Brighton & Hove Fairness Commission

Dear Commissioners,

Please find enclosed the evidence pack for the **Older People & Wellbeing** meeting taking place on 16th March, 2016 at Portslade Town Hall, 6-9pm.

This month's evidence pack contains:

- **Silver Cities –** Realising the potential of our growing older population
- **The Brighton & Hove Age Friendly City Programme -** Annual Review 2014
- **The End of Formal Adult Social Care – Executive Summary**
- **The End of Formal Adult Social Care -** A Provocation by the ILC-UK
- **Healthy Ageing & Food –** Bringing a food focus to Brighton & Hove as an 'Age Friendly City'
- **Community wellbeing 'Voice of the User' report:** Summary for stakeholders
- **Community Navigation in Brighton & Hove** - Evaluation of a social prescribing pilot
- **Age UK users submission to Fairness Commission**
- **DueEast Neighbourhood Council –** Older people and wellbeing case study
- **Group submission to Fairness Commission –** Community Transport
- **Brighton & Hove Impetus –** Submission to Fairness Commission
- **Adult Social Care** – Annual User Survey
- **Older Peoples Council –** 2nd Submission to Fairness Commission
- **Group submission to Fairness Commission –** Older People issues
- **The LGBT Health and Inclusion Project**: A Local LGBT Older People's Group – Stakeholder Roundtable
- **Fairness Commission submission** of responses from users of St John's Cafe, Cornerstone
- **Carers Centre -** Statement for the Fairness Commission on Older People

I look forward to meeting with you all next week.

Kind regards

Julia Reddaway
Policy Team

IPPR NORTH

REPORT

SILVER CITIES

REALISING THE POTENTIAL OF OUR GROWING OLDER POPULATION

Ed Cox,
Graeme Henderson
and Richard Baker

December 2014

Institute for Public Policy Research

ABOUT IPPR NORTH

IPPR North is IPPR's dedicated thinktank for the North of England. With its head office in Manchester and representatives in Newcastle, IPPR North's research, together with our stimulating and varied events programme, seeks to produce innovative policy ideas for fair, democratic and sustainable communities across the North of England.

IPPR North specialises in regional economics, localism and community policy. Our approach is collaborative and we benefit from extensive sub-national networks, regional associates, and a strong track record of engaging with policymakers at regional, sub-regional and local levels.

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SMART IDEAS
for CHANGE

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SUMMARY

This report is about the impact of two great global trends upon developed economies: urbanisation and demographic ageing. With falling birth rates and most people living longer and healthier lives than previous generations did, population ageing is now the dominant demographic trend in advanced economies. While different places experience it in different ways, this trend is clear everywhere.

The response to this fundamental shift in the structure of our populations has tended to focus on a narrow group of perceived challenges. National governments have tended to homogenise and problematise ageing, focussing on worries about rising health, pension and welfare costs and a declining labour force on the basis of technical 'dependency ratio' calculations. More nuanced responses have sometimes been pursued, but the potential that many older people have has not been fully appreciated or reflected in public policy.

Similarly, at a sub-national level, cities and regions have sought to service the welfare and care needs of ageing populations, rather than look at the issue in the round across their economic and social policies. For example, many have attempted to maintain their labour forces by competing for a cohort of younger workers that is in relative decline, thereby reducing the availability of services to large groups of both older and younger people. This situation is increasingly unsustainable.

This report aims to promote a positive, long-term and integrated response to ageing in cities which will contribute to the delivery of economic growth, employment and inclusion for people of all ages.

Demographic trends

By the early 2030s, people aged over 50 will comprise around half the adult population in the UK – a rate which is representative of the OECD family of developed nations. It is expected that by 2037 the average age of the UK population will rise from 39.7 years to 42.8 years, and the number of over-80s to double to 6 million, which will yield a much older age profile across the overall population (which by 2037 is expected to number 73 million) (ONS 2013a). It is estimated that the number of people who will be eligible for a state pension will increase by 31 per cent between mid-2012 and mid-2037 (ibid), and that income and wealth disparities within the older population will grow over this period.

As is already clear, there are significant economic as well as social consequences to the breakdown of the traditional 'three-generation model' of family life, and of major changes to intergenerational relationships and transfers of wealth and income. Whereas in previous eras younger generations benefited from 'downward' family transfers in the form of education, inheritance and lending, we are increasingly seeing 'upward' pressures, with older generations relying on their children for resources such as informal care

There are important regional variations within these overall patterns of demographic change in the UK, with the three Northern regions (the North East, the North West, and Yorkshire and the Humber) expected to experience the lowest population growth and the highest 'dependency ratios' between now and 2036. But even within the north of England the factors that affect population change vary between urban and rural areas, largely as a result of different patterns of migration.

Responding to demographic change

In the global policy literature it is possible to identify three broad approaches to ageing – with 'ageing' in this context understood as one of, or a combination of, the following.

- A story about growing numbers of older people, with the focus of policy therefore being on the mobilisation, experience and roles of older people, and on meeting their health and social needs.
- A story about a shift in the balance of the overall population, derived from a number of interacting demographic trends, with the policy focus being on the redistribution of roles, resources and responsibilities across generations.
- A story about increasing diversity, concerning the numerical trends described above and the social changes derived from cohort effects, migration and so on. Here the focus of policy is therefore on issues of personalisation and integration.

These narratives can be discerned in high-level policy statements, and they are fed through into the design and delivery of local programmes and projects. At an international level, the focus has mainly been on the rights of older people, the promotion of 'age-friendly environments', and on inclusion. There have also been some programmes focussed on intergenerational equity. Nationally, there have been several strands to UK policy on ageing, including tackling age discrimination, nurturing skills and lifelong learning, and managing the burgeoning health and social care bill, though the main focus has been on protecting pensions while adjusting the retirement age. UK policy has tended to be piecemeal and fragmented, particularly since 2005.

At the sub-national level, both within the UK and elsewhere, there have been more strategic initiatives to address demographic ageing, particularly in those places that are most affected by it. In some cities and regions there have been pioneering attempts to develop a more progressive policy agenda, including some notable examples, including the following, which are examined in this report.

- Brabant in the southern Netherlands has developed a regional innovation strategy to develop new products and services which promote active and healthy ageing.
- Livorno in north-west Italy has promoted economic activity for the over-50s through targeted training and senior apprenticeships, mid-life careers advice and job guarantees through a range of public and private partners.
- Japan, the country with the most pronouncedly ageing demographics, has developed a network of 1,600 'silver human resources centres' in municipalities across the country. In Toyama, for example, these have focussed on supporting older people to maintain their involvement with regional agricultural industries, and have combined with radical planning measures to maintain population density.
- In both Manchester and Newcastle in the UK, city-based strategies have emphasised local citizenship and involvement in decision-making, and universities in both cities have established centres of excellence on research on ageing.

New approaches and realising opportunities

What many of our case studies show is that new approaches can create significant opportunities for older people to become critical actors in local economic development – as producers, consumers and investors – with broader economic dividends for populations as a whole.

Silver producers

The employment rate of workers aged between 55 and 64 has increased markedly in the UK (Eurostat 2014: 3). The employment rate among those aged 65 and over has increased faster still, and has grown faster than that of any other age group over the

last decade. This has been caused in part by changes to key benefits affecting the over-50s, but also by the growing numbers of people choosing to remain within the workforce or to start their own businesses. Senior entrepreneurship is at its highest level ever, with approximately 600,000 individuals aged over 50 engaged in early-stage entrepreneurial activity (Levie et al 2013). Older entrepreneurs also tend to be more successful in terms of start-up survival rates: 70 per cent of start-ups founded by older people were found to last longer than three years, in contrast to only 28 per cent of those created by younger entrepreneurs (Patel and Grey 2006).

Silver consumers

The older population is responsible for 40 per cent of consumer demand in the UK, and spends £200 billion per year, yet they only attract 10 per cent of the UK's marketing spend (Harper 2009). In fact, 'over the past two decades, consumption by Europeans aged 50 or over has risen three times as fast as that of the rest of the population' (Deloitte 2009: 8). When people think of the silver consumer, they immediately think of the obvious sectors – healthcare, pharmaceuticals and adapting homes for independent living. However, older people constitute large proportions of consumers in many other broad sectors, particularly leisure and tourism, financial services, consumer goods, food and beverages, retail and technology. Households with a head of household aged between 50 and 64 spend more on both health and recreation than any other age category (Skentelbery 2008: table A13). Over-50's in the UK buy, for instance, 80 per cent of all top-of-the-range cars, 50 per cent of skincare products, and 80 per cent of leisure cruises (ActiveAge 2012).

Silver investors

Wealth has concentrated towards the older segments of the population, in the forms of pension funds, housing and other property, and a range of other capital and financial assets. While discussions about the role of pension funds have tended to focus on the institutions that hold these assets, debate about the potential roles of older people' s accumulated wealth in housing and other locations must focus more directly on older people themselves. Equity release is an emerging area for exploration and innovation, but is currently focussed on younger age cohorts. Retirement communities are increasingly popular in the US and continental Europe, but have not yet been widely developed in the UK. HM Treasury has found evidence of a significant inclination among older people to invest in enterprise investment schemes and venture capital, but this propensity is concentrated among older, married men in the south of England. This suggests that more could be done to encourage investment further afield if the right institutions and schemes are put in place.

Despite these significant opportunities, it is important to recognise that older people continue to face significant barriers to participating in the labour market, and as consumers and producers. Despite recent growth in the employment rate of the over-50s in the UK, in countries such as Belgium, Luxembourg and the Netherlands this rate has risen twice as fast as it has in the UK (Eurostat 2014). Issues such as poor health, ageism, caring responsibilities, poor skills and weak policy coordination are all holding back new approaches to demographic ageing.

Principles and policies for silver cities

A number of principles emerge from our analysis that must underpin successful approaches to demographic ageing both at national and local levels. These can be summarised as follows.

- **Moving beyond stereotypes:** recognising that there is increasing and significant diversity across age cohorts. Policies, laws and other measures that presume the potential, needs and interests of individuals based on their age are inadequate responses to our changing demography.

- Taking an 'asset-based approach': recognising population ageing as an economic opportunity which can benefit the whole population, rather than just a social care problem.
- **Developing multi-agency co-operation** with a focus on identifying mainstream approaches to promote lifelong adaptation, service improvement and pooled funding rather than just small-scale, targeted projects. At the national level, this includes cross-departmental coordination, as well as devolving decision-making and programme design to local actors who can respond to diverse local circumstances.
- **Recognising older people as key co-producers** of better economic and social outcomes, through active engagement in all areas of wider strategic planning and public life.
- **Long-term political commitment to strategic planning for demographic ageing**, building on learning from local, national and international examples.

This report does not intend to articulate a national strategy for an ageing population. However, other IPPR reports have set out some important planks upon which a silver economy can be built. These include the following.

- '*People providing a significant amount of unpaid care should have the right to adjust their working arrangements to enable them to remain in employment rather than relying on the benefit system.*
- *Entitlement to care services for those on low incomes should be extended to older people with moderate needs, to enable them to stay at home and live independently. This should be paid for by limiting entitlement to winter fuel payments to those who are eligible for pension credit.*
- *An independent review should consider how the national insurance system could be used to progressively lower the cap on care costs and raise the asset threshold, using the principles of contribution and risk-pooling to help finance long-term care costs.'*

Lawton et al 2014

- There should be new insurance products and other financial instruments to encourage older people to make adaptations to their homes. GPs should also be able to 'prescribe' home adaptation grants.
- Decent space standards and Lifetime Homes standards should be phased into national building regulations requirements and new homes built to these specifications discounted stamp duty up to a sale value of £500,000 where the buyer is over 55.
- Local authorities should be given the freedom to deploy their borrowing capacity via housing revenue accounts and housing corporations to invest in sheltered accommodation and 'intentional community' models should be systematically tested in the market by social housing providers and the Department of Health.

Davies 2014

While it is right that there should be a national framework to better address the costs of ageing, some of the most progressive approaches to demographic ageing can be found at the sub-national level. For this reason, it is our principal recommendation that **every city in England that doesn't have one should consider developing a strategy for demographic change, with a strong emphasis on the potential of the silver economy and links to wider strategies for economic growth and public service reform**.

While every strategy will need to be developed according to the specific opportunities and challenges that exist locally, there are some common issues that should be considered.

- **Analysis:** every city strategy needs to understand the specific demographic drivers affecting the locality, including the segmentation of the older population.
- **Skills:** each strategy should focus on continuous training and lifelong learning for all employees, with some of the offering being tailored to the over-50s to

ensure that they can adapt to changing labour-market demands. In practical terms, this might mean developing personalised and flexible vocational training programmes.

- **Business support:** cities should work with local businesses to better understand and explore the opportunities available to them in terms of employing older people, ensuring accessible workplaces, and developing products and services for the burgeoning older people's market.
- **Older entrepreneurship:** it should be ensured that tailored business support and advice are made available to older entrepreneurs to enable them to establish and grow their businesses, given that their needs are often different to those of younger people.
- **Innovation and investment:** work with universities to identify areas for innovation and commercialisation of research around issues of ageing – including, but not exclusively, on issues of health and social care.
- **Active labour market programmes:** cities should work with partners to develop active labour market programmes that include a specific emphasis on the employment challenges facing the over-50s – not least involuntary redundancy.
- **Integration:** strategies should ensure that employment support and health and care systems within the city are better joined up. A strong economy and a healthy population are mutually reinforcing, so better integrating work and healthcare programmes can bring real benefits.
- **Adaptations:** cities must address issues around 'quality of life' for older people, ensuring that a wide range of accessibility and age-friendly adaptations are made to the public realm.

This report unashamedly highlights the 'assets' and opportunities that an ageing population offers, rather than dwelling on the 'burdens' and challenges – there is already plenty in print that takes that perspective. We do not mean to naïvely imply that ageing does not present any challenges. Rather, by focusing on opportunity, this report seeks to act as a corrective to the negativity of other research. While it by no means constitutes a blueprint for national or local silver economic strategies, it draws on good practice from overseas to provide a number of principles and building blocks upon which both local and national policymakers can build.

1. INTRODUCTION
OUR GROWING OLDER POPULATION

Population ageing is the world's dominant demographic trend. Most people can now expect to live longer and healthier lives than previous generations did, and the balance of our population is being transformed by the combination of extended life-expectancy and declining birth rates. This is impacting on a range of economic and social issues such as the structure of the labour market, demand for housing and public services, and wider consumption in the economy. In cities and rural regions across Europe and other developed economies – each of which will experience a different mix of underlying trends within this wider global shift – there is an ever more urgent need to focus on the realities and the implications of these trends.

Generally, however, the response has been a narrow one, focussed on the problems of ageing. At a national level, governments have concentrated on the perceived costs of population change with regards to pensions and demands on health care and welfare systems, and have defined the issue in terms of the decline in the age-based 'dependency ratio'.[1] This has led to significant changes in the policy framework, which have aimed to reduce these costs.

There have been some positive policy changes aimed at increasing the output of this ageing population. For example, in areas such as labour market policy there have been initiatives to promote the extension of working lives through delayed access to state retirement support and an evolving legal framework regulating age discrimination. However, there has yet to be a comprehensive focus on the potential economic contribution that the growing older population could make.

A similar balance of approaches can be observed at the sub-national level. In general terms, in most regions and cities the response to ageing has been one of managing the costs of service delivery and focussing on attracting a cohort of younger workers that is in relative decline. Efforts to seek out new sources of economic growth from the potential economic contribution of an area's growing 'silver' cohort have been few and far between.

However, neglecting such efforts is becoming increasingly unsustainable. By the early 2030s, people aged over 50 will comprise half the adult population in the UK (ONS 2013a). Even taking into account the planned gradual changes in the state pension age, the 'dependency ratio' will continue to decline as the population ages. The longstanding problem of higher levels of unemployment and economic inactivity among those who are aged over 50 also remains to be addressed..

Beneath the headlines trends there are other interesting patterns.

1 The 'dependency ratio' is a population-based calculation which divides the number of people within an economy who are productive by the number of those who are dependent. Traditional applications of this have been age-based, dividing the number of so-called 'working age' people with those who are either below 'working age' or above 'retirement age'. This ratio has been declining in all developed economies as a result of ageing populations, and has been a key driver of age-based policy reform. We contend that it fails to take account of trends within these age groups. One example of this is the increasing number of people who are of 'retirement age' but are productive; another is the changing life-course patterns of many groups over successive generations within the 'working age' population who are not productive for a range of reasons, such as women raising children, students in further and higher education, and older workers who are excluded from the labour market. It also fails to recognise the different levels of productivity of different individuals within economies.

- Rates of employment among older people over retirement age have been increasing, and these increases have been concentrated in some particular high- and low-skill occupations.
- The economic inactivity rate has soared for working-age men in recent decades – up from 4.9 per cent in 1971 to 17.1 per cent in 2011 (Spence 2011). Only a mirroring trend of decline in the proportion of women classified as economically inactive has managed to keep the overall working-age inactivity rate fairly constant (ibid).
- There are growing disparities in the distribution of wealth in the economy between age groups, with many older age people sitting on sizeable property values and financial investments.
- However, there is an increasing diversity of experience within this older age group – between those who are asset-rich and those who are asset-poor – in terms of health, expectations, role, skills and attitude.

This diverse pattern will continue to change. The experiences of future cohorts who reach older age may be very different to those of today, due to changing financial conditions or advances in health care, for example. We can anticipate that in future, while many older people will be comfortable – very comfortable, in some cases – the current decline in defined-benefit pensions and the increasing number of families who are being priced out of getting a foothold on the property ladder (and who therefore will not have property assets to rely on in their later years) an increasing number of people may find older age to be a time of hardship.

It is also important that we recognise the implications of our changing demographics for all parts of the population, and look at population ageing as a process that has broader resonance. There are important implications for younger people in work managing an older workforce, for example; for employers worrying about skills shortages as older people reach retirement ages, and how to retain and transfer valuable skills; and for city leaders thinking about infrastructure pressures like the housing stock and transport links.

2. DEMOGRAPHIC ANALYSIS

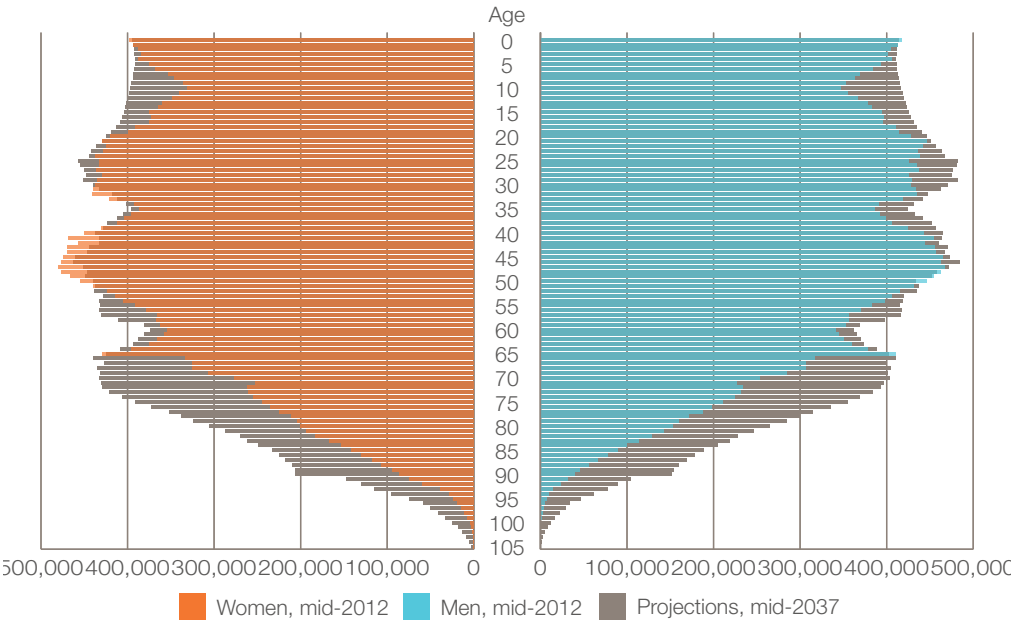
So what are the facts? The continued demographic shift to an older population is well documented. The intergenerational impacts of this shift, and the diversity within our older population, are, by contrast, less well understood. Moreover, there is little recognition that these shifts in population structure are happening at differing rates both between and within regions. Partly as a result of lower internal and international immigration, the UK's northern regions in particular are ageing faster.

2.1 UK-level trends

The most recent UK population projections (ONS 2013a) show that the UK population is set to increase by 9.6 million between mid-2012 and mid-2037, from an estimated 63.7 million to 73.3 million; it will pass the 70-million mark in 2027. A key cause of this accelerated growth is the anticipated natural increase (that is, the rate by which births outnumber deaths), which will account for 57 per cent of the projected increase over the next 25 years (ibid).

Alongside this aggregate growth, the population is expected to continue ageing, with the average age rising from 39.7 years in 2012 to 40.6 years in mid-2022, and to 42.8 by mid-2037. The number of people aged 80 and over in the UK is projected to more than double to 6 million by mid-2037 (ibid) (see figure 2.1).

Figure 2.1
Estimated and projected age structure of the UK population, mid-2012 and mid-2037



Source: adapted from ONS 2013a

Underlying these figures is the important assumption that net migration – which tends to be focussed among younger age-groups – will continue to increase by 800,000 over each five-year period between 2012 and 2037, adding just over 4 million people to the overall population by 2037 (ibid). As well as being younger,

migrants tend to exhibit higher levels of fertility than the settled population, and so have an important effect on the rate of ageing in the overall population in terms of both their initial migration impacts and their subsequent births (see table 2.1).

Table 2.1
Projected components of population change (millions), in the UK, mid-2012 to mid-2037

	2012–2017	2017–2022	2022–2027	2027–2032	2032–2037
Population at start	63.7	65.8	68.0	70.0	71.7
Births	4.0	4.1	4.0	4.0	4.0
Deaths	2.8	2.8	2.9	3.1	3.3
Natural change	1.3	1.3	1.2	0.9	0.7
Net migration	0.8	0.8	0.8	0.8	0.8
Total change	2.1	2.1	2.0	1.8	1.6
Population at end	**65.8**	**68.0**	**70.0**	**71.7**	**73.3**

Source: ONS 2013a
Note: Figures may not sum due to rounding

By the end of this cycle, in the mid-2030s, the rate of natural change is anticipated to slow to some extent, as the accelerator effect of the 1945–1955 baby boom tapers off.[2] However, the long-term position will be a much older population overall.

These figures will have an important effect on the pattern of resources, the shape of consumption and the productive capacity within the economy – assuming current patterns of behaviour. For example, despite the forthcoming increases to the state pension age under current legislation, the number of people of state pension age is projected to increase by 31 per cent, from 12.3 million in mid-2012 to 16.1 million by mid-2037, even with the rapidly changing age of eligibility provided for in current policy (ONS 2013a). Furthermore, at the eldest end of the age range, the number of people aged 80 and over in the UK is projected to more than double to 6 million by mid-2037 (ibid).

Aggregate figures also fail to capture the huge and increasing diversity of health and wealth levels within this ageing population. This is true not only of different socio-economic groups, but of different geographies: different places have very different older cohort effects. For example, the life expectancy gap between the local areas with the highest and lowest life expectancies increased significantly between the periods 2004–06 and 2008–10 (ONS 2011a).

Looking at changing income and wealth patterns, an interesting and important story emerges. Analysis of the English Longitudinal Study of Ageing (ELSA), commissioned by the UK government in the early 20th century as a definitive dataset on population change, shows that there are considerable differences between the average and the range of incomes of those people in early and late old-age, with the median income of a 65-to-69-year-old one-quarter higher than that of someone aged over 80. Most of this is explained by cohort effects, in that people reaching old age now (for instance) have higher incomes than people now over 80 did when they were the same age, a difference derived in particular from ongoing involvement in employment and productive activity, and the development of pension systems (Harrop 2013).

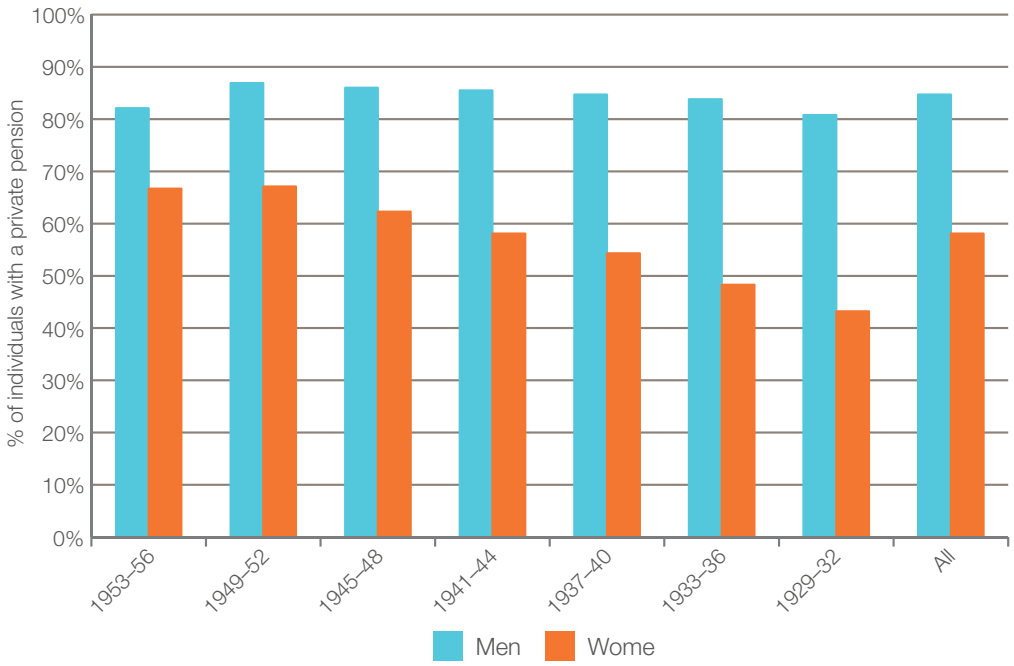
ELSA breaks down the population into four-year cohorts, and seeks to illustrate key trends among the current older population on this basis. Figure 2.2 provides

2 It is important to note that within this analysis there is an important lack of consensus about whether the age of mortality will continue to extend and by what rate

an illustration of pension income for five successive groups of four-year cohorts. As Banks et al (2012) explain,

> *'Total pension coverage has been relatively stable across successive cohorts of men, at around 80–90%. By contrast, pension coverage among women is lower than that among men and exhibits clear cohort differences. Among women born in 1929–32, on average 43% are covered by a private pension, while coverage is 67% among women born in 1949–52.'*
>
> Banks et al 2012

Figure 2.2
Pension coverage, by cohort and sex



Source: Banks et al 2012
Notes: 'Pooled ELSA 2002–03 to 2010–11. Sample size is 18,164 repeat observations of 5,649 men and 21,460 repeat observations of 6,492 women. Regression analysis of pension coverage on a set of cohort dummies is used to test for statistically significant differences between cohorts, assuming no time or age effects. Such analysis shows that for men the only consecutive cohorts that are significantly different from one another are the 1953–56 and 1949–52 cohorts and the 1933–36 and 1929–32 cohorts, while for women all consecutive cohorts are significantly different from one another with the exception of the 1953–56 and 1949–52 cohorts. Figures are weighted' (ibid).

The increase in pension coverage among later cohorts of women, which is not observed for men, arises for a number of reasons, including increased labour-market attachment among women in these cohorts; changes in UK law that removed the right for employers to exclude part-time employees from their occupational pension schemes; and changes in social norms regarding whether women in couples undertake independent retirement saving.

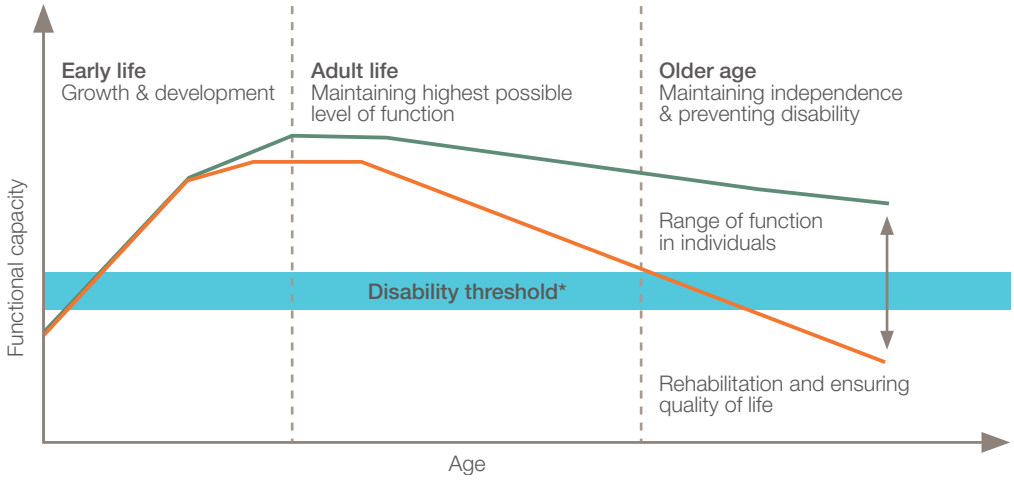
The effect of this increase in pensions coverage will, subject to the value of the pensions, impact on long-term indicators of incomes and economic security. It also demonstrates that previous expectations of widespread poverty among older people in the future should change, although the existence of inequality and pockets of deprivation will persist and may indeed become the main feature

within this age group. Finally, it indicates that there is ongoing potential for new market developments as cohorts move through the population.

Elsewhere in the evidence base, important intergenerational impacts are being identified which are global in scale. The National Transfer Accounts (NTA) project,[3] for instance, has been established to measure, analyse and interpret macroeconomic aspects of age and population ageing.

The project identifies four economic activities that are central to the intergenerational economy: working, consuming, sharing, and saving. In the traditional three-generation model set out in figure 2.3 below, there are assumed to be extended periods at the beginning and at the end of life when people consume more than they produce. These periods are balanced by the working ages, during which people produce more than they consume.

Figure 2.3
Maintaining functional capacity over the life-course



Source: Adapted from Kalache and Kickbusch 1997

In this traditional model, sharing and saving provide the means for filling the gaps between production and consumption for the young and the old, through intergenerational transfers such as taxation to fund primary and secondary education for the young, pensions for the old, and free health-care programmes for both young and old. These are supplemented by downward family transfers from parents and grandparents through family rearing, inheritance and lending. However, evidence from this study suggests that in the new four-generational family structure that is emerging, it is the oldest generation which increasingly relies on their children for fulfilment of these needs, with the transfer system increasingly reversing the flow of resources (Lee and Mason 2011).

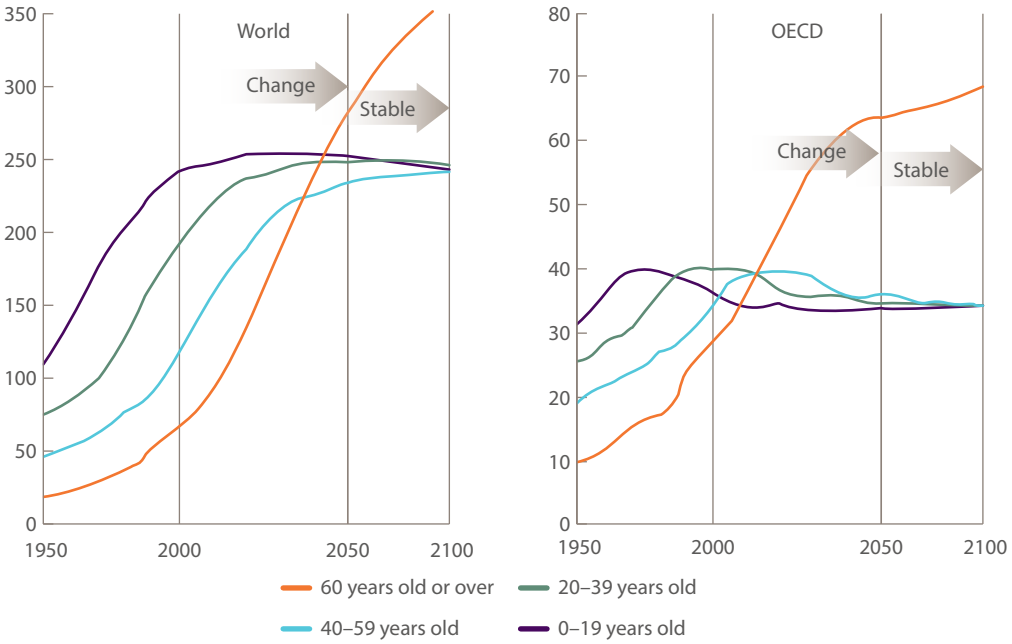
Demographic trends are fundamentally changing this economic model by altering the intergenerational relationships between cohorts, which are at the heart of these life-cycle models. These transfer systems have already begun to reverse in direction, particularly in places like Japan and the parts of Europe experiencing the largest ageing population redistribution such as Spain. The authors expect these patterns

3 Supported by the World Bank and led by the Center for the Economics and Demography of Ageing, University of California at Berkeley, working with universities across 33 states. See http://www.ntaccounts.org/web/nta/show/About%20NTA

to spread to other developed countries over the next two decades, unless they are addressed (ibid).

These are hugely important issues. Across the 33 member states of the OECD, the so-called 'dependency ratio' of pension-age populations to working-age populations is expected to double from about 20 per cent in 2000, to reach 40 per cent by 2050 at a time of rapid transition, before settling into a 'new normal'. In this 'new normal' by 2050, it is projected that about one-third of the OECD population will be aged over 65, with an additional 245 million people in this age group relative to 2011. For OECD countries, the over-60s is the only age group which is projected to expand between now and 2100.[4]

Figure 2.4
Changing numbers of people (millions) in different age groups across OECD member states



Source: http://www.oecd.org/governance/regional-policy/background-on-sustainable-urban-development-policies-in-ageing-societies.htm

Clearly, if this substantially larger older population is ill, poor and inactive then this scenario could be highly challenging. However, if it is wealthy, healthy and continuing to contribute then it offers a range of economic and social opportunities. Indeed, the authors of the NTA project argue that the most effective means of preventing the potential negative impacts of the these trends is maintaining the active economic contribution of the two older age bands, with the aim of rebalancing intergenerational resource flows.

2.2 Regional trends

There are highly diverse local and regional patterns of demographic change, although for almost all areas the predominant theme is one of ageing.

4 http://www.oecd.org/governance/regional-policy/background-on-sustainable-urban-development-policies-in-ageing-societies.htm

Table 2.2 below shows projected population changes by English region and age group in the decade to 2021. London is predicted to have the largest overall population growth (at 14.2 per cent), and the North West and North East are projected to grow the least (by 4.4 and 4.9 per cent respectively). The three northern regions are the only ones which will not experience double-digit population growth over this 10-year period.

However, within this general picture, by far the greatest component of this growth is the 65-and-over age group; and for the northern regions, given their relatively smaller overall growth, the growth of the older cohort is the defining feature of their projected demographic change. The North West and the North East are the only regions in England to see their population aged between 16 and 64 *decrease* over the decade.

Table 2.2
Population change in regions by age group, 2011– 2021

	Population (thousands)		Percentage population change by age group			
	mid-2011	mid-2021	All ages	0-15	16-64	65 and over
North East	2,596	2,724	4.9	7.9	-0.7	22.7
North West	7,056	7,364	4.4	9.0	-1.1	20.3
Yorkshire and the Humber	5,288	5,657	7.0	9.3	2.4	22.2
East Midlands	4,537	4,928	8.6	11.7	2.8	27.2
West Midlands	5,609	5,989	6.8	10.3	1.8	21.3
East	5,862	6,458	10.2	14.9	4.2	26.6
London	8,204	9,371	14.2	19.0	12.1	18.7
South East	8,653	9,453	9.3	12.8	3.5	26.5
South West	5,301	5,743	8.3	12.9	1.8	25.3
England	53,107	57,688	8.6	12.6	3.7	23.6

Source: ONS 2011b: 5

London's larger increases are driven by much higher international migration, and a relatively large difference between births and deaths. Outside London, the southern regions have much higher levels of net migration than the northern regions. For instance, net internal migration is projected to be 5.3 per cent between mid-2011 and mid-2021 in the South West, but -0.3 per cent in the North West (ONS 2011b: 6). Whether these trends continue is the subject of increasingly pronounced political debate.

Population ageing is therefore in many respects a more pressing issue for the northern regions. This perhaps helps to explain why some cities in the North have taken among the boldest and most comprehensive actions so far to address it. These initiatives are highlighted later in chapter 4 of this report.

However, looking at areas within the North, shows that there is also a complex picture emerging here. Work by the N8 Research Partnership on the patterns within emerging local enterprise partnership (LEP) territories (Hudson and Cannon 2011), commissioned by the Northern Way, shows interesting variations across the region.

Table 2.3 provides population growth projections for each of the eleven northern LEP areas, and shows growth rates ranging between 1.0 per cent in Liverpool and 16.6 per cent in North Yorkshire for the years to 2036 (ibid). Looking beyond these headlines, the influence of different factors on these trends varies from place to place, as figures 2.5, 2.6 and 2.7 below illustrate.

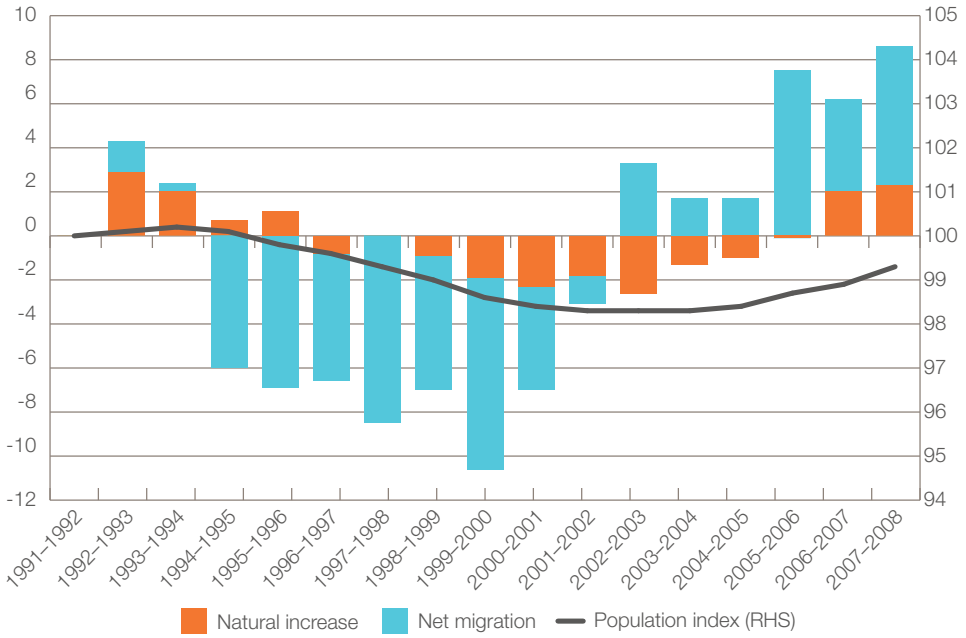
Table 2.3
Projected population change for Northern LEP areas, 2011–2036

LEP	Populations (000s)		Increase (%)
	2011	2036	2011–2036
Greater Manchester	2,611	2,861	9.5%
Liverpool City Region	1,493	1,508	1.0%
Leeds City Region	3,001	3,464	15.4%
Sheffield City Region	1,809	1,980	9.4%
Cheshire and Warrington	904	977	8.1%
Tees Valley	676	721	6.7%
Cumbria	532	606	13.9%
Hull City Region	935	1,011	8.2%
North Yorkshire	596	695	16.6%
North East	2,025	2,311	14.2%
Lancashire	1,522	1,706	12.1%
Northern England	13,617	15,215	11.7%
Rest of England	38,123	45,060	18.2%
England	53,240	61,999	16.5%

Source: Hudson and Cannon 2011
Note: Population figures are projections aligned with the 2008-based National Population Projection

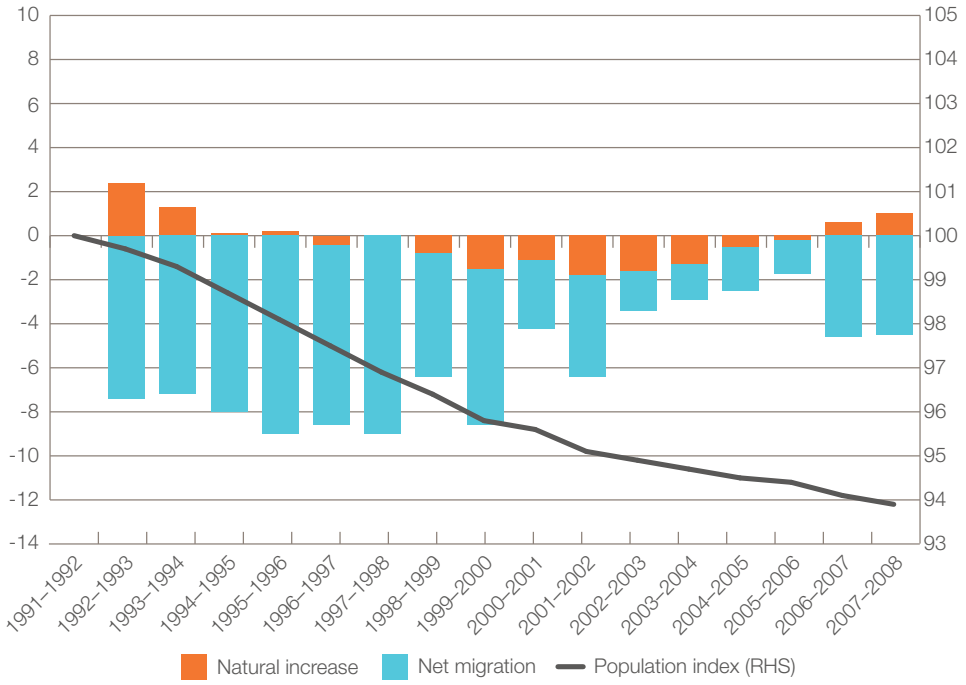
In the North East, recent growth and the return to population levels of the early 1990s has been largely the effect of positive net migration, with natural increase only returning to a positive balance in the mid-2000s.

Figure 2.5
Population change (%, and population index with mid-year-1991–mid-year-1992 = 100) in the North East, 1991–2007



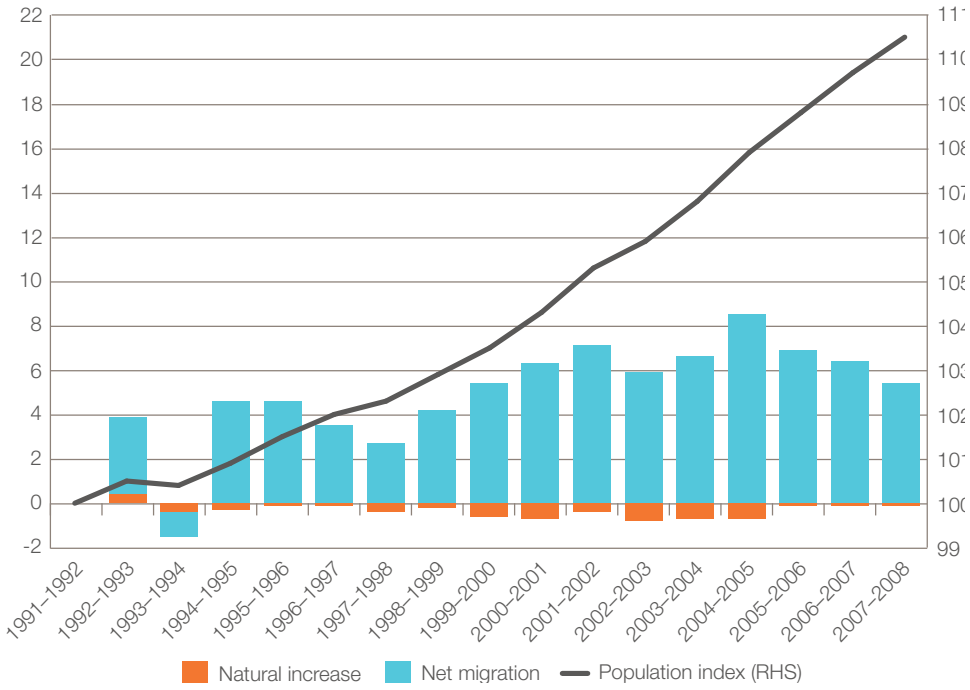
Source: Rees et al 2011

Figure 2.6
Population change in Merseyside (%, and population index with mid-year-1991–mid-year-1992 = 100), 1991–2007



Source: Rees et al 2011

Figure 2.7
Population change in North Yorkshire (%, and population index with mid-year-1991–mid-year-1992 = 100), 1991–2007



Source: Rees et al 2011

In Merseyside, overall population change has been on a downward trajectory for two decades, with only the last two years of the cycle in this period seeing a small growth in population.

However, a very different story is evident in North Yorkshire, with population growth building throughout the 1990s and 2000s, driven entirely by population movements into the area.

These charts demonstrate the great variations in demographic trends between areas. Similarly, table 2.4 below shows the total and percentages of the over-65s in mid-2012.

Table 2.4
The over 65s population by northern LEP (mid-2012)

LEP	Number of over-65s	Total population	Percentage over 65
Greater Manchester	406,000	2,702,200	15.0%
Liverpool City Region	266,200	1,511,400	17.6%
Leeds City Region	482,100	2,972,600	16.2%
Sheffield City Region	308,200	1,744,900	17.7%
Cheshire and Warrington	173,300	906,000	19.1%
Tees Valley	115,500	663,600	17.4%
Cumbria	107,600	499,100	21.6%
Humber	173,600	921,200	18.8%
York, North Yorkshire & East Riding	240,300	1,138,500	21.1%
North East	353,100	1,938,700	18.2%
Lancashire	268,800	1,465,700	18.3%

Source: ONS 2013b

The over-65 population is smallest in percentage terms in the relatively young Greater Manchester LEP area, where they comprise 15 per cent of the population. In more rural areas such as Cumbria and York, North Yorkshire and East Riding, they make up around 21 per cent of the population (ONS 2013b).

Table 2.5
Old age dependency ratios (16–64 population versus population aged 65 and over), northern England, 2011 and 2036

LEP	Ratio of population aged 16–64 to pop. aged 65+	
	2011	2036
Greater Manchester	3.1	1.7
Liverpool City Region	3.8	2.4
Leeds City Region	3.2	1.7
Sheffield City Region	2.9	1.9
Cheshire & Warrington	3.3	2.0
Tees Valley	3.8	2.8
Cumbria	3.2	2.1
Hull City Region	3.7	2.3
North Yorkshire	2.9	2.3
North East	3.3	2.2
Lancashire	4.3	3.0

Source: Rees et al 2011: 30

Using the 'dependency ratio' to illustrate population changes over the next 25-year period, table 2.5 above suggests that across the northern England this ratio is expected to decline from 3.4 persons of working age to each person over 65 in 2011, to 2.2 in 2036 (Rees et al 2011). The ratios decrease across each of the LEP areas, but there is substantial variation in the size of the reductions. It is projected that the ratios in Greater Manchester and Leeds will fall particularly dramatically, as their younger populations start to age.

Table 2.6 shows the projected impact of demographic trends on the 'working-age' population throughout the north of England, illustrating the effect of ageing and other population trends. It shows that significant labour-force decline is expected in most northern LEP areas during a period in which the overall population is projected to grow significantly (Rees et al 2011).

Table 2.6
Projected labour force, 2011 and 2036

LEP	Working age population (000s)		% change, 2011–2036
	2011	2036	
Greater Manchester	1,170	1,120	-4.3%
Liverpool City Region	635	559	-11.8%
Leeds City Region	1,363	1,391	2.1%
Sheffield City Region	823	801	-2.7%
Cheshire & Warrington	415	398	-3.9%
Tees Valley	320	299	-6.6%
Cumbria	243	250	2.8%
Hull City Region	473	458	-3.1%
North Yorkshire	282	298	5.9%
North East	922	939	1.8%
Lancashire	712	719	1.0%
Northern England	**6,891**	**6,764**	**-4.1%**

Source: Rees et al 2011: 41
Note: The time series starts at 2011 = 100. Constant labour force participation rates by age and sex applied from 2001.

2.3 Summary

- The overall UK population is expected to rise to over 73 million by 2037, with the average age rising from 39.7 to 42.8, and the number of over-80s to double to 6 million (ONS 2013a). This will result in a much older age profile across the UK population.
- It is estimated that the number of people who will be eligible for a state pension will increase by 31 per cent between mid-2012 and mid-2037 (ibid), and that income and wealth disparities within the older population will grow, to the benefit of some and detriment of others.
- The breakdown of the traditional three-generation model of family life, and major changes to intergenerational relationships and transfers of wealth and income, will have significant socio-economic consequences.
- There are important regional variations within these overall patterns of demographic change, with the three northern English regions expected to experience the lowest population growth between 2011 and 2036, and to have the highest dependency ratios by the end of this period.
- Even within the north of England the factors affecting population change vary between urban and rural areas, largely as a result of different patterns of migration.

3. NATIONAL AND INTERNATIONAL RESPONSES TO DEMOGRAPHIC CHANGE

There have been a range of responses to the trends described in the preceding chapter. While at face value the trends look simple to understand, different policy bodies have offered different interpretations and drawn different conclusions, which in turn has contributed to the variety of different policy responses.

In the global policy literature it is possible to identify three broad approaches to ageing – with 'ageing' in this context understood as one of, or a combination of, the following.

- A story about growing numbers of older people, with the focus of policy therefore being on the mobilisation, experience and roles of older people, and on meeting their health and social needs.
- A story about a shift in the balance of the overall population, derived from a number of interacting demographic trends, with the policy focus being on the redistribution of roles, resources and responsibilities across generations.
- A story about increasing diversity, concerning the numerical trends described above and the social changes derived from cohort effects, migration and so on. Here the focus of policy is therefore on issues of personalisation and integration.

These narratives can be discerned in high-level policy statements, and they are fed through into the design and delivery of local programmes and projects.

3.1 International frameworks

The first significant initiative which aimed to deal with an ageing population dates back to 1948, when the government of Argentina submitted a draft declaration on old-age rights to the UN general assembly. It 'contained several articles that referred to rights of older citizens to assistance, housing, food, clothing, health care, recreation and work, as well as to "stability" and "respect"' (UN-DESA 2008: 2). Although it was not adopted at that time, the issue of ageing populations and the approach to older people remained a focus for discussion, and in 1982 the UN adopted the Vienna International Plan of Action on Ageing at the first World Assembly on Ageing, thereby providing the first international instrument for action on development issues of ageing (ibid).

This plan of action identified three priority areas, with its thinking broadly defined by an understanding of ageing as both a social phenomenon with wide-ranging implications, and a question about the role, needs and contributions of the growing older population.

1. Sustainable development in a world exhibiting population ageing
2. The maintenance of good health and well-being in older age
3. The establishment of an appropriate and supportive environment for all age groups (adapted from UN-DESA 2008: 2).

The purpose of the plan was to help governments formulate their policies on ageing by guiding national and international efforts, and by strengthening the capacities of governments and civil society organisations to deal effectively with demographic ageing.

This was followed in 1991 with the UN's 'Principles for Older Persons'. The statement, which was adopted by the UN general assembly to provide a framework for policymakers to incorporate the rights and needs of older people into national development programmes, had a more narrow focus than the previous plan. It focussed on and underscored the contribution that older people make to their societies, and highlighted five quality-of-life characteristics: independence, participation, care, self-fulfillment and dignity (UN-DESA 2008: 3).

A decade later, the Madrid International Plan of Action on Ageing, adopted in 2002 at the Second World Assembly on Ageing, aimed to re-invigorate the political focus on an agenda on ageing, emphasising international cooperation and assistance in this area. This plan has guided the drafting of policies and programmes at the national level, aiming to inspire the development of regional and sub-national plans and providing an international framework for dialogue (UN-DESA 2008: 3–4).

The World Health Organization (WHO) launched its Age-friendly Environments Programme in 2007. It was the first pan-international effort to helps cities and communities become more supportive of older people, by addressing their needs across eight dimensions:

- the built environment
- transport
- housing
- social participation
- respect and social inclusion
- civic participation and employment
- communication
- community support and health services (WHO 2007).

The WHO established the Age-friendly Cities and Environments Network to share their local experiences. A city or community that wants to become a member of this network must commit to continually assessing and improving its age-friendliness, involving older citizens throughout the process.[5] The cities also need their mayor or council to formally indicate their commitment to their localities becoming more age-friendly. Over 200 communities have joined the network, including a 12-strong UK network of age-friendly cities.[6]

3.2 EU-level action

Although limited by a lack of legal competencies, European institutions have mounted a response to demographic ageing though a series of strategic policy documents, creating an agenda for action. Ageing featured strongly in the Lisbon agenda for economic growth, published in 2000, but its priorities were markedly differed from those of the UN and WHO, which took a rights-based approach. The European Council's agenda (EC 2000) focussed on the theme of active ageing policy, and related it to concerns about low growth rates, high unemployment and social exclusion. It called attention to the 'employment deficit' in the 55–65 age cohort, and the ways in which it was contributing to both the weakness of growth rates in the EU economy and the exclusion of many people from society.

5 http://www.who.int/ageing/age_friendly_cities_q_and_a/en/
6 http://www.bjf.org.uk/age-friendly/news/uk-age-friendly-cities-network

In response, the Commission suggested better labour market policies and the establishment of a knowledge-based economy as means of promoting social protections systems which could 'ensure sustainable pension provision within an "ageing" population' (ibid), and greater focus on training, retraining and learning.

A specific EU-wide target was set at the European Council at Stockholm in 2001, which called for a net increase in the employment rate of older workers (defined as those aged 50–65) to 50 percent – a net growth of 5 million (CEU 2002). Furthermore, the 2000 employment directive[7] included provisions requiring EU member states to bring forward legislation to prohibit discrimination on the grounds of age in the labour market no later than 2006.

However, in 2004 the Kok review of the Lisbon strategy criticised a lack of progress towards meeting these objectives (European Communities 2004). The review posited population ageing as one of three main challenges facing the EU economy, and warned that strategies for lifelong learning and active ageing were not being put in place. It recommended that member states develop a 'comprehensive active ageing strategy by 2006', and a timetable linked to the implementation of the employment directive and the 2007–2013 financial perspective (a multi-annual budget) (ibid). He recommended that this strategy should include 'incentives for workers to work longer and for employers to employ and retain older workers; increasing participation in lifelong learning for all ages, especially for low-skilled and older workers; and improving working conditions and quality in work.' (ibid: 34)

Partly in response to the Lisbon agenda, EU institutions have produced several important reports on population ageing. In 2002, a Commission report stressed the potential difficulties of raising labour-force participation among older workers because of attitudes to older employed people and the required changes in policy (CEU 2002).

In 2003, guidelines for the employment policies of member states recommended ensuring access to continuing training, recognising the importance of health and safety at work and eliminating incentives for early exit from the labour market. The gradual raising of the average retirement age in the individual member states was another measure suggested.[8]

In March 2005, the Commission published its broadest EU document on demographic ageing. The green paper 'Confronting Demographic Change' called for a 'new solidarity between the generations', recognising that demographic change had implications for all parts of society, not just older people. It suggested three essential priorities which broadened the understanding of the response to ageing to include an effort to rebalance the demographic trends by promoting active family policies and childcare, and judicious encouragement of immigration; an agenda concerning intergenerational effects, ensuring a balance between the generations in the distribution of the benefits of growth; and finding new bridges between activity and inactivity for both older and younger people (CEC 2005). For the sub-national level, these priorities have also been reflected to some extent in subsequent EU cohesion policy, which aims to help support sub-national responses to demographic changes in regional and urban policy.

7 European Council directive 2000/78/EC, 27 November 2000. See http://eur-lex.europa.eu/LexUriServ/LexUriServ.do?uri=CELEX:32000L0078:en:HTML

8 http://eurofound.europa.eu/observatories/eurwork/articles/2003-employment-guidelines-and-recommendations-adopted

3.3 UK national policy approaches

Until the end of the 1990s, the UK's responses to ageing tended to be fragmented and dispersed across different policy areas. However, attempts to develop a more coherent and integrated policy approach were promoted from 1998, inspired by the Millennium Debate of the Age (MDA), a two-year campaign run by Age Concern England and a range of partners. Inspired by the White House Conference on Ageing, the MDA initiated a national debate which ranged from high-level academic and policy discussion to public debates and events, in an attempt to shift perceptions and highlight the importance of the issue. Focussing on five broad themes – work and lifestyles, paying for age, health and care, values and attitudes, design and the built environment – its aim was to push the issue up the policy agenda and promote a strategic national response.[9]

Subsequent policy responses evolved in response. An important milestone was a report from the Cabinet Office's Performance and Innovation Unit (2000), *Winning the Generation Game*, which set out a comprehensive approach to changing the labour market for older people. It provided a framework for a focus on skills and lifelong learning, changes to the pensions system, and the implementation of the EU employment directive.

This was followed by the 2005 strategy paper, *Opportunity Age: Meeting the challenges of ageing in the 21st century* (HM Government 2005). This was presented as a cross-cutting response to ageing, and offered a programme of policies aimed at mobilising and supporting the growing older population. Commitments made in *Opportunity Age* which were subsequently delivered included the following.

- The introduction of **age discrimination legislation** in employment and training in 2006, implementing the EU employment directive; the creation of the Equalities and Human Rights Commission in 2007 to provide an independent equality body covering ageing; and the promotion of the Equalities Bill, which extended protection against discrimination by giving public bodies the public duty on to promote equality in the fields of goods, facilities and services.
- In the area of **employment and benefits**, reform of incapacity benefit and the introduction of the employment and support allowance in October 2008.
- In **education and training**, the Train to Gain initiative was introduced, accompanied by a range of measures to improve work incentives, including changes to pension rules (including those concerning working while receiving a pension, and pension deferral).
- Commitment to **lifetime home standards** as part of the 2008 'Lifetime Homes, Lifetime Neighbourhoods' strategy.[10]
- In **transport**, accessibility planning was introduced; free bus travel for over 60s was introduced locally in 2006, and then extended nationally in 2008.
- Measures concerning **leisure activities** included free swimming for over-60s in over 80 per cent of local authority pools from April 2009.
- In **care services**, the 'Our health, our care, our say' white paper[11] was published in 2006, and led to the 'Putting People First' social care transformation programme which was supported by an additional £500 million for each financial year between 2008/9 and 2010/11.
- The evaluation report on the **individual budget** pilot programme[12] was published in October 2008, and led to the national roll-out of personalised budgets.

9 See http://www.theguardian.com/society/1999/nov/24/guardiansocietysupplement6
10 http://www.cpa.org.uk/cpa/lifetimehomes.pdf
11 https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/272238/6737.pdf
12 http://www.york.ac.uk/inst/spru/pubs/pdf/IBSEN.pdf

- In terms of a greater focus on tackling **pensioner poverty**, the Pension Service was developed as the Pensions Disability and Carers' Service, which launched in April 2008.
- Pilots of **joined-up working** and preventative services (Link Age Plus[13] and Partnerships for Older People Projects [POPPs][14]) were completed and evaluated.

These initiatives were supported with a **stronger framework of governance**, including a cabinet committee responsible for a public service agreement which set out a commitment to older people's wellbeing as a top government priority. However, while *Opportunity Age* had grand aspirations, many of them were never realised. While the period between 1997 and 2005 was seen by many as an exciting phase for those involved in ageing policy, this 'mainstreaming' of ageing policy tailed off after 2005, when lead responsibility for it passed from the Cabinet Office to the Department for Work and Pensions. This had the effect of narrowing the focus of ageing policy onto employment and social security issues.

Nevertheless, with the completion and evaluation of this programme, a further paper, *Building a society for all ages* (DWP 2009), was published in 2009. This paper put forward a broader vision which went beyond issues of service delivery and the mobilisation of older people and began to put into place a societal approach to ageing, organised around a number of themes.

- **'Having the later life you want':** promoting and supporting whole life planning and preparation for later life through financial security and social support networks, including the creation of an interactive 'one-stop shop' for helping people plan ahead and make decisions on a range of issues, from financial affairs to health concerns to opportunities for leisure and learning.
- An **'Active at 60'** package to build confidence, promote healthy ageing, education and training and provide information about lifestyles and relationships, supported by an all-in-one smartcard.
- **'Older people at the heart of families':** recognising the role that grandparents play in families, and looking to further support this role by strengthening intergenerational relationships and care-giving, and also supporting those older people who are caring for both older and younger relatives at the same time.
- **'Engaging with work and the economy':** continuing the programmes of work to boost labour market activity, including by abolishing the default retirement age, promoting entrepreneurship and self-employment, and seeking to develop older people as intergenerational mentors.
- **The grey market:** the creation of an 'innovation and growth team' of experts from academia, business and the age sector to promote business development, design and marketing to improve the focus and supply of goods and services.
- **'Improving financial support':** reintroducing the link between earning and pensions to maintain older people's standard of living, and a continuing focus on improving the quality of private pensions available and the targeting of pension credit.
- **'Better public services for later life':** strengthening the focus on lifelong physical and mental health promotion to improve health in older age, and greater focus in the care system on ameliorating the impact of conditions of old age to promote independence.
- **'A Good Place to Grow Old':** for the first time, the development of a programme through a national agreement with local government to promote the importance of ageing issues at a local level, and provide funding to test

13 https://www.gov.uk/government/collections/linkage-plus

14 http://webarchive.nationalarchives.gov.uk/+/www.dh.gov.uk/en/SocialCare/Deliveringadultsocialcare/Olderpeople/PartnershipsforOlderPeopleProjects/index.htm

new and innovative approaches to delivering local services for older people. This became known as the Ageing Well[15] programme.

- A linked programme, 'Building communities for all ages', aiming to use a £5.5 million Generations Together programme to fund 12 intergenerational demonstrator pilot projects with the aim of stimulating strengthened intergenerational relationships and challenging stereotypes (adapted from DWP 2009).

This strategy was not unimplemented due to the change of government in 2010. The Coalition government has not published a cross-cutting strategy of this kind, and has adopted a different approach to the ageing agenda. Key initiatives which it has put into place include:

- following through on the abolition of the default retirement age in 2012
- protecting key aspects of the social protection framework, including pensions, free travel passes, and cold-weather payments, at a time of austerity and cuts in other public spending programmes
- the reintroduction of the link between pensions and earnings.

The lack of action and urgency at a national level, particularly since 2005, has transferred many of the challenges of an ageing population to local government and its partners. However, there remains no national strategy, and no specific resource allocation to support this work.

15 http://www.local.gov.uk/ageing-well

4. ACTION AT LOCAL AND REGIONAL LEVELS

Approaches to ageing policy at the sub-national level broadly fit into one of two categories.

1. **Programmes and projects developed to respond to funding programmes.** In most cases these programmes have been supported through European structural or transition funds, or as projects responding to national policy directions with central departments, often in the area of health. These initiatives tend to be quite limited in scope, or time-limited within the constraints of funding timetables, but larger in terms of free resources. However, there seems to be little evidence of effective mainstreaming into core resources from many of these, and many of the projects expire with their funding.
2. **Mainstream programmes designed within core resources.** These initiatives tend to be more evolutionary, place-based and embedded in core funding programmes, and as such tend to be strategic rather than funding-led approaches. Because of this, they tend to operate over longer timescales and require more time to deliver changes, which are often difficult to attribute to a specific programme; indeed, many appear to operate within individual services. The most effective programmes in terms of surmounting this 'departmentalism' appear to be those that involve strong engagement of external actors, or user engagement. In addition to core and departmental finance, they seek to access external resources such as those highlighted above, which prove to be useful resources for experimentation and strategic development. Engagement in national and international networks, such as the Healthy Cities Network,[16] provides further opportunities for collaborative learning and experimentation.

Common to both of these approaches are, broadly speaking, three motivations. Some programmes and strategies focus on how to keep down the costs of ageing borne by the state. Others focus more on how to benefit the silver economy by attracting the silver pound and inward investment, and commercialising innovation linked to ageing and the rapidly expanding silver market. A third set of motivations concentrate more generally on how to make cities better places to grow old.

These three motivations are not mutually exclusive. Leeds, for instance, with its 37 'neighbourhood networks' which support older people to take part in a range of social and cultural activities, focusses on both keeping costs down and making the city a better place to grow old. Newcastle, on the other hand, wants to make the city as age-friendly as possible through its Elders Council,[17] but is also aiming to incubate and market innovation in ageing through its Campus for Ageing and Vitality.[18] The best city ageing strategies should aim to make progress on all three fronts.

Many of these localised examples are linked to international programmes. For example, the WHO has developed an extensive Global Network of Age-Friendly Cities and Environments programme,[19] and as a result numerous developed nations have taken a city-regional approach to addressing issues of population ageing.

16 http://www.healthycities.org.uk/
17 http://www.elderscouncil.org.uk/
18 http://www.newcastle-hospitals.org.uk/hospitals/newcastle-general-hospital.aspx
19 http://www.who.int/ageing/age_friendly_cities_network/en/

Other cases have been led independently from within cities or regions in response to identified opportunities or challenges, and have been supported either by the allocation of mainstream resources or by accessing external funds, for example from European or national programmes.

This chapter sets out five case studies highlighting good practice in this field.

4.1 International city strategies

Case study 1

Brabant: smart health and innovation

The province of Noord-Brabant is in the south of the Netherlands, and borders Belgium to the south-west and Germany's North Rhine-Westphalia state to the east. Noord-Brabant is home to about 2.4 million people (EPRC 2006). It is a polycentric region with five medium-sized cities – Eindhoven, Tilburg, Breda, Den Bosch and Helmond – surrounded by a large number of close-by smaller settlements, with small rural territories in between. As with other provinces in the Netherlands, it has two levels of governance. Each province has significant responsibility for strategic-level functions such as transport and planning. There are also elected local municipalities which are responsible for local service provision. In Brabant, significant coordination functions and collaborative programmes are evident across a range of economic and social issues.

There have been three distinct phases in policy responses to demographic ageing within the province. These date back to the late-1990s, when the province introduced an €800,000 a year Vitality in Age programme. Its stated aim was: 'the retention of independence among older people and the increased influence of older people themselves'. Its primary activities were a range of smaller projects with local groups on issues such as computer literacy, safety and crime prevention, and better housing for older people. (EPRC 2006)

This was followed by a further phase of work which focused on raising awareness of demographic ageing within municipal government and civic society more widely. The Brabant *Between Rejuvenation and Demographic Ageing* initiative ran for the years 1999–2003, during which period time the provincial executive set itself six goals:

- *'to explore and clearly portray the consequences of demographic trends*
- *to share with others the knowledge and research results*
- *to bring about awareness and a change in attitudes (including drawing attention to ageing among ethnic minorities in the province)*
- *to explore, and help, other innovative initiatives responding to demographic trends*
- *to draw up a picture of what the role of the province should be so that Noord-Brabant would be better prepared for the future*
- *to expand internal knowledge of demographic ageing within the Provincial Executive (including making population ageing part of the agendas of individual policy departments).'*

EPRC 2006

An evaluation in 2003 reported that these goals had largely been achieved. The evaluation showed that it had been particularly successful in highlighting the challenge in rural areas and the economic opportunities (EPRC 2006).

Noord-Brabant became active in the pan-European Silver Economy Network, which was led by North Rhine-Westphalia and involved a number of regions across the EU, and which aimed to benefit from the economic opportunities of ageing. Noord-Brabant's particular focus has been to embed ageing within the wider innovation strategy for the region. As an example, the *Brabant Region of Smart Health 2020* sets the ambition to address demographic ageing through innovation, with the goal of easy independent living at home and healthy ageing.

This programme has been accelerated since 2013 with the aim of developing new products and services for citizens over a focussed two year programme. It is facilitating several regional networks that are already active in the field of Active & Healthy Ageing aiming to bring together municipalities, health insurance companies, health and social care organisations, housing corporations, user organisations, companies and knowledge institutes to identify ongoing issues and to take a problem solving approach. In this context it is supporting experimentation and open innovation in the following areas:

- **dementia:** stimulating crossover innovation in health care through collaboration between the public sector and innovative SME solutions
- **self-management and informal care:** raising awareness among all stakeholders and gather evidence on the impact of the use of innovative services and platforms
- **eHealth:** create a sustainable digital infrastructure and stimulate the wide-scale deployment of eHealth solutions.

It is also engaging in European regional networks such as European Innovation Partnership on Active & Healthy Ageing (EIPAHA) and focussed networks on themes like assisted living.

The experience in Noord-Brabant is an interesting example of a developmental and evolutionary approach with mainstreamed approaches and innovation emerging from an initial narrow focus. It illustrates clearly the long term nature of the issue and the value of ongoing evaluation and strategy development as the parameters and localised impacts of the issue are identified and understood. It also demonstrates the benefit of involving users in the development of the programmes, but also being able to recognise wider impacts, risks and opportunities which would not necessarily derive from the immediate group engaged.

Case study 2

Livorno – 'A Knowledge Province for Seniors at Work'

The province of Livorno in Italy, a polycentric area in west Tuscany, has been working on a succession of European funded programmes to promote active economic activity among the over 50's over the two programming periods between 2000–2007 and 2007–2013. This is in response to an ageing population in the region caused by enhanced longevity and declining birth rates. Livorno is 'characterized by a strong local diversified economy, with the interweaving of various productive specialisations, and a labour market that… [has] maintained stable levels of employment and lowered explicit unemployment' (Breidahl et al 2008: 12).

The focus of local strategies for active ageing is based on continuous training and lifelong learning for the over 50s, and the programme sits within a broader Local Employment Action Strategy. The broader strategy has targeted actions at four target groups; the young, women, workers with atypical contracts, and senior workers (Daman 2007: 11). The project 'Livorno : a knowledge province for seniors at work' has focussed on the promotion of a knowledge-based labour market which can maintain senior workers from the production sector in work, by taking action to prevent them from becoming redundant and supporting the return of those who have lost their jobs for whatever reason to return to work. As well as involving local private and public sectors, it has learned from transnational relationships with partners from Belgium, Ireland and Denmark, (ibid: 11) and an evaluation report or the work up to 2007, published in 2008, reports on the programmes carried out across the four countries (Breidahl et al 2008).

In Livorno, the key activities in the programme to 2007 were:

- personalised and flexible vocational training courses
- the establishment of a helpdesk to give career advice and support to the over-50s
- encouragement for senior apprenticeships

- financing for business start-ups (adapted from Daman 2007: 11).

Particular attention was given to the different needs of older men and women (ibid).'The project has offered older workers the opportunity to redesign a conscious plan of life and career with the support of operators, facilities, tools that have helped make them active, conscious and competitive' (Breidahl et al 2008: 12).

The project has been led by the province of Livorno, who provided leadership, partner coordination, political relationship management at all levels, and the commissioning framework. However, the programmes themselves have been delivered through other bodies and organisations.

- **Public authorities** – acting to shape local services to be conducive to employment of older workers and providing guarantees to support creation of businesses and jobs for the over-50s.
- **Equality bodies** – who contributed to the implementation of gender policies through the promotion of potential employment of female older workers.
- **Trade associations** – who contributed to engagement of the target audiences, paying particular attention to the identification of more professional backgrounds in the local market.
- **NGOs** – acting to promote agreements aimed at ensuring the balance between flexibility and security.
- **Permanent territorial centres** – responsible for adult education, used their structures and human resources to implement programmes of employability training activity for the over 50s.
- **The University of Florence** was engaged as the scientific coordinator, providing evidence and monitoring the development and delivery of the work (Breidahl et al 2008: 14.

Since 2007, the main focus for the programme has been job creation, and linking across to wider programmes of social inclusion, integration and intergenerational relations. Among the first projects approved under the programme and added to the work programme was one designed to promote better-quality employment experiences: 'Better jobs for 50 plus', which learned from other European experiences of attempting to improve the quality of labour-market participation of workers over the age of 50.

Case Study 3

Toyama Comprehensive Welfare Plan for the Elderly

Japan's Silver Human Resources Centres provide a good example of how institutions can help match up older talent with work opportunities, thus ensuring that this available talent is better utilised. Of all countries, Japan is experiencing demographic ageing at the fastest rate. Since they were initiated in Tokyo in 1974, the network of Silver Human Resources Centres[20] has grown rapidly, with the aim of creating 'dynamic communities and to support meaningful and fulfilling lifestyles for older persons through the provision of appropriate work opportunities' (ILCJ, no date) for those aged 60 or over who want to take them up.

The centres offer a new framework for older people to work in the community, and were consolidated as a national initiative by a law passed in 1986. Today there are Silver Human Resources Centers in about 1,600 municipalities throughout Japan.

The International Longevity Centre Japan describes the work of the centres as follows:

20 Source to International Longevity Centre, Japan website

'Each Center is contracted work by corporations, households, public organizations, and others and then it allots the work to its registered members based on the work content, frequency, and volume. Members receive a financial disbursement from the Center calculated based on the content of the work they performed and the number of hours they spent.'
ILCJ, no date

The work that the centres undertake can be roughly divided into seven categories, including:

- indoor and outdoor general work (for example cleaning parks, weeding gardens, or security and cleaning)
- facility administration (such as car parks, schools and community centres)
- office work (general office work, reception work, addressing of envelopes)
- Specialised work (bookkeeping, translation, computer programming)
- Customer services (reading of meters, delivery services, sales)
- Public services (traffic control, housekeeping)
- Technical skills (Gardening, carpentry, repairs) (adapted from ILCJ, no date).

Some centres offer classes and training programmes to their members to enable them to engage in a wider range of work opportunities. These can be varying lengths depending on members' job aspirations, and include highly specialised roles such as nursing and other care services. They commonly offer housekeeping and childcare, as well as mentoring for other older people (ibid).The City-Region of Toyama was created in April 2005, by bringing together previous administrative arrangements across Toyama and a number of surrounding towns and cities, in order to create a coherent strategy of managed change and critical mass at a time of and ageing and declining population (Kono 2008). As a result of this combination of factors the city was experiencing significant decline in population density and the agricultural industries which were key to its local economy were struggling to maintain a labour force (ibid). Through a combination of urban redesign around transport routes and improved public transport and the environmental and housing offer, the city administration has managed to concentrate its population in a smaller area, supporting the sustainability of the city centre economy and community, and reducing the costs of travelling and environmental degradation. Alongside, there has been a strategy to maintain the agricultural sector and food security by linking farms in the surrounding areas more strongly to farmers who have located themselves in the city. And a third strand of the city strategy has been about the mobilisation of the older population of the area.

Within this context, the Toyama Comprehensive welfare plan for elderly has been created for the period 2012–2014 with the aim of using the older population to fill gaps in the labour market through Silver Human Resources Centres. One of the key approaches has been to deploy older workers through a specialized Silver Human Resources Centre, enabling the replacement of retiring farmers with a new source of labour from among the over 65 population. One particular initiative has been to link the ageing workforce agenda with the agricultural agenda through a focus on growing medicinal ingredients designed to maintain health for people of all ages through a Health Longevity Centre. This has also been linked to the development of a cluster of research assets within the city on experimental nutrition and molecular biology.

4.2 UK city strategies

The UK is known to be one of the most centralised nations in the developed world, and many of the main policy drivers of economic development, employment, health and social care are held by central government.

However, some cities which have developed their own strategies for addressing issues of ageing. Furthermore, beyond these leading examples many other cities

and towns have shown interest in and commitment to working in this area, driven by the growing realisation that these issues are genuinely important to the future of their local economy and civil society. It is also the case that there is little policy direction coming from the UK government to deal with this issue, so local areas have had to take their own initiatives.

As with the international case studies highlighted above, those that have been most successful in implementing ageing strategies have cited long-term and sustained high-level political commitment as being an essential component of their success. This has certainly been instrumental in the success to date of the strategies of Manchester and Newcastle – the two English cities internationally recognised as having exemplary 'age-friendly strategies'.

Manchester declared itself an age-friendly city as the next step of its 'Valuing Older People' strategy, which was launched in 2003 (MCC 2014: 79). In Newcastle, a strong collaboration between Newcastle University, the NHS and the local authority has seen the development of a strategy for innovation around the themes of ageing and health, linked to Newcastle Science City. While these are ground-breaking initiatives, even they have remained disconnected from some of the wider strategic approaches being taken forward in their cities, –for example, on economic development of wellbeing, an issue that both are seeking to address at present.

Case study 4

Manchester – a great place to grow older

Manchester was the first UK city to be accepted into the WHO Global Network of Age-friendly Cities in 2010, and has a ten-year strategy, 'Manchester: A Great Place to Grow Older', which sets out how it can become a more age-friendly city, where older citizens have a high quality of life and have a key civic role in the city (MCC 2014). Manchester has perhaps done more than any other UK city to ensure older people input into the broadest possible range of the city's projects.

The Age-friendly Manchester Older People's Board (formerly the Valuing Older People board) and a dedicated multi-agency staff group make sure that older people have a voice in a broad spectrum of the council's work. There is also wider consultation through the Manchester Older People's Forum, which has a membership of around 180 and meets three times a year. The programme has taken a 'citizenship approach' to ageing, as opposed to medical and care approaches. This is set out below in table 4.1.

Table 4.1
Comparison of citizenship-based, medical and care policy approaches to ageing

Medical	Care	Citizenship
Patient	Customer	Citizen/rights to the city
Focus on individual	Focus on individual, family and informal networks	Focus on neighbourhood and city
Clinical interventions	Care interventions	Promoting social capital and participation
Commission for 'frail elderly'	Commission for vulnerable people	Age-proofing universal services
Prevention of entry to hospital	Prevention to delay entry to care system	Reducing social exclusion
Health (and care system)	Whole system	Changing social structure and attitudes

Manchester council's efforts to ensure that policymaking across its work is better joined up is benefitting older residents. Examples of this work include the following.

- A **positive images of ageing campaign**, which has included taking over city-centre advertising sites, and producing exhibitions and calendars that challenge ageist stereotypes.
- The city's **cultural offer for older people** which features 20 city arts and heritage agencies working together to extend older people's involvement in cultural production and planning, targeting the most vulnerable and excluded.
- The **age-friendly locality programme**, which involves setting up networks of frontline staff groups, providing small grants and giving older people a voice in local decision-making.
- A range of **demonstrator neighbourhood projects**, most notably the Age-friendly Old Moat project. Funded by Southway Housing Trust, this project used a range of participatory research methods to explore spatial and social aspects of ageing to draw up a partnership plan of action.

The council recognises, for instance, that the health and care system needs to play a part in helping people move into work and remain in work, as employment is a key determinant of health. The out-of-work population has a 20 per cent higher rate of preventable deaths, and one in seven unemployed men is diagnosed with clinical depression within six months of losing their job (Eeckaelaers and Regan 2014). A strong economy and a healthy population are mutually reinforcing and therefore better integrating work and healthcare programmes can have real benefits. Older workers naturally are among the largest beneficiaries of such an approach. This approach can, however, run up against challenges created in coordinating actions by multiple bodies – the council, the combined authority, CCGs and DWP.

Manchester is trialling having GPs send patients who have been off work for two weeks to a 'fit for work' service run by the council. The motivation behind the service is to minimise the risk of that person falling out of the workforce permanently, and where possible to speed up their journey back to work. A whole personal assessment is done of the patient's needs and they can then be prescribed with any of (or a combination of) fast-tracked physiotherapy sessions, debt and relationship support and brokering with employers workplace changes for when the patient is ready to return to work. There is a similar service tailored for those unemployed and with a health condition. Some have passed the work capability assessment test but can benefit for instance from basic skills courses and a focus on increasing confidence skills.

The University of Manchester also has a research institute, the Manchester Institute for Collaborative Research on Ageing (MICRA), which promotes innovative research on all aspects of ageing. Its aim is to bring academics, policymakers and older people together to bridge the gap between academic research, and policy and practice.

> *'Manchester has established itself at an international level as a leading authority in developing one of the most comprehensive strategic programmes on ageing.'*
>
> John Beard, Director, Department of Ageing and Life Course, World Health Organisation

Case study 5

Newcastle – 'Everyone's Tomorrow'

In 2007 Newcastle city council published the plan *Everyone's Tomorrow*, alongside the Elders Council of Newcastle and the Quality of Life partnership, with the aim of making Newcastle more age-friendly (NCC 2007). The Elders Council is a key part of this and meets every two months, with as many as 800 older citizens attending its meetings.[21] Newcastle University has done a lot in developing innovation around the theme of ageing. While it has yet to have a major breakthrough in commercialising its

21 http://www.elderscouncil.org.uk/

research, it has an aspiration to develop an internationally renowned cluster on ageing expertise in the same way that London has its financial services and Aberdeen has oil and gas. It attributes its success to date to starting early, first in medicine in the 1960s, before expanding out to social sciences dealing with ageing. However, the jewel in its crown is the world's first Campus for Ageing and Vitality. Other European cities are now starting to catch up, particularly in the Netherlands.

One area in which cities often could do more is working with local business community to show them the economic benefits that age-friendly cities could deliver for their businesses. Newcastle through its *AdvantageNewcastle* and *Changing Age for Business* projects has tried to do this. The projects managed by Newcastle Science City and the University respectively have been helping business leaders within the city region to work out how they can gain a competitive advantage through placing more focus on the ageing population.

Newcastle University has tried to help businesses take advantage of the opportunities linked to ageing. Its original model was to use academics on a consultancy basis. Now they make use of intermediaries who are cheaper than academics, interested in real world solutions and speak both the languages of academia and business. The university also provides public input into the research process. It recruits experienced older people to help shape researcher's research, including what they are researching and how to make the research as useful as possible. Businesses also want to understand how to market their products to older consumers.

5. THE SILVER ECONOMY
REALISING THE OPPORTUNITY

Each of the case studies in the previous chapter demonstrates the importance of adopting both social and economic approaches to demographic change, which typically stand in contrast to – or alongside – medical or health-and-social-care approaches.

Drawing on these case studies and other specific examples set out below, this chapter attempts to set out three different ways of understanding the as-yet untapped potential of the growing older population: as producers, as consumers, and as investors.

5.1 Silver producers

There has been a substantial increase in the number of older workers over the past two decades, and this trend is getting stronger. The employment rate of workers aged between 55 and 64 in the UK has increased markedly in recent years (Eurostat 2014: 3). The employment rate among those aged 65 and over has increased faster still, and has grown faster than that of any other age group over the last decade. The number of workers working beyond the state pension age nearly doubled from 753,000 in 1993 to 1.4 million in 2011 (ONS 2012). A variety of factors have contributed towards these increases – from improved health and wishing to remain active in society, to more people experiencing financial burdens which leave them with no choice but to keep working.

The average older worker differs in a number of ways from other workers. Older workers are far more likely to be self-employed. Equally, they more often tend to be working part-time: around two-thirds of workers above state pension age work part-time, compared to 25 per cent of those below that age (ibid). While larger employers such as B&Q or BMW tend to be thought of as being the most older-employee-friendly (as is discussed below), older workers are in fact more likely to stay on in smaller firms.

BMW: adapting its workplaces for older workers

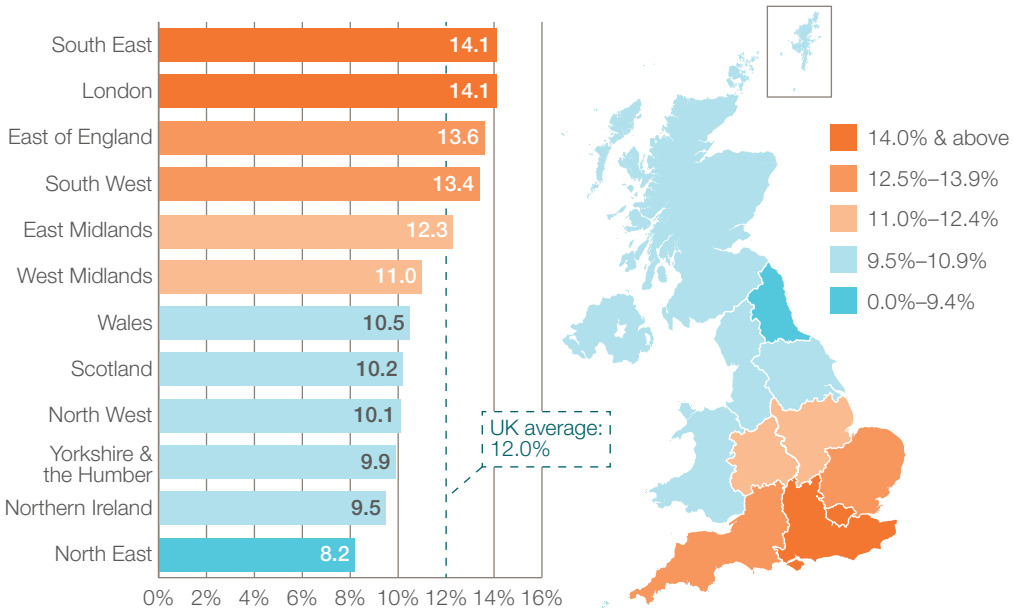
While many companies have adapted their workplaces for older workers, BMW have been able to quantify the benefits of doing so. Their efforts highlight the fact that small and relatively cheap changes can reap substantial benefits. BMW made 70 small but wide-ranging adjustments, such as orthopaedic footwear and adjustable work tables, to one of their plants, at a total cost of approximately €40,000. This led to defects on the line being reduced to zero, decreased absenteeism, and an overall rise in productivity of 7 per cent. These changes to the physical work environment were implemented alongside better health management and training, options for phased retirement, and more flexible working models. For instance, workers have a 'full-time select' option which allows them to take up to 20 additional days of leave each year (Erfurt et al 2012).

There is a clear gender divide in terms of the typical job held by older workers. While two-thirds of men working above the state pension age had jobs classed as higher skilled, the same proportion of female workers were in lower skilled jobs (ONS 2012). Women are also more likely to have to balance work with caring responsibilities (or give up work altogether for this reason). Nonetheless, it is

women who have largely driven recent increases the in employment rates of people in their 50s and 60s (Ben-Galim and Silim 2013).

As with other aspects of our analysis, there are significant spatial variations to these overall patterns. The South East and London, closely followed by the East of England and the South West, have the highest employment rates among those above the state pension age. The three northern regions, on the other hand, are in a much less developed position, with the lowest rates of employment among older people of the English regions. There are distinctive population issues for northern regions which explain these statistics, which reflect the long-term demographic consequences of its industrial history in terms of skills and health profiles, and the consequences of the economic transition which, over the last few decades, has caused many older workers to become unable to use their skills.

Figure 5.1
Older worker employment rates by UK region, 2010/2011



Source: ONS 2012

Are older workers keeping the young out of work?

The alarming rise in youth unemployment has been the one of the most visible trends of the recent economic downturn. By contrast, older workers seem to have weathered the recession much better. Delving underneath the headline figures, however, shows that the picture is somewhat more complex. While the UK employment rate of workers aged between 55 and 64 has increased, it continues to be much lower than the overall employment rate of the total workforce. In particular, for those unfortunate enough to become unemployed, the picture is much less rosy for older citizens. Almost half of those over-50s who are unemployed have been out of work for more than a year, compared with a quarter of unemployed 18-to-24-year-olds (ONS 2013b).

Long-term effects can be obscured by shorter-term policy concerns. Youth unemployment is rightly a key concern for policymakers at the moment, but that should not mean that responding to the changing shape of the labour market, which is impacting every country within the OECD as a result of ageing, should become less of a priority.

The idea that older people working longer locks younger people out of the workforce is based on the fallacy that there is always a fixed amount of work to be done. It is possible that in individual cases, an older worker staying on might prevent a younger

worker taking a specific job. However, they will not always be competing for similar roles, and more importantly, the more people are in work, the more consumers with money there are. This in turn leads to growth in the economy and the potential for more jobs. For instance, in the US the National Bureau of Economic Research could not find any evidence of older workers taking jobs away from younger ones (Erfurt et al 2012). Researchers in Canada and France found evidence that greater workforce participation among older people was associated with greater participation among young people, due to the increase in the overall economic pie (Baker et al 2010). Trying to play one generation off against another is not only unhelpful, but is based on false economics. The role that older people play in looking after grandchildren while their parents are out at work highlights the importance of intergenerational cooperation in modern society.

Recent changes to employment support allowance (ESA)/incapacity benefit (IB) have increased the pressure on inactive sick and disabled claimants, which means that we can expect more people to register as jobseekers or enter the workforce. Since about half of current ESA/IB claimants are over 50, many older people have been compelled to re-enter the labour market. There is a real danger that many will struggle to find jobs and be left in a precarious financial position.

Becoming or remaining an employee is not the only option for remaining in the workforce. Senior entrepreneurship is at its highest level ever, with approximately 600,000 individuals over the age of 50 engaged in early-stage entrepreneurial activity (Levie at al 2013). As highlighted by N8 research, there is significant potential for start-ups by the over 50s to capitalise on the business opportunities arising from demographic change and an older population, if given the right support (Cannon and Kurowska 2011). This is particularly true of the lifestyle, tourism and leisure, life enhancement and assisted-living markets. 'Olderpreneurs' also tend to be more successful in terms of start-up survival rates: 70 per cent of start-ups founded by older people were found to last longer than three years, in contrast to only 28 per cent of those created by younger entrepreneurs (Patel and Grey 2006). One representative survey of 46–65-year-olds found a seven-fold increase in those wanting to start up a new business venture relative to their parents' generation (Standard Life 2009). There would be potential for the number of older entrepreneurs to grow much higher, if they were given the same access to seed capital and funding that younger entrepreneurs have. Would-be 'olderpreneurs' often are confronted by age-limits for financial products and higher interest rates for loans, or excluded from insurance products (Erfurt et al 2012).

'Olderpreneurs': case-studies

The Prince's Initiative for Mature Enterprise (Prime)[22] has helped a large number of unemployed people over the age of 50 to start their own businesses. The case studies below give a sense of the breadth of the enterprises started by older people, and the individual circumstances and misfortunes that ultimately led to their creation.

Anne Williams (59, from Stamfordham, Newcastle upon Tyne)

Anne was made redundant from her last job. Having begun her career with Proctor & Gamble, and since worked at BBC TV Newcastle, the National Trust and AQA, Anne decided to use her considerable project-management, secretarial and PA skills to start a virtual personal assistant business, LinchpinPA.

Running the business from home, Anne has been able to secure 20 clients, two of whom she works for on a daily basis. To further boost her business, Anne secured funding from the North East Rural Growth Network for marketing support, and has since been asked to be a guest blogger for Clarand Accountants. She also has close relations with Colleagues on Tap, a network to help home-workers.[23]

22 http://www.prime.org.uk/

23 Adapted from http://www.prime.org.uk/everyone-needs-a-linchpin/

Tony Palmer (58, from Basildon, Essex)
At the age of 52, Tony was hit by a double blow: he was made redundant, and was diagnosed as suffering from myalgic encephalopathy (ME). Despite applying for a number of opportunities he never found a new job, and decided to cash in his pension to fund a glass-engraving business – Crystal Mountain Glass.

After getting advice and support from Prime, attending workshops provided by HM Revenue and Customs on tax, and joining a local business club, Tony has been able to make Crystal Mountain Glass into a sustainable business. Working from his workshop located in his home, Tony exports to countries across the world, including New Zealand, Australia, the Caribbean, the US and Canada. He has also produced awards for Transport for London, the Greater London Authority and the Child Poverty Unit in Whitehall.[24]

David Buck (59, from Bolsover, Derbyshire)
David was a fitness instructor, but doctors advised him to give it up as he was causing permanent damage to his knees. Fitness had been a major part of David's life, so when he was looking at his options he decided to turn his hobby of microlighting – flying small aircraft – into a business, offering trips and lessons to paying customers.

After a staggered start, Microlight Flights has taken off, and David has gone on to establish a successful business, employing several people and investing in a state-of-the-art flight simulator to help train his clients how to pilot a microlight aircraft. David wants to continue to grow the business and has future plans to add two more aircraft to the flight school and further develop his simulator to a full-motion one with a wrap-around screen, which would make it the first of its type in the UK. Furthermore, David is developing new headsets for his microlight aircraft, as well as looking to sell the on-board camera system unique to Microlight Flights, which was developed by a successful entrepreneur from the TV show 'Dragons' Den'.[25]

Beyond simply keeping them in work, the accumulated knowledge of older people can and should be better harnessed within the workplace. Older workers have often built up a vast amount of experience from working in the same or similar fields for many years. This expertise is not being properly utilised in workplaces, and by society at large. We need to look at how we can start to make the necessary cultural shift to ensure that this under-utilised knowledge is better understood and fully made use of. This can range from informal mentoring through to more structured training.

Flexible working and wider social contributions

Older people obviously contribute to wider civic society in many ways other than through employment, including the contributions they make as carers and as grandparents (which will be outlined later in this report). In fact, 55 per cent of people in their 60s and 28 per cent of those in their 70s volunteered or provided unpaid care in the last month (Lawton 2013).

Too many workplaces and jobs continue to be organised around the ideal of a full-time employee who has no caring responsibilities or health issues. The actual workforce, by contrast, is growing ever more diverse. This creates a mismatch, which in turn leads to lower workforce participation rates and increasing numbers of people becoming marginalised in lower quality jobs as they are unable to fit this full-time ideal (OECD 2006). When asked about their aspirations for their long-term futures, a representative sample of 46–65 year olds stated that they wanted to continue to be involved in work but on their own terms (Standard Life 2009). Making employment work for older people in this way is key to keeping more of them in the workplace for longer. This might be achieved in part by adapting the workplace to allow for their reduced agility, and though providing them increased flexibility to continue working efficiently but balance this with other demands such as caring for relatives.

24 Adapted from http://www.prime.org.uk/success-is-crystal-clear-for-entrepreneurs-glass-business/
25 Adapted from http://www.prime.org.uk/david-sets-up-a-flight-business-that-soars-to-success/#more-10402

Killby & Gayford's flexible working

The construction firm Killby & Gayford has made use of a number of flexible working options to retain the skills and experience of older workers, including:

- part-time working for later phased retirement
- a pool of skilled retired employees to provide holiday cover, as a better alternative to agency workers
- ad hoc consultancy contracts to retired, professionally qualified employees
- flexible working to help employees who are returning to work after serious illness, or supporting them through periods of care for ill relatives.

The firm has found that employing workers on a flexible basis – whether part-time, on condensed hours or working on a project specific –makes real business sense. It allows them to make a bigger return on investment in training and development, and benefit from retained skills and knowledge (HM Government 2012).

5.2 Silver consumers

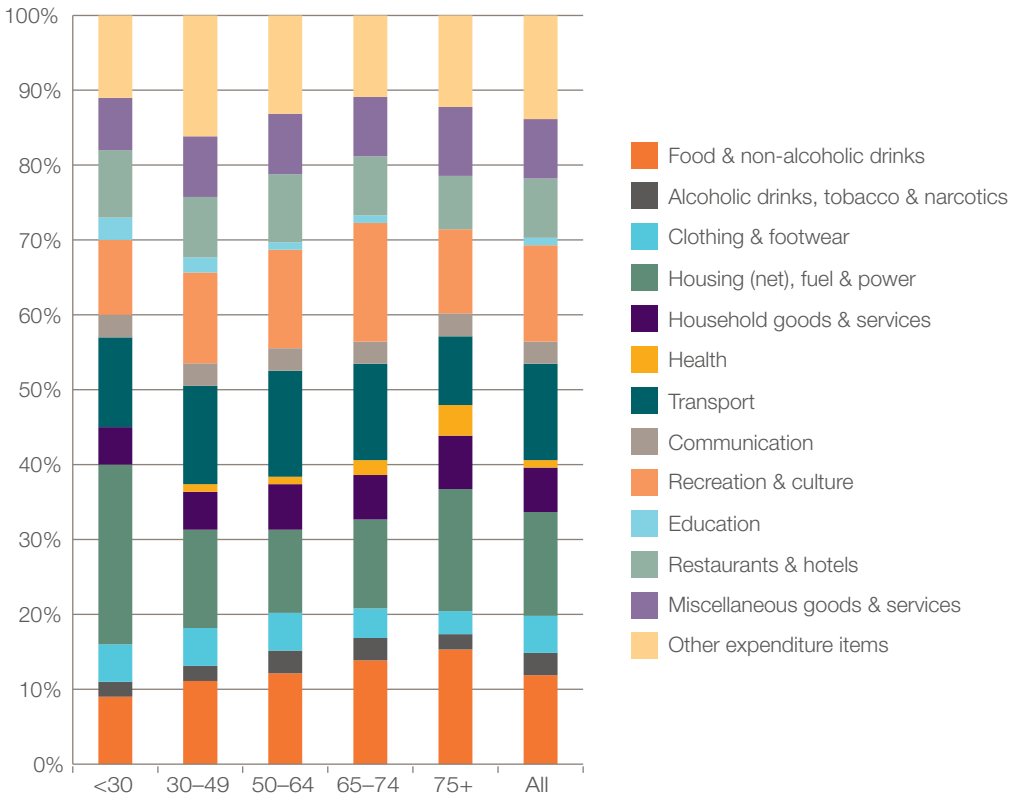
Statistics are often quoted showing that older people own the lion's share of private wealth in the UK, but there is also evidence that they are spending it. The older population is responsible for 40 per cent of consumer demand in the UK, spending £200 billion per year, yet they only attract 10 per cent of the marketing spend (Harper 2009). A 2010 survey found that 39 per cent of over-65s thought that businesses had little interest in their consumer needs (Age UK 2014). In fact, over the past two decades, consumption by Europeans aged 50 or over has risen three times as fast as that of the rest of the population (Deloitte 2009: 8).

Of course, older consumers are not a homogenous group. In terms of different cohorts, average household wealth peaks in the 55–64 age group, and then slowly falls among older cohorts (ONS 2014a). Much of this fall is due to reducing pension wealth. In terms of financial assets, households headed by an older person hold considerably larger sums. Average net financial wealth peaks among households headed by someone aged 55–64 (£18,000), and although it falls to £10,000 for households with a head aged 85 or above, this is still much more than, for instance the 35–44 year old cohort (£2,500) (Daffin 2009: 33). It is therefore difficult to understand why most businesses make a clear distinction between 20-year-olds and 40-year-olds, yet lump 50- and 70-year-olds together into the same category.

When people think of the silver economy, they immediately think of the obvious sectors – healthcare, pharmaceuticals and adapting homes for independent living. An overlapping high-growth market is that of health and wellbeing, with more people wanting to live healthier for longer. However, older people constitute large proportions of consumers in many other broad sectors, particularly leisure and tourism, financial services, consumer goods, food and beverages, retail and technology. Households with a head of household aged between 50 and 64 spend more on both health and recreation than any other age category (Skentelbery 2008: table A13). Over 50's in the UK buy, for instance, 80 per cent of all top-of-the-range cars, 50 per cent of skincare products, and 80 per cent of leisure cruises (ActiveAge 2012).

The proportions of household expenditure spent on some goods and services vary quite considerably between different age groups, as table 5.2 below shows. Food and health account for an increasing proportion of household budgets as people get older. The proportion spent on recreation and culture, by contrast, increases when the household reference person is 65–74 but decreases for the 75-and-over category. The proportion spent on communication remains fairly consistent across all age categories.

Figure 5.2
Household expenditure as a percentage of total expenditure, by age of household reference person, 2012



Source: ONS 2013c

There is still a gap between what older consumers want and what the markets are providing. Products, services and marketing need to be better tailored to this high-growth market. Marketeers report being uncertain about how to communicate with older people, although companies such as Marks and Spencer and Dove have shown that this barrier can be overcome (ActiveAge 2012). The perception of seeing older people as savers rather than also consumers also must be challenged.

Firms such as Intel, General Electric, Danone and Philips have set up dedicated research initiatives to understand more fully the needs of older consumers, covering diverse areas from nutritional needs to retirement plans (ibid). However, there is evidence that medium- and smaller-sized businesses are more responsive to older consumers, creating wholly new products and services (EIU 2011).

Attracting the older consumer

Kaiser Supermarket in Berlin redesigned itself to suit the needs and requirements of its older customers. This included a variety of small but significant changes such as lower shelves, larger labelling, and trolleys with seats. In the four years following this redesign, more than 60 per cent of its customers were aged over 50, and sales increased by 25 per cent above forecast figures. A Tesco store in Newcastle near the Campus for Ageing and Vitality sought advice from this Kaiser Supermarket regarding how they might replicate some aspects of their approach.[26]

26 http://www.dailymail.co.uk/news/article-1050195/Tesco-reveals-Britains-pensioner -friendly-supermarket--magnifying-glasses-seats-trolleys.html, and http://news.bbc.co.uk/1/hi/england/tyne/7587427.stm

A good example of a company getting it right in terms of marketing their product to the older consumer is Müller. In 2011 they recruited Joanna Lumley as the face of their advertising campaign for Vitality, the UK number-two bestseller in the 'functional drinks' market. After extensive market research she was chosen to appeal to the brand's 'holding back the years' group, aged 55–70 (ActiveAge 2012). The campaign championed maintaining good health through balanced meals. Nonetheless, a lot of advertising is failing to impress older citizens. One 2005 study found that 70 per cent of over-55s felt that advertising did not speak to their needs (Metz and Underwood 2005).

Sometimes the simplest adjustments can make huge differences to older consumers. Adapting existing products and services so that they meet their needs can be just as beneficial as creating brand new products.

> *'In many European cities one of the main groups eating out in restaurants are those over 50, yet very few 50-year olds are able to read a menu by candlelight without their reading glasses. That is because menus are usually designed by young people… and not for senior citizens. What a crazy situation: the people who the restaurants want to market to cannot read their sales literature.'*
> Patrick Dixon, quoted in ActiveAge 2012

Many older people fear having to be dependent on others. Nine per cent of 70–74-year-olds, and 32 per cent of the 85–89 age group, reported that they had difficulties with shopping (UK Data Service). E-commerce can help overcome these difficulties, and we can see from table 5.1 below that for certain items such as holiday accommodation and books, magazines and newspapers, the over-65s are already just as likely as younger cohorts to have made online purchases over the last 12 months.

Table 5.1
Purchases over the Internet, by age group, 2010

	16–24	25–44	45–54	55–64	65+	All
Clothes, sports goods	58%	45%	46%	43%	38%	52%
Films, music	50%	50%	33%	27%	25%	47%
Holiday accommodation (e.g. hotels)	46%	53%	54%	47%	44%	44%
Household goods (e.g. furniture, toys)	52%	41%	46%	39%	37%	43%
Books, magazines, newspapers (including e-books)	40%	43%	39%	41%	40%	39%
Other travel arrangements (e.g. transport tickets, car hire)	36%	42%	48%	35%	32%	36%
Tickets for events	37%	40%	34%	21%	19%	35%
Electronic equipment (including cameras)	31%	24%	22%	14%	15%	25%
Food or groceries	32%	25%	16%	17%	17%	24%
Video games software & upgrades	30%	20%	9%	8%	8%	23%
Share purchases, insurance policies & other financial services	24%	23%	18%	13%	11%	20%
Other computer software & upgrades	18%	17%	23%	22%	20%	18%
Telecommunication services	17%	14%	16%	13%	13%	15%
Computer hardware	13%	15%	14%	11%	10%	13%
e-learning material	8%	5%	2%	2%	2%	6%
Medicine	6%	6%	9%	12%	10%	6%
Other	4%	6%	7%	5%	5%	5%

Source: ONS 2010: 15

Some city administrations have played a key role in helping local companies better adapt their products for, and market them to, older consumers. Newcastle and Brabant, discussed in the previous chapter, provide two particularly notable examples.

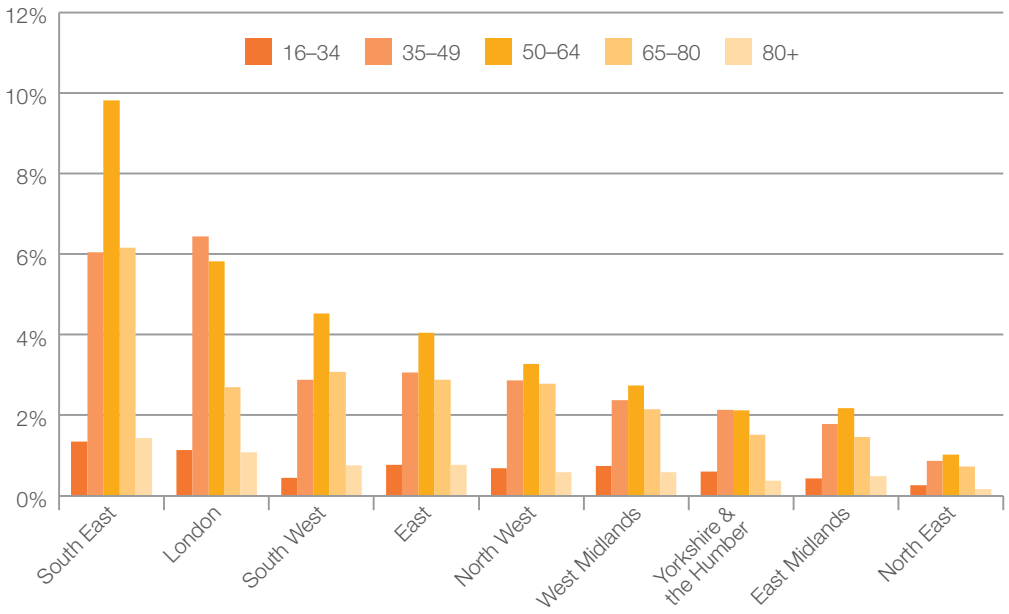
5.3 Silver investors

As wealth has concentrated towards the older segments of the population, there has been increasing discussion about how to mobilise it.

This wealth is concentrated in many locations – in pension funds, in housing and other property, and in a range of other capital and financial assets. While discussions about the role of pension funds have tended to focus on the institutions that hold these assets, debate about the potential roles of older people' s accumulated wealth in housing and other locations must focus more directly on older people themselves. In policy circles the most emphasis has been put on unlocking this wealth to enable older people to provide their own financial support in later life.

Housing is the most widely spread asset: in 2011, 74 per cent of households in England owned their home (ONS 2011c),[27] and despite wide variations in regional wealth patterns, the demographic concentrations are common across the UK with the highest concentrations of housing capital in the older age groups (see figure 5.3).

Figure 5.3
Housing wealth distribution in England, by region and age bracket, 2011



Source: Searle 2013: 1

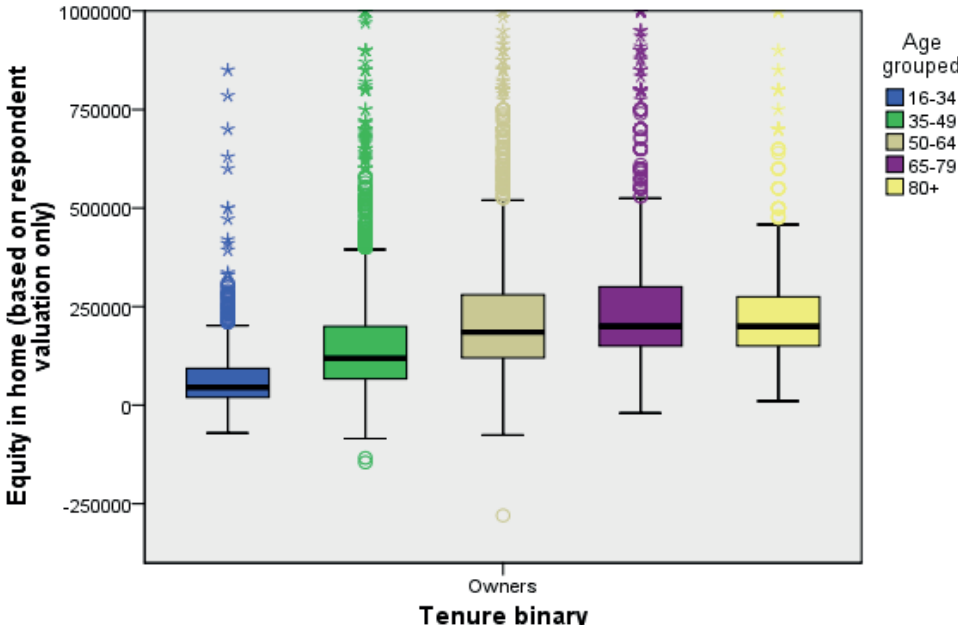
Significant shifts in housing tenure over the last two decades mean that older households (aged 65 and over) are more likely to own their home outright in 2011 (71 per cent) than in 1993 (56 per cent). Other segments of the population are experiencing delayed purchasing and are therefore renting more. In 1993 over half (56 per cent) of people under 35 had bought their own home, while one-fifth

27 This includes outright owners and people buying with a mortgage.

(20 per cent) were renting in the private sector. In 2011 this situation had almost reversed: 34 per cent had bought their home, while 46 per cent were renting privately (Searle 2013: 3).

Housing patterns within the older segments of the population are highly diverse, and that diversity is greatest among 50–64-year-olds. 'Within this group housing equity ranges from -£280,000 (negative equity) to £1 million or more [and] there are also 0.7 million people in rented accommodation who have no housing equity' within this age group (ibid: 2). Similar variations exist in the over-65 age group, and as longevity increases and the wealthier cohorts live longer, it would be reasonable to expect this wealth to move through the age ranges accordingly.

Figure 5.4
Distribution of housing wealth (£) in England by age, 2011



Source: Searle 2013:2

These trends offer both economic opportunities and challenges. Attempts to release these resources into the economy through equity release products are slowly developing: rather than just products which release cash, they now include equity release mortgages. However, there are reservations about these products – significant questions have been raised about their desirability because of the level of charges levied by financial services companies to help manage the levels of risk inherent in this area, and wider concerns expressed about eroding what is widely seen by older people themselves as a familial asset to be passed on through inheritance, especially where that asset was previously inherited. The industry itself has recognised the need for more innovation.[28]

Other approaches to the use of housing wealth have included the creation of retirement communities, which seek to attract private homeowners to invest in bespoke locations,[29] and continuing care communities such as the demonstrator project Hartrigg Oaks, established by the Joseph Rowntree Foundation in York

28 See for example http://www.more2life.co.uk/news/advisers-turn-to-equity-release-for-interest-only/
29 See for example http://www.retirementvillages.co.uk/

the 1990's,[30] which combine residential and care services into a privately funded package. These have yet to realise significant commercialisation in the UK, as they face challenges in terms of both cost and public perceptions. However, the concept has significantly higher penetration in the US, and can be seen to have succeeded indirectly in the form of the migration and concentration of large communities of UK expatriates into EU countries such as Spain and France.

More recently, the social housing sector alongside local government, health services and housing providers, has sought to reimagine housing models for later life, seeking to design higher quality and more flexible mixed housing and care models and addressing themselves to challenges created by both individual and community perception and the challenges of mixed budgeting across different public and private funding schemes (see NHF 2011).

These models and ideas need much more development, and must respond to the conditions at a very local level. More integrated and flexible local finance, combined with integrated local planning, could help to enable these forms of development to move forward.

5.4 Business investment

However, it is not only in the field of housing that there are opportunities to take advantage of the wealth of the older population.

Given the increasing concentration of wealth described above, we might have expected more work to have been done to improve our understanding of the opportunities that there are to unlock these resources in other parts of the economy. There have been celebrated cases of successful older people taking decisions to unlock their wealth, such as multi-millionaire older entrepreneurs Bill and Melinda Yates, who decided to divest themselves of their wealth for social investment purposes through their Foundation. However, less has been done to explore opportunities to unlock investment from other parts of the older community, in support of a wider range of private and social enterprises. This promises to be a fertile avenue for future work as the trends described in this report continue.

Research by the Treasury on the demographics of individuals involved in the Enterprise Investment Scheme (EIS), Venture Capital Trusts (VCT) and Community Investment Tax Relief (CITR) aimed to fill part of this knowledge gap by profiling the demography of these groups through an analysis of those investors claiming the tax reliefs through self-assessment (SA) (Mason and Harrison 2010).

> *'The EIS and VCT schemes aim to help small, high-risk companies raise funds aided by offering tax reliefs to investors. CITR is designed to increase investment in underprivileged areas of the UK through investments in small businesses in those areas.*
>
> [Treasury analysis highighted that] *in 2006/07:*
>
> - *Around 2,000 companies raised around £700m through EIS. Over 12,500 individual investors (investing uniquely in EIS) claimed income tax relief on over £400m of invested funds in EIS through SA.*
> - *Around 100 VCTs raised around £230 million. Over 8,000 individual investors (investing uniquely in VCT) claimed income tax relief on over £200 million of invested funds in VCT through SA*
> - *Up to a further 1,000 individual investors investing in both EIS and VCT claimed income tax relief on over £80m of invested funds in EIS/VCT.*

30 http://www.jrht.org.uk/communities/hartrigg-oaks

- *Under CITR, over 100 companies claimed corporation tax relief on around £500,000 of invested funds and over 250 individual investors (investing uniquely in CITR) claimed income tax relief on over £5m of invested funds for the year of CITR claims through SA.'*

Mason and Harrison 2010: 70

The study concluded that there were clear differences between the structure of the general population and those claiming reliefs for these forms of investment with a concentration of claimants among middle-aged and early-older-aged, male and married parts of the population, based in the South of England. While the authors of this analysis did not offer particular policy conclusions at this stage, it serves to illustrate the key importance of the older parts of the population in using their individual wealth to support business growth and suggests that more could be done to encourage this form of investment.

The research evidence about other, more novel investment vehicles requires much more examination, but the way in which findings differ according to age range suggests that more could be done to understand and consolidate these forms of investment.

6. BARRIERS TO HARNESSING THE SILVER POTENTIAL

As highlighted above, the UK employment rate of workers aged between 55 and 64 has increased significantly in recent years, but far less than it has in some other European countries (Eurostat 2014: 3). The UK has the potential to do much better, although those areas which are ageing fastest tend to face the greatest barriers to change.

As we saw in the case studies in chapter 4, cities can play a key role in helping address some of the most pervasive barriers standing in the way of the UK's potential to become more age-friendly. In the area of health, they can ensure that work and health-care programmes are better joined up, while helping to ensure that older people are included and empowered in processes affecting their lives (be it product development or how city halls make decisions). However, other barriers – particularly the struggle to balance care and work responsibilities – will require a combination of local and national policy responses.

Below we highlight six of the most pervasive barriers to fully realising the potential of an older population in the UK and its cities.

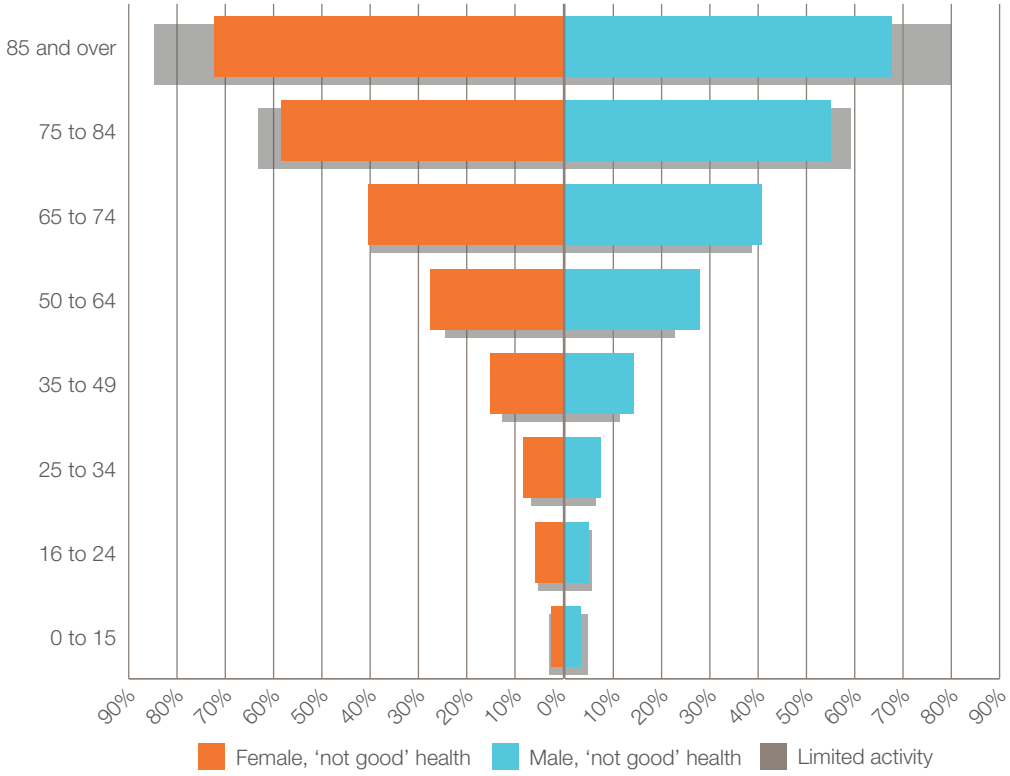
6.1 Health

We are living longer lives, and people are on average living more years with a disability. In the 2011 census, half of people aged 65 or over in England and Wales (excluding those residing in communal establishments) described themselves as being in 'good' or 'very good' health, compared with 88 per cent of those aged under the age of 65. Fifteen per cent of people aged 65 and over reported that their general health was 'bad' or 'very bad' (ONS 2013d).

Research suggests that disability and poor health are preventing nearly half a million people who are approaching retirement from working (TUC 2012). As the state pension age rises there is a danger that more and more people will become stuck in limbo between the labour market and pensionable age. Encouraging individuals and their employers to take better care of their health is therefore essential. The issue is most stark in those most disadvantaged areas of the country – for example, 50-year-old men and women living in Tower Hamlets have a lower disability-free life expectancy than those nearby in Richmond (an 8.1 and 9.2 difference in years, respectively)(ONS 2014j. A Glaswegian can already expect to live between 11 and 14 years less than someone born in Kensington and Chelsea, and the gap is widening.[31]

31 http://www.theguardian.com/news/datablog/2010/oct/20/uk-life-expectancy-estimates

Figure 6.1
Percentage of census respondents reporting their general health to be 'not good', and having limited activity, in England and Wales, by sex and age, 2011



Source: ONS 2013e: 19

6.2 Ageism

Despite the protections afforded to older people by the Equalities Act 2010, age discrimination remains a very real issue and holds back the economic potential of older people as both workers and consumers. One recent study illustrated the bias older jobseekers face compared to their younger counterparts, be it deliberate or unconscious. The researchers used a randomised process to apply for over 1,200 jobs as both an older and younger workers, with the CVs received by potential employers being identical in every way apart from the date of birth (Tinsley 2012). The responses displayed a sizeable bias against older workers, with the 51-year-old applicant getting less than half as many favourable responses as the 25-year-old. Other studies have found similar results (Riach and Rich 2007).

64 per cent of people still believe age discrimination to be a serious problem in the UK.[32] This discrimination holds back the potential of our ageing population in a multitude of interlinked ways. While we acknowledge that people build up a wealth of experience and knowledge throughout their adult lives, we as a society become dismissive of this knowledge after an arbitrary cut-off point. As the BMW example highlighted in section 5.1 demonstrates, given the right conditions, older workers can be just as productive as their younger colleagues.

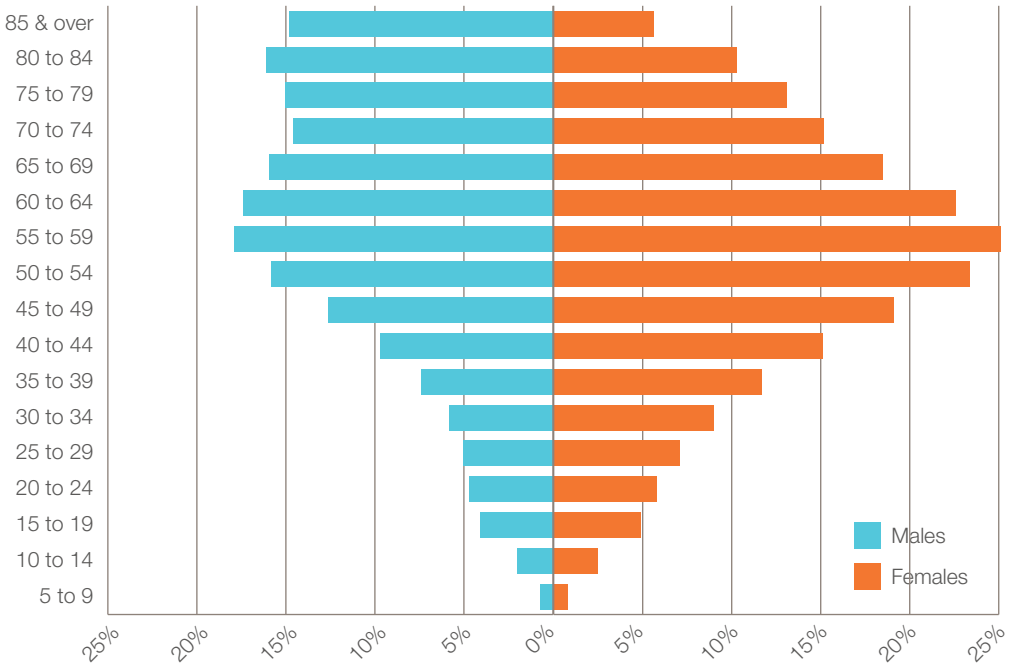
32 http://www.ageuk.org.uk/latest-press/archive/age-uk-research-shows-age-discrimination-is-rife-in-europe/

Another major car manufacturer has received plaudits for testing its cars using a worker wearing a specially made outfit that restricts mobility to mimic some of the mobility issues facing older people. While this is a worthy aim, it does beg the question, Why not involve older people with mobility issues themselves in the testing process? In many other sectors, addressing the specific needs and demands of older customers does not even happen at all. It is extraordinary that a segment of the UK population responsible for 40 per cent of the country's consumer demand attracts 10 per cent of marketing spend (Harper 2009).

6.3 Caring responsibilities

One in 10 people living in households in England and Wales (5.8 million) provide unpaid care for someone with an illness or disability. Figure 6.2 below shows quite strikingly that more of this care is provided by women than by men' it also shows that almost half of all unpaid carers are between the ages of 45 and 64.

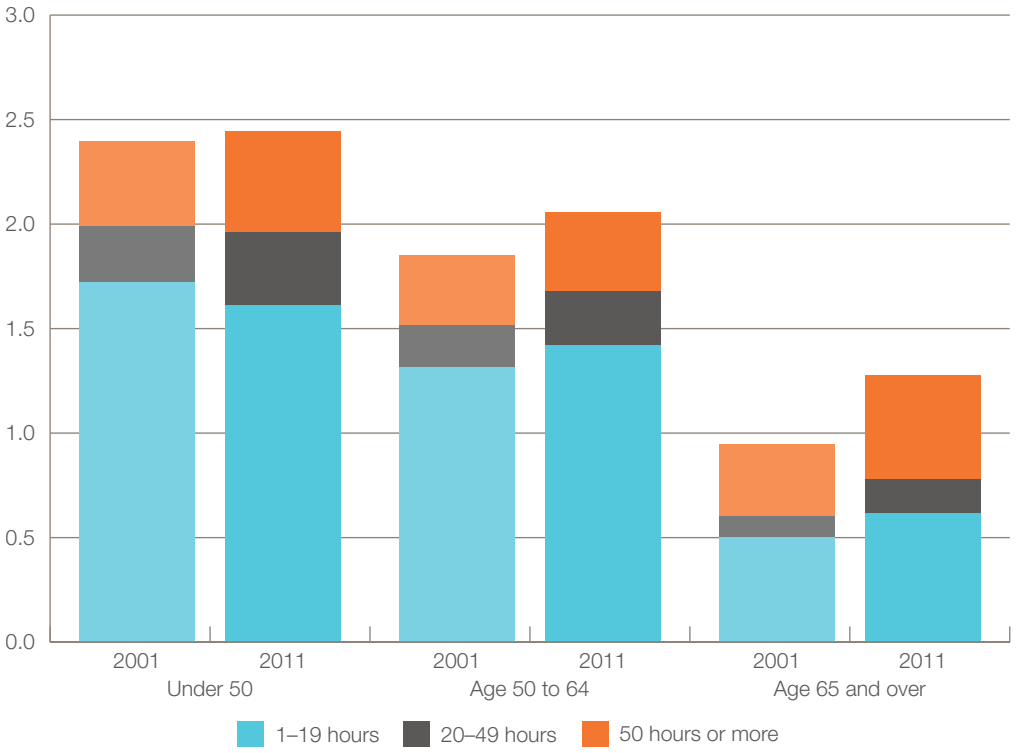
Figure 6.2
Percentage of people in providing unpaid care in England and Wales, by sex and age, 2011



Source: ONS 2013e: 18

It has been estimated that the care for older people that is provided by families is worth around £55 billion (McNeil and Hunter 2014). The number of unpaid carers rose by 600,000 between 2001 and 2011, with the number of people providing 50 or more hours per week growing particularly dramatically (White 2013). Increasingly, it is falling on older people (both those in the 50–64 category and those aged 65 and over) to take on this caring role, frequently for a partner or spouse. Fourteen per cent of over-65s living in households in England and Wales provided unpaid care in 2011 – this represents an increase of 17 per cent relative to the previous decade (ONS 2013d).

Figure 6.3
Number of carers (000s) in England and Wales by age and weekly hours of care provided, 2001 and 2011



Sources: ONS 2001 and 2011b

Caring can be highly demanding and unpredictable in its time requirements. Many people struggle to balance its demands with those of their careers, and as a result have to leave the labour market to care for partners and relatives. Once out of the labour market, many are lost to it for good. This is especially true of women, who make up almost two-thirds of the unpaid carers workforce. Despite these difficulties, more than one-fifth of unpaid care is provided by those also in work (ONS 2013f).

Providing care for 20 or more hours per week has been shown to have a substantial and negative impact on employment. Recent research has suggested that as little as 10 hours a week can make it difficult for individuals to stay in work (King and Pickard 2013). In 2009/10 there were 315,000 working-age carers who had left work and remained out of the labour market (Pickard 2012). A House of Lords select committee has underlined the loss to the national economy that this constitutes: the lost working hours amount to around £5.3 billion (HL-SCPSDC 2013). For those who do try to balance work and care responsibilities, the evidence shows this leading to absenteeism, lateness and lack of concentration (Gautun and Hagen 2007, Gabriele et al 2011).

This issue is only going to get more acute as the baby-boomer generation ages and the number of people with caring requirements continues to expand. IPPR's recent report, *The generation strain*, highlights the fact that a family care gap is likely to occur by 2017, when the number of older people in need of care is expected to exceed the number of adult children able to provide it (McNeil and Hunter 2014). By 2032, 1.1 million older people in England are expected to need care from their families – an increase of 60 per cent, while the number of adult children able to care for older parents will have risen by just 20 per cent (Pickard 2013).

Key to addressing this issue will be creating a culture of more flexible working, and providing carers with more employee rights.

Caring is also linked to health in two important ways. Firstly, caring can have a strong negative impact on the health and wellbeing of carers, due to the stress and isolation it can cause. Secondly, those areas with the highest prevalence of people who are 'limited a lot' in daily activities also have the highest percentage of residents who provide 50 hours or more care per week (White 2013). While this is hardly surprising, it highlights the way in which the problem differs across areas, and that those areas with the most severe health needs will also have more carers under greater pressure.

Figure 6.4
Percentages of people who are 'limited a lot', and who provide 50 hours or more of unpaid care, in local authorities in England, 2011

Source: White 2013: 15

6.4 Grandparenting responsibilities

'In the UK, grandparents provide childcare to 42 per cent of families with children over nine months old. For families in which the mother is in work or education, 71 per cent receive some level of childcare from grandparents, and 35 per cent relied on grandparents as the main providers of childcare (Statham 2011)... Grandparental care can range from ad hoc babysitting to acting as the primary provider of childcare… This type of care has enabled many families to more easily reconcile work and caring responsibilities, and it plays a crucial role in enabling parents, and particularly mothers, to (re-)enter the workplace. After maternity leave, around half of new mothers depend on informal care provided by grandparents (Grandparents Plus 2013). This type of care is particularly helpful for low- and middle-income women, who have a

lower probability of resuming work after maternity leave and often find childcare prohibitively expensive (ibid)… Just as they did as parents, grandmothers who care can once again find themselves juggling childcare responsibilities and work... Caring has significant impacts on the wellbeing and financial stability of older women in particular, many more of whom face the difficult challenge of balancing work and family obligations than men of a similar age do.'

Ben-Galim and Silim 2013

6.5 Lack of resources at the right level

At a national level, ageing is an issue which cuts across a number of departments and funding streams with unclear ministerial responsibilities. The issue lacks political leadership. By comparison, Canada and Ireland have dedicated minsters for older people, while both Wales and Northern Ireland have older people's commissioners.

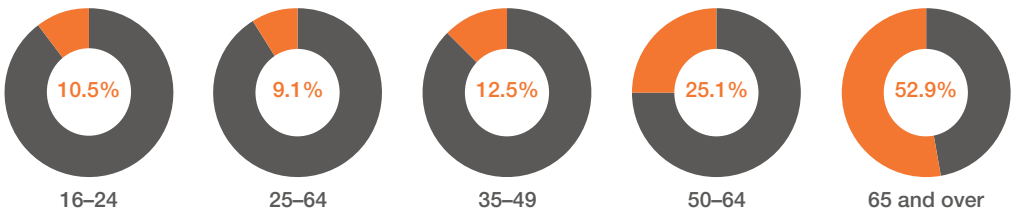
Local authorities and cities are having to deal with the challenges that arise from an ageing population, but they are worried that in the medium term they will lack sufficient resources to address them. This is perhaps most starkly illustrated by Barnet borough council's now famous 'graph of doom', which showed that on current projections, within 20 years the north London council will not be able to fund any services except adult social care and children's services, meaning there would be no money for libraries, parks, leisure centres or bin collections. Other councils have suggested that they will arrive at this scenario within an even shorter timeframe. This issue of limited resources also can prevent those areas that are ageing the fastest from maximising the upsides of an older population – for instance, through helping employers adapt to an older workforce and ensuring that local residents take steps towards healthier lifestyles.

Those cities that are doing most in terms of making themselves age-friendly realised the significance of this demographic shift 10–20 years ago, and recognised that things would have to be done differently. The lack of urgency at a national level is in part due to many of the challenges playing out more at a local level. Equally, as we described above, some parts of the country are ageing faster than others. Local areas must tailor their approaches and priorities to the differing pressures in different areas.

6.6 Skill levels

Those approaching retirement age are less likely than younger cohorts to have qualifications, and those over 65 are the only age group in which over half of people report having no qualifications (see figure 6.5).

Figure 6.5
Percentage of people in England and Wales with no qualifications, by age group, 2011

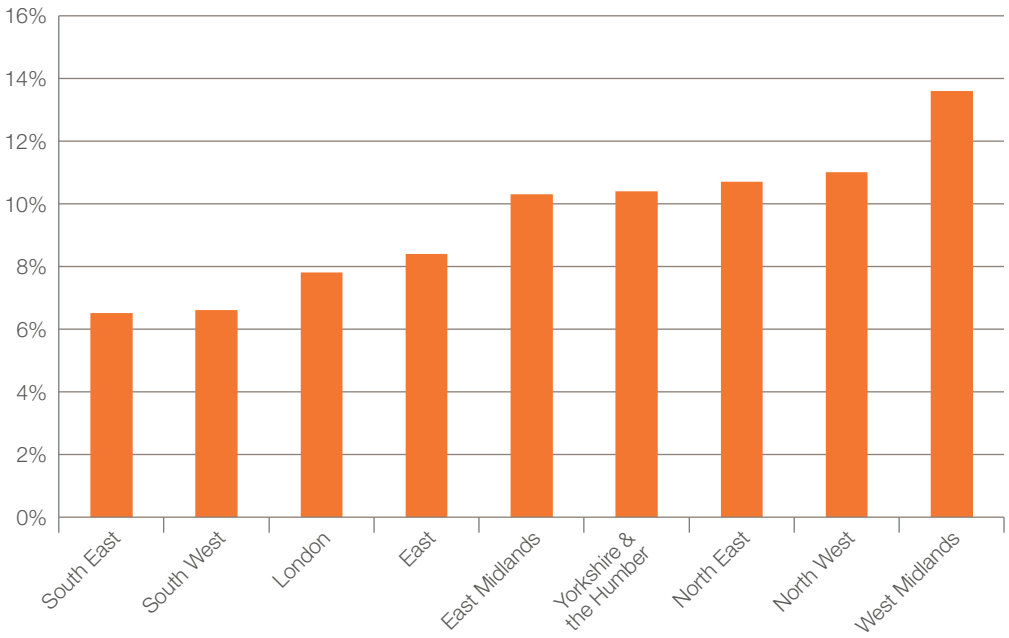


Source: ONS 2014b

This contributes to the struggle that many people over 50 face when trying to find new jobs. As mentioned above, almost half of over-50s who are unemployed have been out of work for more than a year (ONS 2013b). While future generations are likely to be at

less of a disadvantage in terms of skills, it remains a crucial issue for the current cohort of older workers, and those who would like to be in work. Again, there is considerable variation across the country: twice as many people have no qualifications in the West Midlands as in the South East and South West (Nomis 2014).

Figure 6.6
Percentage of people in England with no qualifications, by region, October 2012–September 2013



Source: Nomis 2014

7. CONCLUSIONS AND RECOMMENDATIONS

This report has highlighted the demographic challenges currently facing the UK, and the limitations of using over-simplistic three-generational models, focussing on dependency ratios and problematising old age. While the health and social care implications of an ageing population are important, other countries are showing that more asset-based approaches to intergenerational change provide a much more progressive framework within which to tackle demographic change.

Furthermore, although population ageing is a widespread phenomenon across the UK, there are very diverse experiences of growing old, and different places have distinctive cohorts of older people that require very different approaches to policy and practice.

For this reason, while recognising that national policymaking remains critical for providing a national framework for boosting the silver economy, there needs to be a much greater emphasis on local strategic planning, particularly within the functional economic areas represented by city regions.

Our recommendations therefore centre upon three areas:

- some principles for addressing demographic ageing
- developing a national framework for enhancing the silver economy
- developing city-based strategies for the silver economy.

7.1 Principles for addressing demographic ageing

Distilling many of the messages from the analysis and case studies in this report, it is possible to highlight a small number of key principles that need to underpin an approach to demographic ageing at both national and local levels.

- **Moving beyond stereotypes:** recognising that there is increasing and significant diversity across age cohorts. Policies, laws and other measures that presume the potential, needs and interests of individuals based on their age are inadequate responses to our changing demography.
- **Taking an 'asset-based approach':** recognising population ageing as an economic opportunity which can benefit the whole population, rather than just a social care problem, and supporting people into older age in an active way.
- **Developing multi-agency co-operation** with a focus on identifying mainstream approaches to promote lifelong adaptation, service improvement and pooled funding rather than just small-scale, targeted projects. At the national level, this includes cross-departmental coordination, as well as devolving decision-making and programme design to local actors who can respond to diverse local circumstances.
- **Recognising older people as key co-producers** of better economic and social outcomes, through active engagement in all areas of wider strategic planning and public life.
- **Long-term political commitment to strategic planning for demographic ageing**, building on learning from local, national and international examples.

7.2 A national framework for a silver economy

Chapter 3 identified recent national approaches to old age, the large majority of which focussed on health and social care outcomes rather than the asset-based approach articulated here. Despite significant protections given to pensions and other older age benefits, the Coalition government has lacked any meaningful strategy concerning ageing in the UK.

This report is not the place to articulate a full-blown national strategy for our ageing population, although other IPPR reports have set out some important planks upon which the costs of an ageing society can be addressed. These include:

- '*People providing a significant amount of unpaid care should have the right to adjust their working arrangements to enable them to remain in employment rather than relying on the benefit system.*
- *Entitlement to care services for those on low incomes should be extended to older people with moderate needs, to enable them to stay at home and live independently. This should be paid for by limiting entitlement to winter fuel payments to those who are eligible for pension credit.*
- *An independent review should consider how the national insurance system could be used to progressively lower the cap on care costs and raise the asset threshold, using the principles of contribution and risk-pooling to help finance long-term care costs.'*

Lawton et al 2014

- There should be new insurance products and other financial instruments to encourage older people to make adaptations to their homes. GPs should also be able to 'prescribe' home adaptation grants.
- Decent space standards and Lifetime Homes standards should be phased into national building regulations requirements and new homes built to these specifications discounted stamp duty up to a sale value of £500,000 where the buyer is over 55.
- Local authorities should be given the freedom to deploy their borrowing capacity via housing revenue accounts and housing corporations to invest in sheltered accommodation and 'intentional community' models should be systematically tested in the market by social housing providers and the Department of Health.

Davies 2014

While it is right that there should be a national framework to better address the costs of ageing, we need a new, more local approach to generating silver economies.

7.3 Developing city-based strategies to promote the silver economy

As this report has highlighted, some of the most progressive approaches to demographic ageing can be found at the sub-national level. For this reason, it is our principal recommendation that **every city in England that doesn't have one should consider developing a strategy for demographic change, with a strong emphasis on the potential of the silver economy and links to wider strategies for economic growth and public service reform**.

While every strategy will need to be developed according to the specific opportunities and challenges that exist locally, some common issues that should be considered include the following.

- **Analysis:** Every city strategy needs to understand the specific demographic drivers affecting the area, not least but not exclusively the segmentation of the older population – varying levels of health in different cohorts, skills levels, different ethnic backgrounds and spatial distribution. Based on this analysis, cities can then adopt more targeted approaches to those with particular opportunities or challenges.

- **Skills:** Developing a focus on continuous training and lifelong learning for all employees, with some of the offering being tailored to the over-50s. In practical terms this might mean developing personalised and flexible vocational training programmes. It should also mean that the concept of careers advice is broadened to include advice on retirement decisions and how people can extend their working lives through an integrated understanding of skills and training, finance (including pensions implications) and health.
- **Business support:** Working with local businesses to understand and explore the opportunities available to them in terms of employing older people, and also developing products and services for the burgeoning older people's market and ensuring age-friendly workplaces.
- **Older entrepreneurship:** Ensuring that sources of tailored business support and advice are available to enable older entrepreneurs to establish and grow their business, given that their needs are often different to younger people. This might be less focussed on sources of finance, and more on confidence, skills and support for business planning and delivery.
- **Innovation and investment:** Working with universities to identify areas for innovation and commercialisation of research around issues of ageing – including, but not exclusively, on issues of health and social care. Presenting an ageing population in positive terms with a view to promoting inward investment opportunities on the basis of a burgeoning older cohort.
- **Active labour market programmes:** Working with partners to develop active labour market programmes with a specific emphasis on the employment challenges facing the over-50s, not least those dealing with involuntary redundancy.
- **Integration:** Ensuring that employment support and health and care systems within the city are better joined up. A strong economy and a healthy population are mutually reinforcing, and so better integrating work and healthcare programmes can have real benefits. One model that appears to be a good one to build on is Manchester's Fit For Work service,[33] through which, after a personal assessment, patients are prescribed with any of (or a combination of) fast-tracked physiotherapy sessions, debt and relationship support, and assistance with brokering changes in the workplace with employers once the client is ready to return to work. The government recently announced that it will introduce a national health and work service. Once an employee has reached four weeks of sickness absence, they will be referred to this service by their GP for an assessment by an occupational health professional.[34] While this is to be welcomed, it should be extended to those who are out of work, so that their GP can refer them to condition-management and work-progression services.
- **Adaptations:** Addressing issues around 'quality of life' for older people with a view to ensuring a wide range of accessibility and age-friendly adaptations are made to the public realm.

This report unashamedly seeks to highlight the 'assets' and opportunities that an ageing population offers, rather than dwelling on the 'burdens' and challenges – there is already plenty in print that takes that perspective. We do not mean to naïvely imply that ageing does not present any challenges. Rather, by focusing on opportunity, this report seeks to act as a corrective to the negativity of other research. While it by no means constitutes a blueprint for national or local silver economic strategies, it draws on good practice from overseas to provide a number of principles and building blocks upon which both local and national policymakers can build.

33 https://www.pathwayscic.co.uk/manchester-fit-for-work-service.html
34 https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/362480/fit-for-work.pdf

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The Brighton & Hove Age Friendly City Programme

Annual Review 2014

Brighton & Hove has over 35,500 people aged 65 and over, 11,500 of whom are over 80, and a growing number of people live alone. If you make a city friendly for older people, it will be friendly for everyone.

The Brighton & Hove Age Friendly City Programme

We want older people have a good quality of life and for the city to be a great place in which to age. We are following the World Health Organisation's age friendly city approach, which helps cities around the world encourage and support active ageing.

The programme focuses on eight areas, identifying how to make them accessible to and inclusive of older people:

1. outdoor spaces and buildings
2. transportation
3. housing
4. social participation
5. respect and social inclusion
6. civic participation and employment
7. communication and information
8. community support and health services

Who is involved?

The Brighton & Hove Age Friendly City programme is led by the city council in partnership with key older people's organisations in the city and older people's groups. We work together to find new approaches and solutions to reshape the city's environment and services to be age-friendly.

Our aims are simple, we want:

- Older people to enjoy all the city has to offer
- Older people to have the opportunity to be active citizens and shape the services that affect their lives
- The city to support people to age actively
- To give older people a chance to improve their resilience, through the best early intervention

What do we do?

We support older people to identify what they want to change and then help them do it.

- We gather information on what is happening in the city, discuss our findings with policy makers, service providers and older people to identify more age-friendly approaches and solutions.
- We work together to develop and test new ideas to support local people and citywide organisations create projects that help older people stay healthy and well.
- We challenge stigma around ageing by presenting a positive profile of older people, their assets, issues and concerns.

Brighton & Hove City Council

AFC Achievements

In the last year...

37

events celebrated Older People's Day, attended by over **1000 people**

The new housing strategy included

9

specific actions to support older people.

26

organisations worked together to find solutions around transport and older people.

30

new projects for older people were funded by The Healthy Neighbourhood Fund

2

consultation forums for older people met regularly.

Fabrica's Growing an Older Audience programme provided over

100

events, projects and courses.

OVER 1000

activities are available citywide for older people

4951

new older people participated in sports and physical activity.

30

older people aged up to 82 play ping pong every week at King Alfred.

3 citywide photographic exhibitions promoted positive images of ageing.

Executive Summary

Is this the end for formal adult social care? While many have welcomed the government's acknowledgement that adult social care requires more funding, this paper argues the proposed measures outlined in the Spending Review will not be sufficient to meet the growing care needs of an ageing population. Indeed, they are likely to result in a polarisation of care – private formal care for those that can afford it, rising reliance on informal carers and increasing unmet needs for those that can't. However with local government facing more real terms spending cuts, we are unlikely to have the required infrastructure to move to a model of care that relies so heavily on family and community support.

More specifically this paper finds:

The care crisis

- Numbers accessing care services have fallen by half a million since 2008/9 (a drop of 30%)
- Yet the population continues to age – the over 80s have risen by 800,000 in the last decade.
- We estimate that approximately 1.86 million people over the age of 50 in England (1 in 10) have unmet care needs – an increase of 120,000 people (or 7%) since 2006/7.

Assessment of changes outlined in 2015 Spending Review

- Our analysis of data from 326 local authorities, shows that the councils with the highest concentration of older people and unpaid carers will be the ones that will bring in the ***least*** amount of money from the 2% council tax precept.
- Even if proposals bring £3.5bn into adult social care (which is highly unlikely), this will still only mean that spending on care returns to 2015 levels by the end of the parliament.
- This would imply an overall fall in expenditure on care as a proportion of GDP putting us firmly towards the bottom end of the OECD league table.

Increased reliance on unpaid carers and rising unmet need

- There are already around 1.5 million people providing over 50 hours per week of unpaid care.
- Reductions in formal care services will put a greater burden on unpaid carers who are typically middle-aged women. This could threaten to undo some of the progress made in raising female employment rates over the last 20 years to the detriment of the wider economy.
- Unpaid care can also put a significant strain on the individual providing it, yet carers receive little support for what they do. Carers Allowance is currently set at just £62.10 per week for those providing at least 35 hours of care a week – that's less than £2 per hour of care provided.
- Without greater support, both financial and formal care support, greater unpaid caring could risk an erosion in the quality of care provided and will have adverse implications for carers' wellbeing.
- But those who have a family to support them may be the lucky ones. We estimate there are approximately 4.3 million people aged 50+ in England who are living alone (that's roughly 1 in 5 middle aged and older people living on their own).

The end of formal adult social care

A provocation by the ILC-UK

Ben Franklin

December 2015

Love later life

Centre for Later Life Funding

www.ilcuk.org.uk

Centre for
Later Life
Funding

About the Centre for Later Life funding

This report is the second publication from The Centre for Later Life Funding, which in turn, sits under the guise of the ILC-UK. The Centre is, in part, a continuation of its predecessor body the Care Funding Advice Network (CFAN) – a coalition of organisations and individuals seeking to improve on the Care Act's recognition of the need for financial advice.

The Centre represents a significant expansion in terms of scope and output to include policy briefings and research papers, which consider not just questions about care funding but questions about funding retirement more broadly. And critically it will focus on developing ideas and solutions to these questions. We think that the artificial separation of retirement funding from care funding is unhelpful given that long-term care can be one of the biggest costs that people face during their retirement years.

Executive Summary

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Increased reliance on unpaid carers and rising unmet need

- There are already around 1.5 million people providing over 50 hours per week of unpaid care.
- Reductions in formal care services will put a greater burden on unpaid carers who are typically middle-aged women. This could threaten to undo some of the progress made in raising female employment rates over the last 20 years to the detriment of the wider economy.
- Unpaid care can also put a significant strain on the individual providing it, yet carers receive little support for what they do. Carers Allowance is currently set at just £62.10 per week for those providing at least 35 hours of care a week – that's less than £2 per hour of care provided.
- Without greater support, both financial and formal care support, greater unpaid caring could risk an erosion in the quality of care provided and will have adverse implications for carers' wellbeing.
- But those who have a family to support them may be the lucky ones. We estimate there are approximately 4.3 million people aged 50+ in England who are living alone (that's roughly 1 in 5 middle aged and older people living on their own).

Introduction

The nature and shape of the UK state is changing. As our population ages, an increasing proportion of public expenditure is being directed towards services used by older people. In 1997-8, 33.8% of government expenditure was directed at the health service and older people and this is set to rise to 42.3% by 2020[1]. However, there is one critical age-related service that remains woefully underfunded – adult social care.

Adult social care is the misunderstood sibling of healthcare. While healthcare is free at the point of use, the provision of state support for adult social care is subject to a means test. But despite this key difference, many do not realise that they have to pay for care, and instead assume it will be free when they need it like the NHS. In addition, state funding for adult social care comes from local government coffers rather than being funded through a global budget like its bigger sister the health service. Perhaps for these reasons, successive governments have cut spending on local government which has, in turn, resulted in falling public expenditure on adult social care[2].

In recognition of the care funding crisis, in the last parliament, the Government agreed to implement the so called "Dilnot reforms" which would result in a more generous means test and a "cap" on care costs, but this has since been delayed until 2020 with some anticipating it being scrapped altogether.

In this context, the 2015 Spending Review marked a critical moment for the future of adult social care. With reports of many providers struggling to stay afloat and falling numbers of people accessing care services, the Chancellor announced further funding for the sector. The plans include:

- **Council tax precept:** The Government will enable councils to be flexible in raising their council tax by 2% explicitly to raise funds for social care.
- **Better care fund:** The Government have also stated there will be a £1.5bn increase in the Better Care Fund.
- **£3.5bn?** Taken together, the Government anticipates these changes potentially bringing in an additional £3.5bn to adult social care by the end of this Parliament.
- **Dilnot delayed not cancelled:** The Government reiterated their commitment to implementing the Dilnot reforms in 2020 saying they have been postponed but not cancelled.

In light of these proposed changes, this short paper asks – is there a future for formal adult social care, and if so, where does this future lie, and if not, what might be the long term consequences?

The care funding crisis

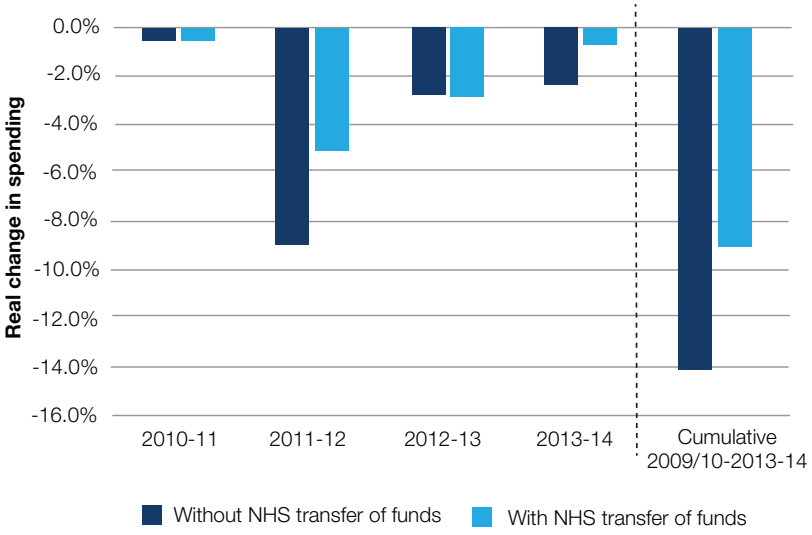
The Government's proposals for adult social care must be viewed in the context of the long-term funding challenge facing the sector. Over the last five years, the adult social care sector has faced real terms funding cuts of around 9 to 14% depending on whether or not NHS transfers are included within the calculation[3].

1 Whittaker (2015) Skewed Britain is no country for young men, Blog post for Resolution Foundation: http://www.resolutionfoundation.org/media/blog/skewed-britain-is-no-country-for-young-men/

2 Local government has tried to limit the extent of spending cuts to social care – preferring to cut other services instead. This has meant that social care accounts for an increasing proportion of total local government spending despite the fact that social care expenditure has been falling.

3 NHS transfers are direct transfers from the NHS to fund adult social care

Figure 1: Real change in adult social care spending: 2010/11 to 2013/14



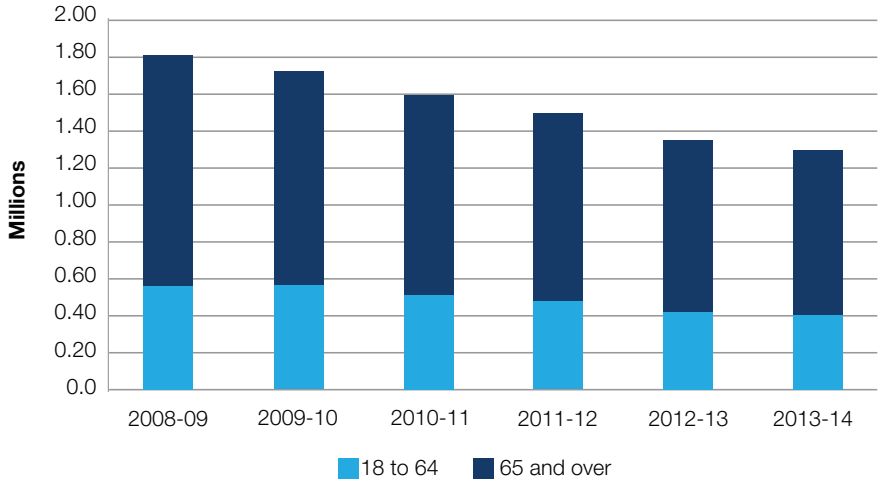
Source: King's Fund

Such funding pressures have meant reductions in services for those who need them. In 2014, the National Audit Office (NAO) found that some providers were struggling to meet all but "users' basic needs and investing in staff skills and training". Indeed around half of local authority directors of adult social care reported that cost-saving was putting pressure on the financial sustainability of private sector providers. The NAO's report suggested that such a situation is particularly challenging for small, independent local providers, who typically hold around 80% of the market share in many localities[4].

The care sector has warned that "up to half of the care home market will become financially unviable and care homes will start to close their doors". And it is not just the care home sector that is feeling the strain – 74% of domiciliary home-care providers who work with local councils have said "they will have to reduce the amount of publicly funded care they provide." The home-care sector has said that "if no action is taken…this would affect half of all of the people and their families who rely on these vital services"[5].

The funding squeeze is having a real impact on peoples' lives, reducing the numbers accessing care services – particularly amongst older people but also for those under 65. Since 2008-9 the numbers of older people (aged over 65) receiving care has fallen by 30%, while it has fallen by around 26% for those aged 18-64. As a result there are now half a million fewer people receiving care services than there were in 2008-9.

Figure 2: Numbers of people receiving care services



Source: HSCIC

4 NAO (2014), Adult social care in England: overview https://www.nao.org.uk/wp-content/uploads/2015/03/Adult-social-care-in-England-overview.pdf

5 Campbell (2015), Half of UK care homes will close unless £2.9bn funding gap is plugged, charities warn, Story for the Guardian: http://www.theguardian.com/society/2015/nov/21/half-uk-care-homes-close-funding-gap-nhs-george-osborne

Despite fewer people receiving care, there remains a high level of demand

The UK's population is ageing and it is the oldest age group which is rising the fastest. Between 1980 and 2014, the number of people aged over 80 in England has more than doubled from 1.3 million in 2004 to close to 3 million by 2014[6]. Over the last 10 years alone, this age group has grown by over 800,000. Evidence collected for this report suggests that during this time, the number of middle aged to older people who have problems undertaking Activities of Daily Living (ADL) but do not receive any support has risen.

In focus: unmet care needs

Using data from the English Longitudinal Study of Ageing (ELSA), we have calculated the level of unmet need by first identifying all those who struggle to undertake certain activities and then estimating the numbers who do not receive any help with them. The activities include:

1. Dressing
2. Walking across a room
3. Bathing or showering
4. Eating, such as cutting up food
5. Getting in and out of bed
6. Using the toilet, including getting up or down

Based on this approach, we estimate that in 2012/13, there were 1.86 million people over the age of 50 in England who had unmet needs – an increase of 120,000 people (or 7%) since 2006/7[7]. This means that around 1 in 10 people aged over 50 has an unmet care need.

Increased numbers of unpaid carers

Reduced access to formal social care means many are increasingly reliant on unpaid carers including family and friends whose numbers continue to grow. The most up to date and reliable information on informal carers comes from the 2011 Census. This showed a stark increase in the number of carers in England and Wales, from 5.2 million in 2001 to 5.8 million in 2011. Unpaid care increased at a faster pace than population growth between 2001 and 2011 and this was true for all regions other than London during the period. Of all unpaid carers, around 3.7 million provided 1-19 hours per week, 775,000 provided 20-49 hours and 1.4 million provided 50 hours or more unpaid care.[8]

Women were notably more likely to be unpaid carers than men, accounting for 57.7 per cent of unpaid carers in England and Wales[9]. Women aged 50-64 are particularly likely to take on caring roles – in 2011 nearly 1 in 4 women of this age took time to care for others.

Will the measures contained in the Spending Review make a difference?

At a national level, it is hoped that the measures outlined in the Spending Review – which includes more resources for the Better Care Fund (£1.5bn) and the council tax precept (hoped to bring in £2bn) will bring an additional £3.5bn into adult social care by the end of the parliament.

Despite these measures, it is difficult to know exactly how funding for adult social care will play out over the next four years. Unlike the NHS there is no global budget for care, instead it is up to local authorities to determine how much they actually spend including whether or not they choose to take advantage of the new precept and raise council tax in order to generate additional funds for social care. But with local government having their funding from central government cut by 56% over the course of this parliament, how they manage their entire budgets including adult social care expenditure is likely to be a substantial challenge.

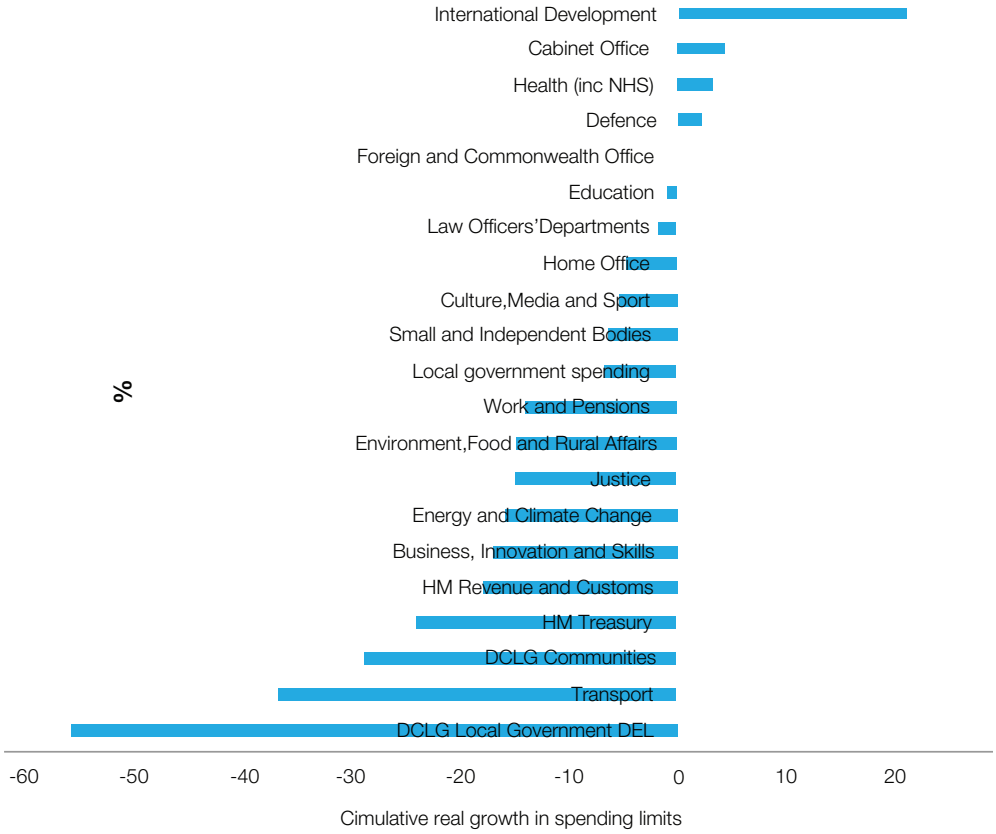
6 ONS 2014 Mid-Year Population Estimates

7 There are earlier waves in ELSA but they do not contain equivalent data on ADLs so cannot be used for direct comparison purposes

8 ONS (2013) 2011 Census Analysis: Unpaid care in England and Wales, 2011 and comparison with 2001: http://www.ons.gov.uk/ons/dcp171766_300039.pdf

9 ONS (2013) Full story: The gender gap in unpaid care provision: is there an impact on health and economic position?: http://www.ons.gov.uk/ons/dcp171776_310295.pdf

Figure 3: Resource Departmental Expenditure Limits 2015-16 to 2019-20



Source: HM Treasury , Spending Review and Autumn Statement: https://www.gov.uk/government/publications/spending-review-and-autumn-statement-2015-documents/spending-review-and-autumn-statement-2015

What we do know is that even if £3.5bn is succesfully raised for care, this will still only mean that spending on care returns to 2015 levels by the end of the parliament[10]. In addition, the proposals imply that the £3.5bn would be backloaded – with funding falling over the next two years before rising in the last[11]. This means a continued short-term funding squeeze for the sector as a whole, before some relatively limited rest bite later on.

Local authorities will be impacted in different ways

The council tax precept is likely to exacerbate regional and local inequalities. Our analysis underlines what many others have already suggested - the local authorities that most need additional funding for care will generate the least amount of funding through the precept.

Methods

By combining the government's Live Tables on Local Government Finance with the ONS' Mid-Year 2014 Population Estimates, it is possible to calculate what an additional 2% in council tax might generate per older person in each local authority in England. We then plot this additional revenue per head against the likely demand for care across all local authorities (measured in terms of the proportion of people aged over 65).

Findings

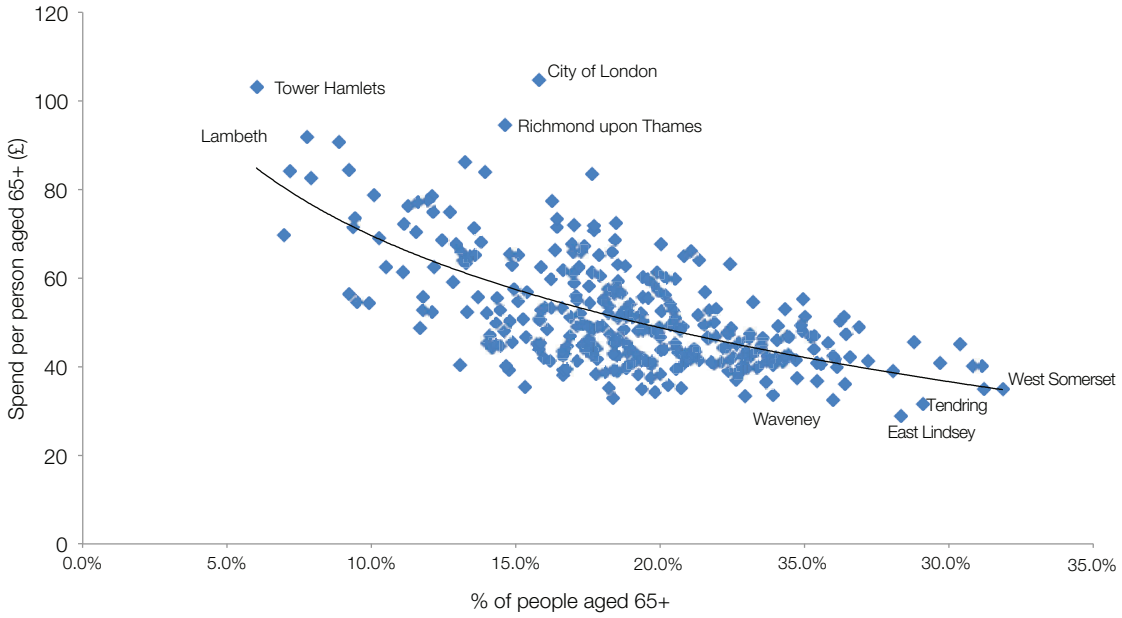
We find that the local authorities with the highest proportion of older people will bring in the ***least*** amount of money for every older person per year. In other words, the places where there is likely to be the highest level of need, will bring in the least amount of additional resource to spend on social care. In Lincolnshire's East Lindsey for instance where 30% of people are aged over 65, a 2% rise would bring in just under £30 per older person per year. By contrast, in Richmond Upon Thames, where just 15% of people are aged over 65, the rise would bring in an additional £95 per older person per year.

10 Appleby (2015) "UK's health and social care spending plans: more of the same?" Data briefing for the British Medical Journal, BMJ 2015;351:h6458

11 Appleby (2015) "The Spending Review - what does it mean for health and social care?", http://www.kingsfund.org.uk/audio-video/john-appleby-spending-review-health-social-care

The below chart clearly demonstrates the inverse relationship between likely demand for care and the additional funding the precept would provide.

Figure 4: Anticipated additional spend per head by concentration of older people across LAs

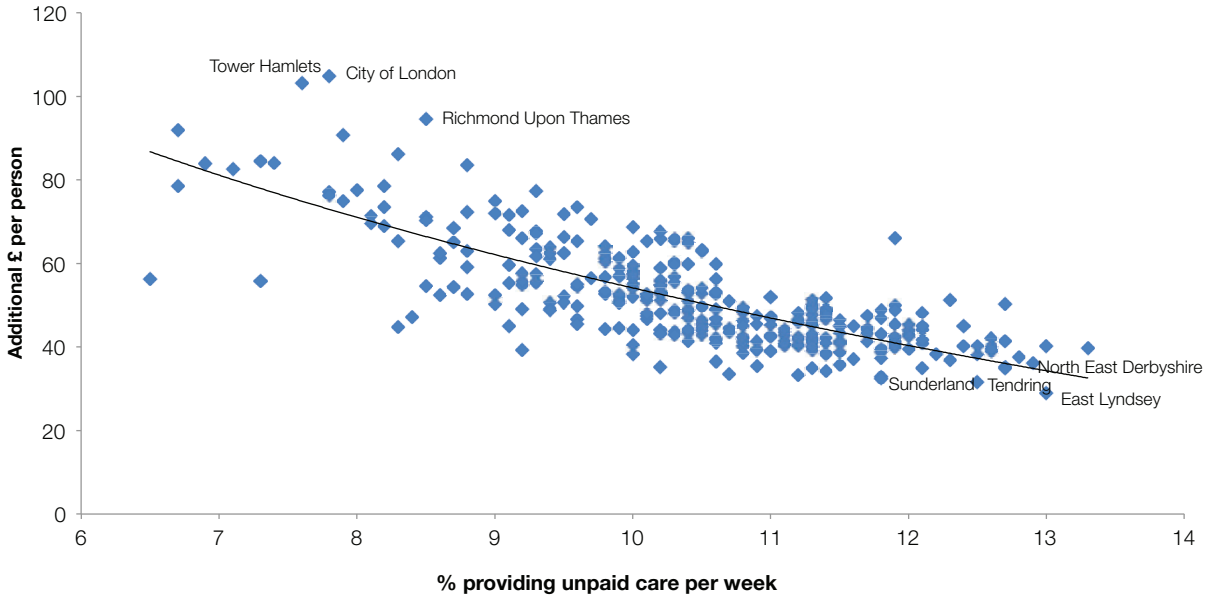


Source: Author's calculations based on ONS and DCLG data

Greater burden on informal carers

It should perhaps come as no surprise that older local authorities have a higher proportion of unpaid carers than younger local authorities. Since the precept will bring in less money to older local authorities than younger ones, this will limit the extent to which it can ease the burden on unpaid carers. To demonstrate this, we repeated the above analysis, but rather than including the proportion of people aged over 65 we included the proportion of people undertaking unpaid care in a week[12]. The chart below shows that the precept will bring in signficantly less money where there is a higher reliance on unpaid carers. For instance in East Lyndsey, where around 13% of the population provide unpaid care, the precept could bring in around £30 compared to over £90 in Lambeth where less than 7% of the population provide unpaid care[13].

Figure 5: Anticipated additional spend per head by concentration of unpaid carers by LA



Source: Author's calculations based on ONS and DCLG data

12 The local authority data on unpaid carers was taken from the 2011 Census.

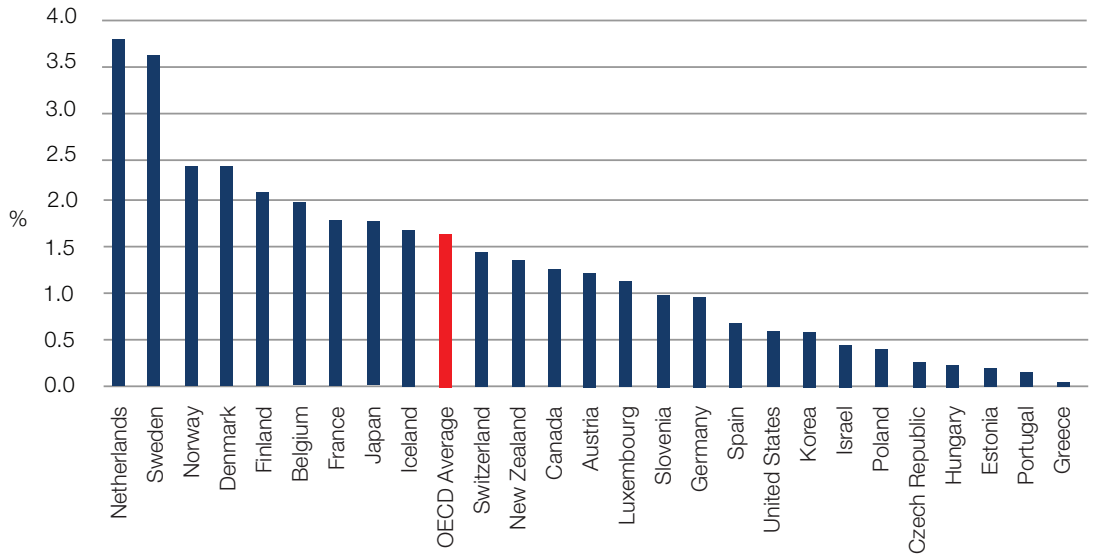
13 The results are robust to different amounts of unpaid care (i.e. this example is any amount of unpaid care, whereas we also looked at proportion providing intense unpaid care of 50+ hours a week).

Now of course, not all councils will decide to raise taxes. Richard Humphries from the King's Fund estimates that rather than bringing in an additional £2 billion for adult social care the precept will bring in just £800 million – less than half the government's intended target, though we won't know the exact figure until the end of the parliament by which time it may be too late[14]. And of course, some of the additional money is likely to go toward funding the new living wage rather than adding additional capacity. Given the extent to which the sector has already been squeezed, the precarious financial position of some of its providers and the rising demand for care, this could result in a further reduction in access to formal adult social care, increased reliance on informal care and rising unmet need.

Adult social care: towards a new model

Even if real terms spending on care is maintained at current levels, this would still imply an overall fall in expenditure on care as a proportion of GDP. It would fall from around 1.1% of GDP today to around 1% by 2020 and it would fall even further if the precept does not bring in as much as anticipated[15]. To put this in context, such a level of spending as a proportion of economic output, would put us firmly in the bottom half of the OECD league table. While cross-country comparisons are somewhat hazardous because different countries categorise health and social care in different ways and operate different funding models, average public expenditure on care in the OECD was 1.6% of GDP in 2011 – significantly above our current and anticipated level of spending[16]. Indeed, it would mean that we are closer in terms of expenditure to central and Eastern Europe than to the bastions of adult social care in Denmark, Norway and Sweden.

Figure 6: Expenditure on LTC as a % of GDP (2011)



Source: OECD

Unintended side effects

Unless further funding is found in this parliament, we may be moving towards a mixed and somewhat polarised system of care with some private formal care for those that can afford it, alongside rising reliance on informal carers and increasing unmet needs for those that can't.

An army of unpaid carers

A greater reliance on family carers may help to alleviate some of the pressures currently facing the adult social care sector, but such a response to the care crisis could have unintended consequences, not least an erosion in the quality and professionalism of care provision.

But there are likely to be other socioeconomic consequences of putting more reliance on informal care. With middle aged women the most likely group to care for family members, increased reliance on unpaid carers could undo some of the significant gains made in female employment seen over the last twenty

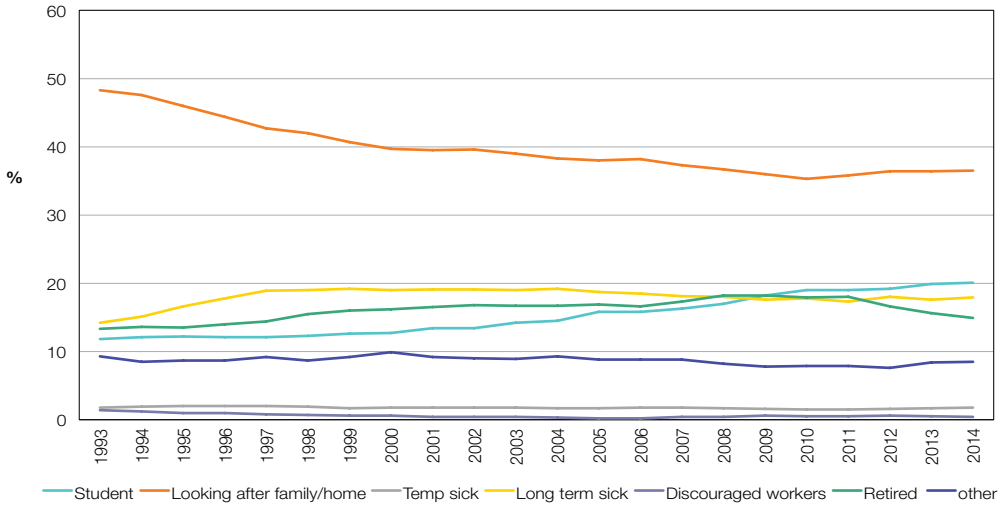
14 See Campbell (2015) Using council tax to offset care cuts 'will widen gap between rich and poor', Story for the Guardian: http://www.theguardian.com/politics/2015/dec/06/council-tax-offset-care-cuts-widen-gap-rich-and-poor-kings-fund?CMP=share_btn_tw

15 Calculations based on Office for Budget Responsibility estimates for current spend on long-term care and economic growth forecasts (real GDP).

16 OECD (2013) Health at a Glance: http://www.oecd-ilibrary.org/sites/health_glance-2013-en/08/09/index.html?itemId=/content/chapter/health_glance-2013-79-en&mimeType=text/html

years. As the below chart shows, these employment gains have been driven by a substantive fall in the proportion of women who are economically inactive because they are caring for family members. That trend may already be starting to unwind. Since 2010, the fall in the proportion of women who are economically inactive because they are looking after their family appears to have levelled off and may even be starting to rise.

Figure 7: Reasons for being economically inactive (women)



Source: ONS Labout Market Statistics (2015)

Unpaid carers make a significant contribution to society. In 2015, a report from CarersUK estimated the economic value of unpaid carers at £132 billion per year – 7% higher than in 2011[17]. But unpaid care can put a significant strain on the individual providing it – especially those providing 50 hours or more a week, of which there are around 1.4 million people. Yet carers receive little support for what they do. Carers Allowance is currently set at just £62.10 per week for those providing at least 35 hours of care a week. This amounts to under £2 per hour of care provided. And as this report has illustrated, there will be little additional funding through the precept directed to those local authorities where unpaid carers make the biggest contribution.

Going it alone

In the future, those who have a care need and can rely on family to support them may be the lucky ones. For the purposes of this report, we have estimated that there are approximately 4.3 million people aged 50+ in England who are living alone (that's roughly 1 in 5 middle aged and older people living on their own), and we know that the chances of living alone rise with age[18]. Without family or friends to support their care needs, and with falling levels of formal support, this group faces a particularly worrying future.

Concluding remarks

The settlement for social care outlined in the Spending Review does little more than paper over the cracks which many of those in need of care are already falling through. While some will be able to rely on family to support their needs, increased prevalence of unpaid caring may have adverse consequences for those providing support, for the economy as a whole due to reduced employment, and may even lead to an erosion in the quality of care provided. If we really are moving to a model of care that is almost entirely reliant on family and community support, then we must have the adequate infrastructure in place to support the needs of informal carers. Yet with local government facing more severe real terms spending cuts, it is difficult to see where this capacity is going to come from. The future for adult social care looks bleak.

17 Buckner and Yeandle (2015) Valuing carers 2015, report for CarersUK: http://www.carersuk.org/for-professionals/policy/policy-library?task=download&file=policy_file&id=5479. This estimate assumed a unit cost of replacement care of £17.20 per hour, which, the report argues is in line with the official estimate of the actual cost per hour of providing homecare to an adult.

18 Beach (2014) Loneliness in older men, report for ILC-UK and Independent Age: http://www.ilcuk.org.uk/images/uploads/publication-pdfs/Loneliness_in_older_men_report.pdf

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All library photos posed by models.

Contents

1 Why support older carers?

The 2011 Census revealed that there over 1.8 million carers aged 60 and over in England – almost 16% of the population of this age range. This includes a huge 20% of the population in the 60–64 age group, compared with 12.6 % of the overall population. The number of carers aged 85 and over grew by 128% in the last decade (Carers UK and Age UK, 2015).

This group is often invisible, with many older carers providing long hours of vital care and support while their own health and wellbeing deteriorates, resulting in poor physical and mental health, financial strain, and breakdown in their ability to carry on caring.

With an ageing population and increasing demand on health and social care services, supporting older carers better is a key way of keeping people at home, independent and healthy. It can also help to reduce unplanned hospital admissions and avoid premature admission to residential care.

What this toolkit aims to do

This toolkit is targeted at commissioners of health and social care in England and aims to highlight the needs of carers aged over 60 and to show tried and tested ways they can be supported. It shines a spotlight on particular issues most likely to impact on older carers, influenced by factors such as their own life stage, who they are caring for, their circumstances and their own health. This can help inform commissioning to properly and most cost-effectively support them.

It will also help commissioners fulfil duties to prevent, reduce and delay needs and to support older carers under the Care Act 2014.

It is important to remember that older carers are not a homogenous group. Every carer has specific and personal circumstances. The needs and wishes of each individual carer and responses to them will be unique but there are clear recurring issues which, through listening to the needs of older carers in your community and commissioning good quality services, can help older carers stay healthy, independent, and more able to maintain choice and control over their own lives.

Although the terminology and legislation referred to in this guide applies to England the standards and rationale are applicable across the whole of the UK.

About Carers Trust

Carers Trust is a major new charity for, with and about carers. We work to improve support, services and recognition for anyone living with the challenges of caring, **unpaid**, for a family member or friend who is ill, frail, disabled or has mental health or addiction problems.

We do this with a UK wide network of quality assured independent partners, through our unique online services and through the provision of grants to help carers get the extra help they need to live their own lives. With locally based Network Partners we are able to support carers in their homes through the provision of replacement care, and in the community with information, advice, emotional support, hands on practical help and access to much needed breaks. We offer specialist services for carers of people of all ages and conditions and a range of individually tailored support and group activities.

Our vision is of a world where the role and contribution of **unpaid** carers is recognised and they have access to the trusted quality support and services they need to live their own lives.

The services offered by each Network Partner vary but can include:

- Emotional and practical support for carers including providing care in the home to enable carers to take a break.
- Carers emergency services, offering help in a crisis.
- Outreach work in GP surgeries, hospital wards and schools to reach carers who haven't come forward for support.
- Information and advice on issues such as benefits, grants and other help available.
- Giving carers a voice so that they are listened to by local decision makers.
- Helping carers to share experiences though group support and social activities.
- Access to education, training and employment.
- Supporting young carers through preventative, whole-family work and clubs, activities and mentoring in schools.

To find your nearest Network Partner, call 0844 800 4361 or visit **Carers.org**.

Carers Trust also supports carers through interactive services **Carers.org**, **babble.carers.org** and **matter.carers.org**.

2 Older carers – the Care Act and the wider context

To understand the needs of older carers, it's first important to understand the demographics of this group, who they are caring for and how much care they are providing. 54% of carers in England aged over 60 are male, contrasting with 42% of the caring population as a whole. Three in five of carers aged over 85 are male (Carers UK and Age UK, 2015), showing that the gender balance shifts significantly in this older population of carers.

Research in 2011, in a survey of 639 older carers, found that the majority (55% of the whole sample) were caring for their spouse or partner but this increases in older age groups – in the 70 and over group, 87% are caring for a spouse or partner. Approximately a quarter of carers across the age groups were caring for an adult son or daughter.

Older carers in England (UK Census 2011)

	Age 60–64	Age 65–69	Age 70–74	Age 75–79	Age 80–84	Age 85+
Number of carers	630,195	426,510	298,741	226,249	151,674	87,346
Percentage of carers in overall population of this age group	20.0%	17.1%	14.8%	13.8%	12.7%	8.8%
Percentage of carers providing 50+ hours of care per week	20.1%	27.5%	37.5%	45.1%	50.9%	55.4%

Almost one in ten people aged over 85 provide **unpaid** care and the number of carers aged over 85 is expected to double over the next 20 years (HM Government, 2014). Most carers aged over 80 spend more than 50 hours a week caring – with this data corroborated by research in 2011 where most carers aged over 70 recorded caring for over 60 hours a week (The Princess Royal Trust for Carers, 2011). This is a huge task for people whose own health may well be deteriorating, and whose caring role goes unnoticed and unsupported.

The number of older carers is increasing at a greater rate than for carers as a whole. The total number of carers rose by 11% in the ten years between the 2001 and 2011 census, while the number of older carers has risen by 35%.

A national policy perspective

Families and communities depend on carers to provide support that would otherwise need to be met by services – and research suggests the economic value of the contribution made by the UK's carers per year is in the region of £119bn (Buckner, L. and Yeandle, S, 2011). Particularly in times of economic constraint, the support provided by **unpaid** carers is desperately needed, as the need to provide this care would otherwise fall on already overstretched services. Supporting carers themselves to ensure they can carry on caring makes economic sense, and national policy reflects this.

Significant shifts in policy framework have been spearheaded by the Care Act 2014. There is increased emphasis and resources being targeted at greater integration of health, social care and community services to streamline and meet the needs of the changing demographics of the population, with a particular focus on prevention and on reducing unplanned admissions to hospital.

The Care Act 2014

The Care Act 2014 largely came into force in April 2015, with some elements due to come into force in April 2016. It puts in place significant new rights for carers in England including:

- A focus on promoting wellbeing.
- A duty on local authorities to prevent, reduce and delay need for support, including the needs of carers.
- A right to a carer's assessment based on the appearance of need.
- A right for carers' eligible needs to be met.
- A duty on local authorities to provide information and advice to carers in relation to their caring role and their own needs.
- A duty on NHS bodies (NHS England, clinical commissioning groups, NHS trusts and NHS foundation trusts) to co-operate with local authorities in delivering the Care Act functions.

Taken together, these new rights should have a significant impact on carers and the support available for them. However, this is dependent on local authorities putting these in place in a context of financial constraint. A range of publications are available in addition to the Act and its regulations and guidance, to enable local authorities to interpret these new duties (see the Local Government Association website **www.local.gov.uk**).

NHS England's Five Year Forward View

NHS England's Five Year Forward View (NHS, 2014) places emphasis on supporting carers and particularly highlights those who are aged over 85. It promotes work with GPs and the voluntary sector to identify and support carers. The voluntary sector is recognised as a vital resource, often with reach into underserved groups

and impact well beyond that which statutory services can achieve. It is recognised as providing a rich range of activities including information, advice and advocacy from expert paid staff, alongside the added value that volunteers may bring. The report encourages partnership with voluntary sector organisations that may include grant funding over multi-year periods to achieve positive outcomes.

The Better Care Fund

The Better Care Fund (NHS England, 2015) provides local authorities and clinical commissioning groups – though health and wellbeing boards – with a shared fund to invest in agreed local priorities which support health, care and support, focusing in 2015/16 on reducing unplanned admissions. It provides a key opportunity to promote integration in provision to ensure availability of a range of preventative care and support services. Plans for 2015 were required to state how much was being allocated to carer-specific support indicating that this is a clear priority. Integration is likely to remain a priority in the years ahead, and supporting carers is a key element of this.

The needs of older carers

There is general recognition that some carers can be harder to reach, or perhaps easier to overlook and less likely to access services. Very often this can be because barriers exist in the structure and accessibility of services for some groups of carers or because carers do not expect to receive or actively seek support. In addition, many carers simply do not recognise that they are a carer.

It is vital that those working in a wide range of community based services including primary care are equipped to recognise carers and proactively help them to access appropriate information, advice and support.

Research has shown a range of areas of concern. For carers as a whole, The Personal Social Services Survey of Adult Carers in England 2012–13 (Health and Social Care Information Centre, 2013) showed that particularly high levels of carer needs, expressed in terms of poor quality of life scores, were reported among carers with mental health problems of their own, among carers from Asian/British Asian communities, and among those caring for 15–20 years. This length of caring role is very common, for example, when caring for an adult son or daughter with a disability.

Specifically in relation to older carers, particular needs to consider are:

- Carers aged 60–69 often juggle caring with the demands of work and financial pressures while those aged over 70 may be more likely to find it difficult to cope with the physical demands of caring.
- Carers will be caring for people with a wide range of health conditions and disabilities, with varied emotional and physical demands and concerns for the future.
- Over 16% of older carers in research in 2011 (The Princess Royal Trust for Carers, 2011) were caring for more than one person. This is more common for the younger age group 60–75 where significant numbers care for a parent as well as an adult son or daughter, grandchild or someone else with a disability or long-term health condition.

The following sections look at each of the key concerns for older carers from some of the research above. Each of these areas has been identified for older carers in general but there may be particular groups where an area would be most likely to be a pressing issue, which is highlighted. Each section then looks at how services can be commissioned to help address each of these issues.

Measuring impact: Carers Star

All services that support older carers will need to be able to demonstrate their impact on the lives of the carers they support. The Carers Star is an outcome measurement tool which has been developed for use specifically with carers and covers seven key areas – health, the caring role, managing at home, time for yourself, how you feel, finances and work.

See **www.outcomesstar.org.uk/star-guides** for more information or email Carers Trust at **star@carers.org**.

3 Identifying and involving older carers

Many carers simply do not realise they are a carer – they may simply think of themselves as someone's wife, brother, son, partner, friend, neighbour. However, unless carers are identified, it is difficult to get support to them until they reach crisis point. Identifying carers in primary care and community pharmacies, and in other community settings, and referring carers to local carers organisations, can be the first step in helping someone to realise they are a carer and begin to get the support they need.

Particular attention may be required to recognise and involve carers who are less likely to approach services or speak out themselves.

Identifying older carers

Older people may be more reluctant than other carers to ask for or accept help and less likely to reveal their caring status or to identify themselves as a carer. This could be for a range of reasons including a sense that asking for or accepting help is a failure on their part. They may also be fearful of someone else taking over or even removing the person they care for from them, or the person with care needs may be adamant that they will not accept care from anyone else. Additionally, there is often a sense of dignity in remaining independent. It may therefore be that services need a particularly skilled and sensitive approach to older carers to address their concerns and this may be a process rather than a one-off intervention.

A caring situation may not be obvious especially if the person being cared for is not living at the same address. However, older carers are likely to be accessing primary care services such as their GP and community pharmacies with a range of health or other needs for themselves or the person they care for, so these are important places to identify older carers. Health and care staff undertaking home visits are also in a key position to identify carers.

It is important to train health and care staff in carer awareness and the importance of carer identification, and also to establish referral pathways with local carers organisations. This can help ensure that health and care staff not only identify carers but refer them to a local agency which can ensure they are offered a carer's assessment, and are linked in with a range of local support.

Identifying older carers from diverse communities

Lesbian, gay, bisexual and transgender carers

Research shows that lesbian, gay, bisexual and transgender (LGBT) carers may be less likely to be identified by social care professionals (Musingarimi, P, 2008), than other carers and therefore less likely to receive support and be involved in

decisions. In addition, they may have concern that services or workers may not be LGBT friendly, or they may feel uncomfortable about coming out to people who can help (LGBT Foundation, 2015). With LGBT people making up 5–7% of the older population this is a significant issue.

Carers from black, Asian and minority ethnic backgrounds

Carers from black, Asian and minority ethnic backgrounds (Gregory, C, 2010) are also less likely to take up services or be recognised and involved. All organisations can and should be responsive to the specific needs of black, Asian and minority ethnic carers, but the low take up of mainstream services is often seen as the carers not taking up what is on offer, rather than thinking through institutional barriers or whether the support is culturally appropriate.

Black, Asian and minority ethnic carers are not a homogeneous group and the diversity between and within communities as well as cultural perceptions of disability and caring need to be carefully considered.

Research shows that unless specific provision is made to engage marginalised groups, user and carer involvement will continue to reflect broader social divisions and exclusion (Beresford, P, 2007).

May be most likely to affect

All carers, in particular:

- Older carers new to a caring role.
- Carers of people with long-term degenerative conditions, for example dementia.
- Older carers from black, Asian and minority ethnic backgrounds.
- Older carers from the LGBT community.
- Carers with communication difficulties or whose first language is not English.

Examples of services to identify older carers including from diverse communities

- Links between primary care and community services and local carers organisations to identify and refer carers.
- Training for staff in hospital based and community services in carer identification and referral.
- Targeted work to reach and support marginalised carers (links with duty under the Care Act for local authorities to identify carers and for the NHS to co-operate).
- Joint work with local voluntary groups supporting people from different parts of the community to reach carers from diverse backgrounds.

Positive practice example in the Carers Trust network

Reaching carers in partnership with community pharmacies – Carer-friendly Pharmacies

The Carer-friendly Pharmacy pilot, a partnership between Carers Trust, the Pharmaceutical Services Negotiating Committee and the Centre for Pharmacy Postgraduate Education, has highlighted the key role community pharmacies can play in identifying carers and helping them access other forms of support.

Community pharmacy teams offer a wide range of services to carers such as ordering, collecting and delivering prescriptions, and giving advice on the correct use of medicines.

Following carer awareness training and equipped with bespoke resources to facilitate quick and easy referrals, the pharmacies who took part in the pilot went on to identify 247 carers of whom 118 were aged 60 and above and 19 were aged 80 and above.

With the carer's permission, carers were referred to their local carers organisation and the pharmacy also let the carer's GP practice know that they were a carer.

For more information see **https://professionals.carers.org/carer-friendly-pharmacy-pilot**.

4 Health and wellbeing

The health and wellbeing of older carers has been highlighted as an area of significant concern.

Research in 2011 (The Princess Royal Trust for Carers, 2011) found that:

- Two thirds of older carers have long-term health problems. Commonly reported conditions are arthritis and joint problems, back problems, heart disease, cancer and depression.
- One third of older carers report having cancelled treatment or an operation they needed due to their caring responsibilities.
- 50% reported that their physical health had got worse in the last year, and 70% said specifically that their caring responsibilities had a negative impact on their physical health.
- Across all of the older age groups, more than 40% said their mental health had deteriorated over the last year, with 75% of the 60–69 age-group saying that caring had a negative impact on their mental health.
- Less than 50% of carers over 70 who had to lift the person they care for, think that they do this confidently or safely.

Many older carers caring for a partner find themselves having to provide personal care alongside having to do all the household jobs that once were shared, resulting in high levels of stress and physical fatigue.

Tiredness is also a significant issue when a carer is on call for 24 hours a day and may be awake often in the night to attend to the needs of the person they care for. Dealing with challenging or unpredictable behaviour also causes particular stress and emotional strain, for example when then person being cared for has dementia.

Carers' health deteriorates incrementally with increased hours of caring (HM Government, October 2014). This is a concern as data shows that the oldest carers are more likely to spend more hours caring than those who are younger, particularly as this is compounded by the fact that age-related illness will be more likely.

There is a considerable body of evidence (Conochie, G, 2011), to show that carer wellbeing is a key factor in hospital admissions, readmission and delays in the transfer of care. For example, a whole systems study tracking a sample of people over 75 years old who had entered the health and social care system found that 20% of those needing care were admitted to hospital because of the breakdown of a single carer on whom the person was mainly dependent (Castleton, B, 1998).

Supporting Carers: The Case for Change (Conochie, G, 2011) also highlights that carer-related reasons for admission to nursing or residential care are common,

with carer stress the reason for admission in 38% of cases (Bebbington, A et al, 2001). This suggests that giving carers extra support to manage their caring role more effectively and maintain good health could reduce unwanted residential care admissions.

Deterioration in carer health and wellbeing therefore is likely to increase demand on health and social care services for both the carer and the person with care needs. Preventative interventions to support the carer may therefore reduce the likelihood of increased future health, social care or residential care needs of both parties.

May be most likely to affect

Mental health and wellbeing:

- Carers caring for more than one person.
- Older carers working and caring.

Physical health and wellbeing:

- Carers aged over 75.

Both physical and mental health:

- Older carers who need to do physically demanding caring tasks.
- Older carers who often need to be up in the night.
- Older carers of people with dementia or people with challenging behaviour.
- Older carers who have little back-up from other friends or family.
- Older carers who feel strongly about coping without outside support or where the person with care needs is reluctant to accept help from anyone other than the carer.

Examples of services to support carers' physical health

- Health checks for carers aged 60 or over (focusing on both physical and mental health), followed by action to address identified concerns and access to flu immunisation.
- Initiatives to identify and support both the carer and the person with care needs around trigger factors for hospital admission, for example falls and incontinence.
- Opportunities for carers to pursue own interests and activities away from caring.
- Moving and lifting training for carers who need to lift the person they care for.
- Prompt access to appropriate aids, adaptations and equipment.

Examples of services to support mental health and emotional wellbeing

- Access to breaks from caring.
- Opportunities to talk to someone who understands in a non-judgemental way. This includes culturally-specific support for black, Asian and minority ethnic groups and LGBT aware support.
- Opportunities to share experiences and swap information with other carers including those in similar situations, through training courses, workshops and peer-support mechanisms.
- Access to talking therapies specifically targeted at carers.
- Training and support in dealing with difficult behaviour.

What can good support look like?

Case study: Malcolm

Malcolm is 86 years old and living in a rural market town. He has cared for his 83-year-old wife, Linda for the last ten years. Linda has Parkinson's disease, which has led to a dramatic deterioration in her health over the last decade. Her mobility is limited and she now needs two people to help her move from her bed to a chair. In addition, she is doubly incontinent.

With Malcolm's support, Linda has been able to remain in the comfort and familiar surroundings of her own home. Despite very little communicative ability and her limited mobility, Linda's quality of life is supported by the care Malcolm provides.

Malcolm has developed his own health needs and relies heavily on the regular support that the local Carers Trust Network Partner has provided for him over the last ten years. When his dedicated Carer Support Worker visits his home twice a week Malcolm is able to step back from his 24/7 caring role and take some time out for his own wellbeing. He particularly loves to visit his local church and help with church business while the worker is taking care of Linda.

Malcolm has described the service as his lifeline. He knows that the Carer Support Worker is able to take care of his wife's care needs (including hands-on intimate personal care) and this gives him the peace of mind to leave Linda in their safe hands and take some time out to enjoy a life outside his caring role. This dedicated support has given him the help that he needs to maintain his caring role throughout the last ten years, despite his own and Linda's health needs.

Positive practice in the Carers Trust network

Giving older carers a break: Crossroads Care Harrogate, Craven, Selby and York – breaks service

Crossroads Care Harrogate, Craven, Selby and York, supports a high proportion of older carers, particularly those aged 80 plus living in a large, mainly rural area. The oldest carer that they support at present is 96 years old.

The breaks service offers paid Carer Support Workers who visit the home and take over the care of the person with care needs. This allows the carer an opportunity to step back and take a break, so supporting their physical and mental wellbeing.

Staff assess the needs of each client individually, enabling the Carer Support Workers to undertake the tasks normally carried out by the **unpaid** carer so that they can use the time to do whatever they want – housework, shopping, leisure pursuits or simply taking a relaxing break.

Promoting wellbeing through access to counselling: Carers Support Merton – counselling service

Carers Support Merton's carers counselling service attracts many older carers. The service offers 16 sessions with a counsellor, for a donation of up to £3 per session. As part of the wider work of the organisation it seeks to increase the resilience of carers by providing support for their mental and emotional wellbeing.

Many older carers find that the service provides them with a reflective space to share concerns and experiences and make sense of them. Some carers want to talk about and come to terms with fears for the future. The service is often used by carers who are caring for someone at the end of life or following bereavement and provides support through this challenging time of grief and transition.

The organisation recruits volunteer counsellors who are qualified or on recognised training courses that comply with the British Association of Counselling and Psychotherapy Code of Ethics and Practice. All counsellors must evidence being in regular, professional supervision.

Providing breaks and preventing escalation of needs: Carers Association in South Tyneside – Befriending Sitting Service

The Befriending Sitting Service provides an opportunity for carers to have time out from their caring role. It offers a befriender or volunteer who will sit with the person with care needs or assist them to go on outings. The majority of carers using the service are aged over 70 and around 70% of those are caring for someone with dementia.

Carers and the people they care for are matched with a paid befriender or volunteer. Paid befrienders offer a regular weekly visit of around 2–3 hours to spend time with the person with care needs, share news and memories or accompany them on an outing. Carers with the highest needs on the waiting list are given priority for receiving the service. Volunteers offer similar support on a less structured basis. The service allows the carer to have a break, safe in the knowledge that they know the person they care for is being looked after.

Befrienders and volunteers are also able to recognise emerging needs and concerns, and intervene early to offer support. The service is particularly helpful for carers after the person they care for is discharged from hospital, helping both the carer and the person they care for to stay active and preventing readmission.

This service has a strong partnership link with the local Alzheimer's Society which offers free training for volunteers and makes regular referrals to the project.

The service is supported with a mix of funding from the clinical commissioning group and South Tyneside Council.

5 Financial concerns

For many older carers, financial concerns can have a particular impact on their wellbeing. Older carers can feel significant anxiety about financial matters and may be reluctant to access services that would support them or the person with care needs due to limited financial means.

Research findings show that:

- Carers aged 60–64 may experience some of the greatest financial difficulty (The Princess Royal Trust for Carers, 2011).
- Many carers give up work to care and find it hard to return to the workplace after a period of absence (HM Government, October 2014). It should be remembered that many people work well into their 70s and even older.
- Many thousands of older carers are missing out on benefits to which they are entitled because they do not know what is available, they are reluctant to claim benefits, they assume that they would not be eligible or because the process for applying is too complicated (Age UK, 2014).
- Carers of adult sons or daughters with learning or other disabilities have concerns about their future which include financial concerns (Mencap, 2012).

Carers approaching retirement will be at a key point in life where changes in income may be a particular concern. Welfare benefit entitlement may alter over time, reflecting increasing age or changing health needs of the carer or person with care needs. Carers may need specialist advice in order to understand these changes and to make benefit applications accordingly.

The Care Act specifically takes account of someone's economic wellbeing as part of a definition of what issues need to be considered with regards to wellbeing overall. Additionally, local authorities are required under the Care Act to identify adults (including carers) who would be likely to benefit from independent financial advice and help them to access it, so that they can get support to plan and prepare for the future costs of care or to consider how they meet current care costs.

May be most likely to affect

- Carers aged 60–70.
- Older carers who have given up work to care.
- Older carers who have not accessed appropriate information and advice.
- Older carers of an adult son or daughter with a disability.

Examples of services to support carers' financial circumstances

- Information and advice about welfare benefits.
- Support to claim benefit entitlement.
- Carers discount card schemes.
- Support for working carers to remain in work.
- Small grants for carers.

Support for carers to improve their financial circumstances are often provided as part of a holistic package of support by carers services.

What can good support look like?

Case study: Norman

Norman is 90 years old and cares for his wife, Joyce, who is 89 and has become very frail with osteoporosis and arthritis. Norman takes care of most of the day-to-day tasks around the home including cleaning, shopping and cooking and had managed for the last three years without any outside help. He helps Joyce with getting dressed and washed.

However, recently Norman's own health has deteriorated and he is finding that he is becoming very tired. He was concerned about asking for help as he feared that he and Joyce might be separated and that she may need to go into residential care. A relative who was concerned about him persuaded him to speak to his local Carers Trust Network Partner who arranged a home visit.

The Support Worker from the Network Partner offered help in a variety of ways. She understood Norman's concerns about asking for help and supported him and Joyce to access social services and receive an assessment of their needs. As a result, a care package was put in place to help Joyce remain at home and to take the strain from Norman. The worker also helped Norman to claim Attendance Allowance and this allowed him to pay for some help to do some of the household tasks. Norman was linked up with a local male carers support group and now enjoys getting out from time to time and meeting other carers.

The support that has been put in place has enabled Norman and Joyce to remain together in their own home and has helped Norman to be able to continue caring for his wife and to have enough rest so that his own health has improved.

Positive practice in the Carers Trust network

Meeting older carers' financial and other needs: Redbridge Carers Support Service – older carers project

Currently 500 older carers are registered with the service. Many older carers find it difficult to leave the person they care for in order to access drop in based services and prefer a face-to-face service rather than internet or telephone based options. This service was designed to meet their needs.

Within two weeks of an older carer contacting the project, an assessment visit is made to the carer's home by their allocated Support Worker. The carer and the Support Worker develop a personalised support plan which identifies the immediate information and advocacy needs of the carer as well as longer-term needs to address isolation and wellbeing. Where the carer is looking after a spouse or partner, one of the goals is often around how they can do activities together as partners.

Carers are supported to make claims for welfare benefits they may be entitled to, and referrals made to statutory and other voluntary sector agencies. Some carers need time and support to accept help from other agencies and the service often finds itself helping support statutory services by being the hub and knitting services together by being able to take the time to explain what the various services do and support carers to accept help.

Volunteer befriending is one of the services provided as part of the support plan. Befrienders can visit a carer once or twice a week in order alleviate isolation. They will also make phone calls to check in with the carer.

The support plan will also highlight the core Redbridge Carers Support Service activities available to all older carers. These may include:

- Basic computer training so shopping can be done online and Skype can be used to keep in contact with family members. 60 older carers have accessed these classes in the last two years.
- The Carers Emergency Alert Card which provides reassurance when the carer is outside the home.
- Social and creative activities such as card-making workshops.

6 Social isolation

Older carers are often concerned about their own social isolation caused by the demands of caring and by the gradual weakening of friendships as caring continues. Older carers of a partner may have lost a joint social life and interests. After the caring role comes to an end, particularly after the death of the person with care needs, time spent caring may have eroded friendships and interests outside the home, leaving the former carer in an extremely socially isolated situation.

Social isolation is compounded by a lack of respite and breaks from caring. More than two thirds of older carers in the Always on Call, Always Concerned research (The Princess Royal Trust for Carers, 2011) reported not getting breaks away from caring at all with a further third only getting a break once every 2–3 months or less.

Studies have shown how supporting carers or providing them with a break can improve their health. One study found that 35% of carers without good social support experienced ill health compared with 15% of those with good support and that fewer carers experienced mental health problems if they had taken a break since beginning their caring role (Singleton, N, et al, 2002). Additionally, it is acknowledged that male carers tend to be less likely than female carers to access carers services and breaks and this can compound issues of isolation. Research in 2014 found that older male carers often felt local support services did not meet their needs (Slack, K and Fraser, M, 2014).

A key principle in the Care Act is that of prevention of the escalation of need. Local authorities have a duty to prevent, reduce or delay the need for support and this specifically includes provision for carers. Services that help to reduce loneliness and isolation are specifically highlighted in the guidance as an important factor to address this duty.

May be most likely to affect

- Older carers providing 50 hours or more a week of care or where the person with care needs is housebound or has mental health problems including dementia.
- Older carers who do not receive respite support or breaks.
- Older carers who feel strongly about coping without outside support or where the person with care needs is reluctant to accept help from anyone other than the carer.
- Less mobile carers.
- Carers for people at the end of life and bereaved carers.
- Older male carers.

Examples of services to support carers' social inclusion

- Peer support groups.
- Befriending schemes (face-to-face and telephone).
- Respite care services.
- Carers social groups.
- Outings, short breaks and activities for carers.
- Training and support to use IT.
- Activities which can involve the carer and person they care for together.

What can good support look like?

Case study: Barbara

Barbara is 72 and has been caring for her partner, Rowena, 68, for the past six years due to her chronic obstructive pulmonary disease. Rowena is on a continuous supply of oxygen and had been experiencing depression for a number of years. She had also been extremely anxious and withdrawn. Barbara had found it increasingly difficult to cope with her caring role as Rowena was very nervous about having other company other than her partner and daughter and so Barbara was becoming less and less able to leave her.

The Carers Trust Network Partner introduced a volunteer befriender to Barbara and Rowena four years ago. The befriender built up a good relationship with the couple and Rowena now confides in her. The befriender started to engage Rowena in craft activities at home and Barbara was able to leave them together and enjoy some time to herself. Over time, Rowena started to go on outings with the befriender, which she had not felt able to manage for a number of years. They now go on trips to the garden centre and local park.

Barbara is astonished at the change in Rowena's outlook. She can see that with the support of a befriender Rowena feels more independent, capable and valued. Barbara is able to have some time to herself, see friends and link in to activities, and feels more able to cope with her caring role.

Positive practice in the Carers Trust network

Building an inclusive older carers community: York Carers Centre – addressing loneliness and isolation

York Carers Centre has worked closely with the Joseph Rowntree Housing Trust in New Earswick to identify older carers to address issues of loneliness and isolation. It uses the local hall to provide a place for older carers to meet and have a meal together. This ensures that carers are never far from home or the person they care for so they are more likely to attend meetings.

The meetings provide an opportunity for participants to take part in social activities, get information and advice and have respite from their caring role. The group sometimes has visiting speakers, such as a local solicitor to talk about will-writing. The group is involved in having a say about the developments that are happening on the housing estate and links in with other activities at the hall. The carers centre support staff are also able to help carers to consider their own health and wellbeing and ensure that they are receiving the support that they need.

The group is funded with local authority funding and a grant from a York-based charitable foundation. This has enabled the group to buy tablets – responding to an expressed interest in the use of new technology by carers. This has led to inter-generational work with younger carers showing older carers how to use the tablets. The focus is on the use of tablets to aid socialisation, increase engagement in community links and take advantage of technology, for example by learning how to use health apps.

This gives carers increased patient access to their own medical health records and allows them to be more involved in managing their health through access to new technology. It has also opened up opportunities to use the tablets for reminiscence activities, which are especially valuable for carers of people with dementia.

The older carers group provides a local solution for about 20 carers each week where they can receive a range of help and build friendships. Some carers have gone on to socialise outside the meetings and access other local community activities together.

Combating isolation for carers of people with dementia: Swindon Carers Centre – Open Minds group

Swindon Carers Centre started a group in 2013 for carers over the age of 65 who care for someone who is over 65 or has some form of dementia. This was in response to a specific request from carers as they found it difficult to attend events if they could not go along with the person they were caring for.

The group was named Open Minds by the carers themselves. They meet monthly with a different type of activity each time – including craft, singing, dancing and outside entertainment. The group is facilitated by two members of staff and a couple of volunteers who help with refreshments and other tasks. As a result of a very well attended tea dance this has also now become a regular bi-monthly event with around 52 carers and the people they care for attending.

Taxis are provided for people who have mobility issues or could not otherwise attend the events. This service is supported by volunteers from the church who host the dance and is an excellent example of community partnership working.

Carers have stated that they find the group a safe and welcoming environment where difficult behaviours are not frowned upon. The group has become extremely popular and has a regular attendance of around 46 people. It has now become widely known throughout Swindon.

The group has been funded by a local charitable fund and is now looking to develop and expand due to the overwhelming popularity and success of the project.

7 Concerns for the future

More than 80% of older carers responding to research (The Princess Royal Trust for Carers, 2011) had worries about the future including what will happen to the person they care for if they can no longer care for them. There is also considerable concern among older carers about how they will cope if the needs of the person that they care for become more severe.

The Care Act requires that a carer's assessment considers the carer's potential future needs for support as well as those currently present. Carers play a significant role in preventing increased needs for care and support for the people they care for. It is important that local authorities also put in place support to prevent carers from developing needs for care and support themselves. This could include emergency planning, as well as planning for what help may be required if and when the health of the carer or person with care needs deteriorates.

In some areas an emergency care scheme exists, where arrangements are in place to deal with situations where a carer, for example is taken unwell. Research suggests that the peace of mind this brings for carers enables them to continue to provide day-to-day care and promotes their own resilience, knowing that if anything untoward happens, there are arrangements in place (Elwick, H and Becker, S, 2011).

The Care Act guidance also highlights that services which encourage early discussions in families about potential changes in the future are important in addressing a local authority duty to prevent escalation of need. It specifically mentions conversations about potential care arrangements or suitable accommodation should a family member become ill or disabled.

Lasting power of attorney

If there is concern that the person with care needs will lose their capacity to make decisions for themselves, it is important that lasting power of attorney is put in place while they still have capacity to express their wishes.

It is often assumed that lasting power of attorney relates only to finance and property, when in fact it can also relate to health and welfare, meaning that a person can let their wishes for their future care be known. Often, due to the sensitivity of the subject, people wait too long to put lasting power of attorney in place, resulting in a much longer and more complex process later. Further information on making a lasting power of attorney is available at **www.gov.uk/power-of-attorney/overview**.

Older carers of adult disabled sons and daughters

Older carers of adult disabled children will often have been caring for their son or daughter (sometimes more than one) since they were born, as well as possibly caring for their own parents or partner. Research (Mencap, 2012) indicate that key concerns and needs for this group of carers are:

- The need for help with emergency planning in case the carer is admitted to hospital.
- The need for help with planning for the future financial, housing and care needs of the person being cared for. This includes legal information about leaving money or property by will or trusts.
- The need for assessments and care packages that recognise the changing needs of both the parent carer and the person being cared for as the parent becomes less active and needs more help with domestic and personal care tasks. Parents in this situation, as well as their son or daughter, may express fears that they may be separated. This mutual caring needs to be recognised and receive an appropriate response through sensitive use of personal budgets and practical help (Foundation for People with Learning Disabilities, 2015).

Carers of people with dementia

Carers of people with dementia also have particular needs in terms of planning. With nearly half of carers aged over 75 caring for someone with dementia (Carers UK and Age UK, 2015), this is a crucial group whose needs should be addressed. Research commissioned by Carers Trust (Newbronner, L, et al, 2013), identified the caring journey undertaken by carers of people with dementia and the different needs of carers at various points of this caring journey.

Ten stages of caring were identified and associated needs described including timely diagnosis, information about dementia and its progression, when the capacity of the person with dementia declines, when the person loses mobility or develops behaviour problems, and when incontinence becomes an issue. These form a framework for how support for this group can be developed. Planning for these can be a vital element in helping carers cope.

May be most likely to affect

- Older carers of adult disabled children.
- Older carers of people with deteriorating health conditions.
- Carers aged over 75.
- Older carers with poor or deteriorating health.
- Older carers who feel strongly about coping without outside support or where the person with care needs is reluctant to accept help from anyone other than the carer.

Examples of services to support older carers to plan for the future

- Emergency planning support.
- Emergency care schemes.
- Long-term planning support.
- Counselling and mentoring support.

Positive practice in the Carers Trust network

Helping older carers plan for the future: Wandsworth Carers Centre – Emergency Planning Service

Wandsworth Carers Centre offers a framework and support for carers to plan for the future and for emergencies. Many of those using this service are older carers. The centre uses the Carers Star outcomes measurement tool and often during discussions around this with carers they will identify the need for a carer to plan for the future and for emergencies.

The Emergency Planning Service primarily receives referrals from social services as well as self-referrals and works with carers to identify the services that would be required in the event of an emergency if they were unable to care. The carer is then provided with a card with a unique identifier. The information from the plan is logged on social services' records so that in the event of an emergency a record of the needs of the person being cared for can be easily retrieved and emergency support can be put in place.

The Future Planning Service allows carers to consider options for the future as, perhaps, their caring ability gradually decreases or the needs of the person they care for increase. These conversations are sensitive as carers may find these issues particularly hard to face. Skilled staff are therefore needed to help carers with this. The centre is also trialing short courses specifically designed to help carers begin to have these difficult conversations and to understand the variety of options that may be available for the future.

Emergency support and longer-term planning: Carers Trust in Greater Manchester Crossroads care service – Bolton Older Carers Project

The Bolton Older Carers Project provides:

- Short-term emergency support to older carers in crisis (for example if they are unwell or have an accident that prevents them providing care).
- Help with future planning for older carers and the people they care for.

Carers Trust in Greater Manchester had identified that the capacity of older carers to continue caring can diminish over time as a result of failing health, reduced

energy and exhaustion and that older carers had serious concerns about what would happen to the person they care for when they were no longer able to care or had reduced capacity for caring.

The Bolton Older Carers Project takes a strategic approach to the provision of services to older carers by not only providing short-term emergency support when there is a crisis, but also supporting and advising older carers with long-term planning options. Workers make a visit to each older carer to carry out an initial assessment which will be used in an emergency situation, provide them with information so they can make informed choices about future emergency situations, and help put together a plan for the longer term. The service also:

- Provides information and signposting to other services.
- Helps the family to make a referral to appropriate services to help them continue in their caring role.
- Supports families to think about the future and consider options for the longer term.
- Assists older carers to plan, prepare and consider options for the time when they are no longer able to care.
- Supports older carers to put in place an emergency plan.

The project has two dedicated part-time Support Workers who provide emergency support when required, engage with older carers to build up relationships and put in place long-term plans, and support carers to deal with problems before they turn into crisis.

Having support available in an emergency and future planning in place gives great peace of mind and comfort to older carers living in Bolton.

The project takes referrals from Bolton Council's Adult Care Team and Bolton Carers Support.

8 Information and advice

Information and advice is crucial to carers, both to help them in their caring role and also for aspects of their own lives. However, carers often say that access to information is patchy, or comes too late to be of most use.

The Care Act 2014 now places a clear duty upon local authorities to provide an information and advice service for those with care needs, and carers. In particular, the Care Act guidelines are clear that such information and advice is likely to include a range of approaches and channels including face-to-face, telephone, peer support, online and media information.

It is important that carers and families have time to think through their options and make informed decisions about their own lives alongside caring, including decisions about remaining in education or paid employment, claiming benefits and contributing to pensions. Early access to information and advice and, where appropriate, early intervention (rather than waiting until a crisis occurs), are key elements in supporting people to undertake caring roles effectively.

A number of 'trigger points' for the provision of information and advice are also suggested in the Care Act:

- Hospital entry or discharge.
- Diagnosis of health conditions.
- Application for Attendance Allowance, Carer's Allowance, Personal Independence Payment.
- Contact with local support groups and charities.
- Contact with or use of private care and support services.

Many older carers are more likely to approach services to get support for the person with care needs than themselves and may never self-identify as a carer. It is therefore vital for staff and volunteers in other health, social care and community settings to be carer aware and to recognise that someone may be a carer and in need of information and advice. They should also know where to signpost people and what information and advice services are available.

Older carers may particularly struggle to access standard information and advice services due to being unable to leave the person with care needs at home for long enough periods of time or due to their own mobility. They are also less likely to have access to online information. Therefore, provision that takes into account these limitations is key to supporting older carers.

Examples of services providing information and advice for older carers

- Services providing access to timely information and advice as these underpin every area of carers' needs and concerns, including those listed above. For example, a carer may need information and advice about the medical condition of the person with care needs, especially at critical points such as at diagnosis or while in hospital following a trauma (for example, a stroke or fall).
- Services available to support carers' needs or the needs of the person they care for. Information may be needed about:
  - Power of attorney, wills and trusts.
  - Welfare benefits.
  - Health and social care services, pathways and assessments.
  - Access to breaks from caring.
- Services to help carers maintain their own health and wellbeing.

Carers may also need:

- Options about how they access information, for example online; leaflets; phone helplines and face-to-face.
- Active assistance to claim welfare benefits or social care assessments.
- A range of information options and assistance available for carers whose first language is not English.
- Proactive initiatives to check-in by phone with older carers identified as caring intensively and/or caring for people with degenerative conditions, for example dementia or cancer, to identify deteriorating situations.
- Home visits for older carers who are caring intensively and/or caring for people with deteriorating conditions.

Positive practice in the Carers Trust network

Ensuring older carers get the range of information and advice they need: Camden Carers Centre – Older Carers Outreach Project

This project works with carers who are aged 70 and over to reduce isolation and improve the health and wellbeing of older carers. A key part of the service is a targeted telephone outreach service which works with isolated or housebound carers to encourage them to re-engage with their local communities and support services, where appropriate.

The service can offer support based on the needs identified and examples of outcomes achieved include:

- Identifying risk where carers are lifting the person they care for and likely to cause themselves harm, and referring for appropriate support.

- Carers feeling happy that they have a connection with the carers centre and able to turn to them if their situation deteriorates.
- Information and referral to other relevant organisations to offer carers support.
- Identifying safeguarding concerns and taking appropriate action.
- Providing access to a programme of events and activities. These include joint events for carers with the people they care for, especially in situations where the person they care for has dementia.
- Specific outreach work to very isolated or housebound carers, to encourage them to re-engage with their local communities and support services, where appropriate.

Public health is funding an expansion of this service to include the recruitment of volunteers to offer outreach support to carers in their own homes and help carers with identified concerns. This includes linking with specialist support, supporting the carer and person with care needs to accept and access help with the caring role, linking carers to each other to create new networks and accompanying carers to community activities when they are lacking in confidence to go alone. This service will also help carers to consider the sustainability of caring relationships and to support people through difficult decisions.

Carers access the service through referral from health and social care, supported housing, local day centres and community centres or can self-refer.

9 Assessment, support planning and involvement

Assessment

Carers are often unaware of their rights to a carer's assessment, or are unclear of its purpose, or are fearful of intrusion from social care professionals. Sometimes they are anxious that they are being assessed to see if they are a "good enough" carer. A great deal can be done to improve these perceptions including providing information in advance to help understand the purpose of an assessment and plan for it, and ensuring follow up, as found by research by Skills for Care and Carers Trust (Carers Trust and Skills for Care, 2013).

The Care Act opens up the right to a carer's assessment to all carers in England with the appearance of need, regardless of their financial resources or those of the person they care for. This must establish the carer's need for support and how practical it is for them to carry on caring. It is vital that the assessment is a meaningful experience for carers, and that they have the chance to fully engage with this.

Assessments may be combined, for example the carer can be assessed along with the person with care needs but this must be the wish of everyone being assessed. However, this can lead to a situation where one party is reluctant to state their feelings for fear of upsetting the other, and may result in their needs not being expressed or addressed.

Carers can also be offered self-assessments. However, self-assessments are not appropriate for all. Many carers are not aware of support available or are reluctant to ask for it. A face-to-face assessment is often needed to build trust and open up possibilities for support.

If carers have difficulty in engaging with the process of assessment then local authorities have a duty to provide independent advocacy to represent and support carer involvement in assessments and preparing support plans.

Support planning

Carers themselves have the right to a support plan following an assessment and to be involved in the preparation of a care and support plan for the person they care for and to receive a copy of that plan. Processes need, therefore, to be in place both to recognise and involve the carer when the person with care needs is in contact with health and social care settings and to appropriately assess the support needs of the carer themselves. They also need to ensure assessment and care and support plans link together appropriately and use a whole family approach.

Some carers value the flexibility of a direct payment for the person with care needs so that they can buy in appropriate help, for example help getting the person with care needs to bed – others feel overwhelmed by the burden of employing and

managing someone, and processing the direct payments. Support therefore is often needed to ensure that managing direct payments does not become another job for an already overstretched carer.

Carers who are eligible will, under the Care Act, have a personal budget for their own support. Carers should be encouraged to think about what would help them improve their own wellbeing, and a very broad approach taken to what a carer's own direct payment can be used for, providing it supports them to meet this objective.

Involving carers as experts and partners in care

The NHS Five Year Forward View (NHS England, 2014) acknowledges the need to recognise that patients, their family and carers are often 'experts by experience'. Many older carers have very long experience of caring and yet this may be easily overlooked. The Triangle of Care (Carers Trust, 2013) model for carers of people with mental health problems, including a specific adaptation with the Royal College of Nursing around carers of people with dementia, is a clear and comprehensive model that demonstrates good practice in partnership working between service users, carers and professionals. It shows the benefit of involving carers as partners in the care of the person they support, both for the carer themselves and the person they care for.

May be most likely to affect

- Older carers interacting with statutory and other services about the needs of the person they care for.
- Older carers who feel strongly about coping without outside support.
- Older carers from diverse groups less likely to access assessment.

Examples of services to support assessment, support planning, and involvement

- Assessment and planning processes which are flexible to meet the needs of carers.
- Advocacy services to represent and support carers if needed.
- Involvement of carers as partners in care, especially at key points in the life of the person being cared for, for example admission and discharge from hospital, during care planning, and at points where the care needs change.
- Information, advice and training that addresses different aspects of caring at different points in a caring journey.
- Creative carer involvement in local strategic planning in health and social care.
- Training for professionals to raise carer awareness.

What can good support look like?

Case study: Yusuf

Yusuf, who is 86, cares for his wife Fatima who is 89. Yusuf has been caring for her for around four years.

Yusuf provides Fatima with physical support with moving around indoors, getting out of a chair and in and out of bed. He also supports her with getting in and out of the shower and helps her with getting dressed, particularly helping her to put on her shoes and socks. He accompanies her outdoors, providing reassurance and physical support. He also offers emotional support, making sure that she takes her medication and accompanying her to her appointments.

Fatima does the cooking but needs help with tasks such as reaching, lifting and carrying.

Yusuf feels that their relationship is very good but that caring has limited his social life as the difficulty of going out with Fatima means that he often has to leave her at home. He cannot go out for long and when out he is constantly checking to see if Fatima has phoned. He doesn't get to see his sons and their families as often as he would like to.

The Carers Trust Network Partner supported the couple with:

- A successful claim for Attendance Allowance.
- Obtaining equipment including a pendant alarm, chair, shower chair, shower rail and frame.
- Accessing a carer's assessment.
- A Carers Emergency Card.
- A £400 Carers Break grant towards a holiday break.
- Information and advice about the Mental Capacity Act and lasting power of attorney.
- Obtaining a cinema discount card to help them get out more.

Yusuf felt that the services provided gave him peace of mind, stress relief and helped to prevent injury from lifting.

Positive practice from Carers Trust

The Triangle of Care: Carers Included: A Guide to Best Practice for Dementia Care (Carers Trust and Royal College of Nursing, 2013) was developed in partnership with carers, people with dementia and professionals to help acute hospitals identify and support carers when the person they care for is admitted to hospital. The Triangle of Care is based on six principles which if implemented by a hospital ward (and wider acute services) means the carer is identified earlier, involved equally in care and provided with support. It provides an opportunity to ensure the best care for the patient by engaging fully with the carer and ensuring the carer has support

for their own health and wellbeing as well as addressing any support needs for the person they care for. The guide, developed by Carers Trust and the Royal College of Nursing, includes good practice examples as well as a self-assessment tool to enable services to measure where they are and how they can improve.

The Triangle of Care – six standards

1. Carers and the essential role they play are identified at first contact or as soon as possible thereafter.
2. Staff are 'carer aware' and trained in carer engagement strategies.
3. Policy and practice protocols regarding confidentiality and sharing information are in place.
4. Defined post(s) responsible for carers are in place.
5. A carer introduction to the service and staff is available, with a relevant range of information across the care pathway.
6. A range of carer support services is available.

(Carers Trust and Royal College of Nursing, 2013)

10 Bereavement and life after caring

Many older carers will have been caring for many years. Some will have given up work to care for a parent or partner and others will have been caring for an adult son or daughter for most of their adult life.

The period when the caring role comes to an end because of the death of the person they care for is a particularly vulnerable time for the carer, who has to deal with both bereavement and the loss of a key role in their life. Research (Larkin, M, 2009) shows that carers report feeling a 'void' after the death that is linked, of course, to the bereavement but also quite clearly to the loss of their caring role. It takes time, effort and often external support to help rebuild a different life after caring.

Often much of the contact that the carer has had with others has been related to their caring role (for example social care staff, medical appointments and paid Carer Support Workers) and so the former carer can easily become very isolated and struggle to re-engage socially. There is often a limited time post-bereavement when carers can access carers services and the full emotional effect of the loss can take some time to emerge.

Carers can also experience challenges with the change in their day-to-day caring role when the person they care for moves into permanent residential care. The carer still has a significant caring role but this will change considerably and carers will need to cope with a considerable period of readjustment.

Examples of services providing support after caring:

- Counselling services.
- Life after caring peer support or training groups.
- Information and advice services and signposting.
- Befriending schemes.
- Advocacy and mentoring services.

What can good support look like?

Case study: Patience

Patience is 66 years old and cared for her mother, Angela, who was diagnosed with dementia seven years ago. Patience gave up work at the age of 59 to care for her mother as her condition had deteriorated. Angela moved in with Patience at that time and Patience had managed to continue to care at home right up till the point when Angela was taken into hospital with a chest infection just before her death six months ago. During the past seven years Patience has lost contact with most of her friends and her only other relatives live abroad. The last two years in particular had allowed her little time to have a life outside her caring role.

Since Angela's death Patience had really struggled to find purpose in her life and had become depressed and anxious about going out. She had seen her GP and been prescribed anti-depressants.

Patience was invited along to a facilitated group for bereaved carers at her local Carers Trust Network Partner over eight sessions. At this group she met other bereaved carers who understood what she was going through and she felt able to discuss her grief and loss for the first time. She gradually began to be able to think about how to rebuild her life and feel more positive about her future. By the end of the group sessions she was looking into undertaking voluntary work, had made new friends and was feeling more confident.

Positive practice in the Carers Trust network

Supporting carers looking after someone at the end of their life: Carers Network, Westminster, Hammersmith and Fulham – End of Life Carers Project

The End of Life Carers Project is a specialist project for carers aged 65 and over looking after someone approaching the end of their lives. It is funded for three years by City Bridge Trust, was set up in autumn 2014 and is being delivered by Carers Network across Westminster, Hammersmith and Fulham. Eligible carers are those looking after someone:

- who has a terminal diagnosis and is likely to die within a year, or
- who is aged 80 and over with complex conditions, or
- who is in residential care.

Through home visits and over the phone, the project helps carers have a better quality of life by ensuring they access all the financial, legal and practical help and information available from both statutory and voluntary services. Through the provision of services, equipment and breaks, it helps carers to have some life of their own alongside caring. It also helps the person they are caring for to choose to die at home if they wish. Both the carer and the person being cared for therefore have more choice and control at this stage in their lives.

Through one-to-one sessions and in workshops, carers are able to talk about the following kinds of issues:

- How to start talking about dying to the person being cared for, to family members, friends and others.
- Condition-specific information and end of life choices around the person's wishes about where they die and treatment options.
- Funeral arrangements and practical matters following a death.
- End of life and spirituality and culture.
- Carers' transition planning at the end of their caring role.

Key to the success of the project are the close working relationships developed with a range of health and social care agencies. Strong links have been made with the local GP's End of Life Register, with the broader primary care providers, hospices, Macmillan Nurses, Admiral Nurses, hospitals and Community Matrons.

11 A checklist for local support

1 Identification

- Is training in place to raise awareness of older carers in order to enable health and care staff to proactively identify them and know what to do?
- Do we have clear referral pathways in place for those agencies identifying older carers, including referrals to local carers organisations?
- Do we ensure we identify carers from diverse communities?

2 Prevention

- What services do we have in place that prevent, reduce or delay the need for support for older carers?
- Do these services specifically address the following needs:
  - Health and wellbeing (physical, mental and emotional).
  - Financial concerns.
  - Social isolation.
  - Concerns for the future.
  - Life after caring/bereavement.

3 Information and advice

- Are information and advice services easily accessible for older carers who may have difficulty in visiting a central point in restricted times or do not have internet access?
- Do staff and volunteers in information and advice services understand and recognise key trigger points in the caring journey?

4 Assessment and support planning

- Are there clear accessible pathways for older carers to receive a carers assessment?
- How is this information shared?
- Are face-to-face and individual assessments offered as well as combined assessments and self-assessments?
- Are there agreed ways of support planning for carers, and involving older carers in developing care and support plans for the people they care for?

- Are older carers supported to use direct payments for themselves and others?
- Is assessment and support planning for carers and people with care needs joined up so that a whole family approach is used?

5 Recognition and involvement

- How do we involve older carers in local policy and service development?

6 Monitoring and evaluation

- How do services measure the impact of their work on older carers' health and wellbeing, financial situation and social isolation?

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All library photos posed by models.

DRAFT May 2015

Healthy Ageing and Food – Bringing a food focus to Brighton and Hove as an 'Age Friendly City'



Why this report?

The aim of this report is to scope the existing work in the city around food and older people, and the future potential. As part of a wider process of reimagining our city, we aim to identify what an 'Age Friendly City' might look like through the lens of food. We take a look at what is already happening in the city, including picking out some examples of good practice. We also try to identify the barriers to accessing good food; where there are gaps in either provision or understanding, and identify opportunities. Thank you to everyone who has given their time to talk to us.

The context of this work is Brighton and Hove's ongoing activity to become an ***Age Friendly City*** following acceptance as part of the international network coordinated by the World Health Organisation (WHO). Age Friendly Cities have at their core "the desire and commitment to promote healthy and active ageing and a good quality of life for their older residents"[1] An underpinning principle is that older people should be seen as active contributors to, not just recipients of services.

1 http://www.who.int/ageing/projects/age_friendly_cities_network/en/

The WHO Active Ageing Policy Framework

The underlying approach to the report has been taken from the WHO Active Ageing policy framework areas, taking a positive 'life course' approach to healthy and active ageing[2]. The WHO identifies that good nutrition is important for preventing ill health - especially the impact of chronic disease - in older people[3]

a) **Promoting good health and healthy behaviours** at all ages to prevent or delay the development of chronic disease. Being physically active, **eating a healthy diet**, avoiding the harmful use of alcohol and not smoking or using tobacco products can all reduce the risk of chronic disease in older age. These behaviours need to start in early life and continue into older age.

b) Minimizing the consequences of chronic disease through early detection and quality care (primary, long-term and palliative care). While we can **reduce the risk of chronic disease through a healthy lifestyle**, many people will still develop health problems in older age. We need to **detect** metabolic changes such as high blood pressure, high blood sugar and high cholesterol **early** and **manage them effectively**. But we also need to **address the needs of people who already have chronic disease**, **care for those who can no longer look after themselves** and ensure that everyone can die with dignity.

c) Creating physical and social environments that foster the health and participation of older people. Social determinants not only influence the health behaviours of people across the life course, they are also an important factor in whether older people can continue to participate. It is therefore important to create physical and social environments that are "**age-friendly" and foster the health and participation of older people.**

d) Reinventing ageing – **changing social attitudes to encourage the participation of older people**. Many current attitudes to ageing were developed during the 20th century when there were far fewer older people and when social patterns were very different. These patterns of thinking can limit our capacity to identify the real challenges, and to seize the opportunities, of population ageing in the 21st century. We need to develop new models of ageing that will help us create the future society in which we want to live.

- *A life-course approach to healthy and active ageing - Framework for report taken from Good health adds years to life – briefing for world health day 2012, WHO*

This report has been prepared by the Brighton and Hove Food Partnership for the city's Age Friendly Steering Group and the Brighton & Hove Public Health Commissioner at Brighton and Hove City Council. The recommendations will also inform

- The 'Healthy older people' preventative approach the City Council is developing in relation to commissioning services.

2 http://whqlibdoc.who.int/hq/2012/WHO_DCO_WHD_2012.2_eng.pdf

3 "Healthy ageing is a lifelong process. Patterns of harmful behaviour, often established early in life, can reduce the quality of life and even result in premature death. Poor nutrition, physical inactivity, tobacco use and harmful use of alcohol contribute to the development of chronic conditions: 5 of these (diabetes, cardiovascular diseases, cancer, chronic respiratory diseases and mental disorders) account for an estimated 77% of the disease burden and 86% of the deaths in the European Region. The most disadvantaged groups carry the greatest part of this burden." http://www.euro.who.int/en/health-topics/Life-stages/healthy-ageing/data-and-statistics/risk-factors-of-ill-health-among-older-people

- The actions relating to older people in the city wide Food Poverty Action plan, which the Food Partnership is coordinating along with the City council.
- Progress in delivering the city's food strategy
- Project development /funding bids

Relatively few Age Friendly cities focus on food so this scoping exercise may be of interest to other cities nationally and internationally.

A noticeable exception is Udine in Italy, where quarter of the population are over 65, and against a background of recession, an army of volunteers - themselves mainly retired - cook and deliver 'meals on wheels' around the city; and there are a number of other services such as a "No alla solit'Udine" ("No to loneliness") helpline where "Three telephone operators are employed by the municipality to answer their calls, and decide what kind of help they need. A cadre of around 1 000 volunteers from 30 organizations offer a variety of services, from delivery of groceries to counselling, taking someone to the hairdresser or reading a book aloud. "[4]

This report was put together from March to May 2015, as a deliberately time limited scoping exercise. It was based on desk research, structured interviews, informal conversations and visits to a range of different settings which relate to food and older people in the city. The report is designed to provide an overview and some guidance on future directions - it is not exhaustive and in particular does not pretend to include a full range of voices of older people, though opportunities were taken to consult with older people where possible.

How old is old? Who are these "older people"?

Activities in the city use different definitions of 'older' e.g. some defining 50+ and some 60+. Age is increasingly not used as a definer e.g. services such as sheltered housing which have historically been for 'older people' are now offered to 'vulnerable' people whatever their age and have also been renamed as seniors housing. Nutritionists look at a likely shift in nutritional needs at around 75+ (see below) but stress that in practice this depends on the individual.

For this report we have chosen to think in terms of the individual as age brackets do not seem to be all that helpful e.g. nutritional guidance would be very different for someone who is overweight compared to someone who is underweight whatever their age; and people's experiences of ageing happen very differently.

We have therefore not looked at an age definition, but have put a focus instead on different settings in relation to older people.

- Older people living at home independently
- Older people supported to live in their own homes
- Older people living in residential care / nursing care setting

This is in order to think in a practical way about where any information or support may need to be targeted. For example, if someone is reliant on a carer to prepare their meals, the carer is also involved in ensuring access to food and a healthy diet. In a residential setting food provision would be largely

[4] http://www.euro.who.int/en/health-topics/Life-stages/healthy-ageing/views-on-ageing/examples-of-good-practice/community-solidarity-in-udine,-italy

controlled by the staff and so these would be the target for any message, as individuals have much less say although best practice is to involve residents in meal planning as much as possible. These categories are to help us with thinking through the issues, they are not hard and fast, and there is of course overlap between them e.g. someone may be active and living at home but have a small amount of formal or informal care support.

Residential care is not covered in detail in this report, as the 'active ageing' focus is all about a preventive approach to help people to remain well and at home, rather than entering into residential care. However it was felt important that people in residential settings were included as they a are group with the least control over how they eat hence in some ways the most vulnerable, therefore a small number of recommendations have also been made regarding this group.

3 different settings this report looks at in relation to older people and food		
(1)Older people living at home independently Cooking and shopping for self	(2) People **supported** in their own accommodation - As well as older people themselves, focus for messages is on **carers** paid and unpaid ● **Informal (partner/family/ neighbour/ volunteer)** ● **Formal (paid carers)** ● **Sheltered housing staff** ● **Intermediate care staff**	(3) People in a nursing home/ **residential care** setting Less control by older people themselves, focus for messages is **staff** **(+ suppliers** if meals bought in) ● **Care homes** ● **Nursing homes** ● **Hospice/end of life**

Food and nutrition - and food beyond nutrition

Older People and Malnutrition

As people age they may not eat well or get all the energy and nutrients from the food they eat. Whilst as in the general population, there is concern about obesity, in relation to older populations there is greater concern about people who are "undernourished" or eating inadequately[5]. Confusingly malnutrition is an umbrella term, which is mainly used for undernutrition, but can also include over-nutrition and an imbalance of nutrient intake.

Undernutrition greatly increases the local and national cost of providing health and social care, as people that are malnourished will experience increased ill health, muscle weakness, increased length of stay in hospital, increased risk of infection, slow recovery after surgery, poor wound healing and increased risk of mortality.

The 2014 Malnutrition task force: "Undernutrition in later life is very common and affects over a million older people. It increases the risk of ill health and infections and can result in a longer recovery time from surgery and illness[6].

Undernutrition is often both the cause and consequence of disease and ill health and the contributing factors can be complex and arise for many different reasons. Some of these reasons are associated with ageing itself. A reduced appetite due to less energy expenditure, deterioration in taste and smell (which can be exacerbated by some medications) or eating problems due to difficulty chewing or swallowing will all reduce the enjoyment of food and may lead to a reduction of overall food intake. Dehydration is also very common, as many older people with diminished appetites or poor nutrition may miss out on their fluid intake from food, therefore need to increase their liquid intake.

The needs of individuals at either end of the dietary spectrum are relevant

Healthier choices food that is moderate in salt, sugar, total fat and saturated fat is important for people with diabetes (or at risk of diabetes), people who are overweight, have high cholesterol or high blood pressure.

Higher energy options are needed for those who require extra calories. (NACC report)

If someone is at risk of malnutrition they need to eat energy and nutrient dense diet i.e. choose foods that higher in fat and protein, a message that does not seem to be widely understood and appreciated. So for example a pudding like apple crumble and custard would be entirely appropriate.

[5] More than 3 million people in the UK are either malnourished or at risk of malnutrition at any given time. The majority of these are living in the community, with 5% in care homes and 2% in hospitals (BAPEN, 2012) http://www.bapen.org.uk/professionals/publications-and-resources/commissioning-toolkit

[6] http://www.malnutritiontaskforce.org.uk/wp-content/uploads/2014/07/Prevention_Early_Intervention_Of_Malnutrition_in_Later_Life_Local_community.pdf

Identifying people experiencing malnutrition including use of the Malnutrition Universal Screening Tool (MUST). Insert MUST tool into appendix

Malnutrition is often unrecognised, but with the use of effective screening, not only are malnourished patients identified and treated, but effective management of malnutrition will reduce the burden on health and care resources for example from delayed recovery and complications from surgery. About 40% of people who are admitted to hospital or care homes are malnourished (BAPEN report, 2008). Regular screening is the only way that malnourished individuals can be identified and appropriate action taken.

Nutritional screening is a quick, simple procedure that should be undertaken as part of the admission or initial assessment of a person on hospital admission, on arrival in a care setting or if a GP or Practice Nurse has concerns about a person from observations (for example loose fitting rings, reporting lack of appetite, evidence of muscle waste or dental pain/ broken teeth)

It is not clear to the extent to which this tool is being used by staff in adult social care in Brighton & Hove CHECK Question – is there data on the use of the tool by Adult Social Care?

Brighton & Sussex Universities Hospital (BSUH) Quality Account 2013 – 14 identified that they had failed to reach their own target of improving nutrition screening and treatment rates. They were aiming for 98% compliance with Malnutrition Universal Screening Tool (MUST) but in only 90.5% of the notes reviewed had the patient received a full nutritional review using the MUST score (BSUH Quality Account 2013-14)

Training for health, social care and community based staff

In 2013 NICE recommended the use of training (either face to face or e-learning) on nutritional screening using 'MUST' for staff working in hospitals, primary care and care homes to aid implementation on the new NICE Quality Standard for Nutritional Support of Adults: http://guidance.nice.org.uk/QS24

The Food Partnership's Community nutrition team have been delivering training for support staff on behalf of the Council for 5 years (about 40 people a year come on the courses). ADD detail on which teams attend

Food and Nutrition for Support staff is an introductory level course and includes portion size, label reading, the Eatwell model and using the malnutrition universal screening tool (MUST). There is a more detailed course for care home staff that covers **meeting individual needs** including dietary implications of common medical conditions including dysphagia and dementia.

Key thoughts and observations from the trainer:

- A surprising number of support staff (working in the community homecare team and residential settings) that still haven't seen the eat well plate or not sure of the key nutrition messages if they have
- A high number of staff working with older people are not aware of MUST and that everyone should be nutritionally screened.

What are the other nutritional recommendations?

The nutritional requirements of older adults are mainly the same as those for the rest of the population; therefore the general healthy eating recommendations for fat, salt, carbohydrate and fibre apply. Unless they are at risk of malnutrition, older people should aim to meet all of the evidence based recommendations set by

the UK government.[7] There are also, however specific recommendations for Vitamin D and energy intake for older people in the UK.

- Energy requirements decrease with age due to changes in body composition. Muscle mass decreases whilst fat mass increases, resulting in a reduction of basal metabolic rate. Population "Estimated Average Requirements" (EAR) for energy are therefore lower for the 65-74 age group, with a further reduction for those 75 years and over.
- In the UK the majority of people obtain most of their vitamin D through the action of summer sunlight on the skin. However, older people make vitamin D less efficiently, may wear more clothes when they go outside, or may go outside less often due to mobility issues. SACN? (2007) recommends that all adults aged over 65 years should take a vitamin D supplement to enable them to meet the requirement of 10µg (micrograms) a day. This is particularly common in residential care homes but also common for people supported in their own homes if they do not get outside much.

Overweight / obesity

Maintaining a healthy weight throughout the aging process age by eating a healthy, balanced diet and exercising regularly can help in the prevention and management of diabetes and other diseases. It can also reduce the risk of surgery, including routine surgery and improve surgery outcomes.

My cholesterol is down to 5 from 5.4' My painful joints are much less painful'
Shape Up Participant

20% of people seen in 2014/15 by the Community Nutrition service for one to one and group weight management programmes were 55-64 years and 15% were over 65 years. Older participants are often the ones that report a reduction in a secondary medical condition eg arthritis and medication as a result of the intervention.

Eatwell workshops older people

The Food Partnership delivers eat well workshops in partnership with community groups including sessions targeted at older people. In 2015/16 six Eatwell workshops funded by Public Health as part of the Tier 1 healthy weight work will be targeted at older people's groups.

Healthy Choice Award – Residential Care Settings

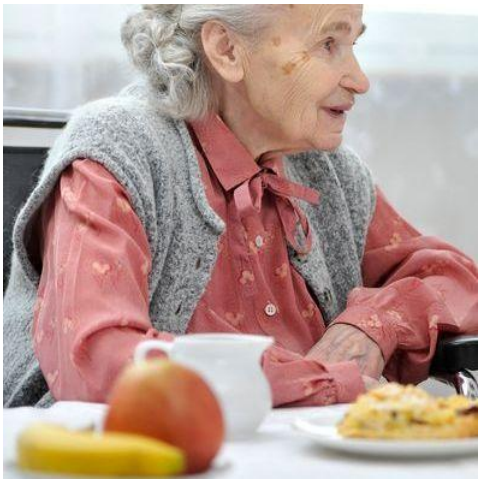
The Healthy Choice Award is a joint initiative from the Food Partnership and Brighton & Hove City Council, which looks at meals and snacks offered in breakfast clubs, nurseries and residential care homes. Working together, the aim is to award settings which serve varied, nutritious and age appropriate menus. Further recognition is given through the Healthy Choice Award Gold - to those settings working towards nine key sustainability standards. The gold award encourages local, sustainable and higher welfare where it is available, affordable and appropriate. Residential care homes can receive support and advice on menu planning from the Food Partnership's nutritionist. 15 residential care homes in the city currently have the award which is only a small proportion of the total number of care homes in the city. There has not been

[7] By COMA in 1991 and the subsequent update by SACN 2001. https://www.gov.uk/government/publications/sacn-dietary-reference-values-for-energy https://www.gov.uk/government/publications/sacn-update-on-vitamin-d-2007

resources to undertake targeted promotion work to these settings in recent years although the award is well received by places that find out about it.

Nutrition and the role of meals

A recent study[8] concluded that whilst good nutrition is fundamental to active and healthy ageing, too much research into nutrition has focused on what happens if food supplements (e.g. vitamin supplements) are taken, rather than looking at what people actually eat. The resulting evidence about supplements is often inconclusive and also shows many supplements to be ineffective.



The study stresses however one way to ensure proper nutrition in older people "is to maximise their intake of essential vitamins, minerals and bioactive compounds from natural food sources" – i.e. good nutrition is better achieved from **good meals** rather than via supplements - and that "there is vast potential to focus further on promoting health through adequate intake from diet in this age group'. The study suggests that a 'Mediterranean diet' is one such 'good' diet.

> "It's such a treat to get food like this…If you're living on a tight pensioners budget, there just isn't anything left to spend on good food" – Hove Methodist Church attendee.

Going beyond nutrition, Brighton & Hove's food strategy[9] and the overall approach of the Brighton & Hove Food Partnership is to emphasise that meals play an important social and cultural function. A recent Food Partnership 'Shared Meals'[10] included visiting various settings, where researchers heard that shared meals encourage people to eat more nutritionally. People said how they would not go to the effort of making as many food options/variety of foods if just cooking for themselves. Instead, often people eat a sandwich. This anecdotal evidence supports the current nutritional research; eating with familiar others increases food intake; indeed energy intake increases 18% when eating with friends compared to baseline[11]&[12].

[8] JRC Science and Policy reports - The Role of Nutrition in Active and Healthy Ageing, Tsz Ning Mak & Sandra Caldeira, 2014

[9] http://bhfood.org.uk/food-strategy

[10] Eating Together: exploring the role of lunch clubs and shared meals in Brighton and Hove, Brighton and Hove Food Partnership 2015

[11] Burke, D; Jennings, M; McClinchy, J; Masey, H; Westwood D; Dickinson A. 2011. 'Community luncheon clubs benefit the nutritional and social wellbeing of free living older people', Journal of Human Nutrition and Dietetics, 24, 277-310.

[12] Wallace, C; Wiggin P. 2007. The Role and Function of Lunch Clubs for Older People, Welsh Assembly Government New Ideas Fund, University of Glamorgan/Concord Associates.

The current picture - Issues and Barriers

Shopping

Being able to shop for food is an important part of staying well and independent. However according to Age UK 19% of people aged 65 or over report they have a longstanding illness that prevents them from shopping or makes it difficult for them.[13]

Living alone in itself can be a barrier. We heard that food is often sold in quantities which are unsuitable for single people on their own, or that smaller quantities are more expensive with people unable to access 'buy one get one free' deals and 'family size' discounts. The preference for purchasing smaller quantities weekly is also a barrier to online shopping for some people as the delivery cost adds to the cost of food.

Other barriers include age unfriendly packaging, store layout (include height of shelves, deep trolley and freezers) and lack of rest spaces. Getting to shops was also seen as a barrier in certain areas of the city.

In other parts of the country Age UK offer a shopping service check if anyone in Brighton runs something similar eg Impetus?

Cooking for yourself

We heard that whilst many people continue to shop and cook well into older age, one barrier can be a change to physical mobility, or a sensory impairment (especially becoming blind). There is however some very good practice around 'reablement' [CHECK TERM] for example when people have had a stroke there is a service to help them to relearn cooking skills and building confidence, using different methods and equipment. However this seems to only be available to people who have specific conditions [and….?... intermediate care?]

There is a range of specialist equipment available to help e.g. appliances which have been adapted; and saucepans that are lighter and easier to grip. However it is hard to know if all the people who would benefit are aware of where to get these tools.

The reality the greatest barrier is that many people simply aren't motivated to cook and eat well if they are eating alone.

> "I live on my own. My husband passed away 10 years ago… I'm a widow who doesn't have anyone to cook for" – Holland Road Baptist Church attendee

This feeling can be especially prominent following the loss of a partner. It seems that in contrast with the previous comfort and sociability of eating together food and meal times can exaserbate feelings of isolation. There can be an additional practical consideration if the partner has been the who one generally cooks as the remaining partner may not have the skills or confidence to cook for themselves. The 'Old Spice' programme run by the Food Partnership and subsequently picked up by other organisations in the city has had some success in reaching older men who have lost partners but provision of this training is patchy. [is there any

> "We were contacted by the daughter in law of an older man who had lost his wife and was not thriving…. Our carer discovered that he wasn't eating well because he couldn't bear to go into the kitchen. It reminded him too much of his wife. The carer started to go to the shops with him and together they gradually reintroduced cooking. She rang the office excited one day to say that he was peeling carrots in the kitchen and whistling - he had got his mojo back" - Local private care agency

[13] Food Shopping in Later Life Age UK (June 2012)

data about success of old spice?] Another successful course has been cooking with a microwave sharing tips and recipes on the wide range of meals that can be cooked in this way.

We also heard that many people - not just single people - are using ready meals from supermarkets, whether prepared by themselves or heated up by a carer. This seems to be a developing market with Marks and Spencer's recently launching a range aimed at 'mature' customers[14]. Whilst some people are reportedly very happy with ready meals as a staple diet it seems that others are less so. There seems to be little guidance on choosing a ready meal which is nutritionally appropriate, and as with other prepared food there can be concerns about nutritional content, sugar and salt levels[15]. Indeed some of the 'healthy' guidance on ready meals (e.g. 'low fat') might actually be inappropriate for someone at risk of malnutrition who should be looking for high fat or protein alternatives.

Carers (unpaid family members / friends)

According to the 2011 Census almost 24,000 people of all ages in Brighton & Hove provided some informal care, many of which will be looking after older people. However older people themselves are also carers. The peak age for caring in Brighton & Hove is 50-64 years (25% of people in this age group are carers) although even among people over 85 years 5% are providing some form of unpaid care.

The national organisation Carers UK acknowledge that nutrition is an important but often hidden issue for carers and their families, with 60% of carers worrying about the nutrition of the person they care for.[16] Caring can be very demanding and may result in the carer neglecting their own diet due to their caring responsibilities. Carers UK have also produced guidance for carers on eating well for their own health[17] Question do carers health checks include weight checks / MUST screening if not they should Vic to speak to Sheila (they would include BMI check but not MUST (MUST would be used if identified by a nurse) The Shape Up Wellbeing Coach Service (delivered by Albion in the Community) offers carers above an ideal weight one to one support in their own home or a suitable nearby community venue to help them manage diet and exercise.

Practice nurses are responsible for undertaking carers health checks and older people's health checks and need to be well trained in how to identify people who may be neglecting their diet and sign post people to support.

Locally there is very little information available for people caring for older people about food although interviews with the Carers Centre confirmed that shopping and cooking are key roles of carers. They felt that more information , support and advice would be beneficial especially if the focus was on healthy eating on a budget (either at home or at community venues) given the tight financial situation many carers are in especially carers of pension age who are not entitled to carers allowance. They suggested that printed information would be useful for example a '5 points' fact sheet - not just aimed at carers but also for older people themselves. They also felt that practical tips or demos on skills for shopping / cooking for someone else would be helpful.

Help for carers and older people to be more digitally included to benefit from online food shopping (saving time), was also identified as a gap. This echoes conversations with Age UK that including tutorials on doing online supermarket shopping and helping people to set up 'favourite item' lists should be include in IT training

[14] http://www.independent.co.uk/life-style/food-and-drink/features/many-elderly-people-turn-to-ready-meals-but-can-they-compete-with-a-proper-dinner-10153295.html
[15] http://news.bbc.co.uk/1/hi/health/3756451.stm

[16] http://www.carersuk.org/help-and-advice/health/nutrition/
[17] http://www.caerphilly.gov.uk/CaerphillyDocs/Adults-and-older-people/Carers/Eating_Well_Leaflet_Carers_UK.aspx

sessions with older people. Carers are also a good route for raising awareness of meals in the community (see later) and may provide the means of getting people to activities. The network of carers coffee mornings and meetings provide an opportunity to reach older carers and those that care for older people.

Additionally the importance of respite for carers is well documented and any work on food and carers (of older people and older carers) could consider options for food related respite activities such as those provided by the Carers Centre Allotment or food related carers breaks / 'time for me' sessions.

Paid Care Workers preparing meals

For many older people currently - and this trend is likely to increase - cooking and shopping are carried out by a paid care worker. There are a number of barriers to healthy meals here, including whether the paid care worker understands the nutritional needs of older people; and whether they have the knowledge and skills to cook. However the primary barrier seems to be the time allowed for visits (which may be as little as 15 minutes) which make it impractical to do much more than heat up a ready meal in a microwave. One care agency we spoke to used longer appointments and recruited people with cooking skills, reporting that many of their clients are keen to get away from ready meals, and report much higher levels of satisfaction with 'simple home cooking (such an as omelette) but this seems to be the exception rather than the norm.

Delivered meals/ meals on wheels/ Community Meals

Around 200 people in the city receive community wheels or 'Meals on Wheels', currently delivered by the Royal Voluntary Service (RVS - formerly the WRVS) under contract from the city council. Meals are brought frozen and heated up on the spot by RVS volunteers or staff who also provide a 'safe and well' check. The number of people receiving this service has been gradually reducing over recent years, perhaps in part reflecting price increases to the service. Around half of community meals clients are requested and paid for privately; and around half of people receive the service from adult social care.

Although we don't have figures, there appears to be much use of private meal delivery services ranging from local takeaways which offer delivery; to companies specifically set up to deliver frozen meals for microwaving e.g. Cook (www.cookfood.net) which has an emphasis on taste/ 'home cooked' quality and Wiltshire Farm Foods (www.wiltshirefarmfoods.com), which has an emphasis on nutrition and catering for older customers and special diets e.g. soft, pureed meals and 'reformed' meals where the puree is reshaped to look more appetising. Newhaven firm Brilyn (www.mealsonwheels.uk.com) delivers freshly cooked meals on plates for reheating to residents in the East of the city e.g. Woodingdean and include a 'safe and well' check and cater for special diets.

As demand for community meals is dropping in its current form, there a danger that providing the service will become unsustainable. This is a pattern nationally and some local authorities, for example Islington, have withdrawn them altogether. However there are opportunities in the current climate e.g. moving towards direct payments and individual choice; and also around making meals more palatable and sustainable (current meals come frozen from Wales); and some recommendations have been made around how a meals on wheels service can be retained in the city.

Support from Neighbours and Networks

There is of course a great deal of informal unrecorded activity from family, friends, neighbours and other communities such as faith groups, where people may provide or share a meal. Nationally franchises such as

'Casserole Club'[18] can act as a bit of a halfway house between informal and more structured community activity, using a web based platform to help "people share extra portions of home-cooked food with others in their area who are not always able to cook for themselves". Locally, 'Know My Neighbour' encourages links at neighbourhood level e.g. Xmas Mince Pie meet up. There is a 'know my neighbour' week planned for May 2016. The Neighbourhood Care Scheme run by Impetus works with local volunteers to support older people amongst others. [speak to Impetus or include as an action for them to feed in after]

The co-ordinator of Time for Me Befriending felt that their volunteers would benefit from and be interested in training around food and nutrition for older people and in tips and techniques around using food memories to engage older people .

Eating outside the home - lunch club, shared meals, days centre

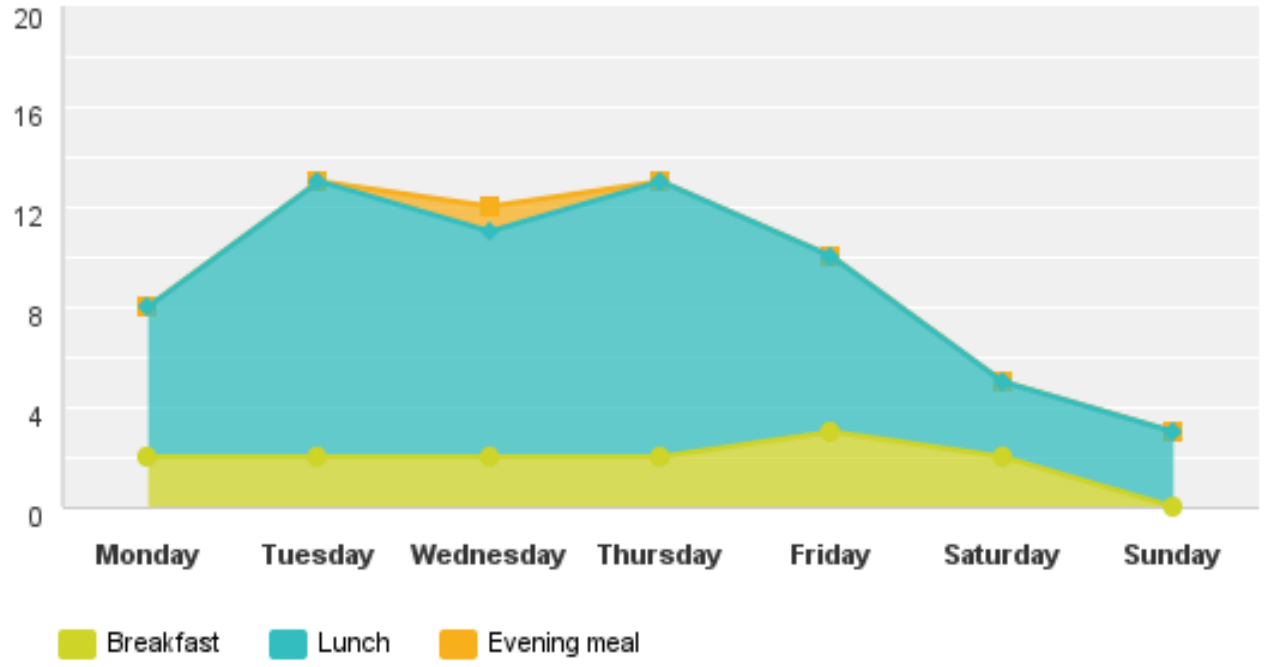
In parallel to this report, the Food Partnership has been exploring the role of 'Shared Meals' in Brighton & Hove. **1,265 shared meals take place each day, or almost half a million a year** and these shared meals play a vital role in our city's wellbeing, including those who are at greatest risk of isolation, poor nutrition and food poverty. As well as food and company, they nearly all offer support and advice, and often act as a gateway into other services. Shared meals take place in lunch clubs, day centres, and community growing projects and increasingly in private care homes, who are responding to a gap in the market by offering meals for non-residents. There are also shared meals in settings such as sheltered housing, where they tend to be resident organised - for example 'fish and chip clubs'. Changes to the way that that social services funding is allocated means that in future more people will receive 'individual budgets' or be entirely self funding. For some people, so long as they are accessible and there is the right transport and support, '**meals in the community'** options might be preferable to 'community meals' i.e. people might prefer to experience a shared meal such as a lunch club; or a café, pub or restaurant rather than receive a 'meals on wheels' meals package to their home in isolation. We noticed that some people are already 'serial lunch clubbers' visiting a different lunch club on different days of the week in preference to cooking / eating at home. However there are gaps in provision, with lunch clubs in particular running less at weekends.

Local provision was seen to be the most successful and projects such as the Hangleton and Knoll Project cite their strong links with community as key to success in their food projects. However there is also a significant gap in provision identified in the **North and East** of the city - often in areas where access to shops is also tricky creating a double barrier.

Good Practise Example: In Somerset Day Centre, a local greengrocer takes orders for fresh fruit, vegetables and eggs, which some members find very convenient. This may be a good service to offer in other settings?

[18] https://www.casseroleclub.com/

Lunch club provision by day of the week and area of the city



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It would be good to compare this map to the one of older people living in poverty in the Director of Pubic Health Report

There is also a perception barrier, Although it was hard to get clear data on this, it seemed that a preconception of place might prevent some people from using lunch clubs (It's "not for me") and we wondered whether there could be the opportunity to subtly 'rebrand' provision, learning from high profile/ social media savvy profile shared meal organisations such as The Real Junk Food Project. Some quite subtle changes of wording (changing

'lunch club' to 'shared meal' or 'social meal' and meeting people's 'interests' rather than providing 'activities') might help to do this.

An important finding was that providers are facing an increase in demand which they may lack capacity to meet. For more details on shared meals see the Food Partnership report[19].

Older People as Active participants

As with gardening projects (below) older people should be seen as a resource, with skills, wisdom and time to share; rather than as passive service users. Many lunch clubs and shared meal settings rely on older people as volunteers – we saw a whole range of volunteers up to 95 years old, and most reported great satisfaction from their experience of volunteering - "keeping going keeps you going!" It was noted that in particular what people called the 'younger older' - or more active - volunteers play a key role and that this pool is likely to get smaller in future as retirement ages rise.

Gardening and food growing

There is strong evidence for the physical health benefits of gardening, especially in later life summed up popularly as 'Gardening linked to longer lives'[20] due to the beneficial effects on cardiovascular health. One study suggested being active reduced the likelihood of a heart attack, stroke or angina by 27% and death from any cause by 30%[21].

Locally the evaluation of the Harvest project[22], which was a four year Lottery-funded project to encourage people to grow their own food, offered compelling evidence that, as well as physical health, gardening is highly beneficial for mental health and wellbeing.

> "Older people responding to the project's evaluation survey reported greater benefits from gardening than other respondents. 93% said they gardened to access fruit & veg, 52% did so in order to be physically active, 42% did so to improve their mental health and 24% to meet other people." - Harvest evaluation survey result

An extensive survey of allotment usage in Brighton & Hove showed that older people, who currently benefit from a discount in allotment rental, rate their allotments particularly highly as contributors to both health and happiness[23].

In a survey of 800 plot holders 209 responses were from people over 60. Of these 80% said that having an allotment was important / very important for their health and happiness.

> "An allotment is a 'social service' too and helps to avoid loneliness and isolation, so therefore the cost of the service cannot be estimated in traditional ways" - Plot holder survey

There is also participation by older people in the city's 70+ community gardening projects, either specifically for older people (e.g. in Hangleton and Knoll) or mixed age. Anecdotal

[19] Eating Together: exploring the role of lunch clubs and shared meals in Brighton and Hove, Brighton and Hove Food Partnership 2015

[20] E.g. http://www.bbc.co.uk/news/health-24710089 http://www.express.co.uk/life-style/health/570786/Gardening-key-longer-life-Doctors-prescribe-health-boosting-hobby

[21] http://www.nhs.uk/news/2013/10October/Pages/Can-DIY-and-gardening-help-you-live-longer.aspx

[22] http://bhfood.org.uk/food-strategy

[23] Brighton & Hove Allotment Strategy 2014-2024, Brighton & Hove City Council & Brighton & Hove Allotment Federation http://www.brighton-hove.gov.uk/content/leisure-and-libraries/parks-and-green-spaces/allotment-strategy-2014-2024

reports and observations by Food Partnership staff suggest older people make up a significant proportion of participants at these garden projects.

Reduced mobility can be a barrier. The Food Partnership previously ran a 'Grow Your Neighbour's Own' project which put people who wanted to grow food in touch with people who needed help gardening, but this ceased due to difficult logistics in making matches across a large city (with gardens concentrated on the outskirts and gardeners in the centre). AgeUK Brighton & Hove's 'Help at Home' scheme matches older people with vetted, freelance gardeners that they can pay to maintain their spaces. Brighton & Hove City Council tenants who are over 70 or have a disability can also apply for free gardening help. The allotment strategy includes plans to increase the number of smaller and accessible mini allotments which could help some older people to keep gardening even if a regular plot becomes unmanageable.

A recent pilot 'Fit for Gardening' training day organised by Active for Life and the Food Partnership had high interest - with 20 signups and 15 people attending on the day. Attendees were mainly older people (67% 50-64 yrs old and 17% over 65), mostly suffering from long-term health conditions who wanted support to get back into gardening safely. The focus was on stretches to help with things like back pain, aches and pains. Helping people to keep gardening as long as possible means these people continue receiving the physical and mental health benefits that gardening brings.

Both allotments and community gardens have benefits around reducing isolation and seem to help in building cross-generational communities for mutual benefit, with some participants in the allotment survey noting older people often act as a source of knowledge around growing which is highly prized by younger people. The Hangleton and Knoll project are piloting a 'Men in Sheds' project specifically for isolated older men and it will be interesting to see the outcomes.

Participation in food growing has an obvious benefit, in that people are able to access fresh nutritious produce, and in the case of community growing projects, often a shared meal cooked on site. However the food access benefits are almost an 'added extra' compared to the physical and mental health benefits.

The "Growing Health[24]" report takes an evidence-based approach to summarising these health and wellbeing benefits of food growing for different groups. As well as providing a useful summary of relevant studies, it highlights some local gaps in provision, e.g. there is strong evidence of the therapeutic value of gardening projects for people with dementia, yet despite the large number of such groups in Brighton & Hove, there are none which are geared to people with dementia.

Restaurants and cafes

We heard that many of those who are mobile i.e. have cars or can use buses; or who have support with transport prefer eating outside the home in restaurants and cafes, and that the cost can be comparable to home delivery of meals. There are special OAP meal deals in some settings, which help to keep the price down. Some people would prefer smaller portions and it was noted that some settings which offer a children's menu won't let older people order from it, even if requested.

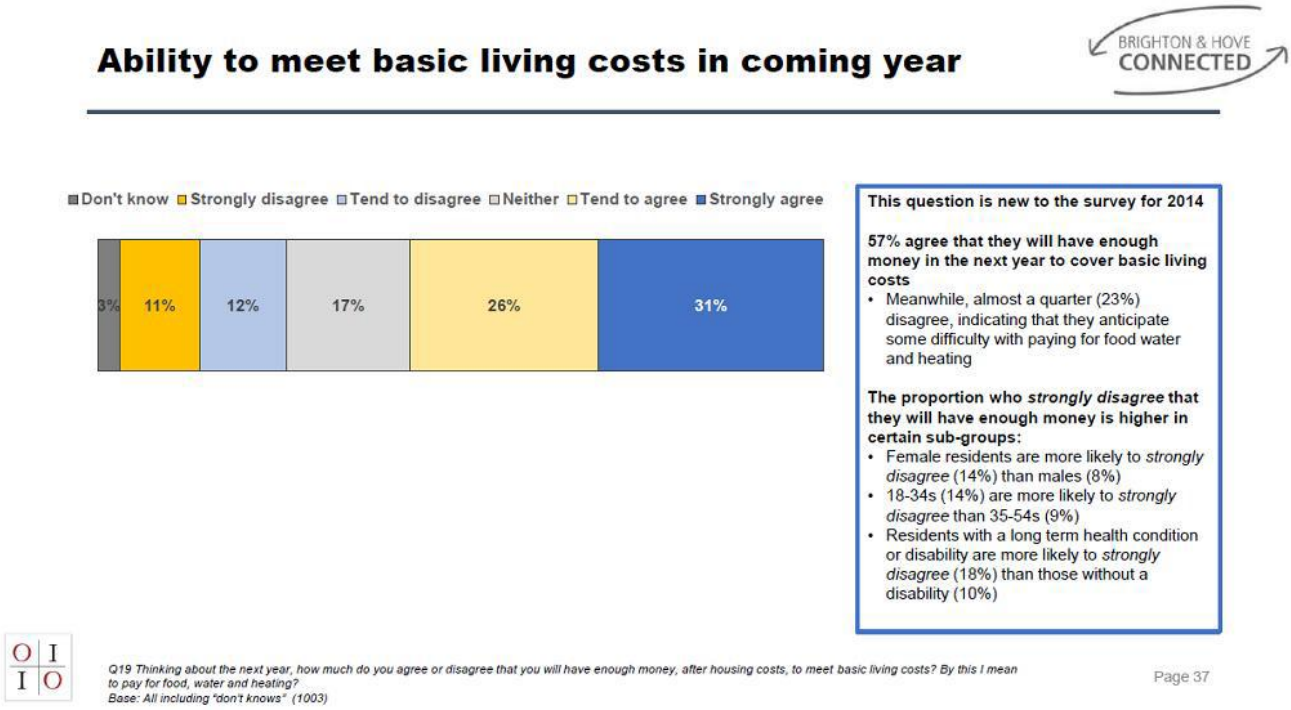
[24] **Growing Health: Food Growing for Health and Wellbeing,** Garden Organic and Sustain, April 2014 www.growinghealth.info

For many people retirement means more time and more freedom. One of the messages we repeatedly heard is that older people are primarily people and not everyone wants a special OAP deal or lunch club - they want to eat in 'normal' settings

Food poverty and food access*; digital access; transport*

Whilst there is no single definition of food poverty, definitions stress that food poverty is about more than hunger and most definitions focus on being able to eat nutritiously, rather than just to eat[25].It is clear that food poverty is increasing both nationally and in Brighton and Hove, with the November 2014 city tracker survey showing that nearly a quarter of the city anticipate difficulty paying for food/fuel, with particularly high levels of insecurity for those with a disability or long term health condition.

As people grow older they typically spend an increasing proportion of their income on food, domestic energy bills, housing and council tax; in households headed by someone aged 75 or over this amounts to 40% of their weekly expenditure. This makes them particularly vulnerable to price inflation such as those seen in recent years for food and energy [JRF REFERENCE?]



The Brighton & Hove **Director of Public Health's 2015 report** includes a focus on food poverty, out of concern that the cost of diet related ill health in the city is already high and is likely to increase further; and the number of food banks in the city has increased to 14, the majority opening in the last two years.

Food poverty is a complex area and about more than money on its own. Several interviewees stressed that for many older people the issues may be as much about **food access** as about income. Barriers to eating well include:

[25] The evidence review for the **Feeding Britain, the Parliamentary Enquiry into Food Poverty and Hunger** published in December 2014 *selected* this definition: "Food poverty can be defined as the inability to afford, or to have access to, foods which make up a healthy diet. Those experiencing food poverty may have limited money for food after paying for other household expenses; live in areas where food choice is restricted by local availability and lack of transport to large supermarkets; or be lacking in the knowledge, skills or cooking equipment necessary to prepare healthy meals. *Written evidence from the Public Health Nutrition Team, Central London Community Healthcare NHS Trust*. https://foodpovertyinquiry.files.wordpress.com/2014/12/food-poverty-appg-evidence-review-final.pdf

- a lack of transport
- shops that are not well laid out for accessibility
- limited provision of local shops particularly those selling food ('food deserts') and/or high cost and limited choice of food items in local shops
- 'digital' exclusion or inability to access the internet for shopping
- lack of time for shopping/preparing food e.g. people with extensive caring responsibilities
- access to cooking adapted equipment
- cooking skills

Having said that it is clear that a number of older people are living on a reduced income, in a climate of rising prices [26] and lack of money is a major barrier to eating well for many people. The 'heat or eat' dilemma is a particular issue for older people who may require higher levels of heating for longer in the day. Free bus passes were widely praised, but if people are unable to access buses then taxi fares are relatively high. The Carers Centre raised concerns about any reductions to carers allowance and/or changes to benefits for disabled people that would reduce household incomes.

Some older people may be reluctant - due to perceived stigma or lack of knowledge - to access the welfare benefits they are entitled to. Food banks nationally and locally report low usage by older people, both due to stigma and lack of accessibility. Q. does this mean transport?

- Older people's spending decreases as they age, although certain specific areas of expenditure increase, most notably food and non-alcoholic drink (12% to 19%) and housing, fuel, and power (12% to 24%) (Collard & Hayes 2013).
- Almost one in ten 70-74 year olds face difficulties when shopping because of 'a physical, mental, emotional or memory problem', rising to 60% of those aged 90 or over (Atkinson & Hayes 2010).
- The probability of an older consumer making a purchase on the internet declines markedly with age, such that only 23% of 60-64 year olds were found to have made an online purchase in a 12-month period, which reduced to 13% in the 65-69 year old group (Atkinson & Hayes 2010).[27]

Transport emerged as the key issue for both shopping for ingredients and for accessing cooked food outside the home, especially for those without or with limited access to online shopping options. We noticed that the most popular lunch clubs (50+ attendees) are either on main bus routes, or provide transport options via arrangements with volunteers, or community transport minibuses or both. The survey for the 'Shared Meals' report found that:

- ***61%** of projects find '**transport**' the biggest barrier to people accessing the project*
- ***32%** of projects find '**accessibility**' the biggest barrier to people using the project*

[26] **Feeding Britain, the Parliamentary Enquiry into Food Poverty and Hunger** published in December 2014 shows that food, energy and housing prices have risen disproportionately in the UK to other European countries, and incomes have not kept pace. https://foodpovertyinquiry.files.wordpress.com/2014/12/food-poverty-feeding-britain-final.pdf

[27] Population Ageing & the Voluntary Sector: Key Figures & Projected Trends April 2014 https://cvsanpc.files.wordpress.com/2014/03/population-ageing-the-voluntary-sector-key-figures-projected-trends.pdf

Dementia

Dementia is a major barrier to eating well, and can also be a factor in dehydration. It can lead to changes in food preferences, in particular a liking for sweeter foods, and people who are confused may miss meals, forget to eat or forget they have eaten already, resulting in under or over nutrition.

- It is predicted that there will be over 1 million people with dementia by 2021 in the UK (Green & Lakey 2013). Insert local data on numbers

People may need specialist eating equipment or support to eat and they (or their carers) may not know how to access this. Additionally, we heard that some people with dementia may have very limited cooking facilities at home if these have been removed because of concerns about safety.

The Alzheimer's Society produces a useful overview and a practical factsheet[28]. A number of people with dementia attend day centres in the city.

Sensory impairment

This has been mentioned above, noting that blindness can be a barrier in connection with cooking and shopping; and some interviewees also picked this up as a major factor in increasing isolation. Both blindness and deafness can be a barrier to shopping; and to attending community activities such as lunch clubs.

'Entrenched' Isolation

Research demonstrates that loneliness is felt particularly acutely by older people: almost one in ten people aged 65 and over report regularly or always feeling lonely[29] Staff, volunteers and service users in local lunch clubs talked about isolation itself becoming one of the factors in generating isolation. Once people start to get isolated, they can quickly lose confidence in socialising. It is also easy to lose motivation for cooking and eating, and quickly become depressed. There can be vicious circle here as good nutrition is vital for good mental health; yet depression can make it hard to cook and eat well. There seems to be a number of people in extreme isolation, not in touch with services or even with anyone, who are in a sense the 'hardest to reach'. Even knowing about these people is a challenge and the 'city wide connect' project is engaging police and fire service staff in helping to identify them.

> "I don't get depression now that I come here. I used to just sit at home, between the four walls in front of the telly – same in, same out… Now I come and see my friends every week" – Somerset Day Centre attendee

Yet food itself is a way to bring people together, and a number of service users (especially in day centres) stressed that attendance had turned around their depression and transformed their lives. Crucially in a day centre setting this had come about with support - attendance arose via a referral from a doctor or social services; and often with transport provision. Some lunch clubs are working with befriending groups to support very isolated people to attend, and this seems very successful, although currently only reaching a small number of people.

[28] http://www.alzheimers.org.uk/site/scripts/documents_info.php?documentID=149

[29] Social Exclusion Unit, A Sure Start to Later Life, 2006

Eating well in older age recommendations:

In this section we pull together some of the suggestions and priorities drawing from the issues and barriers identified above, starting with underlying principles; and also including some 'to consider' suggestions which aren't firm recommendations but ideas for discussion which will be presented to the Age Friendly Steering Group for consideration.

Recommendations on some underlying principles for an Age Friendly 'food' City:

GOOD NUTRITION MEANS GOOD MEALS! In considering nutrition for older people, food should be looked at in a holistic way, recognising that meals can be an opportunity to socialise, share and enjoy. Food is vital for good mental health and wellbeing as well as good physical health. Whilst good practice on supplements should be followed (e.g. Vitamin D supplements offered residential settings), in general the vision for a Healthy Ageing City should be that that everyone in the city is able to access tasty nutritious meals.

CHOICE and TASTE 'Older people' are primarily 'people.' Everyone is different, and people's relationship to food is complex. As with other provision relating to older people, and in a climate of personalised budgets and increasing individual choice, we should avoid 'one size fits all' food answers and recognise people have different cultural traditions, their own styles and preferences, so a range of provision is vital. A Healthy Ageing city should encourage and enable choice.

BE BRAVE AROUND INNOVATION There are opportunities especially for the voluntary and community sector to help provide some of these options around food; whether that is 'rebranding' existing lunch clubs so that people feel they are 'for them'; or developing new methods of delivering cooked meals. There is a danger that if local organisations don't rise to these challenges then choice will be much more restricted to national commercial chains rather than local provision.

A 'LIVING WELL APPROACH' The most effective mechanism is a preventative approach so that people don't become isolated and/or vulnerable to food poverty in the first place. The limited support available should target times when people are especially vulnerable (e.g. following bereavement and hospital discharge)

OLDER PEOPLE ARE A COMMUNITY RESOURCE. They should be seen as active participants - not passive recipients. A Healthy Ageing City should ensure that there are opportunities for volunteering made available and accessible, whether on gardening projects, community lunch clubs or in other settings.

Practical Recommendations for achieving this vision –

These Recommendations are for discussion specifically by the Age Friendly Steering Group but will also be of interest to others in the city. The recommendations have been grouped together for convenience, but ***please read them in relation to the main body of the report above which outlines the barriers to accessing a healthy diet, and looks at the evidence of what works***.

Recommendation 1: Explore how to better provide information on nutritional needs, equipment, ready meals, home delivery and shared meals outside the home - including discussing who pays, how to use non-internet methods (e.g. radio, paper based) and how to improve knowledge about them amongst professionals and others who can signpost e.g. via the Its My Life website and care package assessments

1) There is a general lack of knowledge about **nutritional needs of older people** and how these change. It is also not clear where people might go to if they are seeking information. The Carers centre suggested a '5 points' fact sheet - not just aimed at carers but also for older people themselves.

2) There is also an information gap about **equipment and adaptations** which could make cooking and eating easier for someone with changed mobility or a sensory impairment

3) The issue of **ready meals bought from supermarkets** is important due to the increase in people using them not just as an occasional treat but as a main source of nutrition. There is a need for more guidance on these, perhaps as an information sheet, and/or alternatively manufacturers could be encouraged to offer better guidance, although engagement with supermarkets might be better taken forward at a national level.

4) There should also be better information available about the **options for home delivery** and the existing alternatives to community meals ('meals on wheels') including private companies.
5) There should be better information on where to go for **shared meals outside the home** such as lunch clubs, and even though the on-line 'It's local actually' directory lists them people reported that they found it hard to find lunch clubs on the site and wanted paper based or other ways of accessing information
6) ***Also Consider:*** whether there needs to be local work on how to choose nutritious ready meals in a supermarket and/or whether this suggestion should be passed to a national organisation.

Recommendation 2: Provide/continue training on nutrition and cooking skills for family carers, paid care workers and residential staff, and continue the Healthy Choice award in residential settings. Look at providing training for individuals on cooking for themselves, both cooking from scratch and adapting to changed mobility or sensory impairment.

There was a strong sense that better training is needed for those who provide food for older people - in particular **employees of care agencies** which increasingly are responsible for putting food on the table. This should cover an understanding of nutrition but also should ideally cover basic cooking skills for simple home cooking and given the limited time available could include top tips for microwave cooking.

1) Training for staff in **residential settings** is also seen as very important and it is vital this should be continued and developed, to ensure these settings are meeting government guidance on nutrition and ideally going beyond in providing food that is palatable and sustainable.
2) Training in using the **MUST** tool and monitoring of use in healthy and social care settings
3) **The Healthy Choice Award** in residential settings is a good vehicle for helping to ensure nutritious food provision, and educating the people involved, so it should be continued and developed.
4) There should also be more options for people to learn **skills and confidence to cook** for themselves whether this is cooking from scratch (e.g. Old Spice) or learning about how to adapt existing skills and use different equipment in response to reduced mobility or sensory impairment. Current support is patchy (e.g. good practice around reablement)

Also consider: the major barrier identified around the lack of time available for carer's home visits - is there any scope for changing or influencing this?

Recommendation 3: Ensure that people can continue to be provided with nutritious meals at home, if that is their choice; explore alternatives to 'community meals' or meals on wheels' ; and if cooking is offered via a care package make sure there is enough training and –above all – time allowed.

1) There should continue to be a **subsidy** (whether by direct payments or other means) to people who would otherwise not be able to afford community meals or their alternatives as it seems likely the costs to health services caused by people not eating well would outweigh the cost of the subsidy.
2) There should be **market development** around alternative **'meals on wheels'** models (perhaps using the city east/west/central 'hub' division) which could offering greater choice e.g. via suppliers e.g. existing or new voluntary or community groups or social enterprises; other potential providers such as Sussex Partnership NHS Trust, or private companies e.g. Brylin may have capacity to deliver to the east of the city. There should be an exploration of whether existing kitchens could be used for meal preparation e.g. in day centres, community buildings, school kitchens
3) There must be **supported nutritious food provision at home** which reaches people who are housebound or who don't want to go out even if they are offered support to do, even if this is not via a community meals/'**Meals on wheels'** service (which is a challenge to provide via the current local authority model)
4) If food at home is offered via a **care package** rather than via community meals, then there should be adequate training for carers, and sufficient time allowed for each visit.

Recommendation 4: Improve the availability and understanding of options for eating outside the home; and support for voluntary and community sector and neighbourhood level activity – including gardening projects. New shared meal provision should focus on the gaps e.g. In the East and North of the city; and at weekends.

1) Commissioners and other decision makers should recognise the major but largely unrecognised role that **shared meals** e.g. lunch clubs are playing in improving the health, nutrition and mental health of the city – tackling isolation, food poverty and acting as a gateway to advice and support - and help ensure that projects can keep up with the increase in demand identified in this report. Cost, access and (especially) transport are key factors in people accessing them

2) Future planning on support for food groups such as 'shared meals' providers (e.g. micro- finance, management, help finding volunteers) should take into account the **support needs** identified by current groups outlined in the 'Shared Meals' report and help these groups to continue to thrive in the face of increasing demand. The Food Partnership and others should develop a project proposal on how best to support this section of the community food sector.
3) Interested parties should note there are gaps in shared meal provision (especially lunch clubs) at weekends and in the **East and North of the City**. As local provision is the most successful model (52% of people accessing shared meals live nearby) this is likely to be a barrier to access. Additionally groups such as the Hangleton and Knoll project suggest that their **community focus and links** strengthened their food work, as they knew their neighbourhood well and had effective reach. Opportunities for **intergenerational shared meal options** for example schools inviting older people to join the school lunch should be developed (School Meals Service)
4) Providers and funders should be brave when they look at how could expand provision; and **consider opportunities** for providing shared meals in new settings within existing resources - for example the new focus for seniors housing as community hubs could provide a setting for residents and/or others in the community
5) A lot of shared meal activity is informal e.g. between neighbours. There should be support for initiatives such as '**Know My Neighbour Week' in May 2016** and schemes such as the **neighbourhood care scheme**.
6) **Food growing** whether at home, via community growing projects or allotment growing has well evidenced positive impacts on health and wellbeing as well as food access, and should be encouraged and supported. The **OAP concession for allotments** should be retained. The '**Fit for Gardening'** pilot could provide an effective model and roll out should be explored.

Also consider:

- Could/should there be a city wide campaign on the right of older people to order smaller/ cheaper portions (where they are on offer) in restaurants and/or clarify whether people have the right to order children's portions if they are on offer?
- Could we/should we look at how as a city we can **'rebrand'** the image of lunch clubs and similar to encourage more people to think they are for them?
- Is there potential to work with supermarkets on 'what makes an age friendly shopping experience'

Recommendation 5: Food poverty is increasing in the city, and in relation to older people is strongly related to food access. There should be better retirement planning advice included in money advice; and a focus on transport, digital inclusion and provision of better cooking equipment.

1) Food poverty is about much more than money, but having an adequate income in retirement was seen as vital to avoiding food poverty. Therefore **Money Advice Services** in the city need to become better at helping people plan retirement; and continue to focus on benefit maximisation for older people.
2) **Transport** plays a crucial role in enabling people to shop and also to access meals options outside the home. **Free bus passes** play an important role and should be retained. **Community transport** plays an important role for some lunch clubs - but there are also other methods e.g. recruiting volunteers to help drive people. Groups should refer to the Federation of Disabled People's **'Out and About' guide**

for this and other useful examples and guidance on ensuring effective (free) insurance provision for volunteer drivers http://www.thefedonline.org.uk/citywide-connect .

3) **Digital inclusion** (access to the internet) is lower amongst older people than in the general population, making it harder to shop without leaving the house and also to find information. Whilst some attention should go to providing information by non-digital means (see above) there is also a recommendation around increasing digital inclusion in the city. Digital inclusion projects should use internet shopping as a practical focus during courses with older people so that people get support to set up 'favourites lists' etc which will help them shop in future. Communications work should take into account different 'levels' of IT confidence for example people may be happy to receive and read information but be less confident about shopping or paying for things online for fear of 'scams'
4) Providers of furnished housing for older people, whether local authority (e.g. sheltered housing), housing association or private, should be encouraged to offer **fridge freezers** rather than a fridge with a small icebox, to help with food storage and freezing portions (especially useful for single people) and if appropriate to consider offering specially adapted appliances.

Also consider:

- Could there be a project around **better ready meals** and/or **delivery of cooked foods** to potential settings for lunch clubs and shared meals - is this something the Food Partnership should explore?
- **Can food access be offered via shared meal settings?** In Somerset Day Centre, a local greengrocer takes order for fresh fruit, vegetables and eggs, which some members find very convenient. This may be a good service to offer in other settings?
- Is there a need for a **food shopping** service?

Recommendation 6: Dementia, Sensory impairment, and 'entrenched' isolation emerged as particular barriers in relation to good nutrition. Food growing should be explored for people with dementia; support to befriending organisations prioritised; and support targeted at the right times (e.g. hospital discharge, bereavement) to prevent isolation occurring in the first place

1) In relation to dementia, there is compelling evidence for the benefits of **gardening and food growing** and the city should explore whether there could be provision to address this gap
2) There should be more access to training and support to help people to adapt existing skills and use different equipment in response to reduced mobility or sensory impairment. Current support is patchy (e.g. good practice around reablement) – See also recommendation 2
3) Entrenched isolation is especially hard to identify and tackle and **befriending organisations** play an effective role for helping some of the 'hardest to reach' so should be supported, along with neighbourhood initiatives (see above).
4) The most effective intervention regarding extreme isolation is to prevent people becoming cut off in the first place - This was a cross cutting theme which emerged from many conversations and it is recommended that commissioners look at ensuring support is targeted at the most vulnerable times (e.g. bereavement and hospital discharge) and good practice elsewhere e.g. in providing 'food bags' for people to take home from hospital, so they are able to eat during the gap before a care package is put

in place; [ask Chloe for reference]

Conclusion and recommendation on next steps

This report has been deliberately designed as a scoping exercise. It contains an ambitious mix of principles and practical recommendations which are for discussion by the Age Friendly Steering Group. The final 'product' may therefore look very different from this draft.

If we are taking a bold approach to reimagining our city, using food as a lens though which to view it, is important to involve older people themselves as part of that process , and the final recommendation is that as this should be the next step.

Recommendation 7: This report should no w be 'sense checked' by organisations involved in the intial interviews; and further input sought via older people's groups for example the Age UK Research group and via Impetus's network of neighbourhood carers. ***Input from steering group required***

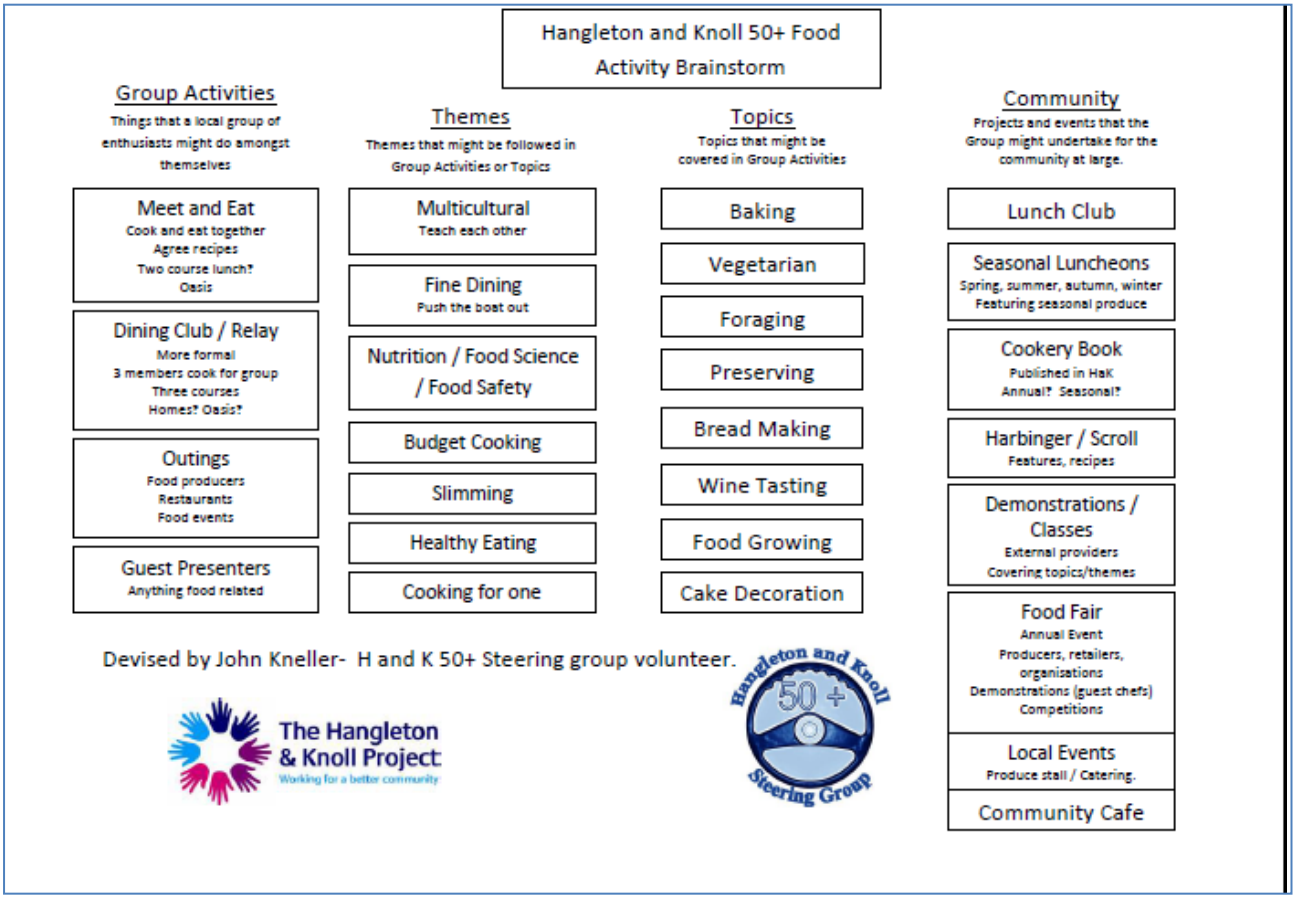
Brighton & Hove Food Partnership is a hub for information, inspiration and connection around food. We're a not-for-profit organisation that delivers a range of community projects such as:

- Cookery courses for beginners and those looking to teach others
- Helping people grow food with others in their community
- Tips and advice on reducing food waste at home
- Setting up community composting sites across the city
- Healthy eating advice and workshops
- Advice on food poverty and support for food banks
- Weight management programmes for adults and families

In 2012, we launched the city's second food strategy which sets out how collectively as a city we will achieve a vision of a healthy, sustainable and fair food system for Brighton & Hove. The strategy aims to tackle health inequalities, reduce food poverty, support local food businesses and reduce the environmental impact of the way we produce, consume and dispose of food.

Appendix A:

Mind map of potential food activity – shared with kind permission of John Kneller and Hangleton & Knoll 50+ Steering Group



whatworkswellbeing.org

What Works Network

Community wellbeing 'Voice of the User' report: Summary for stakeholders

What Works Centre for Wellbeing, Community wellbeing evidence programme
December 2015

This short report summarises the stakeholder engagement activities that the What Works Centre for Wellbeing community wellbeing evidence programme carried out between June and September 2015. We would like to thank all the organisations, groups and individuals who shared their views with us.

Who did we consult with, how many and how?

In June, we created a large database of interested and relevant stakeholders by inviting people from amongst consortium members' relevant contacts, and from a database of local authority contacts. We also provided a subscription link on the What Works Centre for Wellbeing website. The database currently holds around 1,800 people, 95% of them are in the UK, but there are also subscribers in Europe, the USA, Australia, and South America.

We used workshops, interviews, online questionnaires and community sounding boards to speak to over 650 people (Figure 1). This included stakeholders from central, local, and devolved government, NHS, charities, charitable trusts, businesses (e.g. housing associations, developers, and insurance companies), academia and local communities.

Hopkins Van Mil also conducted two pairs of public dialogues in Belfast and Bristol, where they spoke to 40 local residents.

We held our engagement activities between June and September 2015 in Glasgow, Exeter, Birmingham, Cardiff, Leeds, Belfast, Durham, Liverpool, London, Grimsby and Bristol.

Figure 1: Stakeholder engagement process and map

What is important to wellbeing in a community?

We wanted to know which community level factors stakeholders identified as important for wellbeing. We asked participants in the community sounding boards, public dialogues and workshops. Their responses included:

- **Social capital / social networks:** for example, neighbourliness and relationships within communities, networks of family and friends, community spirit
- **Participation and voice:** being listened to, young people having a voice, civic engagement, access to information, co-production, wide representation
- **Safety and security:** fear of crime, feeling safe walking home at night
- **Environment:** green and open space, cleanliness
- **Local facilities:** public transport, childcare, access to education, pubs
- **Health:** health services, access to healthy lifestyle e.g. food, exercise
- **Community identity:** connectedness and belonging
- **Activities:** access to culture, activities, sports, volunteering
- **Equality, diversity and inclusion**
- **Financial security:** jobs, local economy
- **Affordable housing**
- **Governance:** accountability, joined up systems
- **Access to support**

> *"I see it in social capital terms… amount of space and opportunities to mix: mix between social groups."* – Interviewee

Social networks, participation, environment, local facilities and **safety and security** emerged as particularly strong themes and were mentioned in all consultation activities.

What is 'community wellbeing'?

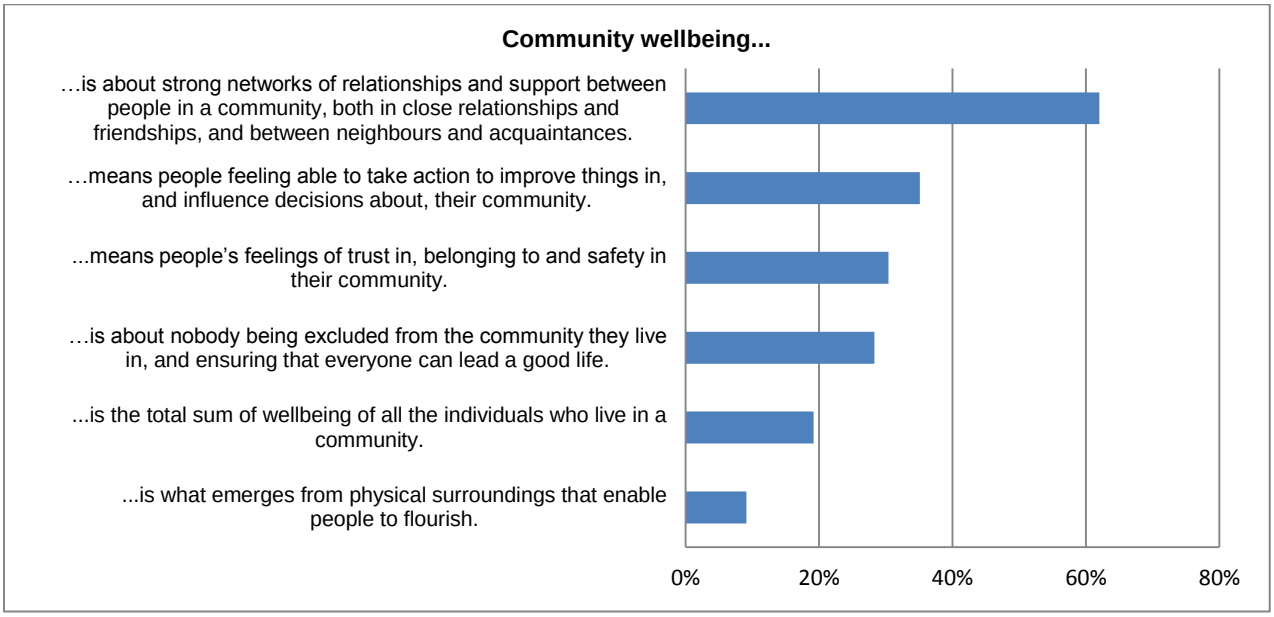
We wanted to explore whether community wellbeing is the total sum of(or average) wellbeing of all the individuals who live in a community, or whether it is something else. We asked people in the online questionnaire, interviews and community sounding boards about their understanding of community wellbeing.

Overall, the stakeholders we spoke to understood community wellbeing as primarily being about social networks and connectedness.

> *"We have a local group which has taken over a piece of unused green space and is making a community garden with places to walk, sit and play and a vegetable garden. It has brought people together and is improving community cohesion, social capital and individual wellbeing."*
> Online questionnaire respondent

Figure 2 shows online questionnaire responses (283) to the question 'which of the following statements comes closest to how you understand community wellbeing?'

Figure 2: Definition of community wellbeing: online questionnaire



What kind of wellbeing evidence (types and topics) do stakeholders need?

We wanted to know what kind of wellbeing evidence stakeholders felt would be useful to their work, both in terms of the types of evidence, and the evidence topics. The topics that came up most frequently were:

- Social relationships and networks
- Health and public health
- Community development
- Participation and volunteering
- Co-production
- Safety
- Opportunities for informal social interaction

"Wellbeing has tended to be a very academic subject we're trying to convert into something that's very clearly actionable and can influence decisions'. For policy-makers this might be 'a checklist of ten questions that policy-makers should ask themselves based on domains of wellbeing, or whatever it is." – Interviewee

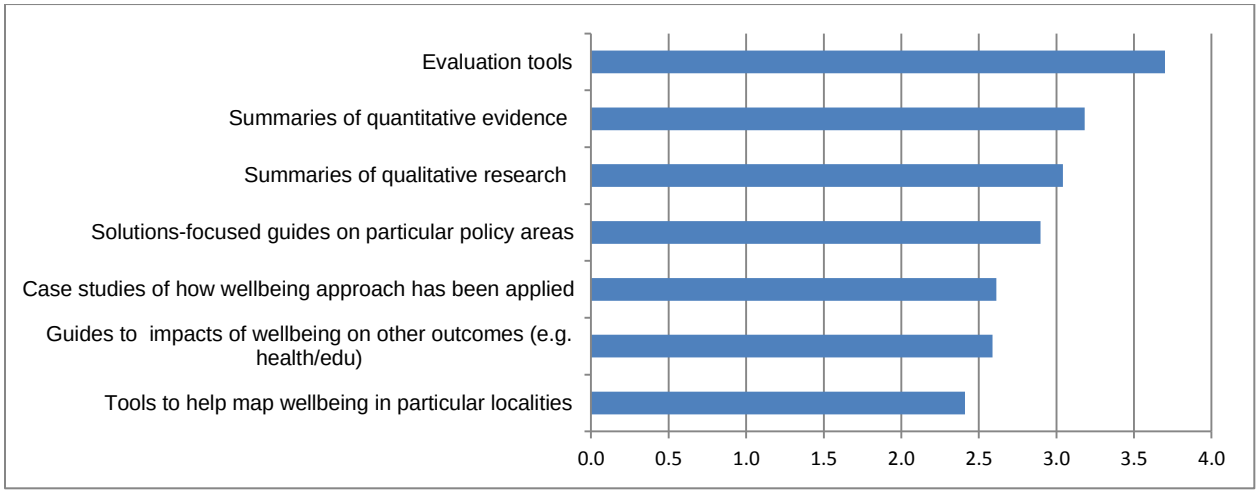
There was broad agreement amongst stakeholders that diverse types of evidence are needed, including bottom-up evidence from service providers and qualitative data (Figure 3). However, some senior stakeholders from government and the third sector, and participants in the workshops, told us that quantitative evidence was more important because the government favours it.

"What evidence is there for the relationship between well-being and usage of health services? Does it have a contribution to prevention and therefore financial savings?" – Workshop participant

Some stakeholders suggested that evidence of how wellbeing leads to other outcomes, like reduced expenditure and use of health services, is needed in order to make the economic case for wellbeing. However, some individuals preferred to talk about the intrinsic value of wellbeing and resisted the 'commodification' of it.

Stakeholders from Wales, Scotland and Northern Ireland expressed a need for context-specific evidence. Others said evidence must be comparable between different regions of the UK.

Figure 3: Ranked outputs and tools that stakeholders want: Online questionnaire



What are the barriers to using wellbeing evidence?

In our analysis of the online questionnaire responses, we found that there is a gap between people's intended and actual use of wellbeing evidence. This finding was confirmed by discussions with participants in the workshops.

We wanted to find out what barriers people face in using wellbeing evidence, so included questions on this topic in the workshops, online questionnaire and interviews. We found that the most common barriers were:

- Not knowing it exists
- A lack of capacity to access and understand it
- A lack of evidence that is high quality, timely and addresses the complexity of the issues
- Wellbeing evidence is not perceived as credible by others

In the online questionnaire, the most common challenge was that "there is not enough evidence that is up to the quality standard that I require, e.g. randomized controlled trials (RCTs)", which 44% of

"We want this evidence to be so strong that the government and the Treasury cannot turn away the findings because they're methodologically unsound." - Interviewee

respondents chose.

> *"I don't think there's resistance to wellbeing. The white elephant in the room is the funding crisis. It's increasingly difficult to innovate and do long-term planning."* - Interviewee

Stakeholders across the board regularly referred to the 'current climate' and issues of funding and resources. For example, the 'funding and resources' challenge was mentioned in 7 of our 10 workshops, and it was also referred to in interviews.

Find out more

To find out more about the What Works Centre for Wellbeing's *community wellbeing evidence programme*, contact whatworkswellbeing@neweconomics.org.

What is the What Works Centre for Wellbeing?

The What Works Centre for Wellbeing is a UK government-funded initiative recently launched by the What Works Network to enable a range of stakeholders to access independent, high quality, accessible evidence syntheses on wellbeing. Over the next three years, teams will explore wellbeing evidence in the following areas; work and learning, culture and sport and community wellbeing.

Sign up to updates from the wider What Works Centre for Wellbeing here: http://whatworkswellbeing.org/

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Community Navigation

in Brighton & Hove

Evaluation of a social prescribing pilot

Executive Summary

November 2015

By Clair Farenden, Catherine Mitchell,
Seb Feast, Serena Verdenicci

impetus

Brighton & Hove age UK

Prime Minister's Challenge Fund EPIC Working Together To A Healthy Future

Contents

Acknowledgements

The evaluation of Community Navigation in Brighton & Hove was led by Impetus. Patient interviews were conducted and analysed by an independent consultant supported by volunteers.

We would like to thank interview participants who gave their time to the evaluation, volunteers who conducted patient interviews and the GPs and surgery staff who gave their time to the study.

In particular we would like to acknowledge and celebrate the work of all Community Navigator volunteers for sharing their skills and time throughout the pilot and for the additional work completed by Karen Hmaimou, Kirat Randhawa and Simon Amphlett in conducting patient follow-up interviews and Serena Verdenicci for reviewing other social prescribing pilots nationwide.

We would also like to thank our colleagues Jane Lodge at Brighton & Hove CCG and Jess Sumner at Age UK Brighton & Hove for their on-going support of Community Navigation, along with consultant Catherine Mitchell, who ensured we reached a broad and representative sample of patients and provided impartial analysis of patient outcomes.

Finally, we would like to take this opportunity to thank Jenny Moore, whose work as Development Manager during the first months of the pilot was fundamental to ensuring the success of the service.

Introduction

This is an evaluation of the Community Navigation service, a one-year social prescribing pilot. The model for the pilot was based on Age UK national templates, drawing from their vast knowledge and experience of delivering other similar services across the UK.
Brighton & Hove Integrated Care Service (BICS) invited Age UK Brighton & Hove (AUKBH) and Brighton & Hove Impetus to work on designing the model as part of its Extended Primary Integrated Care (EPIC) Programme, which aimed to improve access to primary healthcare services in Brighton and Hove, based within 16 GP practices across the city. Brighton & Hove Impetus became the main delivery partner, working collaboratively with AUKBH and BICS throughout the pilot.

The EPIC Programme was funded by the Prime Minister's Challenge Fund from August 2014 until May 2015, then granted an extension until November 2015. It was created to 'improve access to Primary Care and for patients to see the right person, at the right time, in the right place'.
The social prescribing workstream reflects the desire of some GPs to reduce consultations being carried out with patients that frequently attend the surgery presenting non-medical issues affecting their health and wellbeing. In these cases, the GPs' response is necessarily limited but accessing social support and non-medical services can help reduce attendances and improve broader health outcomes for the patient.
More information on the other 4 workstreams within EPIC can be found at: www.epic-pmchallengefund.uk

The Community Navigation service was designed to increase the capacity of GP practices to meet the non-clinical needs of patients with long-term conditions and other vulnerabilities, e.g. low to moderate depression, bereavement, social isolation, financial difficulties.

The service aims to;

- Link patients with groups, services and activities that can help improve their health and wellbeing, including sources of social, practical and emotional support.
- Promote self-management through the use of patient-centred methods and an empowering approach; involving patients in exploring options and making decisions about the support they access.
- Provide a bridge between Primary Care and the voluntary and community sector, linking GP surgeries with a broader range of non-medical services that can support patients' wellbeing.
- Collect evidence about the use of and need for groups, services and activities in Brighton & Hove that support patients' health and wellbeing.

The Community Navigation pilot received £172,276 over sixteen months between August 2014 and November 2015. Navigators began seeing the first clients in GP practices from October 2014. The Community Navigation service was delivered by a team of three part time staff and 16 Community Navigators. During the first 12 months of providing the service, 322 patients were seen.

This report analyses twelve months of patient evidence from the start of October 2014 until the end of September 2015 along with reflections on learning, challenges and successes throughout the whole pilot.

About the Community Navigation (CN) model

Community Navigators work in GP surgeries to assess patients' non-medical support needs and help them access groups, services and activities that can broadly improve their health and wellbeing.
Navigators are volunteers with a background in helping people meet their social or support needs. They are recruited, trained and supported by a volunteer co-ordinator at Brighton & Hove Impetus.
Potential volunteers are invited to a one-to-one interview with CN staff and assessed for suitability against a set of criteria. Those selected attend 2 days' training covering every aspect of the Community Navigation journey including all CN policies and procedures. They also practice each stage of the CN process and are given a bespoke handbook covering all CN guidelines and training notes. Once Navigators have completed

this initial training, they begin an intensive induction process which involves shadowing experienced Navigators, one-to-one meetings and telephone support from the Volunteer Coordinator and meeting staff at their surgery before they begin seeing their first clients. CN staff also conduct periodic observation visits. On-going individual support is continually provided for CNs to discuss strategies and receive guidance in supporting their clients. Group support and training is given via a monthly 'Action Learning' meeting where Navigators share learning, issues and solutions as well as receive service news and themed training sessions from CN staff and guest speakers. All CNs have further access to specific training that can support them in their role via Brighton & Hove City Council (BHCC) and Voluntary & Community Sector (VCS) opportunities available.

The Community Navigation journey

1. The Navigator offers up to 6 appointments of around 45 minutes each, which mostly take place in the GP surgery, or in the person's home if they are housebound. Shorter appointments also take place over the telephone where needed. The Navigator's relationship with patients is facilitative, empowering and short-term. They encourage and enable people to take up groups, services or activities and do not create dependence on the Navigation service itself. Navigators do not offer any medical advice nor do they have access to patients' medical records.
2. Navigators work one-to-one with patients, adopting a motivational interview technique 'guided conversation' to assess non-medical support needs. They work in a person-centred way to find solutions which fit priorities identified by the patient.
3. Navigators find information about services, groups and activities by using a referrals directory developed and regularly updated by the Community Navigation service, along with local knowledge and other research as needed. One-to-one advice and support for the Navigator is also provided by the volunteer co-ordinator.
4. Navigators then facilitate referrals by supporting people to attend groups, activities and services that can help meet their needs. Links to the community are also facilitated so people can re-engage and reduce their isolation.
5. Once a facilitated referral has been made, the Navigator contacts the patient to find out if they were able to take up the service, group or activity and offers further support if needed.
6. When the case is closed, a short summary of the Navigation process is given to the GP to place on the patient's medical record, including issues identified and which services or groups have been referred to. Patients are made aware of this during their first session and can request to opt out of any or all information being entered on to their medical record.
7. Staff and volunteers in the office contact clients 3-6 months after the case is closed to conduct a follow up interview over the telephone. Patients can be re-referred to the service if needed.
8. Navigators also act as a bridge between community services, groups, activities and GP surgeries, creating better two way communication and relationships based on increased awareness and understanding.

About this evaluation

This evaluation was collated by Impetus staff following guidance from Brighton & Hove Clinical Commissioning Group (CCG). Patient interviews, volunteer surveys and GP practice surveys were conducted and analysed by an external consultant to counteract reporting bias and to advise on ensuring our methodology was sufficiently robust.

The evaluation has five main aims;

- Assess the impact of the pilot; for patients, volunteers and GP practices
- Analyse costs-benefits and social value
- Outline key lessons, challenges and successes
- Discuss opportunities and risks

Executive Summary

Twelve months into delivering Community Navigation within GP surgeries, the pilot can report on numerous lessons, recommendations on good practice and positive patient outcomes regarding the provision of a social prescribing service. Results from consultation and follow-up interviews show that Navigation is effective for patients, GP surgeries and volunteers.
Patients feel listened to and understood by Navigators, have increased access to the right services at the right time and are able to take the next steps towards improving their health and wellbeing.
GPs continue to increase referrals, are satisfied with the quality of the service and are seeing positive benefits for their patients.
Navigators value their volunteering role and suggest the training and support provided by the staff team enables them to carry it out effectively.

Key Successes

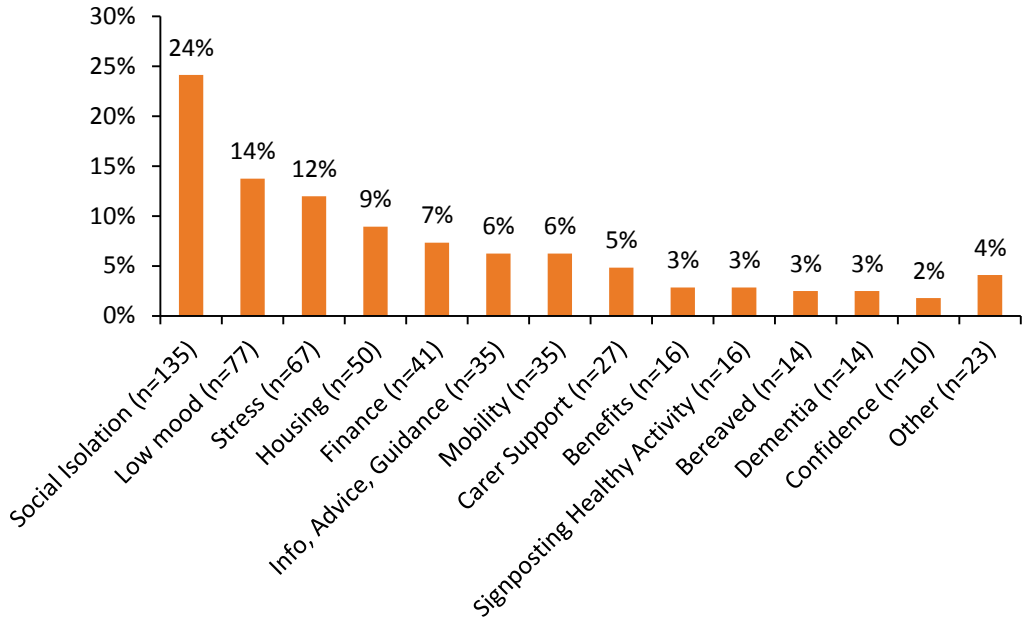
- 393 patients were referred across 16 surgeries during the first 12 months of the pilot and 741 referrals were made to groups, services and activities patients would not have otherwise accessed.
- The service attracted a highly experienced and skilled volunteer team to carry out the Community Navigator role. Most Navigators have a previous or current career in healthcare, social services, teaching or counselling.
- There were overall improvements to patients' health and wellbeing as a result of Community Navigation with 93% saying they had all the information they needed to address their issue and 62% being able to take the next step within 3-6 months.
- Patients reported 98% satisfaction with the service saying they felt listened to and understood. 85% said they would recommend their Navigator to family and friends.
- GPs and Practice staff reported 89% satisfaction with the quality of the Community Navigation service with 95% saying the service is effective at providing a referral route to non-medical services and 87% reporting it as effective at improving the wellbeing of patients.
- Volunteer retention throughout the pilot was high, with over half the Navigators remaining on the team after one year, despite only signing up to an initial six month commitment.
- Volunteers gave an average of 7 hours per week of their time during the first 12 months of the pilot, which calculates at 5824 volunteer hours given to Community Navigation.
- The service developed positive and effective relationships between Health and VCS partners, fostering a shared understanding and learning.
- A positive and effective partnership between two VCS charities was developed; B&H Impetus and AUKBH.
- Effective working practices and procedures were developed, to meet the needs of patients, Navigators and GP practices.
- The pilot saw an upward trend in referrals throughout the first year of reporting.

A year in numbers

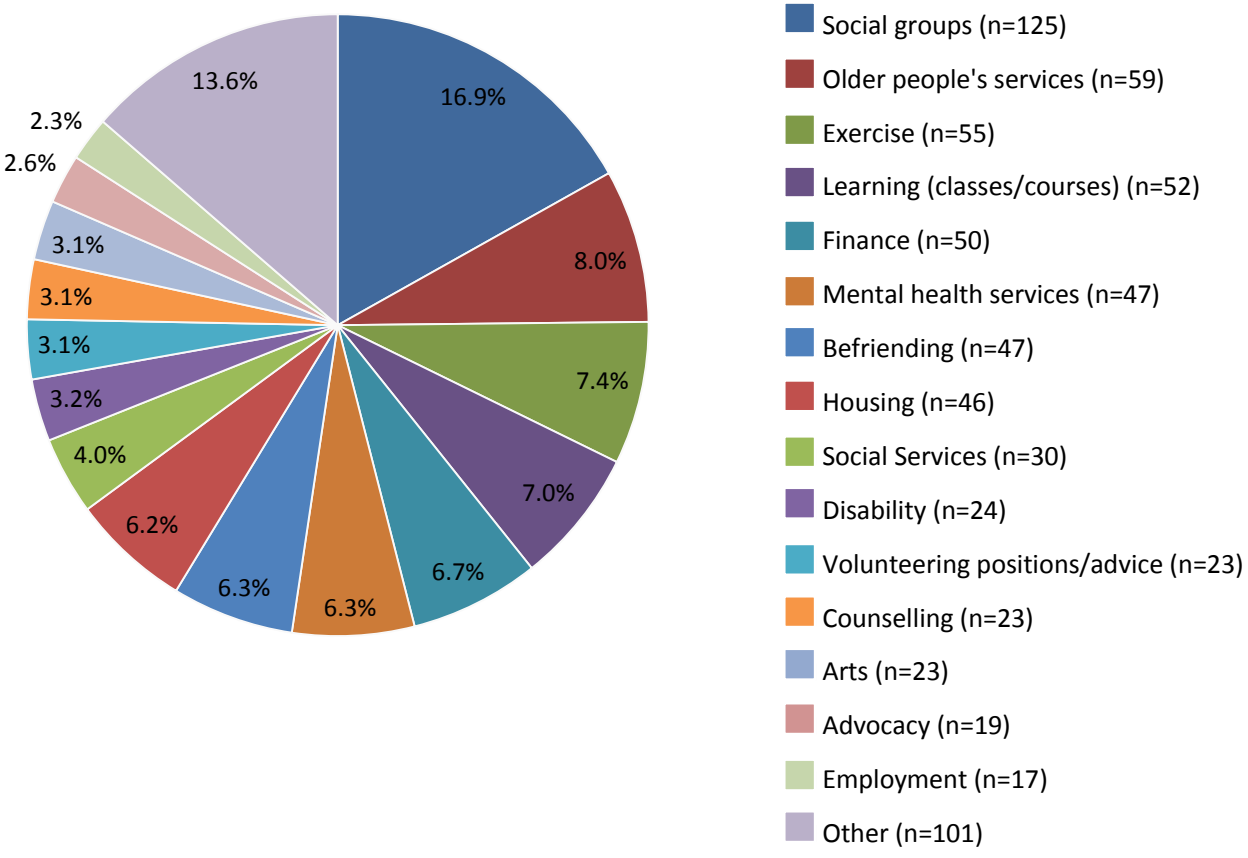
During the reporting period (October 2014 – September 2015):
393 referrals were made from GPs
322* patients seen by a Navigator
1188 total number of Navigation sessions
741 total number of referrals to groups, services and activities
3 per patient, average number of sessions
16 days / 2.3 weeks, the average patient wait time from visiting the GP to the first session with a Navigator
5824 volunteer hours were given
4% (16) patients referred had complex needs that required specialist support or care co-ordination
23% of patients that worked with a Navigator had mobility needs, including wheelchair use
62% of patients referred to Navigation were aged over 55

** The 71 patients who were referred but did not see a Navigator either did not attend any appointments made or did not want the referral.*

The most frequent referral reasons were: social isolation, low mood, stress, housing, and finance issues. Most clients presented with multiple referral reasons.



The main categories of referral made to groups, services and activities include social groups, older people's services (e.g. Age UK Help at Home, nail cutting, LifeLines), exercise, adult learning courses, and support with benefits and finance.



The top 5 services Navigators referred to

1. The Hop 50+ (social and practical support for older people)
2. Impetus Neighbourhood Care Scheme (Befriending Service)
3. Access Point (Social Services)
4. Age UK Information and Advice Service
5. Money Advice Plus (debt and benefits advice)

Patient Outcomes

Results showed that, 3-6 months after completing the process, Community Navigation proves effective. Patients feel listened to and understood by the Navigator, are more able to access the right service at the right time and are able to take the next steps towards improving their health and wellbeing.

85% of patients said they would recommend their Community Navigator to family or friends.
98% felt listened to and understood by the Navigator .
84% experienced improvements in their sense of wellbeing.
93% said they had gained access to the right information to help address their issue.
49% were able to access services, groups or activities following the Navigation process. Barriers to access include; lack of disability access, not feeling welcomed at the group or activity and lack of response from the service they were referred to.
62% of patients interviewed were able to take the next step identified with their Navigator after 3-6 months.

Community Navigation is more effective in supporting people to make positive choices and take the next step when 3-6 sessions are offered.

Patient Case Studies

Rita is 55, is housebound and isolated following an accident and has problems with welfare benefits and debts piling up. The Navigator applied for a grant from the Brighton District Nursing Association Trust and Rita now has a mobility scooter. The scooter has enabled her to attend the surgery, which has reduced the need for home visits from GP and nursing staff. She was also supported to apply for a Winter Warmth Grant to help with heating costs and was referred to Age UK to help apply for personal independence payments (PIP).
“Thank you so, so much, I can’t believe it. You’re like my guardian angel; you’ve got so much done!”

Fred is 72, caring for his wife and feeling overwhelmed. The Navigator contacted the Carers Centre who helped him create an action plan. Fred is now accessing more support for himself and his wife. He says “Thank you so much, you’ve opened the door to things”

GP Practice Outcomes

GPs and other practice staff were asked what impact they thought Community Navigation makes for their patients and their practice.
The results showed a vast majority of GPs and practice staff were satisfied with the quality of the Community Navigation service. Most respondents thought it had improved wellbeing of their patients and increased the surgery's links with the local community. The majority of GPs suggested the service has decreased the amount of times patients came in to the surgery for non-medical issues.

- 89% GPs and practice staff are satisfied with the Community Navigator service.
- 95% of GPs and practice staff think the service is effective at providing a referral route to non-medical services.
- 87% GPs and practice staff think the Community Navigation service is effective at improving the wellbeing of patients.
- 84% think the Community Navigation service is effective at improving the surgeries' links to other resources and services in the community.
- 68% of GP practice respondents think the Community Navigation service is effective at reducing the amount of time patients attend the surgery with non-medical matters, whilst 19% did not know.

GPs commented:

"I would really value having our Community Navigator stay on for our practice. I know patients have gained a lot from her too."

"I really think the service is a good one to offer help to patients and point them in the right direction with non-medical problems therefore 'freeing' GP appointments to be used for the unwell and those that need them."

Volunteer Outcomes

Good practice in recruiting, training and supporting volunteers is essential in providing an effective Navigation service. Volunteers should be recognised for their contribution by all partners at every available opportunity.

Operating the service with volunteers also requires a higher level of flexibility than is usually expected of paid staff. Volunteer Community Navigators are highly skilled individuals and with a wealth of experience and skills to offer. Most have worked or are currently working in a related profession, e.g. healthcare, teaching, social services or counselling. Volunteers feel well trained and supported to carry out their role effectively and value the experience and opportunity it brings them.

Navigators want to feel part of GP surgery teams and need to have direct follow up contact with GPs regarding cases. Community Navigation is an effective volunteer opportunity to support people into employment or change to a health related career. Navigators value further opportunities for training on key issues affecting patients (for example mental health, housing).

Volunteer Community Navigators commented:

"I have personally gained a great deal from being a Community Navigator; personal satisfaction, becoming even more aware of problems in society, networking, gaining knowledge of the NHS, charities and services in Brighton and Hove. Feeling useful in old age!"

"I think the project works well because it is short-term and solution-focused. This helps clients become empowered rather than dependent and also means there's an end in sight for the Navigator."

Social Value

Evidence gathered during the pilot suggests Community Navigation;

- Supports patients' wellbeing by utilising a 'whole-person' approach
- Increases access and contributes to health equality
- Supports partnership working between Health and Voluntary and Community Sectors
- Improves community cohesion and integration of services
- Provides an opportunity for the city to utilise a highly skilled volunteer team
- Provides an opportunity for local people to gain additional skills and compete in the job market

Net Savings in Primary Care

The Community Navigation model was based on an Age UK service in Penwith and Cornwall. Evidence from a matched cohort study there showed a 12.7% increase in Primary Care capacity, translating as a £1500 cost saving per patient per year. If we extrapolate and assume a comparable affect in Brighton & Hove, this would result in Community Navigation providing a net cost saving of approximately £1365 per patient. Considering that at least 1000 patients could have access to Navigation each year if the service is provided citywide, this means that;

£1.36 million per year of GP time could be put to more effective use by providing the Community Navigation service as part of the Primary Care offer in Brighton & Hove.

Lessons Learnt

Numerous lessons can be drawn from developing and implementing the Community Navigation service, including; the development of shared perspectives between Health and Voluntary and Community Sectors, utilising volunteers in providing a social prescribing service, understanding how to build relationships with GP surgeries, the need for flexibility and a definition of what it means for a GP practice to be 'Navigator ready'.

Conclusion

Community Navigation in Brighton & Hove has proved to be successful in providing a social prescribing service that is closely linked with Primary Care. The person-centred methods used resulted in significant improvements to patients' health and wellbeing. Patients have been provided with the right information to help them access social, emotional and practical support. Patients have also been able to make positive choices concerning their broader health and wellbeing needs and most have already taken steps to improve their situation.

Partnership working between the Health and Voluntary & Community Sector has promoted a shared understanding of the differing approaches and methods used to achieve positive outcomes for patients and a growing number of GPs demonstrate trust in the Voluntary & Community Sector by referring their patients to the service.

Numerous lessons have been learnt about working flexibly, building relationships between sectors, operating the service with volunteers and what it means for a GP surgery to be 'Navigator ready'. The pilot has also collected evidence about the need for and use of groups, services and activities in Brighton and Hove.

Analysis of key findings and learning throughout the pilot produced a detailed understanding of how to provide a suitable, high quality and cost effective service in partnership with Primary Care. The pilot can also share its awareness of challenges, risks and opportunities in developing and providing a social prescribing service using a volunteer model. Learning from the pilot led to key recommendations for longer term development and a series of model options and associated budgets for providing the Community Navigation service citywide.

Key Recommendations

1. Integration with Primary Care is vital to the success of the service. The main referral route should continue to be GPs, and Navigators should continue to be based within GP surgeries.
2. Community Navigation is more effective in supporting people to make positive choices and take the next step when 3-6 sessions are offered.
3. Volunteers need to be well trained and supported, as well as recognised for their contribution by all partners at every available opportunity. Operating the service with volunteers also requires a higher level of flexibility than is usually expected of paid staff.
4. When working across sectors, a well-developed service level agreement is needed from the outset to foster a shared understanding of aims and expectations as well as to ensure the service can be delivered as cost effectively as possible. This should include details of governance structure and arrangements.
5. When implementing a new service based in GP surgeries, it is important that CN staff meet the whole practice team. This requires an appropriate lead in time when implementing the service in multiple surgeries.
6. Some GPs and Practice Managers are able to support the service and refer more patients than others. They can be utilised as champions of the service to encourage others to refer.
7. All surgeries hosting the service need to be 'Navigator ready' to ensure an effective and equitable service is delivered for patients.
8. Referrals mechanisms should be simple for GPs, practice staff and volunteers to use, and tailored flexibly to suit individual surgery systems as needed.
9. Providing regular feedback about outcomes for patients encourages a higher number of referrals from GPs as well as ensuring greater appropriateness of referrals. The CN service should provide regular reports for each surgery showing reasons for referral and services referred to.
10. Streamline the governance structure by utilising the more commonly used 'steering group' approach.
11. Patient outcomes have been measured using a variety of methods throughout the pilot, including patient follow-up interviews. As the landscape of health and VCS services shifts, new models of outcomes measuring need to be identified and implemented, e.g. monitoring of distance travelled, bench-marked with patients before and after Navigation.

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Submission from Age UK Brighton & Hove

Answers to Fairness Commission's Questions

Advocacy Service

How do you think the Council and its partners can make Brighton and Hove a fairer place to live?

75% of the Advocacy Service referrals received since the beginning of April 2015 have been on housing issues. This evidences the fact that:

a) It is difficult for people in later life (especially those with physical, sensory or mental impairments) to navigate the process of applying to go on the council's Housing Register and bid for social housing.

b) It is difficult for vulnerable people in later life to challenge the actions/inactions of private landlords (including freeholders of buildings in multiple occupation) and their managing agents.

The council should:

1. Ensure an adequate provision of housing suitable to meet the needs of older people, including accessible one-bedroom/studio flats, sheltered housing, extra care housing and care/nursing homes.

2. Make the process of accessing social housing more user friendly and transparent especially for those who do not have access to the internet.

3. Better monitor and, where possible regulate, the activities of private landlords and managing agents to prevent them causing distress and hardship to vulnerable older people.

4. Commission advice and representation for people in later life who are in dispute with landlords (both social and private) or managing agents. This includes the funding of independent advocacy and I&A services.

Referrals received also evidence of loneliness amongst people in later life and the council should:

5. Ensure that there is adequate provision of services within the city to ensure that isolated people in later life can engage with, and contribute to, the community in which they live. This might include providing (or commissioning) befriending services and day centres, luncheon clubs, volunteering and other such opportunities for social interaction along with the development of volunteering opportunities.

What can residents do to make Brighton & Hove a more fair about equal place to live for everyone?

One of the ways in which residents (including people in later life) can contribute to making Brighton & Hove a more fair and equal place to live is by volunteering. That would help to ensure that people in later life have access to services that are relevant to them and also have the opportunity to contribute to the delivery of services thereby increasing social capital. The council should:

6. Support local voluntary sector organisations to ensure that they remain sustainable and can continue to provide volunteering opportunities for residents including people in later life.

DueEast Neighbourhood Council

Supporting collective community action in Whitehawk , Manor Farm and Bristol Estate

Evidence to the Fairness Commission : Theme – Older People and Wellbeing.

Community Assets – the building blocks for health and wellbeing.....

Evidence of the Efficacy and Potential of longer term community centred asset based approaches to health and wellbeing

A Case Study

This Case Study was prepared by Serendipity Community Development Workers and DueEast Neighbourhood council to document just one example of patient engagement in February 2016 and how this linked with and adds value to longer term community development approaches to health

This edited version was finalised by Community Works and submitted as an appendix to a city wide report to NHS England " A Snapshot of Patient's Views : The Practice Group's notice on their contract –February 2016 . Connecting charities , volunteers and businesses. "

Appendix 2- Whitehawk / Serendipity

An example of the community development process that enables this information scoping to be part of a wider engagement process: the local Whitehawk Context

The local context for each of the Practice Group Surgeries in the City is distinct and from a community and patient perspective crucial as an underlying factor in the views and comments they have made about their own Practice Group surgery.

The following gives a thumbnail sketch of the key local issues that inform comments and background to the Practice Group surgery at the Wellsbourne Health Centre in Whitehawk.

a) Health Deprivation Hot Spot : a priority area for tackling health inequalities

- The Whitehawk patient catchment area for the Practice Group surgery includes areas that are among the most deprived and with the least healthy outcomes for patients in Brighton and Hove and indeed some of the country's worst performing areas
- Average male life expectancy in Whitehawk is 9 years worse than in some parts of Hove
- Cancer outcomes including screening rates, surviving cancer and many others are very poor in this area–hence the pilot peer to peer project with Macmillan Cancer Support developed and run by local patients.

b) The creation of the Wellsbourne Health Centre, March 2010: its impact on the local community

- The Centre brought together the Broadway Surgery and Whitehawk Medical Centre, and later the Practice Surgery
- Patients and the local community did not react well to the change that created a new centre, re-located off the main road in the neighbourhood. The previous 2 GP surgeries were both on the main Whitehawk Road easily accessible from bus stops.

The new Wellsbourne Health Centre meant a trip up to the central/northern area of the estate for patients from the Broadway surgery

- From the beginning of the new operation, the lack of a direct bus serving the new centre was raised by patients and the local community as a major problem and the community could not understand the position held by Brighton and Hove Buses. It was repeatedly said that buses could not get down Whitehawk Road to serve the new centre, although it was felt that many coaches regularly make this route to serve the school for school trips on the same road. It was felt that a turning circle at the end of Whitehawk Road practically exists as it is and could be easily adapted similar to that which serves Hove Polyclinic. Patients of the new health centre who have to go regularly to Hove Polyclinic for blood tests have repeatedly remarked that the Wellsbourne Centre should be served directly by a bus
- For at least a year after the opening of the new centre there were considerable complaints from patients and the local community about the difficulty of finding and getting to the new centre, about the lack of lighting and the very poor state of the uneven pathway built from the main road to the new facility and new library which opened the next year in 2011
- Operational difficulties around the co-location of the 2 surgeries sharing a reception area were significant and led to patient confusion about layout, who was who and who they saw about what. These were compounded later by high staff turnover in the Practice which led to much patient inconvenience
- In 2011, the Chair of the PCT met with local ward councillors and NHS staff and agreed some access improvements (lighting and pathway, though the bus route did not change, the bus stop on Whitehawk Way was re-positioned nearer to the beginning of the path to the Wellsbourne Centre)
- In 2012 an open day, co-ordinated by Serendipity, re-launched the Wellsbourne Health Centre, with some community art projects commissioned and the local community more involved in the new centre. The result was a highly successful joint community , NHS and health and wellbeing open day which also involved all the co-located services next to the Wellsbourne Centre – the primary school, the new library , the children's centre and nursery, the dentist , health promotion teams and many community groups and projects.

c) Proximity of County Hospital A and E and Children's Hospital

- The Whitehawk area is home to hundreds of families with young children and many have experienced problems getting appointments at the Practice and other surgeries in the area. The relative proximity of the Royal Sussex County Hospital and Royal Alex Children's hospital and their A&E units has meant that many local people when not getting the services they require from primary care have instead used A&E services as they are more convenient

- This is a significant issue in the area and is anecdotally evidenced by many clinicians and the CCG and BHCC.

d) Closure of Eaton Place Surgery

- The closure of Eaton Place surgery in March 2015 led to thousands of patients seeking new surgeries. Many in the Whitehawk area were directly affected, many in turn who have registered with the Practice Surgery at the Wellsbourne Centre
- Interviews carried out with a number of such patients reveals that they are especially shocked and angry at the prospect of potentially having to make another move so quickly after this last one
- The closure of Eaton Place has had knock on effects locally at the Wellsbourne Health Centre:
    - Patients wishing to register at the Broadway Surgery were in such large numbers that this surgery could not cope and closed its list (although there was a 6 week delay between signalling closure of their list and it actually happening during which time they continued to be deluged with registration enquiries)
    - A branch surgery from Ardingly Court surgery has opened upstairs in the Wellsbourne Health Centre to help cope with the demand for patients in the area seeking a GP.

e) Community development approaches to health and wellbeing

- Community Development work in the Whitehawk area has supported the development of a number of resident and patient led activities in the past couple of years in response to the high levels of interest, health needs and desire to get involved from people the local neighbourhoods
- A new resident led charity Due East Neighbourhood Council has been created and supported by Serendipity, initially through the City Council's pilot neighbourhood governance project in 2012/13
- One of Due East's busiest areas of work is Health and Wellbeing and a Due East Health and Wellbeing Group brings together local residents, patients, community health projects and health and social care providers to discuss, identify priorities and agree and take partnership actions to improve the health and wellbeing of local people
- A strong resident and patient led local infrastructure has established with a legal form and charitable status. It has formally recognised accountabilities with BHCC and the NHS which have been developed in the past couple of years, supported by skilled and experienced community development workers with strong local knowledge and links
- This community health work has been informed by national good practice and developments in community approaches to health, including the NHS Alliance

community development group launch in 2014 of its "Charter for Community Development in Health" under the chair of Dr Brian Fisher. Due East and Serendipity were present at the launch and have been working to these principles in all its work. Dr Fisher was keynote speaker at a health equalities workshop in 2015 bringing these principles and evidence for this method of working to Brighton and Hove

- Due East patient led work in the Whitehawk area is further informed by academic research including " A Glass half full ; how an asset approach can improve community health and wellbeing " (IDeA – LGA) March 2010 and the more recent "Guide to community centred approaches to health and wellbeing " by Public Health England , February 2015
- The well established community led Due East vehicle for engagement is now ready to take on projects and work with service providers in health , primary care, adult social care etc. and is well placed to link and bring added health and wellbeing value to providers in primary care at the Wellsbourne Health Centre.

f) Realising the potential for the Co-located Wider Community Hub services

- The Wellsbourne Health Centre is at the heart of a set of essential public services in the Whitehawk community including a pharmacy, new library, a primary school - City Academy Whitehawk - the Roundabout Children's Centre and Nursery, a community cafe and co-located housing, social services and other city council workers
- In addition, a social housing project to bring 28 new flats will be built right alongside the health centre in the next year
- There is massive potential and scope for joined up partnership working between services and involving the health centre at its heart. However, partnership working has been restricted by the lack of capacity and sometimes will in some of these providers. The new Neighbourhood Hub arrangements being investigated by BHCC could develop a new phase of primary care work at the health centre which links the local community via supported community development work to deliver broader health and wellbeing aims.

Share your community group's views - FS1547005

What does a fair city mean to you? : A fair city is one where all parts of the community have equal access to the range of services they wish to use and, where obstacles to access impact upon sections of the community, arrangements are put in place to overcome those obstacles.

What is fair about life in Brighton & Hove at the moment?: The city has well-developed and high quality public services, complemented by the services that are provided by a buoyant and progressive voluntary and community sector.

What is unfair about life in Brighton & Hove at the moment?: There is a risk that public service providers will reduce their provision of services to the community to the point at which only "statutory" services continue to be funded. This will severely affect vulnerable people in the city who will be challenged to cope without the full range of current services being available to them.

What specific experience or evidence do you have about inequalities and fairness that may be of use to the Commission? : Recommended reading is a research report, published in January 2016 by the ECT Charity, entitled 'Why Community Transport Matters', that demonstrates how community transport services throughout the UK deliver social value and the positive impact community transport has on health, wellbeing and communities. The report includes substantial quantified evidence relating to the costs of loneliness and isolation and the savings that are achievable if a high quality community transport service is available.
See: http://ectcharity.co.uk/files_uploads/ECT_Why_community_transport_matters_Final_version2.pdf

Based on your experience or evidence, what is your or your organisation's analysis of the causes of inequalities in Brighton & Hove? : Part of the cause of loneliness and isolation is the difficulty that lonely and isolated people have in accessing services and reaching opportunities to socialise. Failure to address the issues of loneliness and isolation is imposing a significant and growing cost to the public purse. In our experience, the availability and provision of mitigations, such as affordable and accessible community transport, is a simple way to address the problem.

Are there any people or communities for whom life in Brighton & Hove is particularly unfair? : Older people are particularly vulnerable to the effects of isolation and the inability to socialise, especially if they are unable to get out without the provision of accessible transport that will conveniently serve their home. The availability of an excellent network of accessible public bus services is of no value to someone who cannot walk to the bus stop. Community Transport can (and does) remove that barrier to mobility. Without it, life would be very unfair.

What do you or your organisation believe would be the best ways to tackle inequalities and increase fairness in the city? : Our responses have focused on the issues that face older people who experience isolation and loneliness, particularly those people who have mobility impairments. The local authority should be working in close partnership with a range of voluntary and community organisations to prioritise early interventions that identify individuals living in circumstances that make them vulnerable and support them in addressing those vulnerabilities.

Your first fairness priority: Tackling loneliness and isolation among older people.

Your second fairness priority: Maintaining support (and funding) for organisations that contribute towards tackling loneliness and isolation.

Your third fairness priority: Co-ordinating the work of the agencies that contribute towards tackling loneliness and isolation.

Share your community group's views - FS794873

What does a fair city mean to you? : A place where all people are able to take part, contribute, be supported, travel and live their lives to the fullest.

What is fair about life in Brighton & Hove at the moment?: We have a strong voluntary sector, a diverse community, lots of assets in terms of geography, parks, arts & heritage opportunities and strong sense of place. Generally, statutory agencies want to work in partnership with their communities, and in some cases they do this well.
The council's Third Sector Strategy supports fairness, as does the CCG's commitment to Social Value in its commissioning.

What is unfair about life in Brighton & Hove at the moment?: We are making three separate submissions to put forward three issues that are unfair about life in Brighton & Hove.

Parents with Learning Disabilities
Our experience in working with parents with learning disabilities has revealed the unjust and unfair way in which they are treated by the local authority. Parents are repeatedly set up to fail by a system that does not adequately support them to be the parents they want to be, takes a siloed approach to working across Adult and Children's services and refuses to acknowledge its legal duties under the Human Rights Act, Equalities Act and Care Act. It also fails to adhere to Department of Health guidelines on supporting parents with a learning disability. The result is that our clients regularly have their children removed into care, which has a devastating emotional, social, financial and safeguarding impact on their lives.

There are numerous models from around the UK where Councils successfully support people to parent and save the local authority money in the process . We are using these to raise awareness of alternative models that BHCC could adopt in order to create better outcomes for both parents and children alongside evidence of their obligation to meet relevant legislative duties.

B&H would be a fairer place (and BHCC would save money) if we could adopt a more sensible way of supporting parents with LD.

What specific experience or evidence do you have about inequalities and fairness that may be of use to the Commission? : In Brighton and Hove there are an estimated 5,053 adults aged 18 or over with learning disabilities, of whom 1,065 are estimated to have moderate or severe learning disabilities.

On parents with learning disabilities - much of this is taken from Bristol University's Working Together with Parents Network, who are experts in this field. (http://www.bristol.ac.uk/sps/wtpn/policyessentials/)

The Working Together with Parents Network (WTPN) believes that if provided with earlier personalised support, many parents would not become involved with the child protection system and fewer children would be placed in care.

The foreword to the Department of Health Good Practice Guidance on Working with Parents with a Learning Disability (2007) states in England that:: 'People with learning disabilities have the right to be supported in their parenting role, just as their children have the right to live to live in a safe and supportive environment.'

The guidance recognises that parents with learning disabilities/difficulties can be good parents if provided with positive support. The five key features of good practice in working with parents with learning disabilities/difficulties:

Accessible information and communication
Clear and co-ordinated referral and assessment procedures and processes, eligibility criteria and care pathways
Support designed to meet the needs of parents and children based on assessments of their needs and strengths
Long-term support where necessary
Access to independent advocacy.

services and across health, social care, housing and non-statutory sector) of the need to provide early (page 45).'

Section 17 of the Children Act 1989 (children in need) states that local authorities have a duty to safeguard and promote the welfare of children within their area who are in need and, so far as it is consistent with that duty, 'to promote the upbringing of such children by their families by providing a range and level of services appropriate to those children's needs'.

Early preventative support clearly is essential to this statutory principle and to the principles set out in, for example, Children's Act 2004, Working Together 2013, Think Family 2009.

The Care Act specifically includes support for parenting in issues for which support and advocacy must be provided.

In addition, on people with a learning disability & Mental health:
• People with learning disabilities demonstrate the complete spectrum of mental health problems, with higher prevalence than found in those without learning disabilities
• Between 25 and 40% of people with learning disabilities also suffer from mental health problems
• The prevalence of dementia is much higher amongst older adults with learning disabilities compared to the general population (21.6% vs 5.7% aged 65+)
• Prevalence of anxiety and depression in people with learning disabilities is the same as the general population, yet for children and young people with a learning disability, the prevalence rate of a diagnosable psychiatric disorder is 36%, compared with 8% of those who do not have a learning disability.

We would like to ask the Fairness Commission to consider the above in conjunction with evidence from the Council itself about issues related to the fairness commission. For example we have been refused sight of the full Learning Disability Review and feel that the summary report lacks detail around the views on parents with a learning disability. The reason given for refusing to share this report is confidentiality but we feel that this issue can be surmounted and an open appraisal of the full content is important, including areas where service users were critical.

We want the full Learning Disability Review and the above evidence to be considered by the commission along with BHCC data on:
* numbers of parents with learning disability in child proceedings
* number of parents with learning disability who have had their child(ren) removed
* number of parents with learning disability who were offered a reasonable adjustment to the PPP course
* numbers of parents with learning disability who were offered any other kind of support to parent

Based on your experience or evidence, what is your or your organisation's analysis of the causes of inequalities in Brighton & Hove? : This is far too complex an issue to be summarised in a box!

However, as we have set out above, there are systemic issues which exacerbate inequalities - the way that adults and children's services operate, for example, make lives much less fair for parents with learning disabilities - and needlessly so.

Funding and finance issues - the current reduction in public services supporting certain groups means that that these groups don't have access to the kind of opportunities that others do. These are fundamental to our lives - being a parent, being able to access education, training or employment, being able to travel independently, take part in society, volunteer and contribute.

Are there any people or communities for whom life in Brighton & Hove is particularly unfair? : People with a learning disability, parents with a learning disability, adults with Asperger's, older people who are isolated, those with mental health support needs.

What do you or your organisation believe would be the best ways to tackle inequalities and increase fairness in the city? : Implement learning from other local authority areas on how models such as Shared Lives and adjusted parenting support programmes can enable parents with a learning disability care for their children. We are organising a round table discussion in this issue shortly, with colleagues from areas who are already working in

this way, and we would welcome Fairness Commissioners at that meeting. Details provided to Julia Reddaway.

Your first fairness priority: Enable parents with a learning disability to be able to care for their child by providing adjusted support

Your second fairness priority: Support community based activity which can prevent loneliness, isolation and the health impacts of these

Your third fairness priority: Providing services for adults with Asperger's to be able to engage in work, learning, volunteering.

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Healthy Ageing Evidence Review

This evidence review is part of a series produced by Age UK, in order to provide evidence to underpin decision-making for people involved in commissioning, service development, fundraising and influencing.

Contents

Key messages

- The overwhelming evidence on the spiralling health costs of an ageing population provide strong arguments for funding preventive approaches.
- Programmes that promote preventive approaches, such as the Partnerships for Older People Projects (POPPs) have been evaluated as being effective and cost-efficient.
- Health promotion services that are effective are often providing more than just activities and information – they involve adopting approaches that can change people's behaviours.
- In general, peer mentoring can be very effective and cost-effective.
- Volunteering has benefits not only for society but for older volunteers, who often gain or regain a sense of usefulness and purpose.
- The lay health educator model (the Senior Health Mentor) has been effective in improving healthy behaviours and reaching hard-to-reach groups, and has the potential to be sustained as a low-cost model.
- There will be increasing pressure on costs and funding for services in the next five years, regardless of which politicians are in power.
- The **fit as a fiddle** programme includes a significant range of healthy ageing initiatives. There is still the opportunity to study it more closely for the purposes of future service development.
- International examples of Japan's 'Hureai Kippu', or 'Health Care Currency' time-banking scheme and the US's retirement campuses provide stimulating ideas as to how we might extend our active ageing strategy with suitable partners.

1 Policy context

The last ten years of government policy have included repeated commitments to achieving the goal of healthy ageing. The gap between policy aspiration and practical implementation has nevertheless remained, and could be considered to have widened during this period.

Early national standards

The National Service Framework for Older People[1] sets an aim of extending the healthy life expectancy of older people, with a national standard that 'the health and well-being of older people is promoted through a coordinated programme of action led by the NHS with support from councils'. By 2010, however, although the measure of healthy life expectancy at age 65 remains in the performance management system for the NHS, it is classified as a tier 3 priority, which means that it is one of a number that primary care trusts can choose to prioritise locally – or not *(The Operating Framework for the NHS in England 2010/11)*.[2]

The National Service Framework (NSF) included the evidence base for a wide range of health promotion activities for older people with the strongest evidence found for increased physical activity, improved diet and nutrition, and immunisation programmes for influenza. It also emphasised the importance of older people being able to access whole population health promotion activities (such as smoking cessation) and the benefits of a much wider range of initiatives to improve health and well-being, for example, tackling poverty through benefits advice and support.

Better Health in Old Age[3] presented a very positive picture of progress against the NSF standard, but by 2006 this had been tempered somewhat. *A New Ambition for Old Age*[4] set out the next steps needed to implement the NSF, emphasising the economic case for high uptake of health promotion activities among older people and promising more opportunities for older people to increase their levels of physical, mental and social activities.

White papers and reviews

A series of white papers and reviews on health have been published over the period. In 2004, *Choosing Health*[5] placed the emphasis on enabling individuals to make healthy choices and removing barriers for particular communities, including older people. The strongest message was that, with the exception of children and young people, the role of government was to enable healthy lifestyles, rather than to intervene. In 2006, *Our Health, Our Care, Our Say*[6] repeated the aims for promoting health and well-being in old age as: higher levels of physical activity; reducing barriers; and increasing uptake of evidence-based disease-prevention programmes.

Lord Darzi's NHS Review in 2009 emphasised that building an NHS for the future demands a focus on helping people to stay healthy as well as treating them when they are sick. It committed to offering health checks to everyone aged between 40 and 74 over a two-year period (*High Quality Care for All*[7]). The Review stressed the importance of investment in prevention in the context of the economic downturn.

More recently

The impossible challenge of running the NHS from the centre and the charge of too many top-down targets have led the Department of Health to redefine its role as setting an overall direction and supporting local delivery. Policy has been often been framed as guidance which local NHS organisations can use or not as they see fit. It remains to be seen whether this is a sustainable approach in a period of severe financial restrictions.

The *Prevention Package for Older People*[8] was published as a series of resources to support PCTs in prioritising and commissioning services that promote the health, well-being and independence of older people. Resources published to date include those on falls, foot care, hearing services, intermediate care and discharge from hospital. Further resources have been promised on depression, continence and arthritis.

A continued focus on the health benefits of physical activity for older people can be found in commissioning guidance (*Let's Get Moving*[9]), and in the annual report of the Chief Medical Officer (*On the State of Public Health*[10]).

Looking ahead

There is relatively little to distinguish between Labour and Conservative proposals for health after the election. At the end of 2009 the Government published a hastily prepared white paper (*NHS 2010–2015: From good to great*[11]) that promised a focus on prevention and helping people to stay healthy, linking this to the need for greater efficiency and productivity. In draft policies to date, the Conservative party has promised to change the Department of Health to a Department of Public Health, focusing much more on the prevention of disease than just on cure, and to provide separate public health funding to local authorities.

It is likely that these commitments to prevention and public health will be severely tested when the inevitable reductions in acute hospital services start to bite, whichever party is in government.

2 Definition of healthy ageing

The World Health Organization (WHO) defines **health** as 'a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity'.[12]

Healthy ageing is a concept promoted by WHO, that considers the ability of people of all ages to live a healthy, safe and socially inclusive lifestyle. It recognises the factors beyond health and social care that have a major effect on health and well-being, and the contribution that must be made by all sectors with an influence on the determinants of health. It also embraces a life course approach to health that recognises the impact that early life experiences have on the way in which population groups age.[13]

The Case for Healthy Ageing: Why it needs to be made[14] describes healthy ageing in the following way:

> **Healthy ageing** may be considered as the promotion of healthy living and the prevention and management of illness and disability associated with ageing. Ageing can be thought of as an accumulation of changes over the life course that increases frailty. If we can design and execute effective interventions to prevent or delay the onset of chronic disease and increase healthy life expectancy, there will be social, economic and health dividends for us all. There is an appreciation that the locus of responsibility for the prevention and management of many chronic diseases lies with the individual through their behaviour and the recognition that a range of factors – socio-economic, environmental and cultural – influences this behaviour.

This points to one of the key challenges for the preventive approach – it is not just about providing good information and services. Crucially, it is about persuading people of the healthy ageing argument. Only when we have managed this will they adapt or change their behaviour to adopt a healthy approach.

Although this review looks at healthy ageing, much of the research we refer to relates to well-being. And indeed the quest for well-being is the key area of overlap with the other evidence reviews, as discussed above. We see this relationship as acutely relevant in that good health is both a component of wellbeing as well as a contributor to it. The Institute for Public Policy Research (IPPR, 2009)[15] adapts Nazroo[16] to identify five essential elements of well-being as:

- resilience
- independence
- health
- income and wealth
- having a role and having time.

We can see that health is one of these elements. But it is also clear that poor health will have a detrimental effect on attaining the other four – most obviously in the cases of independence, resilience and having a role.

A related and useful terminology is used by the Partnerships for Older People Projects (POPPs).[17] The programme assessed its impact on improving the quality of life using the Health-Related Quality of Life (HRQoL) 'domains': mobility, self-care, usual activities, pain/discomfort and anxiety/depression. With both, the focus is on outcomes and we can see a similar focus when we consider Age Concern's adoption of the seven outcomes in the social care Green Paper, *Independence, Well-being and Choice*.[18] These are:

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

And closely related to these are the five areas that make up the Services Debate framework for developing services. These were developed from the results of the staff and partner questionnaire and the subsequent workshop:

- living independently
- having fun and keeping well
- coping in challenging times
- being ion control
- participating and contributing.

So we can see there are a number of different ways to 'cut the cake'. But ultimately we are talking about the same ingredients interacting with each other to realise a wider more positive state of the human condition that we aspire for everyone to reach. And which we believe we can influence through providing services (and convincing arguments) that promote healthy ageing.

3 The need for healthy ageing services

WHO's Active Ageing Policy Framework[19] points out that despite the best efforts in health promotion and disease prevention, people are at increasing risk of developing diseases as they age. The following provides a précis of their analysis of particular risk areas.

Smoking – not only does this increase the risk for diseases such as lung cancer, it is also negatively related to factors that may lead to important losses in functional capacity. For example, smoking accelerates the rate of decline of bone density, muscular strength and respiratory function.

Poor oral health – primarily dental caries, periodontal diseases, tooth loss and oral cancer cause other systemic health problems. They create a financial burden for individuals and society and can reduce self-confidence and quality of life. Studies show that poor oral health is associated with malnutrition and therefore increased risks for various non-communicable diseases (NCDs).

Alcohol – while older people tend to drink less than younger people, metabolism changes that accompany ageing increase their susceptibility to alcohol-related diseases, including malnutrition and liver, gastric and pancreatic diseases. Older people also have greater risks for alcohol-related falls and injuries, as well as the potential hazards associated with mixing alcohol and medications.

Nutrition – eating and food security problems include both under-nutrition (mostly, but not exclusively, in the least-developed countries) and excess energy intake. In older people, malnutrition can be caused by limited access to food, socio-economic hardships, a lack of information and knowledge about nutrition, poor food choices (e.g. eating high-fat foods), disease and the use of medications, tooth loss, social isolation, cognitive or physical disabilities that inhibit one's ability to buy foods and prepare them, emergency situations and a lack of physical activity. Excess energy intake greatly increases the risk for obesity, chronic diseases and disabilities as people grow older. Insufficient calcium and vitamin D is associated with a loss of bone density in older age and consequently an increase in painful, costly and debilitating bone fractures, especially in older women.

Medications – because older people often have chronic health problems, they are more likely than younger people to need and use medications – traditional, over-the-counter and prescribed. Medications are sometimes over-prescribed to older people (especially to older women) who have insurance or the means to pay for these drugs. Adverse drug-related reactions and falls associated with medication use (especially sleeping pills and tranquilisers) are significant causes of personal suffering and costly, preventable hospital admissions.[20]

Adherence – it is estimated that in developed countries adherence to long-term therapy averages only 50 per cent. In developing countries the rates are even lower. Such poor adherence severely compromises the effectiveness of treatments and has dramatic quality of life and economic implications for public health. Without a system that addresses the influences on adherence, advances in biomedical technology will fail to realise their potential to reduce the burden of chronic disease.[21]

Psychological factors – including intelligence and cognitive capacity (for example, the ability to solve these problems and adapt to change and loss) are strong predictors of active ageing and longevity.[22] Often, declines in cognitive functioning are triggered by disuse (lack of practice), illness (such as depression), behavioural factors (such as the use of alcohol and medications), psychological factors (such as lack of motivation, low expectations and lack of confidence), and social factors (such as loneliness and isolation), rather than ageing per se.

Physical environments – older people who live in an unsafe environment or areas with multiple physical barriers are less likely to get out and therefore more prone to isolation, depression, reduced fitness and increased mobility problems. Hazards in the physical environment can lead to debilitating and painful injuries among older people. Injuries from falls, fires and traffic collisions are the most common.

Vision – worldwide, there are currently 180 million people with visual disability, up to 45 million of whom are blind. Most of these are older people, as visual impairment and blindness increase sharply with age. Overall, approximately 4 per cent of people aged 60 years and above are thought to be blind. The major age-related causes of blindness and visual disability include cataracts (nearly 50 per cent of all blindness), glaucoma, macular degeneration and diabetic retinopathy.[23] In all countries, corrective lenses and cataract surgery should be accessible and affordable for older people who need them.

Hearing impairment – leads to one of the most widespread disabilities, particularly in older people. It is estimated that worldwide over 50 per cent of people aged 65+ have some degree of hearing loss.[24] Hearing loss can cause difficulties with communication. This, in turn can lead to frustration, low self-esteem, withdrawal and social isolation.[25,26]

The Case for Healthy Ageing[27] sets out the challenges we are facing as follows.

It is estimated that by 2018 there will be in the UK:

- nearly 7 million older people who cannot walk up one flight of stairs without resting
- 1.5 million older people who cannot see well enough to recognise a friend across a road
- over 4 million people with major hearing problems
- up to a third of a million people aged 75+ with dual sensory loss
- over a million people aged 75+ who find it very difficult to get to their local hospital
- a third of a million people who have difficulty bathing
- nearly a million people with dementia.

Improving Care and Saving Money[28] adds that:

- Approximately 1.26 million adults receive local authority-funded social care now.
- Over 1.7 million more adults are expected to need care and support in 20 years' time.
- In the next 20 years, the number of people over 85 in England will double, and those over 100 will quadruple.
- A fifth of the population of England is over 60, and older people make up the largest single group of patients using the NHS.
- Older people in the UK use three-and-a-half times the amount of hospital care of those aged under 65, and almost two-thirds of general and acute hospital beds are in use by people over 65 (much of this provision is for people in the last 12 months of their lives).
- Older people currently account for nearly 60 per cent of the £16.1 billion gross current social care expenditure by local authorities, and despite a recent downward trend, those aged over 65 still account for approximately 40 per cent of all hospital bed days, with 65 per cent of NHS spend being on those aged over 65.
- Injury due to falls is the leading cause of mortality in older people aged over 75 in the UK.

The rationale for FAAF[29] comes at this from a slightly different angle, noting the challenges around activity and diet (and older men).

1. By 2020, over half of adults in the UK will be over 50 years of age. The persistent trend that the 'older you are, the less you participate' (*A Vision for 2020*, Sport England, 2004), has huge significance for society as a whole, particularly in terms of bringing together older people with younger, more active generations. The challenge is immense. Only 17 per cent of men and 13 per cent of women aged 65–74 take sufficient exercise to meet the international guidelines of half an hour's exercise of 'moderate intensity' on at least five days a week. For those aged 75 and over, this falls to 8 per cent of men and 3 per cent of women.
2. There is also a growing prevalence of obesity in society through poor diet, from which older people are not immune. The main contributing factors are lack of motivation, bad eating habits, fatalism, and health, dependency or disability problems, with falls being a major cause of disability and a leading cause of death for the over-75s. Conversely, disease and illness can also be common causes of under-nutrition. This picture is complicated by the difficulties certain groups have in choosing to eat healthy food due to frailty and availability.

3. Research has also shown that it is difficult to engage older men in health issues: in line with notions of masculinity, older men tend to tough out illness and they are less likely than women to seek help for problems such as depression (*Working with Older Men – a review of Age Concern services,* Age Concern, 2006).

IPPR's *Older People and Wellbeing*[30] noted that:

- There are 1 million socially isolated older people and this number is projected to rise to 2.2 million in the next 15 years.
- The risk of depression as a result of crime can persist over a long period of time.[31]
- The physical fabric of the environment is a big concern.[32]
- The urban environment can have intensely bad neighbourhoods and negative impacts on well-being, but conversely, having a community role (and feeling able to influence the environment) decreases depressive symptoms.[33]
- Older people, though, are more worried about traffic than teenagers, crime and drugs.[34]
- The quality of older people's housing is very important as they are particularly likely to spend long periods of time at home.[35] It is estimated that 2.2 million households with a person over 60 live in unfit housing.[36]
- Living alone is an obvious risk factor. There is a greater proportion of older men living alone now, but women still predominate (75 or over).
- Age discrimination excludes older people from a wide range of services, public places, community life, leisure activities, employment, mainstream culture, media and public debate.

The above headline statistics show overall figures for older people, as well as the occasional insight into the situation of particular groups.

Any deeper analysis for service development would benefit from identifying particular groups and assessing the research relating specifically to them. The IPPR[37] says that certain groups are most at risk from poor emotional well-being – the poorest, the very old, some BME groups, those most isolated, in worse physical health, and those without an active social or community life. Poor health affects over a quarter of all people over 75, making that group particularly vulnerable to depression, social isolation and exclusion.

Stresses associated with poverty are: making ends meet; poor housing; the wider physical environment; fear of crime; poor physical health – these are greater the more deprived you are, and are associated with poor emotional well-being.

Events and transitions in life that can trigger poor mental well-being include: poor physical health; bereavement; retirement; divorce; illness of a close partner; taking on caring roles. These are often associated with a first episode of depression[38] but can be mitigated by the support structures people have, such as family and friends.

Fitter older adults have better cognitive function, with even gentle exercise helping to reduce stress, ease depression and anxiety, and enhance mental well-being.

4 What kind of factors and approaches address these issues?

At Least Five a Week[39] references a wide body of evidence on the beneficial effects of physical activity for older adults on well-being and quality of life:

Mobility – people with higher levels of lifestyle physical activity and sport are more likely to maintain mobility.

Muscle strength – regular strength training using external weights or body weight has been shown to be highly effective in increasing or preserving muscle strength, even into very old age. The increase in muscle strength is accompanied by improvements in functional mobility, such as walking speed.

Falls – exercise programmes, particularly strength training, have been shown to be highly effective in reducing subsequent incidence of falls among older people. In programmes combining strength, balance and endurance training, the risk of falls was reduced by 10 per cent; programmes with balance training alone reduced the risk by 25 per cent; and tai chi reduced the risk by 47 per cent.

Bone health – physical activity can produce a beneficial bone response in all adult ages, although old bone responds more slowly than young bone.

Emotional well-being – physical activity can help improve the emotional and mental well-being of older people. Physical activity is associated with reduced symptoms of depression. It can also reduce anxiety in older people and enhance mood, even where there is no evident improvement in fitness. Rehabilitation programmes that incorporate physical activity have had a positive effect on the emotional functioning and mental health of older people.

Enhancement of cognitive function – there is limited evidence that physical activity can improve at least some aspects of cognitive function among older people. Better cognitive performance in older age – particularly in those tasks that are attention demanding and rapid – is associated with increased aerobic fitness, physical activity and sport participation.

Prevention of cognitive impairment – physical activity may offer some protection against problems of serious cognitive impairment in old age. Two prospective studies show that high levels of physical activity reduce the risk of cognitive impairment – Alzheimer's disease and dementia. One of these studies, with women aged 65-plus, indicated that those with a greater physical activity level at baseline were less likely to experience cognitive decline during the six to eight years of follow-up.

Self-efficacy – physical activity programmes that aim to increase self-efficacy through a cognitive–behavioural approach have been successful in changing behaviour. This work is important because there is strong evidence that initial low self-efficacy for physical activity is one of the most important determinants of functional decline with chronic knee pain, of risk of falling, and of future engagement in physical activities.

Physical symptoms – positive effects on fatigue and energy have been shown in patients with heart failure and chronic obstructive pulmonary disease, and in healthy older people. For every six to ten older people attending a cardiac rehabilitation programme, at least one will have a meaningful improvement in health-related quality of life.

Social functioning – remaining physically active in older age may offer opportunities for maintaining independence. Daily routines involving walking to local shops may mean less reliance on others while at the same time promoting social and community interaction

The Case for Healthy Ageing[40] recommends a range of areas where there are opportunities to improve healthy ageing. These are quite broad, not just detailing service priorities but identifying opportunities to influence provision:

- advice on the review of prescribed medicines
- foot care, especially simple nail-cutting services
- increase the take-up of physical activity, as it can reduce coronary heart disease, certain types of cancers and diabetes, prevent post-menopausal osteoporosis and osteoporotic fractures, reduce accidental falls, and increase social participation – we need accessible, affordable and well-managed opportunities for individuals and groups, that are properly signposted
- vision – we need regular eye tests; the cost of glasses and transport have been identified as barriers
- incontinence – affects 3 to 5 million people, and can ruin a person's life if not properly treated, isolating them at home
- dental care – services need to be more flexible and we must ensure that services are properly targeted at where they are needed
- nutrition / malnutrition – a mix of health promotion and improved hospital services
- hearing – we need better audiology services
- falls and osteoporosis – better falls services and assessments
- health trainers – operating health promotion campaigns, ideally employing older people as peer mentors
- mid-life health check – a lifecheck tool for the over-60s
- vascular checks – better screening
- screening programmes – especially flu and breast cancer.

The rationale for FAAF,[41] and the WHO's Active Ageing Policy Framework[42] draw out the following points on activity, diet and the physical environment. The rationale for FAAF follows this, but also stresses the important links between physical activity and mental well-being:

> We are now recognising the important role that appropriate exercise and nutrition can play in promoting healthy ageing and reducing the decline that accompanies ageing (e.g. improvement of cardiovascular function, the reduction of risk of several diseases, increase in life expectancy, improved muscle and bone strength, leading to a lesser risk of falling).


LBS
3

Similarly, evidence shows that fitter older adults have better cognitive function, with even gentle exercise helping to reduce stress, ease depression and anxiety, and enhance mental well-being.[43] Indeed, a comprehensive review on mental health promotion for older people[44] shows that most enhanced and positive mental well-being comes from participating in physical activity. Rather than considering older people to be past the point of reaping these benefits, research concludes that there is no section of the population in which it is more worthwhile and necessary to promote physical activity.[45]

The WHO Active Ageing Policy Framework says:

> Participation in regular, moderate physical activity can delay functional declines. It can reduce the onset of chronic diseases in both healthy and chronically ill older people. For example, regular moderate physical activity reduces the risk of cardiac death by 20–25 per cent among people with established heart disease (Merz and Forrester, 1997). It can also substantially reduce the severity of disabilities associated with heart disease and other chronic illnesses (US Preventive Services Task Force, 1996). Active living improves mental health and often promotes social contacts. Being active can help older people remain as independent as possible for a long period of time. It can also reduce the risk of falls. There are thus important economic benefits when older people are physically active. Medical costs are substantially lower for older people who are active (WHO, 1998).
>
> Despite all of these benefits, high proportions of older people in most countries lead sedentary lives. Populations with low incomes, ethnic minorities and older people with disabilities are the most likely to be inactive.

Policies and programmes should encourage inactive people to become more active as they age and to provide them with opportunities to do so. It is particularly important to provide safe areas for walking and to support culturally-appropriate community activities that stimulate physical activity and are organised and led by older people themselves. Professional advice to 'go from doing nothing to doing something' and physical rehabilitation programmes that help older people recover from mobility problems are both effective and cost-efficient.

The Institute for Public Policy Research (IPPR) broadens out the picture, adding the wider elements of education and learning and social and community participation. In its *Older People and Wellbeing,*[46] IPPR argues:

> Education and learning is a significant indicator of emotional wellbeing in later life (but community-based funding is highly limited). Taking on an active grand-parenting role can be good for wellbeing (but not suitable for all). The most important factors underlying good mental health and wellbeing are social and community participation – many older people say the most important thing is to feel wanted and needed by others (Lee 2006).

The IPPR and FAAF have plenty to say about volunteering. It is associated with increased life satisfaction and is important for charities that depend upon it.

With many people, the point of retirement is a critical phase. It can result in loss of status and too much unfilled time on people's hands. Volunteering can help older people find a role outside their home and family. Community Service Volunteers (CSV)[47] has described the benefits that volunteering brings with it:

1. A sense of purpose – volunteering made them feel useful and needed once more.
2. A sense of achievement.
3. A structure to life – volunteering provides activities within a meaningful framework.
4. Social benefits – several of those interviewed welcomed the chance they now had of meeting new people and extending friendship circles.

There are, however, barriers to taking part, such as people's skills and fears. Volunteering rates fall as we get older and start falling off from when we retire.[48] The IPPR[49] suggests that we need to take a fresh approach, especially with the over-75s. It identifies 75 as an age where people's well-being has peaked and generally starts to decline quite rapidly.

Personal resilience – self-esteem is a powerful predictor of low-level depression. Good social support and an active social life can lessen the effect of low self-esteem.

Religion – it gives many a sense of purpose and a social network.

Respect – feeling valued and respected contributes to good mental health. It can be fostered through older people's active contribution and participation in schools and other groups. Lack of respect is linked to feelings of being excluded from the mainstream of society.

The rationale for FAAF[50] looked at two important reports. These sought the views of older people directly and evaluated findings on their knowledge, attitudes and preferences regarding their choice of healthy lifestyles.

1. *Promoting Mental Health and Well-being in Later Life,* the first report of the independent UK Inquiry into Mental Health and Well-being in Later Life (Age Concern and the Mental Health Foundation, 2006) showed there are five main factors that impact on older people's mental health and well-being: discrimination; participation in meaningful activity; relationships; physical health; and poverty.

- Older people feel that being able to make contributions to society (and being recognised for them) is good for their mental well-being. Volunteering was identified as a key way of making contributions and participating in society.
- Older people also identify physical activity and maintaining a good diet as the key components of physical health which can have positive impact on their mental well-being.
- The Inquiry report concluded local-level action will make the most difference, and recommended that healthy ageing programmes should be established to encourage older people to take advantage of opportunities for meaningful activity, social interaction and physical activity. Specifically, the Inquiry recommended that such active ageing programmes should promote mental as well as physical health and well-being in their design, delivery and evaluation.

2. *As Fit as Butchers' Dogs?*, the report on healthy lifestyle choice and older people (National Consumer Council and Age Concern, 2006) showed that:

- older people feel that a positive outlook and zest for life is a key factor of health, both in terms of physical and mental well-being
- supportive contact with others is critical for both physical and mental health
- there is a lot of scope for better publicity of facilities that exist and support to provide 'routes' for older people
- information about what is available is not reaching all those who would be interested.

Some groups need more intervention than others, particularly those who present attitudinal barriers.

There is also a strong case made for the contribution towards healthy ageing of National Falls Awareness Days (NFAD) and their successors, National Falls Awareness Weeks (NFAW) in the annual evaluations and in Don't Mention the F-word.[51] The effectiveness of a tailored exercise programme devised by Dawn Skelton and her team on preventing falls and the dramatic negative effects of falls on the future health and well-being on older people are highlighted in the annual awareness campaign.

The series of NFAD and NFAW reports outlines the scope of the national awareness campaign which aims to reduce the human and financial cost of falls (4 million bed-days in English hospitals every year and a cost to the economy of at least £1.7 billion annually).

In recent years, the awareness campaign has focused public attention across the country on falls in the home (stairs), in the street (pavements) and on buses. As an element in the original NFAD scheme, the Minority Ethnic Elders Falls Prevention (MEEFP) programme played a significant part in spreading the message of falls prevention and targeted exercise to previously hard-to-reach groups of older people.[52]

5 Services delivered and their effectiveness

The major service evaluations for this evidence review are as follows.

Ageing Well Programme Final Evaluation Report[53]

This was an innovative programme that ran and expanded from about 1993 to 2007. It enabled older people to become involved in local initiatives designed to improve physical, social and emotional health and well-being.

It was delivered via volunteers and co-ordinators at local level. Many volunteers trained as Senior Health Mentors, following the model used successfully in the USA of the 'lay health promotion' model. The training programme consisted of eight core sessions of about 75 minutes' duration each. There was also a core training pack that volunteers could refer to and build on, but this wasn't used as much as was anticipated. Programme activities were far-reaching, from leaflet and verbal advice about healthy living to a variety of forms of exercise and social activities. Clients were charged for taking part in some activities. The results of the evaluation questionnaire suggested that a majority of the clients would be willing to pay fees to take part.

The programme demonstrated benefits for participants and volunteers, but primarily through the recording of qualitative feedback rather than any quantitative analysis of health improvements against baseline positions. The evaluation did not include a cost-benefit analysis, although the evaluators recommended this for further research.

Many of the health challenges that are identified here were addressed and an innovative peer-to-peer approach was used in an attempt to increase the uptake and response to its messages over traditional 'professional' sources. However, this did lead to some uncertainty as to the status and role of the mentors, who, it seems, were often uncomfortable with the formal title of Senior Health Mentor and tended to refer to themselves just as volunteers.

Age Concern updated the training pack for volunteers in 2009. The role is now described as Health Mentor. Many of the current FAAF projects are using this approach.

Health Trainers and Health Trainer Champions

In 2004, *Choosing Health*,[54] the public health white paper, introduced NHS Health Trainers to provide advice, motivation and practical support to individuals in their local communities. Health Trainers reach out to people who are in circumstances that put them at a greater risk of poor health. They often come from, or are knowledgeable about, the communities they work with. In most cases, Health Trainers work from locally based services which offer outreach support from a wide range of local community venues.

Health Trainers work with clients on a one-to-one basis to assess their health and lifestyle risks. They have facilitated behaviour change, providing motivation and practical support to individuals in their local communities, since 2006.

Health Trainer Champions work with Health Trainers by providing clients with information and signposting them to the NHS and other community services that will help them to live healthier lifestyles and access the support they need.

More than 3,000 trainers and champions have been trained and they have seen more than 60,000 clients. While the final evaluation is not due until October 2010, there have been a number of studies of the programme along the way. Key findings included:

- Peer education is a successful technique in providing information and facilitating behaviour change in a culturally competent way.
- The use of lay workers can also be a sustainable model when funding for a project ends.

Multi-level interventions are likely to have the most significant impact on health inequalities.[55]

Prevention in Practice[5]

This publication contains 24 case studies of services that demonstrate the advantages of taking a pro-active approach in tackling the issues faced by many older people. Many of these examples refer to health services that both provide a much-appreciated service to older people, often in their homes, as well as preventing those same people from being significantly debilitated or put into a spiral of declining health by the lack of a small but essential service.

The value of the service is assessed not only through the words of the users but through their alignment to commissioning criteria and the targets they address, as well as, in some cases, comparisons with the much greater costs of not providing the service (i.e. the cost of hospital admissions).

This brings home the necessity of addressing a locally identified need and then providing a local solution (that meets the terms of the local commissioning practice/framework) to address it.

Examples of the services provided by Age Concerns include the following.

West Sussex Activity Centres

Failing day centres were transferred from the local authority to Age Concern. A range of activities and a hot meal are provided in a safe environment, In addition, formal and informal health support, such as chiropody and social support, are signposted to the client. Costs are supported by the Age Concern.

Oldham Community Café

The café provides affordable, good-quality food and acts as a hub for some other services, including learning opportunities. It is run as a social enterprise.

Gloucestershire Men in Sheds

Older men are encouraged into a group where they can use manual skills, knowledge and expertise to repair and refurbish hand tools in a social group, which is lottery-funded. The project came to a close in summer 2009 when funding ran out.

Surrey Nordic Walking

A **fit as a fiddle** project offering taster sessions and courses, and training people as walk leaders. It is claimed that there are greater health benefits than for ordinary walking groups; but there are some equipment costs.

Age Concern Older Offenders' Project (ACOOP)

Social care, advice and support to older offenders and their families, in prison, pending release and in the wider criminal justice system. The support group aims to improve general health and well-being, and reduce isolation.

Supporting Older LGBT Communities in Central London

This lottery-funded group holds regular social activities, offers telephone advice, befriending and signposting/referrals to agencies. It is intended to reduce social isolation, improve well-being, increase dignity and to enable people to participate in control of the services that are offered.

Kingston Healthy Eating Lunches

A one-year intergenerational project funded by the Department of Health, which promotes positive behaviours in young and old through a range of activities centred around a shared lunch.

Sole Mates Footcare Service, Oxfordshire

This affordable service is available in people's homes or at community venues, GP surgeries, etc. Funded by the county council and local primary care trusts, it provides a simple care service, mainly toenail-cutting, improving independence and mobility.

Timebank, Gateshead

Originally funded as part of a two-year LinkAge Plus project, this applies a model of mutual support. Participants use time and skills to benefit those around them and benefit from the help that others are able to give. Earned time-bank credits can then be cashed in for help and support.

National Falls Awareness Days (NFAD) and Minority Ethnic Elders Falls Prevention Programme (MEEFP)

A strong case has been made in the annual evaluations of the programmes (NFAD reports and the two MEEFP evaluations. A good summary of the advantages of raising awareness of falls is made in *Don't Mention the F-word* and *A Case for Healthy Ageing*.

The NFAD and MEEFP evaluations contain many small-scale examples of successful awareness-raising, but they are primarily a record of activity: specific programmes have not yet been assessed on a cost–benefit analysis basis.

There is scope for future research that not only gives a clearer picture of the national scale, but which could analyse and quantify the effect of awareness-raising in terms of lives saved, disability avoided, quality of life years gained, etc. It seems appropriate that, for one of the services that we believe saves lives and injury, there should be an evaluation that gives concrete proof of effectiveness.

fit as a fiddle[57]

In lieu of an evaluation of the programme, we summarise what the programme expects to accomplish. The Surrey Nordic Walking project described above in the '*Prevention in Practice*' section is an FAAF-funded project.

The FAAF activities are intended to:

- enable more older people to participate in activity
- enhance the capacity of NHS bodies and local authorities to ensure that local facilities and services support healthy lifestyles and are accessible to older people of all ages; and promote, disseminate and target healthy-eating resources
- develop partnerships on a national and regional basis with health professionals, sports partnerships, public and private bodies to encourage working with older people to provide information, advice and support.

The programme can contribute towards the health and well-being of older people by:

- promoting independence and mobility
- engaging and consulting with older people
- improving and integrating local services for older people
- promoting social inclusion and addressing health inequalities
- developing strategic partnerships
- preventing ill-health, disease and disability
- preventing accidents among older people.

Improving Care and Saving Money – Partnerships for Older People Projects (POPPs)[58]

The evaluation argues that promoting independence of older people through a strategic shift to prevention and early intervention can produce better outcomes and efficiency for health and social care systems. The approach was designed to increase learning about how to promote older people's independence, particularly through joint approaches to reducing their/our reliance on long-term institutional care and hospital admissions. The evaluation shows that better outcomes appear to be aligned with approaches which target the right people at the right time and provide personalised responses focused on *working with* the person rather than *doing for* them.

POPPs have increased the evidence base on the benefits of prevention, early intervention and integration by promoting joint approaches to independence in place of hospital or long-term institutional care.

The key messages are:

1. meeting people's needs with a preventive approach can create efficiencies
2. efficiencies are available across the health and social care system
3. quality of life can be improved through preventive approaches
4. involving older people is important, especially in governance and evaluation
5. preventive services can be sustained (as they often win the argument – by demonstrating their cost benefit – for continuation funding)

6. health commissioners have made a significant contribution

7. there were a number of effective interventions
   a. complex need projects were particularly successful
   b. co-located teams with pro-active case co-ordination improved effectiveness.

Small-scale services providing practical help and emotional support can significantly improve the health and well-being of older people, alongside more sizeable services designed to avoid the need for hospital admission.

Neighbourhood warden schemes

Neighbourhood warden schemes are particularly good at encouraging hard-to-reach older people to participate in activities such as exercise classes. Their personal and local knowledge enables wardens to assess needs and recommend appropriate activities.[59] These schemes are particularly useful for prevention, as they are able to provide early intervention.

LinkAge Plus

The LinkAge Plus programme aimed to 'test the limits of holistic working between central and local government and the voluntary and community sector to improve outcomes for older people, improving their quality of life and wellbeing.'[60] It did this by bringing together different forms of mutual help, services and support at the local level.

The programme started and finished with older people themselves, involving them through local groups and forums in planning and delivering provision.

A key principle was shifting the perception of ageing from one of dependency and decline to one of active citizenship, participation and independence.

The pilots showed that working in partnership, involving older people and delivering services that aim to give 'that little bit of help' with daily living can make a difference to the quality of life for older people in a cost-effective way.

Benefits from the LinkAge Plus approach fall into three main areas:

1. there are benefits to both taxpayers and older people from a holistic approach to service delivery, in which the voluntary and statutory sectors work together to improve access, remove duplication and overlap, and share resources

2. the approach has facilitated key services to help maintain independence and improve the well-being of older people, in a cost-effective manner

3. the pilots demonstrated that information and access to services can be improved through partnership working and through a range of innovative approaches to outreach as trialled by the pilots.

6 Services in other countries

McCormick and colleagues suggest that we move beyond the traditional healthy-ageing focus on healthcare and pensions, looking to innovative ideas and practice for healthy ageing. Looking at examples of practice internationally, four principal pillars of healthy ageing emerge:

- relationships
- work
- lifelong learning
- built environment.[51]

Relationships

McCormick and colleagues argue that we need to move away from centralised programmes that deliver a service in isolation to enabling and harnessing everyday relationships. We should recognise that where relationships are built first, access to resources and services often follows.

An excellent example of this principle in practice is Japan's 'Hureai Kippu', or 'Health Care Currency' scheme, a time-bank scheme for care of older people. Volunteers earn credits (in hours), based on both the amount of time given and the arduousness of the task(s). Credits can later be used for oneself, or transferred (i.e. to an older relative living far away) to provide for one's own or one's relative's care in older age. It has been found that people prefer the scheme to paying for services because they build better relationships with carers. Users also prefer the scheme to relying on charities for services because reliance on charities makes them feel dependent.

Work

Encouraging older persons to continue working is often valued for its role in closing the pension gap. However, continuing work (paid or unpaid) can also allow older people to maintain a sense of purpose, to maintain or create social relationships, and to engage in productive activities. It can ease the loneliness, isolation, and boredom that retirement sometimes brings.

An excellent example of this principle in practice is the United States' Experience Corps scheme. Operating in 23 cities, the Experience Corps is an intergenerational project that brings volunteers aged 55+ into primary schools for ten to 15 hours per week. Volunteers receive a $100–300 stipend per month. The programme has been found to improve the physical and mental health of older persons, to provide a meaningful and valued activity, to provide cognitive and physical stimulation to older persons, and to enable social interaction across age groups. Both participation in and satisfaction with the programme are very high.

Lifelong learning

The third pillar of healthy ageing is learning. Learning builds self-esteem and provides a sense of agency, while increasing social interaction and allowing the development of skills that may help one cope with life's challenges. Unfortunately, learning tends to be geared toward the young or to adults when it is occupationally related (for example, helping adults update skills to transition into or find a new job). A number of initiatives that bring learning to older adults have found that there are three essential elements to a successful programme. A communal learning environment, peer-to-peer teaching methods, and empowering older learners to participate rather than simply imparting knowledge to them are essential features of learning programmes for older persons.

Built environment

Finally, the built environment is important to healthy ageing. We need to recognise that there are increasing numbers of older persons living alone, who may be less mobile. The built environment should connect older people to services, activities, and other people. The built environment should allow 'ageing in place' both by helping people to stay in their own homes and to move beyond them.

An innovative example of blending the built environment with older persons' needs can be found in the United States' University-Linked Retirement Communities. Fully inclusive retirement communities, where the older person exchanges their estate for a place in a community, are not new. Residents start out in a self-contained apartment, moving into assisted living units, skilled nursing centres, and/or a dedicated Alzheimer's wing, as necessary. What is innovative is building these retirement communities adjacent to major universities.

There are currently about 60 ULRCs in the US. By linking to universities, the communities encourage an active lifestyle, involving learning and intergenerational contact (while also providing benefits to the university such as student jobs and income from land leasing or sales).

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Adult Social Care

Annual Survey of people using services

Briefing

1. As part the national performance framework for adult care services each Council is required to undertake a survey of people using care and support services funded by the Council, each year. The questions are set nationally, each Council must ask the same core set of questions and there is clear guidance that must be followed in conducting the survey.
2. The survey takes place in February to March of each year, the outcomes are fed back to the Health & Social Care Information Centre , which verifies and collates the data and publishes the results on its website. The most recent available data therefore relates to the year 2014/2015, having been collected in February – March of 2015.
3. The survey covers all people receiving social care services funded by the Council and the Council must follow national guidance re sampling to ensure a balanced response to the survey. In 2014 -15 763 surveys were distributed and 358 people responded (40.1%). Of these people 35% were aged 18 – 64% and 65% were aged 65 and over.
4. The survey seeks to help understand what impact services are having on the quality of their lives. Some of the survey questions form part of the national Adult Social Care Outcome Framework (ASCOF) and therefore it is possible to benchmark performance in relation to these. The outcomes from the survey inform local service improvement planning.
5. Below is summarised the key results , that is the ASCOF indicators, from the 2014-15 survey for Brighton & Hove, with the average outcome for All Councils in England in brackets next to this. Numbers have been rounded up to nearest % point.
    a. **The extent to which people feel they are in control of their daily lives**. In Brighton & Hove 79% of respondents reported they had as much control as they would want or adequate control (England average 77%). A further 17% reported they had some control whilst 3% reported having no control.
    b. **The proportion of people who reported they had as much social contact as they would like.** In Brighton & Hove 42% of respondents had as much social contact as they wanted (England average 45%). A further 40% of people had adequate social contact whilst 16% reported having some but not enough contact and 2% having little social contact and feeling isolated.
    c. **The percentage of people who are satisfied with the care and support they receive.** In Brighton & Hove 66% of people reported they were extremely or very satisfied (England average 65%). A further 28% of people were quite satisfied and 3.5% of people were either quite, very or extremely dissatisfied (the remainder being neither satisfied nor dissatisfied).
    d. **The proportion of people who find it easy to information about services.** In Brighton & Hove 77% of respondents found it very or fairly easy to find information (England average 74%).
    e. **The proportion of people who use services who feel safe.** In Brighton & Hove 69.% of people felt as safe as they want (England average 68%). A further 25% of people felt adequately safe. 2% of people did not feel safe at all and the survey arrangements are such that the Council is able to follow up concerns directly with

these people. The key reasons for not feeling safe linked to risks outside the home such as traffic accidents, falls and health related 'fits or seizures' outside the home.

f. **The proportion of people who use service who say those services have made them feel safe and secure.** In Brighton & Hove 83.% of people that services made them feel safe and secure. (England average 84%).

g. **Social Care related quality of life score.** This is an overarching composite measure which draws on the responses to 8 questions in the survey. The maximum possible score is 24. Brighton & Hove scored 19.5 on this measure compared to an England average of 19.1.

6. The survey asks a range of additional questions which are not part of the ASCOF, for example about whether people are treated with dignity and people's perceptions re whether they are able to keep themselves and their home clean and presentable. Although Councils must ask the core questions in the prescribed national format there is scope to add a few additional local questions. In Brighton & Hove we ask people to score services on a scale of 1 – 10 and what we could do to make the score a 10 when it is a lower rating. Key themes from this question focused on improving home care services and more social contact.
7. Although the survey is focused upon people using adult care and support services clearly the reported outcomes will be linked to broader factors than only adult care services.

FAIRNESS COMMISSION - OLDER PEOPLE'S COUNCIL - SUPPLEMENTARY VIEWS

A Fair City

The Older People's Council made an initial submission to the Fairness Commission in January which identified our top three fairness priorities as communication, benefits take up and the need for investigation into the high suicide rate for older people. We have held a number of discussions with older people since then and wish to supplement the information with an indication of further views.

Older People's situation

A range of themes emerged from our discussions with older people which they felt disadvantaged them and just made daily life more difficult. Those with walking difficulties are challenged by uneven pavements, poor lighting, cyclists on pavements and short-term pedestrian crossings.This included wheel-chair users who felt vulnerable when faced with cyclists on pavements. The need for more seating in both public and private spaces was important.Transport and access to transport for those unable to take public transport was a theme that often arose. The high cost of living in Brighton & Hove and negative media reports and ageism often present older people as well off, with high health and social care costs and a burden on society. However, many older people are suffering from income deprivation with 23.6%[1] affected by income deprivation which is higher than the national average. Many also struggle to maintain their homes and need support and advice in a secure environment where they are not vulnerable to being exploited.

However, many older people actively support younger people and children. Grandparents undertake childcare, and bring benefits to the City in savings made by voluntary work, caring and have shown to be net contributors in monetary terms. A higher proportion of people over 65 spend 50+ hours on unpaid care per week than all other ages at 4.6%.[2] There are many situations where both older people and younger people need support. Bus passes are not just for older people for whilst 39.500 older people use bus passes in the city, there are also 5,839 disabled people who have bus passes. Whilst dementia affects at least 3,000 people in the City, there are also 7,300 people unable to work due to mental health issues. Older people are a diverse group within the City and make a massive contribution to the life of the City, but, there are those that are vulnerable, have long term health problems, lack mobility and need our support. With the backdrop of massive cuts to the Adult Social Care budget it is important that the Fairness Commission recognises that those who are socially isolated and financially limited often with health and care needs should be prioritised.

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[1] Brighton & Hove JSNA 2015

[2] Local insight report for Brighton & Hove Oct 2015 Oxford Consultants for Social Inclusion (OCSI)

Causes of Inequality

We covered some of these areas in our initial submission. However, in addition coming from our conversations there also needs to be a recognition that 19,000 people over 65 suffer a limiting long-term illness. At 53.7% this is significantly above the South-East average of 48%.[3] In addition, whilst life expectancy in Brighton for men is 78.8 years and 83.1 for women there are major differences across the City between the most & least deprived areas. So that in the most deprived of the Brighton & Hove men live 9.4 years less and women 6.1 years less than the average.[4]

There are cost pressures with deteriorating private housing conditions due to dwindling funds and increased costs. Health conditions can also be limiting and gradually affect activities for those with walking difficulties, deafness , eye sight problems and fatigue. Those affected are less able to interact socially and can become isolated.

Best ways to tackle inequalities & increase fairness?

The Council is cutting the cost of information dissemination by going electronic and digital. These cost savings should be diverted to enable the disadvantaged and isolated to be reached by post, paper, telephone and personal contact. There should continue to be health and social care information provided in paper form and sent to the isolated identified through local community groups who could arrange distribution with volunteer groups.

The contact details of all those over 70 years are held on a data base by the Council. Any mail to them such as for Council Tax should include details of befriending, activities and clubs for the elderly. Elderly people with similar care needs could be invited to regular group meetings/talks about their conditions. There could also be a drive linked to benefits take up through this mechanism and as part of a strategy to tackle social isolation.

There should also be a strategy to provide web access to all senior housing schemes run by the Council with a plan to increase digital engagement of residents. At the same time to support should be given to Barclay Eagles, SEEFA, and Citizens Online efforts to decrease digital isolation by actively marketing and supporting their efforts in the creation of digital community hubs. Media communications should challenge ageism and any negative portrayal of any section of society.

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[3] Ibid

[4] Annual Report of Director of Public Health for Brighton & Hove 2014-2015

The Council is supporting 1,100 clients in residential care and 2,111 for care in the community and these figures do not include self-funders. This is also a significant number of people who could be communicated with on a regular basis as outlined above and where possible could participate in the quality assessment of services they receive.

Overall the OPC would want to see more opportunities for participation and a greater voice for older people across the city in the services they need. The OPC proposed that Brighton & Hove Council became an Age Friendly City which was agreed by all the Council. However, the Age Friendly City forum which brought together older people for their views on the range of issues relating to the adoption of an Age Friendly City, to feed into the Steering Group, is now under threat due to lack of support for a small resource to service this group. Volunteers can do so much but do need support to facilitate communication & administration. Obtaining views from older people needs to be prioritised and their concerns need to lead to action by the Council to make Brighton & Hove a City for all generations.

Voices of Older People

To give a flavour of some of the voices of older people we have selected a few to highlight for the Fairness Commission a range of issues many linked to mobility, costs,health and vulnerability:-

“Repairs to my flat have been rubbish. The council sends people who know nothing about the job. They also just mess around and don’t clear the rubbish around the flats.”

“The street lights are terrible at night. Yellow lighting is poor and you can’t see the bumps on the pavement. It means I try to get home before dark.”

“My wheel chair is electric and cannot move quickly. I have had problems with cyclists on the pavements and it makes me worried about getting out and about. I feel vulnerable”

“Pedestrian crossing times are too quick. And on the crossroads (Grand Avenue/ Church Street) you can be waiting for ages. The green man light position is also confusing as it’s low and pointing in the wrong direction.”

“They have stopped the community bus to the day centre. The taxi is now too expensive.”

“ I don’t seem able to get an appointment with my GP when I need one and have to wait for ages.”

“I have prostrate cancer and need access to public toilets when I am out. I cannot wait because of my condition.”

“Its not fair that I have to loose my home to pay for care. I saved and missed out on pleasures to buy my home.”

Our top 3 Fairness priorities

- That the Fairness Commission proposes that the Council commits to meaningful communication with older people, including locally based communities, with an action plan for every area of service provision which is multi-channelled. This should include making best use of the information the Council already holds on older people. There should be a strategy for achieving greater participation of older people in shaping services and the means for them to evaluate the services they do receive.

- That the Fairness Commission suggests that a take-up benefits campaign is undertaken by the Council given the high level of deprivation for older people in Brighton.

- That the Fairness Commission proposes that the Council commissions research into the reasons for the high suicide rate for older people in Brighton & Hove.

Share your community group's views - FS795004

What does a fair city mean to you? : A place where all people are able to take part, contribute, be supported, travel and live their lives to the fullest.

What is fair about life in Brighton & Hove at the moment?: We have a strong voluntary sector, a diverse community, lots of assets in terms of geography, parks, arts & heritage opportunities and strong sense of place. Generally, statutory agencies want to work in partnership with their communities, and in some cases they do this well.
The council's Third Sector Strategy supports fairness, as does the CCG's commitment to Social Value in its commissioning.

What is unfair about life in Brighton & Hove at the moment?: We are making three submissions to the Fairness Commission, to enable clarity of evidence.

Health impact of loneliness & isolation
We know through Neighbourhood Care Scheme (http://www.bh-impetus.org/projects/neighbourhood-care-scheme/), Community Navigators (http://www.bh-impetus.org/projects/community-navigators/) and the Befriending Coalition, that there are a huge number of lonely and/or isolated people in the city. Loneliness can have as severe an impact on physical health as smoking 15 cigarettes a day (Campaign to End Loneliness) and a very high proportion of people who we see through the NCS report that they are depressed (they also report that having a visitor makes them feel better), the most common referral reason for referral to the Community Navigators programme is isolation and loneliness. We don't think it's fair that anyone in our city should be ill and depressed because they are alone when they don't have to be. We have shown over 15+ years that a simple relationship of support and trust between neighbours can dramatically improve people's quality of life.

What specific experience or evidence do you have about inequalities and fairness that may be of use to the Commission? : Evidence on Loneliness

The 2011 Census tells us that there are 14,466 single pensioner (65 years +) households in Brighton & Hove.
We have seen a 30% increase in referrals to our Neighbourhood Care Scheme befriending service in 2014-15.
• Data from Community Navigators pilot project tells us that isolation is the highest issue presented by patients referred to a Navigator (24% of all patients).

Physical health
• Loneliness and social isolation are harmful to our health: research shows that lacking social connections is as damaging to our health as smoking 15 cigarettes a day (Holt-Lunstad, 2010)
• Loneliness is twice as unhealthy as obesity for older people (http://www.theguardian.com/science/2014/feb/16/loneliness-twice-as-unhealthy-as-obesity-older-people)
• Loneliness increases the risk of high blood pressure (Hawkley et al, 2010)
• Lonely individuals are also at higher risk of the onset of disability (Lund et al, 2010)

Mental health
• Over the last 5 years, on average 92% of NCS scheme members have reported a benefit from the support they have received, 44% report feeling less depressed and 54% report feeling more connected to their community.
• Between 2011-12 and 2013-14 a third of volunteers recorded preventative and wellbeing enhancing interventions with the scheme members they visited.
• Loneliness puts individuals at greater risk of cognitive decline (James et al, 2011)
• One study concludes lonely people have a 64% increased chance of developing clinical dementia (Holwerda et al, 2012)
• Lonely individuals are more prone to depression (Cacioppo et al, 2006) (Green et al, 1992)
• Loneliness and low social interaction are predictive of suicide in older age (O'Connell et al, 2004)

Mental health in Brighton and Hove

Brighton and Hove residents have higher levels of mental ill health than the average for England, across a range of

indicators. For example, a third more people have a diagnosis of severe mental illness and nearly 10% more (aged 18 and over) have a diagnosis of depression recorded by their GP.

The BHCC Mental Health and wellbeing strategy (2014) identifies volunteering, trying something new and learning new skills as important tools to improving mental health. It also states 'having some control over one's life and having a sense of purpose are all important attributes of wellbeing.'

Data on health inequalities in Brighton & Hove in the Public Health Annual report, and here http://www.slideshare.net/Gavman/health-inequalities-brighton

Based on your experience or evidence, what is your or your organisation's analysis of the causes of inequalities in Brighton & Hove? : This is far too complex an issue to be summarised in a box!

However, as we have set out above, there are systemic issues which exacerbate inequalities - the siloed approach of the council to services, and the current trend of trying to pass off responsibility for certain groups or activities onto other departments or agencies in particular are damaging.

Funding and finance issues - the current reduction in public services supporting certain groups means that that these groups don't have access to the kind of opportunities that others do. These are fundamental to our lives - being a parent, being able to access education, training or employment, being able to travel independently, take part in society, volunteer and contribute.

Loneliness and isolation can be a result of broad demographic and social changes, such as families being farther flung, loss of a partner or changes to physical health through ageing - but again, we know that there are simple and effective community responses to loneliness that could be available to many more people.

There are also still issues of short sightedness by public services, who pays for a preventative action versus who reaps the reward of it. It is a depressing indictment of our public services that we are still looking at working primarily with people in crisis rather than at an earlier stage when the human cost would so much less.

There is no avoiding the fact that poverty, and the current government's austerity agenda, is a huge cause of inequality in Brighton & Hove.

Are there any people or communities for whom life in Brighton & Hove is particularly unfair? : Older isolated people who are lonely and whose health is worse because of this. It is particularly unfair when we know that there are simple, cheap community solutions to these low level issues which have high and cumulative impact on people's lives.

What do you or your organisation believe would be the best ways to tackle inequalities and increase fairness in the city? : Loneliness and isolation can be tackled through simple neighbourhood and community connections. We propose that greater focus is given to preventative work in the city, acknowledging that the assets within families, neighbourhoods, community and voluntary groups are essential to supporting older people, and others who are isolated. A wider and more progressive view of preventative work and how to genuinely join this up across agencies would be a real step forward. This requires greater vision, leadership and better partnership working that we have at the moment.

There are real lessons that can be learned from recently published work from Southwark & Lambeth Early Action Commission which has examined causes of not only poor health but wider social issues, and identified ways of making preventative work really work, identify the administrative and systematic changes that need to be made to

On a simpler, quicker and more achievable scale, expanding befriending work would have immediate impact on this inequality. We are only constrained in the number of befriending matches that we can make and support by the staff capacity we have in our team. The demand for our Neighbourhood Care Scheme service has increased by 30% in the last year, and we are finding that at the moment, volunteering is keeping pace with this.

Promoting a wider understanding of befriending and volunteering in the city, especially across health services would

also help.

Your first fairness priority: Commit to tackling loneliness among isolated older people, people with disabilities and their carers.

Your second fairness priority: Meet legal obligations to support parents with a learning disability care for their children

Your third fairness priority: Provide support for adults with Autistic Spectrum Disorders

The LGBT Health and Inclusion Project

A Local LGBT Older People's Group – A Stakeholder Roundtable

The LGBT Health and Inclusion Project

NHS Sussex and Brighton and Hove City Council (BHCC) have commissioned a consortium of organisations providing services to lesbian, gay, bisexual and transgendered (LGBT) people in the city to conduct a series of consultations with local LGBT people. The aim is to use the information gathered to feed into local service commissioning, planning and delivery.

The partner agencies are: Brighton and Hove LGBT Switchboard, THT South, MindOut, Allsorts Youth Project, Brighton Bothways and the Clare Project. The consortium has employed a worker to coordinate the project, known as the LGBT Health and Inclusion Project (LGBT HIP).

Please note, the following report presents information about the consultation and engagement work conducted by LGBT HIP and should not be taken as a position statement of any of LGBT HIP's Consortium partners.

Background

This report details findings from a round-table hosted by LGBT HIP about a group or forum in the city for older LGBT people. A local LGBT action-research project called Count Me In Too (CMIT) has presented a number of important findings in relation to the needs of older people (defined as 55+).[1] The research indicated that local older LGBT people were:

- More likely to be on a lower income
- More likely to live alone
- More likely to say that Brighton and Hove is a difficult place to live
- More likely to be in social housing but also to own their own homes.

Housing was an important issue in that fear was reported of going into residential care because of a perception that their LGBT identity might not be understood and respected. 62% of older people said they would be interested in sheltered housing/residential care that is specifically for the LGBT community. However, there was also resistance to the idea of being 'hived off' in to an older LGBT people's 'gay ghetto'.

Regarding social interaction and safety, older people were least likely to experience hate crime but most likely to report feeling unsafe within Brighton in the day or at night-time and to avoid going out at night. They were also least likely to say that they enjoy LGBT venues and events due to ageism and feelings of exclusion.

There were also important health findings: older people were more likely to rate their mental health as poor or very poor but were least likely to report a specific mental health problem. Older people were the second most likely group (after people aged under 26) to report suicidal distress but the least likely to have attempted suicide in the last five years.

[1] Brown, K. & Lim, J. (2009) Count Me In Too. Older People Summary Findings Report. http://www.realadmin.co.uk/microdir/3700/File/CMIT_OlderPeople_16Feb09_v3-1.pdf

Older people were also more likely to rate their physical health as poor or very poor. Regarding sexual health, older people were the least likely to have had sex in the last three years and most likely to say that they don't need a sexual health check-up. However, even among older people who were sexually active, they were more likely to say they don't need a sexual health check-up. Those that had received a check-up were more likely to have had this more than five years ago. On a positive note, older people were more likely to have disclosed their LGBT status to a GP.

More recent national research from Stonewall on the needs and experiences of older LGB people identified similar issues of need.[2] They surveyed 1050 heterosexual & 1036 LGB people aged 55+ across from across Britain. They found that LGB people were:

- More likely to be single
- More likely to live alone
- Less likely to have children
- Less likely to see biological family members on a regular basis.

LGB people were nearly twice as likely to expect to rely on external services such as GPs, health and social care services and paid help. However, three in five were not confident that social care and support services (paid carers, housing services) would be able to understand and meet their needs. Similarly, although they were more likely to have a history of mental ill health and have more concerns about their mental health, over two in five respondents were not confident that mental health services would be able to understand and meet their needs. One in six were not confident that their GP and other health services would be able to understand and meet their needs.

There was also a lack of confidence in disclosing LGB status to service providers:

- Nearly half would be uncomfortable being out to care home staff.
- A third would be uncomfortable being out to a housing provider, hospital staff or a paid carer.
- One in five wouldn't feel comfortable disclosing their sexual orientation to their GP.

The Stonewall report did not focus on the needs of trans people and there is a lack of comparable data for them. However, a very useful briefing from AgeUK identified some important issues regarding the needs of older trans people.[3]

- We are now seeing the first cohort of aging trans people, i.e. older people who transitioned in the 1960s to 1980s. There is a lack of information about people who have transitioned decades ago when medical technologies may not have been as developed as they are currently, leading to complex health issues and medical needs.
- There are also issues for people transitioning in later life whereby surgical and hormonal options may be limited by the physical impact of aging.
- There is a perceived lack of awareness among health and social care providers about the needs and experiences of older trans people.
- There may be disruption to pension/benefit entitlements due to administrative failings and delays resulting from a change of gender identity markers in records and databases.
- There are concerns about the management of preparation for end of life, i.e. that the person's identity and new gender will not be respected in death.

From the CMIT study, there was reportedly a strong desire to be involved and consulted.[4] Given the wide range of issues identified, LGBT HIP focussed on whether there was a the need for an

[2] Stonewall (2011) Lesbian, Gay and Bisexual People in Later Life.
http://www.stonewall.org.uk/documents/lgb_in_later_life_final.pdf
[3] AgeUK (2010) Transgender Issues Later in Life.
http://www.openingdoorslondon.org.uk/resources/AgeUK_Transgender_issues_in_later_life.pdf
[4] Brown, K. & Lim, J. (2009) Count Me In Too. Older People Summary Findings Report.
http://www.realadmin.co.uk/microdir/3700/File/CMIT_OlderPeople_16Feb09_v3-1.pdf

older people's group or forum in the city to bring together older people and stakeholders who could progress an agenda for development and change.

Aims and Objectives

The aims and objectives of the roundtable exercise were as follows.

1. To consult a group of stakeholders about the need for an LGBT older people's group or forum in the city and to make recommendations for further development.

The objectives were:

1. To identify a group of 15-20 individuals to attend a consultation roundtable.
2. To facilitate a two-hour roundtable consultation to explore participants' perceptions of the need for and feasibility of an LGBT older people's group or forum.
3. To provide a briefing paper detailing key learning and recommendations from the exercise.

Pre – Workshop Preparation

The LGBT HIP Coordinator worked collaboratively with the Director of Allsorts Youth Project to develop the roundtable programme, drawing upon her learning regarding the setting up of a local independent project for older Jewish people (L'Chayim). The local Community and Voluntary Sector Forum (CVSF) was approached to identify organisations registered on its database as carrying out work with older people in the city. These groups were invited to the roundtable. In addition, recommended contacts were invited to participate. The session was also published via LGBT HIPs e-newsletter, website and social networking facilities (Twitter and Facebook).

The Consultation Workshop

Eighteen people attended and 14 different local organisations were represented (see appendix 1). The workshop consisted of a series of presentations and small and whole group exercises to identify:

- The understanding of the group regarding the specific needs of local older LGBT people.
- Ways in which issues of difference and diversity might influence the needs identified.
- Whether lessons could be learned from the development of selected other projects with older people or older LGBT people.
- What recommendations could be made to BHCC and NHS Sussex to encourage progress (see appendix 2 for a roundtable schedule).

In addition to learning about L'Chayim, the roundtable benefitted from brief presentations from MindOut, GEMS and Brighton and Hove LGBT Switchboard about their on-going and planned work with older LGBT people. From this exercise a number of findings and recommendations were identified.

Findings

Needs Identified

The exercise reflected many of the findings of the studies cited above. Chiefly, fears of dependency on health and social care services that may not understand the needs and experiences of older LGBT people, as well as homophobia/transphobia among service providers. Participants wanted assurances that the health and social care services they needed and used would understand their experiences, needs and lifestyles and would not discriminate against them. LGBT awareness training for service provider staff was felt to be necessary in equipping

them with the required knowledge and skills, and providing the reassurance that participants wanted.

There was a perception that the likelihood of physical ill-health and disability increased with age. Therefore, better sign-posing and awareness raising among local older LGBT people about services catering for the needs of people living with disabilities or health conditions was also thought needed.

Issues of isolation and lack of local social support were also strong themes. It was perceived that while there could be strong social networks within LGBT communities, such bonds tended to diminish with age. This was expressed especially strongly by some of the men present, who suggested that gay social networks were often created and maintained in the context of the commercial gay scene, which they felt excluded from as they aged. There were also felt to be opportunities to promote better mixing between the L, G, B and T groupings, as opportunities for this were felt to be lacking, with women, bisexuals and trans people especially needing access to a wider range of inclusive social spaces. Mistaken perceptions about the LGBT community among service providers could compound the issue, i.e. that the local LGBT community already had cohesive and developed social networks so that efforts to develop social support for older LGBT people were not needed. As discussed, this did not always reflect participants' views and experiences.

The spiritual needs of older LGBT people were also highlighted. Is was suggested that as people age and experience life-challenging experiences such as illness and the death of loved ones, they may feel more inclined to explore spiritual issues, and that faith organisations could be important sources of practical help and support. However, it was perceived that faith communities have not always been welcoming to LGBT people. More action was thought needed to open a dialogue with faith communities about the issues.

Diversity and Inclusion

Issues of diversity and inclusion were also strong themes. It was thought unhelpful to regard 'older people' as a homogenous group. It was noted that as well as differences related to identity (e.g. sexual identity, trans status, gender, ethnicity, disability), there were thought to be important differences related to age grouping. For example, it was thought that the needs of a person aged 55 may be considerably different from a person in their 80s, and this distinctiveness needed to be recognised. However, it was also proposed that there could be opportunities to encourage peer support across these age groupings.

It was also thought important to recognise the impact of the different histories and experiences of groupings under the LGBT umbrella. For example, the experience of some women present, who had been politicised as a result of their experience of the women's movement, wanted on-going opportunities for engagement and activism with other women, which they perceived were lacking. Men present highlighted their experience of living through the period when AIDS had claimed the lives of many of their peers and who now faced the challenges of being survivors when partners/peers had died. Spaces to be with other men who shared their experience were thought important. The on-going struggles of bisexual people for acceptance and visibility within the LGBT community was also alluded to, which was perceived to be more challenging for bisexual people within an older age cohort due to less open-minded attitudes about sexual orientation. Similarly, the distinctive struggles of older trans people were mentioned, who could not necessarily rely on acceptance and support in the wider LGB community and who might experience heightened exclusion when accessing health and social care services.

Complex issues were also raised about the nature of social support structures for older people within some Black and Minority Ethnic (BME) communities, where it was perceived that there was a particularly strong reliance on family and faith-based resources. This was perceived to be potentially problematic since these sources of support were regarded as not necessarily accessible to older LGBT people. It was felt that more work was needed to explore these complex issues and perceptions.

Issues of digital inclusion were also raised, where it was perceived that exclusion was linked to aging. This was thought to have an especially heightened effect for older LGBT people because much LGBT social interaction was conducted online (e.g. dating, social networking, political activism).

Participation and Engagement

There was a strong drive for older LGBT people to be at the heart of activities and initiatives developed for them. While the roundtable was welcomed, there was a strong view that more and on-going work was needed to ensure that older LGBT people had voice and influence in the city. The developing health and local governance reforms were thought to place a responsibility on the local NHS and Council to facilitate and resource this.

The need to think of imaginative ways to involve men in services and interventions for older people was raised, as it was felt that this was often noticeably lacking. There were thought to be particular implications for the mental health and wellbeing of older men as a result of this in terms of increased risk of isolation.

Media

Participants spoke of important media work they were developing particularly around trans awareness. However, issues of stereotyping and invisibility in cultural and media contexts were raised. While it was perceived that some groupings within the LGBT umbrella had relatively greater public visibility (e.g. younger gay men), there was a distinct lack of cultural representations and opportunities for older LGBT people to be publicly visible.

Knowledge Gaps

It was noted that a lack of up-to-date local data about the size, composition and needs of the LGBT population, including older people, was a hindrance to advocating for more resources and service development.

Lack of Resources

It was also perceived that the local LGBT third-sector was particularly under-resourced, which was reflected in the lack of an LGBT physical space in Brighton and Hove (e.g. LGBT centre or café). This was regarded as a hindrance in developing initiatives for older LGBT people.

What Next?

Having explored the issues, the group was asked to consider a number of key questions to identify its recommendations.

Is a group needed?

There was unanimous support for a group or forum for older LGBT people in the city. It was argued that the distinctive needs and issues for older LGBT people were such, that it was necessary to bring older LGBT people and stakeholders together to progress an agenda for inclusion and service development. Indeed, it was suggested that it was surprising that Brighton and Hove lacked one, given its large and diverse LGBT community, and that this was a testament to the marginalisation of older LGBT people locally.

What should it be like?

A range of ideas were generated as to what the group or forum should do: befriending and social support, advocacy, activism and engagement, awareness-raising, education, strategic development and troubleshooting to alert health and social care providers to issues and

problems were all thought to be important functions. However, it was noted that more input and consultation was needed to inform the precise specification of a group or forum, and it was proposed that funding be sought for a development worker to carry out a timely and focussed scoping exercise.

It was also felt critically important that any new group or forum should avoid duplicating the important and successful work of organisations already working with older LGBT people locally (e.g. GEMS, MindOut), but should seek to build upon and develop this. It was suggested that a 'hub and spoke' model would be a useful approach, i.e. that a new group could act as an organising forum for those already working in this area and those who wanted to. This suggestion warrants further examination.

Who should run it?

There was a great deal of support and enthusiasm among the group to be involved in further development. A clear and overriding message was that this needed to be an intervention both for and of the LGBT community. While LGBT HIP had initiated the roundtable, it was noted that its scope and capacity limited it from playing a coordinating role. However, several participants expressed an interest in continuing discussions and LGBT HIP agreed to facilitate putting these organisations in contact.

Where will the funding come from?

It was proposed that a funding application be developed by interested organisations for submission to BHCC, NHS Sussex and or/charitable organisations to enable a worker to be employed to scope the development of a group or forum for older LGBT people in the city.

Recommendations

This consultation has identified the need for development of a local forum or group for older LGBT people in Brighton and Hove. It is hoped that the following recommendations might act as a guide for action.

1. LGBT HIP will facilitate further contact between attending stakeholders who wished to explore opportunities for further dialogue and development.
2. It is proposed that they develop a funding application to employ a worker (or commission an external body) to scope of the precise specification of such a forum or group and sources of funding for this initiative. This should include on-going involvement of potential service users.
3. Commissioners at BHCC and NHS Sussex should be requested to identify potential sources of funding for the group/forum when the scope is developed and ready for submission.

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Appendix 1: Organisations Represented

- BBC Radio Sussex
- Brighton & Hove City Council Library Service
- Brighton & Hove LGBT Switchboard
- Carers Centre for Brighton and Hove
- Freedom Powerchairs
- GEMS (Gay Men's Elderly Society)
- LGBT Forum of the Interfaith Foundation
- Lifelines
- LLB OPC
- MindOut
- Pensioner Action
- Silver Sounds
- Somerset Day Centre
- UK Advisory Forum on Aging

Appendix 2 – Outline of the Roundtable Session

LGBT OLDER PEOPLE'S ROUNDTABLE
DATE: 23.11.12, 14.00 – 16.00
LOCATION: CONFERENCE ROOM, 5TH FLOOR, 113 QUEENS ROAD, BRIGHTON BN1 3XG
Activity
Arrivals • Introductions & housekeeping • Introduction to the day • Group working agreement
Presentation 1: Issues for older LGB people • Data from the Stonewall Report • Trans data?
Exercise 1: What are the issues for local older LGBT people? • Are the issues the same as Stonewall survey suggests? • Are there any issues missing? • Are there specific local concerns? [Small groups/pairs]
Exercise 2: Identifying difference Having identified the key issues, are there different concerns for different groups: • Different age groups (50-65, 65 – 80, 80+) • Common/distinctive issues for LGB&T • For people who are working/not working. • For people who are disabled or in poor health/in good health • For people from BME backgrounds • Other? [Brainstorm]
Presentation 2: Learning from L'Chayim Older Jewish People's Group • Scoping what was already available • Undertaking needs assessment • Seeking funding • Developing the service • On-going activity and review.
Presentation 3: Other examples of good practice • How did the group come about? • What does it do? • Is there anything you have learned about set-up and implementation that could help here?
Exercise 4: Do the L'Chayim, Gems, MindOut models offer a useful template? • Are there aspects that can be adapted/borrowed? • What would work less well? • What is missing that would need to be added • Who would need to be involved in the development process? [Small groups/pairs]
Exercise 5: What recommendations can we make to the local Council/NHS about the development of a group or forum for older LGBT people? • Is a group needed? • What should it be like? • Who should run it? • Where will the funding come from? [Whole group exercise]
Closure of session • Reminder of group working agreement • How will we feed back • Evaluation forms

How do you think the Council and its partners can make Brighton & Hove a fairer place to live?
Take away age/gender restrictions from services. Stop cutting the funding to useful voluntary organisation and vital services across the city
Build more hostels for homeless people. Open centres for the public to donate to (which would enable people to take dilemas (sic) and guess work out of what's the right and wrong).
Review council tax. Review bus fares
Encourage community spirit
Traffic system – some roads one-way. Roads are too narrow for lorries. Make roads safer
Not closing Hove Library or any more post offices
Provide more, and spend on services for older people, especially minibuses. More places/venues for people to get together, more funding for community centres
If the Council stopped wasting money on things that lose money and done more for the people of Brighton there are a lot of things that would help the Brighton people and these are very important. Housing – should be top of list as there are more sleeping out then there was. I would of thought that this would be dealt with first. The Council seem to waste money every year.
Ensure that rent is kept to an affordable level. In particular look at Local Housing Allowance and market rent so that people on benefits and with disabilities can afford to live in coastal Brighton where the need to live in order to access services and have a social life. Brighton otherwise will become ghetto-ised. Also, those on low wages working in essential community serving roles cannot afford to live here.
Affordable accommodation especially for younger people who are often forces to stay at home, where the cannot afford to move out. Also the services for elderly, vulnerable and people whom are struggling to survive. Keep as many of these services open as much as possible, especially food and clothing banks. Also teach people that can to maybe offer help to less fortunate neighbours.
The council should stop spending money on things that we don't need like the Spinica (sic) on the seafront and spend the money on housing and stop the private landlords charging too much rent for the housing that they have. They should make more day centres for the old people and to stop people having to sleep on seafront.
By not building the spinicer (sic) and spending the money on cheaper housing, the council should not pay themselves so much money.
By not taking away things disabled people need.
In an ageing society – more frail & vulnerable older people – leading to higher costs to NHS & social care. But equally there are more older people (40s, 50s +) who are still relatively fit and active. These could well do voluntary work re social care. Most of this is, now, not covered by Adult Social Care (not in highest category). It is 'preventative' care – and may well prevent later acute and crisis health problems.

What can residents do to make Brighton & Hove a more fair and equal place to live for everyone?
Talk to people and share information about groups and services. Help our neighbours in need. Practical help

Hit and miss. Badger the council! Join the low interest Cooperative

Leave no mess

Working and understanding other people's point of view

Ensure everyone pays their council tax

Mix with others of a different age and range of experiences and backgrounds

Change the council or force them to do what's right and stop messing around. And when they come up with ideas, they should ask everyone in Brighton before carrying out these things. Maybe that is the problem, not giving the Brighton people a real chance to have their say?

To be nice to each other and neighbourly in a way that maybe won't put them out but if they are going somewhere and obviously to be paid to bring something even 1 thing that is heavy to a person back for them if say they live next door or across the way. Teach people it does pay to be nice to each other, to watch out for each other too.

Until the council start doing things we can't do anything.

Have more day centres for the elderly and disabled. Not closing the Towers day centre

Give us a mini bus so we can go out

Older people are reluctant to offer regular help and support – they too have health periods, unpaid (?) holidays, grandparent duties, etc. We therefore need voluntary organisations to manage these services (as Age UK etc do). They need funding to cover admin costs & volunteers out of pocket expenses, etc. But the total costs will be much lower than Council provided services. But Councils are, with austerity, cutting grants to these organisations. There could be a much greater 'self help' among older people. There is plenty already – but there could be much more.

Statement for the Fairness Commission on Older People - Older Carers

Statistics and Background

A recent report published by the Carers Trust outlines the challenging position and demographics in relation to older carers:
https://professionals.carers.org/older-carers-toolkit
There are over 1.8 million carers aged 60 and over in England, almost 16% of the population of this age range. This includes 20% of the population in the 60-64 age group. The number of carers aged 85 and over grew by 128% in the last decade. Almost one in ten people aged over 85 provide unpaid care and the number of carers aged over 85 is expected to double over the next 20 years, a greater increase than for carers as a whole. Most carers aged over 80 spend more than 50 hours a week caring and 3 in 5 carers aged over 85 are male. The total number of carers rose by 11% in the 10 years between the 2001 and 2011 census, while the number of older carers has risen by 35%.

There are 23,967 carers in B&H in total according to the 2011 census, 53% are aged 50 or over which is also the peak age for caring nationally.. A Carers JSNA is in the process of being compiled by the Council and local voluntary sector organisations, including the Carers Centre, are contributing to this work. The B&H Carers Commissioning Strategy has 4 main priorities which reflect those outlined in the national Carers Strategy as follows: identification and recognition, realising and releasing potential, a life alongside caring and supporting carers to stay healthy.

Needs and Services

The Carers Centre currently provides a range of services to adult carers, a large proportion of carers who access them are aged 50 up. Some of these services are funded through the Council/NHS.
The following chart lists areas of need for older carers highlighted by the Carers Trust report, as well as the ways in which the Carers Centre is trying to address these:

Area of need	Particularly vulnerable groups of older carers
Identification and involvement	New to a caring role, caring for people with long-term degenerative conditions, BAME or LGBT older carers, carers with communication difficulties or English as second language,
Examples of Carers Centre services to address these: GP/Pharmacy Link Work providing Carer Awareness training & resources for pharmacists & GP staff, ReachingOUT Lottery funded outreach & support work for BAME and LGBT carers, deprived areas etc, outreach & development work in East Brighton areas. Awareness training for hospital staff and those working in end of life services, e.g. The Martlets Hospice, Community Macmillan Team. Engagement work involving carers in consultations, focus groups, recruitment processes etc.	

Health and wellbeing	Caring for more than 1 person, working & caring, over 75, have physically demanding caring tasks, providing night support, cared-for has dementia/challenging behaviour, no support network, carer wanting to cope without outside input or cared-for reluctant to accept help
Examples of Carers Centre services to address these: 1:1 casework (emotional support, info, advocacy/access to grants), 8 ssessions of counselling from The Rock Clinic or Relate, workshops on managing medication, weekly allotment sessions, referrals for Carer's Assessments and to Back Care Support, help with completion of Emergency Back Up forms. Advocacy and referral in safeguarding situations.	
Financial concerns	Carers aged 60-70, those who have given up work to care, those with lack of appropriate info or advice, caring for adult son or daughter with a disability
Examples of Carers Centre services to address these: Support with completion of Carer's Allowance forms, information about other benefits & referrals to Welfare Benefit specialists, individual grant applications, referrals for Carer's Assmts and Carers Card discount scheme, advocacy, free legal surgeries around wills & trusts, Powers of Attorney etc.	
Social isolation	Providing 50 hrs or more a week of carer, cared-for is housebound or has mental health problems, no respite support/breaks, carer wanting to cope without outside input or cared-for reluctant to accept help, less mobile carers, cared-for at end of life, bereaved carers, older male carers
Examples of Carers Centre services to address these: 5 monthly local carers' coffee mornings (info & support), monthly stroke carers group, Time4Me days twice a year, male carers group, casework (including home visits), referrals for Carer's Assessments, social outings for East Brighton carers, some specific activities for BAME and LGBT carers.	
Concerns for the future	Carers of disabled adults, cared-for has deteriorating health condition, aged over 75, carer or cared-for reluctant to accept help
Examples of Carers Centre services to address these: Referrals for Carer's Assessments/Reviews and for Social Care Assmts/Reviews for the cared-for person, advocacy with statutory agencies, end of life casework, free legal surgeries on issues such as NHS Continuing Healthcare, Powers of Attorney, Wills & Trusts. Carer's Assessments for carers going through the Memory Assessment Service, carried out by our MAS Carer's Needs Assessment Worker.	
Information and advice	Important for all older carers, some links to financial concerns (above)
Examples of Carers Centre services to address these: Advice & information provided by Support Workers through 1:1 casework, cover surgeries at the office and cover 'phone line Mon-Fri 9-4pm. Info provided through a range of groups & coffee mornings. Carers' info packs provided through GP surgeries.	
Assessment, support planning & involvement	Carers needing to communicate with statutory & other services about the needs of the cared-for person, carers wanting to cope without outside input, carers from diverse groups less likely to access assessment
Examples of Carers Centre services to address these: Referrals for Carer's Assessments and Social Care Assessments, advocacy and joint working with other agencies, encouragement through casework for carers to accept help, outreach to diverse groups through community events and networks etc.	
Bereavement and life after caring	Challenging for all older carers
Examples of Carers Centre services to address these: 1:1 end of life and bereavement support, weekly allotment sessions, Bereavement Factsheet with info about other sources of help, activities 5 x a year for carers bereaved less than 1 year,	

signposting on to self-run Carers Centre affiliated group for those bereaved more than 1 year (e.g. Breakaway Group).

Case Study written by a Carers Centre Support Worker

Andros, a 75 year old Eastern European man living in Brighton, has been a full-time carer since 2008 for his wife, Anna, who has various health conditions including Parkinsons, depression and osteoporosis (which has left her reliant on a wheelchair to get around and on Andros and carers to mobilize). He himself suffers from poor health due to a heart condition and chronic back problems.

Andros's caring role is very significant and extensive. He helps out with all aspects of Anna's personal care on a daily (and nightly) basis, helps to lift her in and out of her wheelchair, coordinates all her medical appointments and care, and in addition has sole responsibility for running the house (the cooking, cleaning and shopping).

The impact that this has had on Andros and on his own physical and emotional wellbeing has been highly significant and detrimental. Physically, it has exacerbated his ongoing back problem and emotionally he has become exhausted and fraught due to chronic sleep deprivation, when Anna wakes him up on an hourly basis every night to ask for help to turn over in her bed or be helped onto her commode. He has also intermittently felt at 'his wit's end and near breaking point' for being subjected to her extreme anxiety and occasional temper outbursts. This has been so severe at times that Anna's social worker has called a couple of safeguarding meetings with the couple, the manager of the care agency providing Anna's care and myself to look into what extra support needed to be put in place for both Andros and Anna.

As Andros's allocated Support Worker, my role has involved a mixture of ongoing emotional support, advocacy, liaising with Anna's social worker about general and specific safeguarding concerns and referring Andros for various relevant services. There have been several occasions when Andros has only felt comfortable in confiding in me about how close to breaking point he has been feeling. When these occasions have occurred I have stressed the importance of passing this information on to statutory services and have gained his agreement to do so. The fact that I have been able to support him over a longer period of time than usual has been an important factor, not only in gaining his confidence but also in being able to continue to advocate on his behalf when further difficulties have arisen.

When I first started working with Andros I referred him for a Carer's Assessment (which resulted in a Carers Card, an Emergency Back-Up Plan and extra regular respite for Andros) and to the council's Back Care Advisor for Carers for guidance on how to protect his back while moving Marie.

Andros also identified that he would really welcome and benefit from some massage sessions so I secured him some funding from a local charity for six massage sessions, which really helped ease some of his back pain and stress levels. Additionally, I referred him to Relate for 8 funded counselling sessions to provide him with a safe space to deal with some of his mounting feelings of frustration towards his wife and about their situation.

Local Gaps and Needs

Although the Carers Centre provides services to try and address the issues for older carers highlighted in the Carers Trust report, funding for some of these is due to end in 2016, particularly the development and outreach aspects of our work. Funding for our East Brighton Support & Development Worker will cease end of March 2016 *(Public Health funding)* and although we will maintain the monthly coffee mornings in East Brighton this will leave a gap in relation to **EB outreach & development work** and occasional one-off **social activities**. This will therefore reduce

our capacity in the areas of **identification and involvement** and also **social isolation**. Public Health funding for **carer counselling** will also cease at the same time and carers will be redirected to the Wellbeing Service and/or low cost options. We are concerned that counselling available through the Wellbeing Service for older carers will be limited. We do welcome the fact that a new service is being tendered locally for **bereavement counselling**, while at the same time are concerned that carers have not been identified as a priority group in this tender, particularly older carers.

Our Lottery funded work is due to finish end of August 2016, this will reduce our capacity in relation to **outreach & development work specifically related to LGBT and BAME carers**, as well as our ability to provide BAME and LGBT specific activities. Again this is highlighted as an area of need in the Carers Trust report. This will also impact on our **1:1** work as Lottery currently funds 1 full-time Support Worker *(as well as 1 full-time Development Worker)*. The Carers Trust report stresses the need for **1:1 support** for older carers and home visits for those who are caring intensively and/or caring for people with deteriorating conditions. While we do have some capacity for this, particularly within our end of life support work (funded by the Council/CCG), we are concerned that much of the current emphasis is on short-term interventions or groups which do not suit the needs of all older carers. We are also finding increasing numbers of carers in the very old category (90+) contacting us.

While we continue to try and draw funding from other charitable sources, in order to maintain and expand our current services, this has become much more difficult due to increased competition. We are the only organisation in the city providing specific support to older carers and carers of older people across the full range of health conditions and disabilities. Volunteers are fully involved in many aspects of our work but cannot replace some of the services outlined above.

Other important issues for older carers locally include the increasing need for **specialist welfare benefit/financial advice,** the shortage of **adapted housing** locally, **transport** issues particularly for those living in outlying geographical areas, concerns of older **learning disability carers** about changes in service provision, the need for more **'rolling respite'** & other forms of respite and also for more **dementia** specialist services. Another concern among many older carers is the increasing emphasis on using **IT** as a way of accessing information and assessments thus excluding those who do not have the necessary access or knowledge.