed that the majority of this promotion appears to be led online – which unhelpfully excludes older people who are unable to use the internet, and those who cannot afford to.

A second common complaint, also highlighted by a number of reports including *The Long Cold Winter* published by the Institute for Public Policy Research (IPPR),²³⁴ relates to the inconsistency of energy suppliers' eligibility criteria for such tariffs. The Working Group notes with interest the calls of groups such as the Fuel Poverty Advisory Group for a mandated social tariff and welcomed the previous Government's commitment to place social tariffs on a statutory footing on completion of the voluntary agreement in 2011. We will watch with interest the action of the new Government on social tariffs and fuel poverty.

2.6 Guidance, Support and Planning

The Working Group has also heard many who highlight the inconsistent nature of financial guidance and support available to people approaching later life. Linked to this is a seemingly common lack of preparation and planning for older age among the same group.

Surma Older People's Club

Surma is a Toynbee Hall-run support and activities facility targeted at older people in the local Bangladeshi community from the Spitalfield and Banglatown wards and Tower Hamlets. Over 100 users visit the Surma centre frequently for a number of different services, including welfare benefits assistance, access to Pension Credit, Disability Living Allowance and pension transfer to Bangladesh.

Each month Surma arranges between 70 to 100 different sessions for older people. Some examples from the last six months include:

- Coffee mornings.
- A bowel cancer awareness session.

²³³ Ofgem, *Monitoring Suppliers' social programmes 2008-09*, London: Ofgem, 2009, p1

²³⁴ Institute for Public Policy Research, *The Long Cold Winter: Beating fuel poverty*, London: Institute for Public Policy Research, 2010, p16

- A visit by the disability option team from the Mile End Hospital to meet users and explain their services.
- A Bangladeshi mental health awareness day.
- A 'National Smile Day' where Tower Hamlets PCT dental health team were invited to visit the Surma users.
- An event on 'World elder abuse' at Toynbee Hall.

Case study: Faisal

Faisal, one of the Surma's regular users, had a stroke recently and became housebound. He required assistance with care and financial help in order to meet his extra care need. Faisal's wife rang a Surma Project Worker for help. The Surma Project Worker visited Faisal immediately, completed a referral form to the DWP and arranged a visit by them to bring an Attendance Allowance claim form and help Faisal to complete the claim form properly.

DWP officials visited Faisal to help him to complete a claim form and submit it. Following some correspondence Faisal was awarded Attendance Allowance, and higher rate care component of £71.40 a week. Additionally an Outreach Worker also referred Faisal's wife to an agency to claim Carer's Allowance. The claim is now being processed.

2.6.1 GUIDANCE AND SUPPORT

'It's not always clear who to turn to on these things. Sometimes you just want some basic guidance.'

A recently retired pensioner, in evidence to the CSJ

Entering older age, particularly the transition into retirement, can be daunting and uncertain. Whilst there are many excellent employer schemes which provide detailed assistance – both before and after entering retirement – as well as a number of very successful voluntary sector initiatives run by organisations such as Age UK and Counsel and Care, our review has heard there are numerous older people who simply cannot access sound guidance and advice. It is also true to say that many of the concerns older people have in relation to advice and guidance, or the need to access it, are triggered by bereavement or failing health.

This apparent lack of support or guidance was borne out by results of public polling this review commissioned. According to a third of the older people we polled the support and guidance they received approaching retirement was 'poor'. Another third said it was 'adequate'. Just eight per cent described the assistance they received as 'excellent'.²³⁵

According to a third of the older people we polled the support and guidance they received approaching retirement was 'poor'.



Surma older people's club Manager Abul Azad and Toynbee House resident Shiv Banerjee, who gave evidence to the CSJ about older people in Tower Hamlets and the Bangladeshi community

235 YouGov, *Attitudes of People over Retirement age*, June 2010

Furthermore, despite some encouraging initiatives launched under the previous Government – including publications like *Your Guide to Retirement* by Money made clear as part of the Money Guidance initiative – a significant amount of the advice and guidance available to older age appears to remain internet based. This can inadvertently exclude many pensioners who either cannot afford internet access or who are unable to use it. It can be particularly restrictive in financial terms when one considers how many capitalise on internet promotions, discounts and deals, or indeed take guidance from informative internet ‘best buy’ tables for such things as energy contracts or financial services.

Added to this we have also heard that in too many communities access to sound and simple advice – which may be given through such traditional channels as the local authority or local Citizens Advice Bureau – fails to reach older people vulnerable to, or living in, social exclusion.

Financial Abuse

Although our review’s primary focus is on pensioners living in financial and social poverty we could not ignore the tragic nature of financial abuse in older age.

A 2007 study of the 471 cases handled by Action on Elder Abuse during a twelve month period revealed that:

- Over £2 million was reported stolen, defrauded and coerced from elderly victims;
- 18 houses were sold or taken without consent (equivalent to £3.3 million worth of property);
- An additional 13 houses were given away under pressure, including blackmail, or without full awareness (equivalent to £2.4 million worth of property).²³⁶

It found that the majority of victims were women aged over 81 years old and the majority of perpetrators were sons and daughters.²³⁷ As the ongoing work of organisations like Action on Elder Abuse demonstrates, this is an issue too often overlooked by policy-makers.

Scams

‘Fetcham woman, 84, loses £176,000 to rogue traders’

BBC News, 20 June 2010²³⁸

236 Action on Elder Abuse, *Briefing Paper: The Cost of Living*, ‘growing up is free, growing old is expensive’, July 2007, p1

237 Ibid.

238 BBC News, ‘Fetcham woman, 84, loses £176,000 to rogue traders’, 20 June 2010, accessed via: http://www.bbc.co.uk/news/10359927?utm_source=twitterfeed&utm_medium=twitter

‘Penniless pensioner’s suicide after lottery scam’

Daily Mail, 7 July 2010²³⁹

There also remains an unnecessarily persistent challenge in reducing the threat of financial scams targeting or affect vulnerable older people. Whilst scams affect people of all ages – research from the Office of Fair Trading estimates that UK consumers lose approximately £3.5 billion a year as a result of them²⁴⁰ – the Working Group recognises the particularly devastating impact they can have on those in later life, and their immediate family members.

As frequently harrowing newspaper articles remind us, and as powerful public awareness campaigns like Think Jessica highlight,²⁴¹ there are many older people who face extreme emotional and financial pressure to respond to such schemes, and need help not to do so. A recent survey published by Help the Aged and Barclays revealed that 70 per cent of older people are targeted by financial scams each month, and almost four in ten older people fear they would be unable to spot a scam if they were approached.²⁴² Furthermore, shocking figures collated by Think Jessica found that for one particular scam 22,000 victims replied to a mail shot in one day, and sent £500,000 in response.²⁴³

In evidence to the CSJ Older Age review Marilyn Baldwin, founder of Think Jessica, said this:

‘I know of some pensioners who are receiving between 80 and 100 scam letters a day – one disabled gentleman has to collect his sack of mail from the sorting office because it cannot be delivered in the normal way. Some of our society’s most vulnerable people are being sucked in to spending vast amounts of their life savings on these manipulative and ruthless criminal scams. Many are now at risk of poverty. I would urge everyone to visit the Think Jessica website to see the shocking reality of criminal scam mail in the UK and the damage it does to many thousands of its victims who are consumed by it. There are several common sense solutions which would put an end to this neglected problem so it is time we woke up to them and took action.’

Marilyn Baldwin, founder of the Think Jessica campaign – www.thinkjessica.com

52 per cent of people we polled said they didn’t give much thought to growing older (in terms of income, accommodation and lifestyle).

YouGov poll for the CSJ Older Age review

239 Daily Mail, ‘Penniless pensioner’s suicide after lottery scam’, Daily Mail, 7 July 2010, accessed via: <http://www.dailymail.co.uk/news/article-1292710/Penniless-pensioners-suicide-lottery-scam.html>

240 Office of Fair Trading, *Research on impact of mass marketed scams*, London: Office of Fair Trading, 2007, p8

241 See www.thinkjessica.com. Think Jessica was established by Marilyn Baldwin following the tragic and chronic targeting of her mother, Jessica, by criminal gangs using postal scams

242 The Daily Telegraph, *Majority of pensioners are targeted by scams every month, charity warns*, 16 September 2008

243 Accessed via: <http://www.thinkjessica.com/>, 15 July 2010.

Think Jessica calls for several simple elements of reform to combat the problem. It calls for increased public awareness about the extent and damage of the criminal mail problem. It calls for recognition of the condition that held Jessica's life hostage and eventually caused its premature end. Think Jessica also calls for new and simple support mechanisms to be triggered by Royal Mail and other delivery agencies for those people receiving scam mail. Presently, due to its desire to strictly deliver all mail and refuse to initiate any degree of quality control in these scams, the Royal Mail is failing those who are targeted by these criminal gangs.

The Working Group is clear, therefore, that if stakeholders with the power to act on these points – particularly the Royal Mail – had been serious enough about doing so, the routine and devastating impact of these scams would be a problem of the past.

2.6.2 PLANNING

Whilst we need to provide helpful information for those at the point of serious need – whether caused by care requirements, the loss of a partner or other unplanned circumstances – the Working Group is also aware of the need to encourage personal planning for later life.

We have been struck by how little personal planning many of the older people we have come into contact with undertook in younger life. Although much of the debate about personal older age planning tends to focus less on pensioners in poverty and about maximising pension pots, managing savings and releasing capital amassed in assets such as property, the Working Group recognises the role that it has in preventing pensioner poverty, or in alleviating it, even taking into account the unique challenges presented by life on a low income.

There is a cultural apathy towards planning for older age, particularly in terms of money. Many young people and young professionals we consulted with for this section readily dismissed retirement, or even pension planning, as something to delay thinking about until much later in life. Furthermore, as Aviva's *Real Retirement Reports* reveal, there is an alarming lack of savings provision amongst the group of people approaching retirement (aged between 55 and 64). Aviva has found that 23 per cent of over 55s have less than £2,000 in savings and over a third has under £10,000. Moreover, although the mean monthly savings for over 55s was £142, four in ten were saving nothing on a monthly basis.²⁴⁴

As part of our anecdotal evidence gathering several members of the Working Group visited Regenerate RISE, a community project attended by many lower income older people in Putney and Roehampton, and conducted an informal focus group poll on several themes. Perhaps one of the most striking responses was in a question about planning: half of the respondents said they hadn't given

244 Aviva, *The Aviva Real Retirement Report – Issue Two*, London: Aviva, 2010, p8.

much thought to growing older. In one on one conversation both at this project and elsewhere, many older people were even more candid about their failure to plan adequately for growing older.

These findings were further substantiated by our review's polling. In terms of income, accommodation and lifestyle, over half of the respondents said they didn't give much thought to growing old. Only one in ten said they planned as comprehensively as possible for later life. This kind of ratio was consistently reflected throughout our consultation process.

CHAPTER THREE

Community and Lifestyle

Chapter Findings: Summary

- An individual's social and physical environment has a significant impact on their health, lifestyle choices and likelihood of living in poverty.
- Loneliness, distinct from both isolation and solitude, can have as much of an impact upon an older person's life expectancy as smoking. We have heard that the problem of loneliness is particularly pronounced among older people.
- Crime and the fear of crime remain common concerns of older people. Furthermore, offences like vandalism, theft and violent crime impact disproportionately upon our poorest communities.
- Although there have been considerable improvements, access to transport remains patchy for some older people. This can leave them feeling trapped at home. The number of journeys using taxis is highest among people who live in the lowest income quintile, and yet the expense of taxis often proves a serious drain on financial resources.
- Given the significant changes to the body's functioning and metabolism, maintaining a healthy diet is crucial in later life. Yet among the poorest older people in the UK malnutrition is too common: eating well on a tight budget is a significant challenge for many of the poorest pensioners.
- Exercise has been conclusively shown to reduce risk of many medical and physical ailments. Yet overall it remains the case that brisk walking, swimming and other types of physical exercise drastically decline as people get older with the risk of inactivity even greater in Britain's most deprived communities.
- Though in general older people form a large part of the volunteer workforce in the UK, in the most deprived communities this figure drops dramatically. The benefits of volunteering, both for the volunteer as well of course for society, are widely recognised.
- More than half of the 17 million people in the UK without internet access are aged over 65. Digital exclusion limits participation in meaningful work, can limit opportunities to communicate with friends and family and, in terms of on-line shopping and price-hunting, can mean older people are at a financial disadvantage to the rest of the population. Barriers to entry include the perceived prohibitive level of necessary investment and ongoing cost of computers, as well as the perceived complexity of technological arrangements and process and a lack of self-confidence.



Attendees of Regenerate RISE lunch club in the London Borough of Wandsworth who gave evidence to the Review

3.1 Community

3.1.1 THE NATURE OF NEIGHBOURHOODS

The Social Environment

The CSJ has published extensively on the nature of social breakdown, dysfunctionality and poverty within our poorest areas. In doing so it has identified five common pathways to poverty. They are family breakdown, educational failure, economic dependency and worklessness, debt and addiction to drugs and alcohol. We have also seen how such areas tend to be characterised by high crime rates, anti-social behaviour and static local authority housing which stifles social mobility.

As we explore within this chapter, many such communities are intense beacons of health inequality, low life expectancy rates and poor physical and mental wellbeing. As we set out in this report it is clear that the nature of an individual's community has a profound impact on the nature of an individual's lifestyle and choices. The lifestyle decisions of people in our poorest areas must be considered within their community context. A child growing up in a community where family life is often dysfunctional, worklessness is intergenerational, school standards are poor and crime is fuelled by drugs and alcohol, will find it much more difficult to break away from these factors.

The direct and indirect impacts of some of these factors on poorer older people – such as family breakdown, personal debt and crime – are discussed in this report.

The Physical Environment

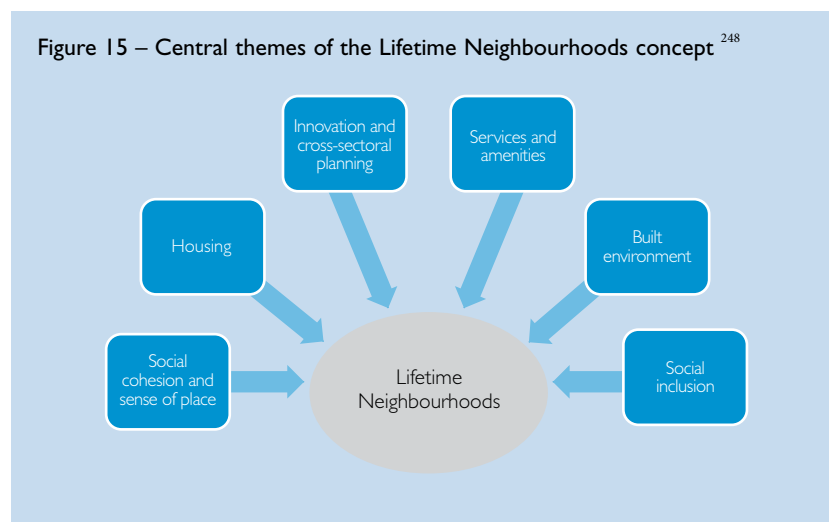
The physical nature of our neighbourhoods and local communities is important to overall quality of life and well-being. This is true across all age groups, but our review is acutely aware of its relevance for older people. Although many older people are self-sustaining in later life, it is also true that because many experience a reduction in physical and mental capability, as well as self-confidence, basic neighbourhood facilities become pivotal in helping to remain active and independent. This means that pavements must be safe, public toilets accessible and benches available. As well as this, there is also a need to be intentional in analysing the access to local shops and statutory services. For example approximately one in ten people over the age of 75 reports having poor access to a corner shop, a supermarket, a post office, or doctor's surgery and 16 per cent report poor access to a local hospital.²⁴⁵

²⁴⁵ Department for Communities and Local Government, *Housing in England 2007-08: A report based on the 2007/08 Survey of English Housing*, Department for Communities and Local Government, 2009, p162

Lifetime Neighbourhoods

Many people across the country report being satisfied with their local area: just under half (49 per cent) were very satisfied with it as a place to live.²⁴⁶ That said there is a challenge for policy-makers and planners to ensure there is adequate local provision for older members of society who, it seems, can legitimately feel their unique needs are neglected. This is particularly relevant to those living in deprived communities, as well as ethnic minority groups, who generally have lower levels of satisfaction with their area.

To the previous Government's credit, as well as organisations such as the Joseph Rowntree Foundation, the International Longevity Centre UK and the World Health Organisation, these needs have been recognised more clearly in recent years through the development of the Lifetime Neighbourhoods concept. In leading the debate about the importance of Lifetime Homes the Joseph Rowntree Foundation also prompted the development of Lifetime Neighbourhoods. Further to this in 2007 the World Health Organisation published *Global Age-friendly Cities*, a report on its project activity which built on its Active Ageing initiative and called for a fresh approach to the design of cities, in order to accommodate older people more effectively and prepare for the many ageing societies globally.²⁴⁷ During the same period the previous Government published a series of reports which explored implementing the newly developed concept of age-friendly lifetime neighbourhoods. The central themes to the lifetime neighbourhood concept are drawn below.



Many of these themes are covered in individual chapters and sections of this report, so it is unnecessary to focus extensively on the concept here. However,

²⁴⁶ Ibid., p159

²⁴⁷ World Health Organisation, *Global Age-friendly Cities: A Guide*, Geneva: World Health Organisation, 2007

²⁴⁸ Department for Communities and Local Government, *Towards Lifetime Neighbourhoods: Designing sustainable communities for all*, London: Department for Communities and Local Government, 2007, p8

the Working Group broadly welcomed the commitment of the previous Government to the Lifetime Neighbourhoods concept and, although members are disappointed by the lack of subsequent action following its emergence, we will monitor the actions of both central and local government closely over the coming months.

3.1.2 RELATIONAL WELL-BEING

Thankfully the majority of older people in the UK enjoy high levels of relational well-being. The majority do not experience social isolation or persistent loneliness.²⁴⁹ There is a huge amount of social activity in which older people participate – from age-exclusive holidays to book clubs – and there is positive service provision – such as free bus passes – which many older people utilise to maintain friendships and social networks.

Yet, as our report highlights, there remains a section of our older population trapped in a very different reality. Far too many older people in our society, particularly as members of this review have seen in our poorest communities, still live in social exclusion, loneliness and isolation.

Social Isolation

Social isolation in older age – understood broadly as a lack of contact and engagement with close family, friends or associated social groups – is a key component of social exclusion and affects many older people as a result. It is a particular risk to males who live alone and have never married; older people without children or close relatives; and those in failing health.²⁵⁰ And as we have seen this often means those living on a low income.

This is consistent with Thomas Scharf's report *Growing old in socially deprived areas*. In that report almost half (48 per cent) of respondents were assessed as living in medium or high isolation. It was also found that older pensioners were significantly more likely to live in social isolation than younger pensioners.²⁵¹ Furthermore our anecdotal evidence gathering has highlighted how many people cite a fear of social isolation as a cause for concern in regards to entering older age.²⁵²

Yet there are clear reasons for hope. During our review members visited The Crossway project in Birmingham, run by a local church and targeted on socially isolated or vulnerable members of the older population. We highlight its essential work below as recognition of the problems, and possible opportunities, surrounding isolation.

249 See for example Social Exclusion Unit, *A Sure Start to Later Life*, London: Office of the Deputy Prime Minister, 2006, p19

250 See for example *Independent Age, Briefing 1: Links between social exclusion, loneliness and digital exclusion in older people*, p2

251 Scharf et al, *Growing older in socially deprived areas: social exclusion in later life*, London: Help the Aged, 2002, pp88-89

252 Ibid., p3

The Crossway

The Crossway runs a Support for Older People scheme where they offer a range of free services to help older people in their community prevent, and break free of, social isolation and loneliness.

The services they provide include visiting individuals in their own homes, Nursing Homes & Hospitals; running events for older people; overseeing weekly over 70s drop-in club; and providing or overseeing practical support such as providing transport to appointments and help with shopping. It also hosts a twice weekly session with a council funded Neighbourhood Officer and offers a weekly collection point for the local Credit Union.

'The Crossway is helping older people to feel valued by giving time and showing them love'

Anne Horder, The Crossway Coordinator

Case Study: Simon

Simon is a man in his eighties with multiple health problems who realised that he was becoming increasingly isolated and depressed, and decided to do something about it before it got worse. After seeing a leaflet in his local library he contacted his local church to inquire about activities for older people.

The church arranged for Simon to be visited in his flat by the Support Worker for Older People every two or three weeks for about a year – sometimes by a volunteer, sometimes by the Support Worker. During this time Simon organised a place for himself at a Day Centre and a Lunch Club and bought himself an electric scooter.

When The Crossway was opened in 2008 Simon quickly became a regular visitor – often calling in on his way to and from the shops. Since helping him the Crossway has seen a positive shift from a tendency towards isolation and depression to someone who enjoys going out and making social contacts in his community.

The Crossway also supports Simon in a variety of ways including accompanying him to Hospital and Doctor's appointments, and carrying out some practical jobs in his flat through their Practical Assistance in the Community scheme.

Loneliness

Another significant issue we have encountered during our review – closely linked with social isolation – has been the extent of loneliness amongst older people in deprived communities.

The tragedy of loneliness in older age is often triggered by the death of a spouse or by the common experience of being alone in later life. More than half of people aged 75 years old and over live alone;²⁵³ half of all older people cite the television as their main form of company;²⁵⁴ and thousands face loneliness at key points during the year when many of the general population celebrate together with friends and family – in 2006 500,000 older people spent Christmas day alone.²⁵⁵ Work undertaken by the previous Government identified a group of older people who experience



Anne and Catriona at The Crossway, Birmingham

253 Office for National Statistics, *General Lifestyle Survey 2008*, Table 3.3 (GB), London: Office for National Statistics, 2010

254 Help the Aged, *Isolation and Loneliness Policy Statement*, London: Help the Aged, 2008, p6

255 *Christmas Day survey 2007* (unpublished), ICM Research for Help the Aged, 2007

“Apart from this project, I have no one to talk to and nothing to do. It gets me out of the house.”

Elderly lunch club participant, in evidence to the CSJ

severe exclusion: according to research cited by the Social Exclusion Unit more than one million people over 65 years old (approximately 11 per cent of the total population over 65) report feeling lonely often or always²⁵⁶ and a similar proportion feel trapped in their own homes.²⁵⁷

A harrowing indicator of loneliness in older age is the number of Public Health Funerals, or paupers' funerals, where no family members or friends can be traced, or no one is willing to pay for the funeral. There were 2,200 such funerals last year in England and Wales, a high and broadly stable number during recent years.²⁵⁸

The Northwood Live At Home Scheme

The Northwood Live at Home Scheme (NLHS) is a community-based befriending scheme for older people living alone in their communities. NLHS provide a variety of services to many older people including befriending, outings, regular social gatherings, information and advocacy, assisted shopping, pub lunches, transport, and a regular telephone link to all of their members. The majority of members are unable to leave home unassisted due to mobility difficulties or frailty.

The scheme currently provides support for 130 older people with 37 volunteers assisting in the delivery of activities. The volunteers provide a crucial social link to the member, often increasing their confidence and encouraging them to mix with other members, and attend social gatherings. By providing these services NLHA provides support to older people to prevent isolation and loneliness and helping them integrate back into the community.

A Member's Story

The Live at Home Manager visited a lady aged 82 living alone in her own home. She had been recently widowed and had cared for her husband through a long term illness. Due to caring for her husband, she had been unable to get out and about for several years, had mobility difficulties and was unable to go out without the assistance of family. The lady's family did not live in close proximity and due to work commitments it was often weeks between visits. With encouragement from NLHS staff and with volunteers providing door to door transport and support the lady joined in the scheme's regular social activities. At one of the scheme's regular teas the lady asked if it was possible for the scheme to arrange an outing to see the film *Mamma Mia* as she loved musicals. The outing was arranged and during the performance the lady was laughing, singing and clapping along with 20 friends made since joining the scheme. At the next Live at Home activity, when asked if she had enjoyed the outing, she replied:

'Oh yes, it was marvellous, I never dreamt I would ever do such things again in my life, I haven't stopped singing the songs all week.'

256 Victor, C, Scharf, T, *Social Isolation and Loneliness*, (eds) Walker, A., Hennessy, C.H. *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*, London: Office of the Deputy Prime Minister, 2006, p55

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

258 Local Government Association, *Public health funerals: A survey of authorities in England and Wales, 2010*, July 2010, London: Local Government Association, p3

Understanding Loneliness

Experiencing loneliness is not the same as experiencing isolation or solitude. The Working Group supports the definition outlined during a seminar hosted at the *Anchor Trust* by Dr Bill Thomas, a Harvard-educated physician, board-certified geriatrician and founder of the Eden Alternative. According to Dr Thomas loneliness is ‘a pain an individual feels when they want companionship but can’t have it’.

However obvious this distinction might seem, it is one many policy-makers and professionals appear to have failed to grasp. According to some people we have met this has been a particularly relevant flaw in trying to alleviate loneliness through certain community initiatives or by providing activities in care homes – many have failed to recognise that loneliness can be just as acute for an individual whether they are alone or in group of people. No matter how well-intentioned, it can be wholly insufficient to simply provide things for people to do or places to go. Any strategy to defeat loneliness has to be grounded in the understanding that it is not simply a matter of being alone – loneliness is a physical and psychological pain of desiring companionship, not just activity and company.

The Impact of Loneliness

There is a high volume of academic and anecdotal research on the impact of loneliness and it is important for policy-makers to understand the physical and emotional harm it can do to individuals.

A number of international studies highlight how the quality of social interaction and relationships affects an individual’s quality of life and life chances.²⁵⁹ Most recently, a study published by academics at Brigham University, Utah, found that individuals with adequate social relationships have a 50 per cent greater likelihood of survival than individuals who have negative social relationships.²⁶⁰ Staggeringly this is comparable with the impact of smoking cessation, and equates to a more significant impact on mortality risks than common factors like a lack of exercise and obesity.



A key safe may be positioned outside the front door of an older person receiving home care (inside is a key to that door). Required if an older person lives alone, is insufficiently mobile to get to the door, and has no relatives living near enough to let the carer in, a key safe is thus an icon of isolation

Tackling Social Isolation and Loneliness

In view of the dramatic impact of loneliness upon the life chances of individuals, the Working Group has heard the frustrations of many about the previous Government’s failure to act on the implementation of its *Sure Start to Later Life* report.²⁶¹ The report acknowledged that there were many older

259 See for example, *Independent Age, Briefing 1: Links between social exclusion, loneliness and digital exclusion in older people*, p1

260 Holt-Lunstad, J; Smith, TB; Layton, JB; *Social Relationships and Mortality Risk: A Meta-analytic Review*; published in PLoS Med 7, 2010 accessed via: <http://www.plosmedicine.org/article/info%3Adoi%2F10.1371%2Fjournal.pmed.1000316#aff1>

261 Social Exclusion Unit, *A Sure Start to Later Life*, London: Social Exclusion Unit, 2006

people living in social exclusion (including loneliness) who would benefit from a coordinated effort from local agencies and services to help them reconnect to their communities. Yet, as with much of what the previous Government attempted to do to reduce poverty and social exclusion, despite strong analysis and a working consensus there was frustrating inactivity across Whitehall at the point of implementation. A key lesson from this failure, which had several causes, must be one of local leverage. In this case, so we heard, the lead department (the DWP) struggled to drive reform because of a lack of direct leverage – leverage perhaps more easily utilised by departments like Education, Health and DCLG.

Despite this, the Working Group is aware of a number of initiatives being led at the local level – mainly by the voluntary sector and supported well in cases by local authorities – which are targeting older age loneliness and exclusion. The best models we have encountered almost universally originate from the voluntary sector and strike a balance between personal empowerment and care, as well as meeting the cultural needs of different isolated communities. Aside from the more traditional befriending services led by organisations like Age UK and SVP (Society of St Vincent de Paul) we have chosen to highlight three such outstanding models.

Nubian Life, White City

Nubian Life, based in the Nubian Life Community Care Resource Centre, was established in recognition of the many African-Caribbean Elders who had and remain excluded from mainstream services due to their cultural needs. It currently provides day care services for 87 elders with a medium to high need, and a luncheon club which provides the main meal of the day for 95 elders.

Len's story

Len was living in squalor and was found by police in his flat having suffered a stroke. Through their advocacy service, Talking for Change, Nubian Life:

- Liaised with Charing Cross Hospital nursing staff and Social Services to plan his care whilst in hospital and then his discharge plan.
- Arranged for Prince's Trust volunteers to sort through his belongings and to clear his flat.
- Liaised with Housing Staff to have the flat fumigated and cleaned, the electrics rewired and a new kitchen and bathroom installed; alongside new flooring in the bathroom and kitchen and the whole flat redecorated.
- Successfully applied for a Community Care grant to buy clothes, bedding and furniture.
- Successfully applied to a charity for a television set.
- Liaised with his bank to:
 - Access funds to purchase a bed, flooring, chairs, fridge and cooker.
 - Reviewed his account and discovered it was not the best account for him.
 - Change his account to a local branch and set up a savings account.
 - Set up direct debits for his pension and weekly housing charges to be paid.

After liaising with Nursing Home & Police upon his discharge from hospital Len was placed in a nursing home out of the Borough. He was highly distressed by this and withdrew into himself as he was the only African-Caribbean person in the home. Nubian Life worked alongside the nursing home staff to tackle the failing equality practice Len encountered. They were also able to organise transport and funding for him to attend the Nubian day care facility.

Whilst in the nursing home Len went missing and Nubian Life informed the police and provided details of his description and local places he visited. The advocacy service was on alert for ten hours until he was found. The lead advocate arrived at the nursing home at 11:00 pm and had to stay with Len until he had calmed down, eaten and gone to sleep.

When Len finally returned home the advocacy service worked with his social worker to plan his home care support plan and escorted Len to hospital appointments and referred him to the following services:

- Speech Therapy
- Incontinence service
- Memory clinic
- Falls service

This work took over ten months and to date Nubian Life still assists Len to remain in his own home and maintain an independent and healthy lifestyle – irrespective of his memory loss. They monitor his weekly care service and ensure that he is reviewed quarterly via an Occupational Therapist. This year they have supported him to become a trainer, so he can train care workers working with people with memory loss.

Nubian Life still provides weekly support to Len in collecting his pension, bill payments and the ordering of his incontinence pads. They also arrange and support him in attending hospital and GP appointments, and in the last few months have supported Len in registering his Power of Attorney. Nubian Life has also facilitated the reunion of Len with his daughter that he had never seen, and facilitated and organised their itinerary when she visited him from New York.

‘Money could not buy enough words to say thank you, you have made my life worth living.’

Service user Mr Linford Whyte

The project takes referrals from a range of local sources including Social Services, PCTs, churches and other voluntary sector groups. It runs a range of services that tackle loneliness and exclusion including day care, lunch clubs, a keep-in-touch service for people who are ill or housebound, and advocacy support to open up local services and a befriending service.

‘Nubian life’s existence has enhanced the lives of so many elders by keeping them in the community. The centre and our activities add to the quality of their lives, making space for self-expression. We have created a safe environment where dignity, choice and a sense of belonging are the main ingredients of family life as we know it’.

Judy Griffith, Chief Executive

Regenerate-Rise, Roehampton and Putney

Regenerate-Rise aims to tackle isolation and social exclusion amongst the elderly. They offer a range of activities to help older people live independent lives and improve their physical and mental wellbeing. Since 2006 they have provided a service for 321 older people on a regular basis by reaching out and helping older people who have become isolated, particularly for those who have experienced major health problems.

'Regenerate-RISE is rising to the challenge of reaching the isolated elderly across the UK in order to radically change and improve the latter years of individual lives. We want to make a difference to older people by restoring hope, building bridges, realising dreams and regenerating our communities in order that life for older people can be for living and not simply for existing.'

Mo Smith, Chair of Trustees

Judith

When Judith was first visited by RISE, she lived in sheltered housing for the blind in a flat which had very little furniture. The room was bare and empty and Judith had become very isolated and afraid to go out. The only time she left her room was when escorted to the communal lounge for a cheese and wine evening. Her husband had died many years earlier and she had no family of her own. Judith hadn't been out of the sheltered housing complex for the blind for 8 months and had become agoraphobic and very nervous.

Through encouragement and assistance Judith attends RISE three or four times a week, goes on a weekly outing and is always keen to participate in all the extra activities including going on all the outings, visits to the theatre, picnics, trips to the coast and visiting people in hospital.

Although she has mobility problems and always needs someone to guide her, she enjoys dancing, loves singing, has been on holidays with RISE and participates in all their activities. With RISE's encouragement she has moved into another flat with more furniture, reads Braille and loves listening to country and western music. She has made friends whom she telephones on a regular basis and occasionally accompanies on other trips. RISE has radically transformed her life and she loves every minute of it.

'Attending RISE can be life-changing for some of the most vulnerable, isolated older people in our community, through the programme of activities, outings and support that we provide.'

Simon Smith, RISE Co-ordinator

Get Together, Participle

In March 2008, with an investment of £250,000 from Westminster City Council, Participle was asked to develop new services to combat the loneliness and social isolation that many older people experience.

The Get-Together programme was developed as a telephone service which aims to introduce lonely and socially isolated older people to each other by operating weekly telephone meetings to share interests, and also to arrange face-to-face group meetings and activities for a small cost to the user.

The service is divided into four types:

- Individual Introductions – Get-Together staff help older people contact other individuals with shared interests.
- Phone groups – Get-Together arranges regular conference calls for up to a group of seven people with shared interests.
- Trips & Transport – Get-Together encourages members to meet the other individuals they have met through

the individual introductions and phone groups; with Get-Together arranging for minibus trips and providing access to mobility scooter hire.

- Activities at Home – Get-Together encourages members to carry out activities at home such as cooking or gardening which members can then discuss in their phone groups.

This model of service can be particularly beneficial for older people who may not wish to open up into a discussion in a day care setting and find it easier to speak and share experiences over the telephone.

These innovative projects, and others we have visited, demonstrate how there is considerable potential within the voluntary sector for reaching people in social exclusion. They also reveal the challenge which confronts policy-makers: replication. We hope the new Government's Big Society initiative will find a way to overcome such a challenge, and make it easier for people with great passion and ability to respond to the level of need within their communities.



Staff from Nubian Life and members of the Working Group

Neighbouring and Neighbourliness

Conceptual Understanding

Within its discussions about relational well-being, social isolation and loneliness the Working Group took evidence on the nature and potential of two further concepts: neighbouring and neighbourliness. Members initially sought to understand the distinction between them, as underscored by extensive published research.

Neighbouring has often been understood as practical, informal interactions within local neighbourhoods, as characterised by the seminal research of Philip Abrams who proposed the following definition:

*'Neighbouring is the actual pattern of interaction observed within any given neighbourhood whether objectively or subjectively defined.'*²⁶²

Distinct from this, neighbourliness is understood by many as a more personal and intentional behaviour, usually linked to stronger personal relationships, commitment and support:

“It is just useful to know there is someone next door, or nearby on the end of the phone.”

Pensioner couple, in evidence to the CSJ



Staff at Regenerate-RISE

262 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

*'Neighbourliness, by contrast, is a positive and committed relationship constructed between neighbours, a form of friendship. It is not a special type of good relationship peculiar to neighbours but an instance of a larger type of relationship contingently arising, in some circumstances, between nigh-dwellers.'*²⁶³

As community development consultant Kevin Harris argued in his book on neighbouring and older people 'neighbouring is not necessarily positive and not necessarily committed, whereas neighbourliness is.'²⁶⁴

The Significance of Neighbouring and Neighbourliness

There are obvious benefits to developing and maintaining strong relationships with people living close by and it is unnecessary to list them here. These benefits are not age-limited, nor is it necessarily more important for older people to have stronger local connections than people of a younger age. Yet, given that the reality of ageing can render individuals less able to cope with certain practical tasks – such as shopping, looking after pets or minor household maintenance – or in maintaining close relationships, it becomes particularly useful to utilise local neighbourhood connections. During our evidence gathering, for example, we heard how this may prove essential in the future design, development and delivery of social care. We also encountered the excellent Karis Neighbour Scheme in Birmingham.

The Karis Neighbour Scheme

The Karis Neighbour Scheme runs a volunteer scheme called Karis Be Friends which provides befriending services to older people in their local community living in poverty, loneliness or isolation. Karis Be Friends volunteers offer support and encouragement, and in practical ways help older people through whatever difficulties they are facing. Last year Karis Be Friends supported 121 older people and visited 90 older people in their homes around 750 times.

'I look forward to Laura coming because I'm here so much on my own; her visits relieve the monotony and give us time to have a chat and a cup of tea.'

Poppy, a Karis Be Friends service user who is housebound and lives on her own

Karis Be Friends also organises social events such as Sunday afternoon teas, coffee mornings and a Christmas Party.

Case Study: Edith

Edith had been in and out of hospital and had significant support from the Adult Mental Health Team. When Edith's care was transferred to the team for older people she was also referred to Karis Be Friends for some support in May 2007. Edith started receiving regular visits at home from her befriender to talk about what she had been doing, her hobbies and interests or about things she was anxious or worried about. Her befriender helped Edith go for a walk in the local area or to the shops, as well as accompanying her to medical appointments if needed.

263 Ibid.

264 Harris, K, *Neighbouring and older people: an enfolding community?* London: Age Concern, 2008, p3

As a result her confidence increased and she has attended several social events that she would not have had the confidence to do. Edith really enjoys going regularly to the Time for Tea events, making new friends and joining in with conversations with volunteers, students, young mums or other older people:

'I never know what I'll be doing next... Dropping or picking someone up from the airport, providing lifts to the summer tea parties, sitting and listening to someone, defrosting a fridge or freezer or going on a trip to the Botanical Gardens. It's nice to feel we might be making a difference to someone's life.'

Natalie, Karis Be Friends volunteer

'Having worked as the Elderly Support Worker for Karis Be Friends for a number of years now and having seen a growing population of older people in our local communities it is apparent that there is an increasing need for befriending and friendship support, where often people are isolated or lonely, and that there are significant benefits that can be gained from this kind of support.'

Helen Bell, Elderly Support Worker

Good Neighbours?

A debate has continued in recent years about whether the culture and extent of neighbouring and neighbourliness has been in decline. It has long been assumed that it is in steady decline. A study published by Co-Operatives UK found that although many people remain willing to help and engage with their neighbours, the UK is half as neighbourly as it was three decades ago. It found that in 1982 the majority of people would speak to their neighbours once a day, whereas in 2010 the majority only speak to neighbours once a week. It also found that half of the British public believes people know more about the daily activity of their favourite celebrities than those of their neighbour.²⁶⁵



Photograph provided by Karis Neighbour Scheme, Birmingham

A recent nationally representative survey undertaken by Gumtree.com, however, has called these research findings into question. Core conclusions of its *State of Neighbourhoods Report* found that each person knows an average of ten neighbours by name; 74 per cent have called on their neighbours in an emergency; almost half have left a spare house key with a neighbour; and more than four in ten have socialised with neighbours. Crucially, more than six in ten people believe their neighbourhood is more than a physical place in which they live; instead viewing it as a network of communication, interaction and support.²⁶⁶

Specific research about older people and neighbours in low income communities has painted an uncertain picture as to the state of neighbourhood relations. Poverty and social exclusion are closely linked, and there are a

265 Co-operatives UK, *Co-operative Streets: Neighbours in the UK*, Manchester: Co-operatives UK, 2010, p3

266 Gumtree, *Gumtree.com: State of Neighbourhoods Report*, 2010, p3

number of studies which further substantiate this.²⁶⁷ And in evidence to the Working Group neighbourhoods expert Kevin Harris wrote this about poorer older people in communities:

'Many older people have difficulty adjusting to changes in their social and built environments: In addition to feeling a general sense of discrimination, older people can often feel economically discarded and left without a role; disempowered by the ethos of consumption, outdated and their memories not valued; They are often bewildered and challenged by the speed of change, for example in terms of the built environment in their neighbourhood, or in the cultural diversity around them; And they will almost inevitably experience network erosion by way of losing personal friends and contacts as they age. It is far harder for older people to get protection from these forces. Inevitably they will struggle to compensate for the loss of members of their social network if they lack resources (not just money and mobility, but also cultural capital and confidence) to engage new non-local contacts. Furthermore, these are compound problems: being disempowered and experiencing exclusion makes it harder to deal with change in your environment; struggling to come to terms with change makes it harder to compensate for the loss of contacts; and so on. These accumulating effects cause profound social damage.'



Neighbourhoods expert Kevin Harris explained the significance of informal community networks to the Working Group.

Thomas Scharf's report *Growing older in socially deprived areas* revealed more about the nature of attitudes of older people towards their neighbours and neighbourhood. As the following table shows many agreed that they would expect to receive help from their neighbours in an emergency and the overwhelming majority said they frequently stopped to talk with people in the area.

²⁶⁷ See for example Harris, K, *Neighbouring and older people: an enfolding community?* London: Age Concern, 2008, pp46-47

Figure I6 – Attitudes towards the neighbourhood: percentage of people responding to statement about their neighbourhood ²⁶⁸

Statement	Agree	Neither Agree nor Disagree	Disagree
I believe my neighbours would help me in an emergency	78 per cent	10 per cent	12 per cent
I frequently stop and talk with people in my neighbourhood	71 per cent	11 per cent	18 per cent
I feel I can trust the people in my neighbourhood	58 per cent	21 per cent	21 per cent

YouGov polling commissioned by our review has also revealed an encouraging level of neighbourhood relationships. 77 per cent of older people we polled agreed that they could rely on their neighbours in case of emergency.²⁶⁹

While the focus of much neighbourhood research has been urban, there are often natural and unique difficulties for older people living in rural contexts. Our review met one older gentleman renting a dilapidated cottage in a very rural setting who perfectly highlighted this point. Although well-known at his local pub (a ten minute drive away), he had to rely on local goodwill and a dedicated friend living 20 minutes away to assist with basic transport needs and provide regular relational contact.

The Challenge for Policy-Makers

Whether neighbouring and neighbourliness are in a period of decline or advancement in our communities, and amongst our poorer older population, is an interesting debate. However, the more crucial issue for policy-makers should be how these concepts can be promoted and encouraged more effectively, and how both could be utilised within the battle to tackle isolation and loneliness. They are clearly tools for developing a localised, bigger society. The Working Group hopes its second report can help put neighbouring and neighbourliness back on the social policy agenda.

²⁶⁸ Scharf et al, *Growing older in socially deprived areas: social exclusion in later life*, London: Help the Aged, 2002, p75

²⁶⁹ YouGov, *Attitudes of people over retirement age*, June 2010

“When we first came here I wouldn’t have dreamt of locking a door, or even shutting it. Now almost nobody over 60 would dream of going into town by themselves at night. I think we have a policeman but I don’t think he is ever there.”

Pensioner, in evidence to the CSJ

3.1.3 CRIME

The National Picture

Another foundational issue which the Working Group encountered time and again during our evidence gathering about communities was crime. Many older people highlighted crime or the fear of it as a concern in their local area.

According to the official measurements of crime – both police recorded crime and the British Crime Survey (BCS) – overall crime has reduced in the last decade. Whatever the flaws of these official techniques,²⁷⁰ this is a welcome trend. Yet, despite the apparent success in reducing crime, Britain remains a high crime society.

According to police recorded crime there were 4.3 million criminal offences committed last year, but according to the more reliable BCS 2009-10, 9.6 million crimes were committed – the equivalent of 26,000 a day. Although this marks an apparent 50 per cent reduction since 1995, the Working Group believes there remains significant work to do to cement and maintain this reduction. And while crime is down, 66 per cent of people still feel crime is increasing nationally.²⁷¹ Just 41 per cent of people believe the criminal justice system is effective as a whole.²⁷²

The official crime statistics for older people make for interesting exploration. According to the BCS only a minority – approximately one person in ten between the age of 65 and 74 – was a victim of crime on one or more occasions last year. For those 75 years old and over it was approximately eight per cent.²⁷³

Based on these official crime figures and our review’s anecdotal evidence, many older people are concerned about crime and worry about victimisation. According to the BCS people aged 65 years old and over are more likely than any other age group in society to feel there has been an increase in national crime,²⁷⁴ more than one in ten people above the age of 55 says they are either very likely or fairly likely to be a victim of burglary, up to 21 per cent feel the same about car crime and approximately one in ten feels it is likely or very likely that they’ll be a victim of violent crime.²⁷⁵

270 Such as the fact that the majority of crime isn’t recorded; that certain crimes are automatically excluded from the BCS; and the concern that there is an under-representation of recorded crime committed in our poorest communities.

271 Home Office, *Crime in England and Wales 2009-10*, London: Home Office, 2010, p7

272 Ibid., p109

273 Ibid., p37

274 Ibid., p123

275 Ibid., p127

Crime and Pensioner Poverty

Further to the national crime picture it is important to recognise that crime disproportionately impacts our poorest communities. Due to the fact that a significant number of pensioners living in poverty and experiencing social exclusion live in these deprived areas, it was important that the Working Group considered its impact on older people in these areas, and how it can be substantially reduced in both the short and long term.

Crime and its consequences are all too often part of daily life in our most deprived areas. Not only is the majority of crime committed in our poorest areas – the majority of offenders in the criminal justice system have a background of poverty and social exclusion²⁷⁶ – but its impact is often most acutely felt by people living in our poorest areas.

As the latest BCS highlights (consistent with previous surveys) the risk of being the victim of vandalism, vehicle-related theft and burglary is higher in the most deprived parts of the country than in the least deprived.²⁷⁷ People living in households with the lowest income are also more likely to feel that crime has increased in the last two years and they are likely to have a high level of perceived Anti-Social Behaviour.²⁷⁸

It is also helpful to note the work of Professor Thomas Scharf et al in *Growing older in socially deprived areas*. This report's findings contrast with the results of national surveys like the BCS in their conclusions that older people are less likely than younger people to be the victims of crime. It highlights that for many older people in socially deprived areas crime is a real and regular threat.²⁷⁹

Local Policing

'Seeing local police is reassuring but we don't see them enough.'

Pensioner, in evidence to the CSJ

One of the key determinants of whether communities are safe, and whether people feel safe in them, is the strength and visibility of local Police Forces.

According to the national figures published by the BCS, as demonstrated below, many older people have close to average levels of satisfaction with their local police.

276 See for example Centre for Social Justice, *Locked Up Potential*, London: Centre for Social Justice, 2010, p5 and Centre for Social Justice, *Order in the Courts*, London: Centre for Social Justice, 2010, pp46-48

277 Home Office, *Crime in England and Wales 2009-10*, London: Home Office, 2010, p166

278 Ibid., p124 and 134

279 Scharf et al, *Growing older in socially deprived areas: social exclusion in later life*, London: Help the Aged, 2002, pp46-63

Figure 17 – Perceptions of local police by age group 2009/10
(England and Wales)²⁸⁰

Age Group	Percentage saying police doing good/ excellent job
All (average)	56 per cent
55-65 years old	53 per cent
65-74 years old	57 per cent
75 years and over	62 per cent

Yet whilst the perceptions of many older people about their local police are positive, there is much to do to achieve levels that policy-makers and local community leaders aspire to. Although close to six in ten older people feel their local police officers are performing to a good or excellent standard, this does mean that four in ten do not. Furthermore, in other BCS public perception results we find the similar mixed picture. On average just over 55 per cent of older people agreed that their local police and council are dealing with anti-



Morris and Carmel Leahy spoke to the working group

social behaviour and crime issues – approximately 15 per cent on average disagreed.²⁸¹ Added to that, only half of all older people agree that their local police and council seek their views and keep them informed.²⁸²

Furthermore, public polling commissioned for this review found just under a third of the older people we polled reported that the level of anti social behaviour and crime in their local area had risen in the last five years, and four in ten people thought that crime and antisocial behaviour had remained the same.²⁸³

Neighbourhood Policing

The introduction of neighbourhood policing by the previous Government, and its intention to establish more effective relationships between local police teams and their neighbourhoods, is to be commended. The ability of local teams – including Police Community Support Officers (PCSOs) – to tailor efforts to meet the needs and requirements of the local area is highly valuable, particularly in responding to perceived fears of crime. During our

²⁸⁰ Home Office, *Crime in England and Wales 2009-10*, London: Home Office, 2010, p140

²⁸¹ Ibid., p136

²⁸² Ibid., p138

²⁸³ YouGov, *Attitudes of people over retirement age*, June 2010

evidence gathering members of the review heard how local teams, especially PCSOs, play an important role in crime prevention efforts and general reassurance of older people. One member of the Working Group has, for example, seen at firsthand the type of excellent work local Neighbourhood Teams lead (along with other local partner agencies) to educate older people about preventing distraction burglaries and bogus callers.

Notwithstanding these pockets of good practice the Working Group endorses the work published in the CSJ's 2009 report *A Force to Be Reckoned With*.²⁸⁴

Whilst *A Force to Be Reckoned With* highlighted some positive developments in modern policing it also outlined crucial criticisms about a failure of leadership, strategy and culture which need to be tackled in order to improve policing and fight crime in our communities. These failures impact people of all ages, but particularly the most vulnerable members of society. Importantly the report found police officers as too often burdened by bureaucracy and central targets and often unable to exercise discretion and professional judgement. It criticised the unbalanced nature of police governance arrangements and it uncovered a concerning lack of public trust in its informal evidence gathering within communities. The new Coalition Government has been clear in its desire to lead reform in these core areas and the CSJ welcomes this. The Older Age Working Group will be careful to monitor both the implementation efforts following these commitments, and their efficacy in improving the experience of the poorest older people in society.

“Seeing local police is reassuring but we don’t see them enough.”

Pensioner in evidence to the CSJ

3.1.4 TRANSPORT

Transport and Mobility

Ageing can make it more challenging to remain mobile and active. In view of this – as we have seen and heard throughout this review – the importance of reliable and accessible local transport networks rises. It becomes more significant as people get older and more journeys are made for essential items such as food.

The 2009 National Transport Survey found that for people aged 70 and above, almost 60 per cent of their journeys are made for shopping and personal business, compared to only a quarter of those aged between 17 and 29.²⁸⁵ Additionally it found that 39 per cent of people aged 70 or over experienced difficulties walking to or taking a bus.²⁸⁶ It also found that individuals aged

284 Centre for Social Justice, *A Force to Be Reckoned With*, London: Centre for Social Justice, 2009

285 Department of Transport, *National Travel Survey* Table NTS0611: Average number of trips (trip rates) by age, gender and purpose: Great Britain 2009, 29 July 2010, <http://www.dft.gov.uk/pgr/statistics/datatablespublications/nts/>

286 Department of Transport, *National Travel Survey* Table NTS0622: Mobility difficulties by age and gender: Great Britain 2009, 29 July 2010, <http://www.dft.gov.uk/pgr/statistics/datatablespublications/nts/>

70 and over with mobility difficulties are likely to make almost 40 per cent fewer journeys than people without mobility difficulties.²⁸⁷ Poor access to transport can have a detrimental impact on the lives of the poorest and more vulnerable older people. It can often mean they are at an increased risk of serious social isolation – as getting to the shops or visiting friends can become near impossible.

As part of its pioneering work on ageing and wellbeing the WHO highlighted the importance of transport. Its report on age-friendly cities found:

*‘13 per cent of people living in rural areas in their later years report poor access to a range of basic services, including GPs, dentists, hospitals, post offices and local shops. Those on low income and those aged over 80 are significantly more likely to report poor access.’*²⁸⁸

The Rural Challenge

Albert’s story

Albert lives on his own in a rural area approximately three miles from his nearest village and approximately 1.5 miles from his nearest pub. Albert used to own a car but due to rapidly deteriorating eyesight his licence was withdrawn. The nearest bus route to him is 1.5 miles away, and the bus stop even further away. The taxis in his area are expensive and few in number. Without the goodwill of fellow members of the village and neighbours he is rendered stuck in his own home and utterly isolated.

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 older, almost a quarter lived in rural areas.²⁸⁹ Even if older people in rural areas are able to access public transport, nearly four in ten rural households do not have access to a supermarket within two and a half miles,²⁹⁰ and the percentage of rural households within five miles from a hospital is 55 per cent, compared to 97 per cent of those living in urban households.²⁹¹

Unsurprisingly, 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; for those in the lowest income quintile

²⁸⁷ Ibid.

²⁸⁸ World Health Organisation, *Global Age-friendly Cities: A Guide*, France: World Health Organisation, 2007, p20

²⁸⁹ Commission for Rural Communities, *State of the Countryside 2010*, Cheltenham: Commission for Rural Communities, July 2010, p19

²⁹⁰ Ibid., p30

²⁹¹ Ibid., p30

their weekly expenditure on transport in a village or hamlet is £50, for those in rural towns it is £32 and for people living in urban areas it is £28.²⁹²

Modes of Transport

During the Working Group's evidence gathering two specific modes of transport were highlighted for consideration: bus and taxi. Access to each of these modes of transport varies according to factors such as income and mobility; with many older people living alone, it is essential that good transport networks are available to all older people no matter what their circumstances.

Transport by Bus

'The free bus pass is a godsend to a lot of my older friends. It means they can get out and about without having to pay a fortune in fares. It gives them a better social life and is better than being stuck in the house. Whenever I go on the bus ... it has elderly people on the bus saying it's wonderful to be able to get out and about shopping in nearby towns and visiting relatives that they wouldn't be able to see if they had to pay fares.'

Response from a pensioner participating in polling of older people²⁹³

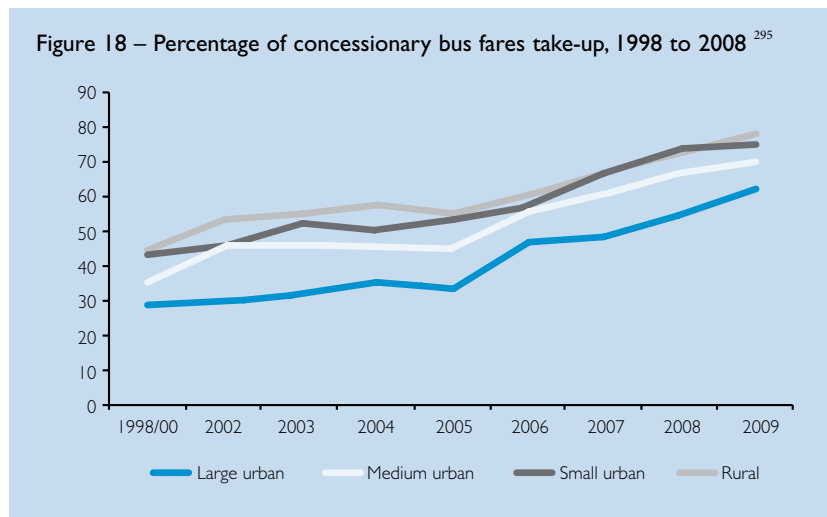
The Transport Act 2000 included a national concessionary bus travel scheme which gave half price fares for people of pensionable age. It was equalised in 2003 for both men and women. In 2006 the concessionary scheme was made free for local travel and extended in 2008 to cover bus travel anywhere in England, allowing anyone over the age of 60 free bus travel. Crucially it also allowed older people to travel across borders from rural districts to the nearest town or city.

Undoubtedly this had an enormously positive impact on the lives of the poorest older people. Since the introduction of free concessionary travel, the number of over 60s who have taken up the concessionary bus fares has risen from 49 per cent in 1998/2000 to 76 per cent in 2009.²⁹⁴

292 Ibid., page 42

293 YouGov, *Attitudes of people over retirement age*, June 2010

294 Department of Transport, *National Travel Survey Table NTS0619: Take-up of concessionary fare schemes by area type: Great Britain, 1998/00 to 2009*, 29 July 2010, Figures are for men aged 65+ and women 60+ to 1 April 2003, then recorded as aged 60+ for men and women, accessed via: <http://www.dft.gov.uk/pgr/statistics/datatablespublications/nts/>



There has, however, been considerable variation in the utilisation of concessionary fares across the type of areas people live. Take-up has ranged from 91 per cent in London to 56 per cent in rural areas, although this disparity is now narrowing.²⁹⁶

A similar pattern applies in relation to people's access to a regular (hourly) bus service within 13 minutes walk from their homes. In urban areas the percentage of people who live within 13 minutes of such a service is around 95 per cent, in rural areas it is 50 per cent.²⁹⁷ It is self-evident that this distance can be significant obstacle for an older person with mobility problems.

'If it wasn't for this service you provide, I would have to change my surgery. I have been with the scheme since it started and I think the drivers are really great, I have never ever been let down.'

'Without the scheme we would have to rely on taxis that could cost up to £15 a time'

RSVP service users

Bus travel provides a vital lifeline for many of the poorest older people who would otherwise be unable to leave their homes. In 2009, more than one in three people over 60 years old (39 per cent) said they used a local bus service once a week, an increase of seven per cent since 2006.²⁹⁸

²⁹⁵ Ibid.

²⁹⁶ Ibid.

²⁹⁷ Department of Transport, *National Travel Survey Table NTS0801: Time taken to walk to nearest bus stop by area type and bus availability indicator: Great Britain and England, 1998/00 and 2009*, 29 July 2010, <http://www.dft.gov.uk/pgr/statistics/datatablespublications/nts/>

²⁹⁸ Department of Transport, *National Travel Survey Table NTS0621: Frequency of bus use for those aged 60 and over: Great Britain, 1998/00 to 2009*, 29 July 2010, <http://www.dft.gov.uk/pgr/statistics/datatablespublications/nts/>

However, the Working Group has noted the difficulty some older people have with accessing their local bus service, especially in rural areas. Whether improvements can be made to the reliability and regularity of bus services will be expanded upon in the Working Group's recommendations report.

Transport by Taxi

Perhaps surprisingly the use of taxis and minicabs is highest among people who live in the lowest income quintile.²⁹⁹ While some poor older people are forced to spend money on taxis, many others are unable to do so due to several factors. First, of course, those on a low income may find it too expensive an option. Second, though, we have heard that some taxi firms are unwilling to take on shorter journeys. These points can render poorer people, particularly those in rural areas, unable to leave their homes.

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 Working Group met with Councillors from Westminster City Council and heard about its Taxicard Scheme, and how it 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.

Another scheme is the Volunteer Driving Scheme operated by the Retired Senior Volunteer Programme (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.

Based on the evidence we have received it is clear that 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 *the* difference between isolation and loneliness or personal and social wellbeing. In this, the unique challenges of living in rural areas are highly visible as Albert's story demonstrates. And whilst overall improvements have been made in a number of the areas we have referenced, many people remain trapped at home or at risk of social exclusion.

“The nearest town is three miles away and the taxis are expensive, not that there are many, as most are private hire firms are only going to the airport and theatres.”

A pensioner in evidence to the CSJ

299 Department of Transport, *National Travel Survey Table NTS0705: Travel by household income quintile and main mode/mode: Great Britain, 2009*, 29 July 2010, <http://www.dft.gov.uk/pgr/statistics/datatablespublications/nts/>

3.2 Lifestyle

Several common lifestyle factors were drawn to the attention of Working Group members during our review as crucial determinants of whether an older individual is likely to experience positive ageing. Specifically, as we have travelled to visit some of our poorer communities and projects within them, it has become apparent that too many of the following themes were often neglected within, or absent from, regular routine.

3.2.1 HEALTH

‘Social justice is a matter of life and death. It affects the way people live, their consequent chance of illness, and their risk of premature death... Within countries there are dramatic differences in health that are closely linked with degrees of social disadvantage. Differences of this magnitude, within and between countries, simply should never happen.’

World Health Organisation, Commission on Social Determinants of Health³⁰⁰

Health, Poverty and Social Deprivation

‘The key message of our report is that the circumstances in which people are born, grow, live, work, and age are the fundamental drivers of health, and health inequity. We rely too much on medical interventions as a way of increasing life expectancy. ... People need the opportunity, the possibility, to take control of their lives - but the conditions need to be right to allow them to do that.’

Professor Sir Michael Marmot, Chairman, WHO Commission on Social Determinants of Health³⁰¹

Significant national and international research demonstrates that there are unacceptable levels of health inequality in the UK. This failure is unequivocally linked to social breakdown and deprivation. Evidence presented by the World Health Organisation’s (WHO) Commission on Social Determinants of Health made clear that it is the nature of the communities in which people grow up and live that determines health and well-being. Its Chairman, Sir Michael Marmot, said this at the time of its report on health inequality in 2008:

Further research published this year has substantiated these findings. First, the previous Government’s *Strategic Review of Health Inequalities in*

300 World Health Organisation, *Closing the gap in a generation: health equity through action on the social determinants of health*, Geneva: World Health Organisation, 2008.

301 The Marmot Review, *Fair Society, Healthy Lives: Strategic Review of Health Inequalities in England post-2010*, London: The Marmot Review, 2010

*England post-2010*³⁰² found that people living in the poorest communities on average die seven years before those in the wealthiest communities, and that an individual's social position will significantly determine their health outcomes. It called for a broader approach to tackling inequalities than through income – such as by giving people control over their lives; developing healthy and sustainable communities; and by strengthening the impact of ill health prevention. Second, the National Audit Office (NAO) published a report which revealed that although life expectancy is increasing overall in England, the gap between average expectancies and those of the poorest is still widening, as well as revealing that the Government was not on course to meet any of its relevant 2010 targets for improving life expectancy rates and gaps.³⁰³

Figure 19 – Health inequalities PSA target (Department of Health) for life expectancy (UK)³⁰⁴

Target	Progress
By 2010 to reduce by at least ten per cent the gap in life expectancy between the targeted group and the population as a whole	<p>Males: seven per cent widening of the gap between 1995-97 and 2006-08</p> <p>Females: 14 per cent widening of the gap between 1995-97 and 2006-08</p>

The ONS has also found that a female born in Glasgow City can expect to live 11.5 years less than one born in Kensington and Chelsea. For males, the difference is 13.3 years.³⁰⁵ And as the aforementioned *Strategic Review of Health Inequalities in England post-2010* found, not only do the people in our poorest communities die younger, but more of this time will be spent living with a disability.

It became apparent that this review should make consideration of three core themes within the health and ageing debate: diet; alcohol; and exercise. The ongoing CSJ Mental Health review will be focusing on the related issues of depression and anxiety.

³⁰² Ibid.

³⁰³ National Audit Office, *Tackling inequalities in life expectancy in areas with the worst health and deprivation*, London: The Stationery Office, 2010, p8

³⁰⁴ BBC News, Social factors key to ill health, 28 August 2008, accessed via: <http://news.bbc.co.uk/1/hi/health/7584056.stm>

³⁰⁵ Office for National Statistics, *Life expectancy at birth remains highest in the South of England*, Newport: Office for National Statistics, 2009, pp1-2

Diet

Weight And Obesity

Despite considerable public health promotion and activity, official figures present a gloomy picture about the weight levels of many older people. From them we can derive, for example, that they are much more likely to be overweight and obese than younger age groups, and that men are more likely to be overweight or obese than women.

Figure 20 - Prevalence (per cent) of overweight and obesity, by age group, 2008 (latest published figures)³⁰⁶

Catagory	16 to 24	25 to 34	35 to 44	45 to 54	55 to 64	65 to 74	74+
Men	33 per cent	58 per cent	73 per cent	74 per cent	78 per cent	83 per cent	72 per cent
Women	34 per cent	45 per cent	56 per cent	64 per cent	69 per cent	72 per cent	66 per cent

But whilst weight gain and obesity are considerable problems within the general health and ageing debate – perhaps fuelled by a common cultural assumption that a ‘middle-aged spread’ is part of the ageing process – it is also important that this review considers the often neglected area of malnutrition. Clearly, it can become more difficult to eat properly on a very tight budget.

Nutrition

Given that ageing involves significant changes to the body’s functioning and metabolism, it is extremely important that older people maintain a healthy diet. This is for energy and strength, immunity and resilience and a well functioning digestive system. As research has shown, malnutrition can also impact on every organ system and result in slower recovery from injuries and illness, it can increase cognitive and functional decline and render people more susceptible to infections.³⁰⁷

Ensuring older people abide by recommended levels of vitamins, minerals and other nutrients is a crucial way of preventing malnutrition. Yet, despite the now commonly understood importance of a balanced diet and the ‘five a day’ campaign, many people in the UK remain malnourished or at risk of being malnourished – a recent study has put the number as high as three million people.³⁰⁸

³⁰⁶ The Health and Social Care Information Centre, *Health Survey for England 2008 Volume 1: Physical activity and fitness*, Leeds: The Health and Social Care Information Centre, 2009

³⁰⁷ See for example Hajjar R.R, Kamel H.K, and Denson K, ‘Malnutrition in Aging’, *The Internet Journal of Geriatrics and Gerontology*, 2004

³⁰⁸ BAPEN, *Combating Malnutrition: Recommendations for Action*, Redditch: BAPEN, 2010, p1

It is calculated that up to 15 per cent of people in the UK aged over 65 years old are malnourished.³⁰⁹ Work undertaken by the European Nutrition for Health Alliance has revealed that those who access health care can have particularly high levels. In its report *Malnutrition within an ageing population* it found that up to 50 per cent of older people admitted to hospital are malnourished on arrival and that the older the patient the higher the risk.³¹⁰ Added to that, research conducted by BAPEN has found that people in social care are also likely to be malnourished: of the care home residents it screened in its Nutrition screening survey, just under a third were malnourished.³¹¹



Photograph provided by Karis Neighbour Scheme, Birmingham

Action Against the Malnutrition of Older People

'It is of paramount importance that malnutrition in later life is recognised as a public health issue on par with obesity.'

Margit Physant, Age UK, in evidence to the CSJ

The previous Government published a Nutrition Action Plan to help tackle the issue.³¹² Five priorities were outlined:

1. To raise awareness of the link between nutrition and good health, and that malnutrition can be prevented.
2. To ensure that accessible guidance is available across all sectors and that the most relevant guidance is appropriate and user-friendly.
3. To encourage nutritional screening for all people using health and social care services, paying particular attention to those groups that are known to be vulnerable.
4. To encourage provision and access to relevant training for front-line staff and managers on the importance of nutrition for good health and nutritional care.
5. To clarify standards and strengthen inspection and regulation.

309 Hajjar R.R, Kamel H.K, and Denson K, 'Malnutrition in Aging', *The Internet Journal of Geriatrics and Gerontology*, 2004

310 European Nutrition for Health Alliance, *Malnutrition within an ageing population: a call for action*, London: European Nutrition for Health Alliance, 2005, p3, p6.

311 BAPEN, *Nutrition Screening Survey in the UK in 2007*, Redditch: BAPEN, 2008, p2.

312 Department of Health, *Improving Nutritional Care: a joint Action Plan from the Department of Health and Nutrition Summit stakeholders*, London: Department of Health, 2007.

It also established an independent Nutrition Action Plan Delivery Board (NAPDB) to monitor progress on these commitments. Its first report, published in February of this year, was less than glowing about the first year of implementation.³¹³ In its core conclusions the NAPDB concluded that there remains a significant problem of malnutrition across society, including in places where there is a duty of care on professional staff and much more needs to be done to reverse this.

Although the implementation of the Nutrition Action Plan is in its early stages, the Working Group recognises that there is a significant amount of work to do in order to tackle this problem, particularly amongst our older population. Crucially, we also recognise the essential role services like Meals on Wheels, and other such voluntary sector organisations play in promoting healthy eating and nutrition at the local level. One such project is highlighted below.

Huddersfield Deanery Project for Older People

The Huddersfield Deanery Project for Older People (HDP) seeks to promote practical, social and spiritual wellbeing of older people of any or no religious background. Specifically it works with older people suffering loneliness and social isolation and who fall outside the support systems offered by the NHS and Adult Social Services. Most are unable to rely on family or friends.

The Project has 215 volunteers and reaches 1,193 older people. Some of the activities that HDP organise are intergenerational opportunities for older and younger people to engage with each other at local high schools; running weekly lunch clubs; and organising exercise classes to help maintain mobility.

'...coming here gets me out of the house, I get to know about other things that are happening, can always get help and advice and important information. I look forward to the meal which I really enjoy and wouldn't otherwise have because I am on my own and don't like cooking for myself.'

Anne, lunch club participant

HDP sells a fruit and vegetable bag every week along with recipes to encourage people to eat more healthily. Working Group members heard evidence that after participating in gentle exercise classes and eating more healthily, some attendees reduced the number of hours that they required care at home, and some also were able to reduce their medication.

'I enjoy getting out of the house and exercising, it keeps me going. I would really miss the group if it wasn't here. I get invited to other events like the tea dances.'

Carol, lunch club participant

Alcohol

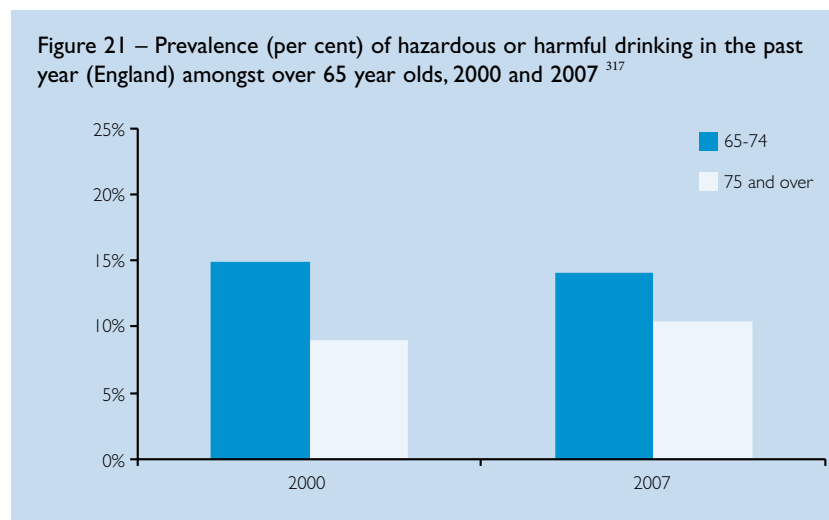
It should be recognised that the majority of people in society adopt a responsible approach to alcohol. According to official figures, more than 75

³¹³ Nutrition Action Plan Delivery Board, *Nutrition Action Plan Delivery Board: End of Year Progress Report*, London: Nutrition Action Plan Delivery Board, 2009.

per cent of people partake in non-hazardous levels of drinking, and less than four per cent engage in harmful drinking.³¹⁴

A Significant Minority

Notwithstanding the sensible majority, as the CSJ's 2007 report *Breakthrough Britain* demonstrated alcohol is a growing problem in too many households and communities – particularly in our poorest areas.³¹⁵ Through mass evidence gathering *Breakthrough Britain* identified a number of underlying and contributing reasons for this, including a lack of integrated policy, dangerously low alcohol pricing, and a dearth of treatment provision. Yet the price we pay for alcohol abuse is not just a social one: alcohol harm is estimated to cost the NHS £2.7 billion in England alone.³¹⁶ In terms of this review's focus, although older people are less likely to engage in binge drinking or associated behaviours, the Working Group is concerned to note that there remain a number of issues which need tackling. As the following graphics demonstrate, there remains a small and persistent level of hazardous and harmful drinking amongst those 65 years and over. Older people dominate the number of alcohol-related hospital admissions each year and people aged 65 and over are the most likely age group to drink every day.



³¹⁴ The Health and Social Care Information Centre, *Statistics on Alcohol: England 2009*, Leeds: The Health and Social Care Information Centre, 2009, p70

³¹⁵ Centre for Social Justice, *Breakthrough Britain – Volume four: Towards Recovery*, Leeds: Centre for Social Justice, 2007

³¹⁶ The Health and Social Care Information Centre, *Statistics on Alcohol: England 2010*, Leeds: The Health and Social Care Information Centre, 2009, p57

³¹⁷ The Health and Social Care Information Centre, *Statistics on Alcohol: England 2009*, Leeds: The Health and Social Care Information Centre, 2009, p70

Figure 22 – Alcohol-related NHS hospital admissions, by age 2007/08 (latest figures published)³¹⁸

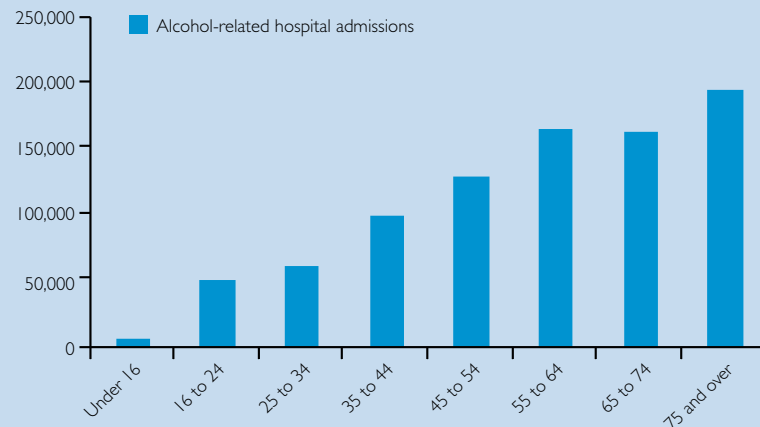


Figure 23 – Percentage of people who reported seven drinking days in the week prior to interview by age (England)³¹⁹

Men		Women	
All ages	66+	All ages	66+
11 per cent	20 per cent	6 per cent	11 per cent

It has also come to the attention of the review that in many respects it is more difficult to detect any casual but unhealthy levels of alcohol consumption amongst older people – this will be particularly true for those who live alone or in social exclusion.

Although these concerns impact a minority of older people, and affect people across the income spectrum, the Working Group has decided to take consideration of them given the clear links to social breakdown. Furthermore, unless we are serious about tackling alcohol abuse across the age ranges, it will prevent people reaching their potential in older age, or even reaching older age at all.

³¹⁸ Ibid., p74

³¹⁹ The Health and Social Care Information Centre, *Statistics on Alcohol: England 2010*, Leeds: The Health and Social Care Information Centre, 2009, p23

Exercise and Physical Activity

The Clear Benefits

The multiple health benefits of undertaking regular physical exercise have been long ascertained; but the health benefits of regular physical activity for older people in particular have been supported by a wealth of international medical research. For example physical activity has a positive impact on the mental health of older people. A 2001 study published in the *Archives of Neurology* has shown that physical activity is associated with lower risks of cognitive impairment, Alzheimer's disease and dementia of any type, with significant trends for increased protection with greater physical activity being observed.³²⁰

What advice, if any, would you give to people approaching pensionable age?

'Keep active'

'Keep as healthy as you can. Try to prepare for it mentally. Try to have something which can occupy your days.'

'Keep fit and eat well'

'Keep fit by walking, swimming etc'

Verbatim responses from people participating in this review's commissioned polling of older people by YouGov

Remaining active also has a positive impact on physical health in later life. Regular physical exercise has been shown to prevent fractures (preventing osteoporosis by increasing bone mass, density and strength) and prevent falls through improving balance and strength.³²¹ The majority of people over the age of 65 are hypertensive, and whilst there are drug therapies to reduce hypertension, the at times fragile physiological condition of older people has meant that measures like regular physical activity have been incorporated into treatments.³²² Moderate exercise training has been demonstrated to help compensate for the progressive decline in the function of the immune system that occurs with ageing.³²³ Regular physical exercise has been frequently linked to a lower prevalence of coronary heart disease, the incidence of which increases with age. Furthermore it has been shown that the quality of life for older people generally improves with regular exercise routines, with

320 Laurin et al, 'Physical Activity and Risk of Cognitive Impairment and Dementia in Elderly Persons', *Archives of Neurology*, 2001, Issue 58, pp.498-504

321 Feder et al, 'Preventing osteoporosis, falls, and fractures among elderly people', *British Medical Journal*, 199 318:1695

322 Tjoa H.I, Kaplan N.M, 'Treatment of Hypertension in the Elderly', *Journal of the American Medical Association*, 1990

323 Friedrich M, 'Exercise May Boost Aging Immune System', *Journal of the American Medical Association*, 2008, 299 (2) pp160-1

muscles becoming reconditioned and thus reducing the incidence of low-level disability, and general flexibility and mobility improving.³²⁴

Participation in exercise and physical activity is also particularly important for older people given that many spend the majority of their time at home, and can therefore engage less in general activity and the often more energised pattern of younger life. Over 65s are estimated to spend 80 per cent of their time in the home, for those over 85 years old it is approximately 90 per cent.³²⁵

The National Picture

Statistics show that many people are failing to engage in recommended levels of physical activity and exercise. Currently these are 'at least 30 minutes of at least moderate activity, either in one session or in multiple bouts of at least 10 minutes duration, on five or more days of the week'.³²⁶ 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. Whilst this is an improvement on the prevalence of activity in comparison with 1997, there remains a huge amount of work to do if the interim and final targets set out early by the previous Government are to be met.³²⁷

Figure 24 – Self-reported summary activity levels amongst older people (England), by age group³²⁸

Self-reported activity level	Men		Women	
	65 to 74	75 and over	65 to 74	75 and over
Meets recommendations	20 per cent	9 per cent	17 per cent	6 per cent
Some activity	33 per cent	23 per cent	30 per cent	16 per cent
Low activity	47 per cent	68 per cent	53 per cent	78 per cent

324 Council of Scientific Affairs, 'Exercise Programs for the Elderly', *Journal of the American Medical Association*, 1984, 252 (4) pp544-6

325 Help the Aged, Older People, *Decent Homes and Fuel Poverty*, London: Help the Aged, 2006, p6

326 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, p24

327 The Health and Social Care Information Centre, *Health Survey for England 2008*, Leeds: The Health and Social Care Information Centre, 2009, pp23-4.

328 Ibid., p44

The challenge of increasing activity levels in later life becomes even starker when broken down by daily routine. As the following graphics highlight, participation in such activities as brisk walking or exercise severely declines as individuals get older. Added to that, the fact that many older people spend much of their time at home is reflected in the average sedentary time many report each day.

Figure 25 – Percentage of people spending on average no time walking or engaged in sports and exercise per week, by age group (self-reported) ³²⁹

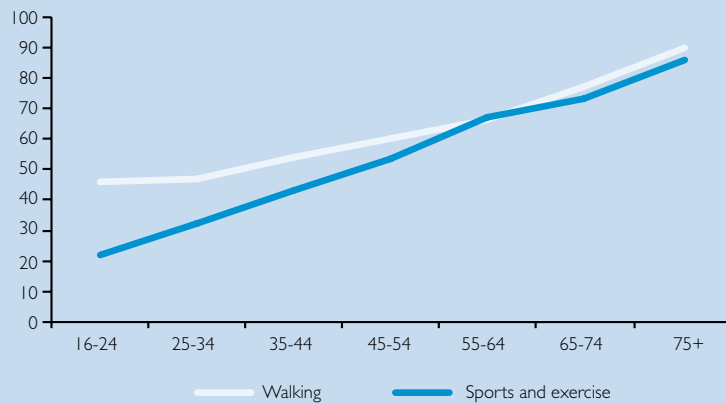
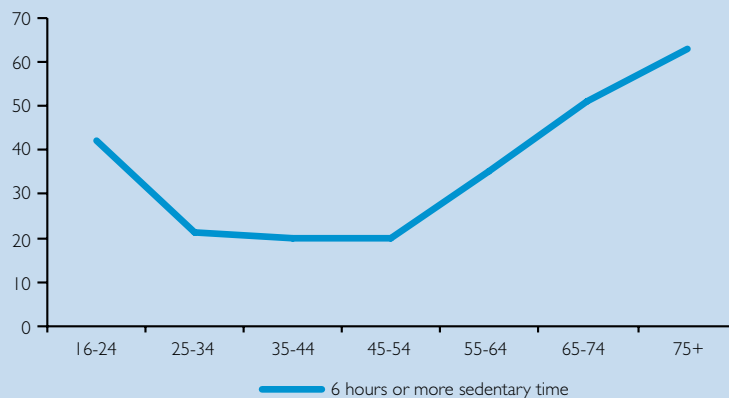


Figure 26 – Percentage of people spending six hours or more sedentary time per day, by age group (self-reported) ³³⁰



Low Income and Health Deprivation

It is also true to note that in the most deprived areas, particularly areas with high health inequality and low income, people are less likely to maintain a sufficient level of physical activity. The latest figures for activity levels within targeted areas of health deprivation reveal lower rates than in non-

³²⁹ Ibid., 51

³³⁰ Ibid., p55

health deprived areas. Added to that, analysis of individual activity levels by household income finds that the lowest income quintile has a much higher rate of low activity than the higher brackets (as the table below shows).³³¹

Figure 27 – Levels of self-reported activity according to income quintile³³²

Self-reported summary activity level	Men		Women	
	Highest household income quintile	Lowest income quintile	Highest household quintile	Lowest income quintile
Low activity	23 per cent	46 per cent	28 per cent	45 per cent

Despite these trends the internet-based YouGov poll commissioned for this review revealed a more encouraging picture. In a poll of people aged 60 or over living in social housing we found that while just under a third (27 per cent) reported ‘never or hardly ever’ taking 30 minutes exercise, nearly half (48 per cent) claimed to take 30 minutes exercise three times a week or more. This breakdown varied minimally across gender, age group and social group.³³³

Barriers to Participating in Physical Activity and Exercise

Studies have revealed that there are two main types of barrier to participating in physical activity and exercise: internal factors and external factors. Internal barriers include the nature of an individual’s beliefs and experiences of participation in physical activity, whereas external barriers relate to their wider environment, the attitudes of other people, and the opportunities to engage that are available to them.

Within these, there are specific factors that often prevent older people engaging in physical activity.³³⁴ These have been found to include the following themes:

³³¹ Ibid., p4

³³² Ibid.

³³³ YouGov, *Attitudes of people over retirement age*, June 2010.

³³⁴ See for example Finch H. *Physical Activity ‘At Our Age’: Qualitative Research Among People Over the Age of 50*, London: Health Education Authority, 1997, p42; and Rai DK and Finch H. *Physical Activity ‘From Our Point of View’*, London: Health Education Authority, 1997, p41.

- Cost constraints.
- A belief that old age prevents engagement in regular physical activity.
- Disinterest in participating or a lack of perceived importance.
- Embarrassment, shyness or a lack of confidence.
- A fear of too much activity and the associated health risks.
- Fear of the local community.

Our own discussions fully substantiated these factors.

Tackling Low Levels of Exercise and Physical Activity

‘Health professionals, particularly GPs, should encourage older people to remain active or increase activity as much as possible. Local authorities must provide affordable opportunities for exercise that appeal to different age groups and must create local environments that are conducive to physical activity throughout life.’

Margit Physant, Age UK, in evidence to the CSJ

It is abundantly clear that activity levels amongst our older population could be, and need to be, significantly improved. It is also clear that the risk of inactivity or low physical activity and poor health is also clearly greater in our most deprived communities. Although, therefore, the policy-response has to be tailored and nuanced – recognising that disability, frailty and low income are significant and legitimate barriers for some older people – the Working Group believes it should be possible to encourage many people in later life, and those approaching it, to become more active. In the context of the impending public expenditure cuts – which in this field has already claimed free swimming provision for the over 60s³³⁵ – and reduced public services, we will seek to explore the most effective community-based models for boosting health awareness and participation, such as Age UK’s regionalised *Fit as a Fiddle* programme or Regenerate-RISE in Putney, and develop our policy solutions accordingly. But more of the same overall failure on physical activity in older age will result in higher rates of health difficulties, a poorer quality of life, and of course higher associated public expenditure costs.

3.2.2 VOLUNTEERING

‘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

335 The Guardian, ‘Government cuts hit 2012 Olympic legacy as free swimming is axed’, Thursday 17 June 2010, accessed via: <http://www.guardian.co.uk/uk/2010/jun/17/government-cuts-2012-olympics>

Throughout the course of this review members have recognised the importance and advantages of volunteering in later life, as well as some of the key factors that hinder many from engaging in it. Much of this work builds on the excellent analysis of organisations such as the Beth Johnson Foundation and the encouraging work of the Volunteering in the Third Age (VITA) initiative, led by WRVS. We are keen for this review to celebrate and promote new opportunities in older age, and we consider widespread volunteering part of that vision, particularly for people in our poorest areas. Increased volunteering across all age groups, whether formal or informal, is also likely to play a crucial role with the new Government's Big Society agenda.



Staff at RSVP who provided valuable evidence on the benefits of volunteering for older people with CSJ Policy Group Manager, Christian Guy

Volunteering: The National Picture

Whilst volunteering levels have remained relatively stable in recent years, they remain lower than would be hoped for. The latest national *Citizenship Survey* reveals that four in ten adults engaged in some type of formal volunteering in the 12 months prior to the Survey, and a quarter volunteered once a month. These proportions have fallen marginally since 2003.³³⁶ In 2009/10 levels of informal volunteering were higher: 54 per cent had volunteered in the 12 months prior to interview and just over a third (29

per cent) had volunteered once a month on average.³³⁷

A breakdown of the volunteering figures by age finds that older people play a crucial role in volunteering patterns across society, particularly on a regular basis. They are often the lifeblood of communities.

Further work, commissioned by VITA, sought to measure the prevalence and impact of older volunteers across more than 470 organisations. The published report based on this work, *The Indispensable Backbone of Voluntary Action*, found that many older volunteers were integral to such fields as Social Services, health, culture and environment. It found that:

- People aged 50 and over formed two-thirds of the volunteer workforce and nearly 70 per cent of the total number of hours provided by volunteers;
- Those aged 65 formed almost a third of the volunteer workforce.³³⁸

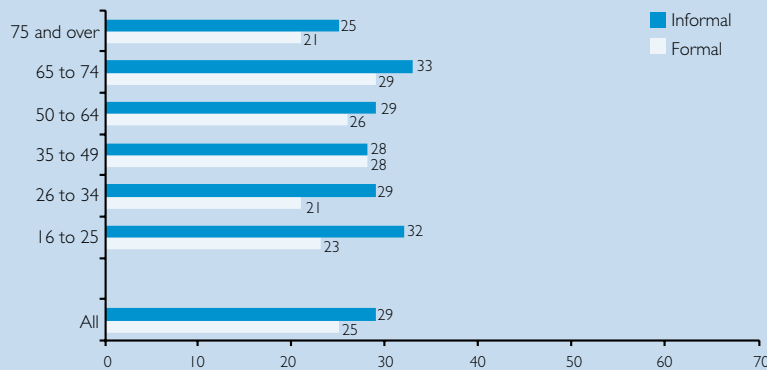
Yet as we have taken evidence about poorer communities, volunteering levels appear to fall. As the *Citizenship Survey* reveals, formal and informal volunteering is higher in the higher socio-economic groups. Those in routine occupations, who are unemployed or have never worked are far less likely to take part in formal volunteering, and informal volunteering, than those

336 Department for Communities and Local Government, *Citizenship Survey: 2009-10*, London: Department for Communities and Local Government, 2009, p9

337 Ibid., pp9-10

338 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, p6

Figure 28 – Percentage of people engaged in formal and informal volunteering each month, by age group³³⁹



in higher and lower managerial positions and professions.³⁴⁰ There is also a link between volunteering levels and qualifications: those with high levels of attainment are more likely to participate than those with low level or no qualifications.³⁴¹ Unsurprisingly the bi-annual survey also reveals that those living in or vulnerable to social exclusion are less likely to participate in volunteering than those who are not.³⁴² This analysis concurs with the experiences of Working Group members.

Added to this, our polling of older people living in social housing revealed that 81 per cent of respondents engage in no regular volunteering at all. 44 per cent cited health reasons as a reason why they don't volunteer, but a fifth said they weren't interested. However, many were involved in carer roles and some continued in paid employment.

The Benefits and Barriers of Volunteering for Older People

'Increasing volunteer hours among the over 65s by 10 per cent is estimated as being worth over £500 million.'

Building a society for all ages, 2009³⁴³

Volunteering in later life is beneficial in many different respects. It is highly positive for society: through voluntary action countless organisations and individuals are changing lives and tackling poverty, isolation and social breakdown. Older people who participate in volunteering are also clear

339 Ibid., p11

340 Department for Communities and Local Government, *Citizenship Survey: 2008-09*, London: Department for Communities and Local Government, 2009, p15

341 Ibid., p16

342 Ibid.

343 HM Government, *Building a society for all ages*, London: The Stationery Office, 2009, p46

benefactors: research has found it is linked to improved mental and physical health, and wider social networks.³⁴⁴ As well as societal and individual gains there are clear economic advantages in harnessing a strong national volunteer base. Yet despite the benefits of volunteering in later life, a number of barriers to increased participation must be recognised and tackled. We highlight four key issues here.

First, we have heard the concerns of those who have submitted evidence about a regular lack of confidence amongst groups of socially excluded older people. Members have heard about the tendency of many to assume volunteering is for so-called ‘good people with lots of skills and not me’. The most effective projects we have encountered tackle those problems by empowering people to use their existing skills in a highly informal manner, without selling it as ‘volunteering’.

Second, many older people – particularly the so-called ‘harder to reach’ – are often unaware of local volunteering opportunities. This is especially true where information about potential involvement is mainly online, or in community venues where many socially excluded people do not venture.

The third barrier brought to our attention is access-related. As highlighted by the evaluation of the VITA initiative, a lack of access to safe transport and money can exclude some in our poorest areas and most socially excluded groups:

*‘Not surprisingly many people talked about the importance of being able to travel safely to the volunteering experience. Very few talked about wanting to claim their expenses and wanted the organisation to benefit from them not claiming. However, cash expenses given on the day would mean that more people can access the volunteering roles. Many older people, at risk of isolation, are the very people that are less likely to be able to afford safe travel.’*³⁴⁵

Given these concerns we have been encouraged to note several projects that have decided to pay expenses to volunteers in advance, where this would remove obstacles to participating.

The fourth core barrier presented to members of the review has been a cultural one, usually rearing its head in the form of bureaucracy, insurance and risk averseness. As Volunteering England’s 2010 Manifesto made clear, approximately half of the people who would like to volunteer are put off by the bureaucracy.³⁴⁶ Whilst the CRB process receives justifiable criticism for its slowness, complexity and overly cautious culture – one member of the review

344 See for example ‘Volunteering in later life: is it good for your health?’ *Voluntary Action: The Journal of the Institute for Volunteering Research*, Volume: 8 Number: 2, Institute for Volunteering Research, 2006

345 Volunteering in the Third Age, *Volunteering in the Third Age: Final Report*, London: Volunteering in the Third Age, 2007, p13

346 Volunteering England, *The Power of Volunteering: A Manifesto from Volunteering England*, London: Volunteering England, 2010

has had four checks in four years for example – we have also heard about the considerable impact of its reputation on those who want to volunteer. We received the following submission which seems to typify this point:

Michael, 71, is keen to volunteer with his local befriending service and hears about the nature and purpose of the CRB application process. He is immediately full of worry about his one-off conviction for minor theft from a local shop as a younger man. He fears for his local friendships and reputation, as well as letting others down who may find out in the process. He decides not to pursue his application even though he is reassured by his local group that the conviction will not prevent him helping as a befriender on the scheme.

The CRB process performs an important function. However, in view of the continuing concerns we have noted about it, as well as its disproportionate impact on older people such as the case highlighted, we welcome the Home Secretary's recent announcement that the Independent Safeguarding Authority's vetting and barring scheme is to be reviewed.

We also note the reported ongoing tendency of insurance companies to impose restrictive upper age limits on volunteers. Whilst these age limits may be necessary for the insurance companies in a business sense, it can further fuel a culture that dismisses older people on the grounds of their age, rather than allowing them to maximise their capabilities.

Thankfully, we have encountered charities working around such constraints and engaging older people in innovative volunteering. One such model, which should guide future volunteering strategy, is noted below.

The Retired and Senior Volunteers Programme (RSVP)

The Retired and Senior Volunteers Programme, part of the national charity CSV, promotes and supports older people to volunteer in their local communities. In RSVP the volunteers are active people in the community responding to local needs, and developing as well as managing projects. Some older people's charities see older people as beneficiaries of services, but RSVP prides itself on enabling them as deliverers, managers and innovators of projects. RSVP is volunteer led and managed, helping to give every older person the opportunity of getting involved.

RSVP's work includes volunteering in schools to help children with their reading; running befriending schemes; or volunteering in the local community to provide transport for people to medical appointments, knitting groups or healthy activity groups.

Case study: Alan

Alan is 81 years old and volunteers as a car driver for RSVP. Alan says he volunteers for two main reasons. First because, as he says 'Life's been good to me and I wanted to put something back.' Secondly Alan is also very concerned about the potential problems of ageing, such as mental decline, and views volunteering as a way of combating this:

'In order to pick people up and get them to the surgery or hospital in time for their appointments, I need to give myself an exact programme and structure the day. I'm glad about that because I'm helping them and helping myself. It makes my day worthwhile and keeps me away from daytime TV.'

Case study: Rose

Rose is 93 years old and volunteers in her local primary school:

'I relate my wartime stories, and in turn, the children teach me how to use the internet and tell their own stories to me. I really enjoy the interaction with the children, and they love learning from an older generation. It is such a pleasure to see children's faces glow with delight and satisfaction when they hear stories and ask questions about the past. I can hardly wait for Wednesdays to come around and I see them again. For me volunteering is fun, and it certainly keeps me young.'

By encouraging older people to play an active role in their communities, RSVP helps older people overcome isolation and social exclusion as well as look after their peers, and other older people.

3.2.3 DIGITAL EXCLUSION

"Why should I bother with the internet? Even if I did try, it would be too complicated and open me up to problems."

A pensioner in evidence to the CSJ

A National Challenge

Another recurring theme highlighted during our review was digital exclusion. In the last two decades communication and interaction has changed fundamentally, both in how personal relationships are managed and how information or advice is accessed. Logging on to check emails, social networking accounts or websites is something the majority of people now take for granted, but for those who left the work place before such practice was commonplace, or who simply don't have access to such technology because of income or location, this can be entirely alien.

Whilst the debate about digital exclusion and its prevalence encompasses a range of technologies, including access to mobile telephones, digital television and other assistive technologies, the main focus of our review will be the internet. In the main this has been led by the fact that the internet is fast moving from a beneficial accessory to an essential tool.

Although digital exclusion is a pressing issue for broad social policy development – it is estimated that 17 million people in the UK still do not use computers or the internet³⁴⁷ – it is a particular challenge for older people. Unsurprisingly digital exclusion, particularly the inaccessibility of the internet, becomes more prevalent as individuals age: more than half of those without

³⁴⁷ HM Government, *Delivering Digital Inclusion: an action plan for consultation*, London: HM Government, 2008, p9

internet access are above the age of 65 and almost 60 per cent are retired. According to the latest internet access statistics less than 40 per cent of people over the age of 65 have ever used the internet. In broader terms, more than half of those without internet are single, widowed, separated and almost 60 per cent are female.³⁴⁸ Furthermore, we know that 10 per cent of people aged between 60 and 69 have access to the internet but don't use it.³⁴⁹

Digital Exclusion and Social Deprivation

There is a clear link between digital exclusion and social deprivation. Of those without internet access approximately half (49 per cent) are within the official DE socio-economic group. According to the same research, those who were over 65 and of the DE social grade accounted for just under a third (28 per cent) of all people excluded³⁵⁰ – a figure likely to rise as more people over 65s from higher socio-economic groups get online. Added to this, a recent study found that 15 per cent of the entire population – more than six million adults – live in both social exclusion and digital exclusion.³⁵¹ This analysis concurs with our evidence gathering visits to a number of deprived communities, and to projects working within them.

“I would find it really useful to order my food shopping from home, but I wouldn't know where to start.”

A pensioner in evidence to the CSJ

The Impact of Digital Inclusion

In chapter two we referenced the impact that digital exclusion can have on older people who would benefit from such things as information and access to discounted energy tariffs, as well as free financial advice. And there are clear broader advantages for older people who have access to such technology, as well as the ability and self-confidence to utilise it. As Independent Age and the Calouste Gulbenkian Foundation highlight in their joint report *Older people, technology and community*, there are several core benefits. For example, older people who are 'digitally included' can benefit from participation in meaningful work or other activities, they have increased (and often less expensive) opportunities to communicate with friends and family, and they are able to pursue interests in further learning and hobbies.³⁵² Our review has seen the benefits older people who are able to use online shopping facilities can experience – whether in ordering their weekly shop if that becomes difficult or in searching for sizeable internet discounts and deals. Whilst the internet

348 Department for Communities and Local Government, *Understanding Digital Exclusion*, London: Department for Communities and Local Government, October 2008, p26

349 Ofcom, *Digital Lifestyles: Adults aged 60 and over*, London: Ofcom, 2009, p6.

350 Department for Communities and Local Government, *Understanding Digital Exclusion*, London: Department for Communities and Local Government, October 2008, pp26-7

351 Digital Exclusion Team, *The Digital Inclusion Landscape in England: Delivering Social Impact through Information and Communications Technology*, London: Digital Inclusion Team, 2007, p5

352 Independent Age and the Calouste Gulbenkian Foundation, *Older people, technology and community*, London: Independent Age, 2010, p5

and email have their clear faults and risks, and whilst for some older people the weekly food shop is an important part of their routine and gets them out of the house, the Working Group is of the view that access to the internet and associated features more often prove life enhancing for the majority.

Barriers to Inclusion

In recognising that too many older people live in digital exclusion and in understanding its clear links to social exclusion, as well as in noting the benefits that many who access technology experience, it is also important to understand the main barriers to wider inclusion for poorer older people.

Four core hurdles have been identified by our evidence gathering process and members' discussions with older people. They are: a perceived prohibitive level of necessary investment and ongoing costs – many are surprised and deterred by the price tag of computers (even if they are lower than assumed) and the cost of ongoing connection contracts; a lack of self-confidence and skills – many older people in poorer areas have little experience of computers or confidence to use them, which can be a significant barrier to their potential benefits; a lack of awareness about the benefits of the internet – according to research and some of our anecdotal work many older people are unaware or even disinterested in the changes the internet and email can bring; and the complexity of arrangements and process – purchasing a computer and setting up an internet connection with a provider can be extremely daunting and expensive without help from family or friends. For example we met a pensioner living in a rural area, who already had basic internet access, who encountered tremendous difficulty in attempting to improve the service and switch to a better deal:

'Following a promotional leaflet from another service provider I wanted to upgrade my internet to a quicker speed. You would not believe the hassle I had to go through in trying to do this. After weeks of phone calls, misleading commitments, sections of small print and line tests, I managed to secure a better deal. But I regularly questioned whether it was worth it all.'

A pensioner, in evidence to the CSJ

There are a range of initiatives targeting older people in digital exclusion – ranging from Race Online 2012 strategy and Silver Surfers Day to the promotion of local libraries as facilities for use. The Working Group is particularly interested in the appointment of Martha Lane Fox as the UK's Digital Champion and the new Government's stated commitment to boost digital inclusion. It will be vital to ensure that poorer older people remain at the heart of this work, and that it becomes integral to agreed efforts on tackling broader social exclusion. We will be looking for models of good practice, such

as the one below, in increasing internet access and tackling that aspect of digital exclusion.

Coffee and Computers, Leatherhead, Surrey

One member of the Working Group established an informal intergenerational Coffee and Computers project, in partnership with a local youth cafe and Age Concern, to target digital exclusion amongst older people in Leatherhead. In two pilot periods ten older people from the local social housing estate – many of whom had never used a computer – participated in six weekly sessions, led a volunteer computer tutor, and alongside a group of young student mentors from the local Sixth Form College who had been given permission to build it into their academic week.

Not only were many of the older people introduced to computers and guided steadily in the basics of word processing, email and internet shopping, but many also built new and positive relationships with the young people who had volunteered for the project. Several decided to save money to buy a computer and one did so immediately as a result of some money from family members supportive of the initiative. Crucially, several of the older people from the pilots were recruited as volunteers for future sessions and remain involved today.

‘Coffee and computers has played an important part in our community by breaking down barriers between young and old. Young people supporting and training older generations has led to an even greater impact on relationships and removed some unhelpful perceptions. Sharing a community space associated with young people has also helped to build bridges.’

Andy Gill, Community Projects Manager, Leatherhead Youth Project

CHAPTER FOUR

Housing

Chapter Findings: Summary

- Poor housing conditions can have a significant impact on health and, as people become older, become even more crucial to overall physical and mental well-being.
- Official figures show that over a third of homes were classified non-decent in 2008 (7.4 million), with almost half of private rented housing being non-decent; almost a quarter of housing association property being non-decent; and showing that social sector houses were in a better overall condition to those in the private sector.
- Many older people want to remain in their own homes for as long as possible, but there are currently three quarters of a million people over 65 that need specially adapted accommodation.
- Older people have higher expectations of retirement housing than previous generations. Changing demographics mean a diverse range of care and support services is required from which older people can select according to their needs. The low-level support provided by retirement housing can help older people stay independent for longer and stave off the need for more expensive stays in hospitals or nursing homes.
- The total number of older homeless people is small in comparison to the general older population but they are among the poorest and most disadvantaged members of our society. Older homeless people often have multiple difficulties including severe mental health issues and substance abuse problems. There has been an increasing demand of services from older homeless people but specialist projects catering for this group have been closing.

As we have referenced throughout the report so far our ageing society presents a number of serious and urgent challenges. One such challenge is its impact on housing. We have also heard many argue that, despite a multiplicity of reports and strategies under the previous Government, as well as some resulting tangible improvements, there remains much to be done to offer the poorest older people a better housing reality, now and in the future. Five key policy areas have frequently dominated the debate. They are: low income homeowners; housing and neighbourhood design; adaptations and improvements; specialist housing; and homelessness. At the outset, however, we consider the context of the debate.

4.1 More Than a Roof

Where a person lives underpins their sense of place, identity and worth; a home is not just a roof, but a reflection of status and closely bound up with our sense of who they are. Therefore it is not surprising that loss of home

and loss of control over an individual's living situation is closely linked to psychological health and well being.

As an *Eskrigge Social Research* study concluded, housing is considered by older people to fundamentally determine whether they will be able to live well in later life.³⁵³ Home is where older people spend most of their time; people over 65 spend over 80 per cent of their time in their homes, and people over 85 spend 90 per cent.³⁵⁴ Someone's home has a crucial impact on every aspect of their health and well-being beyond the physical shelter housing provides. There is a wealth of research which finds that it is also the quality of an individual's housing environment that matters a great deal.³⁵⁵ Poor housing conditions – such as damp, coldness and mould – have obvious and serious effects on mental and physical health that only worsen as a person ages. Therefore, it is important to recognise that housing standards, as well as access to housing, matter. This chapter considers both points.

It is also imperative that we understand housing within the broader community context. As we have previously referenced, the CSJ has looked extensively at social breakdown and the causes of poverty in communities as well as the common prevalence of poor local services. It has undertaken detailed analysis of the social housing which tends to dominate areas of deprivation and reinforce dependence, rather than promote social mobility. The 2008 CSJ report *Housing Poverty* made a number of radical recommendations which if implemented, would instigate brave reform and reshape life for many living on these estates.³⁵⁶ The link between housing and these communities is particularly relevant to the Working Group given that a quarter of pensioners living below the traditional income poverty line live in rented social housing.³⁵⁷

4.2 A Housing Crisis

Many people are rightly concerned about the lack of affordable housing in the UK and its impact on those aiming to take their first step onto the 'housing ladder'. Demand for housing far exceeds supply and the shortfall between the two is ever-growing. As a result, owner-occupation is now an unattainable goal for many sections of the population. Added to this, many people seeking to buy a property have been severely stifled by the economic downturn, in the form of much-reduced mortgage lending and high interest rates for low deposit applicants.

353 Clough et al, *Homing in on housing*, Eskrigge Social Research, 2003

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

355 See for example the published work of the World Health Organisation, Europe, via: <http://www.euro.who.int/en/what-we-do/health-topics/environmental-health/Housing-and-health/publications>; Kreiger and Higgins, *Housing and Health: Time Again for Public Health Action*, Seattle: Public Health—Seattle & King County, 2002, published in *The American Journal of Public Health*, Vol 95, No.5, 2002; and Care and Repair, *Healthy Homes, Healthier Lives*, Nottingham: Care and Repair, 2002

356 Centre for Social Justice, *Housing Poverty*, London: Centre for Social Justice, 2008

357 Department for Work and Pensions, *Households Below Average Income: An Analysis of the Income Distribution 1994/95 – 2008/09*, London: Department for Work and Pensions, 2010, p168

As well as these points, there are specific concerns about the nature and provision of housing for older people, particularly for many who are living on a low income or in deprived neighbourhoods. This chapter will consider these points.

4.3 The Ageing Society

As we have referenced throughout this report our society is ageing rapidly, which has significant implications for national housing policy.

Demographic projections about trends in society's population growth reveal the nature of the specific future housing challenge. According to the previous Government half of the predicted housing growth by 2026 will be driven by households headed by people 65 years old and higher, and there will be a further 2.4 million older households in England.³⁵⁸ Added to this the 75 and over age group is growing at a faster rate than younger age groups and it is expected that the number of older disabled people will double by 2041.³⁵⁹ It is widely understood that housing policy, like any other area, must recognise and respond to these trends.



Amy Swan from the National Housing Federation providing evidence about older people's housing

4.4 The Present Situation

The annual *English Housing Survey 2008-09* outlines the national breakdown of housing tenure as below. The overwhelming majority of people are owner-occupiers, with most paying a mortgage.

Figure 29 – Breakdown of tenure (England), 2008-09 (approximated millions)³⁶⁰

Year	Own outright	Buying with mortgage	All owner occupiers	Social renters	Private renters	All household
2008-09	6.8	7.9	14.6	3.8	3.1	21.5

358 Department for Communities and Local Government, *Lifetime Homes, Lifetime Neighbourhoods*, London: Department for Communities and Local Government, 2008, p20

359 Ibid.

360 Department for Communities and Local Government, *English Housing Survey Headline Report 2008-09*, London: Department for Communities and Local Government, 2010, p10

When broken down by age we find a very similar proportion split between owner-occupiers and renters.³⁶¹ And for older people living below the 60 per cent income poverty line, as we have referenced in chapter one, approximately two thirds are home owners.³⁶² These figures are broadly reflective of the 2001 census survey which found that between 60 per cent and 70 per cent of older people own their own homes.³⁶³

Within the older age groups and categories it is also interesting to note the diversity of housing provision. 95 per cent of the 419,000 people in care homes in England and Wales are older people;³⁶⁴ and approximately 718,000 people live in sheltered and retirement housing.³⁶⁵

4.5 Low Income Homeowners

The rise in people's life expectancy has coincided with a social revolution in tenure. This has come about through such phenomena as 'Right to Buy' and unprecedented access to mortgages for lower income groups, which has resulted in a massive shift into owner occupation by lower income groups. As low income home owners can expect between 20 and 30 years living on limited means, the affordability of home maintenance is a real issue for many older people.

One of the complicating factors when looking at older people's housing is the massive inequity in the spread of property values. A London-centric view has contributed to a stock response of 'equity release' as the solution to a range of issues. However, analysis based on average property values has limited use when the division between London or the South East and the rest of the country is so dramatic, and differences even within one geographic area can also be very great. A 'Right to Buy' flat's value on an ex council estate in Burnley is a world apart from a semi detached house in a desirable part of rural Lancashire.

We have also heard of a sense of inequity amongst lower income householders who find themselves living in worse housing conditions than their neighbours who rent. Although they might be on the same or lower incomes, they receive no state subsidy for their housing costs whereas if they had remained social tenants they would be in receipt of housing benefit.

Given that two thirds of older people living on or below the poverty threshold either own their own homes outright or are paying a mortgage, the Working Group considered it important to investigate some of these relevant and related themes.

³⁶¹ Ibid., p16

³⁶² Department for Work and Pensions, *Households Below Average Income: An Analysis of the Income Distribution 1994/95 – 2008/09*, London: Department for Work and Pensions, 2010, p168

³⁶³ Office for National Statistics, *Focus on Older People*, London: Office for National Statistics, 2004, p5

³⁶⁴ Laing and Buisson, 'Occupied places in April 2009', *Care of Elderly People: UK Market Survey*, 2009, p3

³⁶⁵ EROSH, *Speaking up for social housing*, Chippenham: EROSH, 2009, p1

4.5.1 OUTSTANDING BALANCES AND LOW ASSET VALUE

We recognise that for some of the 800,000³⁶⁶ older people living below the income poverty line with a mortgage, there are significant difficulties and pressures in daily life. In its recent quarterly report on retirement *Aviva* found that of the 12 per cent of people aged between 65 and 74 years old who had a mortgage, the average balance was £51,000. For those aged 75 and over it was £31,000.³⁶⁷ For people of a pensionable age living on a low income a budget of this size can be overwhelming. We have heard that this is a reality for some people who took advantage of the sale of council housing in the 1980s.

Added to the problem of outstanding balances is the significant regional variation in asset values. These highlight that, even taking into account a regional variation in the basic cost of living, there is less capital to be realised in certain parts of the UK than others. This adds to the challenge for those willing to utilise capital but struggling to make it last, particularly those at the early stages of older age. The Aviva report presents a breakdown of these variations as the following table demonstrates.

Figure 30 – Selected house price variations (UK)³⁶⁸

Self-reported summary activity level	House Price
London	£366,797
East Midlands	£191,690
North East	£191,120
South East	£288,462
Yorkshire	£186,968

4.5.2 SELLING UP?

Perhaps the most common issue drawn to the attention of the Working Group in relation to low income home owners has been the debate about whether they should have to sell their house in order to release capital to pay for certain social care or income needs. The sensitivity, difficulty and complexity of this debate cannot be overstated.

366 Department for Work and Pensions, *Households Below Average Income: An Analysis of the Income Distribution 1994/95 – 2008/09*, London: Department for Work and Pensions, 2010, p165.

367 Aviva, *The Aviva Real Retirement Report – Issue Two*, London: Aviva, 2010, p15.

368 Aviva, *The Aviva Real Retirement Report – Issue Two*, London: Aviva, 2010, p14.

In its evidence gathering and discussions the Working Group has heard a passionate defence of people's right to keep their home, particularly in order eventually to pass on as much of its value as possible to loved ones. However, there are convincing challenges to this, largely based on the argument that an individual's largest asset should not be exempt when moving into residential care or applying for other state entitlements. This challenge has become ever more potent as fears for our immediate economic future have intensified. The fears of those unwilling to sell their homes are clearly real and understandable, but we cannot ignore the pragmatism of opposition to these standpoints.

The Working Group also recognises a common resentment, in specific relation to paying for residential care, that while the present system provides free care for the very neediest, it does not for those who have sought to save as much as possible. This, so it is felt, disincentivises saving and penalises people who have made efforts to plan for later life. Whilst the majority of older people do not currently require residential care, it is apparent in view of our ageing population, of the present and worsening failure to fund preventative services and of the projected increase in disability and long-term care needs, that policy-makers must confront these issues presently.

It is encouraging that the new Government has established an independent social care commission to wrestle with these difficult challenges, and make recommendations about how we structure and pay for social care to meet both immediate and long-term need. Members of the review hope all political parties and stakeholders will engage in sensible debate in working with and responding to the Commission. In addition to this the Working Group has dedicated chapter five of this report to social care.

4.5.3 EQUITY RELEASE

In looking at the situation of low income homeowners – especially those living below the poverty line – we acknowledge the potential role of equity release schemes in providing regular income or a lump sum amount to pay for a specific need. Clearly such schemes can offer a positive option to some older people keen to release capital from their home and improve their quality of life. However, during our exploration of the schemes we encountered some significant barriers which need to be overcome in order to improve the offer to the poorer older homeowners, as well as some general observations which are worth noting.

Barriers to Equity Release

Many older people face several considerable barriers in releasing equity from their homes, such as the reluctance of lenders to release credit to low income groups, and the fact that as interest rates rise so does the cost of equity release. Our findings fully corroborate with the three common barriers to equity release which have been highlighted by the Joseph Rowntree Foundation (JRF) in its ongoing development of the Home Cash Plan, outlined below.

There have been three core and consistent barriers to low income older people accessing reliable and wholly advantageous equity release. In its report

*Can equity release help older home-owners improve their quality of life?*³⁶⁹ the JRF is correct to reference these as:

- A reluctance to reduce the inheritance older people wish to pass on to family members;
- The complexity and risk of accessing their housing equity, particularly in terms of interest rates and the trustworthiness of market providers;
- Legitimate concern that releasing equity as regular income will jeopardise means-tested benefit entitlements and applications.³⁷⁰

Furthermore, as noted by the House of Commons Work and Pensions Select Committee,³⁷¹ it is also clear that equity release can limit a pensioner's ability to respond to new or progressing care needs should they seek sheltered housing, extra care facilities or wish to move to a lower maintenance property. And, in view of the considerable disparity in property values around the country, equity release as a model may be insufficient for those with lower property valuations.

There is, therefore, an important role for reliable independent and accessible financial advice for those who are considering equity release.

A New Model for Equity Release?

Notwithstanding these cautions the Working Group welcomes the innovative pilot project, *Home Cash Plan*, developed and led by the JRF.³⁷² The pilot was developed in close consultation with the DWP and is currently being delivered in partnership with local authorities and a provider in the three boroughs of Islington, Kensington and Chelsea, and Maidstone. Crucially, it appears to build on the three common barriers to accessing equity release, and is particularly helpful as it has been structured in such a way that means it will not affect the majority of applicants' entitlement to Pension Credit. The pilots are running over a twenty month period and the JRF will publish independent evaluations after July 2011.

4.6 Design and Suitability

4.6.1 LIFETIME HOMES

The Lifetime Homes, Lifetime Neighbourhoods concept is a design model for making homes more suitable and easily adaptable to the changing needs of the occupant over their course of their lifetime. The model developed included:³⁷³

369 Joseph Rowntree Foundation, *Can equity release help older home-owners improve their quality of life?*, York: Joseph Rowntree Foundation, 2010

370 Ibid., p4

371 House of Commons Work and Pensions Select Committee, *Tackling Pensioner Poverty*, London: The Stationery Office, 2009, pp72-3

372 Joseph Rowntree Foundation, *Can equity release help older home-owners improve their quality of life?* York: Joseph Rowntree Foundation, 2010.

373 Homes, *Revised Lifetime Homes Standard*, July 2010, accessed via: http://www.lifetimehomes.org.uk/data/files/For_Professionals/accessible_revisedlthstandard_final.pdf
<http://www.lifetimehomes.org.uk/pages/q1.html>

- Space to set up a bed on the entrance level so that someone temporarily unable to use stairs (e.g. after a hip-operation) can still remain in that home. This also entails that toilet facilities are accessible to the entrance.
- Space for convenient movement in hallways, rooms and through doorways.
- Potential for future provision of grab rails.

The Lifetime Homes concept has been widely embraced and is a major step forward in terms of preparing housing for a new demographic situation. In 2004, for example, the Mayor of London's *London Plan* included a vision for housing in the capital in the 21st century.³⁷⁴ Acknowledging 'the severe shortage of accessible housing in London', the *London Plan* recommended that:

- All new housing is built to Lifetime Homes standards since they provide the best way of providing homes that can adapt to a person's changing needs.
- Ten per cent of all new housing is designed to be wheelchair accessible.

Despite this, not all new homes are yet built to this standard and, of course, new homes only account for a tiny proportion of the overall housing stock. The DCLG *Lifetime Homes, Lifetime Neighbourhoods*³⁷⁵ report, published in February 2008, aimed to ensure that all public sector funded housing is

built to Lifetime Homes Standards from 2011. But while these levels will be mandatory for public sector housing, private developers – and just over 50,000 older people are private sector tenants³⁷⁶ – are free to choose which code level they wish to develop at. The report describes the Government stimulating 'change through public funding, benchmarking and incentives' and sets out what it can only describe as an 'aspiration' that all new homes will be built to Lifetime Homes Standards by 2013.³⁷⁷



Ann Stuart from Hammersmith and Fulham Council

4.6.2 HOUSING AND NEIGHBOURHOODS

As we have already noted, it is also crucial to consider housing for older people in the context of its relationship with the wider community. In chapter three we have highlighted the fact that there are crucial factors within commissioning that must be considered when exploring housing design, as the very title of *Lifetime Homes, Lifetime Neighbourhoods* stresses how interconnected housing

374 Mayor of London, *The London Plan: Spatial Development Strategy for Greater London, Consolidated with Alterations since 2004*, London: Greater London Authority, 2008, pp70-1.

375 Department for Communities and Local Government, *Lifetime Homes, Lifetime Neighbourhoods: A National Strategy for Housing in an Ageing Society*, London: Department for Communities and Local Government, 2008, p14

376 Department for Work and Pensions, *Households Below Average Income: An Analysis of the Income Distribution 1994/5 – 2008/9*, London: Department for Work and Pensions, 2010, p152.

377 Department for Communities and Local Government, *Lifetime Homes, Lifetime Neighbourhoods: A National Strategy for Housing in an Ageing Society*, London: Department for Communities and Government, 2008, p90.

is with the environment in which it exists. By designing neighbourhoods to include facilities such as benches and toilets, making sure that pavements are even and in a good state of repair, and insisting that there is good public transport and local facilities, older people can move around with increased confidence and remain socially and economically active.

Simple provision of services such as these can ensure that older people are at less risk of becoming socially isolated and means that they can contribute more fully to society, all the while also reducing the risk that they will require help from health and Social Services.

In September 2009 CAGE, the Government's advisor on architecture, urban design and public space, made a similar point in *Homes For Our Old Age*:

*'It is not just the homes themselves that are important to maintaining independence: a local environment with accessible shops and services is vital, too.'*³⁷⁸

The report, which examined a number of case studies, identified key lessons. Among them were that internal house design and layout needs to be flexible to accommodate changing care or support needs. It also stressed that:

*'Design for social care means future-proofing the buildings we already have so that a resident knows they can remain in their home as their needs change.'*³⁷⁹

Substantiating this, our Working Group regularly heard from older people about the importance of the design of a home and how it was fundamental to their quality of life.

4.6.3 DESIGN TO COMBAT LONELINESS

A common theme when consulting older people on housing is their desire to remain or become part of a community, whether within a development or a wider neighbourhood. As US expert on older people's housing Dr Bill Thomas told the authors of this report, more effort is needed from developers to design their properties to recognise and reduce loneliness. Also, as he is quoted as saying in *Inside Housing*:

*'There are people who are really good at housing but do not see loneliness as a problem. I bet it is not an everyday concern of people who design housing that people are lonely, but in the field of ageing it is an important problem.'*³⁸⁰

378 Commission for Architecture and the Built Environment, *Homes for our old age: Independent living by design*, London: Commission for Architecture and the Built Environment, 2009, p3

379 Ibid., p7

380 Accessed via: <http://www.insidehousing.co.uk/news/care-and-support/design-can-stop-loneliness/6510159.article>, 11th June 2010.

There are also concerns that a lack of engagement with older people and the wider community during the planning stage can result in buildings and environments that do not reflect older people's cultural needs and sensitivities, or that are divorced from the wider community. We have heard many worry that design and planning decisions must do more to include older people.

4.7 Maintenance, Improvement and Adaptation of the Existing Stock

4.7.1 DECENT HOMES STANDARD

Undoubtedly, the previous Government's decent homes standard has driven up standards in the social rented sector. This is to be welcomed. However, we have also heard that despite improvements in the social sector, very real concerns remain about the condition of a number of properties belonging to home owners and those rented in the private sector. This is relevant to our review given that just over two-thirds of older people below the income poverty line are in such housing.³⁸¹ Just less than three million older vulnerable households live in the private sector, half of which are privately owned.³⁸²

The Decent Homes Standard

The Decent Homes Standard (DHS) is a minimum standard to which social housing must be improved. It was launched in 2001 by the DCLG aiming to improve the condition of social rented housing.

The targets which were set by the DHS were for all social housing managed by local authorities and Registered Social Landlords (RSLs) to meet the DHS by 2010; and in 2002 a second target of increasing the proportion of vulnerable groups living in decent homes in the private sector to 70 per cent by 2010 was added, with the aim of a further increase to 75 per cent by 2020.

The DHS four criteria to be met are:

- A house meets the current statutory minimum standard for housing;
- It is in a reasonable state of repair;
- It has reasonably modern facilities and services;
- It provides a reasonable degree of thermal comfort.

In 2006 a new Housing Health and Safety Rating System (HHSRS) was introduced which replaced the previous 'Fitness Standard' and became the new statutory minimum standard referred to as part of Decent Homes.

381 Department for Work and Pensions, *Households Below Average Income: An Analysis of the Income Distribution 1994/95 – 2008/09*, London: Department for work and Pensions, 2010, p168

382 Department for Communities and Local Government, *Lifetime Homes, Lifetime Neighbourhoods: A National Strategy for Housing in an Ageing Society*, London: Department for Communities and Local Government, 2008, p32

Official figures show that over a third of homes were classified non-decent in 2008 (7.4 million), with almost half (44 per cent) of private rented housing being non-decent; almost a quarter of housing association property being non-decent (23 per cent); and showing that social sector houses were in a better overall condition to those in the private sector.³⁸³

4.7.2 DECENT ENOUGH?

However as this review has heard, the decent homes standard does not provide the full picture. For example many of the issues specifically relating to housing for those with age-related disabilities are not covered by the decent homes standard. Indeed, the factors determining whether housing meets the needs of an individual are, by their nature, dependent on that individual and can often be better addressed by targeted home improvement agency services (see section 4.7.5).

In January 2010 the National Audit Office published a report evaluating the Decent Homes Programme (DHP).³⁸⁴ It found that the DHP had improved the living standards of vulnerable households for over one million homes, and the percentage of non-decent homes had fallen to 14.5 per cent as at April 2009. It also found that the number of non-decent homes belonging to Registered Social Landlords (RSLs) had fallen from 21 per cent to six per cent, despite RSLs being under no statutory requirement to meet government targets.

However, the targets which were set for all social housing managed by local authorities and RSLs to be of a decent standard by 2010, and for increasing the proportion of vulnerable groups living in decent homes in the private sector to 70 per cent by 2010, will not be met. It found that as of April 2009 almost 86 per cent of social housing homes were decent which, although a reduction of 1.1 million non-decent homes, left approximately 305,000 homes in a non-decent condition and that the last of these homes would not be of a decent standard until 2018/19.

With regards to the target of 70 per cent of vulnerable people living in decent homes in the private sector, the report found that this had increased to 68 per cent, compared to 57 per cent in 2001. However, because of the introduction in 2002 of the HHSRS, which laid down more stringent criteria for a decent home to be achieved, the number of non-decent homes increased so that as of 2007 only 61 per cent of private sector homes were found to be of a decent standard.

383 Department for Communities and Local Government, *English housing Survey: Headline Report 2008-09*, London: Department for Communities and Local Government, 2010, p32

384 National Audit Office, *The Decent Homes Programme*, London: The Stationery Office, 2010

Although welcome progress had been made in reducing the number of non-decent homes, the NAO criticised the DCLG's oversight of the programme. Specifically criticised features were: the lack of preparation in determining the total cost of the DHP; lack of accurate monitoring of how many homes had been made decent and at what cost; a lack of good monitoring of good practice and cost-effectiveness of different approaches; a lack of monitoring of whether value for money was being achieved for funds provided to local bodies which carried out work; and not carrying out a review much earlier into whether value for money was being achieved.

In March 2010 the Committee of Public Accounts (CPA) also looked into the effectiveness of the DCLG and the Homes Community Agency (HCA) that oversees the DHP. In its report the CPA acknowledged that although they welcomed the improvements that had been made, with regards to the monitoring and accountability of the programme:

'Full accountability for public money is not optional and the Department needs to improve its financial control over this Programme. It is still not clear how much the Department itself has actually spent on the Programme and we are not convinced that the Department has secured best value from the funds given to Arms Length Management Organisations'.³⁸⁵

4.7.3 MAINTAINING HOMES

Many older people want to remain in their own homes for as long as possible, but often due to declining mobility and poor household design, day to day living can become increasingly difficult. Common struggles include climbing up and down stairs, using the bathroom, and getting in and out of bed. Figures published by the ONS show that men in the UK can expect to live their last 7.2 years with a disability, and for women the average is 9.4 years;³⁸⁶ with numbers of older disabled people expected to double from 2.3 million in 2002 to 4.6 million in 2041.³⁸⁷

As people's needs increase as they get older they will need more support, especially if their savings have dwindled and they are unable to afford adaptations to their home. Statistics show that there are currently three quarters of a million people over 65 that need specially adapted accommodation.³⁸⁸ So as people get older, their homes may have to be adapted to help them remain in a safe environment. Research has shown that:

³⁸⁵ House of Commons Committee of Public Accounts, *The Decent Homes Programme: Twenty-first Report of Session 2009-10*, London: The Stationery Office, 2010

³⁸⁶ Office for National Statistics, *Statistical Bulletin: Health expectancy at birth and at age 65 in the United Kingdom, 2005-2007*, London: Office for National Statistics, 2010, p2

³⁸⁷ Personal Social Services Research Unit, *Thirty-Five Years On: Future Demand for Long-Term Care in England*, London: Personal Social Services Research Unit, 2006, p3

³⁸⁸ Department for Communities and Local Government, *Housing in England 2006/07: A report based on the 2006/07 Survey of English Housing, carried out by the National Centre for Social Research*, London: Department for Communities and Local Government, 2008, p48.

- For people over 65 years old, approximately one in three (3.4 million) people will suffer a fall each year, costing the NHS an estimated £4.6 million a day, totalling up to £1.7 billion per year.³⁸⁹
- The most likely place for someone aged 75 years old and over to be injured as a result of an accident is in their own home.³⁹⁰
- The principal cause of injury leading to a hospital admission or death for people over 65 is a fall.³⁹¹
- Of those who suffer a hip fracture, half will never regain the mobility they had previously and 20 per cent of people will die within three months.³⁹²

Reducing the number of falls through certain household adaptations does not only make a huge difference to quality of life in the physical sense. People who have suffered a serious fall can also suffer increased anxiety, depression and a lack of confidence. They can experience social isolation, require a higher use of medication, and realise an increased dependence on health and Social Services and unpaid primary carers.³⁹³

And as we found in the Comprehensive Spending Review submission by the housing action charity, HACT 'Fit for Living' Network, older disabled homeowners face particular difficulties when trying to maintain their homes; and it is essential for their homes to be in a fit state in order to remain independent.³⁹⁴

The benefits of adaptations to reduce the risk of falls and accidents were stated in the report *Better Outcomes, Lower Costs*:

*'With the current demographic changes in society, any policy with the power to reduce the costs of health and social care for older and disabled people must be of interest to Government. If the policy produces improved quality of life outcomes it will be all the more welcome.'*³⁹⁵

389 Age UK, *Falls in the over 65s cost NHS £4.6 million a day*, 21 June 2010, accessed via: <http://www.ageuk.org.uk/latest-press/archive/falls-over-65s-cost-nhs/?paging=false>

390 Health Education Authority, *Physical Activity and the Prevention and Management of Falls and Accidents Among Older People: A Framework for Practice*, London: Health Education Authority, 1999, p1

391 Health Education Authority, *Physical Activity and the Prevention and Management of Falls and Accidents Among Older People: A Framework for Practice*, London: Health Education Authority, 1999, p6

392 Todd CJ, Freeman CJ, Camilleri-Ferrante C. Et al, 'Differences in mortality after fracture of hip: the East Anglian audit', *British Medical Journal*, 1999, 310:904, accessed via: http://www.bmj.com/content/310/6984/904.abstract?ijkey=7d50d316e62036ed3f7069825e34906e2b9324dc&keytype=tf_ipsecsha

393 Ibid., p10

394 HACT 'Fit For Living' Network, *Tackling poor housing for the most vulnerable, older homes owners: How this meets Government priorities: Addressing the Key Comprehensive Spending Review Question posed by HM Treasury*, HACT, 2010

395 School for Policy Studies University of Bristol, *Better outcomes, lower costs: Implications for health and social care budgets of investment in housing adaptations, improvements and equipment: a review of the evidence – Executive Summary*, Leeds: Corporate Document Services under licence from the Controller of Her Majesty's Stationary Office published for the Department for Work and Pensions, 2007, p2

4.7.4 SOURCES OF HELP

If lower income older home owners or tenants with disabilities require adaptations in their home, the two main sources of financial support are Community Equipment Services (CES) and the Disabled Facilities Grant (DFG).

Community Equipment Services (CES)

Local authority Social Services and NHS community trusts provide community equipment to help older, ill, and injured people to maintain independent living.

There are two types of community equipment: Simple Aids for Daily Living (SADL) is inexpensive, typically under £100, easy to use and requires little installation or explanation of how the product can be used to assist mobility at home, such as devices to help with bathing. Complex Aids for Daily Living (CADL) is a system that generally needs to be installed and is more expensive. It may also require carers to be trained in usage, for example hoists.

In June 2006 a programme called Transforming Community Equipment Services (TCES) was established and its aim was to develop a more effective gateway for people to access SADL through accredited local retailers, with the programme being implemented throughout the country.³⁹⁶

However, a report by the Centre for Economics and Business Research published in December 2009 had concerns about the TCES programme. Among its findings was that as SADL only accounts for 26 per cent of the total cost of community aids, it does not take into account the fact that SADL and CADL are often used in tandem, and so is not an integrated approach to delivery; the model could actually be more inefficient and lead to additional costs of £13.4 million; and the flat rate retail fee might not incentivise smaller retailers to stock community equipment.³⁹⁷

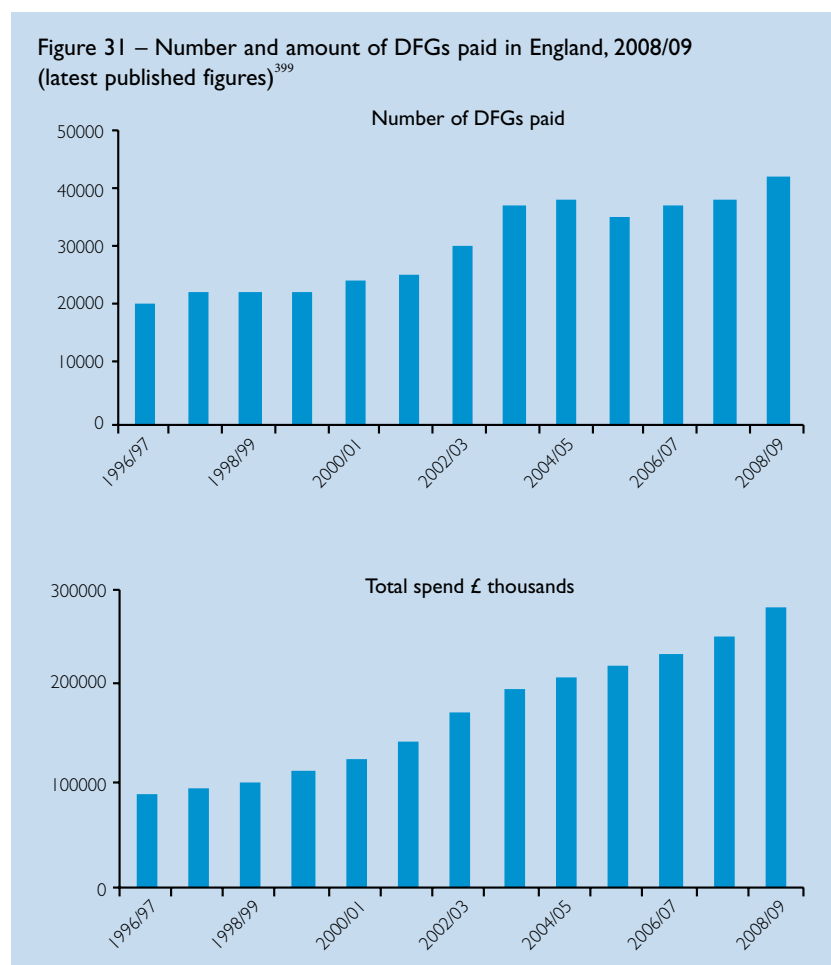
Disabled Facilities Grants

Introduced in 1990, A Disabled Facilities Grant (DFG) is a means-tested, mandatory grant administered by local housing authorities to provide adaptations in the homes of disabled people, with bathing adaptations one of the most common applications. We have heard they offer a lifeline to many older people. A local authority must carry out a nationally determined means-test to see whether the person is eligible for a DFG. The main beneficiaries of the DFG are older people; 70 per cent of grants are made to people over 60

396 The programme was sponsored and led by the Department of Health's Social Care, Local Government and Care Partnerships Directorate; operating as part of the Care Services Efficiency Delivery programme.

397 Centre for Economics and Business Research, *Transforming Community Equipment Services: A review of the financial and economic impact of the proposed community equipment services retail model*, London: Centre for Economics and Business research, 2009, pp4-5

years old,³⁹⁸ and are granted to people to help them make adaptations to their homes to a current limit of £30,000.



One of the changes to the DFG in recent years has been that local authorities up until 2008 had to match the funding that was provided by the DCLG for DFG on a 60 per cent to 40 per cent ratio, but changes mean that this is no longer a legal requirement. DCLG had expected Local Authorities (LAs) to continue to prioritise maintaining or increasing DFG funding in order to meet rising demand.⁴⁰⁰ Despite this expectation, Care and Repair England has noted that an increasing number of LAs are reducing their DFG budget in light of these changes.⁴⁰¹

³⁹⁸ Department for Communities and Local Government, *Disabled Facilities Grant Programme: The Government's proposals to improve programme delivery*, Wetherby: Department for Communities and Local Government, 2007, p10

³⁹⁹ Up until 2003-04, the amount includes mandatory and discretionary grants, from 2004-05 only mandatory grants are included. Department for Communities and Local Government, *Housing Strategy Statistical appendix: 1996/97 – 2007/08*, Table 314. Accessed via: <http://www.communities.gov.uk/documents/housing/xls/140930.xls>

⁴⁰⁰ Department for Communities and Local Government, *Disabled facilities Grant – The Package of Changes to Modernise the Programme*, Wetherby: Department for Communities and Local Government, 2008, p8

⁴⁰¹ Care and Repair, *Briefing of Disabled Facilities Grants Developments*, March 2010, accessed via: http://www.careandrepair-england.org.uk/pdf/dfg_brief_march_2010.pdf



Working group meeting with Joseph Oldman from Age UK giving evidence on some of the housing issues which older people face

Additionally from 2010/11 the ringfencing for the funding for DFGs might be removed and the funding pooled with other local authority programmes, pending the outcome of pilot schemes which are due to run until November 2010.⁴⁰² This is worrying as the number of older people experiencing a disability in later life is expected to increase as noted above.

4.7.5 HOME IMPROVEMENT AGENCIES

Home Improvement Agencies (HIAs) are not-for-profit services run primarily by housing associations, local authorities and charities to help older people who live in their own homes (particularly older home owners) to live there independently for as long as they choose. The services they provide are a combination of the practical, technical and advisory. HIAs can organise builders to carry out essential home repairs and adaptations and help older people to find assistance with paying for the work; install minor adaptations and undertake essential small jobs, or install security measures using their directly employed 'handy-people'; and provide information and advice about care, support and alternative housing options in order to help older people plan for the future. HIAs can be particularly helpful when older people are discharged from hospital so that they do not return to a cold, damp and unsafe environment. Medium and large scale adaptations will typically be funded by a DFG and may be for such items as bathroom adaptations, stairlifts and kitchen modifications, all of which help people to live more independent lives.

Traditionally HIAs have offered help with the full range of works on a person's home, from large scale adaptations to smaller maintenance tasks. The majority also operate handyperson schemes. Handyperson schemes aim to give older people basic assistance such as mending a leaking tap, putting up a grab rail, changing locks, or mending broken windows after a burglary. When in 2006 the Joseph Rowntree Foundation published *The Report of the Older People's Enquiry into 'That bit of help'*, which looked at services that provided help to older people, it showed that handyperson schemes were the most valued.⁴⁰³

In providing evidence to the Working Group, Foundations, the national body for HIAs, said that there is currently very high demand for HIA services. We also heard criticism from others that LAs operate long waiting lists and tend to ration such resources for adaptations and repairs to a damaging extent, thereby limiting the efficiency of operation of HIAs in their efforts to organise adaptations and repairs.

⁴⁰² Ibid., p11

⁴⁰³ Joseph Rowntree Foundation, *The Report of the Older People's Enquiry into 'That bit of help'*, York: York Publishing Services Limited, 2006, p75

In 2008, new funding of £33 million up to 2011 was allocated towards supporting the expansion and development of handyperson services, with every local housing authority in England being provided with funds. Additionally a further £1m was set aside for expanding housing options information and giving advice for older people through the national voluntary sector led FirstStop housing advice initiative.⁴⁰⁴

At the same time extra funding was allocated for DFG. Although the extra funding was welcomed it came with the removal of the obligation on local authorities to match the national funding, noted above. When Foundations carried out a survey⁴⁰⁵ of local authorities' provision of DFGs they found that:

- 71 per cent reported an increasing demand for DFGs among people over 65 years old.
- Nearly one in four had exhausted their DFG budget by October 2009 (that being halfway through their budget year), and almost one in three were significantly over-committed.
- Only 43 per cent had managed to stay within their budget for the year.
- Over 50 per cent had recorded an increase in the waiting times for DFGs.

Even though HIAs that provide services such as handyperson schemes are highly valued by older people, no single organisation is responsible for their ongoing funding as their benefits cut across social care, health and housing. The Working Group has concerns that these services are vulnerable to cuts or at risk of being diverted to other areas due to the current economic climate, particularly with the removal of the ring-fencing for Supporting People funding, an important source of both funding and co-ordinated commissioning of such services.

4.7.6 THE BENEFITS OF IMPROVING HOMES

It is widely acknowledged that promoting preventative strategies in people's homes through adaptations and repairs, lowers the longer term burden of costs for residential care and intensive home care. The Office for Disability Issues' report *Better outcomes, lower costs* found that, for example, by making adaptations to the home of a seriously disabled wheelchair user so that they could move back home from residential accommodation, it would provide direct savings within the first year, and that every year's delay of moving a person into residential accommodation would save on average £26,000 per year, less the average £6,000 cost of an adaptation.⁴⁰⁶

404 Department for Communities and Local Government, *Lifetime Homes, Lifetime Neighbourhoods: A National Strategy for Housing in an Ageing Society*, Wetherby: Department for Communities and Local Government Publications, 2008, page 12.

405 Foundations, *Adapting for a lifetime*, January 2010, Derbyshire: Foundations, pp16-17

406 School for Policy Studies University of Bristol, *Better outcomes, lower costs: Implications for health and social care budgets of investment in housing adaptations, improvements and equipment: a review of the evidence*, Leeds: Corporate Document Services under licence from the Controller of Her Majesty's Stationery Office published for the Department for Work and Pensions, 2007, p10

The same report also found that as 83 per cent of people waiting for adaptations have no home care requirement, not only would providing an adaptation reduce accidents, defer admission to residential care and improve quality of life, it could also reduce or prevent the cost of a home care requirement, which currently costs £5,000 per year for one hour of home care a day.⁴⁰⁷

Further evidence of the efficacy of preventative strategies is provided by the Audit Commission report *Fully Equipped*.⁴⁰⁸ In the report, it was stated that although a low importance is attached to community equipment, where research has been carried out into its clinical effectiveness it found that it provides good outcomes and reduced costs. It further stated that:

*'If a drug was discovered with a similar cost-profile, it would be hailed as the wonder-drug of the age.'*⁴⁰⁹

4.7.7 HELP BEFORE IT'S TOO LATE

Although adaptations and improvements provide an invaluable service to many older people, a criticism of the current system is that it is too bureaucratic and complex. This has a major effect on the efficacy of the delivery of services, being a crucial factor of service provision for older and vulnerable people due to the possibility of deterioration, or even greater danger.

This was highlighted by the aforementioned report, *Better outcomes, lower costs*, which identified a local authority which had spent £89,000 in one year on adaptations in the home for people who died before they could take full advantage of them. Furthermore in its report *Time to Adapt*,⁴¹⁰ Care & Repair stated that with regards to the delays some older people face waiting for services:

'The result is human misery. Older people are facing the undignified situation of living, sleeping and eating in a single room with a commode in the corner, being washed down standing in a child's paddling pool in their kitchen or crawling up the stairs on their hands and knees. Professionals who want to support disabled people find themselves debating whether a person has a social or a medical need to bathe (able to offer help with the latter but not the former) in the face of inadequate budgets and rationing of provision.'

407 Ibid. p11

408 Audit Commission, *Fully Equipped: the provision of equipment to older of disabled people by the NHS and Social Services in England and Wales*, London: Audit Commission, 2000

409 Ibid., p64

410 Adams, S. & Ellison, M, *Time to Adapt: Home adaptations for older people: The increase in need and future of state provision*, Nottingham: Care & Repair, 2009, p6

Even the Department of Health has admitted that the current service:⁴¹¹

- Struggles to meet the needs of the population who would benefit from equipment.
- Does not meet the needs of the whole population.
- Will not meet the needs of increased demographics.
- Is at risk where local budgets are under pressure.
- May not promote independence, choice and control for all.

4.7.8 SUPPORT IN THE CURRENT ECONOMIC CLIMATE

By helping to keep older people living comfortably in their own homes, the Supporting People programme provides most of the funding that HIA's use to help reduce the amount of care older people need from health and Social Services.⁴¹²

In its report *Research into the financial benefits of the Supporting People Programme*, DCLG found the overall net benefit of the programme was £2.77 billion, and that the removal of Supporting People services would lead to increased health care costs, tenancy failure and homelessness, and increased crime and residential care packages.

It is clearly essential that these services are well supported and continue to be provided to older people who need them. As the Audit Commission stated in its report *Fully Equipped*:⁴¹³

'Equipment for older or disabled people provides the gateway to their independence, dignity and self-esteem... It is no exaggeration to say that these services have the potential to make or break the quality of life of many older or disabled people, and of the 1.7 million people who provide informal care for more than 20 hours per week.'

In the current economic climate with expected expenditure cuts looming, the Working Group shares the concerns of others that this vital funding will be vulnerable to diversion away from preventative service support, and be concentrated towards people with higher needs. More still, there is a real risk it will simply disappear into other budgets administered by local authorities.

4.8 Specialist Housing for Older Age

Another important housing option for older people is sheltered and specialist retirement housing. During our evidence gathering it became apparent that we needed to look at some of the specific issues in this sector. Although the vast

411 Department of Health, *Transforming Community Equipment Services – Community Equipment provides a gateway to independence for millions of people*, accessed via: <http://www.dhcarenetworks.org.uk/csed/TransformingCommunityEquipmentService/>, updated 23/06/10

412 Wilson W, *Disabled facilities grants (DFGs) – Standard Note: SN/SP/3011*, London: House of Commons Library, 2010, p8

413 Audit Commission, *Fully Equipped: the provision of equipment to older or disabled people by the NHS and Social Services in England and Wales*, London: Audit Commission, 2000, p6

majority of older people live in mainstream housing, and can continue to live independently with home care or adaptations made to their property, a small percentage live independently in sheltered and retirement housing.



Residents of Barkingside sheltered housing

4.8.1 WHAT IS SHELTERED AND RETIREMENT HOUSING?

Throughout our evidence gathering the Working Group noted that the public perception of retirement housing was almost overwhelmingly negative; although notably this is not the view of older people who are themselves living in retirement housing. In this regard we have heard the calls for this to be challenged and consider that older people should be provided with informed choice of the different models of housing available.

Sheltered and retirement housing is designed for older people who prefer, and are able, to live independently. There are usually communal facilities such as a lounge for activities, a garden, laundry and guest room. An important benefit of sheltered and retirement housing is that each resident has their own front door, which gives older people the choice of whether to enjoy the company of communal life or maintain their privacy as they wish.

The principal differences between sheltered and retirement housing is that retirement housing is usually owner-occupied. As the property is purchased, this type of housing is usually occupied by older people with a reasonable to high level of equity and income.

If an older person has a low level of equity and income then they will typically access sheltered housing which is usually rented from housing associations or local authorities. Although historically this type of housing had access to an onsite manager, far fewer now have this service as the national trend has been towards floating support.

For the purposes of this chapter the term 'retirement housing' shall include both sheltered housing and owner occupied retirement housing.

During the 1970s and 1980s large numbers of social retirement housing schemes were built with small bedsit flats. Although still popular in some sought-after areas (such as city-centres), bedsit flats are proving increasingly difficult for social landlords to let. High levels of empty flats make bedsit schemes unviable financially and landlords must consider remodelling or disposing of the buildings, however, remodelling reduces the number of flats in a scheme and can therefore reduce the landlord's income, making the property even less viable to run.

It is widely recognised that older people have higher expectations of retirement housing than previous generations, a fact which we might attribute to their belonging to the 'baby boomer' generation. Older people usually seek accommodation with a separate bedroom and will favour properties with two bedrooms. Most providers of retirement housing are now building only two-bedroom housing but there is still a large stock of less popular bedsits and one bed flats which will (in most locations) continue to prove unpopular.

Most retirement housing has traditionally provided a standard package of low level support to all residents, however, changing demographics mean this no longer meets the diverse needs of older people today and so a range of care and support services is required from which older people can select according to their needs. However, just because older people have different needs does not mean that the core services, such as onsite managers, should be removed as for many older people it is the sense of security which attracts them to retirement housing to begin with.

4.8.2 RETIREMENT HOUSING VERSUS REMAINING AT HOME

We have heard how the reasons for moving into retirement housing vary from person to person. In a YouGov poll for the CSJ, 33 per cent of older people in retirement housing said they had moved there because of deteriorating health; 15 per cent had moved for reassurance and security; 14 per cent because of a desire to downsize; and 24 per cent for different unspecified reasons.⁴¹⁴

There are significant issues to address in retirement and extra-care housing. Changing demographics and the increasing care needs of an ageing population mean that, as Age UK outlined in its report *Agenda for Later Life*⁴¹⁵, there are uncertainties over how funding will be provided in the future, over poor housing design, and over services being diverted to people living in their own homes. Action needs to be taken to develop a strategy which ensures specialist housing is not overlooked.⁴¹⁶

An extremely useful contribution to the discussion about why older people choose to remain in their own homes, even if those properties may not meet existing needs, was contained within a report commissioned by the DCLG, by the Housing our Ageing Population Panel for Innovation (HAPPI),⁴¹⁷ which presented a dilemma for housing policy.

HAPPI gathered good practice to develop proposals to ensure that future housing for older people was not only sustainable and inclusive, but affordable too.

The HAPPI report concluded that there is little choice available for those wishing to move because of the assumption that:

‘...as we age we will wish to stay put in family homes acquired over a lifetime – often houses with gardens – even though the priorities that led us to choose these homes no longer apply’.

414 YouGov, *Attitudes of People over Retirement Age*, June 2010

415 Age UK, *Agenda for Later Life 2010*, London: Age UK, 2010

416 Ibid., p65

417 Homes and Communities Agency, *HAPPI: Housing our Ageing Population Panel for Innovation*, London: Department for Communities and Local Government, 2008

However, it went on to stress that:

‘...a housing ‘offer’ tuned to the priorities of older age can have real appeal, tempting ‘empty nesters’, and those prepared to plan for future care needs, to trade in homes that have often become a burden for something new.’

The panel focused on how the quality of life of our ageing population could be improved by influencing the availability and choice of high quality, sustainable homes and neighbourhoods; how public perceptions of mainstream and specialised housing for older people could be challenged; how the aspirations of older people could be raised so that they demanded higher quality and more sustainable homes; and how to spread the awareness of innovative housing and neighbourhoods for older people.

Among the ten key design elements of the space of the home that HAPPI identified were:

- Balconies and outdoor space;
- Adaptability and ‘care ready’ design;
- Shared facilities and ‘hubs’;
- Plants, trees, and the natural environment;
- Energy efficiency and sustainable design;
- External shared surfaces and ‘home zones’.

4.8.3 THE BENEFITS OF RETIREMENT HOUSING

We have heard how the low-level support provided by retirement housing can help older people stay independent for longer and stave off the need for more expensive stays in hospitals or nursing homes. In addition, a move into retirement housing frees up the stock of larger homes for families who may need them.

Dedicated On-Site Support

Most retirement housing offers low-level support through a scheme manager or warden, although some providers of retirement housing have recently moved from scheme managers to ‘floating’ or visiting models, which has proved unpopular with many customers. The concept of a dedicated scheme manager within a retirement housing development is greatly valued by older people.

In a survey by Sheltered Housing UK, almost all the residents they surveyed thought a scheme manager or warden was necessary.⁴¹⁸ And research by housing provider Anchor Trust supports this view – with more than three-quarters of Anchor tenants saying the scheme manager service was among the top reasons for living in sheltered housing.⁴¹⁹

418 Sheltered Housing UK, accessed via: <http://www.insidehousing.co.uk/news/care-and-support/sheltered-residents-%E2%80%98bring-wardens-back%E2%80%99/6508395.article>

419 Anchor Trust, unpublished research.

As well as reassurance and a security benefit, scheme managers or wardens can play a crucial role in creating and maintaining links with the wider community (since a downside of this type of housing can be its insularity). They can also facilitate activities which enable older people to remain active.

Recent moves by some providers towards floating support, rather than dedicated resident on-site support, undermine this and have prompted a great deal of local opposition. This has prompted Deputy Prime Minister Nick Clegg to say that local authorities and housing associations considering removing scheme managers should ballot tenants on the plan.⁴²⁰

This is a critical issue when older people are considering moving into retirement housing. One of the main reasons for doing so is the knowledge that there is a warden on site should they need any assistance. Understandably, therefore, the move towards floating support has angered many people as when they moved into sheltered housing they expected that the service would continue to be provided.

So although warden services are highly valued by residents, their removal and replacement with floating wardens is expected to increase unless there are major funding changes to help pay for this service. No such changes are anticipated at present.

Support Networks

We have heard how retirement housing can also help to generate support networks, both among older people, and others living nearby. An active scheme manager can encourage the involvement of outside groups providing local support that families may not always be able to. Often, as the model below shows, these networks span the generations.

The value older people feel in being part of a close, supportive community – particularly across the age spectrum – is also reflected in results from the YouGov survey for the CSJ cited above, in which 77 per cent of older people in retirement housing said they could rely on their neighbours in case of emergency.⁴²¹

A Safe Environment

All retirement housing is designed to offer good quality, safe and secure accommodation. The physical security offered by retirement housing can also directly address the fear of crime often experienced by older people. As we noted in chapter two, according to the British Crime Survey, people aged 65 years old and over are more likely than any other age group in society to feel there has been an increase in national crime;⁴²² 40 per cent of older people surveyed in socially deprived areas had been the victim of one or more type of

420 In an interview with www.insidehousing.co.uk, accessed via: <http://www.insidehousing.co.uk/ihstory.aspx?storycode=6509531>

421 YouGov, *Attitudes of People over Retirement Age*, June 2010

422 Ibid., p123

Chirton Lodge

Chirton Lodge is a retirement housing complex in North Shields, Tyne and Wear, which houses 44 tenants aged between 65 and 93, and has created a thriving community both within the scheme and externally, including developing a partnership with a local young people's group, the Phoenix Detached Youth Project.

'Our partnership with the Phoenix Project seeks to establish intergenerational relationships between the older people who live at the scheme and disadvantaged local young people. I feel many of the youths and staff from the Phoenix Project now know myself and the tenants well enough to count us as their friends.'

Christine Walker, scheme manager of Chirton Lodge

One tenant and participant in the partnership, 75-year-old Ella Hannant, commented:

'When you get to know the young people you realise they're good kids. We have a laugh with them; on one outing we went for fish and chips, then they showed us how to play crazy golf. We also share a minibus, which has been so beneficial for all of us. It's a great project.'

Both Christine and Ella have won the Chairman of North Tyneside Commendation Award for their work in the community, and the scheme's work with the Phoenix Project earned them a nomination in last year's Tenant Participation and Advisory Service Awards. As Christine puts it:

'Even if I can just encourage a small group to talk and get together once or twice a week in the scheme, their outlook on life changes and they open up to the wider community. If an older person is made to feel needed and useful it can make a huge difference to their life.'

Youth Worker with the Phoenix Project Becky Rowe said:

'As a project we were keen to get involved with the tenants from Chirton Lodge to address young people's anti social behaviour. When the partnership got going anti-social behaviour around the scheme completely stopped. Both the young and older people learned a lot from spending time together, shattering misconceptions on both sides.'

One of the young people involved is Amie, 16, who is currently studying for her GCSEs and is planning on a career in hairdressing. She said:

'The older people really surprised us – sometimes they're a worse influence on us than we are on them! Having the project is brilliant – it gets young people off the streets and gives us something positive to do.'

crime in the two years prior to the review; approximately two-fifths of older people worried about crime in their homes and on the streets; and only seven per cent said they would feel very safe out alone after dark.⁴²³

We recognise that having secure door entry systems and scheme managers or wardens provides tangible reassurance to older people that help them

⁴²³ Scharf et al, *Growing older in socially deprived areas: social exclusion in later life*, London: Help the Aged, 2002, pp46-63.

continue to lead independent lives. In addition, most retirement housing will offer an emergency alarm system (operated through a pull cord or pendant) in the resident's flat which is usually linked to a communications centre and can contact family members, an emergency service or a doctor if required.

Repairs and Maintenance

Repairs and maintenance are managed by the provider, offering the older people peace of mind. In addition, good retirement housing can underpin reablement services designed to help older people regain the skills and confidence they need to live independently after an illness or accident. These services are usually short term (typically six weeks) and help older people relearn how to, for instance, wash and dress themselves, so that they require less care delivered into their home. The design of retirement housing, and the low-level support provided by a scheme manager, contribute to the effectiveness of this approach.

4.8.4 EXTRA CARE HOUSING

The Working Group recognises that the provision of extra care housing can help older people to live independent lives, as well as support people with increasing care needs. We briefly explore extra care housing in section 5.4.1.

4.8.5 SUPPORTING PEOPLE IN RETIREMENT HOUSING

The provision of good quality retirement housing and support for the least advantaged older people is dependent on government funding for housing benefit and the Supporting People programme. Spending on housing benefit, which has risen from £14 billion to £21 billion over the last ten years, is being cut by £1.8 billion a year until the end of the current parliament.

The Supporting People Programme provides funding for around 815,000 older people with support needs and is administered by local authorities, with many using Supporting People funding to pay for scheme manager and alarm call services in sheltered housing.

A report by the DCLG, *Research into the financial benefits of the Supporting People programme*, estimated that the annual cost of providing Supporting People services to older people principally in sheltered accommodation was £258 million, but that this provided an overall net financial benefit of more than one billion.⁴²⁴

The reduction in funding of the Supporting People programme has been identified as a major factor in local authority provision of dedicated on-site wardens, with local authorities arguing that more older people can be



CSJ Researcher Paul Langlois during a visit to Bradbury Centre, Woking

⁴²⁴ Department for Communities and Local Government, *Research into the financial benefits of the Supporting People programme*, London: Department for Communities and Local Government, 2008, p105

supported on a ‘tenure neutral’ basis with floating support wardens providing services to help older people remain living in their own homes in the community for longer.

In 2009 Age Concern and Help the Aged gave evidence to the DCLG Select Committee’s inquiry into the Supporting People Programme where they stated:

‘In three years time 38 per cent of sheltered housing will have floating support (as opposed to warden services) from a base of 5 per cent five years ago.’⁴²⁵

The removal of warden services by providers has provoked legal challenges. In 2009 a conjoined hearing application for Judicial Review was launched in the High Court against Barnet and Portsmouth Councils’ removal of resident warden services in their sheltered housing schemes.⁴²⁶ The High Court held that both councils had behaved unlawfully by failing to take into account the terms of their residents’ tenancy agreements and also had failed in their duty under the Disability Discrimination Act by not taking into account the effect their decision might have on their residents.

The Government needs to ensure that any changes to future expenditure with regards to housing benefit are made with full consideration that many older people are among the most vulnerable in society, and need to be at the forefront of any decision making. The Government should also consider whether the removal of the ring-fencing of the Supporting People programme will lead to the withdrawal of essential services which help older people remain independent and significantly improve their quality of life.

4.9 Older Age Homelessness

Although the total number of older homeless people is small in comparison to the general older population, they are among the most disadvantaged members of our society and some of the hardest to engage.

“Three words best sum up the older homeless: invisible, hidden and isolated.”⁴²⁷

Older homeless people often have multiple difficulties including severe mental health issues and substance abuse problems. Further research published by St Mungo’s identified that among homeless people there exist high

levels of Tuberculosis, renal failure, abscesses, Deep Vein Thrombosis and blood borne viruses (especially Hepatitis C). Cases of trench foot have also

425 Communities and Local Government Committee, *The Supporting People Programme: Thirteenth Report of Session 2008-09* Volume 1, London: The Stationery Office, 2009, p58

426 Boyejo & Ors, R (on the application of) v Barnet London Borough Council [2009] EWHC 3261 (Admin) (15 December 2009) accessed via: www.bailii.org/ew/cases/EWHC/Admin/2009/3261.html

427 Shadow Secretary of State for Health Paul Burstow (now of Minister of State for Care Services, Department of Health) Speaking at a Westminster Hall Debate on Homelessness on 27 January 2004

been recorded.⁴²⁸ Such multiple needs mean they are often difficult to provide accommodation for. A survey by the charity Homeless Link found that almost 60 percent of older homeless people over 50 had multiple needs in addition to homelessness.⁴²⁹

And as we have heard during our review, there are many reasons why an older person might find themselves homeless. Family breakdown is usually a common factor, and other causes include bereavement, redundancy, eviction, addiction, and mental health problems. In the case of Ruth, below, the initial trigger was the damage of family breakdown.

Case study: Ruth, aged 71

Ruth was made homeless in August 2008 following a relationship with a co-resident family member which became unsustainable. At first Ruth went to stay in local hotels and B&Bs but when her money ran out she was asked to leave. With no other option she was forced to attempt living on the streets. Unsurprisingly, at the age of 71, Ruth found this extremely difficult, eventually turning to Age Concern for help.

Ruth's immediate need was to find somewhere to sleep. Age Concern rang all the local hostels. Finding them all full, they then contacted the local DWP, only to be informed it would take up to two weeks to arrange Ruth's Housing Benefit claim. In the interim Age Concern found a hotel that would offer Ruth some emergency accommodation even though her Housing Benefit was not agreed, on the basis someone would pay for her short-term rent. Friends of the Elderly (FOTE) agreed to supply a £140 grant to pay for seven nights bed and breakfast. Two weeks later, however, Ruth's Housing Benefit had still not been processed, requiring other charities to step into the breach.

4.9.1 A NATIONAL CRISIS

Local authorities have statutory obligations in the event of someone being homeless or being threatened with homelessness.⁴³⁰ Official figures show that in England in 2009 there were a total of 31,430 households accepted as homeless and in priority need, and the number of all people who were accepted as being statutory homeless due to their old age was 600.⁴³¹

However, as the number of homeless people is difficult to estimate due to their transient nature, it seems that official figures underestimate the scale of the problem. Most people living in hostels, for instance, are not classified as being statutory homeless and do not appear on local authority registers. Research by the UK Coalition on Older Homelessness Project (COHP) estimated that there are 42,000 homeless people over 50 years old, as shown by the table below.

428 St Mungo's, *Homelessness: it makes you sick*, London: St Mungo's, 2008, p2

429 Homeless Link, *Multiple needs good practice briefing*, London: Homeless Link, 2002, p3

430 Housing Act 1996, Part 7. For someone to be classed as statutory homeless, they have to be a UK or Irish citizen or have an established right to stay; they have to be homeless or threatened with homelessness within 28 days; they must have a priority need; and not be intentionally homeless.

431 Department for Communities and Local Government, *Table 773: Statutory homelessness: households accepted by local authorities as owed a main homelessness duty, by Priority Need category, England, 1998/999 – 2009/10*, accessed via <http://www.communities.gov.uk/housing/housingresearch/housingstatistics/housingstatisticsby/homelessnessstatistics/livatables/>, on 3 September 2010

Figure 32 – Estimated number of homeless people over the age of 50 at any point in time, by group.⁴³²

Group	Estimated numbers at any point in time	Scope of estimate
Rough sleepers	300	Great Britain
Living in hostels or equivalent	5,000	England
Self-placed in bed-and-breakfast or other temporary accommodation because they have no other option	12,000	Great Britain
Imminent releases from prison and nowhere to go	100	England and Wales
Staying with friends or family in overcrowded conditions	24,000	England
Imminent risk of eviction	500	England
Estimated total	41,900	

4.9.2 HOSTELS

Direct access hostels are open all year round to provide temporary accommodation for those in immediate need of shelter. The Working Group has heard evidence that there is a hidden problem of homeless people stuck in hostels and struggling to move into permanent housing. The Working Group has also heard evidence that many older homeless people find hostels highly intimidating, often feeling safer on the streets.

A report by COHP on hostels in five cities found that 28 per cent of older homeless people had been staying in the same hostel for over five years and 16 per cent of people had been in the same hostel for over ten years.⁴³³ When asked to identify the support needs of their residents, the providers showed that half of all residents were institutionalised and dependent on living in a supported

⁴³² UK Coalition on Older Homelessness, *Coming of age: opportunities for older homeless people under Supporting People*, London: Homeless Link, 2004, p23

⁴³³ The UK Coalition on Older Homelessness, *Audit of older homeless people September 2007: Summary of findings*, London: Homeless Link, p3. Due to differences in classification of older homeless people by different authorities, ranging between 45 and over to 60 and over, the age of 45 years and over was used for their study.

environment.⁴³⁴ Equally, however, research carried out by the Salvation Army on its 50 residential centres identified that almost half of their clients were ready to move out of their current hostel, but due to the lack of social housing stock available they are forced to remain where they are.⁴³⁵

In recent years government programmes such as the Hostels Capital Improvement Programme, led by the Office of the Deputy Prime Minister (which ran from 2005/06 to 2007/08), and the Places of Change Programme (PCP), led by the DCLG, which started in 2008, have made major improvements in the provision of services to homeless people. There has been some progress in helping people move from a hostel to a more permanent home.

The Working Group welcomes these improvements to the provision, and improved condition, of hostels, but many older homeless people are still struggling to move from homeless provision housing back into permanent housing. This, we hear, is often due the lack of joined-up services when an assessment is carried out to identify their needs.

“Too many older homeless people are living long term in hostels as their care and support needs increase and they become frailer and more institutionalised. There is an urgent need to develop some long term housing projects, on the model of sheltered housing but with extra support, to cater for those people whose needs go beyond what traditional sheltered housing can offer. This would offer older people some quality of life and independence in their later years and be a cheaper option than leaving them in hostels.”

Sarah Gorton, Homeless Link Policy Manager in evidence to CSJ

Case Study: Stephen

Stephen, in his early 60s, moved into a hostel in January 2007. He previously lived in second stage accommodation, but had been unable to manage his tenancy: he had been smearing faeces in his room and had caused a number of fire alarms due to leaving food in the oven. He had also lost a dramatic amount of weight and was highly disorientated.

An initial risk assessment at the hostel identified Stephen as a man with a long term alcohol dependency who also suffered mental deterioration. Stephen was passed between the mental health team and physical disabilities team, as they could not decide whether Stephen's mental state was caused by long term drinking or a specific mental health condition. Both teams assessed Stephen but concluded that without the necessary tests they could not help him. These tests needed to be carried out at a GP's surgery which Stephen refused to attend. Due to a lack of support available for Stephen at the hostel, staff often took on the role of carers, rather than key workers. Social Services did arrange a care package for him but would not start this until he had the appropriate blood tests done – the blood test that Stephen refused to give.

Stephen was eventually admitted to hospital after he collapsed in the hostel with a severe urinary infection and malnutrition. Since this time, he has been in a mental health ward, he is unable to walk or even feed himself, and he is incontinent. The hospital contacted the hostel and said that they would recommend Stephen should be housed in a high support care home, as the hostel was inappropriate for Stephen. The hostel therefore issued Stephen with a notice to quit and informed Social Services who eventually agreed to re-house him.

434 Ibid., p4

435 The Salvation Army, *A home for all?: Homelessness policy challenges for Labour's third term*, London: The Salvation Army, p6

We have also heard evidence that care packages, where they exist, are not tailored to meet the needs of older homeless people. This is often driven, it seems, by a focus on process not the quality of outcomes. In some instances care workers have been tasked with helping someone to get out of bed at 8am, when that person may have been drinking all night; and similarly care workers rigidly tasked with helping someone to bed at 6pm.

4.9.3 RESETTLEMENT

Resettlement services are vital for moving older homeless people from temporary provision to more permanent housing such as sheltered or supported housing. However, due to the lack of suitable medium and long term accommodation, homeless people can remain in temporary housing for much longer than they need to.

As well as finding accommodation for older homeless people, many people will require extra services to help manage their lives. Floating support is often essential to help older homeless people who have secured tenancy to ensure that they stay healthy and are responsible for many of the day to day activities which most of us take for granted, such as paying bills and using and paying for utility services.

When asked what accommodation would suit older homeless people moving from hostels, providers indicated that:

- 39 per cent would require independent or sheltered housing with additional long term floating support.
- 33 per cent would require independent or sheltered housing with initial resettlement support.
- 22 per cent would require 24 hour high care support, for instance in a care home.

Sheltered housing schemes can provide accommodation for older homeless people and a level of support which is obviously not available in private rented accommodation. Also, having the knowledge that they are now living in a secure environment with communal services can often provide a good platform for older homeless people to begin to settle into a less chaotic and more stable life.

Currently, however, there are significant barriers to older homeless people seeking to move into a sheltered housing. For example:

- As sheltered housing schemes have communal areas, some scheme managers are reluctant to accept older homeless people. Especially if that homeless person has a history of anti-social behaviour or substance abuse problems, scheme managers fear affecting other residents.
- A lack of furniture or other household goods needed to furnish a flat.
- Past arrears can make it harder for a homeless person to secure a tenancy as they will be liable for double rent right at the start of their new tenancy.

4.9.4 THE FUTURE

The Homelessness Working Group

In 2010 the first cross-government meeting of the Homelessness Working Group took place between Ministers from eight departments. It is tasked with preventing and reducing homelessness, and exploring how policies across departments can improve the lives of homeless people.

It has already been announced that the way rough sleepers are recorded will be changed to give a clearer, more reliable reflection of the numbers of people sleeping rough across the country. At the last national count of rough sleepers, only 76 out of the then 354 councils contributed to the count.⁴³⁶ The Working Group will wait with interest to see the emerging progress from this group. We hope particular attention will be given to older homeless.

Drug and Alcohol Strategy

Members of the Working Group also heard evidence of a concern with regards to the current drug and alcohol strategy, with far less investment in reducing alcohol related harm than in reducing drug related harm. Where treatment provision exists it focuses more on binge drinking and antisocial behaviour, and so homeless people often get overlooked.

Even when services are offered it is more about harm minimisation than effective treatment, the Working Group heard evidence from a homeless charity that some care workers were taking individuals to the off-licence to buy alcohol, as mobility problems meant they were unable to make the journey unaided. Merely maintaining someone who has an alcohol problem will do little to help move to a healthy lifestyle and reintegrate back into our communities.

The new drug and alcohol strategy under development (at the time of writing) provides a real opportunity to tackle the problem of older age addiction. It should help addicts to access as much recovery-oriented treatment as possible.

⁴³⁶ Department for Communities and Local Government, *Grant Schapps taking action to address homelessness*, 16 June 2010, accessed via: <http://www.communities.gov.uk/newstories/housing/158770411>

CHAPTER FIVE

Care

Chapter Findings: Summary

- Six million Britons provide unpaid care for relatives and loved ones. Caring roles have become increasingly intense and isolated, resulting in the increasing ill health of carers and the increasing vulnerability of those they care for. Well-recognised solutions to this urgent problem – most prominently, regular respite care – are currently underutilised.
- Currently 1.2 million older people in England and Wales receive services from their local council. Due to the expense of long-term care three quarters of the £7 billion total budget goes to the quarter supported in that context.
- Evidence shows that preventative services such as home aids and adaptations, day care and reablement ‘blasts’ following hospitalisation can effectively prevent or delay higher-dependency situations among older people. Yet it is these non-statutory services currently under threat as local councils, even before the Coalition Government’s severe departmental spending cuts, attempt to ration their services and contain their budgets.
- Despite multiple attempts in the last 20 years to increase joined-up working between health and social care, lack of integration still remains a defining feature of the present system, particularly pronounced at the level of hospital admission and discharge.
- The current policy drive to keep people in their own homes for as long as possible depends largely on the availability and quality of home care packages. Yet since 1994 the proportion of older people receiving home care has halved; by international standards England has an atypically low proportion of people receiving formal home care; and the prevalence of care being provided in slots as short as 15 minutes is a regular complaint.
- The profile of the care home population (half of whom are funded by the state) has altered dramatically even in the last decade. People are far frailer and more dependent than in the past. Despite this, the lack of medical presence in residential and nursing homes, particularly GPs, is a defining feature of the current system.
- While policy-makers wait to decide how to fund care, care home providers complain of drastic underfunding by local authorities. ‘On the floor’ this typically translates into low staff ratios, under-serving residents and putting already badly paid care workers under enormous pressure.

5.1 Introduction

We began this review of older age by highlighting the fact that older people have too often been a ‘political football’ in Westminster. With public attention on older people regularly dominated by the debate on the social care system and how to fund it, older people have been in danger of being portrayed solely as a problem society has to pay for. As many have told this Working Group, this ‘burden to be borne’ message can have a detrimental effect on older people

who currently have a care need, those who care for them and older people at large.

As a direct response to this, we have tried to broaden out from a debate about care and pensions. Our focus has been wider: to encompass the range of issues that impact on older people's quality of life and to celebrate older age. That said, it is clear from our evidence gathering that social care is a very real concern for older people. Approximately 2.5 million older people in the UK have a care need⁴³⁷ and almost half of those aged 75 and over have a longstanding limiting illness.⁴³⁸ Therefore, while social care may not be the only issue affecting older people, it is certainly a key one. That is why it is the subject of this fifth chapter of our review.



Andrea Rowe, a former Chief Executive Officer of Skills for Care, provided evidence for our chapter on care

5.2 Social Care

5.2.1 WHAT IS CARE?

The Department of Health defines social care as *'the wide range of services designed to support people to maintain their independence, enable them to play a fuller part in society, protect them in vulnerable situations and manage complex relationships'*.⁴³⁹ Those 'wide range of services' can be broken down into two categories:

- Personal care – help with the more intimate activities of daily living such as dressing, eating, washing and going to the toilet.
- Practical help in the home – things like domestic cleaning and assistance with shopping. Though distinct from personal care, often domiciliary care packages contain an element of both of these types of care.

Whether personal or practical, care can be provided across a range of venues:

- In a person's own home, including purpose-built retirement/sheltered accommodation – usually referred to as 'domiciliary' or 'home' care.
- At community venues such as drop-in and day care centres.
- In care homes, whether residential or nursing. In these settings a distinction is made between personal care services and board and lodging.

Unlike health care in England and Wales, social care provided in any of these settings is not free at the point of use. Publicly subsidised care support, provided by local authorities, is only provided for those with the highest needs

437 Wanless, Sir Derek, *Securing Good Care for Older People: Taking a Long-term view*, London: The King's Fund, 2006, pp30-31

438 Office for National Statistics, *National Lifestyle Survey 2008 - Table 7.2*, 2010, Newport: Office for National Statistics

439 Department of Health, *Our Health, Our Care, Our Say*, London: Department of Health, 2006, p18

and lowest means. That is, to qualify for state support an adult in the UK has to demonstrate eligibility on two fronts:

First, needs eligibility: every person in the UK is entitled to an assessment of his or her care needs by their local authority. Currently someone's level of need is categorised as 'low', 'moderate', 'substantial' or 'critical' in accordance with the national *Fair Access to Care Services* (FACS) framework set by the Department of Health in 2003. Each local authority has discretion over its own budget as to which of these four bands it will fund. In recent years, as we will see in section 5.4.5, local authorities have tightened their eligibility, concentrating their support for people with the highest needs, i.e. the 'critical' or 'substantial' end of the FACS spectrum.

Second, to qualify for support an older person has to be financially eligible. Social care in England and Wales is also strictly means-tested, varying according to the venue where care is provided:

- The threshold for eligibility for long-term care in a care home is nationally set: for April 2010/11 someone has to have savings and capital (i.e. including the value of any home) below, in England, £23,250 and, in Wales, £22,000.
- Eligibility for domiciliary care typically focuses on income and savings rather than assets. It is set by local authorities rather than nationally, though different local council's charging policies are supposed to comply with the Department of Health's Fairer Charging guidelines, which state it would be unfair to reduce someone's net income below the Pension Credit, plus 25 per cent.⁴⁴⁰

To understand why publicly subsidised social care is only available for those with the highest needs and lowest means it is necessary to outline briefly the history of social care in this country.

5.2.2 HISTORICAL CONTEXT

The present social care system is a construct of 1948. The National Assistance Act, based largely on Sir William Beveridge's wartime report *Social Insurance and Allied Services* (1942), nationalised the responsibility for benefits but made local authorities responsible for other welfare services for the elderly and infirm. Unlike the NHS and benefits like family allowance, social care was not designed to be universally accessible and free at the point of use. Rather it was always intended to be strictly means-tested, 'a safety net to be stretched beneath the minimum platform of insurance benefits'.⁴⁴¹

As set out by the National Assistance Act, the responsibilities of local authorities were largely concerned with residential provision. So Section 21

440 Department of Health, *Fairer Charging Policies for Home Care and other non-residential Social Services*, Guidance for Councils with Social Services Responsibilities, London: Department of Health, 2003, p8

441 Timmins N, *The Five Giants: A Biography of The Welfare State*, Revised and Updated Edition, London: Harper Collins, 2001, p136

obligated local authorities to provide residential accommodation for people who ‘by reason of age or any other circumstance are in need of care and attention which is not otherwise available to them.’⁴⁴² But in the 1950s, following the newly revealed merits of deinstitutionalisation in the child care field, a consensus began to form around the preference of providing community rather than residential care.⁴⁴³ Supporting older men and women to live in their own homes for as long as possible was not only a cheaper option for the state; given evidence of the poor quality of life in residential homes, it was also considered more humanitarian.⁴⁴⁴

However, just how little community care had been developed 20 years later was indicated, as Sir Derek Wanless has argued, by fresh policy objectives issued in the mid-1970s to redirect development away from residential facilities.⁴⁴⁵ But in the 1980s the opposite happened, as the availability of non-means-tested social security resources to fund residential care (through the open-ended ‘supplementary benefit’) incentivised families and local authorities to admit older people into care homes. (The system meant that if as a local authority you provided domiciliary care or care in the community to an older person it came out of your budget. If on the other hand you admitted someone into residential care the funding of that was shunted across to central government). Therefore, while the care home sector may have been increasingly privatised in the 1980s (for the first 30 years of the welfare state, until Britain’s monetary crisis of 1976, residential care had been largely provided in public sector facilities), it was still the state footing the bill. Social security support placements of people into independent care homes rose from zero to over £800 million between 1979 and 1988.⁴⁴⁶

But the era of a universal benefit for residential care could not last forever. Recognising the scale of demand brought by an ageing society, as well as the way social security had become a safety valve to relieve pressure on local authority budgets, the Conservative Government of the early 1990s realised that the open supplementary benefit for residential care was set to bankrupt the country. Sir Roy Griffiths’ report of 1988 led to a White Paper in 1989 and then the landmark social care reform which was the Community Care Act (enacted in 1990 but only implemented in 1993). Eligibility criteria for care was tightened; local authorities alone were to be responsible for paying for the great majority of new state-funded placements into nursing and residential homes; and community care, famously declared by Griffiths to be ‘a poor relation; everybody’s distant relative but nobody’s baby’,⁴⁴⁷ was back on the

442 National Assistance Act 1948, Section 21

443 Wanless, Sir Derek, *Securing Good Care for Older People: Taking a Long-term view*, London: The King’s Fund, 2006, p11

444 Ibid., p11

445 Ibid., p12

446 Ibid., p13

447 Griffiths R, *Community Care: Agenda for action: A report to the Secretary of State for Social Services by Sir Roy Griffiths*, 1988, London: HMSO

agenda. Consequently, the care home population has declined from a peak of 511,000 in 1993 to a current 419,000.⁴⁴⁸

The other major development in social care over the last 40 years relates to nursing homes. Historically, older people with chronic conditions and high levels of dependence were typically cared for in NHS long-stay geriatric hospitals. Since the 1970s, however, the majority of these have closed, with independent nursing homes inheriting this population of clinically complex patients. This has had huge repercussions in terms of medical provision for those people, as we outline in section 5.6.5 below.

According to many, the story of social care since the Second World War has been the slow recognition of the scale of demand driven by an ageing society. Demand for care in later life is greater than anything conceived of in 1948. And so, first in 1990 with the Community Care Act and the capping of the universal benefit for residential care, and then again in 2006 with the demand forecasts in Sir Derek Wanless's review of social care for the King's Fund, it has become increasingly clear how unsustainable our current social care system has become.

5.2.3 CURRENT POLICY CONTEXT

In terms of social care, recent policy developments and debates, at both a national and a local level, may be divided into three categories.

- A debate about principles. What ideas should inform any reform of social care in Britain?
- A debate about actual reforms. Based on these principles, what should be changed to create the optimal social care system in England?
- A debate about funding. How do we pay first for the current system, secondly for the optimal system?

Principles

The governing policy aspiration has been to keep people in their homes for as long as possible rather than admitting to residential care. Not only is this what people prefer, so it is argued, it is also much better for the state, given the cost of residential care.

Vitally connected to the 'staying put' drive is another major policy initiative of the last decade: personalisation.

In December 2007 the *Putting People First* ministerial concordat,⁴⁴⁹ a partnership agreement between central government, local government and the NHS, announced the creation of a personalised service to allow users more independence and greater choice and control over their care. After an assessment by Social Services, instead of someone being told what was going

448 Laing and Buisson, *Care of Elderly People: UK Market Survey 2009*, London: Laing & Buisson 2009, p111

449 HM Government, *Putting People First: a shared vision and commitment to the transformation of Adult Social Care*, London: The Stationery Office, 2007

to be done for them, it would be better – so the idea goes – if the person herself had a say in the solution to her own difficulties. One of the main mechanisms for delivery of this are personal budgets – an amount of funding allocated to a user that allows them to control which services that funding is used to purchase. The previous Government pledged £520 million to assist local authorities to establish systems that ensure most users can personalise their care by 2011, a proportion of which through direct payments.

Reforms

Social care has not suffered from a lack of political attention in the last 15 years. Yet after two Royal Commissions, three major reports by the previous Government and two Commons select committee inquiries the system basically remains unchanged. For the most part we are still in the place we were in 1997. Paul Burstow, the incoming Minister of State for Care Services at the Department of Health, is right to describe the last decade as ‘a decade of indecision.’⁴⁵⁰

In terms of the reforms proposed, in 2009 the previous Government published their long-awaited Green Paper, *Shaping the Future of Care Together*.⁴⁵¹ It proposed the creation of a new National Care Service. To end the problem of the so called ‘catastrophic costs of care’ this new system would provide personal care, free at the point of use, to anyone in England who needed it. The reform in effect would end means-testing, with care being provided to people at whatever venue they needed it – in their own homes, in community venues or in care homes. A year later the government’s White Paper, *Building the National Care Service*, fleshed out the details of this reform. Key proposals were:

- Reablement: anyone needing home care for the first time after hospitalisation would be offered an intensive rehabilitation period to help them get back on their feet.
- Assessment: for the first time there should be nationally consistent eligibility criteria for social care enshrined in law which set the point at which someone becomes eligible for state support. And the results of this assessment would be portable across different local authorities.
- Integration: the referral processes for Attendance Allowance (AA) and social care would be aligned.
- Residential care: anyone staying in residential care for more than two years would receive free care after the second year (though the ‘hotel costs’ of being in care would remain means-tested).

Yet even before the 2010 general election, social care reform met with effective opposition. The Personal Care at Home Bill was defeated in the House of Lords

450 Van de Zee B, ‘Ending indecision: Interview with Paul Burstow’, *New Statesman Supplement*, ‘Social care: who pays?’, 11th October 2010

451 HM Government, *Shaping the Future of Care Together*, London: The Stationery Office, 2009

in March 2010. Since only a third of the £670 million cost of the scheme was to be funded by the Department of Health, the verdict of the Lords, led by President of the Local Government Association (LGA) Lord Best, was simply that the proposals were unaffordable.

Funding

In the early years of New Labour, a Royal Commission into long-term care recommended that free personal care to anyone who needed it should be funded through general taxation. But the proposals were rejected by the government because of the prohibitive expense and because it was not thought sustainable or fair to place such a large burden on working-age adults.

Over a decade later an alternative was finally proposed. In 2010's White Paper the previous Government announced that the reform proposed a year earlier, the creation of a National Care Service comparable to the NHS, should be funded via a compulsory levy payable at retirement by everyone who could afford it. This massive state insurance scheme was considered preferable not only to the current 'pay-for-yourself' system but also to the partnership option (whereby everyone who qualified for care and support would be entitled to a set proportion, with the state providing a higher proportion of care for the less well-off), the voluntary insurance option and funding through general taxation.

But even though it came down strongly on one particular option – a National Care Service – the previous Government had postponed difficult decisions over this crucial question of funding. And in July 2010 the Coalition Government took up where the previous Government left off, announcing the launch of the Commission on the Funding of Care and Support, to consider afresh the various options and to report within a year. Finally, in the 2010 Comprehensive Spending Review the Coalition Government has recognised the spending pressure on care – allocating an additional £2 billion for social care (£1 billion to local authorities and £1 billion to the Department of Health). Whilst we welcome this decision, there are concerns that, first, this can only be a short-term solution and, secondly, that since this money has not been ringfenced it will not reach its allocated purpose but will instead be swallowed up as local authorities are forced to cut other aspects of their budgets.

5.2.4 THE CHALLENGE OF TODAY AND TOMORROW

By 2026 the number of people aged over 85 will double and the number of people aged over 100 quadruple. In 20 years times 1.7 million more adults in England will have a care and support need.⁴⁵² The number of people with dementia could double over the next 30 years.⁴⁵³ On top of this, the shrinking

452 Care Quality Commission, *The state of health care and adult social care in England*, London: The Stationery Office, 2009, p7

453 Department of Health, *Living well with dementia: A National Dementia Strategy implementation plan*, London: Department of Health, 2008, p5

number of people of working age in relation to those of pensionable age means that while the demand for care increases dramatically the care workforce, both paid and unpaid, either fails to keep apace or even shrinks.

The danger of being preoccupied with the projections, however, is that we lose sight of the fact that the impact of demographic change is a reality we have already hit upon. Today people are living longer – in itself of course a cause for celebration – yet often they are living with multiple chronic illnesses, and both society and the state are struggling to cater for this huge demographic shift.

Furthermore, the danger is that the debate about how to fund care in the future diverts our attention away from those men and women who are already ‘in’ the care system. Thus this chapter of our Review will not present arguments about funding proposals or models for how to pay for care in the future. Rather, our focus will be on the current situation of those 2.5 million older people, approximately 30 per cent of the older population, who have a care need (i.e. have some difficulty with activities such as dressing, eating, washing and going to the toilet)⁴⁵⁴ and, more specifically, given the remit of this Review, the poorest within that group, to begin with, the 1.2 million within that group who use social care provided or purchased by their local council (most of whom, given that publicly subsidised care is strictly means-tested, may be assumed to fall within this bracket).⁴⁵⁵ What are the issues facing those people? What is their experience of the relationship between health care and social care?

“Unpaid care for disabled, sick or older people is the bedrock of community care in the UK.”

Carers UK⁴⁵⁶

5.3 Unpaid Care

There are approximately six million unpaid carers in the UK,⁴⁵⁷ twice the number of paid NHS staff and social care workforce combined.⁴⁵⁸ The 2001 Census defined a carer as anyone who responded affirmatively to the question: ‘Do you look after or give any help or support to family members, friends or neighbours or others because of long-term physical or mental ill health or disability or problems related to old age?’⁴⁵⁹

At any one time, one in ten people in Britain look after a sibling, spouse, parent, child or friend who is ill, frail or disabled, and there are over two million new carers every year.⁴⁶⁰ Moreover, most carers look after elderly people: at least 70 per cent of those cared for are 65 years old or over.⁴⁶¹ This huge group of people contribute a massive amount both to society and to the state.

454 Forder J, *Self-funded Social Care for Older People: An Analysis of eligibility, variations and future projections*. PSSRU discussion paper 2505, 2007, p7

455 NHS Information Centre, *Community Care Statistics 2008-9: Social Services Activity Report, England*, 2010, p4

456 Carers UK, *Tipping Point for Care: time for a new social contract*, London: Carers UK, 2010, p3

457 2001 Census Standard Tables, Crown Copyright 2003: ONS, GRO(Scotland) and NISRA

458 Carers UK, *Tipping Point for Care: time for a new social contract*, London: Carers UK, 2010, p3

459 2001 Census Standard Tables, Crown Copyright 2003: ONS, GRO(Scotland) and NISRA

460 Carers UK, *In the Know: The importance of information for carers*, London: Carers UK, 2006, p11

461 Carers UK, *Policy briefing: Facts about Carers*, London: Carers UK, 2009, p5

There are important variations amongst this huge group of people who care for family members and loved ones. First in terms of gender: in England 60 per cent of carers are women.⁴⁶² By the time they are 59 women have a 50:50 chance of having substantial caring responsibilities.⁴⁶³ Second, in terms of ethnicity: there are particularly high instances of caring in some black, minority and ethnic communities. Twice as many Pakistani women are carers when compared with the national average.⁴⁶⁵ And third in terms of age: people over 50 years old make up the majority of carers in our country,⁴⁶⁶ with 1.5 million of those over 60.⁴⁶⁷

There are nearly six million unpaid carers in the UK, currently saving the UK economy an estimated £87 billion a year⁴⁶⁴

It is difficult to give a sense of the kind of challenge unpaid care constitutes. Simply listing the typical activities involved – bathing, washing, dressing, toileting, administering medicines, physical help such as getting in and out of bed or up and down stairs – inevitably sounds reductive. Yet these are the tasks which sustain people who have care needs on a daily basis.

For many, caring is a source of great joy and a responsibility few would want to exchange. But there is also evidence that caring takes its toll:

- Carers who provide a significant amount of care for sick or disabled family members are more than twice as likely to suffer from poor health compared to people without caring responsibilities.⁴⁶⁸ Back injury is common amongst carers who are lifting relatives unsafely.⁴⁶⁹
- According to a Carers UK survey in 2008, 72 per cent of carers are financially worse off as a result of becoming carers.⁴⁷⁰ The vast majority are struggling to pay essential bills, half are in debt, and most report having to cut back on food just to make ends meet and being unable to afford repairs on their house.⁴⁷¹
- 59 per cent of carers surveyed by The Princess Royal Trust for Carers in September 2010 have given up paid work to care.⁴⁷² And on average carers retire eight years early, missing out on years of income and pension contributions.⁴⁷³

462 The NHS Information Centre for health and social care, *Survey of Carers in Households in England 2009/10*, Provisional Results, p2

463 Carers UK, *It could be you*, London: Carers UK, 2001, Summary, p1

464 Department for Work and Pensions, *First Release: DWP Quarterly Statistical Summary: Additional Table 8a*, London: Department for Work and Pensions, p201

465 The Princess Royal Trust for Carers & Crossroads Caring for Carers, *Putting people first without putting carers second*, London: The Princess Royal Trust for Carers & Crossroads Caring for Carers, 2009, p10

466 HM Government, *Building a society for all ages*, London: The Stationery Office, 2010, p14

467 Carers UK/Sheffield Hallam University, *Older Carers in the UK*, 2005, p2

468 Office of National Statistics, *Census 2001*

469 The Princess Royal Trust for Carers and Crossroads Caring for Carers, *Putting People First without putting carers second*, London: The Princess Royal Trust for Carers and Crossroads Caring for Carers, 2009, p10

470 Carers UK, *Real change, not short change: Time to deliver for carers*, London: Carers UK, 2007, p10

471 Carers UK, *Carers in crisis: A survey of carers' finances in 2008*, London: Carers UK, 2009, p2

472 The Princess Royal Trust for Carers, *Carers and finance survey*, London: The Princess Royal Trust for Carers, 2010, p5

473 Carers UK, *Real change, not short change: Time to deliver for carers*, 2007, p13

'In sickness and in health' – Case Study: Harry

Harry is 72 years old. He lives in Dudley in the West Midlands. Ten years ago Olwyn, his wife of 46 years, had a massive stroke. She was in a coma for a week, hospital for six months, and was eventually discharged with the whole of her left side paralysed. Confined to a wheelchair and able to walk only with extensive support, Harry became and remains her primary carer.

'It's 24/7 care', he explains. 'I cook every meal, wash every item of clothing, iron everything. All the personal care and hygiene is in my domain.'

Harry and Olwyn had been retired for two years prior to Olwyn's stroke. Harry had been a PE teacher, Olwyn a nurse. Harry now describes their first two years of retirement as 'idyllic'. *'We would wake up each morning and decide whether it would be one cup of tea or two cups of tea or, if the weather was inclement, three cups.'* But then, in February 2000, their lives were turned upside down.

Harry says that he was totally unprepared to take on the role of primary carer. *'When I started ten years ago I didn't have a clue. While I consider myself a kind person, caring was just not part of my skills.'* But since that time, he has learnt to iron, as well as how to give Olwyn a 'bed-bath', washing her 'from head to toe'. Some existing skills he does see himself as having been lucky enough to have had going into caring. *'My saving grace', he admits, 'is that I've always been quite a good cook, whether curries or joints...'* In addition he has the natural advantage of good physical fitness and strength. Straight after the stroke, when Olwyn could bear no weight at all, Harry had to lift her manually if she was to move at all. Now he can at least get her to stand, but he still has to help to rotate her. *'I can't think of many blokes who can handle their wife at 72!'*

A crisis of this proportion, Harry says, is 'something you've just got to accept.' Since initially the consultant had given Olwyn a three per cent chance of survival, and for the first few months she had no short term memory at all, Harry is grateful that she is still alive and functioning so well intellectually. But things are still very different from how they were. Life since the stroke has basically been about *'reclaiming as much of your previous existence as you can.'* In terms of being a carer Harry says, *'you've got to live the life to really understand it. But you carry on. 'In sickness and in health' was what I promised 46 years ago. And I will do that.'*

We are told that if we were to put a price on the quantity of care provided by unpaid carers we would arrive at a figure of £87 billion, nearly as much as is allocated to the NHS.⁴⁷⁴ Of course, to quantify that amount of money is not to suggest that the state should or could provide care in the place of carers, something which 2010's White Paper recognised clearly:

*'The role of the state is not to replace carers, peer support, volunteering, social networks, or self-care. It is to enable people to do these things, and more...'*⁴⁷⁵

That millions of people provide support for family members and friends is indeed 'the hallmark of a civilised society.'⁴⁷⁶ But what society and the state must do is to support those who do provide such care. And currently it is this

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

475 HM Government, *Building the National Care Service*, London: The Stationery Office, 2010, p79

476 Ibid., p16

which both society and state are, in the main, patently failing to do.

The failure to provide support for carers is something many people recognise. Hazel Short, 75, cares full-time for her husband of 40 years, who was diagnosed with dementia two years ago. She spoke to the Working Group of just how ‘wearing’ and ‘tiring’ her role as a carer is, as well as how she cannot afford the vital respite care she needs to keep on going:

‘The Government doesn’t do enough to support carers. It’s no good talking. We really need action. We really need something to be done.’

This view is echoed by advocates for carers such as the charity Carers UK. ‘The previous Government did a number of different things to support carers,’ Emily Holzhausen, Director of Policy and Public Affairs, told the Working Group, ‘yet there are still far too many people whose health and families suffer as a direct result of their caring responsibilities.’ And Gordon Conochie, of Crossroads Care and Princess Royal Trust for Carers, concurs:

‘There is an increased awareness among both politicians and the general public that carers have their own issues which need to be addressed. What we haven’t reached, however, is the stage where they are effectively addressing those issues.’

Even further, it has been argued that the failure to support carers is a failure to support and value the older people they care for.

5.3.1 THE INCREASING INTENSITY OF CARING ROLES

Significantly, new statistics published in July 2010 showed that the percentage of carers providing 50 hours or more care a week has more than doubled in nine years. This is a phenomenal shift. Today 22 per cent of carers provide 50 hours or more of care a week, compared to 10 per cent in 2000/01.⁴⁷⁸ What it reveals is a growing trend whereby, for more and more people in the UK, caring has basically become a full-time job.

Throughout its evidence gathering, two particular reasons for the increasing

“Over the next ten years this came to be the pattern. The onset of a bout of depression would fetch us home for a while, but when no immediate recovery was forthcoming we would take ourselves off again while Dad was left to cope. Or to care, as the phrase is nowadays. Dad was the carer. We cared, of course, but we still had lives to lead: Dad was retired – he had all the time in the world to care.”

Alan Bennett, *Untold Stories*⁴⁷⁷



Emily Holzhausen from Carers UK providing evidence to the CSJ

⁴⁷⁷ Bennett, A, *Untold Stories*, London: Faber and Faber, 2005, p5

⁴⁷⁸ The NHS Information Centre for health and social care, *Surveys of Carers in households 2009/10 – Provisional Results*, p2.

The percentage of carers providing 50 hours or more care a week has more than doubled in nine years

intensity of caring roles have been brought to the attention of the Working Group: geographical mobility and family breakdown.

First, increasing geographical mobility has led to the physical dispersal of families. Living further away from elderly parents or relatives reduces the ability of both extended family and immediate family members to provide care, duly increasing the burden on co-habiting family members, most particularly spouses. For example, one carer we interviewed who provides 24/7 care to his wife lives in the Midlands, their son on the South Coast. While the son is by no means estranged from his parents, the sheer distance means his visits are neither frequent nor long enough to provide effective relief for his father. Physical dispersal of families simply means that there are fewer people to absorb the care needs resulting from a crisis in an older person's life.

Secondly, though the effects of family breakdown are only just beginning to be understood, its impact upon care for older people is a reality the Working Group has not been able to ignore. What was recorded in the 'Fractured Families' section of *Breakdown Britain* remains the case: family breakdown has led to a significant cultural shift affecting the willingness of many family members to provide care.⁴⁷⁹ This cultural shift is something contemporary sociologists have made much of. Antony Giddens, foremost sociologist of our time, talks of how in a high divorce society like ours, with its implicit understanding that family relationships are impermanent, relationships are '*subject to greater negotiation than before*' so that whereas in the past '*kinship relations used to be a taken for granted basis of trust; now trust has to be negotiated and bargained for and commitment [between kin] is as much of an issue as in sexual relations.*'⁴⁸⁰ Finch and Mason have also described the way in which people now have to work out how to treat their relatives so that '*responsibilities are thus created rather than flowing automatically from specific relationships.*'⁴⁸¹ In terms of care, what that may mean is that being willing to support an older family member increasingly depends on the quality of relationships forged, upon what Finch termed 'cumulative commitments'. This affects not only extended family but the immediate family; explaining, for example, why different siblings within one family might have very different ideas about how much care they should or should not provide for ageing relatives. In any case, in terms of the increasing intensity of caring roles, this cultural shift is perhaps proving as significant as the increasing physical dispersal of families. Fewer family members available or willing to care means that the burden falls more heavily on the primary carer, be they spouse or adult child.

Whatever its cause, this growing trend of unrelieved caring roles is a cause

479 The Centre for Social Justice, *Breakdown Britain*, London: The Centre for Social Justice, 2006, pp62-4.

480 Giddens A, *The Transformation of Intimacy: Sexuality, Love and Eroticism in Modern Societies*, Cambridge: Polity Press, 1992, p96

481 Finch J and Mason J, *Negotiating Family Responsibilities*, Tavistock/Routledge, London and New York, 1993, p167

for alarm because, as has been reported to the Working Group by prominent charities for carers, increasingly intense one-on-one care situations can pose significant dangers to those relationships. With no one else in the equation but the person caring and the person cared for – where ‘each (is) the other’s world entire’⁴⁸² – resentment can often build up, the relationship distorted by such a high level of isolation.

Even worse, the isolation of caring relationships can lead to tragedies such as that of Jean and Derek Randall, both in their mid-70s, who were found dead in their home in Kingsthorpe, Northampton in January 2010. There were no suspicious circumstances: Jean was confined to a wheelchair, her husband was her sole carer, and together they had died in their cold house. It was feared they had been there five days before they were found. ‘*Jean could not do anything for herself at all,*’ a neighbour reported, ‘*and Derek got to the point where he simply could not cope with lifting her, doing her washing or anything.*’⁴⁸³



Faced with tragedies such as this it’s difficult to decide whether culpability fundamentally lies with society or state, whether we should focus our anger on the isolation of many older people in Britain or upon statutory authorities. As a neighbour of the Randalls put it,

*‘It is disgusting that it came to this. I believe they died because everyone who is supposed to care for the elderly in our society did not do it. Everyone passed the buck.’*⁴⁸⁴

Admittedly, as far as the Randall case is concerned, an independent review has exonerated local agencies, finding that the Randalls had refused Social Services’ offers of interim care. This raises the question – as Stephen Burke, Chief Executive of the national charity Counsel and Care and member of this Working Group, has stated – of what can be done to help older people who refuse care and support.⁴⁸⁵ Be that as it may, the Randall tragedy, as many have said in evidence to this Working Group, is an extreme instance of what happens when intense one-on-one caring relationships become isolated and unrelieved. And it is not a one-off. In July 2010 another carer, Stephania Wolf and her disabled daughter were found dead in their bungalow in Wheathampstead, Hertfordshire.⁴⁸⁶ Again it was similarly reported that Stephania had repeatedly turned down offers of help from Social Services to care for her daughter Sam.

482 McCarthy C, *The Road*, London: Picador, 2006, p4

483 Accessed via: <http://www.northantset.co.uk/news/Elderly-couple-found-dead-in-5968938.jp>, 09 January 2010

484 Ibid.

485 Accessed via: www.counselandcare.org.uk/assets/library/documents/39_Mr_and_Mrs_Randall_23.08.10.pdf, 23 August 2010

486 Accessed via: <http://www.guardian.co.uk/society/2010/aug/03/mother-disabled-daughter-deaths>, 03 August 2010

5.3.2 MINIMAL SUPPORT FOR CARERS

Currently state support for carers is extremely limited, whether it be financial support through benefits or direct support from local authorities.

“More help needs to be available to carers who provide regular help. While this may be difficult in current economic circumstances, it should be an ambition for the future.”

A carer, in evidence to the CSJ

The main benefit for carers is Carer's Allowance and the 2009/10 rate is £53.90 a week. Previously known as the Invalid Care Allowance, the benefit was introduced in 1975 as a way of trying to ensure that those who provided care full-time had an income of their own rather than being financially dependent on the person they cared for.

Today around 500,000 carers receive Carer's Allowance. To be eligible for it someone has to care for at least 35 hours a week for someone in receipt of Disability Living Allowance or Attendance and not be earning more than £95 from paid employment.

Carer's Allowance is the lowest of all income replacement benefits, the UK lagging significantly behind other nations in terms of the financial support it provides for its carers. (Ireland, for example, pays a weekly €212). Carers UK report that carers are 'insulted' by the low level of Carer's Allowance.⁴⁸⁷

In July 2008 a Work and Pensions Select Committee concluded that Carer's Allowance was outdated and that carers benefits needed to be radically overhauled for the reason that it neither functions as the feasible income replacement it was intended to be nor takes into account those who care for more than one person⁴⁸⁸ (again unlike Ireland where, if someone is providing care for more than one person, they are entitled to an additional 50 per cent of the maximum rate of Carer's Allowance each week).

In terms of support from local authorities, all carers have a right to an assessment of their needs by Social Services. Yet only 378,000 carers accepted an offer of an assessment in 2007/8, and of those only half received a service.⁴⁸⁹ Officially, the Association of Directors of Adult Social Services (ADASS) have issued guidance recommending that, when assessing someone with care needs, 'councils must properly assess the whole situation', taking into account 'the ability and willingness of the family and other sources of unpaid support to continue to providing support'.⁴⁹⁰ On the ground, however, all too often this fails to happen. Instead, as Gordon Conochie, Policy & Parliamentary Officer for The Princess Royal Trust for Carers & Crossroads Care, told the Working Group:

'When the social worker comes round he or she generally only asks what needs the person has. Too often, the reply is that their wife or husband

487 House of Commons Work and Pensions Select Committee, *Fourth Report – Pension Reform, Session 2007-08*, Section 125, p43

488 Ibid.

489 Carers UK, *Facts about carers*, London: Carers UK, 2009, p6

490 Association of Directors of Adult Social Services, *Common resource allocation framework*, October 2009 (updated June 2010), p19

does most things and they manage fine by themselves. The social worker then leaves not having asked the carer whether they are able to cope or what the impact on their life is. Of course, the rational thing is to do hide your carer under the bed, meaning that's how you'll receive more support from Social Services.'

Low levels of assessments are partly a function of the difficulty of identifying carers. Though we have a sense of the size of the group of unpaid carers in the UK, day to day (like socially excluded older people in inner-city contexts) carers all too often remain a hidden group.

Among the people best placed to identify carers, and particularly carers severely under strain and at risk, are GPs. Research shows the prioritising of support for carers by primary health (for example, through having Carers Support Workers stationed in GP surgeries) translates into dramatically reduced levels of distress among carers.⁴⁹¹ Despite that, many GPs still assume that support for carers is the sole duty of councils. We have heard that, at times, identifying carers is a low priority for primary health care professionals. Given this problem, carers' charities have welcomed the Coalition Government's October 2010 announcement that £4.4 million will be reinvested into schemes focusing on 'early contact' with people who have recently become carers.

5.3.3 RESPITE CARE

It is widely recognised that one of the answers to the serious problem of increasingly intense and isolated caring situations is respite care. It is not a question of replacing primary carers but rather of providing relief at regular intervals, of structuring breaks into a carer's week, month or year. Not only can this provide crucial time-off for the primary carer; it may also serve to introduce other people into the caring relationship, helping to alleviate the problem of intense, isolated one-on-one caring situations.

Yet at present, as far as state support goes, respite breaks are often allocated only to carers who reach thresholds indicating that the crisis is imminent. As one carer stated, in evidence to the Working Group:

'It's a catch 22. The Government is saying, 'more people can be kept at home'. But unless carers have help this won't happen. They (carers) will be overwhelmed and the people we care for will have to go into residential care instead.'

“Before what happened to my husband I was a very busy lady. Nearly two years on it is very wearing and very tiring. I used to swim twice a week, to ease my rheumatoid arthritis. But I haven't been swimming in 18 months because John isn't safe enough to be left alone... There has to be respite for the carer.”

Hazel, 75, carer to her husband John, who suffers from dementia, in evidence to the CSJ

491 The Princess Royal Trust for Carers & Crossroads Caring for Carers, *Putting People First without putting carers second*, London: The Princess Royal Trust for Carers and Crossroads Caring for Carers, 2009, p24

Respite breaks for carers are not holidays. They are essential ‘pit-stops’, and therefore their provision should be the priority in any preventative agenda. As Imelda Redmond, Chief Executive of Carers UK has stated, failure to provide breaks is ‘short-sighted’, since ‘without a break (carers) can often reach crisis point, where their own physical and mental health deteriorates (at which point) trusts will have to provide additional support at additional cost.’⁴⁹²

The previous Government, in its rhetoric at least, recognised the importance of respite care. In June 2008 it published its National Carers Strategy,⁴⁹³ announcing a major expansion of respite care and doubling money set aside for respite breaks for long-term voluntary carers. In 2008/09 £50 million, and the following year



Staff from St Christopher's Hospice providing evidence on care

£100 million, was to be added to Primary Care Trust (PCTs) budgets to fund time-off for long-term carers. But instead of ring-fencing the money, the Government simply asked PCTs to set aside this money from the annual increases in the health budget.⁴⁹⁴ And so when in October 2009 two prominent Carers charities – The Princess Royal Trust for Carers and Crossroads Care – requested spending data under the Freedom of Information Act, they found that only 23 per cent of the first year's money was being spent on carers. Worse, many trusts had no idea how much money they received towards respite breaks, were not telling people

what they were using the money for and had not even spoken to local authorities about publishing a joint plan.⁴⁹⁵ The money they had received was simply spent elsewhere. And so, whatever the rhetoric, in reality it seems respite care continues to be undervalued and underfunded at a local level.

As well as inadequate provision of respite care, the quality of respite care, including the particular way it is delivered, to a large extent determines whether carers accept its offer. Earlier this year Crossroads Care conducted a survey across its 100 schemes, asking the question, ‘What are the barriers to unpaid carers getting a break?’

These are the typical answers given by carers:

- ‘I don't trust the quality of respite care staff coming from agencies.’
- ‘Some staff aren't well enough trained. They don't have sufficient knowledge of dad for me to leave him with them.’
- ‘I don't feel comfortable leaving my wife with strangers. I don't want to feel like I'm abandoning her’.
- ‘Sometimes, just as I've begun to build up a relationship with a care worker, they [the agency] start sending me another.’

492 Accessed via: <http://news.bbc.co.uk/1/hi/health/8303672.stm>, 12 October 2009

493 HM Government, *Carers at the heart of 21st-century families and communities*, London: Department of Health, 2008

494 Accessed via: <http://news.bbc.co.uk/1/hi/health/8303672.stm>, 12 October 2009

495 Accessed via: <http://news.bbc.co.uk/1/hi/uk/8554804.stm>, 09 March 2010

Given the importance of respite care, the Working Group was eager to identify effective providers of respite care. Crossroads Care is one such charity.

‘For Some Much Needed Respite’ - Case Study: Crossroads Care

Crossroads Care is Britain’s leading provider of respite care for unpaid carers. A not-for-profit organisation, Crossroads operates through 100 schemes across England and Wales, each functioning like a franchise, independent but signing up to a partnership agreement. Through these schemes Crossroads Care currently employs 5,000 trained professionals and provides respite support for 35,000 carers. Though it varies for each scheme, overall 73 per cent of Crossroads Care’s total income is received from statutory authorities. And the carers they typically come into contact with will be from the at-risk group who provide 50 or more hours a week of care to family members. Most commonly, the people Crossroads Care support are caring for those with dementia, Alzheimer’s, stroke and cancer patients.

The pathway is simple: a carer will be flagged up, often at the point of breakdown, by social or health services. For instance, a carer is admitted to hospital because the strain of caring has caused their own health to fail. This triggers health and Social Services to look at the needs of person requiring support, and how they can help the carer manage that caring role. Crossroads are then commissioned to provide a break and support for the family. Increasingly common is for service users who have a personal budget to come straight to Crossroads Care for support.

Crossroads tries to tailor its service in particular ways. First, it tries to ensure it employs carer support workers (who go in temporarily to relieve primary carers) who are well trained and highly committed. High levels of training are provided and many schemes also offer staff optional ‘guaranteed hours contracts’. Knowing you will get a definite 17 hours a week of work provides a real incentive to stay. This helps Crossroads to retain the staff they need to provide the quality of service which primary carers want and need, a service where they get to see the same respite care worker consistently and can build a relationship with that particular person. Secondly, to cater to the kind of people whose ‘voices’ were represented in their survey, Crossroads tries hard to focus on the carer themselves. As Gordon Conochie, policy officer at Crossroads Care, told the Working Group:

‘It’s not enough simply to send a carer support worker to look after the person receiving care and send off the carer for a couple hours. In an intense caring situation sometimes the primary carer won’t know what to do with two hours by themselves. So we try to do something extra: we focus on the carers themselves, often bringing them together socially. We want people to feel like they have a more normal life.’

The Working Group saw one example of this in its visit to the Saturday ‘Caring Cafe’ run by Crossroads Care Richmond-upon-Thames. The Caring Cafe is specifically designed for people suffering from dementia to attend along with their carer. While staff are present who are specially trained in dementia, thus allowing a carer to leave their ‘charge’ to go out or attend an on-site meeting, the cafe is also designed to provide a place for carers to be together. ‘When your partner is first diagnosed with dementia,’ says Norm, an older carer, ‘you think you’re the only one. I came here to learn and understand from other carers what I should and shouldn’t be doing.’ Whereas in public places often carers (when they are with the person they care for) ‘feel nervous they will be looked at’, in this environment, so another carer told us, ‘the pressure’s off; no one stares.’

5.3.4 THE DANGER IF NOTHING IS DONE

We have emphasised in this chapter that the ageing society is not a distant prospect but a present reality. In terms of unpaid care, the challenge of people living longer with greater care needs has already arisen. Many carers are already struggling to bear the pressures this new reality presents (shown by the doubling within a decade of the number of carers providing 50 hours or more a week).

But as well as the current strain on the massive group of unpaid carers in the UK, if both the state and society fail to reduce the burden on those who have and will have unsustainable caring roles, future prospects are inauspicious.

The central issue is supply. As the *Crediting Carers* report points out, Rafael Wittenberg, who performed the financial modelling for 2009's Green Paper, has admitted that his modelling assumes an increase in the amount of care provided by carers rising in parallel with the provision of paid care.⁴⁹⁶ But there is no evidence that this will happen. In fact predictions are that demographic and behavioural changes will mean that by 2017 we will reach a 'tipping point' for care when the numbers of older people needing care will outstrip the numbers of working age family members currently available to meet that demand. By 2041 a shortfall of 250,000 intense carers is predicted.⁴⁹⁷

5.4 State Provision of Care

In England and Wales responsibility for social care lies with local authorities. According to the NHS Information Centre, in 2008/09 an estimated 1.22 million people aged 65 and over received services from their local authority (of a total of 1.8 million adults).⁴⁹⁸ Since adults' and children's Social Services were separated (in accordance with the Children's Act of 2004) older people make up 68 per cent of all adult Social Service clients. In terms of expenditure too, as Figure 33 demonstrates, older people currently constitute the largest line-item of adult Social Services' budgets.

A typical Council with Adult Social Services Responsibilities (CASSR) will spend around £92 million on adult services, of which over 50 per cent goes to older people's services. And even before children and adults' Social Services were separated, expenditure on services for older people constituted 43 per cent of the combined budget (compared to 25 per cent spent on children and families).⁴⁹⁹

496 The Princess Royal Trust for Carers & Crossroads Care, *Crediting Carers: building a society to care*, London: The Princess Royal Trust for Carers & Crossroads Care, 2009, p2

497 Pickard, L, *Informal Care for Older People Provided by their Adult Children: Projects of Supply and Demand to 2041 in England*, Report to the Strategy Unit (Cabinet Office) and the Department of Health, PSSRU Discussion Paper 2515, London: Personal Social Services Research Unit, 2008, p12

498 NHS Information Centre, *Community Care Statistics 2008-9: Social Services Activity Report, England*, London: NHS Information Centre, 2010, p4

499 NHS Information Centre, *Personal Social Services Expenditure and Unit Costs England, 2006-7*, London: NHS Information Centre, 2008, p3

Figure 33 – Adult Social Services Expenditure⁵⁰⁰

User group	Total cost (£bn)	Average cost (£m)
Older people	7.4	49
People with learning disabilities	3.5	23.6
People with mental illness	1	7
People with physical disabilities	1.5	10.2
Other (including asylum seekers)	0.4	2.4
Total	13.8	92.2

5.4.1 THE PATTERN OF SERVICE PROVISION

Of the 1.22 million older people supported by Social Services, around 266,000 are supported in long-term care (174,000 in residential care homes, 92,000 in nursing homes). The remaining one million people receive services in the community, i.e. day care, domiciliary/home care, day care, aids and adaptations, meals on wheels, and direct payments.

Yet in terms of expenditure, Adult Social Services budgets are still weighted towards long-term care, although there is considerable variation between different councils.⁵⁰¹ Even taking what people think of as the three core social care costs – home care, residential care and nursing care – we can see that although the people supported in long-term care (i.e. residential and nursing) are a minority, they account for £5 billion of the total £7 billion budget. Figures 34 and 35 show the comparison:

⁵⁰⁰ Local Government Association and Association of Directors of Adult Social Services, *Report on Adults' Social Services Expenditure 2008-2009*, Leeds: York Consulting, 2009, p7

⁵⁰¹ Calculated from Laing and Buisson, *Care of Elderly People: UK Market Survey 2009*, London: Laing & Buisson, 2009, p193

Figure 34 – Older people receiving council services: number of people nationally⁵⁰²

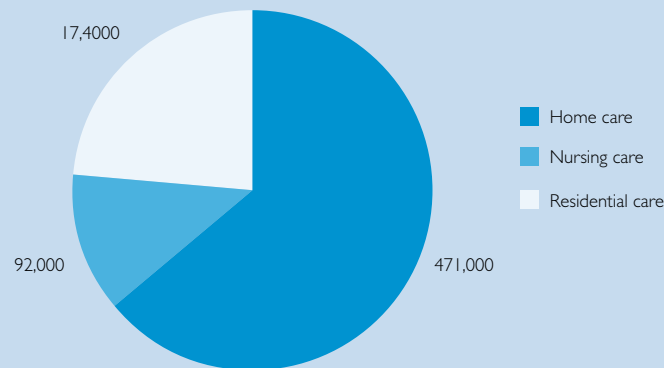
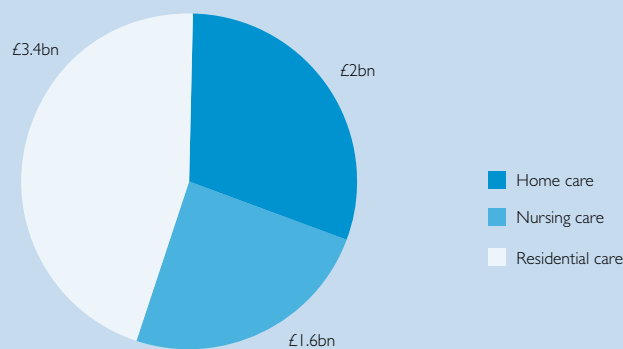


Figure 35 – Older people receiving council services: expenditure nationally⁵⁰³



In terms of the state provision of care for older people, four main themes have been brought to our attention during the course of our evidence gathering. They are prevention, personalisation, health and social care integration and the rationing context. We will look at each of them in turn, before proceeding to a separate examination of the two main venues where these issues surface: care at home and care homes.

5.4.2 PREVENTION

In chapter three of this Review we emphasised the importance of nutrition, exercise and diet to prevent ill health in older age. Here we want to examine prevention specifically in terms of care. Preventative care services are those

⁵⁰² NHS Information Centre, *Community Care Statistics 2008-9: Social Services Activity Report, England*, London: NHS Information Centre, 2010, p29

⁵⁰³ Local Government Association and Association of Directors of Adult Social Services, *Report on Adults' Social Services Expenditure 2008-2009*, Leeds: York Consulting, 2009, p24

which prevent or delay higher-dependency situations among older people, i.e. they are low-level interventions which enable people to avoid or postpone admission into long-term care as well as those which postpone someone's need for intensive domiciliary care packages. They include:

- Reablement services/Intermediate care - intensive short-term 'blasts' of care aiming to get people back on their feet after a period of illness or time in hospital. Reablement may be provided in a residential facility – for example, a six week placement a care home – or alternatively may involve a temporary care package provided into someone's home.
- Day care.
- Aids and adaptations – fitting a house with handrails, for example, significantly decreases the chances of falling, thus preventing the onset of higher-need situations.
- Telecare products – fall alarms and safety sensors (for risks such as gas leaks and bath floods) increase security for older people and help them to live longer in their own homes.
- Extra-care housing.



Staff of Elgin Close Extracare Housing with members of the Working Group

Preventative social care, as the Working Group has been told repeatedly, is absolutely crucial as we come to terms with the fact that we are an ageing society. Staving off high dependency care situations is vital not just because it is better for people and what people want but also given the expense of residential and nursing home care, not to mention unnecessary or prolonged hospital admissions.

Between 2006 and 2009 the Department of Health piloted The Partnership for Older People Projects (POPPs). 29 local authorities bid for a share of the £60 million budget to develop preventative services designed to help older people remain independent in the community. Over three years over a quarter of a million people benefited from 147 new projects, from low-level services such as lunch clubs to more formal preventive initiatives such as hospital discharge and rapid response services. For example, Bradford Council received £2.3 million to establish the Health in Mind project, which included the commissioning of two intensive support teams to provide short-term help to people at risk of admission to acute or institutional care. Significantly, the POPP's evaluation report revealed:

- For every £1 spent on POPP projects £1.20 was saved in emergency bed days.⁵⁰⁴
- Overnight hospital stays were reduced by 47 per cent.⁵⁰⁵
- Use of Accident & Emergency departments dropped by 29 per cent.⁵⁰⁶

504 Personal Social Services Research Unit, *National Evaluation of Partnerships for Older People: Executive Summary*, London: Department of Health, December 2009, p1

505 Ibid.

506 Ibid.

However, despite the recognised savings of preventative care, the pilot period has come to an end, with only 20 per cent of the projects set to be sustained by local PCTs. It thus provides, as many have said to the Working Group, yet another example of a successful pilot which fails to be scaled up or rolled out. Specifically in terms of prevention, it still seems that both central and local government people are often unwilling to match rhetoric on prevention with actual delivery.

Having acknowledged the importance of prevention, during the course of our evidence gathering we have also heard the criticism that much so-called preventative work is currently ineffective. John Bolton, an expert in the field (who, as well as having worked at the Audit Commission and for the Department of Health, has been an Adult Social Services Director at a number of local authorities) told the Working Group that many preventative services in

fact achieve the opposite of what they intend: rather than postponing higher-dependency situations sometimes in so called 'preventative services' can serve to stimulate them.

Such a warning alerted the Working Group to the urgency of distinguishing between genuinely preventative services and those which perhaps make people prematurely dependent.

“People think that supporting older people is like children’s work and the earlier you get in the better. But in fact many so-called preventative services simply make people dependent. The danger is that when you put someone in a care environment they simply adjust to the level of input they’re given.”

John Bolton, in evidence to the CSJ

Reablement

Perhaps the most crucial genuinely preventative measure is reablement. ‘*The biggest issue in social care*,’ John Bolton again told the Working Group, ‘*is how you treat an older person who has just had a crisis or medical intervention*.’ A fall, an illness or a major operation, followed by a stay in hospital, can knock someone’s confidence, cause depression and severely impact upon the routine activities of daily living. In section 5.4.4 below we examine the

lack of integration between social care and health care at the point of hospitalisation. Here we want to raise concerns we have heard concerning the way care is delivered even when Social Services and medical professionals work together. The concern is that all too often a crisis which has landed an older person in hospital is then exacerbated by the way care is provided following their hospitalisation.

First, the Working Group has heard repeatedly that the care model is too often oriented towards admitting hospitalised older people into residential care. Secondly, even if someone is not admitted to residential care and thus requires additional home support upon discharge, all too often what ends up being arranged from the hospital bedside (i.e. at the point of crisis) is a substantial domiciliary care package. The danger, so we have heard, is that to automatically put a substantial care package in place may in fact accelerate an older person’s dependency rather than aid their recovery. It is in effect to abandon any hope of getting that person back on their feet, given the rarity of substantial domiciliary care packages being rolled back.

The solution to this is not to send an older person home from hospital with no support. The answer is reablement, the provision of a short-term blast of care specifically aimed to restore that person's independence (i.e. the care put in is, from the outset, considered provisional). Instead of arranging a long-term domiciliary care package (or even admitting into residential care), reablement provides a typically six week period of support either in someone's own home or sometimes in a residential facility.

In October 2009 the Department of Health published *Use of Resources in Adult Social Care*,⁵⁰⁷ a guide to help local authority senior managers make an effective self-assessment of their social care budgets. Acknowledging that most likely way that local authorities can save money in the future is by reducing the proportion of spend on residential care, *Use of Resources* draws upon best practice around the country to recommend key preventative measures local authorities can use to help them do just that. In the best local authorities approximately 50 per cent of older people using reablement-based intermediate care return home without requiring any package of care.⁵⁰⁸

Given how effective reablement proves, the Department of Health's most recent guidance concerning intermediate care states that no older person at risk of admission to long-term care should have their needs assessed in hospital, nor should they be admitted straight from hospital unless there are exceptional circumstances.⁵⁰⁹ Yet while most local authorities in England and Wales offer some kind of reablement services, and while the very best insist upon and provide six week reablement blasts to anyone likely to be admitted to long-term care from hospital, reablement is not yet provided effectively across the country.

Day Care

The urgency of sustaining and expanding day care services was also brought to the attention of the Working Group. One day care centre visited by the Working Group was Cloverdale, a Friends of the Elderly Day Club in Wallington. Most of the people Cloverdale supports are aged 85 and over. Some clients attend one or two days a week; others come daily. 'The idea is for the place to be like your own front-room', Wendy, the manager explains; 'A home away from home.' The focus is on maintaining people's life skills, as well as combating the isolation of individuals with significant care needs and low levels of mobility. For some, the sheer

“The biggest issue in social care is how you treat an older person who has just had a crisis”

John Bolton, in evidence to the CSJ

“The single biggest discovery by adult social care in the last decade is that many older people will recover from ill health with the right treatment and support.”

Uses of Resources in Adult Social Care, Department of Health⁵¹⁰

507 Department of Health, *Uses of Resources in Adult Social Care: A guide for local authorities*, London: Department of Health, 2009

508 Ibid., p28

509 Department of Health, *Intermediate Care – Halfway Home: Updated Guidance for the NHS and Local Authorities*, London: Department of Health, 2009, p4

510 Ibid., p26

fact of communal meals makes you want to eat (where at home, alone, you might be tempted to skip meals). *'I'd be lost without it,'* says Paul, 78. And for individuals who find it difficult to participate in group activities – such as Lizzie, an 89-year-old woman suffering from dementia – one-on-one care is provided by trained staff.

Too often day care suffers from a perception problem. As Mark Wilson of Friends of the Elderly told the Working Group:

'Day care is totally underestimated. People think it's just about singing and dancing, that it's basically a bit of a jolly. It's not. It's about providing constant life-sustaining support to people.'

Without day care, admission into residential care would be the only option for many people, yet, as we note in Section 5.4.5 below, it is day care which is being severely rationed by local authorities.

Extra Care Housing

Extra Care Housing is an innovation which has developed significantly over the last ten years, proving an effective alternative to residential care. The number of older people living in Supported and Extra Care Housing has doubled from 25,000 in 2003 to 50,000 in 2008.⁵¹¹

Extra care housing (also known also as Very Sheltered Housing or Assisted Living) allows older people with care needs to continue to live in self-contained homes with their own front doors (whether in flats, a bungalow or a retirement village). The benefits of Extra Care Housing are multiple. It offers continuing independence in a safe environment, with care normally accessible from on-site staff 24 hours a day: it allows for flexible care packages; the vast majority of Extra Care residences are modern and designed specifically for older people; and the greater possibilities Extra Care affords for custom-designing an occupant's own space makes it an appealing option for people suffering from dementia (for example, familiar objects and furniture to alleviate confusion and disorientation). For local authorities, meanwhile, the unit cost of the accommodation in Extra Care Housing is on average much cheaper than the equivalent price of residential care. The Adult Social Services Director of one inner London Borough told the Working Group of the tens of thousands of pounds Extra Care was saving her budget every year since she began using it as an alternative to residential care.

The Working Group witnessed first-hand the benefits of the Extra Care option on a visit to Mary Seacole House in Hammersmith. Built in 2005 and consisting of 32 individual flats, the great advantage of Mary Seacole is the way it can cater for significantly different levels of care. And while there are communal facilities and meals, people can keep themselves to themselves,

⁵¹¹ Department of Health, *Uses of Resources in Adult Social Care – A guide for local authorities*, London: Department of Health, October 2009, p36

living as they do in their own flats. What all of this enables is for ‘*people to stay in familiar surroundings for as long as possible*’, as the manager tells us.

The Challenge of Identification

One of the key obstacles to prevention is the difficulty of identifying people who are at risk. All too often diagnosis is far too late. Thus medical practitioners spoke to the Working Group of older people living in poverty arriving at Accident and Emergency departments in poor physical condition. At that point – when they come onto the radar, as it were – admission into long-term care is the necessary step. But as Dr Jane Evans, Consultant geriatrician at King’s College, Denmark Hill, told the Working Group, speaking of many of the older people she sees in hospital,

‘If they could have been identified earlier, treatments and preventative measures could have been started to maintain their independence for longer. People are failing in community but no one notices.’

Furthermore, if reablement is an example of rehabilitation services achieving the prevention of longer and deeper dependency, then alongside this predicting risk and forestalling the onsets of crises – strokes, falls, chronic respiratory or incontinence – is a challenge to which GPs in particular need to rise given the context of the ageing society.

5.4.3 PERSONALISATION

As we saw in section 5.2.3, personalisation has been hailed as a social care transformation programme. The hope is that putting choice at the heart of care will revolutionise service provision, with a consumer-driven market driving up standards of care and the ‘paternalistic’ model of provider-caring-for-recipient being replaced by a model which revolves around the individual’s greater self-management. However, in terms of evaluating the personalisation reforms, the Working group has been alerted to a number of issues.

The Working Group recognises that initiating such a major sea-change across public service provision takes time. Even so, latest figures indicate that only 13 per cent of adult service users in England have access to personal budgets⁵¹² and a recent poll by advice provider Opportunity Links found that four in ten councils have missed a key target for the roll-out of personalisation: having an information and advice strategy in place by April 2010 to support clients to make choices on care and support.⁵¹³ What we have been more

“People are failing in the community and no one notices”

Dr Jane Evans, in evidence to the CSJ

512 The Health and Social Care Information Centre, *Social Care and Mental Health indicators from the National Indicator Set - Provisional further analysis, England 2009-10*, Leeds: The Information Centre, 2010, p11

513 Mathie H, *Adult Social Care Information and Advice Survey: Summary Outcomes*, Opportunity Links, July 2010, p6

concerned with are reports that personalisation has proved more challenging to roll out among older client-users. The Department of Health has admitted recently that '*older people have not benefited to the extent that would be expected given the numbers using Social Care Services*',⁵¹⁴ a judgment which Adult Social Services directors have corroborated in evidence to the Working Group. What directors they see on the ground is a much higher take-up of personal budgets among younger adult with learning or physical disabilities.

Secondly, with the impending public expenditure cuts there is a danger that cuts will renders budgets toothless. That is, will the money allocated to a individual service user to spend as he or she chooses be enough to buy something with? Will personal budgets mean less people find themselves eligible for care support?

Thirdly, the Working Group has heard a number of charities express concern that while many people will be able successfully to become their own care managers, the most socially isolated might find themselves further isolated by personalisation reforms, no longer adequately supported by Social Services. The fear is that 'DIY care' is an unrealistic expectation for those who have become eligible for Social Services support for the very reason that they are unable to cope with life. With impending cuts to Social Services budgets, will there simply be the personnel to support the most deprived to manage their own budgets? The practice in some authorities of offering continuing assistance with support planning to those with complex needs and limited personal capacity or social support needs to be maintained as well as more widely offered.

Finally, personalisation is dramatically changing the way care is delivered. One Adult Social Services director spoke to the Working Group of one older man deemed eligible for support who in the past would simply have been offered a place at a local day care centre. Instead he has recently used his personal budget to join a silver screen cinema club and to employ a personal assistant to write his life story. This modernisation (the transition to personal budgets entailing the cancellation of local authority bulk contracts with care providers) will inevitably prove painful for many providers. Even accepting that, there is still a very real issue facing service providers: the uncertainty of who will want to buy what under personalisation. As the manager of one day care club told the Working Group, '*the real problem is that providers can't plan because they don't know how things are going to pan out*.' The danger is that this will lead to providers pulling out of preventative services which they consider too risky, ensuring that the choice agenda results in older people (though in receipt of their own budgets) in fact being deprived of choices.

⁵¹⁴ Department of Health, *Use of Resources in Adult Social Care: A guide for local authorities*, London: Department of Health, 2009, p14

5.4.4 LACK OF INTEGRATION

Despite significant examples of successful collaboration between health and social care, and despite the persistent policy emphasis there has been on ‘joined-up working’, lack of integration still remains a defining feature of the current system. Local government and health authorities still operate separate budgets, manage separate teams and are driven by different incentives. The consequence is that all too often older people fall between the cracks. We thus welcome the commitment of the Coalition Government to ‘break down barriers between health and social care funding to incentivise preventative action.’⁵¹⁵

At present, alongside the £7 billion also spent on older people’s care by local authorities in England and Wales, in 2009 the NHS spent £4.23 billion on elderly social care. This figure constitutes a 67 per cent increase since 2007.⁵¹⁶ The attribution of so exponential an expenditure increase to the local councils tightening their eligibility criteria (see section 5.4.5 below) has recently been contested.⁵¹⁷ More likely, it is due to the number of people in England in receipt of Continuing Care almost doubling (from around 25,000 to 50,000) due to the new guidance produced by the Department of Health in 2007.

The operation of two parallel systems is, as we saw in section 5.2.2 above, a legacy of 1948. While the NHS was designed to be a universally accessible service, social care was always supposed to be means-tested and remain the responsibility of local authorities. The failure of the 1990 Community Care Reforms to address the lack of integration between health and social care left ‘loose ends dangling’, as Wanless has argued.⁵¹⁸ Thus a decade later New Labour was still speaking of the ‘Berlin Wall’ separating health and social care and restating a desire to establish ‘integrated care that puts users at the centre of services provision’ and pleading the necessity of ‘a new spirit of flexible partnership.’⁵¹⁹ Yet despite the possibilities for partnership opened up by the 1999 Health Act – allowing for the development of pooled budgets and lead commissioning (where health or Social Services authorities can take the lead in commissioning on behalf of both) – today it is still the overall fragmentation of the system we have been repeatedly informed of. For instance, the sheer fact of separate budgets for the majority of health authorities and local authorities means that for Adult Social Service directors strapped for cash there is little incentive to invest in preventative measures such as Telecare to keep people out of hospital.

515 HM Government, *The Coalition: Our Programme for Government*, London: Cabinet Office, 2010, p30

516 Featherstone H and Whitham L, *Careless: Funding long-term care for the elderly*, London: Policy Exchange, 2010, p6

517 Dudley N, ‘Department of Health continuing care guidance caused dramatic rise in long term care spending not tightened local authority eligibility criteria’, *British Medical Journal*, doi:10.1136/bmj.c4613 August 2010. Accessed via: http://www.bmj.com/content/341/bmj.c4121.extract/reply#bmj_el_240094, 20th September 2010

518 Wanless, Sir Derek, *Securing Good Care for Older People: Taking a Long-term view*, London: The King’s Fund, 2006, p15

519 HM Government, *Modernising Social Services*, London: The Stationery Office, 1998, 6.5

“Why should I spend millions on preventative services such as telecare if all the savings will be in health?”

Adult Social Services Director, in evidence to the CSJ

From all we have heard, the hub of this breakdown between health and local government is hospital. The Working Group has been repeatedly informed of health and social care personnel not working together effectively when older people have been admitted to hospital. For example, discharging patients promptly and safely requires the right people being present together at the right time: only when doctors, nurses, social workers and carers are all at the bedside can a patient be best advised and the best

plan of action arranged in terms of home support following a crisis admission to hospital. Frequently, however, that fails to happen, with a delay in discharge proving detrimental to the patient given the well-known risk of deterioration in hospital. Even within health, so we have heard, communication often breaks down, with medical professionals in hospital failing to interact with community health care. Many GPs report the difficulty of managing the continuity of the care of their patients with long-term conditions when hospitals fail to send them the outcome of outpatient investigations and treatments.

Added to that, as experts on dementia have informed the Working Group, memory clinics must be involved in the equation, working out with other agencies if and how it will be possible for a person suffering from dementia to return home. The vision for a better coordinated and more proactive response to this condition prevalent in much older age groups and the cause of great anxiety is well documented in the National Strategy on Dementia launched last year.

72 per cent of councils have chosen to focus their funding for social care solely on people whose needs are substantial or critical⁵²⁰

5.4.5 RATIONING

Since the community care reforms of the early 1990s local authorities have been the main channels of funding for care for older people. Funding from central government, supplemented by Department of Health grants and Council Tax, is not ringfenced within local authority budgets. Rather, each local authority has discretion over its own

budget and how much it pays for care.

To balance expenditure on care with the available funding, councils set eligibility thresholds which limit publicly-funded support for those judged to have care needs above this threshold. Local authorities assess needs broadly within a national framework of criteria: the *Fair Access to Care Services* (FACS) framework, introduced in 2002 to address inconsistencies across the country about who gets support and to provide a more transparent system, yet still within a discretionary system whereby each authority can determine its overall funding for adult social care. But, as critics vociferously complain, this has led to a so-called ‘postcode lottery’, with different councils in England and Wales interpreting that framework differently.

⁵²⁰ Department for Work and Pensions, *First Release: DWP Quarterly Statistical Summary: Additional Table 8a*, London: Department for Work and Pensions, 2010

So, a social worker is called out by someone worried about his or her elderly next-door neighbour, or an older person turns up at a Council's One Stop Services requesting help, or a social worker goes to the hospital bedside of an older person who has had a fall. In each of those cases, how is the decision reached as to whether that person is eligible for state-funded social care?

Figure 36 – The current eligibility framework: the four bands of the *Fair Access to Care Service*⁵²¹

Level 4: Critical – When...

- Life is, or will be, threatened
- Significant health problems have developed or will develop
- There is, or will be, little or no choice over vital aspects of the immediate environment
- Serious abuse or neglect has occurred or will occur
- There is, or will be, an inability to carry out vital personal care or domestic routines
- Vital involvement in work, education, learning, social support systems, relationships and families cannot or will not be sustained

Level 3: Substantial – When...

- There is, or will be, only partial choice and control over the immediate environment.
- Abuse or neglect has occurred or will occur
- There is, or will be, an inability to carry out the majority of personal care or domestic routines
- Involvement of many aspects of work, education or learning cannot or will not be sustained
- The majority of social support systems and relationships cannot be or will not be sustained
- The majority of family and other social roles and responsibilities cannot or will not be undertaken

Level 2: Moderate – When...

- There is, or will be, an inability to carry out several personal care or domestic routines
- Involvement in several aspects of work, education or learning cannot or will not be sustained
- Several social support systems and relationships cannot or will not be sustained
- Several family and other social roles and responsibilities cannot or will not be undertaken

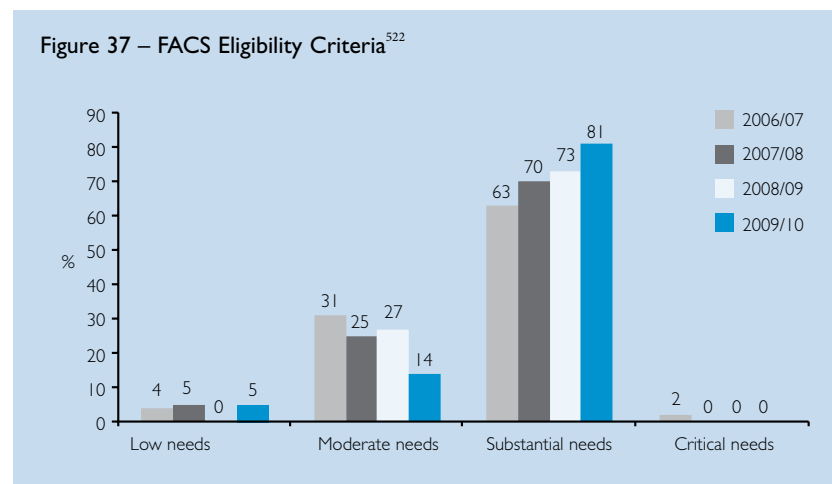
Level 1: Low – When...

- There is, or will be, an inability to carry out one or two personal care or domestic routines
- Involvement in one or two aspects of work, education or learning cannot or will not be sustained
- One or two social support systems and relationships cannot or will not be sustained
- One or two family and other social roles and responsibilities cannot or will not be undertaken

Local councils have responded to the pressure of an ageing society by trying to contain demand through restricting access to services. This has been achieved by consistently raising the thresholds of need eligibility (according to FACS criteria). Figure 37 shows the drift of local authority spend over

521 Department of Health, *Fair Access to Care Services – guidance on eligibility criteria for adult social care*, London: Department of Health, 2003, pp4-5

the last three years, along with a projection for 2009/10. Understandably, very few people prove eligible for council services when they have 'low' needs. Where there has been real change, however, is in the 'moderate' needs category. Whereas in 2006/07 of all the people Social Services departments decided to support 31 per cent were assessed as having 'moderate' needs (thus indicating a commitment at the level of local authorities to prevention) the forecast for 2009/10 is a mere 14 per cent. These findings have been corroborated by those of the regulator, the Care Quality Commission (CQC), whose most recent review indicates that 72 per cent of councils have chosen to focus their funding for social care solely on people whose needs are 'substantial' or 'critical'.



It is widely accepted that, over and above sheer financial eligibility, some means of limiting access to publicly funded support has to be in place. Rationing is inevitable, as Age UK has stated: *'It is accepted that in a system where there are limited resources, there has to be a tool used to decide who does and doesn't receive support.'*⁵²³ Nevertheless, the recent and dramatic drift of local authorities' funding only to those who present 'substantial' or 'critical' needs is having significant consequences:

First, rationing threatens the very preventative work most likely to ease the social and economic pressures on long-term care, an eventuality the previous Government's 2009 Green Paper candidly admitted:

'Too often our existing system makes poor use of its limited resources. Ever-increasing pressures on local authorities mean that resources are increasingly used to offer care and support when people's needs

⁵²² Local Government Association & Directors of Adult Social Services, *Report on Adults' Social Services Expenditure 2008-2009*, Leeds: York Consulting, April 2009, p10

⁵²³ Help the Aged, as quoted in Commission for Social Care Inspection, *Cutting the cake fairly: CSCI review of eligibility criteria for social care*, Newcastle: Commission for Social Care Inspection, October 2008, p31

*are highest. Money could often be better invested in prevention, rehabilitation and keeping people active and healthy.*⁵²⁴

In May 2010, for example, it was revealed that a third of local authorities had left infirm and disabled people waiting for more than three years for disability adaptations to their homes.⁵²⁵ Responses from various councils to a *Daily Telegraph* investigation indicated that many people waited so long for help that they were forced to move into care homes. And while domiciliary care is being squeezed, day care, except for the very frail, is in danger of disappearing all together for those who have a personal care need. This will also have a major impact on the health of those people and thereby their ability to stay at home.

Second, rationing is resulting in rising levels of unmet care needs among the poorest older people in England and Wales. According to an online survey for a 2008 review by the regulator (then the Commission for Social Care Inspection):

- 25 per cent of adults seeking help from their local councils fell outside the eligibility criteria.
- Of those who did meet eligibility criteria, only 30 per cent reported receiving all the help they needed.⁵²⁶

In the four years since that review, eligibility criteria have tightened even further, meaning in Britain there is a growing number of both low income and low asset older people simply falling through the net, people who 10 years ago would have been identified as vulnerable and qualified for care support but now are deemed ineligible for care. Furthermore, recent research by the LSE and Kent University anticipates that if the Coalition Government's 25 to 40 per cent departmental cuts are passed straight on to social care budgets, after the first two years councils will only be able to afford care at home for half of those eligible according to today's criteria.⁵²⁷ We will monitor whether these cuts will be successfully mitigated against by the £2 billion allocated to social care in October 2010's Comprehensive Spending Review.

5.5 Care at Home

As we have already noted, ever since the 1950s social care has attempted to alter its role from supporting older people in institutional care to supporting them in the community. Over the last decade, keeping people in their own

524 HM Government, *Shaping the Future of Care Together*, London: The Stationery Office, 2009, p9

525 The Daily Telegraph, 'Frail and elderly people wait years for basic disability equipment', 2nd May 2010. Accessed via: <http://www.telegraph.co.uk/health/elderhealth/7663358/Frail-and-elderly-people-wait-years-for-basic-disability-equipment.html>, 4th August 2010

526 Commission for Social Care Inspection, *Cutting the cake fairly: CSCI review of eligibility criteria for social care*, Newcastle: Commission for Social Care Inspection, 2008, p44

527 Forder J and Fernandez J-L, *The impact of a tightening fiscal situation on social care for older people*, PSSRU Discussion Paper 2723, PSSRU and Age UK, 2010, p8

homes for as long as possible has been the policy most emphatically endorsed by government. Admission into residential care may well be the right option for some people, those with the highest needs. But helping people to stay in their own homes is not only what most older people want; it is also far more affordable, given the costs of residential care.

How realistic this policy is, however, depends upon the availability and the quality of domiciliary care, whether directly provided or just commissioned by local authorities. Yet during the course of its evidence gathering, the Working Group has heard of the severe rationing of domiciliary care as well as the (in too many places) poor quality of service provided.

In 2008/09 just under 500,000 of the 1.2 million older people receiving council services were receiving home care, a greater number than receiving any other kind of service (including residential and nursing care).⁵²⁸ And yet, despite the drive to keep people at home, the proportion of older people receiving home care has significantly decreased since 1994.⁵²⁹ At that time there were just under a 160 households receiving home care per 1,000 population aged 75 and over. By 2008 this number was down to just over 80.

As we have seen, the 1990 Community Care Act not only put local authorities firmly in charge of social care commissioning; it also allowed them to become brokers and care managers of social care rather than the direct providers. The resultant growth in independent sector provision of care has been most pronounced in terms of domiciliary care. In 1992 just two per cent of domiciliary care hours were provided by independent providers; compared to 81 per cent in 2008.⁵³⁰

5.5.1 THE RATIONING CONTEXT

In 2006 Sir Derek Wanless published his seminal report for the King's Fund, *Securing Good Care for Older People*.⁵³¹ One of the things it demonstrated was that, while social care provided in the community for people with lower levels of need can often delay admission to long-term care, the recent trend in service deployment has in fact been a move away from relatively low-level services. In short, increasingly intensive domiciliary care packages are being provided for fewer people (i.e. whilst the number of households receiving help has dropped since 1994, the number of 'contact hours' provided by councils have risen in

the last decade from 2.5 to 3.5 million hours). What that means, Wanless concluded, is that the 'staying put' policy has been undermined by the rationing of care packages. The fact we are still debating how radically to alter the pattern of service provision indicates 'the relative failure

More and more care is being provided for less and less people

528 The NHS Information Centre, *Community Care Statistics 2008-09: Social Services Activity Report, England*, London: The NHS Information Centre, 2010, p29

529 Wanless, Sir Derek, *Securing Good Care for Older People*, London: The King's Fund, 2006, p52

530 Laing & Buisson, *Care of Elderly People: UK Market Survey 2009*, London: Laing & Buisson, 2009, p32

531 Wanless, Sir Derek, *Securing Good Care for Older People*, London: The King's Fund, 2006

of services to achieve the vision set out over the past 20 years.⁵³² Indeed, by international standards England had an atypically low proportion of the people receiving formal home care: four per cent of the population aged 65 and over, compared to Australia's 21 per cent or Denmark's 25 per cent.⁵³³

Since 2006, moreover, the trend of local authority rationing of care has only increased, as we have shown in section 5.4.5. Predictably, the first group of people to be cut out of services have been those receiving care at home. As we noted above, research from LSE and Kent University has shown that if the departmental cuts announced by the Coalition Government in the summer of 2010 are passed straight onto social care, in 2012/13 the total numbers of older people that would be state-supported would fall by nearly one half of those eligible on today's already strict criteria.⁵³⁴ And the men and women who would lose out, as the authors of the research point out, would not be those supported in residential care but rather those receiving domiciliary care. Further down the line the consequence of such cuts could be less rather than more older people being able to live at home and, potentially, more people entering residential care. Such an outcome would not only severely undermine the policy agenda – helping people to stay in their own homes; it would also be highly counter-intuitive given the savings agenda.

5.5.2 POOR QUALITY OF SERVICE

During our evidence gathering, the most frequently heard complaint concerning domiciliary care related to the brevity of home care visits. Again and again the Working Group was told of domiciliary care workers providing care for only 15 minute periods.

Jerry Nash,⁵³⁵ 66, suffers from a degenerative and terminal illness and is currently in receipt of a four-visit-a-day care package. He told the Working Group that while *'you can't expect the state to do everything. You can't expect them to provide 24/7 relationships'* what did disappoint him was the fact that so many of his care workers were *'in and out of the door in ten seconds.'* Jerry spoke of ways he compensated for this: to make them stay the full hour he insists on having breakfast before bath (so they can't cut corners on breakfast). He also states that the rush induced by *'flying visits'* inevitably leads to mistakes being made. Sometimes it may just be food left in the fridge; on other occasions the mistakes are more serious. One care worker simply announced, *'I'm finished now. I've got to go,'* and then walked out the door having left the cooker on.

During its evidence gathering the Working Group was keen to ascertain the cause of this failing. Two points became apparent. First, that home care is by nature a less accountable realm than residential care: in people's homes care

532 Ibid., p14

533 Ibid., p53

534 Forder J and Fernandez J-L, *The impact of a tightening fiscal situation on social care for older people*, PSSRU Discussion Paper 2723, PSSRU and Age UK, 2010, p8

535 Not his real name

workers are not subject to the immediate supervision they would receive on the floor of a nursing home. But second, and more fundamentally the problem is caused at a commissioning or structural level. Care home providers and staff are often not paid for the time travelling between one client and the next, thereby forcing staff to reduce the already short time available to each individual. In addition, *The Future of Homecare*, a 2009 publication by Counsel and Care and Ceretas, draws attention to the problem of 'reverse e-auctions', whereby local authorities bid downwards in order to pay the lowest possible price for homecare.⁵³⁶ This type of commissioning was intended for items such as stationery and office furniture; as it seeps into social care purchasing, however, it results in the commissioning of time slots as short as 15 minutes.

In addition to the problem of flying visits, the Working Group also received evidence of other challenges to domiciliary care:

- The inability of some care workers to communicate at a point where communication is absolutely vital, e.g. when dispensing medication.
- Turnover for workers in this sector is currently running at an annual average of 22 per cent.⁵³⁷ This is particularly problematic in terms of dementia, as Counsel and Care have highlighted: '*With home visits at irregular times and with different care workers provided for each shift, older people with dementia are most at risk.*'⁵³⁸ Two thirds of people suffering from dementia live at home, and above all what those requiring domiciliary care packages require is consistency in service provision. But all too often what they are receiving is a different face each morning.

'Going the extra mile' – Case study: Vincentian Care Plus

One small, relatively new home care provider the Working Group visited is a good example of domiciliary care best practice. Vincentian Care Plus is a registered charity, managed by Sr. Margaret Bannerton and based in the City of Westminster. A Catholic charity, Vincentian Care Plus provides care for older men and women across a range of backgrounds, but mainly for those on low income suffering from dementia or other forms of mental illness, and those who are socially excluded. At present Vincentian Care Plus employ 23 carers, having been admitted in 2007 onto Westminster Council's list of approved providers of domiciliary care.

For Vincentian Care Plus often the greatest challenge is simply obtaining physical access to homes. For example, commissioned to visit Agnes, 85, whose husband had died the year previously and who was coming out of hospital, at the door Sister Margaret was simply refused entry. After persuading Agnes who she was, she was finally let in, only to find the place a mess and smelling of urine. Malnourished and underfed, Vincentian Care Plus began to give Agnes the care she needed to get her back on her feet.

536 Bernard C, *The Future of Homecare: responding to older people's needs*, London: Counsel and Care and Ceretas, 2009, p16

537 Skills for Care, *The state of the adult social care workforce in England 2010*, London: Skills for Care, 2010, p102

538 Counsel and Care, *All Party Parliamentary Group on dementia inquiry into the dementia care skills of care home staff and staff supporting people with dementia in their own homes – a submission from Counsel and Care*, 2009, p5

Given the funding situation, for Vincentian Care Plus it is an uphill battle not to cut corners but rather to go the extra mile and sustain the drive for quality. *'Caring for 15 minute periods is an abuse,'* Sister Margaret told us. *'Instead what we want to provide is a quality visit – two to three hours at a time - even if it's only once a week.'* *'And the key thing for us is remembering that each person we visit has a story to tell'.* Thus, in addition to providing personal care, a carer's having the time to form a relationship is crucial.

The way in which the actual task of caring is approached is also vitally important. The aim, Sister Margaret told the Working Group, is always to help the client gain or regain confidence. One Vincentian Care Plus carer went into the home of a lady suffering from a urinary tract infection. She ended up providing care for the lady for the last nine months of her life. That carer insisted on not simply doing everything for the lady, but rather taking the time to help her do things herself. *'What about if we do X?'* she would say. *'Will you help me to do Y?'* Over a period of time, Sister Margaret reported, *'the carer helped to give back the lady her self-respect.'*

5.6 Care Homes

There are approximately 419,000 residents in UK care homes,⁵³⁹ of whom approximately 95 per cent were older people. Despite policy drives to keep people in their own homes for longer, and despite the care home population having decreased in recent years, the combined number of people in nursing or residential care homes still remains over two and a half times the number of hospital beds in the UK.⁵⁴⁰



Residents at Norton House Care home at dinner time

As we referenced in section 5.2.2, the state is no longer the main provider of residential and nursing care. Since the closure of NHS long-stay hospitals, the care home market has been largely privatised, with 380,000 places (90 per cent) provided in independent nursing and residential homes (whether charitable or for-profit). But while the state is no longer the direct provider of long-term care, it still remains the primary funder. In England in 2008/09, according to the NHS Information Centre, an estimated 260,000 clients received long-term care services funded by their local authority (173,000 in residential and 87,000 in nursing).⁵⁴¹

Much of recent policy has been focused on the concerns of 'the large number of people who are expected to make provision for themselves'.⁵⁴² Preoccupied with the very real fears of exhausting savings and running down assets to pay for care, the most immediate recommendation of the previous Government's 2010 White Paper was to extend care entitlements so that anyone staying in residential care for more than two years would receive free care after the second year.⁵⁴³ But however important the issues facing

539 Laing and Buisson, 'Occupied places in April 2009', *Care of Elderly People: UK Market Survey 2009*, London: Laing & Buisson, p3

540 158,319, as of 29 June 2010. Department of Health, *Average daily number of available and occupied beds by sector, England, 2009-10*, 'All ward types', London: Department of Health

541 The NHS Information Centre, *Community Care Statistics 2008-9: Social Services Activity Report, England*, London: NHS Information Centre, April 2010, p29

542 HM Government, *Shaping the Future of Care Together*, London: The Stationery Office, 2009, p8

543 HM Government, *Building the National Care Service*, London: The Stationery Office, 2010, p130

Figure 38 – Breakdown of care homes in the UK⁵⁴⁴

User group	Number of people (approximately)
Nursing Home	160,000
Residential Home	220,000
NHS & Local Authority	40,000
Total	420,000

self-funders, they are not our primary concern in this Review. For fear of losing assets presupposes you have assets to lose, yet over half of the care home population qualify for state support precisely because they no longer own their own homes (i.e. they have assets less than the current national threshold of £23,250). Admittedly, some of these people will have started off as self-funders, exhausted their assets paying for care and now ended up on state support. But the majority of these government-supported care home residents are the older men and women with the highest needs and lowest means. For them, the most pressing issues are very different from those which have dominated the debate in 2010.

Furthermore, it may well be true that, going forward, the alternatives to long-term care urgently need to be developed. Investment in Extra Care Sheltered accommodation, the improvement of home care and the expansion of reablement may well help older people in the future to avoid residential care. But at the present time, a large number of older people do need residential care and there are significant problems in the system in which they now find themselves which must be addressed.

5.6.1 THE CURRENT CRISIS

During the course of our research, the Working Group has received evidence from both providers of long-term care (individual care home managers, Chief Executives and operators) and from commissioners (the Adult Services directors). The picture which has emerged is of a system severely overstretched.

Care home providers speak of drastic underfunding by local authorities and complain of a failure to compare like with like when considering the finances of care home placements versus domiciliary care. They point out that older people living in their own homes (whether in the community or

⁵⁴⁴ Compiled from Laing and Buisson, *Care of Elderly People: UK Market Survey 2009*, London: Laing & Buisson, p111

in a purpose-built Extra Care Housing developments) receive full pension, housing and other benefits, the cost of which is borne by central government (DWP) not the local authority. Thus even though it is a significantly cheaper option for local authorities, home care may not constitute as much of a saving to the state overall. Worse, they claim that councils frequently manipulate the monopoly they have in terms of provision (the fact that local authorities fund the majority of places in a home so that, were they to withdraw, the home's revenue would take such a hit it would be forced to close). In one panel of care home managers hosted by the Working Group one manager spoke of his local council pushing him to accept one resident. When he refused on the grounds that the price they were offering was simply insufficient to provide quality care for that resident. He was literally told by the council representative:

'You'd better accept it. Six or seven of us [councils] are working as a cartel to fix prices.'

Local council to a care home manager of care home



Staff of St Christopher's Hospice during an evidence session on care

Nightingale, a care home also registered to provide nursing in Wandsworth, deals with 20 different London councils on account of its historic links with the Jewish community across London. Its Chief Executive, Leon Smith, told the Working Group that some of these local authorities pay barely half what a self-funder is charged. Over the last few years, councils haven't even increased their contributions in line with inflation. Nightingale stays afloat not by overcharging self-funders to make up the shortfall but because it is a charity effective at fund-raising and determined not to turn away people who need to be in residential care.

Economically, the consequence of such a funding situation has been market consolidation and the closure of smaller care homes. According to many, however, smaller residential and nursing homes are often the venues where the best, most person-centred care can be provided and, therefore, that their closure constitutes a huge loss.

On the other side, local authority Adult Services directors spoke to the Working Group of their job being simply 'demand management' and of the huge proportion of their budgets which spill over into the financial black hole which is residential care. They complain that care homes are a 19th century solution to a 21st century problem. As one director told us,

'The fact is that we are going to have to come up with alternatives. The number of care home places which would need to be developed to cater for the care needs of an ageing population is simply unsustainable.'

Instead, commissioners say, ways of building up greater resilience among older people must be developed to fend off the onset of high dependency situations requiring full-time care.

One thing both providers and commissioners agree on is that the current situation cannot continue indefinitely. Clive Bowman, Medical Director of Bupa Care Services, warned the Working Group of what could happen if drastic underfunding is extended into the future:

'Less money per resident combined with escalating costs will mean that hard-won standards of privacy and dignity of accommodation and care will not be maintained. The result could be an unenviable return to multiple occupancy rooms (perhaps four residents to a room) as well as dementia units where, due to reduced staffing, residents are subject to restraint to maintain safety. These are practices which can be seen around the world'.

5.6.2 PROFILE OF RESIDENTS

The profile of the people entering into long-term care has changed dramatically even in the last decade. In terms of our evidence gathering, in every home we visited the story was the same: care home residents are much more dependent. They are 'the frailest of the frail, the sickest of the sick,' as Leon Smith put it. The care home managers, geriatricians, GPs and relatives who gave evidence to this Working Group all attested to the fact that not only are nursing home residents frailer; so too are those in residential care. Today:

- The average age of a care home resident is 80+.
- 75 per cent of all residents in care homes are severely disabled.⁵⁴⁵
- More than 50 per cent of care home placements are related to dementia, stroke and other neurodegenerative disease.⁵⁴⁶
- Large numbers of residents are admitted straight from hospital.
- Among residents are high-levels of incontinence, disorientation, immobility and morbidity.
- The length of stay is much shorter than it used to be: on average under two years.

Whereas in the past older people might have entered long-term care preemptively – to prepare for a higher-dependency situation – because they felt isolated in the community, or even as an alternative for poor housing, today the situation is very different. As one care home manager told us: *'We don't see people who don't need 24/7 care.'*

545 Bowman C, Whistler J, Ellerby M, 'A national census of care home residents', *Age and Ageing* 2004; Vol. 33, No. 5: 1-6, p1

546 Ibid., p1

In 2003 BUPA carried out a census across their 244 care homes. Until then, the care home population had been something of a ‘data desert’. The BUPA census was the largest of its kind, enjoying – being within one organisation – a high return rate. Its most dramatic finding was the considerable overlap between the needs of residential and nursing home occupants.⁵⁴⁷ High levels of incontinence and immobility were found not just in nursing homes but also in residential homes. In terms of admission, it was disease and disability, rather than social factors or non-specific frailty, which had caused 90 per cent of residents of both residential and nursing homes to go into care. The bottom line is that, in terms of what makes people go into long-term care, the drivers are all clinical.



CSJ Policy Manager Christian Guy meets residents at Norton House care home in Westminster

5.6.3 THE DISTINCTION BETWEEN RESIDENTIAL AND NURSING HOMES

Despite the dramatically changed profile of patients, the system has failed to adapt to this new situation. Most significantly, it was drawn to the attention of the Working Group that the very distinction between residential care homes and nursing homes is outdated.

Currently the difference is that care homes with nursing care must have registered nurses on-site 24 hours a day, while people in residential homes fall within the ambit of off-site District Nurses like anyone else in the community. This distinction is sustained at a structural level by the restriction of NHS funding for nursing – the Funded Nursing Contribution to Care (FNCC), at present a £105 weekly payment for each resident – to registered nursing homes. The system is outdated, so it is argued, because it fails to take into account the increasingly clinical profile of people in residential homes. As the Joseph Rowntree Foundation’s 2010 study *Residential care home workforce development*⁵⁴⁸ argues, the continued ineligibility of older people in residential homes for FNCC has a number of unfortunate consequences:

“There are no longer any purely residential homes. In reality they are all nursing homes.”

CEO of care home chain, in evidence to the CS

- It affects the quality of care residential care homes can provide. As Joseph Rowntree argue, ‘*with even longer survival predicted, the ability of residential care homes to continue to meet their residents’ health care need is likely to be limited both due to their current exclusion (as non-nursing establishments) from NHS FNCC in England and due to the resulting need to*

⁵⁴⁷ Ibid., p5

⁵⁴⁸ Wild D, Szczepura A and Nelson S, *Residential care home workforce development: The rhetoric and reality of meeting older residents’ future care needs*, Joseph Rowntree Foundation, 2010

*rely on ad hoc support from busy community nurses and primary care based health professionals.*⁵⁴⁹

- Care home residents who have already undergone the often traumatic move from home into residential care are often forced to move again into a nursing home if their condition deteriorates such that they require more intensive nursing care.
- It limits the ability of residential home care staff to provide for the terminally ill.
- It prevents the clinical up-skilling of residential care home staff under the supervision of the registered nurse.

In addition to this, we have also heard that the introduction in 2007 of a single band of NHS-funded nursing care (replacing the previous low, medium and high band of nursing care) is unrealistic, failing to cater for the further deterioration of someone's needs in nursing care. Someone in a nursing home in the last stages of their life will require even more attention from the on-site nurse than the average patient, and yet under the present system they are entitled to the same amount of NHS funding.

5.6.4 CARE HOME WORKERS

Over the course of this inquiry the Working Group has taken evidence not only from a large number of care workers but also from care home nurses and managers. The picture which emerged from this body of testimony is of a dedicated workforce underpaid, undervalued and demoralised. The two themes which emerged most prominently were pay and staffing levels.

Low Pay

The market rate for care workers in the UK is extremely low. The majority are earning the minimum wage – £5.80 an hour – or fractionally above. There are exceptions: some non-profit care home providers pay staff £7 or above. But right across the board we heard not only care workers, but

also their managers and even employers, admit that the rate of pay devalues the vital care work they do. Tamba Lamina, the manager of Manley Court nursing home in South London, told the Working Group:

“If you don’t pay carers properly, you’re sending out a message that, as a society, we don’t value the work they do nor the people they care for.”

Philippa Gitlin, Caritas Social Action Network, in evidence to the CSJ

‘It’s back-breaking work. I think people deserve more. I see them doing their personal best out there. But then at the end of the month they come to you as a manager and tell you that they don’t get paid something which can sustain them financially. I find it very frustrating’.

549 Ibid., p7

A constant complaint we heard from care workers was that they could typically get paid more stacking shelves in the local supermarket. Why do they stay? Kerry Allen, 27, a care worker from Abbey Park nursing home in Coventry, gave us a representative answer: *'If everyone went off stacking shelves for the same money, who would care for these people?'*

Many care workers see their job as a vocation; the only thing keeping them there is a commitment to the residents they care for. *'You have to love it'*, one health care professional, Evelyn Reid, from the Salvation Army Care Home, Glebe Court, in the London Borough of Lewisham, told us: *'It has to come from the heart. You have to have it within.'* For others, however, the pay is simply not enough: and the turnover is the sector in duly high.

The case study below outlines the day in the life of a typical care worker, the responsibilities and scale of the work involved as well as the low remuneration. In most jobs, moreover, the length of time in a position, enhanced training or great commitment will result in pay rises. In the care home sector, however, this is unusual. In one home we visited three quarters of the 70 staff members had received NVQ 3 level training yet none were being paid any more than when they started.



Norton House Care Home Manager
Felicia Imafidon with a resident

'A day in the life of a care worker' - Case Study: Ayo⁵⁵⁰

Ayo, 42, is married with three children. She has worked as a health care professional at a nursing home in south London for the last eight years. Her typical 12 hour day-shift begins at 7.30am with a handover from the night-shift. This is a key moment in the working cycle, where the day staff can find out if any resident is poorly or has had a fall. Often what happens in the night sets the agenda for the day.

Around 8am, having collected her materials for the day – gloves, aprons, doctor's cream, flannels – Ayo begins to wake residents up. This can be a long drawn-out process, lasting up to two hours. She reports having ten clients to tend to by herself. Most of them are unable to get out of bed by themselves. So she uses hoists – in her view, outdated ones – to manoeuvre people so they can get up. This is physically tiring; she often feels her legs are about to give way. Next she helps them to use the toilet. Then she showers them. Then she dresses them. Then she gives them their breakfast. Then she clears their plates away. Finally she brings them down to the main lounge, at which point she returns to their rooms to collect all their linen and make their beds. By this time it is 10 o'clock and the residents are ready for their 11 o'clock tea and coffee.

Added to this, half the people Ayo cares for are doubly incontinent. On average she changes the incontinence pads of her five clients at least four times a day, a total of 20 pads in the course of a 12 hour shift.

In the afternoon Ayo is involved in co-ordinating activities. In-house this can be anything from card games to dominoes to Nintendo Wii. Sometimes this can involve organising excursions to the local park. Finally, the day finishes, at 7.30pm with a handover to the night shift. Ayo sees a major part of her job as forming relationships with people: *'Once you get to know various residents, you have a bond'* she told us.

550 Not her real name.

In addition to this basic workload, Ayo has a number of other responsibilities. There is the bureaucratic side of the job: each resident will have a full care plan which has to be constantly updated; on top of that every shift has to be written up and every 'incident' fully recorded. All of this documentation takes an enormous amount of time.

Even more important is the palliative care side of the job. The nature of the business now – the profile of the people admitted into the nursing home she works in – makes it inevitable that many will die in the home. For Ayo, sometimes when someone is dying this will involve constant liaising with and hosting of family members. But when there are no family members involved because the client has lost contact with them, Ayo will be the one to hold the hand of the man or woman in her care when they pass away.

For all this Ayo is paid just above the minimum wage, just over £5.80 an hour. When asked about the rate of pay she receives, this is what Ayo told the Working Group:

'This year I received a letter from my employer informing me that I got a pay-rise of two pence an hour. After a whole year's work. You just feel so useless. I didn't want my children to see that letter. In fact I hid it from them.'

Understaffing

Low pay is a systemic problem in British care homes. Yet according to care workers themselves, worse than the low levels of pay are the low staffing levels prevalent across nursing and residential homes in the country. Faced with a hypothetical choice between a pay rise and higher staff-to-resident ratios, many care workers we interviewed opted for more hands on deck.

At present there is no statutory agreement on minimal staffing levels: if there were, as has been reported to the Working Group, many for-profit and not-for-profit care home providers would go out of business. Yet it is widely recognised that a ratio of 1 care worker to 10 residents in today's nursing homes is inadequate.

'On the floor' what understaffing translates to is existing staff being put under severe pressure. Employees from a nursing home in the London Borough of Southwark

told the Working Group that staffing ratios of 1:7 severely undermine the quality of care that home was able to provide. As the home manager put it, *'the staffing they [the care home chain] put out to look after the people is not enough.'*

In this particular home both the manager and the staff spoke bitterly about the large for-profit care home chain owning and operating the home. The company in question, in its effort to drive down cost and increase profit (profit, according to staff, not reinvested back into the care homes) cuts corners and lets down its residents. *'The problem with the sector,'* as Roger Davies, CEO of Methodist Homes and a member of this Working Group, comments, *'is that there are a lot of people doing a good job but they are let down by the people cutting corners. State funding is too low but the quality of care must be paramount.'*

“Low staffing ratios are a widespread problem in care homes across the UK.”

Dr Jo Hockey, Nurse Consultant and Gold Standards Framework Facilitator, in evidence to the CSJ

Another detrimental effect of understaffing is the increasing task-orientation of care work. *'All too often you simply have to dump people,'* one care worker reported. *'You just turn on their TV and rush off to attend to someone else.'* On many occasions, moreover, a second staff member will have to be pulled in to aid a colleague: for example, to help lift someone out of bed, respond to challenging behaviour or escort someone to hospital.

Finally, care workers also reported other effects of the time-pressure which resulted from understaffing: *'Instead of taking time to watch and help someone dress themselves, you end up just doing it yourself,'* one care worker told the Working Group; *'which simply takes away their independence.'*

If they could choose between higher pay and higher staff-to-resident ratios, many care workers would opt for more hands on deck

5.6.5 HEALTH CARE IN CARE HOMES

From all that we have heard, even above the issues relating to staffing, the biggest single failing of the residential care system is the inadequate availability of health care. During our evidence gathering we heard not only care home staff but also palliative care specialists speak of the real lack of medical presence within care homes. In many places residents are a forgotten group, unable to access basic health services which would be far more easily available if they still lived in the community.

GPs

Despite many exceptions and many regional variations, the coverage of both residential and nursing homes by GPs is all too often very thin. This was a constant complaint heard by this Working Group. *'The care here is great,'* reported one relative of a nursing home resident; *'our worry is when they need a doctor.'* The unarticulated assumption of many GPs is that people who have gone into care are now 'covered' and, consequently, low priority. *'Because they now have some support around them, GPs think it can wait,'* as a care home manager put it.

"People in care homes get substandard health care. It's as simple as that."

Medical Director of a London PCT, in evidence to the CSJ

Many home managers, residents and relatives we interviewed talked bitterly of being unable to see a doctor when they most needed one. One 99 year-old resident of a nursing home in North London claimed not to have seen a GP for two years. He spoke angrily of the *'disgusting neglect of old people when they want a doctor.'*

Others felt that someone was far likelier to get better care at home than in a care home. For example, if a patient living at home is losing weight their GP will prescribe a nutritional supplement whereas in a care home that might be harder to come by. As many have noted in their representations to the Working Group, this is frustrating given that it ought to be easier in a care home to identify a medical problem.



Members of the Working Group discussing the conclusions of our interim report

Structurally, care home coverage is not built into GP contracts at all. As Martyn Wake, joint PCT Chair for NHS Sutton and Merton, said in evidence to the Working Group,

‘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.’

The consequence of this is that care home managers needing to get residents seen by doctors typically face one of two scenarios: Either the care home pays a retainer to one local practice and receives a select team of the same doctors. In some places, particularly nursing homes, this basically becomes a ward round. Alternatively, a care home subjects itself to a plethora of different doctors, with each resident registered at a different practice. This scenario breaks down further into two situations. Either GPs actually come into the home, in which case there is confusion and inefficiency as different doctors come at different times. Or, worse, GPs refuse to come into the homes and insist that residents come to them. This, as many managers have complained, is a highly unrealistic expectation, since the people in care homes by definition aren’t highly mobile, have to spend a large proportion of their Personal Allowance (£21 a week) on transport or require staff to escort them, thereby taking staff away from the floor.

Unsurprisingly, care homes opting for the former reported the best health outcomes and lowest rates of hospital admission. For example, in a nursing home, if someone’s condition changes rapidly what is needed is different medication, which is far likelier to be obtained if the care home is dealing with one GP who actually knows the patient.

But many care homes simply cannot afford this option. One CEO of a non-profit care home chain voiced his concern: *‘We don’t think we should have to pay for GPs. It is a scandal that GPs charge care homes to look after residents.’*

Nurses

The challenge does not only concern GPs. With regard to nursing homes, often nurses find themselves swamped with highly complex cases and insufficient medical back-up. *‘Older people with the most complex needs in the country are frequently cared for in nursing homes,’* Dr Jane Evans, a consultant geriatrician at King’s College, Denmark Hill and senior member of the South London Care Home Support Team (see below), told the Working Group:

‘It is unrealistic to be able to expect nurses to manage all their clinical needs. Nursing homes don’t just need money from the NHS. They need clinical back-up.’

One GP we spoke to at a practice in a highly deprived inner-city ward told us that, counter-intuitively, she much preferred visiting residential homes than nursing homes because

'at least in residential homes you can bring in the District Nurse rather than having to rely (as you do in nursing homes) on the in-house nurses many of whom can't even take blood properly'.

The care home sector, as has been stressed to the Working Group, urgently requires younger nurses. Yet at present there is a lack of incentives to their entry; for example the financial package usually compares unfavourably with the NHS and there is a perceived lack of career prospects. In addition, many have spoken to the Working Group of the little emphasis on gerontological training for nurses.

Hospitalisation

The major consequence of poor primary health coverage of care homes is high rates of hospitalisation. 'Services usually default to hospital admission when emergency arises,' Dr Martyn Wake told the Working Group. Unable to reach a doctor quickly, or unable to get a doctor actually to come into the home, care home managers told us that their staff were often at the mercy of NHS out-of-hours services. Over the phone, however, few doctors will take the risk of not recommending hospital admission. Yet, as is widely appreciated, in hospital older people frequently deteriorate, pick up infections or, as we often heard, are inappropriately discharged, quickly ending up back in hospital.

Another detrimental consequence of high rates of hospitalisation from care homes relates to dying. Despite marked improvement in palliative care in many care homes, due in part to the success of the Gold Standards Framework and 2008's End-of-Life strategy, the evidence is that many people are prevented from dying where they would choose (i.e. in the care homes in which they live) on account of unnecessary emergency admission to the hospital.

5.6.6 REGULATION

The proliferation of private care homes since the 1980s inevitably created the need for greater regulation and quality assurance by the state.

The criticism we have heard repeatedly, however, is that the handing over of inspection to a national body in 2002 (now the Care Quality Commission) has led to the growth of policies, procedures, regulations imposed by people very few of whom have real experience of making care homes work. Not only is inspection irregular, critics say – some homes only receive one visit every three years; at present inspectors are unavailable to residents and do not respond to complaints, whether from residents, relatives, staff or managers.

Case Study – Care Home Support Team, South London

The Care Home Support Team (CHST), set up in 2003, has been a successful model of community-based geriatricians, taking medical expertise from King's College Hospital out into nursing homes across the London Boroughs of Lambeth, Southwark and Lewisham. The multi-disciplinary team comprised Consultant Geriatricians, a Consultant nurse, eight older people's specialist nurses, an old age psychiatrist and a pharmacist. Its purpose was to:

- Provide 'floating support' to nursing home providers – i.e. to give specialist clinical advice and back-up via regular visits to nursing homes.
- Conduct proper and regular reviews of nursing home residents.
- Carry out the statutory obligation to provide quarterly and annual assessments of residents in independent homes fully funded by NHS Continuing Care.

Speaking to the Working Group, Nicky Hayes, Consultant Nurse at the CHST, spoke to the Working Group of the particular difficulty facing nurses resident in nursing homes.

'Nurses employed in nursing homes are not required to demonstrate specialist knowledge, skills or expertise which something like dementia requires. As a result they are not always competent at managing the changing needs of residents, seeing the warning signs for example. What the CHST team did was to give nurses the biggest thing they need: confidence.'

It's not only nurses who sometimes lack the requisite specialist knowledge for nursing homes. So do many GPs. Jane Evans, the senior geriatrician at the CHST told the Working Group that among nursing homes residents, *'Cryptic presentations of illnesses often require detective work by experienced doctors. At present GPs find this very difficult.'*

In terms of measuring the effect the CHST has had, we spoke to the manager of one nursing home in the area who had received support. *'They have done a fantastic job'*, said Tamba Lamina, manager of Manley Court nursing home in South London. *'The PCT doesn't have any idea how much the CHST has saved our home in terms of hospital admission.'*

Yet despite these savings, the CHST has been recently decommissioned by Southwark PCT. Providing free support to local nursing homes as well as funding placements of residents is too expensive in this financial climate. *'What is at risk of being lost,'* Dr Evans warns, *'is the education and training and support of care home staff and hence the level of clinical governance for the care of this most vulnerable group of older people.'* And, as Tamba Lamina reflects, *'it's a huge loss... immeasurable.'*

As part of his submission to the Working Group, John Burton, the Head of the Association of Care Managers, stated:

'In an attempt to regulate and standardise care in care homes an expensive and overbearing bureaucracy has been created which diverts attention and funds from the real job. We have elevated audit and spurious 'quality assurance' culture at the expense of real care through human relationships and direct accountability to care home residents and their relatives.'

Among other things, he argues, the system is flawed for the reason that the data is being provided by the very people who are being inspected. The aspect of regulation least likely to uncover abuse – self-assessment – is the very thing which proves so onerous for care home managers, all too often keeping them off the floor and away from the real job of caring and instead chaining them to their desk.

His verdict has been corroborated by many of the care home managers interviewed by the Working Group. One manager, from a care home in a rural area, claimed that the CQC inspector didn't look at any of the things she should have done. The inspector spent the whole time in the office, scrutinising personnel files and residents' care plans. *'They didn't look in the laundry or the kitchen or at the medication system. That's where the errors would be.'* Instead of observing care in action inspectors are all too often focussed purely on procedure.

Finally, the Working Group has been alerted to the problem of duplication of regulatory processes. Julian Kendall, Managing Director of Palms Row Health Care, has been a care home operator since the early 1990s. In the last few years he has had to prepare for assessment not only by the CCQ but also by the local authority. He told the Working Group:

'The fear factor in the last five years has been unbelievable. The CQC are very hard to speak to, while local authority regulators with little or no experience of care come in and try to tell care homes how to do their job.'

“The CQC are a waste of time. They do nothing to improve standards. They don't talk to residents. They just tick boxes.”

Care home manager, in evidence to the CSJ

5.6.7 ISOLATION

During the course of our evidence gathering, we repeatedly encountered care home residents who feel increasingly ostracised. *'It would be nice if the outside world came in here,'* one 99 year-old man told us. There is a large group of older people who need to be in care homes, and yet feel isolated.

Many managers and staff we interviewed spoke of the often declining regularity of visits from friends and family. Other care home staff spoke about residents who, as a result of family breakdown, literally had no communication with anyone apart from care home staff. And yet, with homes understaffed and care workers thereby overstretched, as one manager of a London nursing home told us, *'more than anything what we need is volunteers who will build one-to-one relationships with residents.'*

Volunteering requires commitment. The most pressing need – for volunteers to build one-on-one relationships – requires people to show up regularly, to promise over a

“It wasn't that I didn't know what an excellent place I'd hit on, I'd done my homework. It was that I felt I was being abolished.”

Diana Athill, 'Moving On', BBC News, 21st May 2010

“It would be nice if the outside world came in here.”

99 year-old nursing home resident, in evidence to the CSJ

period of time to meet one individual regularly. But this is exactly here where there is a dearth of provision. Care home managers who gave evidence to this Review spoke of very low levels of volunteering, particularly in urban areas. One manager of a home in the London Borough of Brent told the Working Group that, whereas in the past children from a local primary school would come in – *‘and their visits made such a difference’* – now they are afraid because of the sight of increasingly ill patients. This was a failing she put down to teachers refusing to speak of, explain and educate about illness and ageing.

There are significant exceptions, particularly in rural areas. At one Friends of the Elderly home we visited – The Old Vicarage in Moulsham, Oxfordshire – a devoted volunteer support group visit two or three times a week: organising activities, remembering birthdays, befriending residents, arranging visits outside of the home and helping residents still to feel part of the community. Yet it is exactly these kinds of much-needed dedicated groups of volunteers that are so few and far between. As one manager put it, *‘Why should people be put into these places and forgotten about? They’ve contributed to society all their lives.’*

‘With a little help from my friends’ - Case Study: Mike

For 30 years Mike was Joe’s next-door neighbour in Kensal Rise, North West London. They weren’t just neighbours, though. They were friends, a friendship which became invaluable for Joe when he lost his surviving family members.

In 2009 Joe was diagnosed with dementia and decided to go to Kenbrook Nursing home (Methodist Homes) in Wembley, his placement funded by Brent Council. But when he left home, Mike and three other neighbours got together and decided that, between them, they would make sure that Joe was visited at least every other day in Kenbrook. Since then they have followed through on that promise.

To Mike’s surprise, the home manager of Kenbrook, Marian O’Hara, told us that Mike was a real rarity in Kenbrook. Very few Kenbrook residents, even those not bereft of family members, enjoyed the regularity of visits which Joe did from his old neighbours.

Like many nursing home residents, Joe has been in and out of hospital a number of times during his time at Kenbrook. But in hospital, as Mike puts it, Joe had a number of ‘unwelcome experiences.’ He reported to Mike not only brusque and aggressive responses towards him but even physical abuse. Unsure of how accurate these reports were (on account of the nature of Joe’s illness) Mike didn’t want to jump to conclusions. So he took Joe’s testimony to senior hospital staff, only to be told that, as neighbour and friend rather than family member, he had no right to complain. Data protection rules entailed he couldn’t be provided with any more information because he was not a relative. But, as Mike told them, *‘there are no relatives!’*

Mike sees his job as one of advocacy, *‘shouting for people who can’t shout.’* But, he adds,

‘The authority to criticise and challenge needs backing, and so why, especially in a situation where an older person has no family left, may that authority not be admitted to neighbours and friends?’

CHAPTER SIX

Conclusion

This interim report has attempted to serve two purposes. The first has been to celebrate, respect and champion older age. In many ways life's latter years can be the most rewarding and fulfilling period of life. Our rapidly progressing average life expectancy rates are the mark of an increasingly advanced society, to be welcomed, not bemoaned. Yet the second purpose of this interim report has been to set out the reality of life for some of our society's poorest older people. While longer lives and rich opportunities now characterise later life for many, there is a group of older people which is being left behind and excluded, despite the efforts of policy-makers and the work of some inspirational families, individuals and local organisations. This group of people on the margins of society – some of whom we have met during the review – has lived this way for too long in a nation as relatively prosperous as ours.

While older age spans several generations and its effects vary from one person to another, we have focused on several common areas: money; community and lifestyle; housing; and care.

Furthermore, within each of these chapters several overlapping themes have emerged. These will form the basis of recommendations in the second report.

In this brief concluding chapter we set out these overlapping themes. As we do so, we bear in mind a central observation made regularly throughout our review, that many of the issues outlined in this report are caused, linked or heightened by the experience of loss. This loss, so it seems, is driven by a number of common factors. For example we have seen how many of the decisions, difficulties and even opportunities older people face at some stage are caused by such things as needing to leave employment, the death of a partner, the loss of relationships, a lack of self-confidence, and the diminishing of physical and mental capacity. Moreover, these drivers are often interconnected. An individual who experiences bereavement might also simultaneously be losing their income or their primary carer.

It is in encountering these events – some of life's most trying moments – where older people are likely to face decisions across all the areas we have included in this report, and accordingly make a natural transition into a different quality of life. In this regard what is also abundantly clear has been the extent to which poverty, social breakdown and loneliness both fuel and exacerbate the intensity of these experiences. As this report hopes to have demonstrated, these challenges are rendered all the more difficult when an older person is trapped by such factors. Building on these foundational points

the Working Group has identified the following three themes which will shape our second report. We hope they lay the foundations for a new strategy that tackles older age poverty within the context of a rapidly ageing society and an economically challenging environment.

6.1 Celebrating Older Age within Society

As we have outlined, older people are the heartbeat of much civic participation and social action within our communities and deservedly command respect from the majority of people across society. Without the generosity and talent of older people volunteering levels would be much lower, public services would fall in quantity and quality, and our culture would lose a great deal of its richness.

However, despite the fact that there is much to be proud of in how older people are honoured, as well as how they choose to engage within society, we have encountered a number of issues that hinder the full realisation of potential. Some of these changes are cultural, some practical.

And crucially, it should be noted, this should include a change in political culture. One of the clear observations we have made has been the tendency of political parties, and policy-makers to treat older people as a ‘political football’ for point-scoring purposes – recently in terms of social care and pensions.

Our second and final report, therefore, will set out a range of policy recommendations to ensure we do more to respect, celebrate and utilise older age within society – particularly in our poorest areas. This section will include recommendations about individuals, families, social networks, communities and government. Where appropriate it will tackle directly the recurring issues of regulation and risk averseness across each of the chapter areas we have included in this interim paper. There are signs that this prevailing culture, which so unnecessarily hinders much potential within society, is to be confronted by the new Government. We welcome this and hope to make a contribution to the debate in the second report.

6.2 Personal Planning and Informed Choice

Perhaps the most commonly recurring theme across each of the chapter areas has been personal planning. Its importance, and regrettably often its absence, has become abundantly clear to members of the review. As we outlined repeatedly throughout this report, whether in the field of personal finance, lifestyle, housing or care needs, we encountered a patchiness of planning.

Within this analysis and conclusion, members of our review have also been quick to identify a failure of others integral to personal planning to provide and encourage accessible information for older people, particularly those vulnerable to social and digital exclusion. We have found that the inaccessibility of information and a subsequent lack of informed choice are commonly fuelled by a number of factors including the absence of provision, the complexity of

certain systems and digital exclusion – often caused by poverty or an inability to use technology.

Linked to these failures, and often caused by them, we have also encountered too many older people who have faced crucial life-altering decisions at crisis point. Where informed and encouraged planning would have prepared individuals for decisions about such things as the organisation of their money, whether they would prefer to move house or make adaptations to their existing property as they age, or in taking decisions about the nature of the care they might need (or indeed how it will be paid for), we have instead heard about the pressure of a rushed commitment driven by such things as deteriorating health or the death of a partner. A debate about a new culture of planning – both at an individual and corporate level – would help to ease the trauma of such moments. We will make recommendations about such cultural and practical changes in our forthcoming report.

6.3 Public Sector Provision and General Services

The third overlapping theme derived from our interim report is the provision of public and core services within communities, such as welfare benefits, health and social care, transport and social housing, as well as the utilisation of the voluntary sector in meeting the needs of individuals and communities.

As we have travelled, listened and discussed these points we have tried to analyse the nature, coverage and quality of services that reach poorer older people.

In doing so it has become clear that although much provision is led by well-intentioned and dedicated people – most of whom have chosen to work with older people because of their passion for the role not because of the financial reward – many are struggling to meet demand and provide the desired high quality delivery for older people, particularly under the current intensity of reducing budgets.



Furthermore, many such services have grown accustomed to so-called ‘silo-working’ and self-sufficiency. For example, as we have highlighted in our report, this has often undermined the strategy for preventative working in social care for example. For although there has been near universal agreement about the value of preventative interventions, there has been a regular failure of the core services required for their delivery to work in a genuinely collaborative manner. For instance where have the structural and financial incentives been for a social care team to invest its resources in programmes that reap financial rewards not in their own budget but in that of its neighbouring health team or hospital? The extraordinary rationing by local authorities in recent years is likely to be exacerbated by the current economic environment. It is therefore difficult to envisage how prevention will be a realised goal without radical systemic reform. The enormous financial pressures on the public purse, combined with growing

political will to tackle funding issues for older people's services does create an opportunity for change which the Working Group believes must be seized at both national and local policy level. The Working Group welcomes the recent partnership pilots noted in the report, and the innovative pockets of good practice we have encountered. The challenge is always how these innovative ideas could be shared and developed on a wider scale.

Our second report will also recognise the pioneering work of many in the voluntary sector. The overwhelming majority of projects working with older people and making a difference – particularly in poorer areas – are led by innovative charities. Yet as we have also discovered, and as the CSJ has highlighted in many previous reports, these organisations often face a daily battle to stay afloat. Several have even reported how they believe it would be easier – though not easy – to secure funding were they focused on children or young people. We will address some of these concerns and build on past CSJ voluntary sector recommendations in the forthcoming report.

6.4 Unintended Consequences

As noted above, the unprecedented combination of demographic and financial pressures has had the effect of raising both public and political awareness of the need for systemic change. Indeed, the pre-election jostling by all political parties on the issue of paying for care is, if nothing else, an indication that the issue is now on the political radar as it was not a decade ago.

However, Working Group members have regularly expressed their concerns that the rate of change in public service provision in order to make short-term financial savings runs the risk of significant unintended consequences for individuals and the public purse. For example in relation to care, if it is recognised that systemic change is needed – and there appears to be cross-party consensus that the current system is broken – it is important to protect good preventative services until that change can be implemented properly. Yet as we have noted there is currently little incentive to fund low-level services which prevent the need for more costly services at a later date if the financial saving is in a budget controlled elsewhere. Similarly, altering eligibility to achieve short-term cuts to the public funding of residential and in-home care before the introduction of a new funding regime runs the risk of many older people missing out on vital services.

In publishing policy recommendations and considering the impact of their implementation within our second report, the Working Group aims to avoid falling into the trap of instigating unintended consequences. As far as is possible, the agenda for reform our review will outline should promote shared vision and practice across many of the agencies, organisations and individuals to which it relates.

APPENDIX ONE

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Speeches:

Speech by the Secretary of State for Work and Pensions, Rt. Hon Iain Duncan-Smith MP, *Reinvigorating Pensions*, Thursday, 24 June 2010

Speech by the Shadow Secretary of State for Health Paul Burstow (now of Minister of State for Care Services, Department of Health) at a Westminster Hall Debate on Homelessness, 27 January 2004

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