Agenda for later life is Age UK’s annual overview of how society is meeting the needs of people in later life. It sets out the steps that need to be taken to ensure that we can all love later life.

Each year Age UK reaches millions of older people through our information and advice, services and social enterprise products. We want to see a later life where:

- Everyone has enough money.
- Everyone can feel well and enjoy life, as much as possible, for as long as possible.
- Everyone can access high quality health and care services.
- Everyone is comfortable, safe, and secure at home.
- Everyone has the opportunity to learn, join in, volunteer or work.

‘You have to get on with what you have and make the most of what you have got.’

- Dorothy, 97
We’re Age UK

There are more people aged over 60 than ever before, and we’re the fastest growing group in society.

As we grow older we face new challenges, and maybe even illness, loneliness or poverty.

But that doesn’t stop us being ourselves. We still want to laugh, love and be needed. We want to stay independent and keep doing the things we love. We all want a fulfilling later life.

That’s why we’re here. We stand up and speak for all those who have reached later life, and also protect the long-term interests of future generations. We believe that living longer should be celebrated and everything we do is designed to change the way we age for the better and enable everyone to be part of the solution.

Together, we can create a world where everyone can love later life.

Dorothy Start, 97, spent many years in guiding and looking after disabled children. She now enjoys cooking for friends and Scottish dancing classes.
I am delighted to introduce the 2014 edition of Agenda for Later Life, Age UK’s annual overview of how public policy is meeting the needs of people in later life.

We hope that this year will mark a watershed in ageing policy, and there is much to celebrate. Just before we went to press, two major pieces of legislation affecting older people – the Care Act 2014 and the Pensions Act 2014 – received Royal Assent. Both pieces of legislation are important steps forward in building a solid framework for ageing.

However, legislation alone cannot create the cultural change we still need if we are to create a world where everyone can love later life. We still see too many examples of poor quality health and social care; too many pensioners still living in poverty; and too many people who are isolated and lonely. To tackle these challenges, we need to re-design every aspect of life. And we are doing this against a backdrop of continuing austerity.

This will be a critical year for ageing policy, in the run up to a General Election in the UK, a referendum on independence for Scotland, and globally as the United Nations considers the successor to the Millennium Development Goals. I hope that you find this report helpful in setting out Age UK’s policy priorities for the year head.

Caroline Abrahams
Charity Director
Key indicators for later life

Age UK uses the following indicators to track older people’s quality of life.

Indicator sources are shown on page 92 and for regularly updated statistics see the Age UK Knowledge Hub at www.ageuk.org.uk/professional-resources-home/knowledge-hub-evidence-statistics.

### Trend

<table>
<thead>
<tr>
<th>Trend</th>
<th>✓ Improved</th>
<th>✗ Worsened</th>
<th>– No change or new measure</th>
</tr>
</thead>
</table>

### Ready for ageing?

<table>
<thead>
<tr>
<th>1. Later life (UK): Population aged 60+ and 85+ in numbers and as percentage of total population</th>
</tr>
</thead>
<tbody>
<tr>
<td>Current results</td>
</tr>
<tr>
<td>60+: 14.5 million (22.71%)</td>
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<tr>
<td>85+: 1.44 million (2.26%) (2012)</td>
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<tr>
<th>2. Life expectancy (UK): Life expectancy at age 75</th>
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<tbody>
<tr>
<td>Current results</td>
</tr>
<tr>
<td>Male: 11.9 years</td>
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<tr>
<td>Female: 13.5 years (2014)</td>
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<tr>
<th>3. Later life (world): Estimated population 60+ and 85+ in numbers and as percentage of total population</th>
</tr>
</thead>
<tbody>
<tr>
<td>Current results</td>
</tr>
<tr>
<td>60+: 874 million (12.2%)</td>
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<tr>
<td>85+: 51 million (0.72%) (2014)</td>
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### Enough money

<table>
<thead>
<tr>
<th>4. Poverty (UK): People over current State Pension age with less than 60% of median income after housing costs</th>
</tr>
</thead>
<tbody>
<tr>
<td>Current results</td>
</tr>
<tr>
<td>14% (2011/12)</td>
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<thead>
<tr>
<th>5. Benefit take-up (Great Britain): Percentage of people eligible for Pension Credit who receive the benefit</th>
</tr>
</thead>
<tbody>
<tr>
<td>Current results</td>
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</tbody>
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<tr>
<th>6. Private pensions (UK): Percentage of working-age people contributing to a non-State Pension</th>
</tr>
</thead>
<tbody>
<tr>
<td>Current results</td>
</tr>
<tr>
<td>34% (2011/12)</td>
</tr>
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</table>

### Feeling well, enjoying life

<table>
<thead>
<tr>
<th>7. Healthy life expectancy (England): Average number of years healthy life expectancy at age 65</th>
</tr>
</thead>
<tbody>
<tr>
<td>Current results</td>
</tr>
<tr>
<td>Male: 10.1 years</td>
</tr>
<tr>
<td>Female: 11.6 years (2008–10)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>8. Disability gap (England): Gap between local authorities with the highest and lowest average disability-free life expectancy at age 65</th>
</tr>
</thead>
<tbody>
<tr>
<td>Current results</td>
</tr>
<tr>
<td>Male: 12.1 years</td>
</tr>
<tr>
<td>Female: 12.3 years (2007–09)</td>
</tr>
</tbody>
</table>

### High quality health and care services

<table>
<thead>
<tr>
<th>9. Loneliness (UK): People aged 65+ who are often or always lonely in numbers and as a percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Current results</td>
</tr>
<tr>
<td>1.06 million (10%) (2014)</td>
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<thead>
<tr>
<th>10. Dignity in hospital (UK): Percentage of general public confident that older people are treated with dignity in hospital</th>
</tr>
</thead>
<tbody>
<tr>
<td>Current results</td>
</tr>
<tr>
<td>31% (April 2014)</td>
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<thead>
<tr>
<th>11. Hospital readmissions (England): Number of people aged 75+ readmitted to hospital as an emergency within one month of discharge</th>
</tr>
</thead>
<tbody>
<tr>
<td>Current results</td>
</tr>
<tr>
<td>204,709 people (2011/12)</td>
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<thead>
<tr>
<th>12. Dignity in care (UK): Percentage of general public confident that older people receiving social care are treated with dignity</th>
</tr>
</thead>
<tbody>
<tr>
<td>Current results</td>
</tr>
<tr>
<td>40% (April 2014)</td>
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<tr>
<th>13. Unmet need for social care (England): Number of people aged 65+ with unmet need for social care</th>
</tr>
</thead>
<tbody>
<tr>
<td>Current results</td>
</tr>
<tr>
<td>980,000 (2014)</td>
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### Comfort and safety at home

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Current results</th>
<th>Previous results</th>
<th>Trend</th>
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### Opportunities to participate

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Current results</th>
<th>Previous results</th>
<th>Trend</th>
</tr>
</thead>
<tbody>
<tr>
<td>20. Employment 50–64 (UK): Employment rate for people aged 50–64</td>
<td>68.3% (Nov 13–Jan 14)</td>
<td>67.0% (Nov 12–Jan 13)</td>
<td>✓</td>
</tr>
<tr>
<td>21. Employment 65+ (UK): Number of people aged 65+ in employment</td>
<td>1,040,000 people (Nov 13–Jan 14)</td>
<td>964,000 people (Nov 12–Jan 13)</td>
<td>✓</td>
</tr>
<tr>
<td>25. Digitally excluded (UK): Percentage and number of people aged 65–74 and 75+ who have never used the internet</td>
<td>65–74: 30.8% 75+: 63.3% (2013, quarter 4)</td>
<td>65–74: 34.5% 75+: 68.9% (2012, quarter 4)</td>
<td>✓</td>
</tr>
<tr>
<td>26. Belonging to neighbourhood (UK): Percentage of people aged 65+ who agreed that they felt they belonged to their neighbourhood</td>
<td>79.6% (2012–13)</td>
<td>83.1% (2010–11)</td>
<td>X</td>
</tr>
<tr>
<td>27. Public transport (UK): Percentage of people aged 65+ who describe public transport as poor</td>
<td>11.6% (2012/13)</td>
<td>New indicator</td>
<td>−</td>
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</tbody>
</table>
As last year’s *Agenda for Later Life* went to press, the House of Lords Committee on Public Service and Demographic Change published its *Ready for ageing?* report, concluding that as a nation we are ‘woefully underprepared’ for our ageing population. Since then Age UK has been working with other major charities as part of the Ready for Ageing Alliance, urging the Government and all political parties to face up to the major challenges ahead of us.

These challenges include:

- taking a long-term approach – decisions we take now will affect the wellbeing in retirement of future generations, as well as our own.
- understanding the impact, both positive and negative, of the increase in longevity on individuals and society.
- building political consensus so that it is possible for Governments to make the big decisions.
- ensuring that positive change reaches all parts of society.

It is also clear that ageing is not something unique to the UK. The global number of older people is increasing and is expected to reach over 2 billion by 2050, with some of the greatest rates of increase taking place in developing countries. Understanding the opportunities and challenges ageing brings is essential if we are to help countries to build stronger more resilient economies and societies.

In this chapter we give an overview of how well the past five years have prepared us for ageing, as individuals and as a society, and set out our vision of what is needed to build a society that is ready for ageing.

Note that references to health and care legislation apply only in England.

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**Priorities**

- Age UK will be looking to all political parties to set out a positive vision for our ageing society in their manifestos for the General Election in May 2015.
- In particular, political parties will need to say how they would re-design health and social care around the individual rather than around the system, and ensure that individuals will have enough money in retirement.
- If we are to take serious steps in realising the potential of an ageing society, older people must help to set the agenda and be involved in delivering it.
- We need a continued focus on tackling inequalities in our older population, whether these are financial, health or social inequalities.
- When deciding public spending priorities, local and national government should take into account the social value of maintaining the local infrastructure that can help to prevent isolation and keep communities alive.
- International cooperation must take into account population ageing and help ensure that people in later life in developing countries are treated with the same dignity and respect we expect for older people in the UK.
Looking back over the past five years, we have seen ground-breaking legislation which will set a new framework for later life in future years.

This includes:

• the Pensions Act 2014, legislating for a new single-tier state pension from 2016 but also setting out further increases to State Pension age.
• the Care Act 2014, introducing a complete reform of care and support legislation, as well as a new system for paying for care from 2016.
• the Equality Act 2010, outlawing unjustified age discrimination in goods and services.

This legislation is important and demonstrates that the UK Government is attempting to grapple with the issue of increasing longevity. However, we cannot solve the puzzle one piece at a time. For example, the need to get housing right for older people is recognised in the Care Act, which places a duty on local authorities to include housing as part of integrated health and social care provision. However there is, as yet, no overall strategy for how we can meet the housing needs of an ageing society.

And neither the Care Act nor the Pensions Act will help pensioners living in poverty or with unmet care needs today. As Figure 1.1 on page 11 shows, at age 65 a man in the North East has a life expectancy of 17.1 years, of which he can expect just 8.6 to be disability-free, whereas a woman in the South West has a life expectancy of 21.4 years, of which 12.5 are likely to be disability-free.

These three pieces of legislation also demonstrate the importance of implementation, which is always a far more complex and elongated process. They will not fully achieve their aims unless the new single-tier State Pension is introduced at a high enough level to ensure a firm base for private saving; unless the social care system is sufficiently funded to meet the aspirations in the Care Act, and unless public and private sector bodies at every level take action to end ageism.

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The number of people over 85 in the UK is predicted to double in the next 20 years and nearly treble in the next 30 years.

Where are we now?

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Where are we now?
The economic context

The economic outlook is improving, with the Office for Budget Responsibility forecasting GDP growth of 2.7 per cent in 2014, and 2.4 per cent in 2015. Unemployment has fallen – a trend which has also benefited older workers, as Chapter 6 shows – and inflation is close to target.

Austerity remains with us, however, with the public finances not expected to be in surplus until 2018 and spending cuts focussed on 2016 to 2019. And although older people have been protected from the worst of the benefit cuts, they have been affected by:

- the freezing of age-related tax-free allowances from 2012.
- a growing gap between energy prices and pensioner incomes. Perhaps in contrast to public perception, expenditure on winter fuel payments is actually falling (since the age of eligibility is increasing and the value is reducing in real terms).
- continuing low interest rates. Someone with £10,000 in an emergency fund could have lost £1,157 (after taking into account the gap between interest rates and inflation) over the last 4 years.\[3\]
- high rates of long-term unemployment among older people who have lost their jobs (see Chapter 6).

One change that could affect many people approaching, and in, retirement is the Government’s new cap on welfare benefits (explained in Chapter 2), even though the State Pension is excluded.

An additional and serious challenge, for many older people, has been cuts to the public services on which they depend, for example:

- a 15 per cent drop in real-terms funding for social care since 2010–11, or 10 per cent if you take into account transfers from the NHS.\[4\]
- 46 per cent of local authorities cut spending on their supported bus services in 2013/14, while 36 per cent cut or removed services.\[5\]

As the UK pulls out of a difficult period, we have an opportunity – and a responsibility – to build a stronger, more resilient society for today’s and tomorrow’s pensioners.

Resilience has been defined as the ability to flourish despite adversity, and to bounce back after adversity,\[6\] and can also be described as having the resources you need to provide a cushion against unforeseen events. And resources don’t just mean financial resources – your health and your social networks are equally important.\[7\]

Those lucky enough to enjoy high levels of wealth, excellent health and good social networks are likely to be highly resilient, but if one of the ‘legs’ of the stool fails – when health breaks down, or someone is bereaved, for example – the other two legs become more important. So, for example, cuts in state-funded support for social care have resulted in a greater burden on family and friends. Almost a quarter of people aged 65+ are now providing informal care – up from just over a fifth two years ago – of whom more than half provide over 100 hours of care a week.\[8\]

Building resilience for the future

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Financial resilience

The report of Age UK’s Financial Services Commission was published in June 2014, and sets out how we can develop financial resilience in later life. Financial resilience comes from having a mixture of ‘hard’ resources such as wealth and health, and ‘soft’ personal and social resources such as financial capability. However, the central premise of the Commission’s work is that while there is much that individuals can do to build up their personal resilience, the financial services industry can do more to improve other key aspects of a person’s financial resilience, by providing appropriate products and services. And, of course, the state has an essential role to play in providing the certainty, the framework and in the last resort the safety net needed.

As set out in Chapter 2, in terms of helping people to build up pension savings for retirement, there have been positive developments, including automatic enrolment into workplace pensions, but real concerns still remain that these changes will not be enough to ensure an adequate retirement income for many. The ability to carry on working is an important source of resilience: working and saving for an extra two years beyond SPA can increase retirement income by 20 per cent.\[12\] The number of people working over the age of 65 has passed the one million mark, but continuing to work is not always possible. Chapter 6 looks at how older people can be given better opportunities to participate.

These are all factors that will benefit tomorrow’s pensioners, not today’s. The continued existence of pensioner poverty – affecting around one in seven of all pensioners\[13\] – is a scar on our society, but one that could be...
Physical and mental resilience

Good health is a hugely important resource in retirement, contributing to both financial and social resilience. And, as explained in Chapter 3, it is possible to remain resilient even with health problems. Even though around 70 per cent of people over 75 live with a serious long-term condition; for example, only 40 per cent of men and 50 per cent of women report limits to daily activities.

To help understand what causes people to become frail, Age UK has published research on the experience of people living with frailty. Older people living with frailty have low physical resilience, but too often have to wait until a crisis before something is done. Even then, the response is often to deal with the shorter-term issue without resolving underlying problems – resulting in worse outcomes and higher costs. For example, continued underfunding of social care meant that in 2013/14, there were over half a million days of delayed discharges due to care meant that in 2013/14, there were over 14

If we are to take serious steps to realise the potential of an ageing society, we need to ensure that older people help to set the agenda and are involved in delivering it.

In working towards an age-proofed society we must avoid a top-down, imposed and unbending strategy. Today’s older population is highly diverse: tomorrow’s will be more so, and the nature of the problems will have changed. The person who knows best what is needed, and what would be most helpful, is the person directly affected.

In this section, we set out the cross-cutting themes that older people have told us are essential for successful ageing.

A commitment to equalities and human rights

Although the Equality Act 2010 has outlawed unjustified age discrimination in most goods and services, negative attitudes towards older people and ageing are pervasive in our society, usually based on inaccurate stereotypes. Research has shown that those over 70 are seen as incapable and pitiable, when compared with other groups. These ageist attitudes are all too often reflected and amplified by the media, whose code of practice does nothing to stop pejorative references to somebody because of their age. And there are some major exemptions from the ban on age discrimination, notably for the financial services industry. This leads to constraints such as difficulties continuing a mortgage into retirement, even for those who can afford it.

Research has firmly established that a powerful way to overcome prejudice is to foster close, honest and personal relationships with others who are seen as belonging to a different group. A big step forward would be more initiatives to promote greater intergenerational contact and reduce barriers to good intergenerational relations.

The importance of human rights for older people has been highlighted by shocking examples of abuse and degrading treatment of older people in hospitals and care homes. Refusing help to allow someone to use the toilet overnight; planning to put a couple who had been married for 65 years into different care homes; forcing older people to file VAT returns online; all these have been challenged using human rights legislation. However the real importance of the Human Rights Act is its potential to bring about a fundamental change in the way that public services are provided. Many of the European Convention rights that underpin the Act are not absolute but do require that public authorities show they have considered the impact of decisions on individuals (the right to respect for private and family life, for example). This is a real defence against oppressive institutional practices and ‘one size fits all’ public services.
This is why Age UK is delighted that, in a last-minute amendment to the Care Act 2014, the Government has acted to extend the coverage of the Human Rights Act. It now means that users of care services provided by private and third sector organisations under a contract to, or funded by, the local authority receive the protection of the Act.

**Age-friendly neighbourhoods**

Where we live and our immediate environment have a crucial role to play in developing social resilience and reducing loneliness and isolation. While many older people continue to play an active part in their community, problems with mobility, vision and memory can make neighbourhoods difficult to navigate. Lack of public transport, or somewhere to sit down, or access to clean public toilets limits how far people are able to get around. Poor-quality pavements, poor street lighting or fear of crime can stop people feeling confident enough to go out at all. The decline in local services over the past few decades, characterised by closures of banks, post offices, pubs, garages and local stores has also reduced community resilience.

There is no single agreed definition, but in simple terms, the concept of age-friendly neighbourhoods means designing an inclusive environment for all ages to lead independent lives. An environment that suits an older person with limited mobility is also likely to help someone pushing a pram. While national government can set the framework for age-friendly neighbourhoods, local government has the main part to play.

When deciding public spending priorities, local and national government should take into account the social value of maintaining the local infrastructure that is often important in preventing isolation, such as safe, accessible places to meet, local transport and local shops. This is particularly important in rural areas, where such infrastructure is under threat, but Age UK would also like to see every local authority working towards achieving ‘Age Friendly’ status in line with the Age Friendly Cities movement initiated by the World Health Organisation.

**Action to support rural ageing**

Age UK South Lakeland Village Agents aim to empower older people in rural areas to live independent lives and play a full part in their local communities. Village Agents work a few hours a week providing older people with a friendly first point of contact within the market towns, villages and hamlets of South Lakeland. They provide information, advice and support, but also help to develop new community initiatives based on local need. They are supported by village action groups, including volunteers at Age UK South Lakeland.

Recently the charity has developed a virtual platform for working together with other charities. This Gateway Ehub (www.ageuksl.org.uk) not only enables partners to share events, bulletins and information but also facilitates secure electronic referrals, making the best use of all resources at a local level.
The Government has recognised the need for advice in relation to social care, and is introducing a right to guidance when cashing in pension savings, but information and advice should be recognised as a vital part of local infrastructure and funded on a sustainable basis. This is likely to involve better joining-up and referral systems between agencies. See Chapter 2 for more on financial information and advice.

Public service reform that meets the needs of older people

Over recent years, the state has stepped away from its role as default provider of services in a number of key areas, instead opening up to a diverse range of providers to create a market across public services, transferring power to local and community level, and increasing openness and transparency.

However, this policy has been accompanied by a drive to contain public spending and cuts in local authority spending have reduced community capacity at the local level, particularly for the most excluded. Policy levers to encourage longer-term strategic thinking such as the Office for Budget Responsibility’s fiscal sustainability reports have tended to focus attention on the costs of ageing rather than the opportunities.

As political parties consider their manifestos for the 2015 General Election, Age UK believes that proposals for reform must be based on the following principles:

• Commissioners of public services should secure the most appropriate services for older people. Neither promoting competition, nor providing a choice of providers can be ends in themselves.

• Older people must be able to expect health, care and other services to be co-ordinated and joined-up around their needs.

• Public services are not free-standing functions, they have a role in promoting equality, social inclusion and community cohesion. Services must add value to our communities and promote the growth of social capital.

• Public services must embrace the principles of user engagement and co-design, and consult older people about the design of services for them.

• There must be absolute transparency about accountability. There can be no blurring of the distinction between public services and public responsibilities, and responsibilities must remain clearly located with statutory organisations.

Age-friendly consumer markets

In general older consumers are the same as consumers of any age and face similar problems, for example, the difficulties facing those on low incomes. However, the challenges of ageing may be exacerbated by exclusion from key markets, age discrimination and stereotyping, poor design and poor selling practices. For example, few mortgage lenders are prepared to lend to older borrowers, even if they can well afford the loan. Until these issues are addressed, businesses will miss out on the £128 billion that older households spend each year. In addition, as shown in Chapter 5, rogue traders continue to target older people with scams.

Access to information, advice and guidance

Good quality information and advice is essential to enable people in later life to make informed decisions, plan ahead, access entitlements and services, and play a full part in their communities and society. The changes introduced under the Care Act 2014 and the Pensions Act 2014, not to mention recent abolition of the requirement to annuitise pension savings, make information and advice even more important. For many older people, face-to-face advice is also important, but the local voluntary organisations that provide such services struggle to maintain stable funding. The recent Low Commission report on the future of advice and legal support concluded that an estimated £100 million is needed to provide a basic level of access.

COMMISSIONERS OF PUBLIC SERVICES SHOULD SECURE THE MOST APPROPRIATE SERVICES FOR OLDER PEOPLE. NEITHER PROMOTING COMPETITION, NOR PROVIDING A CHOICE OF PROVIDERS CAN BE ENDS IN THEMSELVES
Building resilience globally

As the number of older people worldwide increases and people’s life expectancy increases, it is clear that building a society for all ages is a global priority.

How we respond depends on sharing knowledge and experiences from countries that already have a higher proportion of older people. It also means being open to what we can learn from other countries.

The challenges we are facing in the UK are also being experienced in many parts of the world, often with governments, communities, families and individuals having to cope with far fewer economic and social resources. Traditional family structures are no longer a guarantee for a secure and safe later life. Younger family members frequently seek work in cities and abroad, and families have to cope with the impact of devastating diseases such as HIV or humanitarian disasters.

There are many ways international support can be strengthened to address ageing issues in developing countries. Of particular interest is the development of a set of goals and targets that clearly spell out commitments to tackling extreme poverty and to which all countries can sign up. This so-called ‘post-2015 framework’ will replace the Millennium Development Goals (MDGs) that have been tremendously influential in reducing poverty, improving health and improving education for millions of people in poorer countries.

In order for the post-2015 framework to be future-fit, it must take into account the increasing number of older people worldwide and support governments to respond more effectively. It is likely to include some references to ageing and older people, but the scale of the ambition remains to be seen.

Underpinning any effort to make better policy for older people anywhere in the world is the need for an evidence-based understanding of ageing. Developing a stronger base of internationally comparable data will help build better policy on ageing in the UK and abroad.
Enough money
All current and future pensioners should have enough money from state and private sources to live comfortably and participate fully in society.

Overview

The first few months of 2014 saw the UK Parliament agreeing to legislation that introduces the new single-tier State Pension in 2016 and further raises State Pension age. Then, in the 2014 Budget, came the surprise announcement of much greater freedom in how we access pension savings.

More freedom to access pension savings without having to buy an annuity will be welcomed by many, but the changes must be well communicated and people will need support to make appropriate decisions. There are also practical challenges for the Government and the industry in implementing significant changes in a relatively short period of time and ensuring there are safe, good-quality financial products that meet people’s needs. But a comfortable retirement depends on having built up enough savings in the first place, and Age UK’s Financial Services Commission found that many coming up to retirement are inadequately prepared for the years ahead.

In introducing changes affecting future pensioners, we must not ignore the needs of those already retired. It is good news that pensioner poverty has fallen over recent years but there are still 1.6 million older people living in poverty. Income levels vary considerably and there is even greater wealth inequality. And with continued debate around social security there is uncertainty about the help that state systems will provide to top up limited income.

Priorities

- Progress has been made in tackling pensioner poverty, but more can be achieved. The Government should set targets and establish a reform programme to work towards the elimination of pensioner poverty.

- To maintain the incomes of current pensioners and avoid future generations falling into poverty, there should be an ongoing commitment to uprate the State Pension by the ‘triple lock’.

- The Government must consider how current pensioners with low state pensions can be brought into the new single-tier pension.

- The social security system must provide adequate support to current pensioners with limited private resources and those approaching pension age who cannot work.

- People need appropriate guidance, information and advice as they approach retirement, at the point of retirement and later on in older age. This must be matched by the financial services industry ensuring products and services are transparent, good value and meet customers’ needs.
Current pensioners

We still have some way to go before all older people have adequate resources to make the most of later life.

Poverty

Relative pensioner poverty has fallen over the last 20 years or so. This is good news, but there are still 1.6 million (14 per cent) of pensioners living in poverty (with incomes of less than 60 per cent of typical household income). Of these, 900,000 are in severe poverty (less than half of typical household income). Some groups are at greater risk of poverty. For example, 29 per cent of private tenants and 25 per cent of social tenants are in poverty compared to 10 per cent of owner occupiers.

Figure 2.1 shows the range of incomes among pensioners. However, financial wellbeing is not solely linked to income levels. For example, the Government also measures “material deprivation” – that is, whether or not older people have essential items and services, or engage in activities most people would consider important such as seeing friends and family. Eight per cent of people aged 65 and over are in material deprivation, but just 2 per cent of pensioners are in both income poverty and material deprivation. The limited overlap can be explained by factors other than income that make it hard for people to manage – for example, extra costs due to disability or where you live. Many other factors can also affect your standard of living, including family and community networks, health, financial management, housing, and individual attitudes and priorities.

Age UK believes that the Government should set targets for the continued reduction and eventual elimination of pensioner poverty. To achieve this goal, the Government should work with national and local organisations to investigate the most effective ways of reducing poverty and establish a clear reform programme. Financial resilience can also be increased through good social support, affordable essential goods and services, and access to information, advice and support to help people maximise their income and make the most of what they have.

State support

The State Pension is the largest single source of income for the majority of pensioners. The Coalition Government made a commitment for this Parliament to increase the basic State Pension by the ‘triple lock’ – that is, in line with increases in average earnings, prices or 2.5 per cent, whichever is highest. This has maintained the value of the basic pension, but other elements of older people’s income, including private pensions and savings income, often lose value in real terms over time. The new single-tier State Pension, which will help many who would otherwise have low State Pension entitlements, will not apply to current pensioners and those reaching State Pension age before 6 April 2016.

Means-tested benefits provide a safety net to protect people on the lowest incomes yet many miss out on this vital support, in spite of work to encourage take-up of benefits. Between £3.7 billion and £5.5 billion of income-related benefits are unclaimed by pensioners every year.

If all means-tested benefit entitlements were taken up, pensioner poverty could be reduced by about 40 per cent.

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31 PER CENT OF ASIAN OR ASIAN BRITISH PENSIONERS AND 20 PER CENT OF BLACK OR BLACK BRITISH PENSIONERS ARE IN POVERTY

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AND 20 PER CENT OF BLACK OR BLACK BRITISH PENSIONERS

ARE IN POVERTY

Source: Pensioner Income Series 2011/12, DWP/ONS 2013. Figure shows median net income for pensioners by income quintile, before housing costs.
Rather than relying on means-tested benefits—which are complex, stigmatising and create disincentives to save—many argue that we should move to a system where people have an adequate retirement income without needing means-tested support.

Age UK believes that state and private pension systems should ensure current and future pensioners are able to avoid poverty in later life. This will need:

- an ongoing commitment to maintaining the ‘triple lock’ for the State Pension.
- looking at how current pensioners can be brought into the new single-tier pension as resources allow.
- setting the State Pension at a level sufficient to cover basic needs.

In the meantime, benefit take-up must be increased through ongoing publicity and making it easier for people to navigate a complicated system of benefits.

However, there is continuing pressure to reduce overall spending on social security and the Government has embarked on a programme of welfare reforms. So far, most of the reforms that restrict benefits have been aimed at those under pension age, although people of all ages could be affected by the introduction of an annual benefit cap on overall spending in 2015–16. The State Pension and Jobseeker’s Allowance will not be covered by the cap, but other benefits, including Pension Credit and Attendance Allowance, will be included. If the cap is likely to be breached, the Government will need to reduce spending or ask Parliament to approve the higher expenditure.

Age UK does not support setting a welfare spending cap, which could lead to short-term cuts and have a detrimental impact on people’s lives. Instead, we want to see a strategic approach to social security spending, including, where appropriate, initiatives to address the causes of rising social security spending, such as improved employment support.

**Wealth**

Having the resources to top up income, to replace household goods, to maintain housing or pay for care, is an important factor in financial resilience. Yet wealth is very unevenly distributed among older people and not always easy to access. For example while one-third of pensioners have more than £20,000 in savings and investments, more than one-fifth have none and one in ten has savings of less than £1,500.

While there has been extensive public debate about intergenerational unfairness the inequality within generations is remarkable and deserving of greater scrutiny.

Housing wealth is many people’s main form of wealth, with about seven out of ten householders aged 65 and over in England owning their properties outright, free of mortgage. The median value of property owned is around £200,000 but levels vary. Housing equity can be released through lifetime mortgages and home reversions or through ‘downsizing’ to a cheaper property. Another alternative for people needing care is a ‘deferred payment’. New rules for deferred payments under the Care Act 2014 will, from 2015, allow people in residential care with liquid assets under £23,250 to defer selling their homes to pay for care until after their death.

Although equity release is now regulated, older people may be deterred by mis-selling scandals in the past, be concerned about having a debt on their property or limiting future options to move or pay for care, want to protect their children’s inheritance, or be unsure how to go about choosing a product. The market is small (20,331 plans sold in 2013) and there have been concerns about confusing and unpredictable exit fees.

Downsizing relies on finding suitable accommodation in an area close to friends, family and services, and for some the whole process of moving may be difficult and costly. It is also increasingly common for older people to have mortgages. Nine per cent of people aged 65–74 have a mortgage and between 2017 and 2032 there will be 40,000 interest-only mortgages maturing each year where the borrower will be aged 65.

So while housing wealth can be a valuable means of financial provision in retirement it is not open to all, it is not an alternative to an adequate pension income, and needs to be carefully considered.

People for whom equity release is suitable should have access to a range of well-designed, competitive products. There should be a wider range of affordable housing options available to those who wish to downsize where equity release is not suitable. Older people also need access to independent housing and specialist financial advice to help them explore options.
New reforms are transforming pensions, but individuals will need to cope with a rising State Pension age and greater personal responsibility.

State pensions
The Pensions Act 2014 introduces a new single-tier State Pension, which will replace the current system for people reaching State Pension age on or after 6 April 2016. This will provide a simpler flat-rate pension that is higher than the standard Pension Credit rate (currently £148.35 a week) for people with 35 years of contributions. It is intended to cost no more than the current system, so while some people will be better off, including many women who have spent time in low pay or with caring responsibilities, others will receive less than they would have done.

In general, those with low State Pension entitlement under the current system will benefit, but Age UK is concerned about some women who will lose entitlement to claim on their partner’s contributions and those with modest incomes who could be worse off overall because they receive less help from means-tested benefits.

The system will be simpler but there will need to be good communications about the changes because during the transition period people may receive more than the full amount (as pension already built up is protected) or less (because they do not have 35 years of contributions or have spent time contracted-out of the State Additional Pension).

How pensions are uprated each year is crucial in ensuring the value of the state pension for future generations. Government projections assume the single-tier pension will be uprated by the ‘triple lock’ but this is not in legislation. The Pensions Policy Institute (PPI) calculates that a younger person with lower earnings has a 63 per cent chance of achieving an adequate retirement income if the new State Pension is increased by the ‘triple lock’, but this could fall to 36 per cent if it is linked only to earnings.

To achieve the aims of providing a good platform for saving and reducing means-testing, the starting level of the single-tier pension must be set at a high enough level and we need a long-term commitment to increase it by the ‘triple lock’.

Responding internationally
Having enough money is a concern for people anywhere in the world. In developing countries, social security is often non-existent and only a fifth of the global population benefit from having a pension. Around 340 million older people are living without any secure income. Many poorer people in developing countries do not work in formal employment; for example they might be subsistence farmers or market traders. This means they do not have the chance to pay into a contributory pension and may not benefit from government income support.

In the absence of comprehensive pension coverage for older people, modest income support called ‘social pensions’ can have a positive impact for the whole community. In Tanzania, a localised social pension scheme implemented by the agency Kwa Wazee found that small, regular, payments to older people had an impact on their nutrition and health status, and resulted in higher school attendance by children in their care. They also help the economy by creating demand for locally-produced goods and services.

A recent feasibility study in Tanzania found that a universal pension costing just 1.3 per cent of GDP could lift 1.5 million people out of poverty.

Globally, the need for a minimum standard of support has been recognised by UN agencies and a wide range of countries (including the UK) through an agreement to create ‘social protection floors’, basic social security guarantees set at a national level to ensure that everyone has access to basic income security and essential healthcare throughout their lifecourse. In order to help reduce poverty in developing countries, the UK Government should actively support the implementation of social protection floors in other countries.

How pensions are uprated each year is crucial in ensuring the value of the state pension for future generations. Government projections assume the single-tier pension will be uprated by the ‘triple lock’ but this is not in legislation. The Pensions Policy Institute (PPI) calculates that a younger person with lower earnings has a 63 per cent chance of achieving an adequate retirement income if the new State Pension is increased by the ‘triple lock’, but this could fall to 36 per cent if it is linked only to earnings.

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Future pensioners

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Waiting longer for your pension
The 2011 Pensions Act accelerated the introduction of an equal State Pension age for men and women at 65 and increased State Pension age to 66 for both men and women by 2020. The 2014 Pensions Act raises State Pension age further – to 67 between April 2026 and 2028. It also brings in provision for reviews to happen approximately every five years to inform future rises.

While, on average, life expectancy is increasing, both the length of time people live and the years they are likely to have free of disability vary significantly (see Figure 1.1 on page 11). So reviews to inform State Pension age must take into account differences in healthy life expectancy between different groups and be subject to agreed criteria relating to notice period and speed and frequency of changes.

If people have to wait longer to receive their pension, they must also have opportunities to extend their working life – see Chapter 6. However, those who are not in work may need to rely on the benefits system. The new Universal Credit combines income-related benefits and tax credits into a single benefit and is intended to provide better work incentives. However, its introduction has been slower than expected. And many people looking for jobs, or who cannot work for reasons such as disability or caring responsibilities, are being affected by benefit reforms. These include restrictions to rent support for those considered to have more bedrooms than they need, and below-inflation increases in benefits.

While Age UK supports the aim of helping people back to work, the benefits system needs to provide an adequate income for those unable to work.

Private pensions
Latest figures show that the percentage of private sector workers paying into a workplace pension rose from 26 per cent in 2011 to 35 per cent in 2013 – the first rise in a decade. Automatic enrolment into workplace pensions continues to roll out successfully, with opt outs far lower than anticipated, so much so, in fact, that the Government has revised its estimates from 30 per cent to 15 per cent of workers opting out. During 2014 we should also see a peak in the number of firms auto-enrolling and it will only be after we pass these peaks that we will get a true sense of opt-out rates. It will be important to also understand more about why people are opting out.

However, many people are still not paying in enough. A key challenge for the future will be to review whether higher private pension contributions or even compulsion are required over the long term. A review would need to investigate whether and how workers can be incentivised to save more. New research suggests that middle income groups are disincentivised from saving more.

But meanwhile, it is vital that the pension schemes workers are auto-enrolled into are of good quality with fair charges. From April 2015 schemes used for automatic enrolment will be subject to a charge cap of 0.75 per cent for their default funds. Other charges, including commissions, consultancy fees and penalties for people no longer contributing will be banned, and independent governance committees introduced for schemes that do not have trustees.

Automatic enrolment will see a dramatic rise in the number of small pension pots – by 2050 it is estimated that there will be around 4.7 million pots worth under £2,000.

The Government also intends to develop a system where small ‘pots’ of pension savings created through automatic enrolment follow people from job to job. This is not the approach that Age UK supported but the implementation of a charge cap does go a certain way towards meeting our concerns.
New ways of sharing risks for the future

Defined contribution schemes, which make no promises around the benefit or level of pension that members can expect to receive, are now the predominant model for pension saving. The Government has been looking at whether there are other models that could strike a good balance between making promises to employees, without making this too unmanageable for an employer to offer. One of the proposals was for collective schemes where members share the risks more. This is potentially a good idea for future consideration, but does flag up the need for excellent scheme governance. The Government intends to legislate to enable such schemes to develop.

New options for pension income

The Government has announced significant changes for people with defined contribution pension pots. From April 2015, they propose to remove the requirement to use pension savings to purchase an annuity, meaning that people can take their entire pension pot in cash if they choose. These reforms are intended to increase choice and prevent people being getting locked into what appear, in the current low interest rate environment, to be poor value annuity rates. The intention is also to offer everybody pensions guidance to help them make their choices.

Age UK has long argued for the need to reform the annuities market but this is a radical departure, being implemented at high speed. The success of these reforms will depend on three things:

• Will the free pensions guidance be enough to help people manage their remaining savings safely over the whole of their retirement, not just at the outset?
• What will be the interaction with other important aspects of people’s personal finances, and in particular debt and the care system?
• Will the financial services industry come up with new good-value financial options that give people the security they need?

Age UK held a Financial Services Commission during 2013/14 to examine how the financial resilience of older people can be improved. By this, we mean the ability of an individual to weather financial challenges throughout later life.

Government, society and individuals all need to play their part in preparing for and maintaining a decent standard of living in later life, but the financial services industry has a pivotal role to play in engaging with individuals and delivering solutions that enable people to:

• build up and maintain their financial resilience
• prepare financially for later life
• stay financially included until the end of their lives.

As part of the Commission, Age UK ran a series of summits to engage senior leaders from the financial services industry, Government, consumer groups and regulators to discuss the key issues facing older people in relation to money, and to develop potential solutions. The Commission was co-chaired by Tom Wright, CEO of Age UK and Dr Alexander Scott, CEO of the Chartered Insurance Institute. In addition to the summits, we carried out research, commissioned think pieces, and consulted older people through our Age UK networks. The Commission culminated in a report published in June 2014. It brought together all the findings of the Commission and set out key recommendations for the financial services industry, regulators and Government to improve, at every stage of retirement, information, guidance and advice and high-quality financial products and services for older people.

Money management and financial capability

The Financial Services Commission found that there needs to be a much more joined-up approach to money advice. It highlighted the increasing complexity of managing money in later life and the need for support to be holistic and joined up across life stages, as well as being accessible, even to those who are not online.

Debt is also a problem for some older people. While the proportion of people aged 50 and over with debts has fallen over time, the amount owed by those in debt substantially increased between 2002 and 2010. In 2010, 10 per cent of older people with unsecured debts were paying more than £85 a week to service their debt. There are also large numbers of people approaching or in retirement with interest-only mortgages.

While the proportion of older people with debt has fallen over time, the amount owed by those in debt has increased substantially between 2002 and 2010.

The Money Advice Service has a fundamental role to play in delivering efficient and effective money advice, including debt advice, and is leading development of a national financial capability strategy. The Money Advice Service should ensure that money guidance and debt advice initiatives are targeted at older people and physically accessible. Age UK also wants to see funding for face-to-face and outreach services protected and focused on the most vulnerable.
A successful financial capability strategy should acknowledge that financial capability is needed throughout the whole of life and recognise the needs of older people at different life stages. Older people continue to experience change throughout their lives – and the needs of people in their late 50s are likely to be very different from those in their 80s and 90s. Financial capability in later life can also be adversely impacted by a range of external circumstances such as bereavement. Unexpected or unplanned events affect people of all ages, but for many older people these events are compounded by the barriers they face in accessing financial services. We are pleased that the Money Advice Service has decided to set out a specific strategy for the financial capability of older people.

Efforts to improve the financial capability of older people must be matched by efforts on behalf of industry to ensure their products and services are transparent and straightforward, and meet the needs of their customers, whatever their individual circumstances.

The Financial Services Commission also recognised the limits of financial capability and planning in an increasingly complex later life. Financial products and services must come with intelligent defaults which support good financial health. For example, we hope that the Financial Conduct Authority will take steps to end the default of low savings rates for those who are unable to shop around.

Planning for later life

Funded by Prudential, Age UK’s Planning for Later Life programme offers holistic information and advice to older people who need to plan for the future after experiencing a key life change. The programme is delivered by a number of local Age UKs and Age Cymru through a mixture of home visits, face-to-face contact at offices or outreach venues, and telephone contact.

As an example, one man, who had been living on a mobile home site, approached the local Age UK after moving into a care home. A volunteer was assigned to help him identify the issues and to help deal with a number of matters that included:

• reviewing his benefits
• changing arrangements for payment of his pension and setting up new direct debits
• supporting him at his financial assessment meeting with Social Services
• arranging for his phone to be disconnected
• paying final bills and re-directing his mail
• liaising with his local bank when they queried why his signature had changed, as a result of his deteriorating health
• ensuring that disposal of his car and mobile home would be dealt with by family members.
Feeling well, enjoying life
Public health is just as important for older people as for other age groups, and prevention even more so. Preventing poor health and health crises in older people should be a core aim for health and care services. Local communities should be designed and maintained to ensure long-term conditions and frailty are not a barrier to living well.

We are living longer and we are staying healthier for longer. People who live to 75 years can reasonably expect to live to 88 for a woman and 86 for a man. These numbers represent the great successes of medicine, public health, and improvements in standards of living over the past century.

However, our risk of living with one or more long-term conditions, such as dementia or arthritis, increases with age. For some of us, our physical ‘reserves’ which can help us respond to shocks or crises are lower, meaning a relatively minor event can have a huge impact on our health and wellbeing.

Traditionally, public services, community support and the places we live are built around waiting for the crisis to happen or by responding to problems in isolation rather than in a way that takes account of the whole of a person’s life. Older people’s ability to manage their health can be undermined by public health approaches and leisure facilities that act to exclude them.

Age UK believes that all of these factors need to be brought together to deliver a truly joined-up approach to health and wellbeing. As older people see wellbeing as a product of good physical, mental and social health and positive living and social spaces, local services must work towards maximising these factors in the round.

Note that this chapter covers health and care services in England only.

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Healthy ageing

Supporting people to live longer is only one part of the picture; we must be as focused on maintaining good health and wellbeing in the additional years many more of us are now living.

Lifelong healthy behaviours will always be the best foundation to protect against poor health in later life. Well-known inequalities in the number of years we can expect to live, both with and without disability, demonstrate that those people able to maintain good health have a healthier and longer later life. For example, women living in the most deprived areas live, on average, almost four years less than those living in the least deprived, but will live for two years longer with disability (and the gap is growing).

However, as well as protecting against serious conditions such as heart disease and cancer, we must also better account for quality of health in later life.

Public health messages should offer a more positive vision for later life and the steps you can take to improve health as you get older. In developing public health guidance, the National Institute for Health and Care Excellence (NICE) talks about successful ageing as ‘survival to an advanced age while maintaining physical and cognitive function, functional independence and a full and active life’. Recognising how this can be achieved across the life-course is crucial. Likewise, the benefits of maintaining, or even starting, healthy behaviours as we get older do not diminish. Stopping smoking, drinking sensibly, eating well and exercising are just as important in later life.

However, older drinkers are still more likely to drink on a regular basis than other age groups. In the 65+ age group, 24 per cent of men and 13 per cent of women report drinking alcohol five or more days per week, the highest of any age group (16 per cent and 9 per cent respectively all ages). Older people are more likely to be admitted to hospital or die from an alcohol related problem.

Older people find it increasingly difficult to take part in regular physical activity because of difficulties accessing forms of exercise, but research has also shown a lack of understanding of the positive impact of physical activity. We also know that a lack of awareness of the impact of poor diet can have an effect on physical and mental health. These issues all point to an absence of older people from public health messaging and programmes.

People over 75 are much less likely to report taking the minimum recommended levels of physical activity. In the 65–74 age group, only 19 per cent say they meet the minimum recommended level, dropping substantially in over 75s to 7 per cent.

SOME 66 PER CENT OF WOMEN AND 86 PER CENT OF MEN OVER 65 ARE EITHER OVERWEIGHT OR OBESE, AND DIABETES NOW AFFECTS 13 PER CENT OF WOMEN AND 20 PER CENT OF MEN OVER 75

How is the Government responding?

The Government recognises the importance of public health and wellbeing in later life and the Public Health Outcomes Framework, which sets out national priorities for public health, includes indicators on health-related quality of life for older people; reductions in hip fractures; and perception of community safety.

However, local authorities, who are now responsible for overseeing public health (it was the NHS up until April 2013), need to be more inclusive in their approach. Joint strategic needs assessments (JSNAs), the mechanism used to describe the state of local health need, have in the past concentrated on prevalence of health conditions among older people against availability of local services. While this is useful, such an approach should not dominate. Making sure wider public health initiatives are relevant and effective for older people is just as important, otherwise we risk simply medicalising wellbeing in later life.

In the face of local authority spending cuts, which have already created a huge gap in social care provision, it is also crucial that ring-fenced funding for their public health work is secure.

Figure 3.1 below shows that there are already 2 million people over 65 living with a disability. Without action, this could increase to over 4 million by 2041, with a significant knock-on impact on demand for care.

Figure 3.1
Projected population of older people with disabilities 2002 to 2041, Great Britain

<table>
<thead>
<tr>
<th>Year</th>
<th>People aged 65+</th>
<th>Older people with some disability</th>
<th>People aged 85+</th>
<th>Severely disabled older people</th>
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<td>12000</td>
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</tbody>
</table>

Source: PSSRU, March 2006, Discussion Paper 2330 Future Demand for Long-Term Care, 2002 to 2042: Projections of Demand for Long-Term Care for older people in England
Nutrition and hydration

Although malnutrition is both a cause and consequence of ill health, it’s often not recognised as a UK health problem. Malnutrition is usually defined by a low bodyweight, unintended weight loss or poor recent nutritional intake and older people are most at risk. Too many older people in care homes, hospitals and their own homes are not eating enough food or drinking enough fluid. An estimated 1.3 million people over 65 suffer from malnutrition, and the vast majority (93%) live in the community.1

Older people become more at risk because of various factors: being alone at home; eating alone; practical difficulties with shopping and cooking; poor oral health; depression; problems with memory; worries about getting to the loo; and being reliant on others for food and drink. Further complicating this picture, the impact of public health messaging around obesity may not be effective on two counts: rates of obesity in older people are very high while for some, concern about becoming overweight may be making malnutrition worse. NICE has identified better nutritional care as a significant potential source of cost savings to the NHS,2 and growing concerns over the quality and management of hospital food have triggered a Government review of standards, led by the Chairman of Age UK, Dianne Jeffrey CBE DL.

Public health bodies need to do more to raise awareness of the risks of malnutrition, how to recognise it, and where to seek help. Older people, families, friends and healthcare professionals all need to be made more aware of how to eat well. To help malnutrition gain a higher profile, a ministerial lead is needed to champion and monitor the work. This would be an important investment in keeping older people healthy and independent for longer.

The Malnutrition Prevention Programme

The Malnutrition Task Force is working on a two-year Malnutrition Prevention Programme funded by the Department of Health. The Programme will test out how whole communities can work together across settings and sectors to implement the five principles of good practice in nutrition and hydration care: raising awareness, working together, identifying older people at risk of malnutrition, supporting and treating them, and monitoring and evaluating individuals and initiatives.

For further information, please see www.malnutritiontaskforce.org.uk
Living well with health needs

Our risk of living with one or more long-term conditions increases as we age, affecting about 70 per cent of people over 75. How we organise society around this fact is vitally important to achieving the best possible quality of life. However, this is only part of the picture in securing better wellbeing in later life.

Frailty

The Secretary of State for Health singled out care for ‘our most frail and vulnerable older people’ as part of his key themes for 2014. Recognising that older people living with frailty require a joined-up approach to their care is a vital ambition for health and care services. But what does living with frailty actually mean and what is the right response?

There is no agreed definition of frailty in a health context. Health professionals often use it to characterise a wide range of people, particularly the oldest old, or just as shorthand for an older person presenting with complex needs. Carers and family members have said they notice a change in their friend or relative as that person gets older, which they may think of as a kind of ‘encroaching’ frailty, whether it’s slowing down or having trouble handling money. Some may see frailty as the reason someone enters a care home or requires longer-term nursing support.

Among care professionals who specialise in older people, there is more of a consensus. Frailty can broadly be characterised as a kind of ‘encroaching’ frailty, whether it’s slowing down or having trouble handling money. Some may see frailty as the reason someone enters a care home or requires longer-term nursing support.

What does this mean for older people?

To start with, identifying people with frailty is crucial – although risk of frailty increases with age, age is not the only factor. Frailty is not ageing. Identification is necessary because older people living with frailty can respond very poorly to even minor changes to their physical and mental health, their environment and/or their social circumstances. Second, we must establish the extent and impact of a person’s frailty. It exists on a spectrum, which could stretch from being otherwise active and well to being at the end of life. Thirdly, incorporating this information into how care is planned, what services are provided, and what their personal circumstances are will help to deliver better outcomes from care, but, most importantly, maximise their wellbeing.

Important, within all of these steps, it is vital that care and support is not static. Adapting to changing needs and enabling older people and their carers to constantly negotiate what works for them at any particular point in time should be a core part of their care. Equally, other parts of their life such as housing, local amenities, and public spaces must be available with this flexibility in mind.

This process does not typically happen and as a result, people living with frailty are often those behind the stories on avoidable admissions to and long stays in hospital; on the growth in readmissions after they are discharged; and poor end of life care.

In a report published in 2014 by Age UK and Ipsos MORI, the experience of living with frailty was investigated in depth. Some of the key insights included:

- Frailty was not a term older people related to themselves, suggesting that it could be alienating when used by health and care professionals.
- A willingness to adapt to changing needs supported good wellbeing.
- Even in a small sample, the needs and circumstances of participants were very different, highlighting the importance of personalised solutions.
- Loneliness was a serious and sometimes pervasive issue.
- Planning and creating work-arounds significantly enhanced the experience and outlook of people living with frailty.

How is the Government responding?

This year, the Department of Health and NHS England launched the Transforming Primary Care programme, an initiative originally conceived as the ‘vulnerable older people’s plan’. It guaranteed a ‘named GP’ for all people over 75, so people are clear who is responsible for their care, and offered extra support for the people with the most complex needs. And NHS England this year published practical guidance on getting services right for ‘safe, compassionate care for frail older people’.

These are both very welcome. At the moment, the provisions for Transforming Primary Care are only in place for one year and are expected to help about 2 per cent of people registered at a GP surgery. If this is to be truly transformative, there must be a long-term commitment to seeing this approach embedded in everyone’s care. This will mean not only making sure existing services are more joined-up and person-centred, but also that the skills and expertise are in place to make it effective. Knowledge and skills in older people’s and end-of-life care remain inadequate and without this, incentivising GPs to identify people and plan their care risks being simply a paper exercise.

This is not only a concern for health services. Improvements in primary care could be undermined by ongoing cuts to social care and poor housing, for example. A participant in our research on frailty had been waiting seven months for an adaptation to her house. In the meantime, she was forced to live in one room of her house, her mental wellbeing deteriorating. People living with frailty often have to wait until their care is a crisis before something is done. Maintaining and enhancing quality of life must be a guiding principle. Health and care services need to incorporate complexity and risk into how they work. They should not be used to write people off or as a reason to accept poor quality outcomes.
Loneliness

Living with frailty can be associated with loneliness, but it is in fact a much more persistent problem across older age and particularly in the oldest old.

Though you can’t have a completely objective definition of loneliness, it can usefully be seen as a subjective feeling of loss or lack of something needed by an individual. A recent CentreForum report on loneliness sought to define it as a ‘feeling of not having the desired quantity and quality of relationships’.

Importantly, loneliness is not the same as social isolation, despite the fact they are often talked about in the same breath. Rates of loneliness can be high in communal settings such as care homes and can be low in some physically isolated, rural areas.

Some of the older people involved in our research on frailty were, on occasions, surrounded by family, yet there was still a qualitative feeling of loss for peer relationships, for example. As such, loneliness itself is the problem as opposed to isolation or lack of social contact. This is a crucial distinction.

Apart from the often severe impact on general wellbeing, the prevalence and impact of loneliness is often underestimated, particularly in the oldest old. One in ten people aged 65+ in the UK say they are always or often feel lonely, an increase on the figures from 2013. It is difficult to tell whether this increase arises because loneliness is actually growing, or because people are more willing to identify themselves as lonely.

The health impact is becoming better understood. Research has indicated that among the health effects are lower immunity to disease, 50 per cent higher risk of death and a greater need for health services including GPs and A&E. One study put the health effect as equivalent to 15 cigarettes a day. Loneliness is not only having a profound effect on the quality of life of many older people, it also has serious implications for their physical and mental health.

Loneliness is not an inevitable part of ageing, though you are more likely to experience a range of risk factors. These include loss of spouses and loved ones; major life changes such as retirement; loss of mobility and increasingly poor health. It is the cumulative effect of such factors rather than being a consequence of getting older.

Call in time

Barbara from Devon was not coping on her own after suffering a double tragedy. Barbara was referred to Age UK’s ‘Call in Time’ telephone befriending service by social services, through which, she was partnered up with her own befriender, Mel. ‘The Call in Time service has helped me dramatically, because I know that a call is coming. If I’m upset I’ve got someone to talk to me, and if I’m happy I’ve got someone to share that with. (As) time passes, I’m feeling much better, but I couldn’t have coped without the support I got from the Call in Time team.’
Tackling loneliness

Loneliness cannot always be prevented, but it is important that the impact is reduced as far as possible. Improving the availability and quality of social contact should be seen as a basic expectation of the communities that older people are living in. However, it is important to find out what people like doing and help them to do it, not just assume they want to be with people of their own age with whom they may have nothing else in common. Communities should work with local government, across the generations, to foster informal networks and to develop age-friendly neighbourhoods that enable older people to participate on their own terms.

Older people experiencing loneliness may be in frequent contact with public services. Putting in place practical support alongside such services, would help to identify the people that are lonely but in plain sight. Training for care staff that helps them to acknowledge and record that someone is lonely or at risk of loneliness would be an important step in achieving this.

Given there is no one root cause of loneliness and everyone is different means that dealing with loneliness must take in a range of approaches. According to the Campaign to End Loneliness, health and wellbeing boards (HWBs) do not so far appear to be taking a sufficiently robust approach to tackling loneliness. Only 7 per cent have a strategy that includes measurable actions or targets for tackling loneliness in older people. With a broad remit for local health and the opportunity to look across service boundaries, HWBs should do more to both assess the level of need in their areas, and to plan a holistic response from all parts of health, care and civic services.

Losing thinking skills is something older people fear most about later old age.

Dementia has long been seen as a bigger concern for people over 55 than a cancer diagnosis, perhaps in part explaining why only 42 per cent of people with dementia in England have a diagnosis. It is estimated to affect 800,000 people in the UK and to account for around £23 billion of costs.

Such figures are well-known in health and care policy circles, but while they illustrate the scope of the challenge, they do not show the impact on lives. And even then, the impact of the symptoms – memory loss, confusion etc – exists alongside the impact of society’s response to dementia. Like any long-term condition, truly meeting the challenge of dementia is not just about finding a way to stop it happening. It is about managing the condition so that people are able to live well with dementia.

What is dementia?

Dementia usually refers to a number of conditions that affect brain function, and symptoms such as problems with memory and difficulty carrying out simple tasks. The most common condition is Alzheimer’s disease and others, including vascular dementia, are linked with poor cardio-vascular health.

What can be misunderstood is that cognitive health is very much on a spectrum. For example, normal cognitive ageing through to mild cognitive impairment can give cause to similar symptoms to those associated with dementia. Work carried out by the Age UK-funded Disconnected Mind project shows that lifetime cognitive abilities can be very consistent, which could mean that what are perceived as age-related changes have been there all along, though perhaps not previously seen as a problem.

Acute confusion and delirium are also very common. This can happen, for example, when an older person’s body is under stress, perhaps during health treatment or because of an infection. People will usually recover from delirium, either on their own or following treatment, but it is important not to confuse it with dementia.

Though there is a huge problem with under-diagnosis, with a variety of reasons for similar symptoms it is not surprising people can feel so fearful of developing dementia. This similarly highlights the importance of awareness and understanding among health and care professionals, not just of dementia, but also ageing more generally.

Unfortunately, evidence continues to show that this is still very poor. The second National Audit of Dementia revealed that 41 per cent of hospitals do not include dementia awareness training in their staff inductions, and only 36 per cent have a care pathway in place for people with dementia. This is despite one-quarter of hospital beds being occupied by someone with dementia.
The spectrum of needs and impact extends just as clearly into living with dementia. Though there are common symptoms – forgetfulness, changes in personality and mood, having difficulty following what people are saying to you – they can manifest in many different ways and will not be precisely the same for two people. Similarly, the severity and trajectory will vary – not everyone will need intense support even after living with dementia for a number of years while others may need to move into a care home relatively quickly (where two-thirds of residents live with dementia).xxvi

This points very clearly to the need to find the right solutions for individuals and their carers, solutions not just for health problems but for all parts of a person’s life.

**A global reality**
The number of people with dementia worldwide is estimated at 44 million and numbers are set to increase dramatically over the next 40 years, reaching 135 million by 2050. More than two-thirds of people currently living with dementia are in low and middle income countries.xxx Despite the high prevalence of dementia in developing countries, there is a distinct lack of awareness that it is a challenge. In many cases, dementia goes undiagnosed.

**The Suffolk Dementia Partnership**
Age UK Suffolk, the Alzheimer’s Society, Suffolk Family Carers and Sue Ryder Care have developed services to give information, advice and guidance to people, and their family carers, throughout the course of their dementia. They offer the Suffolk Dementia Helpline which provides a ‘listening ear’ and answers questions on the condition; Dementia Advisers who will arrange a time to visit people and offer information and advice tailored to their own situation; and local community support, aiming to work with local people to provide a better understanding of what it means to live with dementia and raise awareness.

Changing demographics in many countries mean that traditional family-based care may not be possible. Even where informal help is available, older people with dementia have specific needs that require the assistance of specially trained professionals. In low and middle income countries there are very few geriatric staff available to provide this level of care and support.

There is also a stigma attached to those living with dementia in many developing countries. Cognitive decline makes older people vulnerable with dementia in many developing countries. There is also a stigma attached to those living with dementia. Failing to do so is arguably an ongoing human rights crisis that is only just starting to be fully acknowledged.

**The Prime Minister’s Dementia Challenge in 2012 and the G8 dementia summit declaration in 2013 are important commitments in tackling the challenges facing people with dementia. The former set out to improve health and care services, create dementia-friendly communities and improve dementia research, while the latter focuses heavily on finding a cure or more powerful treatment by 2025.**

The Department of Health has started to implement elements of these commitments into its mandate to NHS England, demanding that rates of diagnosis be improved by 2015. Improvements to timely diagnosis are extremely important, but NHS England must be confident of local NHS services to carry this out effectively. There are already issues with misdiagnosis of depression as dementiaxxxviii (and vice versa) and fewer than half of GPs said they have received sufficient training.xxxix

It is also crucial that the other conditions a person is living with are not forgotten. As the risk of dementia increases with age, so does the chance of living with one or more long-term conditions. Poor management of, for example, arthritis pain could exacerbate distress and difficult behaviour for a person with dementia. Supporting the whole person must mean identifying their specific needs and planning care around their lifestyle and to goals discussed with them and their carers.

This approach is not unique to dementia. It will mean better planning, joined-up care, and access to low-level, but essential, support such as assistance with day-to-day tasks. However, dementia must not be the only gateway to such support and care, and the development of new approaches must be adaptable across other areas such as people living with frailty.

Getting the diagnosis at the right time, with the right support to back it up, improving care of dementia in hospital and care homes, supporting carers, and making sure our communities are dementia-friendly are essential steps in improving the lives of people with dementia. Failing to do so is arguably an ongoing human rights crisis that is only just starting to be fully acknowledged.
High quality health and care
Older people must be able to expect high quality health and care services that are co-ordinated and joined-up around their needs and circumstances.

This chapter looks at both health and social care, reflecting a widespread view that these two areas should be integrated. However, there are structural barriers to achieving this goal, not least that NHS care is free whereas social care is means tested. In reality, the care system goes far beyond NHS and local authority provision, to include services that are not specifically targeted at people with care needs, such as housing and community and volunteer support. However, the largest component in the system is the contribution made by family members and others as unpaid carers, and by older people themselves.

Demographic change means we are seeing a substantial increase in the numbers of people aged 85+, the group most likely to need care and support. The Care Act 2014 is a landmark piece of legislation which does much to improve the social care framework. However, the Act does nothing to plug the enormous and growing gap between provision and need.

The focus of NHS care will increasingly become support for people with long-term conditions rather than short-term interventions for people with urgent or acute health needs, but this is unlikely to compensate for cuts to local authority care and support. We are faced with a scenario where local authority support is restricted to older people who are at imminent risk of losing their independence, while NHS support is intended to reduce or delay hospital admission. This means that people who are not at immediate risk but need care and support to have a tolerable quality of life increasingly have to do without.

Note that this chapter covers health and care services in England only.

Overview

Priorities

- Age UK is looking to all political parties to face the reality of the crisis in care funding and agree a long-term consensus on the role of state-funded care.

- Integration should not just mean closer working between the NHS and local authorities. It must also include housing, the development of supportive communities, and respect and support for the contributions that families, carers and older people themselves make.

- Eligibility for care and support must not be restricted to help to meet basic personal care needs; it must also include the support needed to achieve an acceptable quality of life.

- NHS and care and support ‘cultures’ need to converge, through better understanding of personalisation and more NHS focus on earlier intervention to support people to live well with long-term conditions.

- The increasing prevalence of dementia is a major challenge. Training staff to work with people with dementia should be a much higher priority.

- Cuts to social care should not put increased pressure on carers. Carers should be supported to remain healthy and economically active and to have an acceptable quality of life.
A new framework for care

The Care Act 2014 represents the most thorough reform of care legislation since 1948.

The Act stems from a Law Commission review that was intended to consolidate all existing legislation, but also contains some very significant new developments. These include:

• Implementation of a new system for paying for care, derived from the recommendations of the Dilnot Commission on Long Term Care Funding. This includes a national scheme that will enable home owners to defer paying for care until their home is sold following their death.
• A national system of assessment and eligibility for care and support to replace current local eligibility criteria.
• For the first time in England local authorities will have duties to safeguard adults who are at risk of abuse and neglect.
• Local authorities will be required to provide advice and information, including to people who fund and arrange their own care.
• Local authorities will have duties to manage local care markets to ensure that people – again including those who fund and arrange their own care – have a range of good quality services to choose from.

Most of the detail of this huge reform agenda is not in the Act but will be contained in subsequent regulations and guidance, so a priority for Age UK is to work to ensure that regulations and guidance result in people having clear and coherent rights and entitlements.

The Act will be implemented in the context of another great shift in the care and support system, caused by massive cuts to government funding. Government policy, as set out in the 2012 Caring for Our Futures white paper, is to place greater reliance on the capabilities of individuals, families and communities to provide support, in order to reduce demand for state provision. Recognition of the abilities of older people with long-term conditions and of the role of families and communities is welcome. However in Age UK’s view there are three limitations to this approach.

• Support by families and communities is already the largest component of the care and support system so there is not necessarily unused capacity to compensate for cuts.
• Care and support for people with dementia and/multiple long-term health conditions often requires specialised training and skills.
• Changing family structures will mean that there are more older people with no living relatives; more widely dispersed families; or relatives who are themselves older people and limited in the care they can provide.

Age UK is therefore unequivocal in arguing for the need for increased funding for care and support services. However, care needs in later life are unpredictable and may result in ruinous expenditure for individuals. The market has not stepped in to provide insurance products to enable people to pool these risks and we do not believe that this is likely to change in the short term, so at least some of these additional resources will need to come from the state. Successive governments must, as a matter of urgency, face this reality and agree a long-term consensus on the long-term role of state-funded care. Only then can individuals and families plan realistically to meet future needs.

Without significant additional funding, it is difficult to see a way forward for service provision which doesn’t seriously endanger the dignity, health and safety of older people who need support.

Wellbeing

An essential question that underpins the provision of care and support is ‘what is the system aiming to achieve?’. The Care Act 2014 answers this question by requiring that local authority social services functions should be undertaken with the aim of promoting individual wellbeing. Wellbeing includes dignity, physical and mental health and emotional wellbeing, protection from abuse and neglect, and control over everyday life. The Act also goes beyond ‘care’ outcomes to require local authorities to take account of the person’s need to live a normal life, including factors such as participation in work, education and recreation, family and personal relationships, suitable living accommodation, and individual contribution to society.

The inclusion of dignity as an aspect of wellbeing is particularly important as it recognises the significance of treating an individual with humanity, in a way that they wish to be treated. Unfortunately, the reality of care and support often falls below these essential requirements.

The Care Act introduces a new national minimum level of eligibility for state-funded social care from 2016 to replace the current system based on local eligibility criteria (though local authorities can be more generous than required by the national criteria if they wish). Whether the national criteria support or undermine the wellbeing principle will be one of the most important issues that will determine how well the Act works in practice.

Improving care

Poor quality care is never acceptable, but it is often only when poor care amounts to abuse and neglect that it becomes a matter of public concern. In recent years, there have been a number of well-publicised examples of poor care in the NHS, in care homes and in people’s own homes. Many examples of poor care can be attributed to underfunding, insufficient staff numbers, or lack of staff training. However the difference between a good care service and a bad one is often down to more intangible factors which can be described as the ‘culture’ of an organisation. Care settings that are cut off from the outside world are prone to developing organisational cultures in which the unacceptable becomes regarded as normal. This is a theme of several investigations into unacceptable care, notably the Francis report on abuse in Mid Staffordshire NHS Foundation Trust.
In Age UK’s view there are a number of factors that can drive improvement:

• Leadership is vital, so first line managers (for example care home managers) should be better valued and trained.
• Care settings should never be closed off from the outside world – residents should be supported to have contacts outside the home, and volunteers, friends and family should be encouraged to contribute to the life of the home.
• Patients and service users should be supported to be able to speak out against poor care.
• Residents should not have to abandon their status as citizens with rights when they enter a care home. They should be protected by the Human Rights Act and should have security of tenure so that they do not face the threat of eviction if they complain about poor care.
• Staff should receive training in respecting the dignity and human rights of residents. Regulators and local authority commissioners should take account of the extent to which service providers respect individual rights.
• Regulators and commissioners need to guard against accepting poor practice because it is seen as the norm. ‘Experts by experience’ (lay inspectors) can bring a fresh perspective.
• Professional regulation, standards and ethics should be focussed on respect for the human rights and other rights of service users. The Law Commission intends to publish a draft bill later this year, following its review of professional regulation in health and social care.

Dignity in care
The Partnership for Dignity in Care (which was established by Age UK in association with the NHS Confederation and the Local Government Association) has been funded by the Burdett Trust for Nursing to work with a number of NHS Trusts to develop better professional practice in supporting patients to have a voice in their treatment. This includes supporting nurses and older people to break down the cultural, practical and emotional barriers to listening to patients.

RESIDENTS SHOULD NOT HAVE TO ABANDON THEIR STATUS AS CITIZENS WITH RIGHTS WHEN THEY ENTER A CARE HOME. THEY SHOULD BE PROTECTED BY THE HUMAN RIGHTS ACT
Care in crisis

Our immediate concern remains the chronic underfunding of the current care and support system. This underfunding has been acknowledged to a certain extent by the Government, and in 2013 we welcomed its transfer of £3.8 billion from the NHS for joint NHS and local council projects (the Better Care Fund). Encouraging joint working will go some way to tackle the crisis, but it does little to mitigate the cumulative effect of severe underfunding.

In fact, the strain we reported last year has continued unabated. Councils are continuing to experience an increase in demand for support services, to the extent that care and support demand an increasing proportion of their overall budget (up from 34 per cent in 2012/13 to over 40 per cent in 2013/14). However, the actual spend continued to decrease by an average of 20 per cent from 2011/12 to 2013/14, showing that real-terms funding is scarce. As shown by Figure 4.1, the knock-on effect is to increasingly restrict services to those with the most intense needs, push more caring responsibilities towards family carers, and increase charges for the services that are available.

From 2010/11 to 2013/14, public funding for older people’s social care reduced by 10% in real terms. The trend in recent years has been to tighten eligibility criteria and 87.5 per cent of councils now provide support only to those with substantial or critical needs. The Government must take a serious look at this – those regarded as having moderate needs face daily pressures on their independence. Age UK is calling for the Government to introduce its national eligibility criteria threshold at a level equivalent to the current ‘moderate’ threshold.

Shunting the care burden downstream obscures the quiet crisis many families face. A recent IPPR report highlighted that informal family care cannot keep up with the demand from older people and demand will outstrip supply as early as 2017.

The personal effect of these funding pressures is on the older people who need help today. Unmet need continues to grow, with a steady decline in the number of people accessing help from their local authority, which, set against the growing numbers of older people implies a smaller proportion receive support. And those whose needs are high enough to qualify for state support pay a hefty price – in the last three years alone average fees and charges have increased by more than 16 per cent.

From 2005/6 to 2012/13, the number of people using day care services has nearly halved, and those receiving home care are down by more than a fifth, despite the growth in the number of older people likely to need these services over that seven-year period.
Older people who need help to remain independent should be able to draw on a number of resources, including families, communities, care services, the NHS, and mainstream community or housing services. The challenge is to ensure that potential sources of support work together in an integrated way.

‘Integration’ has emerged as one of the main priorities for the care system. However, the term is not always used consistently and does not always include all potential forms of support. This can mean that strategies for integration overlook vital parts of the system, such as a safer and more accessible environment.

Integration between health and social care and integration within the NHS have been particular government priorities. The Health and Social Care Act 2012 included duties on clinical commissioning groups (CCGs) and NHS England to promote integrated working. In the first ‘Mandate’ to NHS England, which sets out the Government’s priorities for the NHS, integration is one of four key areas where particular progress is expected. Similar provisions are included in the Care Bill. In June 2013, the Government earmarked £3.8 billion, later called the Better Care Fund, to support health and social care services to work together.

However, as a recent report by the King’s Fund points out, there are very real structural barriers to integration. The NHS is supposed to be a universal service whereas care services are restricted by eligibility criteria and means testing. The NHS is funded nationally whereas care services are funded by local authorities. The NHS and local authorities have separate systems for commissioning services. Age UK also sees a fourth structural barrier: different professional values and assumptions as a result of the traditional NHS focus on intervening to effect a cure (rather than supporting people to live well with long-term conditions). The advance of ‘personalisation’ as an organising principle for care and support has struggled to get a foothold in the NHS which, on the whole, remains structured around treating individual conditions or acute and emergency needs.

Ultimately, integration is likely to be about cultural change rather than structural reform. Age UK’s view is that better co-ordination of care for individuals relies to a large extent on the willingness and ability of professionals to adopt a person-centred approach, and ensure effective communication across service boundaries. This should be a cornerstone of professional education and training and workforce development. The NHS and local authorities should recognise the expertise patients, service users and carers bring to commissioning and service design. Both of these priorities entail the extension of personalisation to the NHS.

Age UK’s integrated care programme

Too many older people with multiple long-term conditions are not getting the personalised, integrated care and support they need to live full lives at home and to sustain their independence for as long as possible.

Age UK is working to bring together voluntary organisations and health and care services in local areas to provide people in this position with an innovative combination of medical and non-medical support.

Through the programme Age UK staff become members of primary care led multi-disciplinary teams. The pathfinder for the programme has been underway in Cornwall since 2012. Age UK Cornwall and the Isles of Scilly is a member of the local partnership that forms one of the Government’s 14 Integrated Care Pioneers; the early results are highly promising and the programme currently holds the Health Services Journal national award for managing long-term conditions.

Integrated care in practice

Mr K is living with angina, dementia and suffers a lot of pain in his shoulders and one of his legs, which left him housebound for a number of years. His wife struggled to care for her husband and was in desperate need for some help. Working with the Age UK integrated care programme, Mr K identified that his main goal was to take his dog out for a walk, but due to his lack of mobility and anxiety about leaving the house, both Mr K and his wife were convinced this would be unachievable. With coaching, Mr K’s confidence and ability to stand grew and he is now able to go on walks with his dog. Using a ball thrower, he threw a ball for the first time in years.
Older people are the largest users of health services, representing two-thirds of NHS users.\textsuperscript{xi}

Some 65 per cent of all admissions to hospitals are people aged 65+ and because, on average, they stay longer, they make up around 70 per cent of bed days.\textsuperscript{xii} While in hospital, older people are more likely to be moved multiple times, affecting the length of stay and their experience of care,\textsuperscript{xiii} and can be faced with the attitude that they should not be using up a hospital bed.\textsuperscript{xiv} Staff may assume they cannot cope at home, when in fact there are more serious underlying problems which are not being picked up. One study revealed that of the people admitted to A&E with ‘acopia’ (a pejorative term used in hospitals to describe patients who are unable to cope with activities of daily living), almost 30 per cent actually had sepsis.\textsuperscript{xv} A combination of poor discharge planning, a lack of community support, and poor handover from hospital to primary (GP) care have contributed to increasing emergency readmissions of older people who had previously been discharged.

Research demonstrates that older people have poorer access to treatments for common health conditions. Treatment rates drop disproportionately for people aged 70–75 years in areas such as surgery,\textsuperscript{xvi} chemotherapy,\textsuperscript{xvii} and talking therapies.\textsuperscript{xviii} In spite of these inequalities and the proportion of NHS users who are older, medical undergraduates receive, on average, only 55 hours of geriatric training in five years.\textsuperscript{xix} The Government has acknowledged that it is vulnerable older people for whom the NHS is not providing effective services.\textsuperscript{xx}

Such failures exist in a society that is rapidly ageing and where long-term conditions are becoming ever more prevalent. The number of people aged 85+ is set to treble in the next 30 years.\textsuperscript{xxi} The number of people with dementia is predicted to rise from 800,000 to 1 million by 2025.\textsuperscript{xxii} These factors present challenges that the NHS has for a long time failed to address, making significant changes ever more urgent.

The Government’s Transforming Primary Care programme, launched in April 2014, has begun to give shape to what a different way of working could look like. Identifying people at risk and planning care to avoid crises and admissions to hospital, the backbone of the programme, is a laudable aim. However, the programme is currently only funded for one year and is aimed at the 2 per cent with the most complex needs. To achieve the long-term transformational change required, the Government and the health service will need to be much more ambitious.
Time to change
The need for transformational change is given additional urgency by a very challenging financial backdrop. The King’s Fund published a report in May 2014 that said ‘on its current trajectory, the health and social care system in England is rapidly heading towards a major crisis’, suggesting that 2015/16 could be a ‘financial cliff edge’ where the costs to run the NHS outstrip the funding available. The NHS remains primed to spend a significant amount of its budget in secondary care, typically hospitals. Yet even here, a large proportion of hospitals cannot balance their books, and demands to move money into community care through the Better Care Fund, for example, will make it increasingly difficult to make ends meet. Hospitals will always play a vital role in NHS and care services. However, proactive and coordinated care must come to be seen as just as, if not more, important. Health and wellbeing services must exist across a spectrum: healthy ageing; support to self-manage and live well with long-term conditions; investment in primary and community services to avoid crisis and deterioration; and responsive urgent and emergency care services when people need them.

The NHS persists in compressing itself around the final, and often most expensive, factor above. Making this transition against a tough financial climate and alongside heavy cuts to NHS and care services. However, proactive and coordinated care must come to be seen as just as, if not more, important. Health and wellbeing services must exist across a spectrum: healthy ageing; support to self-manage and live well with long-term conditions; investment in primary and community services to avoid crisis and deterioration; and responsive urgent and emergency care services when people need them. Hospitals will always play a vital role in NHS and care services. However, proactive and coordinated care must come to be seen as just as, if not more, important. Health and wellbeing services must exist across a spectrum: healthy ageing; support to self-manage and live well with long-term conditions; investment in primary and community services to avoid crisis and deterioration; and responsive urgent and emergency care services when people need them. The NHS persists in compressing itself around the final, and often most expensive, factor above. Making this transition against a tough financial climate and alongside heavy cuts to social care is going to be incredibly difficult. Making this transition against a tough financial climate and alongside heavy cuts to social care is going to be incredibly difficult.

Quality health and care is an international priority
The increasing number of older people worldwide, the fact that people are living longer and the rapid pace of change in many countries all mean that there is a growing need for quality health and care services anywhere in the world.

The experience of managing chronic conditions over long periods of time is commonplace in many developing countries. The World Health Organisation estimates that even in the poorest countries the biggest killers of older people are non-communicable diseases (NCDs): heart disease, stroke and chronic lung disease. The greatest causes of disability are visual impairment, dementia, hearing loss and osteoarthritis. The number of older people who are no longer able to look after themselves in developing countries is forecast to quadruple by 2050. These changes are putting enormous pressure on governments in many developing countries that are struggling to manage multiple priorities with very little resources. Economic and social changes are also calling into question the ability of traditional family structures and traditions to look after the needs of the increasing numbers of older people. This is leading to increased reliance on the private sector in some countries with little or no quality assurance standards or supervision.

No matter what the context, simple interventions can make a difference. A good starting point is introducing better training for health professionals in developing countries on understanding the specific health and care needs of older people. Tackling non-communicable diseases, including making available prevention and treatment to older people, would significantly improve the health of people in later life. It is also important to recognise the economic and social benefits low-cost treatments for conditions such as hypertension can bring.

Carers
There are 6.4 million carers in the United Kingdom, and Carers UK estimate that they provide care worth £119 billion a year.

The peak age for caring is 50–59, and almost half of carers are aged 50+. The number of carers aged over 65 is increasing more rapidly than the general population, so existing statistics, which came from the 2011 Census, may already underestimate the number of older carers, particularly as older carers do not always identify themselves as such. It is this enormous contribution, rather than state-provided services, that is the mainstay of the care and support system.

Caring can, however, be the cause of serious disadvantage in later life. Older carers may be affected by the impact of caring on their physical and mental health, income and leisure time. Caring at a younger age can affect income, pension accumulation and the development of social networks, resulting in disadvantage in later life.

Carers are entitled to have an assessment of their needs by a local authority but it is only with the implementation of the Care Act 2014 that there will be a right to support to meet needs identified by assessment. This is very welcome but it must be clear that this is not limited to support that enables carers to continue in their caring role – it must also enable them to achieve an acceptable quality of life based on the Care Act definition of wellbeing. It is also important that assessment of a disabled person does not assume that the person does not have needs because a carer is present. Instead, the needs should be recorded and the contribution that the carer is willing and able to make towards meeting those needs should be shown in the care plan.

It would be a backward step if proposals for the transformation and future funding of social care, or pressures on local authority funding, were to place increased demands on carers. Instead, Age UK wants to see strategies aimed at promoting the mental and physical health of carers, with indicators for evaluating the success of such policies.
Comfort and safety at home
Older people should be able to live safely and with dignity in good quality, warm housing that meets their individual needs, free from exploitation or abuse.

Overview

Where we live often determines the ability of an older person to live healthy, active and independent lives, yet it still doesn't get the priority it deserves. Too many people in later life are living in poor-quality, cold homes at great detriment to their health and struggle to maintain and adapt their homes. Older people also continue to targeted by scams, often in the place they should be safest – their own home.

The major flooding in the UK over the winter of 2013/14 also brought close to home the need to ensure that, both in the UK and globally, older people who are affected by disasters and emergencies receive the longer-term support they need to remain secure and rebuild their lives.

Note that aspects of housing and energy policy are the responsibility of devolved administrations. This chapter focuses on policy in England.

Priorities

⇒ A national strategy is needed to increase the supply of suitable affordable housing designed for older people, to boost local housing markets and benefit all generations.

⇒ The Government should improve the speed, efficiency and availability of home adaptations with continued support for Disabled Facilities Grant, within the Better Care fund – an essential source of help for vulnerable older people.

⇒ Housing agencies should work together with health organisations to ensure that housing support services are in a position to help deliver the Government’s health and social care objectives.

⇒ Older people must have access to expert housing advice, to help them obtain integrated packages of health and care support that give their housing preferences full consideration.

⇒ We need to see far greater investment in improving the energy efficiency of homes as a longer term solution to address fuel poverty.

⇒ More concerted action is needed to protect older people against scammers, and there should also be a National Task Force to tackle financial abuse.
Housing plays a critical role in promoting the health and wellbeing of older people, for example, cold, badly insulated homes are at the root of many winter deaths.

The Care Act 2014 recognises this role and places a duty on local authorities to include housing as part of integrated health and social care provision, including a requirement to consult with social housing providers. These duties are welcome, but present a challenge for local authorities who are under pressure to deal with immediate and acute needs. They need sufficient resources to adopt a longer-term strategic approach to cost-effective housing services that promote independence. An important component of the Supporting People programme has been the delivery of housing support services in both sheltered and ordinary housing, but many authorities have reduced their funding for this.

We are expecting Department of Health guidance on service integration which will cover the delivery of housing and related support services. As part of this, the Government needs to extend local authority funding under the Supporting People programme (totalling £1.59 billion) beyond 2014/15, to deliver integrated and preventative housing services – proven to work for older people.

The Government allocated £3.8 billion under its Better Care Fund programme to encourage an integrated approach to services. There are concerns over whether local commissioning strategies will incorporate housing. It is vital that health and wellbeing boards and Clinical Commissioning Groups (CCGs) understand the difference housing can make to the health and independence of older people. Housing agencies need to actively engage with health organisations to raise awareness of the value and importance of their services.

Older people need a wider range of housing options, as well as better access standards in all mainstream housing, faster and easier routes to obtain adaptations and repairs, and more specialist housing that is better regulated.

Over the last year there has been continued debate over whether sheltered and retirement housing could offer a better alternative to mainstream housing for older people. Ninety per cent of older people live in ordinary mainstream housing but recent research found that 58 per cent of people over 60 were interested in moving and that 25 per cent were interested in buying a retirement property.

However the ‘mainstream vs specialist’ debate is only part of the picture and risks obscuring many other ways of improving housing for older people. The ability to consider retirement housing is determined by where you live and the value of your existing property. Recently, inequalities in housing wealth and its impact on the choices available to older people, have gained much greater attention. This has focused on house price inflation and disproportionate increases in London and the South East. Despite greater potential to release equity in older people homes, housing wealth is not evenly spread across income groups and as Figure 5.1 shows, nearly a quarter of older people do not own their homes. This means that in some regions the choices open to older owners are very limited. They lack the resources to consider retirement housing and struggle to maintain or adapt their existing home.

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**Figure 5.1**

Housing tenure for people aged 65+ in England, 2012/13

- 72% own outright
- 10% buying with mortgage
- 8% private renters
- 5% local authority renters
- 5% housing association renters

Source: English Housing Survey, DCLG 2013
Adaptations to help people to stay at home
Supporting older people to live at home requires help with installing basic home adaptations and equipment, as well as new forms of assistive technology. Ongoing advances in telecare and telehealth are increasing the housing choices available to older people. Remote monitoring and alarms can allow a more flexible approach to care that can particularly benefit those experiencing dementia or cognitive impairment. Some local authorities are bringing independent living services together in a ‘one stop shop’ approach, making it easier for older people and their families to get the range of help they need.

In 2012, the Papworth Trust found that of the 326 Local Authorities which received Disabled Facilities Grant funding, 62 had stopped providing Home Improvement Agency (HIA) services altogether.7 Despite the widespread recognition of their value, adaptation services continue to see cuts, and help with minor repairs and adaptations is a particular problem in isolated rural areas. This situation is counter-productive and costly. It is essential that help for adaptations, currently available through the Disabled Facilities Grant, is maintained under the Better Care Fund and local authorities are encouraged to adopt best practice. The alternative is more older people remaining longer in hospital or having to move into residential care at a higher cost. The House of Lords committee report Ready for Ageing8 called for universal access to repairs and adaptations and said that older people’s housing needs should be given greater priority.

Lifetime homes
Age UK has long argued for the implementation of the Lifetime Homes Standard (a set of basic design features to make new homes more accessible);9 and there is some positive news. The Government intends to implement a new ‘level two’ standard likely to be based on the lifetime homes standard.10 However, this will be left to the discretion of local authorities and is a fundamental shift away from the principle of ensuring that all new homes comply with the higher ‘lifetime homes standard’. Progress on this issue is still vitally important as it will influence whether new modern homes will meet the needs of an ageing population.

Better retirement housing
Age UK supports the need for more retirement housing, but believes the sector is poorly regulated and offers poor financial transparency for prospective residents and their families. When problems do arise for residents, they are not given sufficient support to exercise their legal rights.

In 2013, the Office of Fair Trading (OFT) published the results of an investigation into the unfair charging of fees for selling or sub-letting a retirement property, usually referred to as exit fees. This resulted in concessions from providers, but did not end fee charging. There will be a follow-up market study, conducted by the Competition and Markets Authority, looking at service charges in the leasehold sector.11

As well as supporting better regulation Age UK backs stronger measures to encourage more residents to take control of the managing agents, who maintain and service their schemes. There is also renewed interest in promoting the collective ownership of flats through commonhold tenure.

In the social sector sheltered housing continues to struggle with delivering affordable support services (such as housing wardens) to older tenants. There is ongoing concern about the future of these services when funding under the Supporting People programme comes to an end next year.

Renting in the private sector
In 2013 there were suggestions that more older homeowners were turning to the private rented sector as a way to release home equity.13 Although the percentage of older people living in the private rented sector remains small, around 5 per cent,14 this figure is expected to increase over time with rapid growth in the sector.

Private renting can offer older people flexibility, convenience and a choice of good locations. However, over time it could become increasingly problematic for them unless more is done to address poor conditions, accessibility standards and insecurity of tenure. As the supply of social housing declines, it will no longer provide a safety net for older people forced to leave the private rented sector.

Innovation for the future
There has been continued interest in the need to identify innovative forms of ‘housing with support’ that will appeal to future generations of older people. This includes forms of co-operative housing and co-housing that give older people greater control and encourage sharing and mutual support.

Some local authorities are reluctant to support innovative schemes because of concerns over the additional demands that might be placed on their social care budgets. This ignores the positive benefits to local housing markets as a result of specialist housing freeing up larger family homes. Rather than representing a burden, older people moving to an area often contribute to the local economy by spending on shops and services, as well as making significant voluntary contributions to their community. Well-designed specialist housing can in fact act as a hub for the delivery of services, benefitting other older people living in the community.

‘Extra care housing would meet all my needs while maintaining some independence. The ideal, if available.’ – Older person taking part in Age UK focus group
Housing Advice

Extra care housing continues to grow and is being promoted as a realistic and affordable alternative to residential care. In 2013, the Government provided £300 million to encourage the development of specialist housing. Older people can buy or rent self-contained accommodation offering 24 hour care and support. Although the extra care sector is still relatively small (around 42,000 homes), it raises questions about how it might influence changes in the larger residential care sector. There is growing pressure to move away from institutional forms of care, towards schemes that allow as much self-determination and control as possible. Despite the progress of extra care, adverse financial conditions raise concerns over whether the key communal features of schemes can be retained over the longer term.

Over 2013 we also saw a growing interest in the development of new garden cities as one way of helping to address the current crisis in housing supply. In April 2014, the Deputy Prime Minister, Nick Clegg announced the development of three garden cities in the south east, each offering up to 15,000 homes. New housing developments like these need to encourage an intergenerational approach and offer age-friendly houses and flats that appeal to older people. Older people play a key role in creating balanced, vibrant and healthy communities and often make a significant contribution to their sustainability.

Housing and care advice plays a critical role in helping older people to identify good housing options and gain access to housing support.

At the end of 2013, the Government allocated £1 million to the FirstStop housing advice service, creating 15 new housing option services, including 10 managed by local Age UKs. The service helps older people obtain adaptations, small repairs, financial advice, home support and access to social activities. Although this funding is welcome there still needs to be a long-term strategy to address a growing demand for housing advice to help older people make good decisions that support their independence and wellbeing.

Housing advice to promote independence

Mrs W’s family contacted Age UK Norfolk’s FirstStop Housing and Care Options Service because they were worried about her making a rushed decision after her husband was admitted to hospital. The service explained to Mrs W (who is in her late 80s) her rights and the different options available to her, including self-purchase retirement housing and residential care. Following the death of her husband, the adviser gave Mrs W the confidence and knowledge to make a decision to settle on a self-purchase property in a retirement complex. The adviser contacted partner agencies to arrange a fire safety check and a lifeline alarm system to be fitted to her current property. A care needs assessment was arranged and completed by the local authority. Mrs W has chosen to receive support from Age UK Norfolk’s Home Support and Care service during and after her move to help her remain living independently at home.
Too many older people are living in non-decent housing.

Many older people live in cold and deteriorating housing conditions. Although the percentage is falling, 22.6 per cent\(^{xvii}\) of households containing an older person still do not meet the Government’s Decent Homes standard – the majority of these being found in the private sector.

It is often difficult for older people to find the resources they need to fix and improve their homes. Funding for home improvements and refurbishment has declined, particularly affecting older people on low incomes who own their homes.

It is estimated that poor housing costs the health service £600 million every year and that it is estimated that 1.2 million people aged 60+\(^{xix}\) are living in fuel poverty – equating to 721,000 older households in England living in fuel poverty – equating to about 1.2 million people aged 60+\(^{xvii}\).

The new Government fuel poverty strategy is to improve the energy efficiency of our housing stock. Green Deal and the Energy Company Obligation (ECO) is to improve the energy efficiency of homes, Green Deal and ECO, will produce the scale of change needed. The Green Deal enables people to fund home energy-efficiency measures from the savings they generate on their fuel bills. It takes the form of a loan, with levels limited to ensure that the repayments are no greater than the savings made. The Green Deal has got off to a very sluggish start with only 2,000 Green Deal plans in progress\(^{xx}\) (against 188,234 assessments). The Energy Company Obligation (ECO) provides grants to improve emergency efficiency for vulnerable customers and hard-to-insulate properties – many of whom would be unlikely to be able to qualify for Green Deal, given the costs involved. By February 2014, 680,460 grants had been supplied.\(^{xxi}\)

Time for a new approach

Age UK wants to see a far more vigorous programme of investment in improving the energy efficiency of the UK’s housing stock. This could be funded from the £63 billion the Government is due to receive from carbon taxes between 2011 and 2027. However, it isn’t just about the level of investment made, but also about whether we need to take a different approach, including whether local authorities should have far greater involvement in energy efficiency improvements. They hold the knowledge of the condition of the local housing stock and where the areas of multiple deprivation and poverty are, and so would be better able to target action at the areas with the most energy inefficient homes. They are also well placed to co-ordinate action with health and wellbeing boards, given the link between cold homes and health.

All change in the energy market?

One significant change this year is that the Government and energy regulator Ofgem have sought to make changes to the structure of energy bills, with the aim of making them simpler and easier to understand. From June 2014, energy firms will only be able to offer four core tariffs and must provide an annual statement to every customer. These changes are intended to provide a clearer picture of how different tariffs compare and whether a customer could save money by changing tariff or payment method.

Any simplification of the energy market is to be welcomed, given the overwhelming complexity which has faced households seeking to find the cheapest energy in the past. However, in spite of these changes, finding the best rate is not necessarily straightforward, especially for non-internet users. The changes will also do nothing to address the key issue of the inexorable rise of the cost of energy. While there have been both price rises and cuts in the past few years, the rises tend to be greater than the cuts – meaning that in total for most consumers bills continue to rise. In Autumn 2013 all of the big six energy companies increased prices by between 6–11 per cent.\(^{xxii}\)

The energy market continues to come in for a lot of criticism and Ofgem, the energy regulator, has recommended that the market is referred to the Competition and Markets Authority, although it will take a few years to see if this makes any difference to older people.
Older people continue to be targeted at home by scammers, ranging from individual approaches by rogue traders to mass marketing scams. Much more needs to be done to keep people safe from scams and crimes that occur in their own homes, from distraction burglary to selling involving so much pressure that older people feel forced into buying things they simply don’t need or want. This kind of activity costs victims a significant amount of money each year, with the National Fraud Authority estimating that mass marketing scams alone cost individuals £3.5 billion. The impact on individuals and their families can be much greater than the monetary loss, with some victims becoming isolated from their families and friends, losing self-confidence and developing extreme anxiety.

The Government has made some progress, strengthening consumer redress for misleading and aggressive sales practices, and introducing an action plan on nuisance calls. The nuisance calls action plan increases the maximum fines Ofcom and the Information Commissioner’s Office can levy on companies who breach rules, increasing resources available for enforcement and consultation on further action. However, there remains very little to stop scammers sending letters and emails, visiting homes or calling those who have not opted out of cold calls. The Government should apply similar attention to other channels used by scammers as it has to nuisance calls.

Following the abolition of the Office of Fair Trading, responsibility for tackling scams has moved to Trading Standards which has a National Scams Hub. However, tackling scams takes long-term, concerted action and resources. We also need to see far greater efforts devoted to tackling financial abuse. Cases are complex, and often involve family members or others who have ‘befriended’ an older person who gives them gifts or pays disproportionate amounts for services. Age UK is pleased that the Care Act 2014 includes ‘financial abuse’ within its definition of the abuse in relation to which local authorities have duties to act. However, there should also be a National Task Force to tackle financial abuse, ensuring better coordination between local authorities, banks and other agencies.

Evidence from Age Cymru’s work with older people in Wales on scams has driven the launch of a new campaign focused on protection. Age Cymru believes that older people don’t just need increased awareness of scams but also real barriers to make it harder for scams to reach them. The campaign calls for Royal Mail and telephone and internet providers to do more to prevent scams reaching vulnerable consumers. However, it is Age Cymru’s demands for more ‘no cold calling’ zones that have had the most success so far, with 15 zones created already. A sharp drop in the number of reported doorstep crimes has been seen in some areas, and in others, the introduction of the zone has led to a substantial rise in confidence among residents confronting doorstep callers.
Increasingly older people worldwide find themselves in situations of great insecurity and vulnerability due to natural and man-made disasters and conflict.

- 26 million older people are affected by natural disasters every year.\textsuperscript{xxxiv}
- 97 per cent of people killed by disasters live in developing countries.\textsuperscript{xxv}
- Only 0.2 per cent of UN Flash Appeals for humanitarian relief target older people.\textsuperscript{xxvi}

Climate change means an increasing frequency and intensity of floods, storms and droughts, resulting in scarcities of land, water and energy. Increasing competition for resources is likely to exacerbate conflict; already one-third of humanitarian disasters are caused by conflict. Growing urbanisation is causing more people to live in high-risk areas, such as flood plains, increasing the risk of being affected. Food crises are also rife around the world and are likely to worsen.

When disaster strikes, older people are among the most vulnerable to neglect, injury, death and disease. Yet their needs are different from those of children or the more able-bodied, and often overlooked by governments and non-governmental organisations (NGOs) alike.

For example, many people in later life have restricted mobility, making it difficult for them to flee disaster, let alone queue for aid. They may be given inappropriate food they cannot chew, swallow or digest. They may not receive healthcare to treat chronic illnesses. And they may face the loss of their livelihoods.

Meeting the needs of older people

In order to meet the needs of older people, responses to emergencies must identify older people; consult them on their needs; make aid distributions accessible; deliver age-appropriate emergency relief, healthcare and psychological support; provide financial support; and help communities prepare themselves against future disasters.

The UK Government and international agencies recognise the need to do more, but this is often not translated into real action. The UK Government, working with the UN and other stakeholders, needs to ensure that:

- data collection for emergency programmes assesses the needs of all vulnerable groups and is disaggregated by age and sex
- older people’s needs as a vulnerable group are recognised and acted upon in humanitarian responses at a UK, European and UN level
- UN co-ordination systems act more effectively to respond to age as a cross-cutting issue.

In crises, Age International – working as part of the HelpAge global network – provides support to older people who have been affected and ensures that their interests are represented. In the past five years alone, we have provided assistance to people in later life following emergencies in Haiti, Pakistan, East Africa, Syria and the Philippines.
Opportunities to participate
We want to see a world where each and every older person can fulfil their aims and ambitions, make use of their skills and experience in a way that suits them, and contribute as fully as they wish to society without people judging them because of their age.

Age UK has estimated the economic contribution of people aged 65+ across four key areas: employment, informal caring, childcare and volunteering. This comes to a total contribution of £61 billion a year. Of this, employment is the largest factor, accounting for £37 billion. Informal caring activities add another £11.4 billion, volunteering £5.8 billion and childcare £6.6 billion.ii

It is clear that older people have a great deal to give. However, they face many barriers, including ageism, poor transport links and digital exclusion, that prevent them from playing a full and active role in the economy and society.

Note that this chapter covers both devolved and UK-wide issues.
Over the past year the jobs market has become much brighter, with the overall unemployment rate recently falling below seven per cent for the first time since February 2009. Workers aged 50+ have, overall, experienced a similar pattern, with their employment rate rising from 67.1 per cent in February 2013 to 68.5 per cent in February 2014, and unemployment falling from 4.8 to 4.4 per cent over this period.

However, these positive headline statistics mask many of the difficulties that many older workers face, both in terms of the unemployed moving back into paid work and people continuing to progress their career as they might wish. As Figure 6.1 shows, a considerable proportion of people have left the workforce before State Pension age. While for some people this will be a positive choice, for many it is not.

Long-term unemployment
For people who lose their job in their 50s or 60s, it can be extremely difficult to return to work. Over 44 per cent of unemployed people aged 50–64 have been out of work for more than a year, rising to nearly 50 per cent among men. This rate is higher than for other age groups. This is because of various factors, for example age discrimination and inadequate back-to-work support. It has a huge impact on people’s lives. Being unable to return to work can force people onto benefits or into early retirement, and has an effect on income that lasts a lifetime, even where people do eventually find another job.

Age UK is concerned that not enough is being done by the Government to help people who find themselves in this situation. Back-to-work support differs depending on the provider – Jobcentre Plus support is patchy, although there is evidence that it is improving in some areas, while the Work Programme continues to let down those aged 50+ who find themselves becoming long-term unemployed.

Age UK analysis has shown that older jobseekers have considerably lower successful outcome rates from the Work Programme than younger jobseekers – an inequality which a publicly-funded scheme should be trying to correct.

Challenging negative perceptions
There are several negative perceptions that are commonly associated with older workers, for example, being seen as inflexible, sickly, unwilling to learn new skills, or simply winding down the years until retirement.

In 2013 Age UK commissioned the University of Essex to examine the evidence behind these common perceptions, to try and uncover whether or not it is indeed unfair to assert that older workers are likely to behave in a particular way.

The research evidence showed conclusively that it is not. For example, older workers are less likely to take sickness absence than their younger colleagues. One study found that 3.2 per cent of 16–24-year-olds and 3.0 per cent of 25–34-year-olds took at least one day off in the reference week, whereas only 2.8 per cent of 59–64-year-olds did so. However, the important point to note is that everybody is different, and it is impossible to draw accurate conclusions about someone’s ability or capability, needs or ambitions, based on arbitrary criteria such as age.

As the State Pension age rises and the workforce ages, it is more important than ever to make sure that employers and managers do not write off older workers based on a few outdated stereotypes. Considerably more must be done to help them learn how to use all of their employees’ skills, knowledge and experience, for example, training managers to avoid bias and encouraging fair and transparent workplace cultures.

Flexible working
The right to request flexible working, which has previously applied to parents and some carers, was extended to all employees on 30 June 2014. This gives everyone the right to ask their employer to alter their working pattern, and the employer a duty to give the request serious consideration.

While Age UK fully supports this move, we believe it does not go far enough. We are calling for all jobs to be ‘flexible by default’ by 2020, which would allow people to assume they can work flexibly unless their employer can justify otherwise. This would help create a culture where flexible working is the norm, and help break taboos about the disadvantages of adopting a flexible approach.
As recent research by the Institute for Public Policy Research (IPPR) shows, by 2017 there will be a ‘family care gap’ – more people needing care than the number of adult children able to provide it. This additional strain on relatives’ time and resources emphasises the importance of flexible working, and demonstrates the urgency of employers adopting a ‘flexible by default’ approach to all jobs.

Furthermore, between 2010 and 2012 the proportion of older workers who were working flexibly fell. This worrying decline particularly affected women, who are more likely to have caring responsibilities than men. The potential impact of fewer flexible options is significant, and must be urgently considered by the Government.

As the example, right, shows, flexible working can deliver a significant benefit to both the older worker and employer.

**The importance of flexible working**

Carers UK highlights the case of Janine, whose father was diagnosed with Alzheimer’s Disease eight years ago. She began supporting her mum to care for him, but two years ago Janine’s mum was also diagnosed with dementia and, almost overnight, Janine found herself caring for both parents alongside work and raising two young children. Her employer, a major UK telecoms company that is a member of Carers UK’s business forum Employers for Carers, allowed her to take a period of special leave to put in place the right care services for her parents, and to work flexibly to be with them when they need her and for medical appointments. She said:

‘It is tough and stressful juggling the trials and tribulations of Alzheimer’s, managing to get the children’s homework done and them in bed, and often nights of constant phonecalls. But alongside the importance of maintaining my career for the future, my work also gives me a break from dementia – otherwise it would be all I thought and spoke about.’

**Mid-Life Career Review**

The Mid-Life Career Review aims to provide people aged about 50 with the opportunity to get professional advice about their career options and related issues. The pilot, funded by the Department for Business, Innovation and Skills (BIS), ran between May and November 2013, and was delivered by a range of independent providers. These included the National Careers Service, Unionlearn and, in non-unionised companies, Workplace Learning Advocates (employees who were trained to support and encourage formal and informal learning in the workplace).

More than 200 employers in England were engaged in the initiative, and it reached a variety of participants, from unemployed jobseekers to employees seeking advice on maximising the later years of their career.

The initial findings were positive and showed a clear demand for the service and benefits for participants, for example increased motivation and confidence. People wanted advice on a range of topics including self-employment, caring and their finances.

The Mid-Life Career Review could be an important starting point for engaging pre-retirees with their finances and helping them to prepare for retirement, and as part of a wider process of ensuring people make the right decisions as they come to use their pension savings. For further information, see the website of the National Institute for Adult Continuing Education.

‘What [the Review] made me see is you can’t clump older workers all in one group. It’s a group of older workers who are all individuals. They all have similar issues that they have concerns about and you can do group workshops... but within that they all have individual issues that need to be addressed on an individual basis.’

Workplace Learning Advocate
Volunteering

Later life is a time when many people wish to volunteer and make an active contribution to civic and community life; indeed many community groups are almost totally dependent on older people’s contributions.

Volunteering does not just play an important role in delivering services, but also benefits volunteers themselves, improving physical and mental health; combating loneliness and personal isolation; bringing communities together; boosting independence; providing contentment and satisfaction; and empowering people.

Many more volunteer informally, and many older people take an active role in the life of their communities through campaigning and other forms of social action. Older people’s forums give members a powerful voice in their area. Ten years ago there were about 100 of these forums, now there is one in most areas across the UK.\(^6\)

However, other people would like to volunteer, but face barriers in doing so. For example, some organisations impose upper age limits on volunteers, and the Government should examine how this could be prevented by bringing volunteers under the scope of the Equality Act.

There may also be physical challenges for older people, such as health problems or a lack of transport, that can be addressed locally or through best practice guidance. A flexible and inclusive approach to developing and recruiting volunteers will help to encourage older volunteers.

The recent IPPR research illustrating the ‘family care gap’ that is predicted to arise by 2017 also has implications for volunteering. As older people are increasingly called upon to care for relatives – or help with grandparenting commitments – their absence from community-related volunteering may be greatly felt.

Digital Inclusion

Age-friendly design is driving an increase in take-up of digital technology among younger pensioners, but still 63 per cent of people aged 75 and over have never used the internet.\(^x\)

Age UK believes that older people should be supported and encouraged to get online, but those who cannot or do not want to do so should continue to be able to access services and support in a way suits them.

The proportion of over 65s online has increased over the past year, and the industry regulator, Ofcom, attributes much of this rise to more people using tablets. Use of tablets among 65–74s, for example, has trebled from five to 17 per cent.\(^x\) Age UK has worked with Breezie to produce an age-friendly tablet that aims to facilitate internet use among older people. As members of GoOn, the UK’s digital skills alliance, Age UK has also signed up to the Digital Charter. \(^x\)

This includes a range of measures to help people get online and to make support more consistent and easier to access.

The Government continues to pursue its programme of Digital Transformation, which aims to produce ‘digital services so good that people prefer to use them’. By March 2015, 25 services are due to become ‘digital by default’. People who can use digital services will be encouraged to do so, although there will be ‘assisted digital’ services for those who cannot. Assisted digital support might be provided in person, on the phone, or through other appropriate channels. People will be given help to use the service, or someone will use it alongside them on their behalf.\(^x\)

The Office of the Public Guardian (OPG) is a ‘digital exemplar’ within the Ministry of Justice, and is also conscious that most of its users are aged 65+ and that some will require assistance with online services. Age UK has worked closely to provide the OPG with feedback on its online services to make them as accessible as possible to older people. It is also testing different ways in which local Age UKs can help older people use the online tool to make a lasting power of attorney.

Howevr, outside the public sector many commercial organisations are increasingly providing services digitally. Even so, it is important that all commercial websites are high quality and easy to use for people who may have impairments.

Consumers who are not online must also continue to have access to essential services provided by the private sector, such as banking, energy, water and communications. Industry regulators should meet their Public Sector Equality Duty and ensure that moving services online does not disadvantage those who are digitally excluded.

SOME 28.8 PER CENT OF PEOPLE AGED 65–74 AND 20.3 PER CENT OF THOSE AGED 75+ HAVE PARTICIPATED IN FORMAL VOLUNTEERING IN THE LAST 12 MONTHS\(^v\)

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\(^x\) Age-friendly design is driving an increase in take-up of digital technology among younger pensioners, but still 63 per cent of people aged 75 and over have never used the internet.

\(^x\) Age UK believes that older people should be supported and encouraged to get online, but those who cannot or do not want to do so should continue to be able to access services and support in a way suits them.

\(^x\) Age UK has worked with Breezie to produce an age-friendly tablet that aims to facilitate internet use among older people.

\(^x\) Age UK has also signed up to the Digital Charter.

\(^x\) The Office of the Public Guardian (OPG) is a ‘digital exemplar’ within the Ministry of Justice.

\(^v\) Some 28.8 per cent of people aged 65–74 and 20.3 per cent of those aged 75+ have participated in formal volunteering in the last 12 months.
Public Transport

Many older people rely on public transport to participate in their communities, keep active, or to work.

Among older people, buses are the most commonly used method of public transport and for many it is a lifeline. Since 2008, the national travel concession has allowed older people to travel on buses anywhere in England off peak for free; eligibility is now tied to women’s State Pension age for both men and women. Around 33 per cent of people over 60 take a bus at least once a week and, in 2012, 79 per cent of eligible older people had a concessionary bus pass.

The availability of the free bus pass has been challenged with suggestions of significant cost savings to be made by means-testing it. This fails to acknowledge that there is only a cost where the pass is actually used and research indicates that those in higher-income households tend to make fewer trips using the pass than those in lower-income households. The cost of implementing a means-tested system would outweigh the substantial benefits. Age UK believes the national bus concession must remain free and universal.

In the past two years, significant funding cuts to bus services have seriously affected travel for older people. Consequently, 147 services have been cut or withdrawn completely across the country. The Local Government Association has warned that cuts could see a scaling back of discretionary transport services, such as free peak time travel, community transport services and reduced fares. A reduction in these services will have a significant impact on the lives of many older people, particularly in rural areas. In urban areas 95 per cent of people live within 13 minutes of a regular (hourly) bus, but in rural areas this falls to 61 per cent. Age UK believes that where private transport is not possible, and public transport does not fully service the needs of older people, local authorities should provide alternatives such as financial support towards community transport or taxis.

The Government must recognise the many benefits of accessible public transport for older people and the cost of the problems caused by its absence. Health and wellbeing boards need to give attention to transport links as part of their strategic planning to ensure all older people can access the health care services they need. Local transport authority decisions on public transport need to be based on impact assessments that take into account older people and give much higher priority to preventing isolation.

More must also be done to improve the accessibility of transport for people with reduced mobility, for example, by promoting awareness training for bus drivers, in line with EU regulations on passenger rights. In the light of this, it is extremely disappointing that the Department of Transport is reducing its ‘Access for All’ programme, designed to improve access at train stations, from £43 million to £25 million annually between 2015 and 2019.

FOR 2013/14, 46% OF LOCAL AUTHORITIES HAVE CUT SPENDING ON THEIR SUPPORTED BUS SERVICES, WHILE 36% HAVE CUT OR REMOVED SERVICES

Action to support participation

Being judged and discriminated against because of one’s age is an almost universal experience of being older. It is a significant barrier to being able to participate in society, yet it hasn’t been recognised as such under international law.

At a UN level, there are many framing treaties that seek to create a higher standard that governments should be held accountable to. These human rights conventions fall short of stating the obvious: that we will all hopefully grow older and that there are things we will only encounter in later life.

Articulating an understanding of what growing older means and what people should expect from society can be very helpful in places where laws and policies specific to ageing are not well developed. Existing international human rights agreements are not sufficient for providing this level of guidance and support.

Efforts have been made to show what ageing means for society and what needs to be done to support older people – for example the Madrid International Plan of Action on Ageing (MIPAA) and the UN Principles on Ageing make very clear what older people should expect from their governments. More recently, the Council of Europe agreed a recommendation specifically on the rights of older people. The challenge with these agreements is that they are not legally binding and governments don’t have to act upon them.

As an alternative, UN member states are considering creating a new human rights treaty that is specific to older people – much in the same way they have done for children, women and people living with disabilities. Governments are far from reaching consensus on whether this bold step is necessary, but the fact that they are debating it is an important step forward.

If it were to be created, a human rights convention for older people could help explicitly to tackle age discrimination. It could also provide better guidance to governments and citizens on how to ensure older people are fully included in society. We are a long way from agreeing a new convention, but it is a very real possibility.
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