Evidence submitted to the Older People's Inquiry into 'That Bit of Help'

Edited by Norma Raynes, Heather Clark and Jennifer Beecham

This report draws together the evidence submitted to the Inquiry.

Going beyond the narrow boundaries of health and social care, this report brings together information on policy development and resources relevant to the lives of older people, and an overview of research.

The report takes as its starting point seven key areas central to the lives of older people as independent citizens. These are:

- comfortable and secure homes
- an adequate income
- safe neighbourhoods
- getting out and about
- friendships and opportunities for learning and leisure
- keeping active and healthy
- access to good, relevant information.

The report maps onto each of these seven areas the research evidence, the development of policy since 1989 and the funding streams available to local government officers to assist older people to live independent lives. It sets all this information in the context of current demographic issues and information about health and social care usage by older people.

The evidence reported here was fed into the full Inquiry. *The report of the Older People's Inquiry into 'That Bit of Help'*, edited by Norma Raynes, Heather Clark and Jennifer Beecham, is also available.

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Also available

A companion volume to this report, The Report of the Older People's Inquiry into 'That Bit of Help', edited by Norma Raynes, Heather Clark and Jennifer Beecham, is also available. It is referred to as (Volume I) in this publication. It can be purchased from York Publishing Services (01904 431213) or downloaded from www.jrf.org.uk.

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All of the members of the Inquiry responded to requests for comments on drafts of work prepared by the Secretariat. We valued these contributions. We would like to express a special thanks to Melanie Henwood (Special Adviser to Joseph Rowntree Foundation and a member of the Inquiry) who assisted us with detailed and constructive commentaries, advice and guidance on the chapters submitted as evidence to the Inquiry, relating to the policy context, demographic issues and research evidence.

1 What's happening? Demography, service patterns and experiences

Heather Clark

This chapter contains information on demographic projections and current service use by older people, providing a background into which the Inquiry's discussions need to be located.

The chapter is arranged as follows:

- demographic data and a discussion of current population projections
- health and health experience of older people
- current use of existing services designed for older people and some information on service costs for different groups in the population
- a summary of the key issues.

Demographic background

Population trends 2002–31

In the UK in 2002 there were 10.9 million people of retirement age and over (age 60 for women and 65 for men). This figure represents just over 18 per cent of the total population (Office for National Statistics/Government Actuary's Department, 2003). The numbers are projected to rise to 12.2 million in 2011, 12.7 million in 2021 (taking the change in women's retirement age into account) and to reach 15 million by 2031. The total figure for 2001 includes 4.5 million people aged 75 and over of whom 1.1 million are aged at least 85.

The steady rise in numbers can be seen in Table 1.

Table 1 Projected UK population by age group, 2002–31 (thousands)

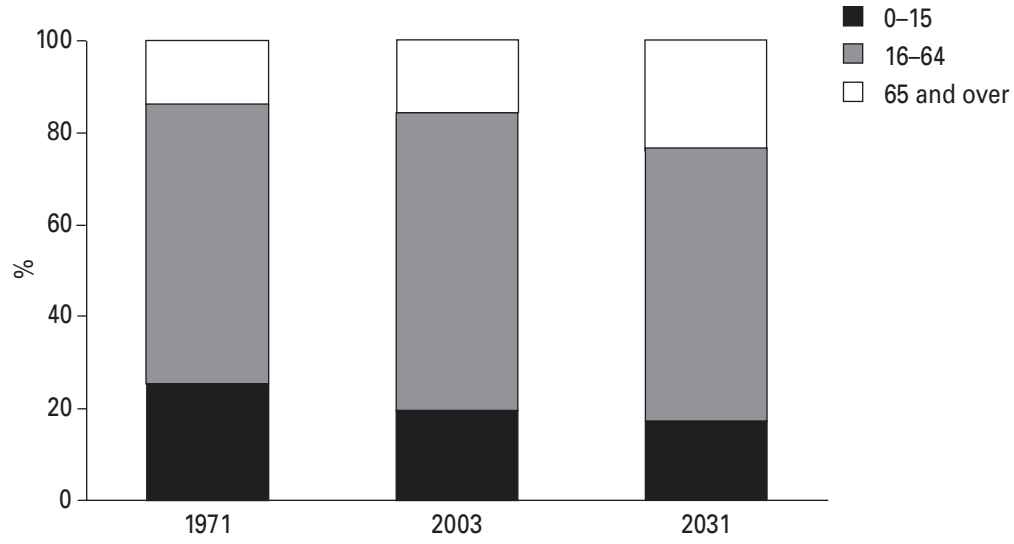
Age	2003	2006	2011	2016	2021	2026	2031
0–14	10,924	10,697	10,385	10,364	10,447	10,553	10,533
15–29	11,234	11,583	11,988	11,873	11,455	11,148	11,130
30–44	13,519	13,253	12,446	12,010	12,405	12,812	12,703
45–59	11,424	11,764	12,325	13,113	12,952	12,186	11,789
60–74	7,948	8,307	9,327	9,900	10,502	11,115	11,871
75+	4,505	4,651	4,930	5,357	6,075	7,088	7,675
Totals	59,554	60,254	61,401	62,618	63,835	64,902	65,700

Source: Office for National Statistics, 2004b.
Note: Totals may not be exact due to rounding.

Under the terms of the Pensions Act 1995, the State Pension age for women will rise to 65 years in 2020. Women born on or before 5 April 1950 will not be affected by the changes. Women born on or after 6 April 1955 will be able to claim their State Pension at 65, and there will be an incremental shift in the State Pension age for women born between 6 April 1950 and 5 April 1955 (The Pension Service, 2003). The change in women's State Pension age clearly impacts upon demographic projections. Without that change, the figures for people of retirement age and over would have been 14.4 million by 2020, eventually reaching 20 million (Office for National Statistics, 2004b).

The figures in Table 1 project an overall decline in the population aged between 0 and 44 years, and an overall increase in the population aged 60 and over. During the period 2002 to 2031, the population of pensionable age is set to increasingly outnumber the under-16 age group so that by 2007 there will be more people over 65 years than under 16 (Office for National Statistics, 2004b). By 2031, it is expected that there will be 136 people aged 65 and over for every 100 children aged under 16. This is indicated in Figure 1.

Figure 1 Age structure, 1971–2031

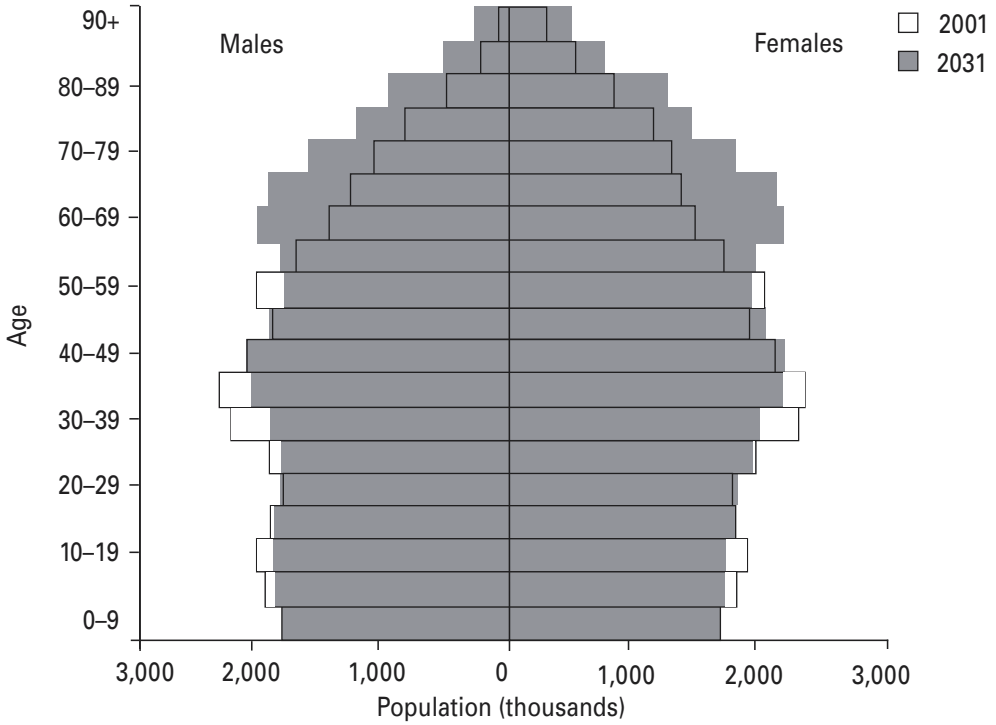


Source: National Statistics Online, 2005.

Longer-term projections for the UK anticipate that by 2051 there will be 17 million people aged 65 and over, comprising 25 per cent of the total population. Of these, 10 million will be people aged 75 and over – 15 per cent of the total population (Office for National Statistics/Government Actuary's Department, 2003).

Figure 2 shows the projected population pyramid for the UK in 2001–31 and illustrates the relative increase in the proportion of the population aged 60 and over.

Figure 2 Population projection pyramid for the UK, 2001–31



Source: Huber and Skidmore, 2003.

Population growth for people aged 60 and over

Table 2 shows that the biggest increases in percentage terms will be among the oldest older people. The number of people aged 80 and over will almost double by 2031 and is set to treble over the next half-century and reach nearly seven million by 2051 (Office for National Statistics, 2004b). The population of older people aged 75 and over will increase by almost 60 per cent in the period 2003 to 2031.

Table 2 Projected population aged 60 and over, 2002–31 (thousands)

Age	2003	2006	2011	2016	2021	2026	2031
60–64	2,943	3,254	3,774	3,485	3,874	4,335	4,274
65–69	2,657	2,706	3,075	3,577	3,315	3,695	4,145
70–74	2,348	2,347	2,479	2,838	3,313	3,085	3,452
75–79	1,932	1,957	2,014	2,169	2,509	2,941	2,758
80–84	1,468	1,460	1,505	1,601	1,764	2,068	2,438
85–89	706	813	923	995	1,104	1,249	1,494
90–94	317	327	380	453	517	603	702
95–99	73	83	94	122	155	191	234
100+	8	10	14	17	26	36	48
Totals	12,452	12,957	14,258	15,257	16,577	18,203	19,545

Source: Office for National Statistics/Government Actuary's Department, 2003.

The age structure of the UK will continue to rise. The average age rose to 38.4 in 2003. It is projected to increase to 43.3 in 2031 (National Statistics Online, 2005).

The elderly support ratio

Figures provided by central government also point to changes in what is sometimes referred to as the 'elderly support ratio'. This ratio is calculated by dividing the population of working age by the population of pensionable age. Figures are given in Table 3 below; they indicate a steady decline in the ratio of people of working age to those over pensionable age.

Table 3 Projected elderly support ratio, 2002–31

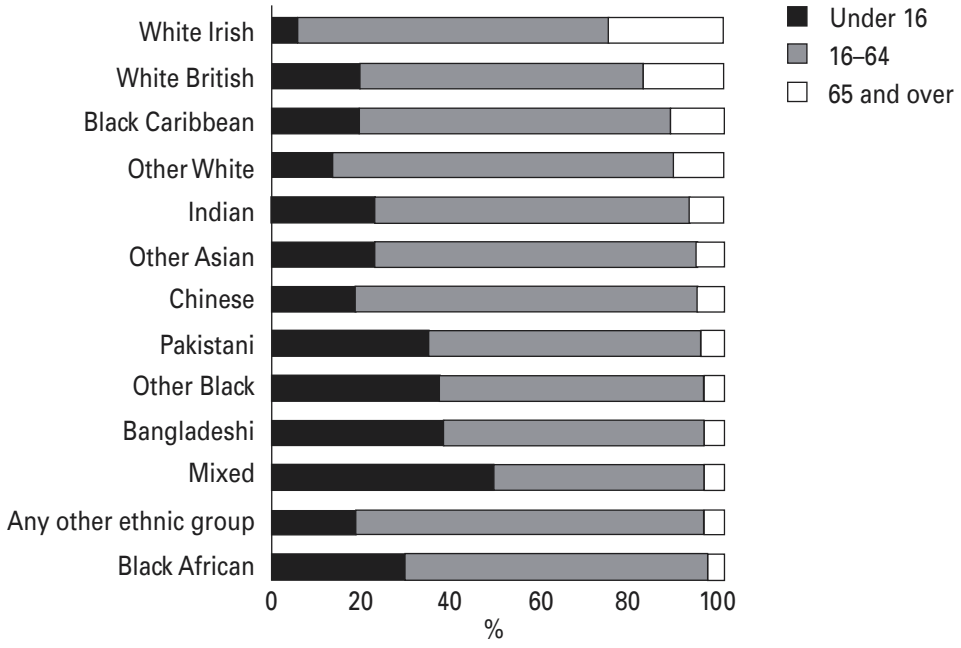
Year	2003	2006	2011	2016	2021	2026	2031
Ratio	3.34	3.29	3.13	3.15	3.15	2.87	2.57

Source: Office for National Statistics, 2004a.

Black and minority ethnic communities

In 2001/2, the UK minority ethnic community numbered 4.5 million, or just under 8 per cent of the total population (Office for National Statistics, 2002). Although there is wide variation between different ethnic groups (see Figure 3), minority ethnic groups characteristically have a younger age structure than the indigenous white population. In 2001, only 5.1 per cent of non-white groups were aged 65 and over, compared with almost 17 per cent of the white population (Pensions Commission, 2004). It is expected that the number and proportion of black and minority ethnic older people will increase (Naegele and Walker, 2002).

Figure 3 Population distribution by ethnic group and age



Source: Pensions Commission, 2004.

Commentary on demographic projections

It is difficult to match up demographic projections because different sources organise their information in different age bands and use slightly different calculation methods. It has also proved impossible to obtain more precise data regarding minority ethnic populations. The numbers of older minority ethnic people are too small to provide meaningful data equivalent to the overall projected age-group profile. In other words, it is not possible to produce the equivalent of Table 2 to describe minority ethnic populations. However, the general trends that are expected can be described.

- Demographic projections of the ageing of the population are often used like a numbers game predicting doom and gloom about the burden of the older population or the demographic 'time bomb'. This latter phrase 'captures the sense of threat which an ageing population is seen to present, particularly in terms of the sustainability of key public policies like pensions, health and long-term care' (Huber and Skidmore, 2003, p. 9).

- However, as Huber and Skidmore point out, the projections do not in themselves tell us how society will accommodate the changes. For example, what will be the impact of the attitudes and expectations of coming generations of older people – particularly the 'baby boomers'? Nor can we predict what will be the impact of other domestic and international issues. We need to act if we are to influence the outcome of the changes.

- The Audit Commission similarly recognises the need for action, pointing out that 'the shift in proportion, composition and attitudes of the older age group has profound implications for public services' (2004a, p. 2). The trends will probably have major implications for pensions, health care and patterns of family life.

- Smith and Mullan (2003) address the issue of the elderly support ratio. In a memorandum focusing on pension issues submitted to the House of Commons Select Committee on Work and Pensions, they point to flaws in the concept including the following:

  The falling population of younger people and therefore youth dependency ratio partly offsets the rising elderly dependency ratio.

  People of working age are not necessarily working nor are they necessarily economically active.

  15 per cent of men aged between 65 and 69 were economically active in 1999 as were 30 per cent of women aged between 60 and 64.

Thus, Smith and Mullan challenge the notion that the ageing population will pose an increasing economic burden. They point out that changes to labour market activity rates and particularly employment rates are far more important to dependency ratios than is the changing age structure. The activity rates themselves reflect changing economic and social conditions (demand for labour, women's employment rates, young people in higher education), and therefore we have a far better chance of controlling these than we do the age structure itself. Smith and Mullan argue that there is plenty of scope to increase the active labour force to compensate for the predicted changes in dependency ratios. These include greater flexibility in employment practices and retirement provision. Moreover, improved health and increasing longevity give scope for raising the retirement age in the future and the possibility that more people will want to continue in some form of paid and productive employment. Very importantly, their paper shows that statistical data can be used to support a range of ideological positions. The desire expressed by the Older People's Inquiry to avoid the charge of 'political campaigning' means that this will need to be taken into account.

As Smith and Mullan argue:

- What was appropriate 30 years ago will not be so in 30 years' time.

- The worst type of policy is that which is based upon panicky assumptions about dependency ratios.

- It is possible to use social policy measures to ensure the affordability of provision.

Planning and policy development need to take into account the contributions made by older people:

- Of people over the age of 50, 6.1 million people are in work and contribute £201 billion to the gross national product, one quarter of the total.

- One in ten employees in their fifties are caring for both parents and grandchildren and two-thirds of grandparents are not the most senior generation in their families. (Ariss and Barnes, 2004)

The 'elderly support ratio' is also referred to as the 'dependency ratio'. This, as the strategy document *Opportunity Age: Meeting the Challenges of Ageing in the 21st Century* (Department for Work and Pensions, 2005) recognises, similarly smacks of ageism. The strategy document states that the relationship between those who are active in the workforce and those who are not is a more meaningful measure. It notes that one million people over pensionable age are in employment, and points to the importance of increasing the percentage of people aged 50 and over who are active in the workforce as one means of counteracting the impact of the changing population structure.

Health and health experience

Health experience of older people

The 2001 Census indicated that half of people aged 75–80 reported long-term illness that limits what they can do, and that this increased to over 70 per cent of people aged 80 and over (Audit Commission, 2004a).

However, figures on self-reported *general* health provide a different picture: less than a third of older people described their general health as poor (Office for National Statistics, 2004b). This mirrors what we already know – that older people do not describe their health solely in orthodox medical terms but within the context of their own lives, their coping strategies, their sense of well-being, and their expectations of what it means to have good health 'at their age'. Nevertheless, older people were more likely to describe their health as 'poor' than younger age groups and, as will be shown below, some minority ethnic groups were more likely than whites to self-report poor general health. Older people see good health as crucial to their independence (Audit Commission, 2004b).

Inequalities in the experience of health

The Acheson inquiry into inequalities in health (Acheson, 1998) confirmed the relationship between social disadvantage and poor health and pointed to the following factors as having a negative impact upon older people's health:

- low income, particularly among those reliant upon means-tested benefits
- fuel poverty
- poor housing
- living alone
- poor access to transport
- fear of crime.

The prevalence of neurotic disorders such as depression and anxiety also increases as household incomes fall (Office for National Statistics, 2004b).

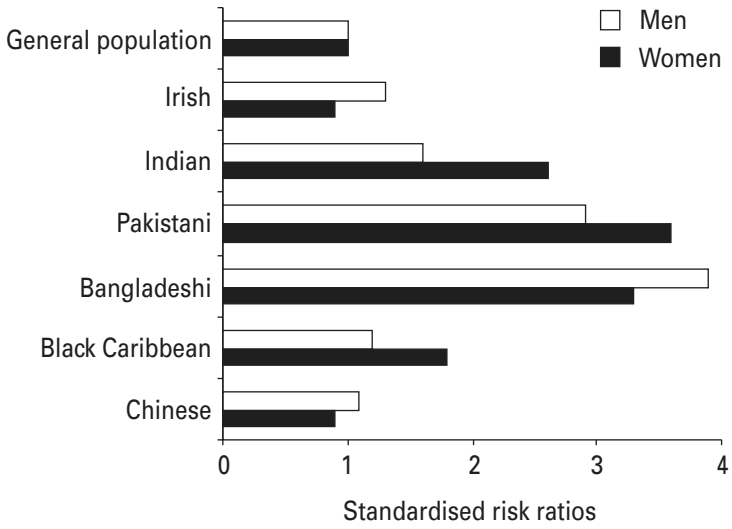
The Pensions Commission report, *Pensions: Challenges and Choices. The First Report of the Pensions Commission* (2004), and *Opportunity Age* (Department for Work and Pensions, 2005) both point to the persistence of socio-economic inequalities in life expectancy and health status in later life.

Black and minority ethnic groups' experience of health

Although the section of the Acheson report on older people did not specifically refer to black and minority ethnic older people, other parts of the report did point to the disadvantages faced by people from these communities. The minority ethnic population is heterogeneous and health status varies between different groups. For example, the report states that people in black (Caribbean, African and 'other') groups and Indians have higher rates of limiting long-standing illness than white people but people of Pakistani or Bangladeshi origin have the highest rates. In contrast, the Chinese and 'other Asian' groups have lower rates than the white population.

Figure 4 shows that minority ethnic groups, and particularly Pakistani and Bangladeshi people, are most likely to report their general health as bad or very bad.

Figure 4 Self-assessed bad or very bad general health by ethnic group and sex in England, 1999



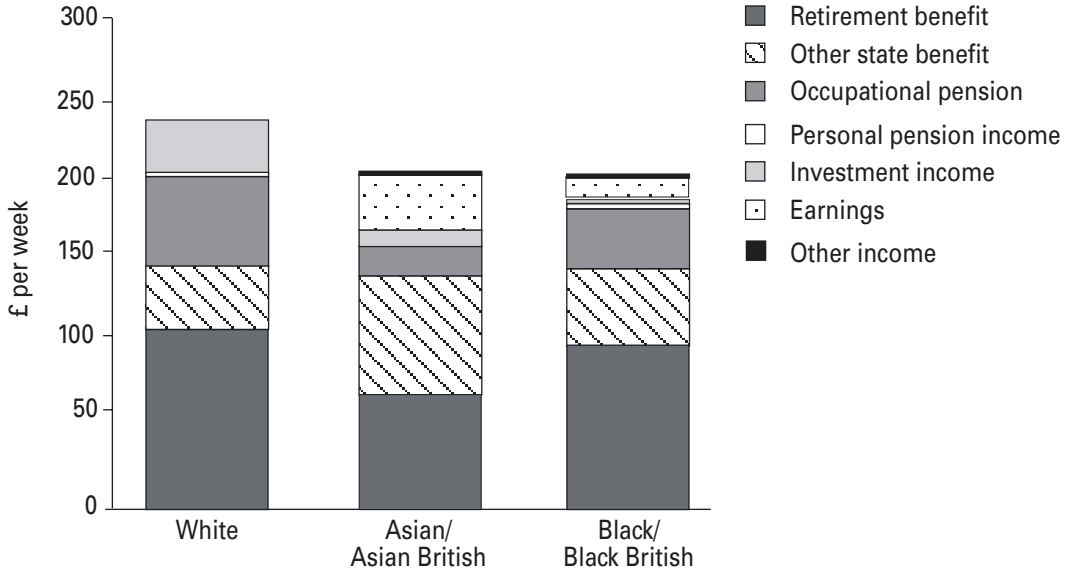
Source: Department of Health, 2001a, Health Survey for England.
Note: This figure from *Social Focus in Brief* on ethnicity contains data for self-assessed, bad or very bad general health, by ethnic group and sex.

The *Health Survey for England 1999: The Health of Minority Ethnic Groups* (Department of Health, 2001a) showed that while rates of self-reported bad or very bad health increased with age among minority ethnic groups, the age gradients were much more pronounced among South Asian groups.

Some minority ethnic groups, especially Pakistanis and Bangladeshis, are over-represented in the poorest fifth of the income distribution and people from minority ethnic groups are generally more likely to be living in poor housing than the white majority and have poor access to transport.

The Acheson report also pointed out that the State Pension scheme is increasingly based upon the assumption that people will have accumulated personal or occupational provisions during their working lives. This, however, would have been impossible for people who migrated to Britain well into their working lives. At the same time, language and other information barriers may contribute to under-claiming of benefits. The Pensions Commission, on the other hand, notes that patterns of labour market participation are equally important: higher levels of unemployment, economic inactivity rates and higher self-employment rates 'reduce opportunities for membership of employer provided pensions' which are reinforced for some by sectoral patterns of employment (2004, p. 66). Figure 5 shows the inequality in income based upon ethnic group.

Figure 5 Average gross pensioner income by ethnic group



Source: Pensions Commission, 2004.

Overall, the research message is that minority ethnic populations face substantial inequalities that impact upon their health and well-being, particularly when measured against objective indicators such as those mentioned above. However, as one study has shown, less formal measures may show a different picture in terms of subjective feelings about health (Nazroo *et al.*, 2003). The researchers interviewed people from four ethnic groups: Caribbean, Indian, Pakistani and white. On all objective indicators the Pakistani group had the lowest scores but when it came to considering less formal indicators such as social support and perceptions of the quality of local amenities, the white group scored lowest. As Nazroo *et al.* comment, migrant groups have often been instrumental in the development of local amenities (places of worship, shops, clubs etc.) while religious communities can play a major role in providing emotional support and practical help, including help with housework. Furthermore, perceptions about the relative importance of various dimensions of health can vary between ethnic groups. In Nazroo *et al.*'s study, for example, Pakistani older men gave greatest value to the continuation of mental health and considered their support systems and local amenities vital to this.

Health status projections

There are no official projections of the health status of the UK's older population (Laing, 2005). As the Royal Commission on Long Term Care observed in 1999, likely trends in health expectancy (i.e. the number of years free of limiting chronic illness)

need to be considered alongside life expectancy. The Royal Commission believed that research evidence supports the view of a general improvement in health expectancy and concluded that there are some grounds for optimism, while continuing to advise caution over the reliability of data. The 'compression of morbidity' thesis holds that ill health will be compressed into the last couple of years of life, regardless of age of death. An alternative view referred to in a footnote in the strategy document *Opportunity Age* published in 2005 suggests that 'there is some indication that the increase in overall life expectancy may be outstripping healthy life expectancy such that the duration of poor health towards the end of life may be lengthening' (Royal Commission on Long Term Care, 1999, footnote 10, para. 1.28). However, it is clear that there are uncertainties about how things will develop and change over time. In *Opportunity Age* the point is made that we will have to monitor trends carefully and address inequalities. It is noted in the same document that 'The broad picture is that the years after retirement are largely healthy and can be made even healthier through relatively simple preventive measures' (Royal Commission on Long Term Care, 1999, footnote 10, para 1.29).

Use and costs of existing services

Contact with general practitioners (GPs)

Contact with GPs is an important issue to consider given the increasing role of primary care trusts in the provision of social as well as medical care. GPs and primary health care nurses may be the point at which older people present issues that are health-related but which require 'social care' input.

Consultation rates vary across a lifetime and show differences on the bases of gender and of ethnic group. For people below retirement age, the highest rates are for females except in the 0–4 age band. In the 65–74 age band there is no discernible gender difference in consultation rates, but among people aged 75 and over more men than women consult their GP. Otherwise there is a broad equivalence in consultation rates with GPs between 0–4 year olds and 65–74 year olds, but a higher rate among the 75 and over age group (Office for National Statistics, 2004b).

Among minority ethnic groups, there is a more marked rise in both consultation and annual contact rates with increasing age, particularly for Pakistani, Bangladeshi and Chinese men, and for Chinese women. For men in the general population, consultancy rates are twice as high at age 55, and for women there is a 10 per cent

increase. For Pakistani, Bangladeshi and Chinese men, they are five times as high (Department of Health, 2001a).

According to the Acheson report (Acheson, 1998) people from minority ethnic groups are more likely than white groups to:

- find physical access to GPs difficult
- have longer waiting times in the surgery
- feel time spent with the GP was inadequate
- be less satisfied with the outcome of the consultation
- be less likely to be referred to secondary or tertiary care.

Health service costs

In 2002/3, £35.08 billion was spent on hospital and community health services in England (Health Committee, 2004). Table 4 shows expenditure by sector and age group.

In Table 4, expenditure for younger people is included under the service sector specifically for older people (referred to somewhat disparagingly as 'geriatrics'). This is due to the allocation of general community patient care (like district nursing and chiropody services) that was initially aimed at older people.

Hospital and community health services specifically for older people use up just 7 per cent of all expenditure; however, the high level of use of services in other sectors, notably acute services, means that overall 46 per cent of NHS expenditure is on older people (Table 5).

Table 4 Hospital and community health services expenditure by sector and age group, 2002/3 (£ million)

Service sector	All births	Age 0–4	Age 5–15	Age 16–44	Age 45–64	Age 65–74	Age 75–84	Age 85+	Total
Acute	0	1,419	692	2,774	3,858	3,995	4,194	2,356	19,289
Geriatrics	0	11	27	161	220	395	853	716	2,382
Mental health	0	11	61	1,895	996	572	726	338	4,598
Other	98	137	76	445	479	449	512	299	2,495
Other community	111	498	445	968	406	199	268	175	3,071
Learning disability	0	34	147	725	479	61	19	6	1,470
Maternity	1,200	0	0	0	0	0	0	0	1,200
HQ Admin	24	36	24	118	109	96	111	66	582
Total	1,433	2,146	1,472	7,085	6,545	5,767	6,683	3,956	35,087

Source: Health Committee, 2004.
Note: Totals may not be exact due to rounding.

Table 5 Proportion of hospital and community health services expenditure by age group

Age band	Proportion of expenditure (%)
All births	4
0–4	6
5–15	4
16–44	20
45–64	19
65–74	16
75–84	19
85+	11

Source: Health Committee, 2004.

Hospital costs

Older people occupy two-thirds of hospital beds (Department of Health, 2001b). As has been indicated above, older people account for the significant use of a number of service sectors. However, in so far as the specific service type for older people is concerned – 'elderly patients' – unit costs are significantly lower than for many other areas (Table 6).

Table 6 Unit costs by service type, 2002/3 (£)

	Interquartile range of unit costs		
	Lower quartile	Upper quartile	National average
Service type	Cost per bed day		
Intensive Therapy Unit/ Intensive Care Unit	1,146	1,517	1,330
Coronary Care Unit	366	568	437
Paediatric Intensive Care Unit	1,272	1,856	1,570
Special Care Baby Unit	288	425	356
Stroke patients	158	262	227
Elderly patients	143	219	166

Source: Netten and Curtis, 2004.

Commentary on health costs

The 2004 Memorandum on public expenditure prepared by the Department of Health for the House of Commons Health Select Committee noted that 'those aged 65 and over accounted for 47 per cent of total expenditure despite being only 16 per cent of the population' (Health Committee, 2004, para. 3.1). Figures relating to the apparently high health care costs for older people are often used as part of the 'doom and gloom' scenario that some commentators suggest accompanies the ageing of the population.

The suggestion that older people use a level of health resources disproportionate to their overall percentage of the population may obscure the fact that health care provision may not itself be proportionate to need. That is to say, there are a number of areas in which there are shortfalls in health care provision for older people – for example, chiropody, community nursing and physiotherapy services (Commission for Social Care Inspection, 2004). At the same time, increased usage of GP services by minority ethnic older people does not necessarily reflect greater satisfaction with and better outcomes from GP services.

As the government itself has also recognised (Department of Health, 2001b), older people in general have not always received a fair deal from health services, having been subjected to poor, unresponsive, insensitive and sometimes downright discriminatory attitudes and practices. The focus should perhaps be upon whether or not health care provision is older person friendly, given that older people are the major users, rather than upon questioning whether older people make disproportionate use of health care services. Furthermore, as citizens, older people have the right to make use of universal services, including health care services.

Contact with statutory social support services, 2002/3

In 2002/3, 1,403,800 people received community-based services from social services. Of these, 989,300 (70 per cent) were people of 65 and over. There was an overall 2 per cent increase in use of community-based services (Department of Health, 2003a). The numbers receiving home care/home help services, however, dropped from 499,300 in 2001/2 to 479,600 while there was an overall 3 per cent increase in the number of home care/home help hours provided (Department of Health, 2003b). This reflects a continuing trend whereby councils are providing more intensive home care/ home help services but to fewer people. Home care respite in the client's own home overnight also fell from 4,700 in 2001/2 to 3,600 (Department of Health, 2003b).

There was, however, an increase in the number of older people receiving Direct Payments: from 900 in 2001/2 to 2,700 in 2002/3. In April 2003 new regulations imposed a duty upon local authorities to offer Direct Payments to all those eligible for them (previously it had been a power rather than an obligation). The number of people receiving equipment and adaptations also rose from 275,400 to 308,200 (Department of Health, 2003a). It is not possible to comment on whether or not this has any impact upon the fall in numbers receiving home care/home help nor indeed whether these were older people who also received a more intensive service. It is, however, the case that quite small equipment items or minor adaptations can reduce the need for services and enhance older people's sense of independence (Clark *et al.*, 1996).

Commentary on social services contact figures

There were an estimated 3.29 million contacts with councils with social services responsibilities in England in 2002/3. Those 1,403,800 receiving community-based services represent under half of the total number of people who referred themselves or were referred by others to social services. According to the Department of Health (2003a), 1,580,000 people (or 48 per cent of the total) were 'attended to solely at or near the point of contact'. The remaining clients were either not offered a service, refused one or received services outside social services, for example health or housing services (Department of Health, 2004a). There are no further details about what happened to the people who were 'attended to solely at or near the point of contact'. One might surmise though, that some proportion of older people was 'screened out' of social care, and probably on the basis that their needs did not fit the eligibility criteria for social services. It is also likely that many were older people, who additionally can find it particularly difficult to get past screening processes when referring themselves or their partners to social services (Help the Aged, 2002).

The report of findings from the 2002/3 Referrals, Assessment and Packages of Care (RAP) collection shows that self-referrals comprised 26 per cent of the total for all contacts (Department of Health, 2004a). Self-referrals were the most likely to be dealt with at or near the point of contact: 75 per cent of all self-referrals were dealt with in this way. Referrals by family and friends comprised 13 per cent of the total and of these 42 per cent were dealt with at or near the point of contact. By contrast, referrals from primary or community health services (11 per cent of the total) resulted in just 27 per cent being dealt with at or near the point of contact.

Only about 5 per cent of all older people are in receipt of home help/home care services from social services. This figure increases substantially, however, among those aged 85 and over. In the year 2001/2, 18 per cent of people aged 85 and over received these services (Office for National Statistics, 2004b, Table 8.11). There is already insufficient domiciliary support to keep older people from entering residential care (Association of Directors of Social Services/Local Government Association, 2003) and this situation may worsen if current models of provision were to continue without substantial additional funding, given the projected increase in the numbers of people of 85 and over. Currently, the proportion of people in the 85+ age group using home care services is approximately ten times higher than for those aged 65–74 (Table 7).

Table 7 Use of care services by age, England, 2003

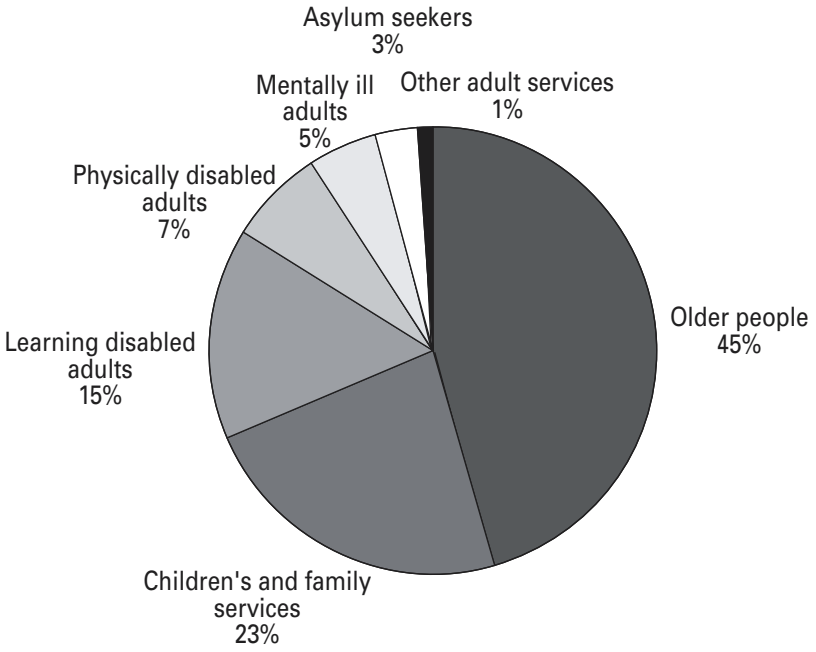
65–74	75–84	85+
1.5%	5.1%	14.5%

Source: Laing, 2005.

Social care costs

As Figure 6 indicates, 45 per cent of personal social services gross expenditure in 2002/3 was on services for older people. The total personal social services expenditure was £15.2 billion, of which £6.9 billion was spent on services for older people. However, charges recouped just over 25 per cent of this expenditure (Department of Health, 2004b).

Figure 6 Client group as a share of gross expenditure, England, 2002/3



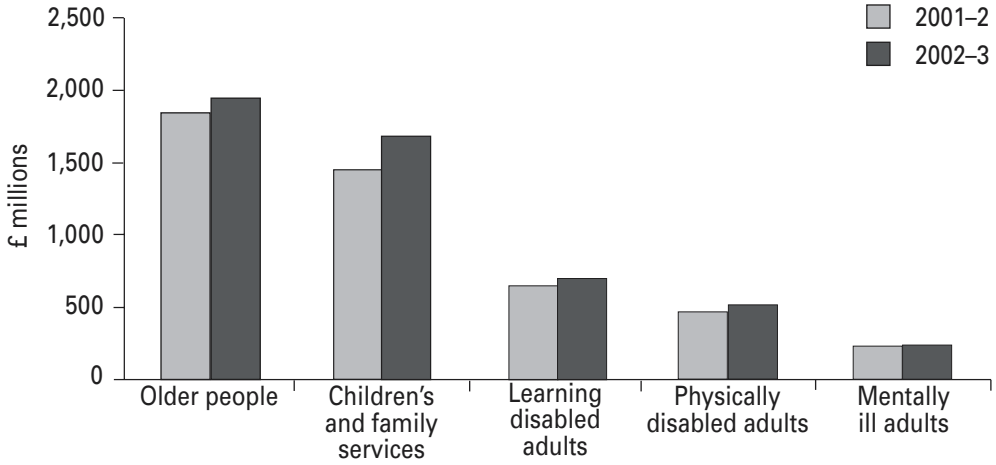
Source: Department of Health, 2004b.

Home care accounts for 70 per cent of all day and domiciliary expenditure for older people.

Commentary on social care costs

Although gross expenditure on older people exceeds that on other groups (see Figure 7) Tables 8 and 9 suggest that older people using home care or receiving direct payments cost less per client than most other client groups.

Figure 7 Gross expenditure for day and domiciliary provision by client group, 2001/2 and 2002/3



Source: Department of Health, 2004b.

Table 8 Costs per person per week: home care, 2002/3

	£
Older people	81
Adults with learning disabilities	238
Adults with mental illness	63
Adults with physical disabilities	99

Source: Department of Health, 2004b.

Table 9 Costs per person per week: Direct Payments, 2002/3

	£
Older people	139
Adults with learning disabilities	187
Adults with mental illness	111
Adults with physical disabilities	206

Source: Department of Health, 2004b.

As Table 10 indicates, 62 per cent of all expenditure upon older people is for residential provision, with only 29 per cent on day and domiciliary provision. There are government targets to increase the proportion of older people receiving local authority funded intensive care in their own homes *vis-à-vis* those supported in residential care. *Opportunity Age* (Department for Work and Pensions, 2005) notes that the target, set in 2002, of 30 per cent of all older service users to be supported at home has been achieved. This shift, however, exacerbates the trend whereby fewer older people receive medium- or low-level services.

Table 10 Expenditure on older people's services by type of provision

Type of provision	Expenditure (£ million)
Assessment and care management	620
Residential provision	4,250
Day and domiciliary provision	1,990

Source: Department of Health, 2004b.

Summary of the key issues

- Clear evidence of the increasing numbers of older people.
- Clear evidence of the increasing rate of growth in the numbers of people living to age 80 and over.
- Evidence that use of health and social care services increases with age. There is no hard data on age-related take-up of community health services until GP-based community data come on stream in 2005. Evidence to date suggests that older people take up a higher proportion of GPs' time.
- Small and decreasing numbers of older people are getting higher levels of inputs from local authority social services.
- Estimates of the impact of the elderly support ratio assume no change in working patterns or pension arrangements. However, these do not reflect the contribution made by older people themselves to the employment market directly or indirectly.
- Services appear *not* to play a major role in the majority of older people's lives. This may be partly a function of limited access to support services through the tightening of eligibility criteria and the targeting of resources on older people with the *most severe* needs (Association of Directors of Social Services/Local Government Association, 2003).
- The Association of Directors of Social Services/Local Government Association report points out that such targeting on the most severe needs reflects the Poor Law legacy underpinning provision for older people whereby public services provide a welfare safety net for those with greatest needs and/or without the personal resources to meet them.
- In the Association of Directors of Social Services/Local Government Association (2003) report *All Our Tomorrows* there is a focus upon older people as 'NHS and social care problems' (Audit Commission, 2004a).

- But older people are citizens and have the right to access universal services such as education, transport, housing, leisure etc. Older people have indicated that these services have a significant influence on their well-being.

- However, older people's citizenship rights in terms of equal access to such universal services have been undermined by institutional ageism.

- Most discussions are based on current service models and on the concept of a specialist service model. However, as Huber and Skidmore argue, current models may not be appropriate in the future and instead we need a dialogue from which 'whole new ones can emerge' (2003, p. 16).

- There is a need for a new dialogue about older people and their relationship to the wider society. The Inquiry provides the opportunity for that dialogue but may need to avoid using the service model as a starting point because 'services' suggests administration and organisation, quality and the rest of the packaging – *the way* something is provided rather than what it is that older people *want* in the first place.

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2 Addressing what older people want? Research review

Heather Clark and Norma Raynes

This chapter summarises findings from some of the research and policy literature that focuses upon older people's views of the help they say they want to continue an independent life.

In addition to the research literature there are two recent reports of particular relevance to the Inquiry. The first was commissioned by the Audit Commission and Better Government for Older People (BGOP), and the second is by the Association of Directors of Social Services and Local Government Association (2003). Both of these call for

- a reconceptualisation of older people as citizens with valuable contributions to make
- services which promote the well-being of older citizens
- the need to ensure the involvement of older people in development, planning and monitoring of public facilities and services. This also reflects what older people say they want.

The Audit Commission and BGOP commissioned five reports. These are summarised in the overview report *Older people – Independence and Well-Being: The Challenge for Public Services* (Audit Commission, 2004a). The reports highlight what older people view as being important to their well-being and to their ability to live independent lives. Identified in these reports and in *All Our Tomorrows* (Association of Directors of Social Services/Local Government Association, 2003) are

- the ways in which current policy, legislative and governance frameworks can help to promote the well-being of older people
- and where they will need to change if the views of older people are to be taken into account.

The overview report (Audit Commission, 2004a) makes the following points:

- Older people need an environment that they can shape, thrive and live life to the full for as long as possible (para. 3).

- Interdependence is a central component of older people's well-being; to contribute to the life of the community and for that contribution to be valued and recognised (para. 5).

The report continues by summarising what older people have said they require to make these a reality. The areas identified reflect those identified in other research that has taken on board the voices and perspectives of older people. There are seven key areas:

- comfortable and secure homes

- an adequate income

- safe neighbourhoods

- the ability to get out and about

- friendships and opportunities for learning and leisure

- the ability to keep active and healthy

- good, relevant information.

There is no suggestion within the reports that any of these areas are of greater priority to older people than others. A key message, as in other research, is that for older people life is joined up, not compartmentalised, so that all of the areas listed are of importance in maintaining individual well-being and an independent life in older age.

We have organised this background chapter in ten parts. The research findings and our summary of the key issues are organised under each of the seven areas identified as important by older people in the reports of the Audit Commission/BGOP (Audit Commission, 2004a).

- comfortable and secure homes and the place of assistive technology (AT) in providing these

- adequate income
- safe neighbourhoods
- ability to get out and about
- friendships and opportunities for learning and leisure
- ability to keep active and healthy
- good, relevant information.

There then follows

- a summary of the key issues
- and final thoughts.

The final section contains the list of works which underpin this background chapter.

Comfortable and secure homes

Addressing the issue of comfortable, safe homes the Audit Commission (2004b) states that older people identify the following as important:

- staying independent in the home
- keeping the house and garden in good order
- the right housing.

Staying independent in the home

The Audit Commission points out that the 'physical environment of the home can dramatically reduce older people's independence' (2004b, p. 19). Similarly, Heywood states that 'people whose mobility is diminished by illness, accident or old age [can] find themselves disabled by their homes' (2004, p. 129). Furthermore, as Huber and Skidmore remind us, older people may be 'forced to go into residential care' not because they are unable to look after themselves but because they are disabled by a

'physical infrastructure (in terms of housing stock) and a human infrastructure (in terms of home care provision) that are inappropriately designed for their needs' (2003, p. 69).

Under the Community Care (Delayed Discharges etc.) Act (Qualifying Services) (England) Regulations 2003, effective from June 2003, social services are required to provide community equipment services (aids and minor adaptations), up to a cost of £1,000 (including fitting) free of charge to eligible individuals.

One study points to the positive results disabled people, including older people, got from both minor and major adaptations to their homes (Heywood, 2001). The benefits included feeling safer, having improved health, needing less help and feeling more independent and confident. Problems were reported, however, which arose from weaknesses in the original specifications. In turn, these problems tended to arise when there was insufficient attention to detail, failure to consult properly with the older person involved, and failure to understand and assess psychological needs or recognise cultural requirements. Where there was proper consultation, the needs of other family members considered and the integrity of the home respected, there was more likely to be a positive outcome.

Age Concern England has also produced reports based upon the experiences of older people, showing how minor adaptations and equipment can enable older people to manage at home without needing substantial service input. One of the reports (Age Concern, 1996) calls for more attention to the prompt installation of suitable equipment and adaptations for older people when they are discharged from hospital, including basic community equipment such as bath seats, bath rails and handrails. The report points to prolonged delays that older people experienced in getting the equipment.

Reports from the Audit Commission in 2000 and 2002 were critical of community equipment services. The first of these reports pointed out that 11 per cent of hospital bed days lost was due to patients waiting for equipment, and a further 3 per cent was because patients were waiting for adaptations to their home. In other words, older people are held up in hospital. The second report (Audit Commission, 2002) did indicate some improvements had been made, but both reports are critical of the lack of priority accorded to community equipment services.

Older people include the provision of aids and adaptations in their criteria of what makes a good quality home care service (Raynes *et al.*, 2001). In the Raynes *et al.* (2001) study, older people included those which would help them get about in the outside world such as seating in and between shops, shopping trolleys like four-wheel prams, a means of transporting oxygen, and buildings accessible for wheelchairs.

For older people, deciding upon and organising their own home maintenance, improvements and adaptations can be very stressful. Help from Home Improvement Agencies (HIAs) has been shown to be very important to older people (Langan *et al.*, 1996; Means, 1998). Often, as Means points out, the help older people require is very modest but essential for maintaining independence and for the 'sense of being "at home" in their present accommodation' (1998, p. 416). However, Care & Repair (2002) report that not all areas have an HIA service; there were only 235 in 2002 (Foundations, 2003). Length of time for job completion is highly variable. For example, the average time taken to visit a client following their initial enquiry is just over six weeks, and on average a minor job could take 22 weeks to complete and a major job could take 43 weeks (Foundations, 2004a). Costs can be prohibitive for people on low incomes.

It is therefore vital that professionals listen carefully to views of older people when assessing the need and type of adaptations and equipment. This may be particularly pertinent at hospital discharge. Research has demonstrated that older people may regard the discharge assessment processes, including those where decisions are taken about what equipment and adaptations are required, as a test of whether they can go home or not rather than as 'positive forums within which their future needs [can] be ascertained' (Clark *et al.*, 1996; Godfrey and Moore, 1996, p. iv).

The ideas of older people about what would be important in a good home discharge are often low cost and low tech. The Fife User Panel, which is comprised of people aged 75 and over, identified 14 characteristics for a good hospital discharge based on the problems they faced when they had been discharged from hospital (Barnes and Cormie, 1995, p. 31):

- Heating in the home should be turned on from the morning of the day of discharge, and the bed should be made up and warm.
- There should be fresh staple goods in the house: milk, tea, eggs, butter etc.
- One meal should be ready.
- The home carer should be in the home waiting if no relative or friend is available or if requested by the patient.
- Family members should have adequate notice of the day of discharge so that they can make their domestic arrangements.

- Discharge times should be given within reasonable parameters: they should know whether it would be in the morning, afternoon or evening.
- At least 24 to 48 hours' notice should be given.
- Services should be in place on the day of discharge.
- Services following discharge should be available seven days a week, including public holidays.
- The GP should call on the day of discharge to make sure the person is settled.
- Nurses should tuck down the person at night at a reasonable time and continue this service until both parties agree it is no longer necessary.
- Arrangements should be made for carers to have keys to get into the older person's home before they come out of hospital.
- It should be ensured that on discharge there is a carer who has willingly accepted and is physically capable of undertaking the role.
- Someone at the hospital should make all the necessary arrangements (similar to the key role once undertaken by the hospital almoner).

Assistive technology (AT) is a modern term which covers aids, equipment and appliances and reflects ongoing 'technological advance and a growing appreciation of how it can support independence' (Audit Commission, 2004c, p. 2). AT can enable people to better manage their homes through, for example, 'smart home' gadgetry which allows the systems and devices in the home to communicate with each other through linked computers and which can be controlled through telephones or remote controls. The Joseph Rowntree Foundation website has a series of pages introducing and describing smart homes.

AT also enables contact and monitoring with and by others outside the home through, for example, interactive broadband communications, other computer communication systems and telephones. This sort of technology has 'the potential to redesign the way in which many aspects of health and social care are delivered' (Audit Commission, 2004c, p. 3). However, there are arguments both for and against the use of AT and home adaptations to enable people to live independently, comfortably and securely in their own homes.

AT can include relatively small and low-cost items of equipment as well as high-tech and more costly items. For example, oral evidence to the House of Commons Select Committee on Health noted that £2 will pay for a temperature sensor in an older person's living room or bedroom, and that 'small investments can make a huge difference' (Health Committee, 2005, Q92).

The primary foci of the Audit Commission's report are telecare and telehealth systems (2004c). Some examples of telecare systems are falls monitors, temperature monitors, flood detectors, carbon monoxide detectors, bogus caller alarms, and lifestyle and movement monitors. These can involve passive infra-red (PIR) detectors in the home or those that can be attached to clothing or worn as pendants or wristbands. Telehealth refers to health services delivered at a distance through various telecommunication- and computer-based means. Examples include teleconsultations, teleradiology, telepathology and telecardiology. It is argued that telecare systems can be used:

- to avoid hospitalisation
- as a form of virtual intermediate care
- as a virtual visiting system, perhaps replacing the need for visits by health care staff while still monitoring the safety of older people with dementia
- as a reminder system, perhaps for medication
- for home security and social alarm systems (Hanson *et al.*, 2002)
- as a lifestyle monitoring system, activating an alert if there is a problem (Brownsell, 2000). Brownsell suggests that telecare has an advantage over radio alarm systems, as it does not rely on older people activating the alarm themselves. His study of an Anchor Trust 'lifestyle monitoring' system points out that 40 per cent of people with alarms do not carry or wear them.

Telehealth (also called clinical home monitoring or telemedicine) allows clinical monitoring to be done remotely through sensors and a telephone line. Telehealth can be used to monitor such conditions as chronic obstructive pulmonary disease, congestive heart failure, hypertension, asthma and diabetes. Research from America and Canada suggests that telehealth has played a part in reducing pressure on acute hospitals and provides clinical care in the home that is equal in quality to hospital care (Audit Commission, 2004c). The evidence from pilots of 'televisits' by nurses and doctors in Spain is encouraging (Wilsdon and Stedman Jones, 2002).

In some ways these technologies build on existing UK provision. NHS Direct and NHS Online both provide initial consultations and preliminary diagnoses, over the telephone or internet. However, by themselves they do not ensure a quality service. Wilsdon and Stedman Jones point out that this relies 'on a much more complex range of factors, such as the division of responsibilities between hospital doctors, nurses and paramedics and the protocols used to sort and prioritise cases' (2002, p. 44).

One difficulty with such AT systems is that they can smack of 'Big Brother' (Winchester, 2002). They may also lead to ethically dubious controls such as the electronic tagging of older people with dementia who wander (Hughes and Louw, 2002). Other difficulties are that smart homes can be expensive and inflexible (Winchester, 2002). Smith cites the concern of Help the Aged: AT can become 'a substitute for the human touch or it can be abused like tagging' (Smith, 2004, p. 20). Tinker *et al.* also warn that 'a diminution of human contact' could result if technical devices became the normal response to the need for help (2000, p. 118). Oral evidence to the House of Commons Health Committee points to the need to avoid intrusion by the use of AT such that the older individual's sense of independence would be threatened and to ensure the continuation of human contact alongside AT (Health Committee, 2005). However, as Huber and Skidmore say, while AT 'can never be a substitute for people', we are in reach of a technology which can perform online a range of 'routine caring or supervisory activities that would otherwise require residential care' (2003, p. 70).

The Audit Commission (2004c) stresses the cost-effectiveness of AT. It argues that potentially AT could:

- enable older people's desire to remain living in their own homes to be met more cheaply

- reduce both emergency hospital admissions and delayed discharges, thereby relieving the pressure on acute hospitals, and on informal carers and agencies

- help people retain their dignity by removing some of the need for assistance with intimate tasks. An example given is of WCs that can wash and blow dry. These have been available for at least 20 years but not widely introduced because of their perceived high costs. Perhaps the best-known model, the Clos-o-Mat, is produced by Total Hygiene and costs around £2,000 (excluding fitting). There is also a new add-on product on the market produced by Magic Clean. This is a bidet toilet seat that adds a wash and dry facility to the existing WC and is expected to cost between £300 and £500. It is advertised as suitable for everyone.

The greatest gain from AT, according to the Audit Commission, will probably come from 'targeting preventative programmes at people who have one or more risk factors' (2004c, p. 18). Fall prevention measures are of particular importance here and preventative AT might include anything from grab rails to fall detectors. Fear of falling is known to be a cause of anxiety for many older people that can limit all aspects of their lives (Heywood, 2004, p. 135). We know also that Home Improvement Agencies are prepared to take on low-tech solutions that focus on targeted fall prevention (Foundations, 2003, 2004b).

Older people have expressed views about the use of AT and smart homes. Reporting Anchor Trust's trial of the Lifestyle Monitoring System (LMS), Brownsell (2000) found that the majority of older people involved in the trial thought the technology was a good thing. Almost half the older people felt that LMS was either essential or very important to their ability to live independently in their own homes; none felt the system was intrusive and some reported feeling safer. As Brownsell says, LMS could play a crucial role in reducing older people's fears of falling and not being able to get help (2000, p. 12).

Winchester (2002) reports positive feedback from older people and their relatives about a television system link that can be activated when the older person does not answer the phone after a specified number of rings. The caller can manipulate the camera to see if the older person 'is in trouble' (Winchester, 2002, p. 34). According to Winchester, this particular technology proved popular with older people. It stopped them feeling isolated and it also reduced worries on the part of relatives. However, this and some other forms of AT are expensive and, as Tinker *et al.* (2000) point out, because of this many older people will have no access to them. The Raynes *et al.* study of home care (2001) found that 20 per cent of the older participants had no telephone and while there is recent evidence to show that the fastest growing users of PCs are older people, only a small number of older people have computers (Raynes *et al.*, 2004). However, it is probable that broadband access will be common in the near future.

Tinker (1999, p. 274) points out that while research has shown that telecare and telemedicine can enable older people to remain in their own homes and/or avoid hospital admission, research has also thrown up issues around:

- patient confidentiality and data protection
- unclear legal issues
- lack of agreed technical standards

- a lack of economic evaluation
- no clear agreement on funding responsibilities.

Research undertaken by the Thomas Pocklington Trust (2003c, 2003d) with vision-impaired people, including older people, gives a slightly different slant on AT. The Trust claims that while there is a range of AT devices available, they are sometimes too specific to suit individual circumstances. The costs may be prohibitive, and/or the devices are perceived as stigmatising.

The Trust also points out that changes to the design of mainstream products and 'add-on' devices would greatly assist independence, such as standard plug-in modules to convert appliances into talking models (Thomas Pocklington Trust, 2003d). This paper provides a substantial list that compares user needs and problems with existing technology. It also identifies gaps in available technology, pointing out that there is a smaller range of devices to assist people with housework and routine activities in the house. The research drew up the following list of attributes, which may be applicable to other groups of older people, to ensure the development of appropriate technology (Thomas Pocklington Trust, 2003c, p. 5):

- Purchase and running costs must be realistic.
- 'Hi-tech' is not always the best solution.
- Adding on assistive technology to mainstream appliances would be useful.
- Assistive technology should not stigmatise the user and should be acceptable to other occupants of the home who do not have sight loss.
- Where possible designs should be offered to reflect personal taste.
- Assistive technology should be easy to use but not at the expense of functionality.
- Devices should be practical and safe.

Getting equipment may not be easy for those vision-impaired older people who are not registered. According to the Thomas Pocklington Trust (2003b), two-thirds of vision-impaired older people are not registered as blind or partially sighted. Older people in contact with eye clinics but who are not registered often fail to receive social care assessments and the information necessary to find out what is available.

Non-registered vision-impaired older people may, it would seem, miss out on the preventative benefits of AT.

The study by Parkinson and Pierpoint (2000), undertaken with the involvement of older people into preventative approaches in housing, points to the high incidence of sensory impairment among older people and stresses the importance of ensuring that lighting levels, surfaces and equipment maximise impaired sight and hearing. Trips and falls are a particular hazard for vision-impaired older people (see also Thomas Pocklington Trust, 2003a). In so far as lighting is concerned, vision-impaired people can find difficulty in gaining adequate information while transport and travel difficulties make it difficult to gain access to the full range of lighting options by visiting, for example, stores (Thomas Pocklington Trust, 2003a). The Secretariat has not been able to locate comparable information from the perspective of older people with hearing impairments.

These examples indicate that there are probably mixed reactions to AT among older people. However, as the Audit Commission (2004c) acknowledges, among the barriers to progress in the greater use of AT are lack of advice and information to the public, funding pressures on statutory agencies and, partly related to the latter, a failure to act upon the research evidence.

AT is not confined to new, high-tech devices but can also include smaller and better-known items such as hearing aids, gas monitors, pendant alarms, and, as Tinker (1999) notes, mobile telephones. There are then clearly a wide range of products, some of which have long been in use: radio pendant alarms, for example, were introduced in 1948 (Brownsell, 2000). These and other small gadgets, as well as flexible space (to accommodate, for example, walking frames), accessible cupboards, and showers with enough room for someone to help, are important (Audit Commission, 2004b). Some home adaptations might come under the rubric of AT but whether all would, for example widening of doorways and lowering of thresholds, is questionable. Terminological concerns aside, however, research evidence from older people about adaptations is important in itself and may provide some transferable lessons for issues around AT and smart homes.

AT and adaptations can support safety as well as independence. However, professional concerns with safety and the management of risk may undermine older people's participation in the assessment process and supersede their sense of independence (Tanner, 1998, 2003; Waterson, 1999; Henwood, 2002) and their coping strategies (Clark *et al.*, 1996). In terms of assessment for the need for equipment and adaptations, a focus upon safety can lead to a situation where equipment is not used, or is used for purposes other than that intended. Older

people can feel that their homes have been taken over by equipment and adaptations (Clark *et al.*, 1996). Heywood (2004) cites a range of literature which points to the detrimental impact upon health when professionals involved in the delivery of adaptations fail to consider the psychological factors and the meaning of home to the recipients. As Heywood (2004) says, when unwelcome adaptations are installed in the home, recipients can feel helpless and disempowered.

Keeping the house and garden in good order

The issue of housing is inseparable from the support available to live safely and independently in the home and maintain its inner and outer appearance. The home is much more than a physical entity and may encapsulate the older person's self and social identity. Clark *et al.* argue that the distinction whereby statutory support is limited to the personal care of the person but not the home fails to understand the links between self and environment: 'The home is not simply a physical environment; it can encapsulate the public and private identity of the older person' (1998, p. 64).

The physical environment of the home is central to the maintenance of older people's independence and sense of well-being. While, as the research discussed below illustrates, this cannot be seen in isolation from other aspects of older people's lives, an important and consistent message is that practical help with tasks in and around the home is very important to older people and highly valued when available. That message comes from research throughout the 1990s and up to the present day, whether it has focused directly upon what older people think of 'that bit of help', or has been based upon 'consumer surveys', concerned with older people's definitions of quality, or has focused upon issues of independence. It also emerged from consultations with older people in the Better Government for Older People pilot areas.

A poll conducted for Wiltshire County Council among older users of social care services found cleaning the home was the service older services users saw as most important (MORI, 1991). A further MORI poll conducted for Anchor in 1996 placed home help high on the priorities of older people, while Tinker *et al.* found that the 'contraction or unavailability of basic cleaning services was a source of resentment' to the older participants of their study (2000, p. 20). The evaluation by Hayden and Boaz (2000) of the Better Government for Older People programme pointed out that consultation with older people showed they wanted help with home repairs, gardening, shopping and spring-cleaning. This was the case whether or not the older people were users of social care services, and, as Clark *et al.* (1998) also found, some older people saw this help as more important than 'personal care'.

Older people, particularly women, see keeping the house up as akin to keeping themselves up and therefore very important (Age Concern England, 1994; Clark *et al.*, 1998; Raynes *et al.*, 2001). To quote an older person in the Age Concern research, 'Once you start neglecting your home – then you neglect yourself' (Age Concern England, 1994, p. 36).

The older participants in all these studies feel that help with housework is essential to maintain their ability to remain in their own homes. The appearance of gardens, and particularly front gardens, is a show of respectability (Wilson, 1994), as is the appearance of net curtains (Clark *et al.*, 1998). Having help with housework and with things like curtains and gardens is important in terms of older people's self- and social identity as competent adult members of the communities in which they live (Clark *et al.*, 1998) and in their sense of pride in who they are (Raynes *et al.*, 2001). It is important to self-esteem and to mental health. At the same time, having a clean and tidy home means that older people feel confident about inviting others inside.

It is important to note that older people say they want 'help', not 'care', in their home. The latter equates with the loss of their independence. 'Help', on the other hand, assisted them to look after themselves as much as possible (Clark *et al.*, 1998). Clark and her colleagues report that older people wanted help only with those tasks they could no longer manage. Continuing to do what they still could was important to the retention of the self-identity as independent. The withdrawal of help with housework by social services was seen as a lack of recognition and understanding of what is important to older people, including their confidence in their ability to remain living in their own homes. Indeed many older people saw such help as standing between them and residential care. The RNIB point out that the lack of low level support increases the risk of having to enter residential care (Thomas Pocklington Trust, 2003b).

Older people have made it clear that what happens in the home is inseparable from what happens outside. Having a bit of help in the home increased confidence and reduced social isolation. Older people do not compartmentalise their lives in the way that services do. They have a much more joined-up approach. This was a central finding of the research by Raynes *et al.* (2001) into the views of older people about what makes a quality home care service. The participants had a holistic or 'rounded' approach which was as concerned about having company, getting out, good transport, feeling safe, better health services and having things to occupy your mind. As the study says, what older people experience and what they do outside their homes affect what happens in their homes.

In the Raynes *et al.* (2001) study, the older participants included within their definitions of a good quality service 'that bit of help' with tasks inside the home: cleaning and small tasks like changing light bulbs. However, their definitions of quality suggest a need to focus also on what are supposed to be universal services, such as health care, transport, the environment, policing and education because these are crucial to people's sense of well-being. Similarly, Means (1998) reports that the older participants in his study included issues of transport, mobility and leisure when talking about home and independence. However, black and minority ethnic people were either unaware of or felt excluded from home care services – a finding that has been a consistent message of other research and reports (Raynes *et al.*, 2001).

Similarly, Qureshi *et al.*'s research found older people 'wanted to be able to plan and organise their days and enjoy a normal pattern of life' (1998, p. 9). Maintaining their own standards of cleanliness and tidiness in their homes was part of that, but so too was feeling connected to the world, avoiding boredom and isolation, and having the resources and information to make their choices.

Henwood *et al.* (1998a, 1998b) found that older people want greater flexibility of services. This was partly to do with housework and help with tasks that involved climbing, but also to do with things like being able to go outside and sit in the sun, go out for a walk, sit and have a chat with the care assistant, and be taken to the shops and the post office to do their own shopping and collect their own pension. Harding and Beresford (1996) also reflect service users' calls for greater flexibility, including the provision of domestic help and shopping (see also Raynes *et al.*, 2001). Langan *et al.* (1996) point out that older people often have to rely on families for shopping trips and for one-off forms of help which services are rarely set up to do. An example quoted in this study is that of shopping around for the best value when items like freezers need to be replaced.

The issue of 'climbing' is very important – changing curtains or light bulbs, cleaning windows and reaching top shelves etc. may all require this but it is a task that home care assistants are not supposed to do. In 1996 the House of Commons Health Committee noted that lack of help with household tasks could lead to risk taking and to falls. A study by Tanner (2001) also reports the risk of falling identified by older people due to dirty floors, while respondents to the Langan *et al.* study talk about their wish for more flexible services which would include cleaning windows and cleaning higher 'than an arm's length reach' (1996, p. 16).

Langan *et al.* (1996) point out that the older participants in their study needed help 'with the myriad of small, often taken for granted tasks' such as having a bath, having

a bed made, having shoes polished, having buttons sewn on, or replacing a light bulb (especially important for those people who have poor eyesight), while an older person cited in the Care & Repair study puts it quite simply: 'It's the small things that matter – who do you turn to when the tap washer needs changing?' (2002, p. 3).

Safety in the home also involves being sure of the people who are coming in. In so far as handymen and tradesman are concerned, older people also want to feel confident that they are not going to be 'ripped off' and that their personal safety is not threatened. Research suggests older people therefore value handyperson schemes (Appleton, 1996). Such schemes also provide an affordable service, and older people in the Appleton study reported such benefits as their homes being more comfortable, and safer and easier to manage as a result of the work done.

The right housing

Most older people want to stay in their own homes and for as long as possible (Commission for Social Care Inspection, 2004). However, supported housing can have a role to play and there should be a range of flexible housing options available. These might include adapting the older person's current home around them (Gilroy, 2003). But for some older people living in properties in poor state of repair and who have health problems, the thought of having to live through the upheavals of major renovations may be too much (Care & Repair, 2003). Older people require the right level of advice to enable them to make informed choices about what is likely to be the most appropriate option for them (Tinker, 1999; Care & Repair, 2003; Audit Commission, 2004b). They also require an opportunity to talk through the pros and cons, and assistance with the practicalities that 'moving on' requires and which can be overwhelming for some older people (Care & Repair, 2003).

At the same time, as a report of the involvement of older people in the remodelling of a local authority dwelling has shown, some older people value and benefit from effective participation in housing management and design and are a valued resource (Gilroy, 2003). In order to design a home that would meet the requirements of older people's quality of life, the older people involved had to counter resistance by housing officers who wanted to retain their own position as experts. Not only did the older people want to be listened to (and in this case achieved this) but also valued the support of a 'critical friend' – in this case an occupational therapist – who could construct their arguments 'in the language of professionals' (Gilroy, 2003, p. 669). One older person involved in the project remarked:

> Up to now it's tended to be what other people think older people would like or even what their own mother liked when she became disabled. Not taking account of all the ideas we have and giving authenticity to our views. You feel folk are listening.
> (Gilroy, 2003, p. 669)

As the title of the paper from which this quotation is taken asks: why can't more people have a say? It is a question that is relevant in other areas.

The decision to move into other forms of accommodation, including sheltered accommodation, can be dependent upon the lack of help available with things like managing the garden (Joseph Rowntree Foundation, 2000), the physical environment of the home, health issues, loneliness and the need for security (Quilgars *et al.*, 1997). Parry *et al.* (2004) found that poor health, sometime in interaction with other factors – bereavement, separation, financial considerations, loss of informal support and the desire to be nearer family and friends – was critical in underpinning decisions to move into supported forms of accommodation.

Moving into retirement housing does not necessarily mark a negative decision or have negative outcomes (Quilgars *et al.*, 1997; Parry *et al.*, 2004). Quilgars *et al.* (1997) report a range of retirement housing tenants' perspectives and for many people the move had been a positive decision, though not for all. For many there were positive outcomes, particularly in terms of their flats being warm, in a good location, secure, with a good view, comfortable and of reasonable size. Some older people also valued the opportunities to socialise and to participate in organised events and outings. For a significant minority, however, there was regret at having had to move and the research points out the need for older people to 'exercise real choice over being able to remain in their own homes through ensuring the availability of home support services and related home improvement initiatives' (Quilgars *et al.*, 1997, p. 59).

An adequate income

This is so important it goes almost without saying: it is the key to independence (Audit Commission, 2004a). Cook *et al.* (2004) suggest that rather than asking 'does money matter?', the question should be 'how does money matter?'. Money is valued not as an end in itself but as a means to an end. 'The value of money rests in what it enables you to do and in the sense of control over personal circumstances that it gives' (Cook *et al.*, 2004, p. 57). Money, for example, enables 'better-off' people to meet their needs for 'that bit of help' through paying for it 'while others may be forced

to wait until a crisis propels them into the high need categories which generate a response from social services' (Means, 1998, p. 417).

British pension levels are among the lowest in northern Europe (Naegele and Walker, 2002). Currently the guaranteed income for older people is only about a quarter of average earnings but many older people lose out on this because of underclaiming of means-tested benefits. Fears around appearing to be in need and losing independence are among the major reasons given by older people for not claiming such benefits (McConaghy *et al.*, 2003), as well as the felt humiliation of having to expose their financial situation to others and fear of losing the little income they have (Cook *et al.*, 2004).

At the same time, as Cook *et al.* point out, older people often do not know what they are entitled to, and sometimes it requires 'highly developed analytical and numeracy skills' (2004, p. 25) to negotiate the complexities of managing monetary resources following retirement – skills which are not well developed among the population in general. There is clearly a need for improved information and advice services for older people if they are to maximise their income, calculate future needs and know how to release capital.

Income varies between older people; however, later life brings with it an increased vulnerability to poverty. It is estimated that over one-fifth of older people are living in poverty (Flaherty *et al.*, 2003). Older women, black and minority ethnic older people, and older pensioners are particularly vulnerable to poverty (Naegele and Walker, 2002). Only about 13 per cent of women of pensionable age are entitled to full basic State Pension in their own right. Scharf *et al.* (2003) also suggest that older people living in deprived areas in England are at least twice as likely to be living in poverty as those in Britain as a whole and that this is particularly acute among older black Caribbean, Bangladeshi and Somali people. Living on a low income can mean cutting back on basic items, including food and household utilities. In one study this was especially apparent among, though not restricted to, minority ethnic older people (Social Exclusion Unit/Office of the Deputy Prime Minister, 2005a).

It is estimated that there are around 1.4 million fuel-poor households in England (Department of Trade and Industry, 2004). A household is fuel poor if it needs to spend more than 10 per cent of its income to maintain a satisfactory heating regime. It is difficult to determine the number of older people living in fuel-poor households but Sefton (2002) estimates almost half are older households.

In the winter of 2003/4, there were an estimated 23,500 excess deaths. Of these deaths 21,500 were of older people, and 18,400 were of people aged 75 and over

(Office for National Statistics, 2004a). The UK has a higher proportion of winter deaths than comparable European countries (Help the Aged, 2004). A recent report commissioned by the British Gas Help the Aged Partnership found that approximately half the householders of older homeowners and private renters in the study were in fuel poverty (Wright, 2004). The study also reports that few older people in England and Wales have heard of the Warm Front Scheme (England) or the Home Energy Efficiency Scheme (Wales), and that those who do know about these schemes have found the eligibility criteria confusing. Wright also points out that existing schemes had been developed without the input of older people.

Safe neighbourhoods

Belonging to a neighbourhood

Peace *et al.* (2003) point to the importance of environment in terms of both location and the home itself, and the importance of familiarity with neighbourhoods – including negotiating the material environment and maintaining a sense of belonging through involvement in creating neighbourhoods.

The Audit Commission notes that many older people have lived in the same place for a long time and 'identify strongly with their neighbourhoods' (2004b, para. 55). Safe neighbourhoods enable older people to maintain their contacts within their community and participate in the life of that community. This in itself, as the Peace *et al.* (2003) study points out, is important to the maintenance and negotiation of identity – particularly in the sense of belonging to that locality. At the same time, locality is particularly important for older people with health and/or mobility problems because it forms a 'spatial boundary within which most social life [takes] place' (Godfrey *et al.,* 2004, p. 41). However, as evidenced by Scharf *et al.* (2003), in deprived neighbourhoods older people can experience levels of social exclusion over and above those of other age groups, which can contribute to 'neighbourhood exclusion'.

There can be a range of physical and other barriers to older people's involvement in the neighbourhoods in which they live. For example, the Audit Commission (2004b) points out that older people often comment on the unsafe state of pavements. The Social Exclusion Unit/Office of the Deputy Prime Minister (2005b) report says that the narratives of older people affected by neighbourhood exclusion point to two key dimensions:

- deterioration of the neighbourhood so that it is now dirty and poorly maintained
- deterioration in the quality of relationships with local residents.

The two, the report says, coincide, while the latter contributes to a loss of the ability to trust other local people. The loss of local facilities – particularly post offices, large retail outlets, toilet facilities near shops and local pubs – comprised a further dimension in the social exclusion of older people living in disadvantaged neighbourhoods. Among the report's recommendations is that neighbourhood renewal policies recognise the impact of such environmental changes upon the lives of older people.

Fear of crime and regeneration of neighbourhoods

There is also a real fear of personal and property crime that contributes to the isolation of older people (Pearson and Richardson, 1994; Clark *et al.*, 1998; Scharf *et al.*, 2003; Social Exclusion Unit/Office of the Deputy Prime Minister, 2005a, 2005b) and this seems to be particularly the case in deprived areas. Contrary to the national average which places burglary and violence against older people at relatively low levels, Scharf *et al.* (2003) found that 21 per cent of the older people living in a deprived area had experienced a burglary and 15 per cent had experienced an assault or had something stolen from them. Unsurprisingly, then, 40 per cent of the sample was worried about burglary and the vast majority said they would not feel safe going out alone after dark.

Safety devices within the home such as safety locks, window catches and bolts on doors can help alleviate fear of burglary. However, bolts can be a risk factor in themselves, preventing entry by others in emergencies (Pearson and Richardson, 1994) and older people can feel locked in (Clark *et al.*, 1998).

Appleton (2002) points out that much is already known by Police Architectural Liaison Officers about how to design without features that encourage crime and anti-social behaviour and that this information can and is drawn on when designing estates. Appropriate lighting and design which recognise the relationship between buildings, pavements, walkways, service areas and garages can 'minimise crime and "feel" safe to those moving in them' (Appleton, 2002, p. 20). There is a need, says Appleton, to look beyond personal security and ensure a safe environment, taking on board the needs of all, including sensory impaired people so that they can move safely within the environment. Examples would be lowered pavement kerbs at crossings, level walkways without obstructions, sensitive placing of posts and

furniture, colour contrasts and distinctive textures designed to signal hazards. Furthermore, says Appleton, older people should be involved in the design of their environments.

The Better Government for Older People conference held in July 1999 at Ruskin College in Oxford also took up this theme. Participants called for the involvement of older people in regeneration projects and a reminder that such projects should not simply be about attracting young people in and decanting older people out but recognise that older people 'are a valuable part of the community and should have the right to live near their friends and families, their roots, the places they know and the amenities they need' (BGOP, 1999, p. 32).

Riseborough and Jenkins (2004) point out that since 2000, regeneration policy has broadened and the government is more interested in engaging with older people. However, while older people, including black and minority ethnic older people, are more involved in local regeneration projects they are still under-represented when it comes to renewing cities and town centres (Riseborough and Jenkins, 2004). Feeling safe in your neighbourhood is closely linked to the importance older people attach to being able to get out and about.

The ability to get out and about

Being able to get around outside the home is important to older people (Audit Commission, 2004b). Research conducted for the Department for Transport and involving six focus groups of older people and 1,445 household interviews highlights the importance of the ability to travel for older people for the purposes of entertainment, participation, independence and social interaction (Atkins, 2001). The report points out that older people, and especially older women, are often reliant upon public transport, particularly buses, but can face a number of barriers to their use. The most frequently mentioned was accessibility – getting on and off buses, carrying items, confusion over use and staff attitudes. Other research has emphasised the importance of accessible transport to older people (Raynes *et al.*, 2001; Parry *et al.*, 2004). Issues around travel information were also raised, as was awareness of concessionary bus fares among car drivers, minority ethnic older people and people aged 75 and over. Car drivers also said they would like information in the form of fact sheets on issues to be aware of as you grow older and on what to look for when buying a new car, such as power steering and automatic transmission.

The importance of motorised scooters in enabling older people to get out and about has been emphasised in some studies (e.g. Raynes *et al.*, 2001; Reed *et al.*, 2003). Planning of roads and pavements needs to take into account the increasing use of pavement scooters (Appleton, 2002), with traffic-free lanes and roads also made safe for wheelchair users (Raynes *et al.,* 2001).

There are services that collect shopping for older people but this is not the same as going shopping oneself. It is worth noting that the older participants to the Clark *et al.* study (2004) on older people and Direct Payments saw great value in being able to have personal assistants accompany them on outings, including shopping, so they could indicate their choices. For older Somali women participants this meant they could meet their cultural norms in terms of the food products they chose where language barriers otherwise made this difficult. The older people participating in Henwood *et al.*'s 1998b study also wanted care assistants to take them shopping. Raynes *et al.* (2001) report the importance of going out shopping for older people and the need of people from minority ethnic groups to do this. The shops they need are not necessarily ones a care assistant would use. However, as Godfrey *et al.* (2004) point out, getting to the shops is not just about buying food; it is also about meeting friends and acquaintances in the street. It is a social event. Seats in and between shops have been identified as important to enable older people to recharge their energy levels on shopping trips (Raynes *et al.*, 2001).

Older people experiencing vision impairment, including sight loss, can experience specific difficulties getting out and more general, though not unrelated, feelings of depression and exclusion. Eye clinic professionals do not always recognise the subjective feelings of loss, nor do they always provide appropriate information about other sources of help. The overall impact can be one of extreme isolation for vision-impaired older people. As an older person said:

> It was like somebody had shut you up in a box and said 'look, that's your place. Stay there.' It is an awful feeling. It really is.
> (Thomas Pocklington Trust, 2003b, p. 6)

The Trust talks about the need for counselling, and for a befriending service for isolated vision-impaired people. The Trust also points out 'the most important unmet need of people with sight loss was simply a wish to go out' (Thomas Pocklington Trust, 2003e, p. 1).

Friendships and opportunities for learning and leisure

Older people want social activities, to maintain networks of friends, to see family members, and to participate in leisure and education opportunities: such activities help promote and maintain older people's mental health and their quality of life (Audit Commission, 2004b). These are among the things that make 'life worth living' (Harding, 1997) or, put another way, they are central to what makes for a good life in old age (Godfrey *et al.*, 2004).

There is strong evidence of a connection between loneliness and poor mental health, particularly anxiety and depression (Audit Commission, 2004b). It is also the case that levels of depression and anxiety among older people increase as gross household income drops (Office for National Statistics, 2004b). Certainly, neighbourhood deprivation and exclusion, together with low incomes, plays a part in loneliness and depression. For example, the Pearson and Richardson study in Tranmere, Birkenhead, paints a bleak picture of loneliness, isolation, depression and anxiety, but the older people involved did not believe these were legitimate problems to talk about or problems which had a solution, and 'this silent suffering was the largest single problem identified in this study' (1994, p. 41). Wenger *et al.* (1996) point not only to low income and poor access to transport as factors contributing to social isolation and loneliness, but also to the impact of widowhood and lack of local social or community networks.

Bereavement, grief, fear of crime, and health problems are among the barriers to going out (Pearson and Richardson, 1994). These, along with loneliness and isolation, are known to be risk factors for depression.

As Andrews *et al.* say, 'life satisfaction and psychological wellbeing among older people are influenced to some degree by their levels of social activity and contact' (2003, p. 349). For social contact to be sustained, transport, a good quality environment, and public facilities that are user friendly and accessible to older people are necessary.

Consultation has shown that older people want there to be a range of activities available to suit different tastes (Hayden and Boaz, 2000). A crucial point is, however, made by Kerr and Kerr (2003, p. 22):

> Older people can use the facilities, clubs, services, and classes that already exist in the community, and therefore do not always need 'specialist' services.

The authors also note that there 'is a danger of creating services specifically for older people, who may be seen as needing "extra" – older people can therefore be seen as a problem rather than as a resource' (Kerr and Kerr, 2003, p. 21). This theme will be addressed later in this report. However, transport has a major part to play, as does the safety of the environment and individuals' income.

People aged 60 and over are represented among those enrolled on adult education courses, though they are far more likely to attend daytime than evening courses (Office for National Statistics, 2004b). However, fees, travel costs and books and materials may be prohibitive for older people on low incomes. As the National Institute of Adult Continuing Education (NIACE) 2000 briefing paper comments, adult education fees are too high and have discouraged many older people, while concessions vary between different parts of the country. In so far as higher education is concerned people are currently not entitled to student loans beyond the age of 54 and the number of older students is insignificant (Soulsby, 2002, p. 27).

The Better Government for Older People conference at Ruskin College, Oxford, in July 1999 emphasised the importance of removing ageist barriers to older people's opportunities for learning and pointed to the importance of learning beginning with people's own heritage, cultures and communities (BGOP, 1999). A similar message from Age Concern stresses the importance of *roots* in education and leisure facilities for older black and minority ethnic people who have migrated to this country and where there may be little opportunity to communicate in their own languages (Age Concern England, 1998). This report suggests that projects that have focused upon cultural traditions have been valuable in countering the alienation that older people may feel. At the same time, there are other positive spin-offs – leisure and education services can provide a means for older black and minority ethnic people to find out about services and entitlements. The report also notes the importance of libraries stocking books in different languages, pointing to the underuse of library borrowing services by minority ethnic older people.

There may be specific issues for people with dementia for whom memory problems can be a factor in decreasing social contact. Research with older people with dementia, however, indicates that companionship and opportunities to socialise are important issues alongside having something to do and somewhere to go (Bamford and Bruce, 2000).

The ability to keep active and healthy

Older people see good health as important to retaining their independence (Raynes *et al.,* 2001). As summarised in Chapter 1, however, older people's definitions of

health do not always accord with professional definitions, which are commonly influenced by the biomedical model of health. This model focuses on biology and disease and tends towards a negative or pathological view of health in old age through a narrow focus on bodies, considered to be in decline as part of the natural consequence of growing older (Sidell, 1995). More generally, the biomedical model provides a negative view of health, seeing it as the absence of disease, and uses measurements of mortality (death) and morbidity (disease) to assess how healthy or unhealthy we are as a society (Baggott, 1994).

Research suggests that older people have a more holistic approach, seeing health as akin to well-being and the ability to carry on with normal living (see, for example, Sidell, 1995; Heywood, 2004). In turn, these concepts incorporate issues around home, friends and family, community and involvement, getting out and about, leisure and social activities, and 'having a laugh'. The older participants of the Reed *et al.* study defined health as 'being able to establish and maintain a sense of ease and enjoyment in their lives, by identifying and reaching their personal goals' (2003, p. 10), while Godfrey *et al.* (2004) point out that even when health and/or mobility problems restrict older people to the immediate locality or the home, this does not mean they give up wanting fun and joy in their lives.

The beneficial impact on health of 'social' and 'productive' activities is discussed in a paper by Glass *et al.* (1999). This paper may be seen as synthesising the biomedical model of health alongside a more holistic approach that emphasises psychosocial well-being. Based on a study involving older people in the USA, Glass *et al.* state that while physical activity is important to health, social activities can be equally important: church attendance; visits to cinemas, restaurants and sporting events; day or overnight trips; playing cards, games and bingo; participation in social groups; and 'productive' activities such as gardening, preparing meals, shopping, community work and employment. While Glass *et al.* define health predominantly in terms of survival or mortality rates, they also point out that social and productive activity is linked to psychosocial health and thereby to physical health. Key messages of the research include:

- Social and productive activities are as effective as fitness activities in lowering risk of death.

- Enhanced social activities may help to increase the quality and length of life. (Glass *et al.*, 1999, p. 482)

As the authors say, this has important implications for public policy, and measures to reduce barriers to social engagement – such as public investment in transport and

day centres for older people – would be beneficial interventions. However, as already pointed out, older people can also use mainstream facilities and most do not necessarily need 'specialised' services. Older people who are frail or who have chronic conditions need extra support to maintain those aspects of their lives that are most important to them. This requires going 'beyond clinical issues to include a whole range of factors … such as being able to maintain interests and social networks, having a comfortable home, an adequate income and being able to get out and about' (Audit Commission, 2004d, p. 4).

While 'health is more than the NHS and social care' (BGOP, 1999, p. 30), older people are concerned with the quality of traditional health services and want greater involvement in setting quality standards. The transition from hospital care to home is also one that can impact upon the independence of older people. The views of some older people as to what constitutes a good hospital discharge have been outlined above. Parry and her colleagues (2004) also point to the high value accorded to home from hospital services by older people. Such services enhance continuity of independence by helping older people 'get back on their feet' and assisting their recovery through practical support.

Additionally, older people stress the importance of services such as dentistry, chiropody and opticians, as well as advice and information about enjoyable ways of staying fit and active and how to overcome health difficulties (Audit Commission, 2004b).

Good relevant information

The Audit Commission (2004b) describes good, relevant information as the key to choice. Maximisation of income requires good information, particularly given the complexity of the pension system in the UK. However, older people express a need for information on a wide range of issues, including information about leisure facilities and how to access them and about reputable tradesmen (Quinn *et al.*, 2003).

The Joseph Rowntree Foundation commissioned three studies on information, advice and advocacy (Kerr and Kerr, 2003; Margiotta *et al.*, 2003; Quinn *et al.*, 2003). These studies highlighted the following issues:

- One barrier to accessing information is being unaware that such information is there in the first place.

- Older people may not be familiar with the concept of advocacy.

- There is clearly a need for better promotion of and publicity for such services.
- Information needs to be in different languages and different formats.
- Older people want topic-based rather than agency-based information.
- One-stop shops and face-to-face communication are preferred.
- Older people should be involved in the development of information strategies and can be and are effective advocates for their peers.

In so far as one-stop shops are concerned, these may not be proactive enough in reaching more isolated older people and so there is an additional need for outreach work (Hayden and Boaz, 2000). In Sourbati's study (2003) of how older people living in sheltered homes used the internet and how they felt about online service access, only a minority of the older tenants were interested in trying the internet. They saw it primarily as a means of accessing entertainment and leisure activities rather than a means to access services. Some tenants were concerned that online service delivery would replace traditional forms of provision and human contact and create further isolation.

A range of websites exist beyond those provided by local authorities and other statutory and voluntary agencies concerned specifically with older people, which can provide information about housing and equipment from small domestic items to larger-scale ones. A selection of these can be found on the final page of this chapter. One project, piloted by the Department of Health as part of the Integrating Community Equipment Services development (www.icesdoh.org), aims to extend self-assessment to assist people in identifying both what they might need in the way of aids in their home and where these could be bought or hired.

Summary of the key issues

All seven areas of life in which help are required are important. These areas are:

- comfortable and secure homes
- an adequate income
- safe neighbourhoods

- the ability to get out and about
- friendships and opportunities for learning and leisure
- the ability to keep active and healthy
- good relevant information.

Deficits in any one of these areas will impact on the well-being of older people and their ability to be independent in any of the other key areas of their lives.

Comfortable and secure homes

- Adaptations and equipment provided to older people in their homes can promote their independence without the need for other substantial service inputs.
- For adaptations and equipment to be effective they need to be provided after proper consultation with the older person into whose home they are to be placed.
- Provision of such aids, equipment and adaptations is variable and costs vary across the country as well as the time taken to provide them.
- Information provided for older people about adaptations and equipment, and their availability, is inadequate.
- Aids and adaptations to the environment external to people's homes can also contribute to older people's independence.
- Older people value low-tech solutions to hospital discharges to promote their independence on their return home.
- Older people have varied views of the value of electronic aids and adaptations, but an increasing number value the introduction of these forms of AT in promoting their ability to live independently.
- In people's homes, appropriate lighting levels, surfaces and equipment are significant contributors to promoting the independence of everyone.
- Practical help with tasks in the house and garden to keep them in good order are very much valued by older people. The appearance of these parts of people's lives is a reflection of themselves.

- Older people want help, not care. Help assists them to look after themselves and deal with tasks they cannot manage. Care equates with the loss of independence.

- Older people are concerned that without help to keep their home in good order and with tasks they cannot do for themselves, they will be admitted to residential care.

- Services to older people in their homes should be flexible, both in terms of what is provided and when it is provided.

- Services should address tasks that older people cannot do, and do not know where they can get help in order to do them, for example changing a light bulb. Older people value handyperson schemes.

- Advice and guidance to make informed decisions about moving to other forms of housing are essential. They will help ensure it is not a negative decision.

- Older people should be involved in housing design and 'critical friends' (professionals) can assist in this.

- Retirement housing is a positive option for many older people because it is warm, easy to manage, well located, and provides links to opportunities for social activity.

An adequate income

- British pension levels are amongst the lowest in Western Europe. Guaranteed income for older people is about a quarter of average earnings. Income varies greatly but there is an increased likelihood of poverty among older people.

- Many older people do not claim the additional financial benefits available to them. The reasons for this include lack of knowledge about them and an unwillingness to appear 'needy'.

- It is estimated that one-fifth of older people live in poverty.

Safe neighbourhoods

- Local neighbourhoods that are viewed as safe are valued by older people, as they enable them to continue to remain part of their local community.
- In impoverished, deprived local neighbourhoods, older people are more isolated and excluded than other members of these communities.
- Crime against older people is higher in deprived neighbourhoods than elsewhere. In these neighbourhoods, many older people report not feeling safe going out alone after dark.
- There are many ways of ensuring safe environments in local neighbourhoods. These include the provision of appropriate lighting that minimises crime and enables people using the neighbourhoods to feel safe. Older people should be involved in the design of their neighbourhoods.

The ability to get out and about

- Older people value the ability to travel to reach entertainment, promote their independence and participate in society.
- Public transport needs to be accessible and easy to get on and off, with and without items to be carried.
- Information about cars suitable for older people is needed.
- Information about travel and fares is valued by older people and needed.
- Planning of roads and pavements needs to take account of the growing use of motorised scooters.
- The need for help to get out and about safely is of particular importance to older people with vision impairment.

Friendships and opportunities for learning and leisure

- Older people want to have social contact with others. Lack of this is linked to loneliness and poor mental health.

- Opportunities to engage in social contact are limited by income, access to transport, lack of community networks and bereavement, as well as fear of crime and poor health.

- Older people can use the facilities, clubs and classes that exist in the community for other people; they do not always need to be specially designed for older people.

- Ageist attitudes limit opportunities for older people to continue to participate in learning opportunities. The cost of accessing these varies across England and can also inhibit participation.

The ability to keep active and healthy

- Older people view health as well-being. This is more holistic than the medical view of old age which focuses on bodies in decline.

- Social activities and those like gardening, shopping or preparing meals have beneficial health-promoting consequences. These activities are relevant to promoting the well-being of frail older people as well as those who are healthier. The promotion of these opportunities is linked to transport and being able to get out and about to meet people.

Good relevant information

- Older people require a wide range of information. Good publicity of the availability of information and where it can be found is important.

- Information should be in different languages and different formats.

- Currently, older people prefer one-stop shops and face-to-face communication to other options.

- Older people need to be involved in the design of information and its implementation and monitoring.

- Information about advocacy for older people needs to be better disseminated. It appears to be little known amongst older people.

Final thoughts

There appears to be an increasingly recognised view that older people are not just consumers of health and social care services and income from the state, via statutory pensions and other targeted benefits, but active citizens and contributors to society. Older people are as heterogeneous a group as any other in our society, thus what they want is variable, although there are some clear common elements emerging from the literature review.

As citizens, older people are capable of contributing to the development of help to promote their independence in a variety of ways and should be involved in the planning and development of the help they may require. This help will include services designed for everyone (universal services), as well as specialist ones.

From this review of what older people want it is clear that older people have joined-up lives and that in so far as 'that bit of help' is concerned this also needs to be joined up. It is also clear that we may not be looking solely at a 'services for' model but also at one that starts with a community strategy that recognises that older people are citizens and not just consumers of specialised services (Association of Directors of Social Services/Local Government Association, 2003). In other words, a community strategy is needed that ensures older people have access to facilities and services that are meant for us all.

In 1986 the Centre for Policy on Ageing argued for a corporate approach by local government in looking at planning, environment, transport, policing and leisure issues as well as community care services, and for the involvement of older people in decision making (Norton *et al.*, 1986). Their messages have been reiterated. Bennington called for a reorientation of the strategies of public, private, voluntary and grass-roots sector organisations, and stressed that this required 'integrated action able to link the policies and programmes of the range of agencies concerned with housing, health, social security, transport, leisure, police, education, social services, employment and older people and their own organisations' (Hayden and Boaz, 2000, p. 13). Both the Association of Directors of Social Services/Local Government Association (2003) and the Audit Commission (2004a) have reinforced this message. It reflects the joined-up approach to well-being and independence that characterises older people's own views.

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Websites

The Joseph Rowntree Foundation: www.jrf.org.uk

Help the Aged: www.helptheaged.org.uk

A selection of websites concerned with housing and equipment:

www.concretexchange.org.uk

www.3rdagehomes.org

www.futureproofhome.co.uk

www.oxoweb.wordkitchen.com

www.caredirect.gov.uk

www.hhrc.rca.ac.uk

www.ices.org.uk

3 Addressing what older people want? Policy context

Heather Clark and Juliet Crissel

Introduction

This chapter provides a snapshot of the policy context to our exploration of the importance of that 'little bit of help'. Any policy review risks being overtaken by events and rapidly becomes out of date. We recognise this reality, and the snapshot is presented of the situation that existed up to autumn 2005, and the journey that had taken place in the eight years since Labour took office in 1997. We do not provide detailed policy analysis so much as a descriptive account of the key milestones relevant to the seven areas of life considered important by older people. These seven areas are:

- comfortable and secure homes
- an adequate income
- safe neighbourhoods
- getting out and about
- friendships and opportunities for learning and leisure
- keeping active and healthy
- access to good, relevant information.

We begin by exploring the overall direction of health and social care policy for older people. Subsequent sections examine some of the wider policies, legislation and government strategies that are relevant to the seven areas outlined above. The major focus is on developments since New Labour came to power in 1997 and, of necessity, will concentrate on policies and legislation emanating from Westminster and therefore primarily of relevance to England. Where it is necessary to provide some understanding of the landscape into which these developments have been introduced, reference is made to policy and legislation pre-dating 1997.

Overall direction of policy for older people

Two key policy documents were published in March 2005: a cross-government strategy, *Opportunity Age: Meeting the Challenges of Ageing in the 21st Century* (Department for Work and Pensions, 2005), and a Green Paper, *Independence, Well-Being and Choice: Our Vision for the Future of Social Care for Adults in England* (Department of Health, 2005a). Together these documents provide a statement of the new direction of policy for older people envisaged by the government.

Both documents emphasised the values of active independence, quality, choice and control for older people – values which the Prime Minister, in his foreword to *Opportunity Age*, states should be embedded in all policies directed towards older people. Both also highlight the contribution older people can, and do, make in many different ways to their own lives, to their communities, and to the local and national economy.

The Green Paper *Independence, Well-Being and Choice* spelt out the government's proposals for social care over the next ten to 15 years. It applies to adults of all ages (including older people) and is set within the context of an ageing society. The Green Paper was outcome-focused and set out seven outcome dimensions 'derived from what people have told us they want', namely:

- improved health
- improved quality of life
- making a positive contribution
- exercise of choice and control
- freedom from discrimination or harassment
- economic well-being
- personal dignity.

These outcomes are consistent with the overall vision of the Green Paper that social care should be 'person-centred, proactive and seamless' and that the lives of people using social care will be transformed through greater control and choice.

The key proposals to deliver the new vision were:

- wider use of Direct Payments and the piloting of individual budgets
- greater focus on preventative services to allow for early targeted interventions, and the use of the local authority well-being agenda to ensure greater social inclusion and improved quality of life
- a strong strategic and leadership role for local government, working in partnership with other agencies, particularly the NHS, to ensure a wide range of effective and well-targeted provision which meets the needs of diverse communities
- encouraging the development of new models of service delivery and technology.

A number of new models of innovative service delivery were outlined in the Green Paper, including Extra Care Housing, Homeshare, Connected Care Centres and assistive technology. Time bank volunteering schemes were also suggested as a way of addressing the social exclusion of some older people. This, together with Homeshare, is noteworthy in that both models potentially involve older people in providing 'services' as well as receiving them, and these approaches are therefore consistent with the concept of older people as contributors.

The strategy document *Opportunity Age* might be viewed as the first attempt by any UK government to take stock of all the issues around the ageing of the population 'in the round' (HM Government, 2005, para. 2). It was co-ordinated by the Department of Work and Pensions but was a collaborative enterprise across many government departments. As the strategy document observes, 'when 40% of the population is aged 50 or more – as will soon be the case – the distinction between services for older people and services for everyone else loses significance' (HM Government, 2005, p. viii). The fact that this strategy document was a cross-government effort underlines the reality that older people cannot be compartmentalised from other citizens in planning and policy development.

Opportunity Age set out three areas as priorities for action:

- to achieve higher employment rates overall and greater flexibility for the over 50s
- to enable older people to play a full and active role in society, with an adequate income and decent housing
- to allow us all to keep independence and control over our lives as we grow older, even if constrained by health problems.

There is an emphasis in both documents on removing barriers to older people's access to mainstream services and facilities. *Opportunity Age* accordingly focuses on removing age discrimination, tackling fear of crime and poor housing, ensuring older people can be actively involved in local planning including transport planning, ensuring older people have access to local opportunities in learning, leisure and volunteering and promoting healthy living.

The documents together signalled the need for a shift in attitudes towards ageing, together with a focus upon preventative and low-level services and new ways of delivering services to ensure that older people can choose what they want. Both documents also discuss the idea that piloting programmes will be part of the future. Such programmes enable the development of an evidence base to ascertain what works and is of use to older people. If, as both documents stress, older people are to play a full and active role in society and all of us as we grow older are able to retain our independence and control our lives, then listening to what older people say they want will be crucial in the process.

The current policy for supporting older people needs to be located in the wider context of evolving health and social care policy. In 1997 the incoming Labour government inherited a policy legacy particularly shaped by the community care reforms of the early 1990s. The 1989 White Paper *Caring for People: Community Care in the Next Decade and Beyond* (Department of Health,1989) was enacted through the NHS and Community Care Act of 1990 and set the broad policy objectives that continue to influence the latest developments.

Caring for People addressed the importance of promoting user choice, enhancing independence and ensuring that service users had a say in how they lived their lives and the services they needed to do so. Needs-led assessment and care management were seen as the cornerstones of the new model.

In the first term of the 1997 Labour government, a White Paper was issued setting out the modernisation agenda for social care (*Modernising Social Services*: Department of Health, 1998). The emphasis of the document was on promoting independence and improving the consistency and quality of services. Key mechanisms for achieving these objectives included the planned extension of Direct Payments arrangements to older people (whereby people can choose to receive a cash payment rather than social care services and they can then use the money to arrange and purchase their own care). Direct Payments had been introduced by the Community Care (Direct Payments) Act 1996. In 2000 new regulations were introduced which extended the scope of the Act to include older people. In 2003 another set of regulations made it a *duty* of local authorities to offer Direct Payments

to those eligible for them (where previously it had merely been a *power*).

In addition, the 1998 White Paper announced the development of guidance on Fair Access to Care that would 'introduce greater consistency in the system for deciding who qualifies for those services' (Department of Health, 1998, para. 2.36).

The relevance of the White Paper to the areas of life important to older people was particularly evident in the emphasis on independence and the recognition of the value of prevention (Social Services Inspectorate, 1999). A Promoting Independence: Prevention Grant was introduced to stimulate the development of preventative strategies and to target low-level support (that bit of help) at people most at risk of losing their independence.

Other important parts of the wider policy context include the following.

- The Health Act 1999 (Section 31) allowed, but did not require, 'flexibilities' to improve NHS and local authority partnership working. The Act removed legal obstacles to joint working by allowing the use of:
  - pooled budgets – where health and social services authorities put resources into a single budget to fund care services
  - lead commissioning – where either the local authority or health authority/ primary care group takes the lead in commissioning services on behalf of both
  - integrated provision – where local authorities and health authorities can merge their services to provide a 'one-stop' package.

- The Local Government Act 1999 had two major purposes:
  - to enable the government to regulate local authority increases in council tax
  - to introduce the Best Value regime into local authorities in England and Wales.

    The Best Value regime is geared to ensuring both quality and cost-effectiveness in local services. Levers to this include Best Value performance indicators and the Act requires Best Value authorities to consult with representatives of local people including service users and others with an interest in the area.

- The Local Government Act 2000:
  - conferred a power upon local authorities in England and Wales to promote the economic, social or environmental well-being of their areas
  - placed a duty upon local authorities to produce a community strategy (in Wales, a community plan) to that end
  - required that in producing (or modifying) the strategy, the local authority must

consult and seek the participation of such persons they consider appropriate.

- The Health and Social Care Act 2001 enabled the establishment of care trusts to further support integrated and coordinated services.

- *The NHS Plan: A Plan for Investment, a Plan for Reform* (Department of Health, 2000) set out the government's long-term vision for the NHS. The NHS Plan covered a wide range of issues, including funding and investment, staff recruitment and retention, buildings and clinical equipment. Crucially, the plan outlined changes to overcome the barriers between health and social services and to bring improvement to services and standards of care for older people.

- *Quality and Choice for Older People's Housing: A Strategic Framework* (Office of the Deputy Prime Minister, 2001) focused on the links between housing, health and social care and the need to better integrate these policy streams. While recognising the diversity of the older population, this policy addressed these central objectives:
  - ensuring older people are able to secure and sustain their independence in a home appropriate to their circumstances
  - supporting older people to make active and informed choices about their accommodation by providing access to appropriate housing and services and by providing advice on suitable services and options.

- The framework identified five priority areas for new policy and service developments:
  - diversity and choice
  - information and advice
  - flexible service provision
  - quality
  - joint working.

It also announced the piloting by the Department of Health of CAREdirect to provide a single information gateway for disabled and older people, covering housing, care and support services and social security.

- *Preparing Older People's Strategies: Linking Housing to Health, Social Care and Other Local Strategies* (Office of the Deputy Prime Minister/Department of Health, 2003) was follow-up guidance to *Quality and Choice.* The guidance adopted a whole-systems approach, pointing to the importance of housing but stating the need to integrate this with care, support and wider services such as transport, safety and crime prevention.

- The Department for Work and Pensions produced a consultative document *Link-Age: Developing Networks of Services for Older People* (2004d). Link-Age is a Department for Work and Pensions-led initiative. It is about building strategic partnerships between organisations to provide an integrated network of services for older people. It adopts a 'one-stop shop' approach to information for older people, including information about services, pensions and other benefits. The consultative document expressed commitment to the citizenship, social inclusion and involvement of people. It proposed three initiatives:
  - the development of joint teams to avoid duplication when asking older people about financial and benefit-related matters
  - the setting up of alternative offices – within local organisations, including those from the voluntary sector – to take older people's claims for benefits on behalf of the Department for Work and Pensions and to verify documents
  - a Partnership Fund to pilot ways of encouraging hard-to-reach groups of older people to improve take-up of benefits.

Parallel to the policies focused on the social care of adults and an ageing society are other statutes, strategies and policies which also promote the interests of older people. The next section of the chapter briefly describes some of these. We have organised them under the areas of life previously identified as important to older people. However, we were unable to identify any specifically relating to information, although this is a theme which runs through much of the policy arena.

Comfortable and secure homes

We have identified a number of relevant statutes and policy documents produced since 1997. These are concerned with various issues, including adapting homes, community equipment and housing and support. These are briefly described below.

Adapting homes

The Housing Grants Construction and Regeneration Act 1996 provides the current legislative framework governing Disabled Facilities Grants in England and Wales.

Local housing authorities have a statutory duty to provide Disabled Facilities Grants to disabled people for a range of adaptations to their home. The grant limit in England is £25,000 and is subject to a financial assessment. The duty is primary and absolute and applies irrespective of whether other assistance is provided by social services or other bodies such as Registered Social Landlords.

The 1996 Act was amended by the Regulatory Reform (Housing Assistance) (England and Wales) Order 2002. The Order extended eligibility, with conditions, to those living in mobile park homes and houseboats. It removed the power of local authorities to give discretionary Disabled Facilities Grants and replaced it with a discretionary power to provide assistance such as top-up monies, small-scale adaptations, and assistance with the acquisition of other accommodation.

Local authorities can set their own conditions for financial assessment for the discretionary grants. They can give assistance in the form of labour, materials or advice. They are required to publish their policy on how they will use the new power, and set out in writing the terms and conditions under which assistance will be given. They must abide by the published policy in using the new power.

The 1996 Act and the 2002 Order also covered issues around the improvement of housing quality, action relating to unfit housing, regeneration and development, and Home Energy Efficiency Schemes. Local authorities can determine their own priorities to improve housing quality in their areas. They should, as part of a housing renewal policy, reflect national, regional and local policy and local strategic objectives. The 2002 Order allowed local authorities to find innovative ways to finance private sector housing repairs and enabled local authorities to make loans and to lever in third party finance.

Community equipment

The Community Care (Delayed Discharges etc.) Act (Qualifying Services) (England) Regulations 2003 merits separate mention. These Regulations required local authorities to provide community equipment and minor adaptations free of charge and without a financial assessment, for the purposes of assisting with nursing at home or aiding daily living. This covers minor adaptations costing £1,000 or less (including the cost of purchasing and fitting). The same exemption from charges applies to intermediate care services for up to six weeks.

The NHS Plan and subsequent Department of Health Circular (HSC 2001/008: LAC(2001)13) also set out targets to be achieved by March 2004 in respect of community equipment services. The aim was to increase the number of people benefiting from community equipment services by 50 per cent and to combine health and social care provision to form a single integrated community equipment service.

Housing and support

The Supporting People programme was launched in April 2003. It provides housing-related support to prevent problems that can otherwise lead to hospitalisation, institutional care or homelessness. It can provide long- or short-term support, including advising people on entitlement to benefits, enabling people to develop the right skills to maintain a tenancy, advising on home improvements and adaptations, and accessing a community service alarm.

The five-year plan *Sustainable Communities: Homes for All* (Office of the Deputy Prime Minister, 2005a) was part of the Sustainable Communities initiative launched by the Deputy Prime Minister in 2003. With a primary focus upon housing and planning it linked housing, public space and environmental quality issues and promised a 'joined up' approach to housing and regeneration and to improve the performance of public services.

Homes for All was geared primarily to assisting working-age first-time buyers on to the housing property ladder partly through the extension of shared equity schemes to social housing tenants. The programme was therefore concerned more with the needs of local economies and the workforce than with the particular needs of older people. Its direct relevance to older people was limited to the following pledges:

- Older people are to be helped to live independently through assistance to remain in their own homes or through accommodation-based support such as sheltered housing.

- Building regulations addressing the accessibility of new homes will be reviewed in order to ensure that all new build meets lifelong needs.

- By 2010 all older people will have 'a decent home'. This recognises that older people, particularly those aged 85 and over, are less likely to live in good quality accommodation than younger age groups.

The definition of a decent home is one that meets all of the following criteria (Department for Work and Pensions, 2004a):

- It is above the current statutory minimum standard for housing.

- It is in a reasonable state of repair.

- It provides a reasonable degree of thermal comfort.
- It has reasonably modern facilities and services.

Older and disabled people can also access support and assistance from Home Improvement Agencies in adapting their homes.

An adequate income

Various policy developments since 1997 are of relevance to the incomes of older people, and are principally concerned with pensions, charges and concessions.

The Green Paper *Simplicity, Security and Choice: Working and Saving for Retirement* (Department for Work and Pensions, 2002) and the strategy document *Five Year Strategy: Opportunity and Security Throughout Life* (Department for Work and Pensions, 2005a) set out the objectives for:

- eradicating poverty among today's pensioners
- providing for tomorrow's pensioners.

Opportunity Age (Department for Work and Pensions, 2005) supported these aims by

- ensuring that people of working age plan more effectively and make adequate provision for their retirement years
- aiming to achieve an 80 per cent employment rate – with a particular emphasis upon older workers – to counter the impact of the dependency ratio
- encouraging pension savings, particularly for lower-paid workers, including through stakeholder pensions (a private market investment). The legislative framework for this was created by the Welfare Reform and Pensions Act 1999, coming into effect from April 2001.

From April 2006 changes in the rules covering occupational pensions mean that people will be able to continue to work for the same employer while drawing an occupational pension. The earliest age at which a non-State Pension can be taken will rise from 50 to 55.

The Pensions Act 2004 was among a number of measures undertaken to achieve higher rates of employment, including among those over state retirement age, and to improve confidence and trust in private and occupational pension schemes. It created the Pension Protection Fund, introduced a new Pensions Regulator, set up the Financial Assistance Scheme and provided for enhanced numbers of member-nominated trustees. It also put into place measures to allow the deferral of claiming State Pension in return for an enhanced State Pension or a lump sum following the period of deferral.

In accordance with the age strand of the European Employment Directive adopted in November 2000, legislation concerned with age discrimination in employment and training will be brought into force in October 2006. The government decided, however, not to remove the age at which the State Pension is triggered – currently 65. The legislation will prevent compulsory retirement below 65 (except where this can be objectively justified). Employers will also have a duty to consider the requests by employees wishing to work beyond this age. *Opportunity Age* announced that the retirement age will be formally reviewed in 2011.

Principles for Reform – the National Pensions Debate (Department for Work and Pensions, 2005b) set out the government's commitment to hold more or less to its current level of public pension expenditure as a percentage of gross domestic product (GDP) through to 2050.

Simplicity, Security and Choice (Department for Work and Pensions, 2004a) announced the establishment of the Pensions Commission to report to the government on the adequacy of the current voluntarist approach to retirement saving.

The State Pension Credit Act 2002 introduced a new state Pension Credit for people aged 60 and over and replaced the Minimum Income Guarantee. Entitlement to Pension Credit is calculated by taking into account income from pensions and earnings, and for savings over £6,000 (£10,000 for those who live permanently in a residential home) £1 for every £500 or part thereof is counted as income. The cut-off point for Pension Credit is around £151 per week for a single person and £221 per week for a couple. The Pension Credit has two elements:

- a Guarantee Credit, to ensure a minimum level of income to those aged 60 and over

- a Savings Credit which provides an additional income to those aged 65 and over who have low or modest incomes in relation to the basic State Pension.

The qualifying age for the Guarantee Credit will rise by stages to 65 between 2010 and 2020. The Guarantee Credit:

- retains the premiums paid to carers and disabled people under the Minimum Income Guarantee regulations
- is guaranteed to rise in line with wages until 2008
- currently guarantees a weekly income of at least £109.45 for a single person and £167.05 for a couple.

Pension Savings Credit may be claimed by those with a weekly income of more than £82.05 but less than £150.55 for a single person and more than £131.20 but less than £220.83 for a couple. The current maximum weekly amounts payable are £16.44 for a single person and £21.50 for a couple. It is estimated that 3.75 million households are entitled to Pension Credit (Department for Work and Pensions, 2004e). *Opportunity for All: Sixth Annual Report 2004* (Department for Work and Pensions, 2004b) set out the Pension Service's Public Service Agreement (PSA) target for at least 3.2 million households to be in receipt of Pension Credit by 2008.

Fuel poverty

The Warm Homes and Energy Conservation Act 2000 placed a duty upon the Secretary of State (for England) and the National Assembly (for Wales) to set out a strategy to ensure, as far as practically reasonable, that people do not experience fuel poverty.

The UK Fuel Poverty Strategy (Department of Trade and Industry, 2001) set out the government's Fuel Poverty Strategy. The overall aims of the Strategy are to end the problem of fuel poverty, concentrating first upon vulnerable householders. A fuel-poor household is defined as 'one that has to spend in excess of 10% of household income on all fuel use in order to maintain a satisfactory heating system' (Department of Trade and Industry, 2001, p. 3). Vulnerable householders are defined as 'Older householders, families with children and householders who are disabled or suffer from a long-term illness' (Department of Trade and Industry, 2001, p. 11).

The Strategy set out a number of measures to deal with fuel poverty. These included:

- improving energy efficiency and improving the quality of social housing
- extension of the Winter Fuel Payments
- better co-ordination of Warm Front/Home Energy Efficiency Schemes
- improving take-up of benefits.

The Sustainable Energy Act 2003 extended the duties of the Secretary of State under the Warm Homes and Energy Conservation Act 2000 to the production of an 'annual sustainable energy' report on progress made, including reducing the number of people living in fuel poverty in the UK.

The Plan for Action on Fuel Poverty in England (Department for Environment, Food and Rural Affairs, 2004a) amended the 2001 target to one whereby 'by 22 November 2016 no person in England should have to live in fuel poverty' (Department for Environment, Food and Rural Affairs, 2004a, p. 7). Among the measures to achieve this are:

- better targeting of Warm Front
- providing all eligible households with central heating
- extending provision of benefit entitlement checks, i.e. identifying areas where entitlements are not being claimed.

The Utilities Act 2000 set out the government's measures to reform the regulatory regimes for the gas and electricity sectors. The purpose of regulation in this area is to protect consumers against abuse of market power by gas and electricity companies. The government is concerned about keeping pace with changing market conditions in the sectors and ensuring the regulatory regime reflects government priorities. Among the provisions of the Act:

- The Gas and Electricity Markets Authority are to protect the interests of consumers.
- They should have regard to the interests of low-income consumers, chronically sick people, disabled people, older people and consumers in rural areas.

- The establishment of an independent Gas and Electricity Consumer Council responsible for resolving complaints, providing information to consumers, and to advocate in the interests of all consumers.

- The Act conferred powers upon the Secretary of State to impose Service Register Licence Conditions upon Gas and Electricity Suppliers.

Under the Utilities Act 2000, Licence Conditions relating to the Priority Services Register (PSR) concern gas and electricity provisions for people who are of pensionable age or disabled or chronically sick. The supplier must, 'where reasonably practical and appropriate':

- reposition meters free of charge for customers on the PSR

- provide special controls and adaptors for appliances

- ensure bills are able to be sent to a third party on request

- ensure their meter is read each quarter if the consumer is unable to do so, and ensure the reading taken is provided to the consumer

- provide advance notice of planned interruptions

- notify all customers of the existence of the PSR at least once a year.

Licence Condition 37(a) refers to gas suppliers and states that they should not cut off the supply of gas during the winter months (1 October to 31 March) to any customer who:

- is of pensionable age and lives alone or with other persons all of whom are also of pensionable age or under 18 years of age

- is supplied with gas at domestic premises

- is in default of his obligation to pay for gas so supplied through misfortune or inability to budget to meet bills for gas supplied on credit terms.

Charges for water

The Water Industry Act 1999 introduced the Vulnerable Groups Regulations. The regulations ensure that tariffs are capped at the level of the average bill for the area for:

- specific low-income groups
- people with specified medical conditions requiring high water use and for which they were receiving medical treatment. The following medical conditions applied: desquamation (flaky skin disease), weeping skin disease, incontinence, abdominal stoma, and renal failure requiring dialysis at home.

Water Industry (Charges) (Vulnerable Groups) Regulations 1999 SI 1999/3441. A Consultation Paper: Reductions for Vulnerable Groups (Department for Environment, Food and Rural Affairs, 2003) noted slow take-up of the Vulnerable Groups Scheme and suggested this may be because people are unaware of the scheme, they are reluctant to give personal information, or there is stigma attached to applying. The regulations recommended that Warm Front checks should be used to signpost people to the Vulnerable Groups Scheme.

The *Cross-Government Review of Water Affordability Report* (Department for Environment, Food and Rural Affairs, 2004b) announced a new pilot scheme to take place in the South West of England. This is an area with higher than average water and sewerage charges. It aims to target 1,000 low-income households to help them make savings on their water bills and to increase their incomes through Benefit Entitlement Checks. The pilot will cover both metered and non-metered households although water efficiency measures will apply to metered households only. It also added Crohn's disease and ulcerative colitis to the list of qualifying medical conditions and removed the criterion that medical treatment must be being received.

Water Direct is a Department of Work and Pensions initiative linked to the Third Party Deduction Scheme. It makes deductions from benefits to pay off the debt when the individual is unable to come to an agreement with the provider. The standard amount for this third party deduction is £2.80 per week. It applies to accommodation costs (but not care homes), gas, electricity, water and sewage, council tax and court fines. People receiving Income Support, Jobseeker's Allowance or Pension Credit are eligible.

Charges for social care

Fairer Charging Policies for Home Care and Other Non-residential Social Services (Department of Health Local Authority Circular LAC(2001)32) was issued under section 7 of the Local Authority Social Services Act 1970 (amended in 2003). The objectives of *Fairer Charging Policies* are to ensure councils' charging policies are demonstrably fair between different user groups and that they do not undermine the overall objectives of social care to promote the independence and social inclusion of service users.

Fairer Charging Policies stated that while councils retain the discretion over charging for social care services, where charges *are* made:

- Councils should ensure that such charges do not put any users' incomes below basic Income Support levels or the Guarantee Credit of Pension Credit plus a buffer of 25 per cent.

- Where disability benefits (including Attendance Allowance) are taken into account as income in assessing ability to pay a charge, councils should assess the individual user's disability-related expenditure and ensure that this does not result in the user being left without the means to pay for any other necessary care or support or for other costs arising from their disability.

- Benefits advice should be made available to all service users at the time of assessment in line with councils' responsibility to maximise the income of users where they would be entitled to benefits and particularly where they are asked to pay a charge.

Free passports

Free passports for people born on or before 2 September 1929 were announced by the Home Secretary on 13 October 2004. This followed an initiative giving free one-year passports to war veterans who wanted to revisit battlefields in the 60th anniversary year of the D-Day landings. This was 'in recognition of what they gave to secure our nation's liberty and democracy' (UK Passport Service press release, 13 October 2004: http://www.ukpa.gov.uk/press_131004.asp).

Safe neighbourhoods

Policy developments and legislation relevant to the development of safe neighbourhoods include those focused on neighbourhood renewal and regeneration, as well as those concerned with crime reduction. The following are of particular importance.

Preparing Community Strategies: Government Guidance to Local Authorities (Department of the Environment, Transport and the Regions, 2000a) stated that the local Government Acts of 1999 and 2000 will ensure that councils will 'actively involve and engage the community in local decisions' (para. 7). In addition to the representation of community and voluntary organisations in Local Strategic Partnerships, partnerships 'should actively seek the involvement of local people in the design and implementation' of community strategies (para. 25).

A New Commitment to Neighbourhood Renewal: National Strategy Action Plan (Social Exclusion Unit, 2001a) set out the Strategy's long-term goals:

- in all the poorest neighbourhoods, to have common goals of lower worklessness and crime, and better health, skills, housing and physical environment

- to narrow the gap on these measures between the most deprived neighbourhoods and the rest of the country. (Social Exclusion Unit, 2001a, para. 13)

A joined-up agenda is central to the Strategy. The document stated that 'lack of joining up at local level' had been a key impediment to progress in tackling neighbourhood deprivation (para. 5.4).

The Strategy addressed the role of Local Strategic Partnerships (LSPs) as drivers of change at the local level. These aim to join up at local level public, private, voluntary and community sectors in one co-ordinating framework. In turn this will enable priorities to be set and services to be aligned, and bring those who deliver or commission different services together with those for whom the services are provided. It also ensures other local partnerships know how they fit into the wider picture, and allows local partners to move to simpler structures 'where it makes sense to do so' (Social Exclusion Unit, 2001a, para. 5.5).

A key task of Local Strategic Partnerships is to prepare a Local Neighbourhood Renewal Strategy. Local Strategic Partnerships were to be in place by April 2002 (initially in the 88 most severely deprived areas).

Our Towns and Cities: The Future (Office of the Deputy Prime Minister, 2000) was geared towards improving the urban environment. It stated that the government wanted to 'encourage involvement by older people in deciding priorities, helping shape policies and ensuring they have more say and control over the services they use' (para. 3.48). The following aims were set out:

- to make towns and cities places where people want to live and work. This was linked to urban renewal, regeneration and sustainability agendas
- to address the challenges of accommodating up to 3.8 million extra households by 2021, consequent upon demographic change and more people living alone
- to encourage people to remain in or move back into major town and cities
- to tackle poor quality of life and lack of opportunity in some urban areas
- to address weak economic performance in some urban areas
- to reduce the impact of urban living upon the environment. (Office of the Deputy Prime Minister, 2000, para. 2)

Bringing Britain Together: A National Strategy for Neighbourhood Renewal (Social Exclusion Unit, 1998) presented the concept of neighbourhood warden schemes through the New Deal for Communities programme. It was argued that a full-time and recognisable official presence is needed to keep an eye on what is happening, to take early preventive action and to be someone to whom residents can turn for assistance when needed (Social Exclusion Unit, 1998, para. 5.22).

Preventing Social Exclusion (Social Exclusion Unit, 2001b) announced the approval of neighbourhood warden schemes and the allocation of £18.5 million to the Neighbourhood Wardens Unit for the period 2000–4.

The Crime and Disorder Act 1998 created a new community-based order – the anti-social behaviour order (ASBO), defined as behaviour that causes 'alarm, distress or harassment to one or more people not in the same household as him/herself' (Section 1). The Act required local authorities and the police to draw up and implement a strategy for reducing crime in their area, allowed local authorities to introduce child curfew schemes for under 10s at night, and empowered courts to issue Parenting Orders.

The Anti-Social Behaviour Act 2003 introduced new powers for the police to deal with anti-social behaviour. These include powers to disperse groups in areas experiencing high levels of anti-social behaviour and to enable the police to close down premises used for the supply, use or production of Class A drugs. It also enabled some social landlords to apply for anti-social behaviour orders and made it an offence to sell spray paints to children under 16. The Act widened the use of fixed penalty notices and applied them to 16 and 17 year olds.

The Police Reform Act 2002 enabled chief officers to appoint suitable support staff ('community support officers') to roles providing a visible presence in the community, with powers sufficient to deal with minor issues. It allowed Registered Social Landlords and the British Transport Police to apply for anti-social orders.

The Distraction Burglary Task Force was set up in 2000 as a multi-agency initiative that promotes local schemes to tackle the problem of bogus callers, including liaising with utility companies and others who call upon older people. Distraction burglary is defined as that which occurs when a trick or distraction is used in order to gain access to a property in order to commit burglary (Home Office, 2005, p. 28). The Task Force publicised good practice to older people and those working with older people.

Getting out and about

Policy developments relevant to older people's concerns with getting out and about have largely been concerned with transport.

The Transport Plan 2010: The 10 Year Plan (Department of the Environment, Transport and the Regions, 2000b) set out the government's strategy and targets for modernising transport and providing an integrated system. Targets include:

- reduction of road congestion in urban areas
- improvements in local road safety and in the accessibility of public transport and the pedestrian environment for disabled people
- a one-third increase in the proportion of rural households living within a ten-minute walk of a bus service providing an hourly or more frequent service.

The Transport Act 2000 placed a duty upon local transport authorities to provide disabled people and people of pensionable age with a statutory minimum concession of local, off-peak half-price bus fares. They should also prepare local transport plans and bus strategies to meet the needs of people living, working, visiting, or travelling through the area. Specifically they should:

- ensure facilities and services for pedestrians
- have 'regard to the transport needs of persons who are elderly or have mobility problems' (Part II, Section 112(2))
- ensure provision of information to the public about local bus services.

The Travel Concessions (Eligibility) Act 2002 equalised the age at which people are eligible for travel concessions (now 60 for both men and women). From April 2006 disabled people and all people aged 60 and over in the UK will be entitled to free off-peak local bus travel. In Scotland, disabled and older people will be entitled to free travel to anywhere within the country, while those living on the islands will be entitled to two free ferry journeys to the mainland each year.

Full Guidance on Local Transport Plans: Second Edition (Department for Transport, 2004a) noted that all local transport plans should identify local accessibility problems, devise strategies and consider how to address the needs of different groups, including older people.

The Future of Transport: A Network for 2030 (Department for Transport, 2004b) presented the government's transport strategy over the next 30 years. Three key themes were addressed:

- sustained long-term investment
- improved transport management
- planning ahead.

It identified three challenges in:

- greater demand for travel through increased affluence
- changes in travel itself
- demographic changes – longevity and smaller households.

The document made some specific references to older people, and identified the need to:

- plan for increasing numbers of older people in the population and to ensure transport systems and services meet their needs
- ensure public transport is accessible
- support the safety of older drivers through support of mobility centres and through the Department for Transport's Mobility Advice and Vehicle Information Service
- encourage local authorities in the use of demand-responsive community transport.

Overview 2003 & Forward Look 2004/5 (Department for Transport Mobility and Inclusion Unit, 2004) pointed out that demographic change, and the ageing of the population, are key drivers of this work. Future priorities were set out (Department for Transport Mobility and Inclusion Unit, 2004, p. 1):

- enabling disabled and older people to use the pedestrian environment and transport services
- enabling disabled and older people to travel safely using cars and other means of private transport
- enabling people to travel by reducing crime and fear of crime
- enabling socially excluded people to reach jobs and services
- promoting diversity in transport planning and provision.

Friendships and opportunities for learning and leisure

There has been relatively little policy development specifically relevant to this theme. Any such development has primarily been concerned with learning and skill acquisition. There are no specific policy documents or legislation that address getting out and about to see friends, although a range of policy areas, such as transport, are of obvious relevance.

The Learning and Skills Act 2000 established the Learning and Skills Council (LSC). The LSC took over the duties of Further Education Funding Councils, Training and Enterprise Councils (TECS) and local education authorities in respect of adult and community learning. The Act stipulated that in carrying out its functions the LSC 'must have due regard to the need to promote equality of opportunity between persons of different racial groups, between men and women, between persons who are disabled and persons who are not' (Part 1, para. 14). The Act also placed a duty on Learning and Skills Councils to secure reasonable facilities for the education and training of people aged 19 and over, including organised leisure-time occupation.

Skills: Getting on in Business, Getting on at Work (Department for Education and Skills, 2005) outlined the government's plans for the country becoming a world class leader in skills (Part 1, para. 1). This White Paper affirmed the government's commitment to safeguard the availability of a wide range of learning for personal and community development (Part 2, para. 232) and to address disparities in funding in different areas of the country for this type of learning.

Keeping active and healthy

There has been an increasing policy emphasis on the importance of healthy active lives for *all* citizens, including older people. Below we highlight the major developments that have occurred since 1997.

The NHS Plan: A Plan for Investment, a Plan for Reform (Department of Health, 2000) has been referred to earlier in this chapter, particularly in respect of the flexibilities that it introduced to encourage partnership working. In addition, a chapter of the Plan was dedicated 'to improve services and standards of care for older people' (para. 15.1). The Plan announced a series of measures to ensure dignity, security and independence for older people, including:

- the publication of a National Service Framework for Older People (NSF)
- free health checks on retirement
- a £900 million investment in intermediate care and related services by 2004.

The *National Service Framework for Older People* (Department of Health, 2001) set out standards to improve the quality of care for older people across health and social services. It was underpinned by four themes:

- respecting the individual
- developing intermediate care
- providing evidence-based specialist care
- promoting an active, healthy life.

The NSF presented eight Standards which together with key interventions and milestones set out to achieve improvements in the following domains:

- rooting out age discrimination
- person-centred care
- intermediate care
- general hospital care
- stroke
- falls
- mental health
- the promotion of health and active life in older age.

The public health White Paper *Choosing Health: Making Healthy Choices Easier* (Department of Health, 2004b) focused on helping people make healthier lifestyle choices and reducing health inequalities. It was underpinned by three principles: informed choice for all; personalisation of support to make healthy choices; and working in partnership. Its six key priorities were:

- tackling health inequalities
- reducing the numbers of people who smoke
- tackling obesity
- improving sexual health

- improving mental health and well-being
- reducing harm and encouraging sensible drinking.

An additional area for action was identified as promoting healthy and active life among older people. It recommended a joined-up approach and linked the policy to the wider well-being agenda of local authorities. It also emphasised the role of primary care trusts working in partnership with local authorities and other partners through Local Strategic Partnerships.

Delivering Choosing Health: Making Healthier Choices Easier (Department of Health, 2005c) outlined the priorities for delivery of *Choosing Health,* together with related Public Service Agreements and targets. One of these priorities related directly to older people and promoted healthy and active life among older people. This was linked to the emphasis on improving the quality of life and independence of vulnerable older people by supporting them to live in their own homes where possible by:

- increasing the proportion of older people being supported to live at home by 1 per cent annually in 2007 and 2008
- increasing by 2008 the proportion of those supported intensively to live at home to 34 per cent of the total of those being supported at home or in residential care. (Department of Health, 2005c, p. 40)

Over the next three years the key steps to be taken are to identify how targets will be delivered, how the NHS and local government will work together and how local delivery will be supported nationally.

The Countryside and Rights of Way Act 2000 placed a duty upon local authorities to take account of people with mobility problems when authorising the erection of barriers (such as stiles, steps, heavy farm gates and narrow bridges) on footpaths or bridleways. The Countryside and Rights of Way Act 2002 placed a new duty upon local highway authorities to publish a rights of way improvement plan for their areas. Funding is supplied from central government for this new duty.

Rights of Way Improvement Plans. Statutory Guidance to Local Highway Authorities in England (Department for Environment, Food and Rural Affairs, 2002) reminded authorities of their duty under the Local Government Act 1999 to consult, among others, representatives of people who use local services provided by the authority and that they should consider the needs and circumstances of a range of people

including those with vision impairment and/or 'mobility problems' – including users of powered wheelchairs.

The Act also amended section 147 of the Highways Act 1980 and empowered local highway authorities to agree with owners, lessees and occupiers of land over works to replace or improve structures 'to make them safer or more convenient for people with mobility problems' (para. 2.219).

Concluding comments and observations

The ageing of the population presents both opportunities and challenges for the government and older citizens.

The policy documents published in 2005, *Opportunity Age: Meeting the Challenges of Ageing in the 21st Century* (Department for Work and Pensions, 2005) and the Green Paper *Independence, Well-Being and Choice: Our Vision for the Future of Social Care for Adults in England* (Department of Health, 2005a), suggest a new direction in relation to the employment of older people and the organisation and delivery of social care where it is needed. These developments are welcome. They reflect a more positive approach to older people in our society.

Relevant also to improving the lives of older people are developments in the wider contexts of health services, local government and communities. Many of these show strong attempts to join up areas of government to promote integrated service delivery. We can also see how legislation, strategies and reviews in areas relating to transport, housing and education, for example, are promoting positive changes for older people. Thus the changes that the government can bring about which will have positive benefits for older people include more universally targeted laws and policies. Policy changes in these areas can help make a reality of the values of active independence, choice and control for older people.

A timeline summary of the legislation and policy documents referred to in this chapter

1989

- *Caring for People* (DoH, 1989)

1990

- NHS and Community Care Act

1996

- The Housing Grants Construction and Regeneration Act
- Community Care (Direct Payments) Act

1998

- *Bringing Britain Together: A National Strategy for Neighbourhood Renewal* (Social Exclusion Unit, 1998)
- Crime and Disorder Act
- *Modernising Social Services* (DoH, 1998)

1999

- *Water Industry (Charges) (Vulnerable Groups) Regulations 1999 SI 1999/3441. A Consultation Paper: Reductions for Vulnerable Groups* (Department for Environment, Food and Rural Affairs, 2003)
- *Promoting Independence: Preventative Strategies and Support for Older People* (Social Services Inspectorate, 1999)
- Local Government Act
- Health Act

2000

- *Preparing Community Strategies. Government Guidance to Local Authorities* (Department of the Environment, Transport and the Regions, 2000)

- *Our Towns and Cities: The Future* (Office of the Deputy Prime Minister, 2000)
- *The NHS Plan: A Plan for Investment, a Plan for Reform* (Department of Health, 2000)
- Warm Homes and Energy Conservation Act
- Utilities Act
- Local Government Act
- Transport Act
- Learning and Skills Act
- *The Transport Plan 2010: The 10 Year Plan* (DETR, 2000b)

2001

- Health and Social Care Act
- *Quality and Choice for Older People's Housing: A Strategic Framework* (OPDM, 2001)
- UK Fuel Poverty Strategy
- *Fairer Charging Policies for Home Care and Other Non-residential Social Services* (Department of Health Local Authority Circular LAC(2001)32)
- *A New Commitment to Neighbourhood Renewal: National Strategy Action Plan* (Social Exclusion Unit, 2001a)
- *The National Service Framework for Older People* (DoH, 2001)
- *Preventing Social Exclusion* (Social Exclusion Unit, 2001b)

2002

- The Regulatory Reform (Housing Assistance) (England and Wales) Order

- *Fair Access to Care Services – Guidance on Eligibility Criteria for Adult Social Care* (Department of Health, 2002)
- *Simplicity, Security and Choice: Working and Saving for Retirement* (DWP, 2002)
- *Rights of Way Improvement Plans. Statutory Guidance to Local Highway Authorities in England* (Defra, 2002)
- State Pension Credit Act
- Police Reform Act
- The Travel Concessions (Eligibility) Act
- Countryside and Rights of Way Act

2003

- *Preparing Older People's Strategies: Linking Housing to Health, Social Care and Other Local Strategies* (ODPM/DH, 2003)
- Community Care (Delayed Discharges etc.) Act
- Sustainable Energy Act
- Anti-Social Behaviour Act

2004

- *Full Guidance on Local Transport Plans: Second Edition* (Department for Transport, 2004a)
- *Choosing Health: Making Healthy Choices Easier* (Department of Health, 2004)
- *Overview 2003 & Forward Look 2004/5* (Department for Transport Mobility and Inclusion Unit, 2004)
- *Link-Age: Developing Networks of Services for Older People* (DWP, 2004d)

- *Plan for Action on Fuel Poverty in England* (Defra, 2004)
- *The Future of Transport: A Network for 2030* (Department for Transport, 2004b)

2005

- *Independence, Well-Being And Choice: Our Vision for the Future of Social Care for Adults in England* (DoH, 2005a)
- *Delivering Choosing Health: Making Healthier Choices Easier* (DoH, 2005c)
- *Skills: Getting on in Business, Getting on at Work* (DfES, 2005)
- *Opportunity Age: Meeting the Challenges of Ageing in the 21st Century* (Department for Work and Pensions, 2005)
- *Sustainable Communities: Homes for All* (ODPM, 2005)
- *Five Year Strategy for Work and Pensions* (DWP, 2005)

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4 Grants available to local authorities

Liz Brooks

Introduction

Local authorities have primary responsibility for delivering services to citizens living in their own homes. This chapter aims to describe some of the funding sources available to local authorities to provide assistance for older people which could promote their independence. We have not attempted exhaustive coverage of what is available but present an indicative selection which gives some idea of the complexity of the funding system that local authorities must navigate. To support them in this we intend this chapter as a kind of map which can be used to locate the sources of income available to the commissioners of the services that older people want. We have designed the map to reflect the areas of life that have consistently been shown to be relevant to older people who want to pursue an independent life.

Overview of local authority funding

Local authorities fund their activities from four main sources: council tax, formula grant, capital grants and specific grants. In 2004/5, English local authorities received £46.1 billion from central government to fund core activities through 'formula grant'. It is known as formula grant because the allocation is based on a formula that takes into account the relative costs of providing different services in a particular local authority area and the relative ability of each authority to raise council tax. Alongside formula grant (which includes a component for policing where relevant), around £12 billion of annual support for capital investment is made available in the form of supported borrowing and capital grants. This supports a mixture of ongoing programmes, largely for maintaining existing assets, and one-off projects to provide new or enhanced assets, including Private Finance Initiative projects (Office of the Deputy Prime Minister, 2004a).

In addition to formula and capital grants, local authorities receive some £28 billion (in 2004/5) of funding in the form of specific grants from different government departments. In the tables that follow we have attempted to draw together many of the current and recently available specific grants to local authorities, working alone and in partnership, that may be used to support older people at home. While a small

minority of grants are targeted, with a specific focus for their delivery, mainly to the 88 most deprived local authorities, the majority are universal – that is, they are either allocated to, or open to tender from, all local authorities.

The tables indicate conditions attached to the grants, including ring-fencing (also known as 'hypothecating'). Ring-fencing a grant means that local authorities must spend it, and must show that they have spent it, on the services specified. Although they have been widely used as a means of influencing local practice, ring-fenced grants can be inflexible for specific local conditions and expensive to administrate. The Audit Commission report *People, Places and Prosperity* (Audit Commission, 2004) referred to the 'Humpty Dumpty' effect – a fracturing of messages from central government down separate silos to local partners who then have to put them together again.

The July 2004 spending review signalled a change of approach, in particular with regard to piloting Local Area Agreements (LAAs) from 2005/6. LAAs are designed to simplify funding streams and join up public services. They are being piloted in 21 areas from April 2005 (with a further 40 due to start in 2006/7). If the pilots are successful, the scheme will be rolled out nationwide in subsequent years.

Local Area Agreements entail a deal between government at central and local level, streamlining funding and allowing councils and their partners the freedom and flexibility to deliver shared priorities. These are structured around three functional blocks: children and young people; healthier communities and older people; and safer and stronger communities.

Along these lines, in 2004/5 ring-fencing was removed from £750 million of grants and a commitment was made to reduce ring-fencing down to 10 per cent of overall central government grant. The Office of the Deputy Prime Minister appears to be leading the way in co-ordinating specific grants programmes and restricting ring-fencing to those areas considered to be a national priority (Office of the Deputy Prime Minister, 2004b).

When the various grants listed below are linked with the system of benefits, allowances and concessions which support older people's finances, the picture is dauntingly complex. An authority seeking to create a safe and engaging community for its older residents might well feel in need of a map to help it navigate its way through the tangle of distinct, parallel and overlapping programmes. The diagram at the end of this chapter attempts to suggest how the grants might fit into the seven areas of life considered important by older people as set out in the report.

What follows is not an exhaustive list, but rather an attempt to bring together some of the materials needed to map this uncharted terrain. We hope that the map we have outlined will assist in thinking about new ways in which the complexity of funding streams can be represented to enable local authority managers to more easily navigate their way around the funding sources so that they can maximise the opportunities to provide that bit of help which older people want and which would assist them to remain independent.

We present the information in this chapter and the accompanying 'maps' in the hope that it will inspire others to take up the challenge of completing the chart, representing all the available funding streams that might be used for 'that bit of help', their crossings and junctions, and their parallel and diverging paths. We suggest the result might bear some resemblance to the schematisation which closes this chapter.

Sources of income available

Current grants – general

Table 11 ChangeUp

Name of grant	ChangeUp (Capacity Building and Infrastructure Framework for the Voluntary and Community Sector)
Where	England
Publications	*Cost Cutting Review of the Role of the Voluntary and Community Sector in Service Delivery* (2002)
Legislation	None found
Purpose	Four strands of work informed ChangeUp: (1) ensuring that the voluntary sector's infrastructure is fit for purpose; (2) strengthening governance and support for trustees and board members; (3) developing the sector workforce's skills; (4) building commitment and appropriate tools to improve the performance of organisations
Websource	http://www.homeoffice.gov.uk/comrace/active/developing/index.html
Ring-fenced, Targeted, Universal*	U
Time-limited	Yes – £80 million over 2003/4–2005/6
Primary focus	'Any charities, voluntary or community organisations, social enterprises, or community interest companies in England only, offering Second-Tier/ Capacity Building Purposes'
Competitive	Proposal and expressions of interest are mainly invited rather than solicited
Match-funded etc.	No
Other comments	

* *For a glossary of local government finance terminology, see Office of the Deputy Prime Minister (2003a). For a table of ring-fenced grants available to local government see Office of the Deputy Prime Minister (2003b).*

Table 12 Social Services Access and Systems Capacity Grant

Name of grant	Social Services Access and Systems Capacity Grant
Where	England
Publications	LAC (2003)10
Legislation	Local Government Act 2000, Section 93
Purpose	'For older people's services the target is to improve the quality of life and independence of older people so that they can live at home wherever possible, by increasing by March 2006 the number of those supported intensively to live at home to 30% of the total being supported by social services at home or in residential care'
Websource	http://www.dh.gov.uk/assetRoot/04/01/27/55/04012755.pdf
Ring-fenced, Targeted, Universal	R, U
Time-limited	Not stated – allocation shown up to 2005/6
Primary focus	Older people
Competitive	No – goes to all England local authorities
Match-funded etc.	No, but allocations vary according to councils' star rating
Other comments	In 2003/4, the grant divided into 3 programmes: £1.6 million for home improvement services; £7.6 million for community equipment; £125.8 million for home care and intermediate services

Table 13 Invest to Save

Name of grant	Invest to Save
Where	UK-wide
Publications	None found
Legislation	None found
Purpose	'The Invest to Save Budget (ISB) is a joint Treasury/Cabinet Office initiative with an aim to create sustainable improvements in the capacity to deliver public services in a more joined-up manner. A key principle of the ISB programme is that investment is provided in return for reform'
Websource	http://www.isb.gov.uk/hmt.isb.application.2/index.asp http://www.hmtreasury.gov.uk./media/34C/0B/vcs_workingtogether_210205.pdf
Ring-fenced, Targeted, Universal	U
Time-limited	Funding available until 2007/8
Primary focus	General
Competitive	Yes – 'Public sector managers are challenged to come forward with proposals which will make a real difference. Competition for support is intense and only the best ideas are supported'
Match-funded etc.	Not known
Other comments	Priority areas for round 7 (2005/6) included health and social care of older people

Table 14 Beacon Councils Scheme

Name of grant	Beacon Councils Scheme
Where	England
Publications	*Modern Local Government: In Touch with the People* (1998)
Legislation	Local Government Act 1999, Part 1: Best Value; Appropriation Act 2004, Chapter 9
Purpose	'The programme will concentrate on the ways in which excellent outcomes have been achieved by beacon councils … The government will make grants available to beacon councils up to a total of £700,000 to help fund the programme to spread best practice in the first year'
Websource	http://www.odpm.gov.uk/stellent/groups/odpm_control/documents/contentservertemplate/odpm_index.hcst?n=2004&l=2 http://www.odpm.gov.uk/stellent/groups/odpm_localgov/documents/pageodpm_locgov_604761.hcsp
Ring-fenced, Targeted, Universal	T – funds are for dissemination of best practice by those councils awarded Beacon Council status
Time-limited	Yes
Primary focus	Each year themes are announced and councils apply for Beacon status on a particular theme
Competitive	Yes
Match-funded etc.	No
Other comments	

Table 15 Carers Grant

Name of grant	Carers Grant
Where	England
Publications	*Caring about Carers* (1999)
Legislation	Section 31 of Local Government Finance Act 2003; Carers and Disabled Persons Act 2001
Purpose	'Its main purpose is to: i. enhance provision of … services to allow carers to take a break from caring by stimulating greater diversity of provision; ii. stimulate a greater awareness by authorities of the need for services in their area to be more responsive to the needs of carers; iii. provide carers services, other than breaks services …'
Websource	http://www.dh.gov.uk/assetRoot/04/01/29/02/04012902.pdf
Ring-fenced, Targeted, Universal	R, U
Time-limited	No
Primary focus	20% carers of children/young carers; 24% carers of adults (18–64)/adult carers; 56% carers of older people/older carers (based on 1995 General Household Survey of informal carers)
Competitive	No
Match-funded etc.	No
Other comments	

Current grants – safe neighbourhoods

Table 16 Neighbourhood Renewal Fund

Name of grant	Neighbourhood Renewal Fund
Where	England
Publications	*A New Commitment to Neighbourhood Renewal: National Strategy Action Plan* (2001)
Legislation	Local Government and Finance Act 1988, section 88B
Purpose	'To provide support to certain local authorities in England … to enable them to improve services in their most deprived areas, including contributing to the achievement of Government targets to narrow the gap between deprived areas and the rest of the country'
Websource	http://www.neighbourhood.gov.uk/nrfund.asp
Ring-fenced, Targeted, Universal	T
Time-limited	Yes – see 'Other comments'
Primary focus	The 88 most deprived local authorities in England
Competitive	No, but allocated according to a specific formula
Match-funded etc.	No, but conditions for the grant may change from year to year
Other comments	£900 million over the three years 2001/02 to 2003/04; £450 million 2004/5 and £525 million 2005/6. 'The grant is intended as time-limited funding to facilitate the more effective, long-term targeting of mainstream resources'

Table 17 Neighbourhood Wardens Scheme

Name of grant	Neighbourhood Wardens Scheme
Where	England and Wales
Publications	*A New Commitment to Neighbourhood Renewal: National Strategy Action Plan* (2001); *Making It Happen in Neighbourhoods – the National Strategy for Neighbourhood Renewal Four Years On* (2005)
Legislation	Crime and Disorder Act 1998
Purpose	Part of the National Strategy for Neighbourhood Renewal, which has the objective that within 10–20 years, no one should be seriously disadvantaged by where they live. Neighbourhood Wardens are intended to be 'a visible, recognisable presence to deter crime and tackle low-level Anti-Social Behaviour'
Websource	http://www.odpm.gov.uk/stellent/groups/odpm_urbanpolicy/documents/page/odpm_urbpol_608422.hcsp http://www.odpm.gov.uk/stellent/groups/odpm_govoffices/documents/page/odpm_govoff_600105.hcsp
Ring-fenced, Targeted, Universal	R, U
Time-limited	Yes, although potentially renewable
Primary focus	Neighbourhoods
Competitive	Yes
Match-funded etc.	Yes
Other comments	

Table 18 'Building Safer Communities Fund' for Crime and Disorder Reduction Partnership (Community Safety Partnerships in Wales)

Name of grant	'Building Safer Communities Fund' for Crime and Disorder Reduction Partnership (Community Safety Partnerships in Wales)
Where	England, Wales and Scotland
Publications	*Building Communities, Beating Crime* (2004)
Legislation	Crime and Disorder Act 1994
Purpose	Funding for the use of partnerships between 'responsible authorities [police, local, fire, health authorities and PCTs] and other local agencies and organisations to develop and implement strategies to tackle crime and disorder and misuse of drugs in their area'
Websource	http://www.crimereduction.gov.uk/regions00.htm http://www.crimereduction.gov.uk/activecommunities79a.htm http://ww2.audit-commission.gov.uk/comsafe/2_1.html http://www.homeoffice.gov.uk/crime/communitysafety/index.html
Ring-fenced, Targeted, Universal	U
Time-limited	Yes
Primary focus	Communities
Competitive	No – set allocations
Match-funded etc.	No
Other comments	

Table 19 Safer and Stronger Communities Fund

Name of grant	Safer and Stronger Communities Fund
Where	England
Publications	*A New Commitment to Neighbourhood Renewal: National Strategy Action Plan* (2001); *Making It Happen in Neighbourhoods – the National Strategy for Neighbourhood Renewal Four Years On* (2005)
Legislation	None found
Purpose	'The Fund will bring together ODPM funding streams on wardens, neighbourhood management, community empowerment and liveability with Home Office funding streams on building safer communities, anti-social behaviour and be agreed through Government Offices'
Websource	http://www.gos.gov.uk/gol/docs/182629/182632/245387/sscf_implementation_guidance.pdf http://www.neighbourhood.gov.uk/publications.asp?did=1315
Ring-fenced, Targeted, Universal	U – but from 2006/7, there will be an element targeted to the most disadvantaged neighbourhoods (the 'neighbourhood element' of SCCF)
Time-limited	Yes – April 2005–March 2008
Primary focus	Communities
Competitive	No
Match-funded etc.	No, but fund will be administered in a new way, 'as a mini-Local Area Agreement, to drive forward the principles of the Devolved Decision Making review, contribute to the rationalisation of multiple funding streams, enhance local flexibility and help to reduce bureaucracy'
Other comments	

Current grants – keeping active and healthy

Table 20 Patient and Public Involvement Forums

Name of grant	Patient and Public Involvement Forums
Where	England
Publications	*NHS Plan* (2000); *Health and Social Care Standards and Planning Framework 2005/06–2007/08*
Legislation	NHS Reform and Health Care Professions Act 2002
Purpose	Increased public involvement in the NHS, where 'the views of patients, their carers and others are sought and taken into account in designing, planning, delivering and improving healthcare services'
Websource	www.cppih.org/documents/ForumHandbookDec04.pdf
Ring-fenced, Targeted, Universal	U
Time-limited	No
Primary focus	Organisations enabling the involvement of all health care users
Competitive	No – there is a PPI for each NHS Trust and Primary Care Trust in England. The only aspect where tenders are invited is for the Forum Support Organisation (each FSO must support at least 2 PPIs)
Match-funded etc.	No
Other comments	

Table 21 Local Authority Health Overview Scrutiny Committee

Name of grant	Local Authority Health Overview Scrutiny Committee
Where	England
Publications	None found
Legislation	Local Government Act 2000 and Health and Social Care Act 2001
Purpose	'From January 2003, Overview and Scrutiny Committees set up in local authorities with social services responsibilities (county councils, London Borough Councils and unitary authorities) have had the power to scrutinise health services. This contributes to their wider role in health improvement and reducing health inequalities for their area and its inhabitants'
Websource	http://www.dh.gov.uk/PolicyAndGuidance/OrganisationPolicy/PatientAndPublicInvolvement/InvolvingPatientsPublicHealthcare/InvolvingPatientsPublicHealthcareArticle/fs/en?CONTENT_ID=4093409&chk=My0xK0
Ring-fenced, Targeted, Universal	U
Time-limited	Yes – run from 2003 to 2006
Primary focus	Local authorities with social services responsibilities
Competitive	No
Match-funded etc.	No
Other comments	

Table 22 The Case of Pointon and South Cambridgeshire PCT

Name of grant	The Case of Pointon and South Cambridgeshire PCT
Where	England
Publications	The Health Service Ombudsman, Case No. E.22/02-03: Complaint against: The former Cambridgeshire Health Authority and South Cambridgeshire Primary Care Trust
Legislation	Health and Social Care Act 2001
Purpose	Eligibility criteria for NHS continuing care funding were inconsistently applied and did not take into account the psychological as well as the physical needs of an individual suffering from dementia being cared for at home. The Ombudsman advised the DoH to review the eligibility criteria for NHS continuing care funding to ensure that the criteria for funding care at home, and the recognition of patients' psychological as well as physical needs, are clearly defined
Websource	http://www.ombudsman.org.uk/improving_services/selected_cases/HSC/pointon.html
Ring-fenced, Targeted, Universal	U
Time-limited	No
Primary focus	All people with continuing health care needs
Competitive	No
Match-funded etc.	No
Other comments	In practice, this judgment could be seen to increase eligibility for an existing NHS funding stream

Table 23 Scotland (2002) free personal social care

Name of grant	Scotland (2002) free personal social care
Where	Scotland
Publications	*Better Care for All Our Futures* (2001); *Carers Legislation Consultation Paper* (2001); *Fair Care for Older People* (2001)
Legislation	Community Care and Health (Scotland) Act 2002
Purpose	Free nursing care in care homes which provide nursing; implementation of free personal and other care in all settings
Websource	http://www.legislation.hmso.gov.uk/cgi-bin/htm_hl.pl?DB=hmso-new&STEMMER=en&WORDS=community+care+health+scotland+act+2002+&COLOUR=Red&STYLE=s&URL=http://www.hmso.gov.uk/legislation/scotland/en2002/2002en05.htm#muscat_highlighter_first_match
Ring-fenced, Targeted, Universal	U
Time-limited	No
Primary focus	People in Scotland who need personal, social or nursing care
Competitive	No
Match-funded etc.	No
Other comments	Unlike in England, people in care homes in Scotland are not eligible for Attendance Allowance. However, people at home are eligible both for Attendance Allowance and free personal care

Table 24 Delayed Discharge Grant

Name of grant	Delayed Discharge Grant
Where	England
Publications	*Community Care (Delayed Discharges etc.) Act 2003: A Brief Guide for Social Services Staff*
Legislation	Community Care (Delayed Discharges etc.) Act 2003
Purpose	'The purpose of the Delayed Discharge Grant is to encourage local authorities to work with health partners to invest to tackle the causes of delays in their local system'
Websource	http://www.hmso.gov.uk/acts/acts2003/20030005.htm http://www.dh.gov.uk/assetRoot/04/06/74/06/04067406.pdf http://www.dh.gov.uk/assetRoot/04/07/19/26/04071926.pdf
Ring-fenced, Targeted, Universal	U
Time-limited	Not known
Primary focus	Any patient in an acute bed, whatever their age
Competitive	No
Match-funded etc.	No, but pooled (health and social services) budgets encouraged
Other comments	

Current grants – comfortable and secure homes

Table 25 Supporting People

Name of grant	Supporting People
Where	England, Scotland and Wales
Publications	*Supporting People – Policy into Practice: A Strategic Framework and Guide*
Legislation	Section 93 of the Local Government Act 2000 for England; Section 91 of the Housing (Scotland) Act 2001 for Scotland
Purpose	Replaces the housing-related support component in Housing Benefit (although this is continued in some cases through Transitional Housing Benefit Grant which has reduced each year since its first allocation in 2003). 'The programme is committed to providing a better quality of life for vulnerable people to live more independently and maintain their tenancies'
Websource	www.spkweb.org.uk
Ring-fenced, Targeted, Universal	R, U
Time-limited	No
Primary focus	Vulnerable members of society
Competitive	No
Match-funded etc.	No
Other comments	

Current grants – getting out and about

Table 26 Liveability Fund

Name of grant	Liveability Fund
Where	England
Publications	*Sustainable Communities: Building for the Future* (2003); *Green Spaces, Better Places* (DTLR, 2002); *Living Places – Cleaner, Safer, Greener* (ODPM, 2002)
Legislation	None found
Purpose	'Liveability Fund to support significant local authority projects to improve parks and public spaces'
Websource	http://www.odpm.gov.uk/stellent/groups/odpm_urbanpolicy/documents/page/odpm_urbpol_023298.hcsp
Ring-fenced, Targeted, Universal	Initially piloted in 27 targeted local authorities across the 9 English regions
Time-limited	Yes – 2003/4–2005/6
Primary focus	Communities
Competitive	Yes
Match-funded etc.	No
Other comments	

Table 27 Rural Bus Subsidy Grant

Name of grant	Rural Bus Subsidy Grant
Where	England
Publications	None found
Legislation	None found
Purpose	'The Rural Bus Subsidy Grant was introduced in 1998/99 and provides for additional local bus services to rural communities previously not well served' http://www.dft.gov.uk/pns/displaypn.cgi?pn_id=2004_0155 http://www.dft.gov.uk/stellent/groups/dft_localtrans/documents/page/dft_localtrans_023545.hcsp
Ring-fenced, Targeted, Universal	U
Time-limited	Until 2006 – possibility of further extension
Primary focus	Rural communities
Competitive	No – based on 2001 census data
Match-funded etc.	No
Other comments	

Grants available from 2006

Table 28 Preventative Technology Grant

Name of grant	Preventative Technology Grant (also known as Prevention Pilots)
Where	England
Publications	*Building Telecare in England* (DoH, 2005); *The 'Telecare Implementation Guide'* (CSIP, 2005)
Legislation	None found
Purpose	'This grant has been established to provide non ring-fenced funding to stimulate the provision of smart alarm and other preventative technology services to vulnerable older people. This has the potential to benefit 150,000 older people by 2008.' (LASSL (2004)26)
Websource	http://www.dh.gov.uk/assetRoot/04/09/73/07/04097307.pdfhttp://www.changeagentteam.org.uk/index.cfm?pid=188http://www.info.doh.gov.uk/etpc/etpc.nsf
Ring-fenced, Targeted, Universal	U
Time-limited	Yes – 2006–8
Primary focus	Older people
Competitive	No – allocated to all local authorities in England with social services responsibilities using Formula Spending Share for Older People
Match-funded etc.	No
Other comments	

Table 29 Partnerships for Older People Projects Grant

Name of grant	Partnerships for Older People Projects Grant
Where	England
Publications	*Partnerships for Older People Projects – A Prospectus for Grant Applications* (2005)
Legislation	None found
Purpose	'Funding for local partnerships to test and evaluate innovative approaches that should sustain prevention work in order to improve outcomes for older people. Each partnership should include a council with social services responsibility (CSSR) who will act as its responsible authority and at least one Primary Care Trust (PCT partner). Partnerships will also include a range of other key local partners who have an interest in supporting the local delivery of their POPP initiative'
Websource	http://www.dh.gov.uk/assetRoot/04/10/53/74/04105374.pdf
Ring-fenced, Targeted, Universal	R, U
Time-limited	Yes
Primary focus	Older people
Competitive	Yes
Match-funded etc.	'Matched funding is not a prerequisite of these pilots, however since POPP funding is specifically for short-term pump-priming it follows that pilots should be able to release funding from elsewhere in the system to ensure sustainability'
Other comments	£60 million ring-fenced for 2006/7 and 2007/8

Recent (expired) grants

Table 30 Promoting Independence: Partnership Grant

Name of grant	Promoting Independence: Partnership Grant
Where	England
Publications	*Modernising Social Services* (1998)
Legislation	None found
Purpose	'to foster partnership between health and social services in promoting independence as an objective of adult services'
Websource	www.dh.gov.uk/assetRoot/04/01/26/76/04012676.pdf
Ring-fenced, Targeted, Universal	R, U
Time-limited	Yes. This grant was for 3 years from 1999/2002 and ended in the 2002/3 financial year
Primary focus	All adult client groups, not just older people (LAC(2000)6, pt 13b)
Competitive	No
Match-funded etc.	No
Other comments	In 2002/3 the Partnership and Prevention Grants were replaced by the Promoting Independence Grant for one year only. See overleaf for entries on these grants

Table 31 Promoting Independence: Prevention Grant

Name of grant	Promoting Independence: Prevention Grant
Where	England
Publications	*Modernising Social Services* (1998)
Legislation	None found
Purpose	'The aim is to stimulate an approach which will: (a) slow down or prevent deterioration in individuals who have been assessed as at risk of losing independence; (b) enable people to exercise self-determination and to live as independently as possible through lower level interventions' (LAC(2000)6)
Websource	www.dh.gov.uk/assetRoot/04/01/26/76/04012676.pdf
Ring-fenced, Targeted, Universal	R, U
Time-limited	Yes. This grant was for 3 years from 1999/2002 and ended in the 2002/3 financial year
Primary focus	All adult client groups, not just older people (LAC(2000)6, pt 13b)
Competitive	No
Match-funded etc.	No
Other comments	As preceding table

Table 32 Promoting Independence Grant: Carers Grant

Name of grant	Promoting Independence Grant: Carers Grant
Where	England
Publications	*Caring about Carers* (1999)
Legislation	None found
Purpose	'The grant … is designed to stimulate diversity and flexibility of provision which enables carers to have a break from caring'
Websource	www.dh.gov.uk/assetRoot/04/01/26/76/04012676.pdf
Ring-fenced, Targeted, Universal	R, U
Time-limited	Yes. This grant was for 3 years from 1999/2002 and ended in the 2002/3 financial year
Primary focus	Carers, but there is a suggested proportion of 80% on adults and 20% on children's services in 2000 (LAC(2000)6)
Competitive	No
Match-funded etc.	No
Other comments	In 2002/3 it was split away from the Promoting Independence Grants and became a separate grant in its own right (see Current Grants)

Table 33 Promoting Independence Grant

Name of grant	Promoting Independence Grant
Where	England
Publications	*Modernising Social Services* (1998); *National Priorities Guidance* (1998); *NHS Plan* (2000); *Valuing People: A New Strategy for Learning Disability for the 21st Century* (2001); *The National Service Framework for Older People* (2001)
Legislation	None found
Purpose	'The broad purpose of the Partnership Grant [see above] remains a central objective for the new Promoting Independence Grant. The emphasis in this guidance is on using the grant to promote new patterns of service providing care closer to home'
Websource	http://www.dh.gov.uk/assetRoot/04/08/31/28/04083128.PDF
Ring-fenced, Targeted, Universal	R, U
Time-limited	Finished in 2002/3
Primary focus	All adult client groups, not just older people
Competitive	No
Match-funded etc.	No
Other comments	This grant replaced the Partnership Grant and the Prevention Grant for one year only (see above)

Table 34 Hospital Discharge and Prevention Scheme

Name of grant	Hospital Discharge and Prevention Scheme
Where	England
Publications	*Building Capacity and Partnership in Care – an Agreement between the Statutory and Independent Social Care, Health and Housing Sectors* (2001)
Legislation	Local Government Act 2000
Purpose	The grant was made available to reduce delays in discharging people from hospital and to enable local authority community care services, including housing partners, to work with local NHS partners to reduce the number of delays where people are awaiting a transfer of care from hospital to community and require community care facilities or support in the community
Websource	http://www.dh.gov.uk/assetRoot/04/01/27/26/04012726.pdf
Ring-fenced, Targeted, Universal	R, U
Time-limited	Yes – last year under this heading was 2003
Primary focus	All people receiving hospital care
Competitive	No – all LAs, although 55 were selected for larger allocations
Match-funded etc.	No, but pooled budgets encouraged
Other comments	Replaced by Delayed Discharge Grant replacement after 2003 (see Current Grants)

Table 35 Care Direct Pilots

Name of grant	Care Direct Pilots
Where	England
Publications	*Quality and Choice in Older People's Housing: A Strategic Framework* (2001); *Quality and Choice in Older People's Housing: The Story So Far* (2002)
Legislation	
Purpose	'Care Direct provides older people and their carers with information about, and access to, social care, health, social security and housing'
Websource	http://www.dh.gov.uk/PublicationsAndStatistics/Publications/PublicationsPolicyAndGuidance/PublicationsPolicyAndGuidanceArticle/fs/en?CONTENT_ID=4006865&chk=WJsEsI
Ring-fenced, Targeted, Universal	R
Time-limited	Last year 2004/5
Primary focus	Older people and their carers
Competitive	'Care Direct is currently being piloted and evaluated in Plymouth, Somerset, Bournemouth, Gloucestershire, Bristol and Devon. Ministers will decide if the service is to be rolled out beyond the pilot sites'
Match-funded etc.	Not known
Other comments	It was decided in 2004 that the Care Direct service would not be rolled out nationwide, but that learning from it would feed into the DWP's Link-Age service

Table 36 Direct Payments Development Fund

Name of grant	Direct Payments Development Fund
Where	England, Wales, Scotland and N. Ireland
Publications	*Making a Difference: Direct Payments* (2005)
Legislation	Community Care and Direct Payments Act 1996 introduced Direct Payments for adults; extended to older people in 2000; extended to carers through Carers and Disabled Children Act 2000
Purpose	'The involvement of community and voluntary organisations will be crucial to the success of Direct Payments as experience has shown that a strong support network is key to ensuring take up. This is why the [Direct Payments Development] fund has been targeted at voluntary organisations, in partnership with councils'
Websource	http://www.dh.gov.uk/PolicyAndGuidance/OrganisationPolicy/FinanceAndPlanning/DirectPayments/fs/en
Ring-fenced, Targeted, Universal	U
Time-limited	Set for three years, 2003–5
Primary focus	All groups who are eligible for receipt of funded social care
Competitive	Yes – successful bids are listed on DoH websource
Match-funded etc.	No
Other comments	

Table 37 Neighbourhood Management Pathfinders

Name of grant	Neighbourhood Management Pathfinders
Where	England
Publications	*Neighbourhood Management (2000)* (Social Exclusion Unit, 2000)
Legislation	None found
Purpose	'The Neighbourhood Management Pathfinder programme is a process not a project. It involves communities working with local agencies to improve services at neighbourhood level'
Websource	http://www.neighbourhood.gov.uk/page.asp?id=577 http://www.socialexclusion.gov.uk/downloaddoc.asp?id=33
Ring-fenced, Targeted, Universal	T
Time-limited	Yes – 2002/3–2004/5
Primary focus	Communities
Competitive	No
Match-funded etc.	No
Other comments	

Table 38 Rural Bus Challenge

Name of grant	Rural Bus Challenge
Where	England
Publications	*Evaluation of Rural Bus Subsidy Grant and Rural Bus Challenge – Summary Report* (2003)
Legislation	None found
Purpose	'The Rural Bus Challenge is an annual competition in which local authorities bid for funding for schemes aimed at stimulating innovation in the provision and promotion of rural public transport, improving quality and choice across the country. The Challenge approach enables the *best* ideas from local authorities to be supported'
Websource	http://www.dft.gov.uk/stellent/groups/dft_localtrans/documents/page/dft_localtrans_024815.hcsp
Ring-fenced, Targeted, Universal	U
Time-limited	Yes
Primary focus	Rural communities
Competitive	Yes – bidding by invitation
Match-funded etc.	No
Other comments	Ran for 5 years from 1998/9–2002/3

Table 39 Urban Bus Challenge

Name of grant	Urban Bus Challenge
Where	England
Publications	None found
Legislation	None found
Purpose	'The overall aim is to contribute to regeneration of deprived urban areas by improving transport provision and to target support on areas of economic or social deprivation. Bids can be made for support for specific schemes, with DTLR funding then being awarded to the best schemes submitted'
Websource	http://www.dft.gov.uk/stellent/groups/dft_localtrans/documents/page/dft_localtrans_508308.hcsp
Ring-fenced, Targeted, Universal	U
Time-limited	Yes
Primary focus	Urban communities
Competitive	Yes
Match-funded etc.	No
Other comments	Ran from 1998/9 to 2002/3

Maps of the landscape

The complex array of grants outlined in the tables can be summarised as a map (Figure 8). Each line represents one of the areas of life which are significant for older people. Each circle on the line is a 'grant stop'. In Figure 9 we have reproduced a variation on a well-known schematic on which other grants could be included to give managers a complete picture of the resources which are available to generate and sustain independence for older people. These maps will need to be developed. They will of course change as new funding streams become available. We hope that someone will take up the challenge to generate a complete map and keep it up to date. Such a map, using the schematic in Figure 9, could help managers access resources to enrich the lives of older people living in their local communities.

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Figure 8 Current and forthcoming grants by theme

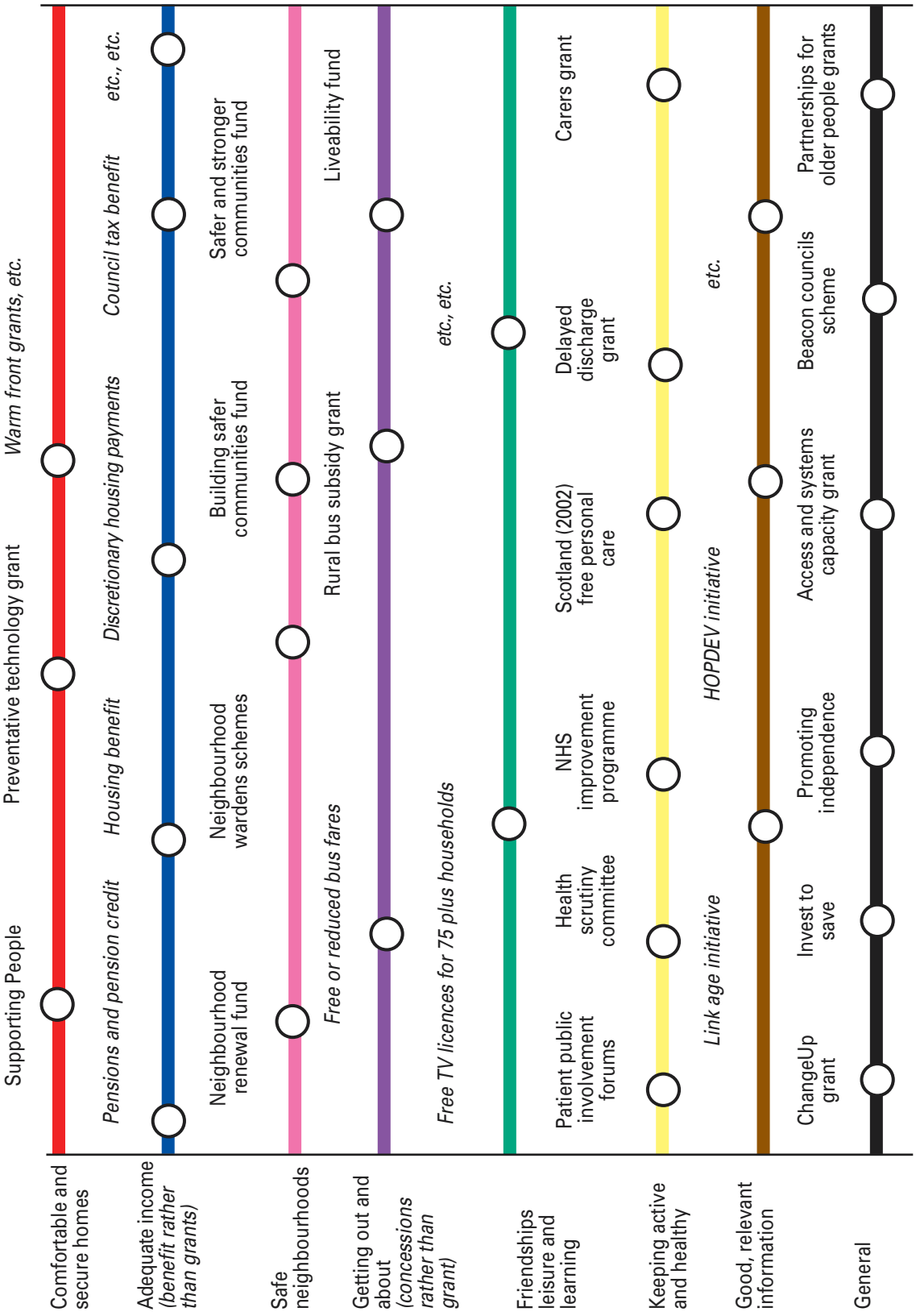

Figure 9 Map of grants