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DOMINE NOS
DIRIGE
CITY
OF
LONDON

OLDER LONDONERS

Edited by
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Institute for Public Policy Research

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IDEAS to
CHANGE LIVES

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EXECUTIVE SUMMARY

Over the next two decades, the number of people aged over 80 is set to double in Britain. This presents challenges for the way public services are delivered, the way our towns and cities are designed, and the way families organise their lives.

While often described as a city for the young, London is not immune to the challenges of an ageing population. The number of people over the age of 80 living in London is estimated to rise by 40 per cent over the next 30 years, reaching 350,000 by 2031 (GLA 2009a). Our research has identified a number of important characteristics of London's ageing population:

- **It is the over-90 group that is growing particularly strongly.** This has implications for the services that will be required – for example, the risk of dementia increases rapidly at this age.
- **There is a greater rise in ageing among London's ethnic minority populations.** This suggests services for older people will have to adapt to the specific needs of these groups.
- **The gap in life expectancy between men and women is narrowing.** This means services will have to be better designed for the needs of older men.
- **Population ageing varies across the London boroughs.** Outer London boroughs have a greater proportion of older people than inner London, suggesting they face the greater challenge.

London's public services must respond to the changing needs of the population they serve. Our research with service providers and older service users across London identified four priorities for public policy:

Focus on services within the community rather than big institutions. The problems associated with ageing – including dementia, home care and social isolation – cannot be solved by a person visiting a hospital or government department to receive a one-off intervention. They require people to change the way they live, constant levels of small support, and regular contact. The health service will need to pool its budget with social care in order to invest in community-based services such as home care, reablement and peer support networks.

Provide a better flow of information about the services that are available across the capital. People are often unaware of the services that are available, which can leave them isolated and as a result prevent an effective social care market from developing. An improved community information infrastructure needs to be created, based on face-to-face advice, peer support and web technology.

Improve assessment and referrals. A recurring theme throughout our research was the difficulty of identifying older people who need support, with almost 30 per cent of people over the age of 80 being isolated from basic services. It is clear that many people are not having their needs assessed early enough and are not being referred between services. Addressing this will require services to put in place data-sharing agreements and frontline professionals to conduct short assessments for issues that are beyond their particular remit, as well as improved training for medical staff to diagnose and manage conditions such as dementia.

Social care requires both investment and reform. Home care should be a particular strategic priority for government investment, given the potential it has to avoid older people being cared for in more costly institutions such as care homes and hospitals.

Investing more money in social care is important, but this must be accompanied by reform of the system. Without this kind of reform, there is a danger that more money will be spent while structural problems – including low productivity, the divide between health and care, and poorly designed services – are not resolved. This research has identified a number of areas where government, commissioners and service providers can start on this journey of reform.

INTRODUCTION

Over the next two decades, the number of people aged over 80 is set to double in Britain. This presents challenges for the way public services are delivered, the way our towns and cities are designed, and the way families organise their lives.

Already, there are signs that the current system is struggling to cope. The King's Fund has estimated that local authorities face a shortfall of £1.2 billion in social care funding over the next four years (Humphries 2011), several local authorities are reducing the number of people who are eligible to receive care services, and newspapers have carried stories of abuse, neglect and the closure of care homes.

At the same time, these signs of crisis have prompted a serious debate about ageing in England. The publication of the Dilnot Commission report has provided a clear proposal for solving the lack of funding in social care, innovative local authorities are starting to commission services jointly with health, and the power of the 'grey vote' is being courted by politicians.

While often described as a city for the young, London is not immune to the challenges of an ageing population. The number of people over the age of 80 living in London is estimated to rise by 40 per cent over the next 30 years, reaching 350,000 by 2031 (GLA 2009a). Preparations for an ageing population in London are complicated by a number of factors, including the fact that older Londoners are more likely to live alone, suffer from poverty and lack support from their families compared to older people in other areas of the country. The city also faces high rates of population churn, a complex infrastructure and a reliance on migrant workers – all of which add to the challenge of designing effective public services.

This comes at a time of great upheaval in the structure of health and social care. According to legislation currently progressing through parliament, GPs will be given more power to commission health services, while local authorities will have added responsibilities for public health and remain in charge of social care. The community and voluntary sector is being encouraged to play a greater role in delivering services and the funding of social care is likely to be reformed in the wake of the Dilnot Commission.

At a time of rapid change, it is crucial that service providers and policymakers are equipped with evidence on how they can adapt to the needs of London's oldest residents. This report summarises the findings from a year-long programme of research.[1] After describing the profile of London's ageing population, it sets out findings in three policy areas:

- Home-based care
- Dementia care
- Social isolation

The research findings are based on over 50 interviews with service providers and older service users across a range of London boroughs alongside a detailed literature review and original analysis of data sets including the English Longitudinal Study of Ageing (ELSA). Our research focused exclusively on older people living in the community, as opposed to those in residential care settings.

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1   See Older Londoners project at http://www.ippr.org/research-projects/44/7117/older-londoners

London's ageing population

In London, the number of people over the age of 65 is increasing at a faster rate than other age groups, and is expected to reach 1 million by 2026. While policymakers tend to focus on the overall number of 'over-65s' in the population, this misses a number of important trends that lie behind the data (all data from GLA 2009a, 2009b).

- **It is the over-90 population that is growing particularly strongly.** While the number of Londoners aged over 65 is expected to increase by 33 per cent over the next 20 years, the number of Londoners over the age of 90 is expected to increase by 95 per cent. By 2031 there will be almost 100,000 Londoners who are aged over 90.

- **There is a larger rise in ageing among London's ethnic minority populations.** While the white over-80 population is expected to rise by just under a third between 2011 and 2031, the size of the ethnic minority population over the age of 80 is projected to almost triple over the same period, rising from 28,600 to 80,000. This means that by 2031 ethnic minorities are expected to make up around a quarter of the over-80 population in London, compared to just 12 per cent in 2011.

- **The gap in life expectancy between men and women is narrowing.** There will continue to be more women than men over 80 years old – but this gap is narrowing. The number of men aged 80+ living in the capital is projected to increase by more than 50 per cent, compared to an increase of less than a third among women. The female population is projected to be 207,800 in 2031, up from 160,400 in 2011, while these figures for males are 144,500 and 95,122 respectively.

- **Population ageing varies across the London boroughs.** While all London boroughs will experience a rise in the proportion of their residents who are over the age of 80, the outer London boroughs are projected to have the highest proportions of older people. The rise in these boroughs can partly be accounted for by the ageing of BME groups (see figures 1 and 2).

- **The services available to older people vary across the London boroughs.** Because social care is commissioned by local authorities, there is variation between the services that are available in different parts of the city. This is clearly seen in rates of home-based care. In Waltham Forest, for example, 6.2 per cent of older people are supported to live independently, whereas in Westminster 17.1 per cent of older people are supported to live independently.[2] Similarly, some boroughs appear much better at rehabilitating older people back into the community after a spell in hospital.

- **The context for ageing differs from other parts of the country.** London provides a unique context for designing services for older people. The care workforce is very different, with a far higher turnover of staff, a greater reliance on migrant workers, and twice the proportion of staff on temporary contracts than in other regions (Skills for Care 2010). Our polling also suggests that Londoners receive less support from family and friends – only 54 per cent of Londoners reported having frequent contact with an older person, compared to the national average of 67 per cent. Added to this, older Londoners are more likely to live alone and suffer from poverty than older people in other parts of the country, resulting in a greater demand for public services.

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2   National Social Care Indicator Set 09/10 at http://www.ic.nhs.uk/statistics-and-data-collections/social-care/adult-social-care-information/social-care-and-mental-health-indicators-from-the-national-indicator-set--2009-10-final-release

Figure 1
80+ population as
a proportion of total
population

2011

Less than 2.5%

2.5–3.49%

3.5–4.49%

5% or more

2031

Less than 2.5%

2.5–3.49%

3.5–4.49%

5% or more
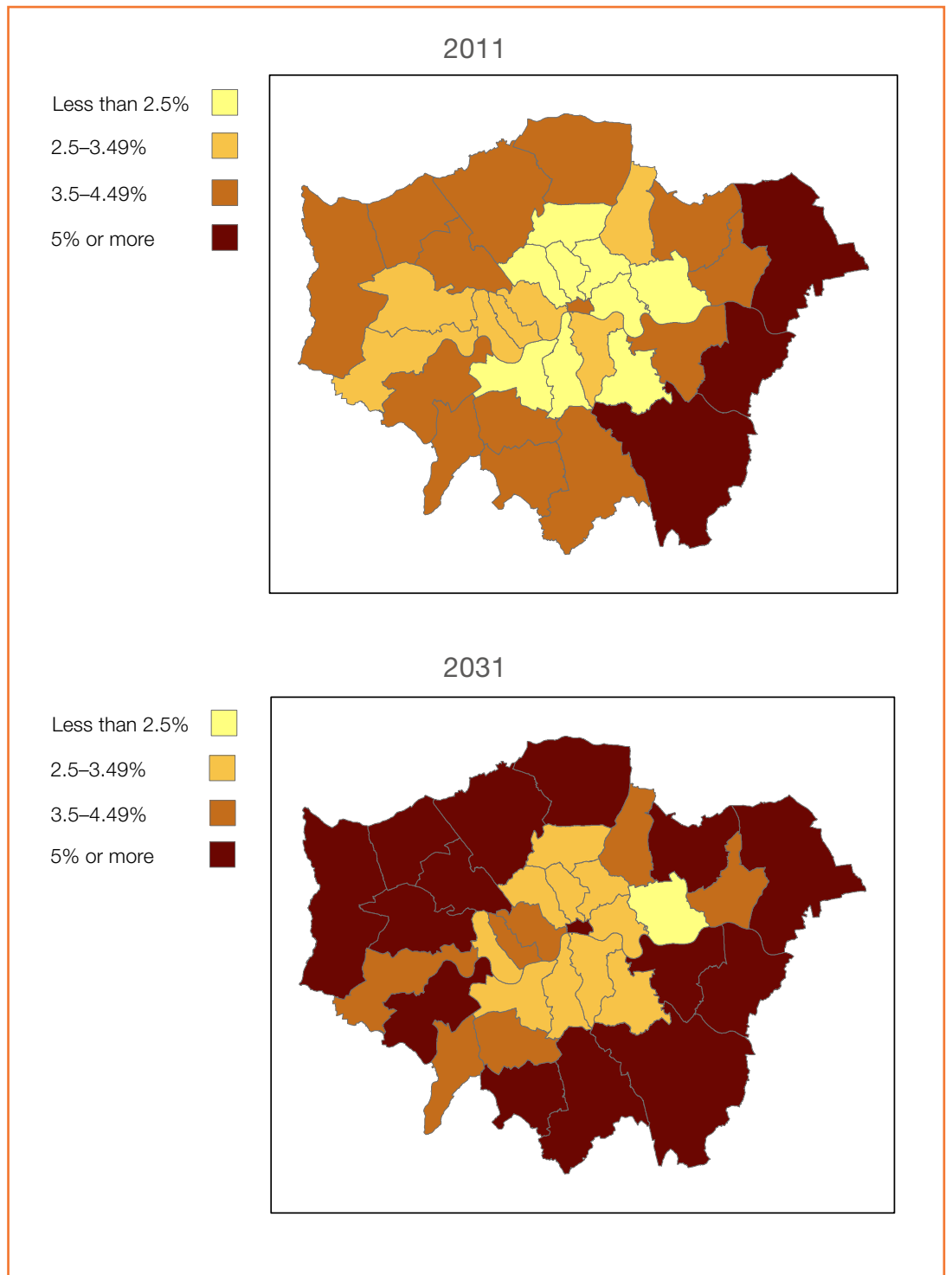
Figure 2
BME population as
a proportion of 80+
population

2011

Less than 10%
10–19.9%
20–29.9%
30% or more

2031

Less than 10%
10–19.9%
20–29.9%
30% or more
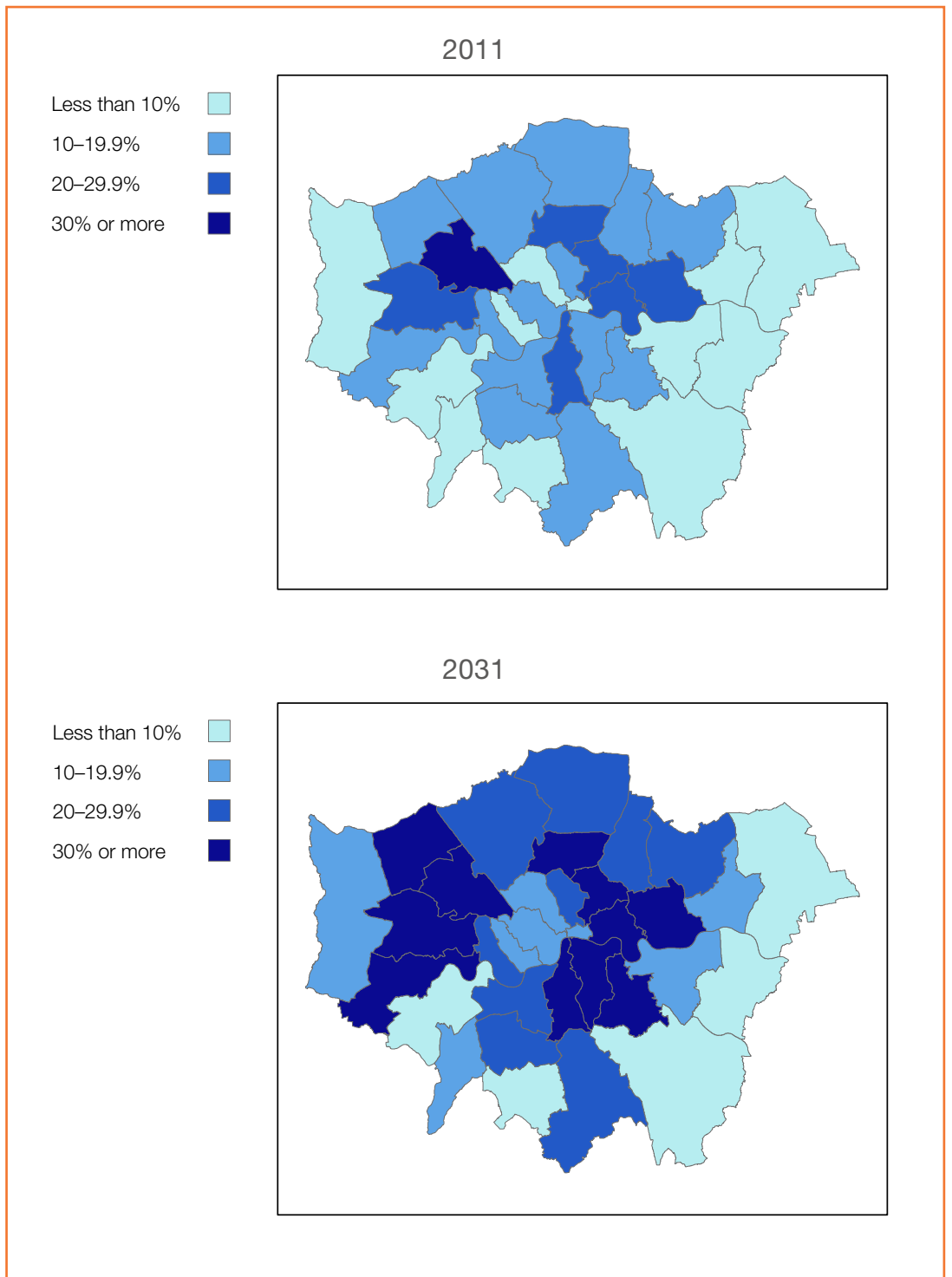
1. HOME CARE IN LONDON

Introduction

Systemic failures in the care system mean that many older people end up in hospital because of a lack of care before they reach crisis point. Age UK has estimated that 165,000 older people in London alone are unable to access the care support they need (Age UK London 2009), prompting fears of a costly 'bed-blocking' crisis in the NHS.

Home-based care has the potential to reduce the pressure on more costly public services such as hospital beds and care home places. It can also enable older people to enjoy the benefits gained from remaining in their homes and communities for longer, significantly improving their quality of life.

Despite the importance of home-based care, a number of problems continue to plague its provision. These include a lack of money in the system, low productivity, poor integration with health services, and a very fragmented market of care providers (Bradley 2011).

Older people living in London are more likely to require home-based care services compared to other areas of England. This is because they are more likely to live alone, lack support from their families and suffer from poverty, resulting in a greater need for public services (GLA 2010).

The care workforce

A hallmark of top-quality care is that it is provided by well-trained workers with enough time to perform their job. Sadly, home care in London is not meeting this test. Low wages, poor progression opportunities and a stressful working environment have led to persistent job vacancies, a high turnover of staff, a low skills base, and a reliance on migrant labour. It has been estimated that social care will require between 0.5 and 1.5 million additional recruits in England by 2025 (Skills for Care 2010). Staff turnover is higher in London than in other areas, and the city also relies more heavily on non-UK-born recruits to fill social care roles, with 75 per cent of its in-home care staff originating from other countries.

This is a long-term problem and it cannot be properly addressed without more money in the system. A key priority for any new funds should be to develop care professionals. Given that social care is a labour-intensive service, productivity cannot be increased without improving the skills of staff. This in turn will require better pay, training, regulation and progression routes.

The future of social care funding

The scale of the challenge facing home care cannot be matched through efficiency savings alone. While there is some potential to increase efficiency and productivity and to redirect spending from other areas, the system will require additional investment in the long run. Further investment in social care should be a major priority for any government.

The way social care is funded in the UK was recently reviewed by the Dilnot Commission (2011). Their report suggested that people should contribute towards the cost of their care up to a threshold of £35,000. After this point, the state would pay for any additional care costs. The commission hoped that this cap would stimulate a private market in care insurance, encourage people to save towards their initial care costs, and prevent people having to pay spiralling care costs that lead them to sell their homes.

While these proposals could help to solve care funding in the long run, they will not resolve the issue for those baby-boomers already approaching retirement. If this group is to contribute to the cost of their care, one option would be to tap into the wealth that is locked up in their homes. This can be done through a form of early equity release or property tax. In New Zealand, for example, local authorities are able to reclaim money on a person's estate when they die, in order to cover the cost of their care. This relieves older people of having to downsize their homes in advance.

These will be politically contentious issues over the coming years, but they must be tackled in order to ensure money is injected into the care system. Once the funding questions have been addressed, it will then be possible to turn to the substantive questions posed by our research about the quality and provision of social care.

In order for home-based care to be of a good quality, it needs to be provided by a familiar care worker who is able to meet the individual needs of the person using care. High staff turnover rates and employees on temporary contracts mean that older people rarely benefit from consistency in their care workers. This is a particular problem in London, with 10.3 per cent of care workers in the city being on temporary contracts, compared with an average of 4.3 per cent across England. Older service users taking part in our research spoke of the disruptive nature of changing care workers and the importance of building trust with the people who enter their homes. This is confirmed in a recent report by the Equality and Human Rights Commission (EHRC) into home care, which highlights a case in which one woman received care from 32 different carers during a two-week period (EHRC 2011).

Many of the people we interviewed spoke of the limited time allocated to care workers for each older person and the lack of flexibility in their job descriptions. The skills of the care worker are central to delivering high-quality home-based care, and the way in which a carer interacts with an older person affects that person's experience of care significantly. Providers need to equip care workers with knowledge of what constitutes good care and the skills to deliver it.

Personalised care

The most effective home-based care is personalised around an individual's needs, rather than delivering prescriptive services for all older people regardless of their specific condition. It was the need for more tailored services that lay behind New Labour's 'choice and personalisation' agenda and the introduction of personal budgets, with which older people could choose directly what to spend their care budget on. There are currently around 6,000 older people using personal budgets in London, representing around 4–5 per cent of older people receiving community services (Age UK London 2010). This figure is set to rise, as the current government have pledged to extend the scheme.

While the introduction of 'choice and personalisation' was a welcome move away from the institutionalised care of the past, there are a number of concerns with how personal budgets have been implemented in London. Many of the people we interviewed expressed concern about the lack of support for managing a budget, a lack of information about what services are available for purchase, and the time it takes to be assessed for a personal budget. One older lady we interviewed, who was preparing to take up home

care services, said: 'At the moment, I've got no idea how much you would get and how you would go about accessing your own carers – I just don't know.' This supports other research which has found that older people are more likely to find managing a budget burdensome than other eligible groups (Glendinning et al 2008).

For personal budgets to deliver on their promise, two things need to happen. First, much better information must be shared on how personal budgets work and the services that people can spend them on. The 'Free to Live' network in Leeds shows how peer networks can be used to help spread information.

Good practice example: Leeds 'Free to Live' personal budget support network
In 2009, a number of people in the Leeds area who were using personal budgets decided to set up a network to support others who were either already using a personal budget or considering taking it up. At first the group held community meetings but, through a process of partnership with the Leeds Centre for Integrated Living and Leeds Adult Services, it has since expanded to incorporate a website with an online forum and resources as well as a telephone support network. These services connect people who are using personal budgets so they can learn from each other's experiences.

For more information see www.freetoliveleeds.org

Second, a better range of services must be provided for older people to choose from, so that the market is not restricted to services that were already being commissioned by the local authority.

Preventative care
Local authority support for home-based care is often provided at very late stages, when people have a critical level of need. There is a lack of coordination between health services and social care, which can deliver more preventative services. Despite there being a number of approaches to home care that could reduce the pressure on more costly services down the line, these are often not utilised. Assistive technology and 'telecare'[3] can help support the work of a carer and enable problems to be identified earlier, but currently there is a lack of awareness of what technology is available and how it can be used. Assessments and adaptations of the home environment can also be used to prevent falls, which cost the NHS £5 million per day (Age UK 2010).

Pooling health and care budgets
Social care is currently commissioned by local authorities, while health care is commissioned in a more centralised way through the Department of Health. This division between social care and health care is a longstanding problem in England. It prevents the kind of joined-up working that might be achieved by, for example, investing in preventative measures in a person's home, so stopping them falling over, breaking an arm, and needing an expensive hospital bed.

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3   Telecare involves using remote technology to monitor a person's health and care, for example through sensors which trigger an alarm if a decline in health indicators occurs.

There have been efforts in the past to achieve better integration between health and care by allowing primary care trusts (PCTs) and local authorities to pool budgets and commission services together. Despite the potential of this approach, pooled budgets in 2009 made up only 3.4 per cent of the total health and social care budget, and this was concentrated in specific service areas – according to the Audit Commission, 'pooled funds are mainly used for learning disability, community equipment and mental health services but rarely for older people's services' (2009: 1).

The government's proposed shake-up of the health system could bring health and social care services closer together, by aligning GP-commissioned health services with local authority boundaries. Ultimately, however, the best way to bring health and social care together is to integrate their funding, thereby enabling joint commissioning and delivery of services at the local level (Humphries 2011).

Services that help older people to return to their own home following a period in hospital are vital for ensuring independence is regained and reducing the incidence of future health problems. These services straddle the boundary between health and social care, and require an integrated approach to ensure a smooth transition between hospital and home and to promote longer-term independence. So-called 'intermediate care' and 'reablement services' can be used to prevent older people being caught in a revolving door between home and hospital. Reablement services have been shown to reduce the cost of later care by as much as 60 per cent, but London is not taking full advantage of these potential savings (Glendinning et al 2010).

Under the right conditions, home care services offer a real opportunity to improve the quality of life for older people and can provide a more sustainable way to adapt to an ageing population. Reforming home care to improve the workforce, and to make it more personalised and preventative, should be a priority for public policy.

Key recommendations

- We urge the government to address the lack of funding in the care system, and back the findings of the Dilnot Commission.
- Local authorities and health services should pilot the introduction of 'supercarers' – professionals who can deliver both health and social care in the home. This would help integrate the services and raise the status of care workers.
- A streamlined system of funding and provision of personal budgets should be developed so that the attendance allowance, primary health services and social care services are integrated. This would provide a higher level of flexibility and choice around where an older person spends their money.
- Peer networks connecting personal budget users should be developed by charities and local authorities to support older people and ensure a better spread of information.
- In the absence of a strategic health authority for London, the Greater London Authority (GLA) should be responsible for overseeing the health and care systems across the city. This will help prevent a fragmented market from developing across council boundaries.

- Care providers should give more flexibility to front-line staff, moving away from a time- and task-based approach and giving more power to the professionals to decide how jobs should be completed.
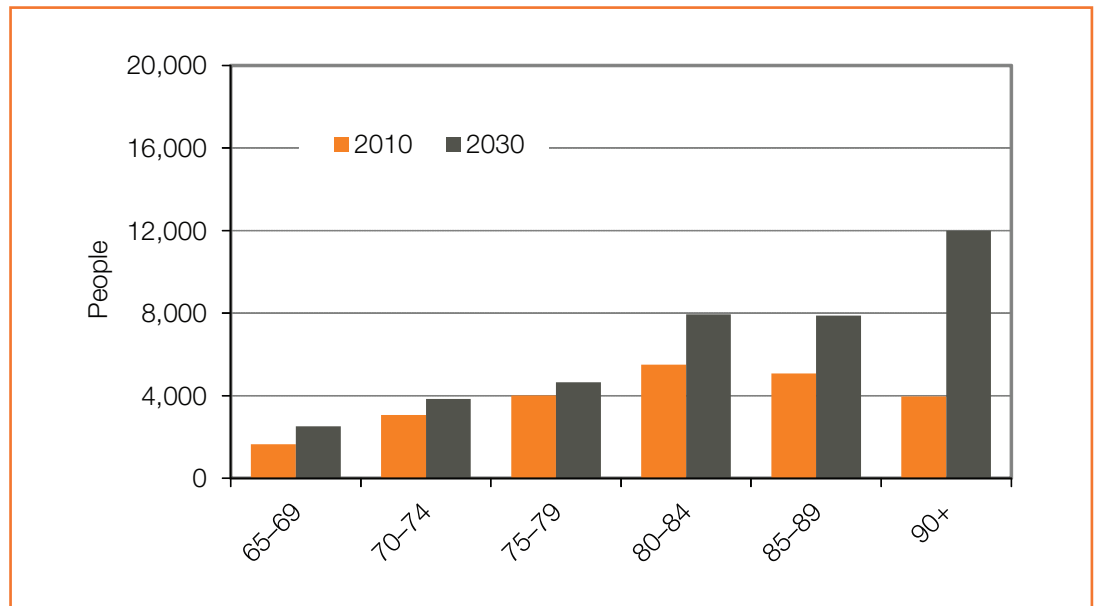
2. DEMENTIA CARE

Introduction

There are currently around 700,000 people in England with dementia. Due to population ageing, the number of people with dementia is set to double to 1.4 million in the next 30 years. Dementia is thought to cost the UK economy somewhere between £15 and £23 billion a year (Alzheimer's Society 2009), spread across health and social care services, as well as individual costs borne by people with dementia and their carers through loss of earnings and payment for personal support. Costs are expected to treble by 2031 (Goodchild 2009).

London faces a series of unique challenges in adequately supporting dementia patients. Poor mental health is more prevalent in the capital, compared with the national average, and there are a range of other factors – such as deprivation, the needs of diverse minority ethnic groups, and social isolation – that can complicate service provision. Recent estimates suggest that around 65,000 people over the age of 65 in London have dementia, including around 1,600 people with early-onset and 63,000 people with late-onset dementia (CSL 2009). Projections suggest that the number of people over 80 in London with dementia can be expected to rise by almost 50 per cent to 96,000 by 2030, as figures 3 and 4 show. A larger number of women will continue to have a dementia because they make up a larger proportion of older age groups.

Figure 3
Trends in dementia by age group for men, 2010–30
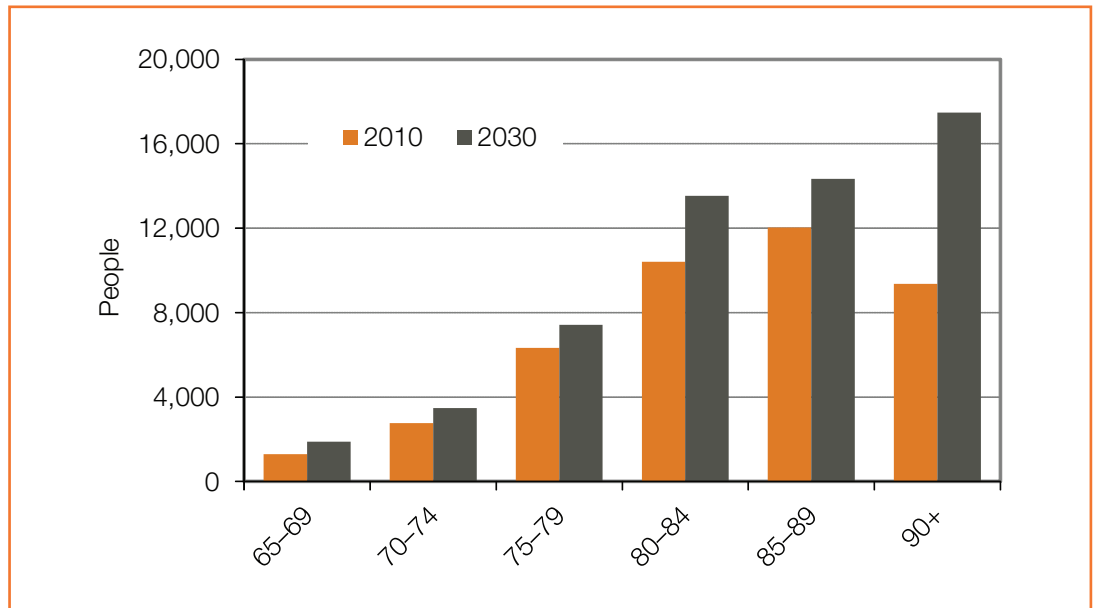
Source: POPPI 2010

Source: POPPI 2010

Health and social care services

For many people, contact with a GP is the first step in gaining a diagnosis of dementia. An important theme in our interviews was that the quality of advice and signposting provided by GPs in London is extremely mixed. Just 31 per cent of the capital's GPs believe they have received sufficient basic and post-qualification training to diagnose and manage dementia (ibid). In one interview, a manager of a community organisation based in Camden said that a good GP who could identify a case of dementia and refer the patient on to other services was rare, and the exception to the rule.

Given that proposed changes in health care commissioning will place more control in the hands of GPs, it is important to find ways to ensure GPs are trained to diagnose dementia and to refer people to information and advice services. This would enable dementia sufferers to access treatments that delay onset, minimise symptoms, improve wellbeing and reduce the costs of long-term care. It is also crucial that GPs are properly held to account for the quality of services they commission.

Overall, the research identified a lack of cohesion between health and social care services. In 2009, the government published a national dementia strategy (DoH 2009), which has encouraged a focus on the whole of the dementia care pathway, but problems remain because of a commissioning model that is fragmented and unconnected in places. One service provider with strategic oversight across London commented that for somebody who is commissioning adult mental health services, dementia is a minor element of their portfolio. Similarly, for someone who is commissioning services for older people, dementia forms only a small part of their remit. Commissioners do not necessarily have sufficient expertise – or are not given a sufficiently broad remit – to be able to think through the whole care pathway from early diagnosis to end-of-life care. A more integrated approach to commissioning is needed.

Advocacy and advice services

Information and advocacy services are essential for people with dementia and for their carers, but our research showed that this support is not always readily accessible. This is, in part, a result of patchy service provision, but is also linked to social isolation, which means that some people are unable to access the services that are available to them.

Problems in the provision of advocacy services were identified at several stages, with a particular problem around points of transition – from hospital to the home, and from home into residential care. Carers also reported that more information was needed in the period before a diagnosis of dementia is made, after it becomes clear that there is a problem but while the carer does not know how to address it or where to turn for help. Gaps in provision need to be addressed.

> **Good practice example: Information prescriptions**
> In some parts of the country, 'information prescriptions' have been piloted. This involves a doctor writing a prescription for a patient to seek advice and information, rather than medication. Being given a written prescription can sometimes spur people to seek advice at an early stage. It also provides GPs with a channel through which to refer people for more direction and assistance, and helps to link the GP with services in the community.

While targeting information at certain points in the care pathway is important (such as at diagnosis and the transition into different settings), the overriding imperative is for information to be consistent and ongoing throughout a person's life. But under a model of services that are commissioned every few years, this consistency can be hard to achieve. One advocacy services provider in Westminster described how, because of changes to her funding, her role had changed three times in the last few years, making the situation 'harder and harder'. The introduction of personal budgets increases the need for good advice and information, as older people and their carers have to make decisions about what services to purchase. Some interviewees acknowledged the benefits of an individualised service, but a note of caution was raised about the capacity to handle personal budgets, especially given the deteriorating nature of dementia as an illness.

Support for social activities and interaction in the community

Activities for people with dementia in London need to better reflect their diverse interests, and opportunities must be available for people with dementia to interact socially with the wider community – not just with others with dementia. While resources tend to be spent on meeting the need for care, community-based activities are an essential lifeline for many people with dementia and their carers. Efforts to support community-based activities would have important long-term financial savings, particularly by preventing unnecessary hospital stays. Commissioning Support for London (CSL) has noted that older people with dementia occupy 20 per cent of acute hospital beds across England, around 70 per cent of whom may be medically fit to be discharged (CSL 2009).

Some service providers noted that a number of daytime care centres provide activities that appeal more to women, and that more services directed at men with dementia could be beneficial. A balance also needs to be found between services which provide specialist care and those that are more mainstream within the wider community. There is scope for

low-level training and awareness-raising with local retailers and in community settings, to achieve greater public recognition of dementia.

Providing services and support for a diverse community

People with dementia have different needs, depending on a range of factors including poor health, social deprivation, alcohol or substance abuse, barriers relating to ethnicity, discrimination, living alone and social isolation. Cross-cutting diagnoses and multiple inequalities introduce a range of additional challenges for service providers who support people with dementia. London, with its diverse BME communities and high prevalence of people with poor mental health, faces particular challenges of this kind.

Some of the service providers we interviewed expressed difficulty in providing support for people with dementia from BME groups. This is partly a cultural barrier: some groups have little understanding of dementia, and so it is not always recognised. Minority ethnic groups are at far greater risk of misdiagnosis and delayed treatment than other mental health service users (Lane and Hearsum 2007). A number of service providers told us about misdiagnoses and the use by medical staff of language that was not meaningful to specific communities.

One interviewee working across London cautioned that any change or support has to come from within the community and not by another organisation 'parachuted in' to provide services for people from minority groups. Ideally, larger organisations should be working in partnership with local community groups. Collaborative work among community organisations (including information sharing and joint working) was flagged up by the service providers we interviewed as being an important way of engaging harder to reach groups. But this poses a number of challenges – in particular, organisations collaborating to bid for funding require support to work together effectively. One service provider, based in Westminster, highlighted the gap in this area, stating that until community organisations are willing to work with other local community organisations from different BME groups it will be difficult to combat all the stigmas and taboos that are associated with dementia.

There is projected to be a particularly steep rise in the number of over-90s living in London in the coming years. This will place increasing demands on dementia services, given that the risk of dementia rises rapidly after this age. Poor rates of diagnosis and referrals and a lack of advocacy and community-based activities will exacerbate the challenge dementia poses to London.

Key recommendations
- Voluntary and community groups should offer ongoing training packages to GPs, to provide an insight into local needs and services.
- GPs should issue 'information prescriptions' to ensure people are channelled towards the relevant advice.
- Embedding advice services in surgeries will help GPs to signpost patients towards services provided by local authorities and the third sector. This would provide a much-needed link between health and care services.
- The NHS Commissioning Board should ensure that the quality of dementia care is included in the new outcomes framework by which clinical commissioning groups will be held to account.
- One of the new 'pathfinder' clinical commissioning groups should pilot an early-intervention approach to dementia care. This could provide the necessary evidence

base to reassure future consortia that commissioning dementia services is a worthwhile investment, one which can result in savings further down the line.

- Local authorities should provide support for community organisations that want to collaborate to bid for contracts, putting them in touch with each other and helping them to complete their bids.[4]
- Service gaps need to be filled in the following areas: training for commissioners, information, advocacy, end-of-life planning, support for carers, bespoke services for minority ethnic groups, and a more diverse range of social activities, especially for men.

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4   CSL currently supports small community organisations to collaborate to bid for contracts but will cease to fill this role in the near future.

3. SOCIAL ISOLATION

Introduction

On a damp autumn morning last October, a volunteer from the charity Contact the Elderly went to visit a 91-year-old lady who lives on her own in a flat in south London. Concerned at the prospect of her riding a mobility scooter with poor eyesight, he made a point of talking to her about it. Her response was strict and angry: 'If I stop riding my scooter, then I might as well die!'

For too many people, growing older is a journey of loss – losing work, mobility and friendships. Surveys of ageing in England show that at least 10 per cent of older people are isolated and a similar proportion report being lonely. These figures increase among the oldest age groups, with 30 per cent of over-80s having limited access to services such as shops and GPs, and 25 per cent being cut off from family and friends (ODPM 2006).

This highlights that too many people face later life cut-off from society, lacking friendships and the sort of everyday social contact that so many of us take for granted. Social networks enable people to enjoy each other's company and navigate life's events, and can provide access to practical help such as transport, informal care and spreading information about services. More fundamentally, social contacts matter for building an inclusive society. Policymakers should be concerned about social networks because they help people to lead a good life.

How isolated are older Londoners?

Social isolation is not an issue that just affects older people. People at all stages of life can suffer from a lack of social ties and an inability to access services. Representative samples of the English population, however, show that the risk of exclusion does increase in later life.

Table 1 identifies the extent of different forms of exclusion for anyone over the age of 50. It shows that the risk of exclusion increases quite sharply after age 80. There are particular problems with 'social exclusion' (a lack of contact with family and friends), 'services exclusion' (limited access to basic services such as shops and GPs) and 'material exclusion' (a lack of material goods such as consumer durables and heating). Older people fare better on other measures such as access to cultural and civic activities, financial services, and feeling at ease in their neighbourhood.

Table 1
Different forms of exclusion among older age groups (%)

Age	Social	Cultural	Civic	Services	Neighb.	Financial	Material
50–59	9	12	13	5	12	9	5
60–69	11	10	10	6	14	9	6
70–79	14	11	10	11	15	11	15
80+	25	14	12	29	14	14	33
All older people	**12**	**11**	**12**	**9**	**13**	**10**	**11**

Source: ODPM 2006 (ELSA data)

While table 1 measures different forms of exclusion, it cannot give a sense of how these different forms interact with each other. Some people may be excluded in several ways – others may not be excluded on any. Further analysis of this data showed that 51 per cent of older people are not excluded on any dimension, 29 per cent are excluded on one dimension, 13 per cent on two dimensions and 7 per cent on three or more dimensions (ibid). This last group – who face multiple forms of exclusion – will clearly require extra support.

London appears to fare badly when it comes to social exclusion and loneliness in later life. Analysis of the ELSA found that living in cities increases the risk of exclusion among older age groups (ibid), while detailed case studies of deprived urban neighbourhoods such as Hackney in east London found that rates of loneliness among older people were twice the national average (Scharf 2011: 32).

These findings were supported by a national opinion poll conducted for IPPR in 2009. The survey asked respondents how regularly they spent time with people aged over 65 they know, including family, friends and people from work. Out of all the regions, the level of contact with older people was lowest in London. Only 54 per cent of Londoners reported having frequent contact with an older person, compared to the national average of 67 per cent (McCormick et al 2009).

The latest wave of the ELSA found that 18 per cent of people over the age of 75 'felt lonely much of the time during the past week'. It is currently estimated that there are 422,000 people living in London who are aged 75 or over. While the ELSA does not provide a regional breakdown of data, if the national average were applied to London it would suggest that the capital has 75,960 people aged 75+ that feel lonely most of the time.

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The risk of social isolation: is 75 the new 65?
The standard discourse about ageing tends to include anyone over the age of 65 as an 'older person'. This rhetoric has not kept pace with the enormous changes to the way people experience growing older. IPPR's original analysis of data from ELSA shows that there is a big difference between 'early retirement' and those over the age of 75. Our analysis shows that people aged 75+ are at greater risk of living alone, not having access to transport and being lonely than those in the 65–74 age group:

- 25.6 per cent of 65–74-year-olds live alone, but that figure rises to 44.5 per cent for the over-75 age group

- 2.3 per cent of 65–74-year-olds never use public transport and do not have access to a car, but for the over-75s that figure rises to 13.3 per cent

- 11.8 per cent of 65–74-year-olds 'felt lonely much of the time during the past week' – that figures rises to 18 per cent for the over-75 age group.

For policymakers keen to target interventions in an age of austerity, a simple but blunt way of targeting those most at risk could be to focus on the over-75 age group, rather than the over-65s as many programmes and benefits currently do.

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Causes of social isolation

The causes of social isolation lie beyond the traditional realm of 'ageing policy'. While traditional areas such as welfare payments and public services have their role to play, the causes of social isolation lie in wider changes to family, society, technology, culture and economy. It is these changes that have prevented a significant number of older people from building meaningful relationships with those around them.

Changes in kinship patterns, for example, mean that there are fewer people in each generation of a family and they are more likely to be geographically dispersed. The growth of ICT has both enabled people to keep in touch over longer distances and reduced the need for more meaningful 'face-to-face' contact. A reliance on the car and the demise of local shops and services has reduced the number of chance encounters people have in their

neighbourhoods. Similarly, the decline of formal membership organisations and the shift to online services has reduced the number of institutions through which people interact.

Lying behind these changes is a shift to what Marc Stears calls a 'transactional mindset' in the way we live our lives (Stears 2011). He charts the rise of commodification and efficiency in a range of spheres – including the workplace, public services and family life – that have undermined a sense of mutual responsibility. So, for example, care for elderly family members is seen as a commodity to be bought and sold, rather than a responsibility stemming from a personal bond. In another example, home care for the elderly is reduced to a set of tasks to be delivered as quickly as possible, rather than something that requires time for interactions between an older person and their carer.

Opportunities for change

Shifting away from this transactional culture towards one built on mutual relationships will not be simple. There is a limit to what government policy can do to tackle these cultural problems (ibid). A fruitful starting point is to look at what is required to help people bond. Our analysis has found three key areas for action:

- services built on relationships not transactions
- creating places for interaction
- improving information sharing to ensure people do not become isolated from services.

Services built on relationships not transactions

The growth of the transactional mindset has been particularly strong in public services. Many of today's service institutions were built up in the post-war period and were designed to tackle acute problems that required one-off transactions: providing a house, prescribing medication, and so on. It is clear that the challenges associated with ageing cannot be tackled in this way. The onset of chronic conditions, disability and social isolation cannot be solved by a person visiting a hospital or government department to receive a one-off intervention. Instead, they require people to change the way they live, constant levels of small support, and regular social contact.

London has too many resources locked-up in large institutions, such as hospitals, and relies too heavily on 'transactional' services, such as GP visits and care delivered through a set of standardised tasks delivered as efficiently as possible. The result is that older people feel alienated from the services they use. Traditional transactional services cannot tackle the problems many older people face, except by treating them at crisis point. The challenge is to design services that enable repeated interactions and help to build 'social capital'. As Charlie Leadbeater (2009) argues, if a service can help build relationships between older people, they can then use those relationships to access wider support. If people have strong relationships and connections they can get help with care, transport, shopping and other aspects of daily living. This will require the health service to pool some of its budget with local authorities in order to invest in things that connect people together – such as time bank schemes, reablement, and better-quality home care that includes time for an older person to relate meaningfully to their carer.

A place for interactions

There has been a welcome shift within ageing policy towards ensuring older people can 'age in place' – in the houses and communities where they live – rather than in care homes. This desire to enable older people to remain in their own homes brings with it a tension, as those who are less mobile or unable to access public transport can be left feeling trapped or isolated in their houses. Many of our older interviewees spoke of the

difficulty they had walking to the shops, and the lack of interaction they had with other people when out of the home. This reflects national surveys which have found that more than 1 million older people feel trapped in their own home (NESTA 2009) and that just under half of those aged over 55 in Britain cannot walk to their nearest GP surgery (Living Streets 2011). This is partly a result of the withdrawal of amenities such as banks, post offices, shops and pubs from local high streets, as they rationalise their operations or are forced out by competitors in 'out of town' locations.

In order for people to form social bonds, they need a shared commitment to a physical location. The way that housing and services are designed in England must reflect the reality that many older residents live on their own and are not very mobile. Planning rules should be adjusted to prevent the withdrawal of key shops and services from a neighbourhood, and there needs to be an expansion of 'door-to-door' transport schemes for older people who cannot walk between transport connections.

Information
One major problem identified in our interviews was that people ended up cut-off from services because they did not know what services were on offer – as one service provider put it: 'The worst thing is information, as far as I am concerned, most people don't know about what is available.'

A community information infrastructure needs to be built that reflects the way people currently lead their lives. This infrastructure should have three features. First, it should be based on personal contacts. This is because people do not generally access information and make rational decisions – they are more likely to observe and copy people who they trust (Ormerod 2010). Second, it should use technology more effectively, ensuring up-to-date information about services is easily available and is used to refer older people between services. Third, it needs a clear and single point of access, to ensure people are not confused by the array of services that are available.

Identifying those who are cut off is the first step to tackling social isolation. The key is to make sure that the few times when people do come into contact with services, that contact is made to count. The most effective systems ensure that at the first point of contact a person has with any service, their wider needs are assessed and they are referred to other relevant services. This can require very unusual partnerships between different services. In the case study below, it involved the fire and rescue service using data supplied by the PCT to target certain households. The fire service in turn used their position as a 'point of contact' to connect older people with Age UK and the local authority.

> ### Case study: Springboard, Cheshire
> In 2007, the Cheshire Fire and Rescue Service introduced a simple yet effective scheme to identify older people at risk of social isolation. Part of their duty as fire officers is to visit the homes of older people to conduct a fire safety assessment and fit free smoke detectors. They realised that they could dramatically increase the number of older people they visited if they had access to the databases kept by the PCT, since these databases included information about potentially vulnerable older people. As a result, they developed a data-sharing agreement, which allowed them to visit many people who would otherwise have been missed. The fire officers then took the opportunity of being in older people's homes to raise awareness of other

services available in the area. They developed a simple 'contact assessment form' in conjunction with Age UK Cheshire, which asks residents whether they would like help or information with a range of activities from claiming benefits to home repairs. The resident's responses are used to refer them to relevant services.[5]

Targeted initiatives to tackle social isolation

Social isolation is ultimately a statement about the way we live. It will therefore require a cultural shift towards services built on relationships rather than transactions, spaces for people to interact, and effective flows of information.

But targeted programmes to reduce levels of social isolation also have their role to play, and can help to connect people to social networks and to basic services. Evaluations of successful interventions identify five key principles that lie behind them (Cattan et al 2005):

- Involve groups of people, avoid one-to-one interventions where possible
- Promote informal networks, not formal membership organisations
- Target particular groups
- Involve service users in the design and delivery of the service
- Develop within an existing service.

Social isolation can be triggered by certain life events, such as a spouse dying or going into a care home, or falling ill and becoming less mobile. This suggests interventions should be targeted around these events.

Key recommendations

- Planning loopholes that allow essential local services to change use without planning permission should be closed. Essential services such as banks and post offices should be given their own category within the 'A' use class, and it should not be possible to automatically change use outside of this class. Any change of use would therefore be subject to planning permission.
- Checklists and questionnaires should be used by a wide range of frontline professionals – such as GPs, housing officers and the fire service – in order to ensure the first point of contact results in referrals to other services.
- London boroughs should initiate information-sharing agreements between a wide variety of services – employment, housing, health, care, benefits and leisure – in order to ensure older people are referred between different services.
- Charities or local authorities should facilitate peer support networks for people who have shared conditions or experiences, such as those using personal budgets.
- Local authorities could use their new role for promoting public health to create a 'single point' for older people to access a range of services. This could be modelled on Tower Hamlet's network of Linkage Plus centres.
- There needs to be reduced reliance on big institutions such as hospitals and care homes to support older people, and a greater focus on improving the delivery of

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5   See Cheshire Fire And Rescue Service 2010

services within the community. This will require the health service to pool its resources with local authorities, for example to deliver better quality home care.

- Public services can be designed to enable social interactions in the wider community, for example by delivering group interventions, building peer support networks, or creating organisations like time banks that provide a structure in which relationships can develop and mature.

CONCLUSIONS

In 2008, the Audit Commission reported that only a third of councils across England were prepared for an ageing population. They called for councils to review their demographic profiles, better identify future needs, and reassess how they design and provide services accordingly (Audit Commission 2008). Similarly, many charities and service providers also require a better evidence base on the needs of the older people they serve. This report responds to these concerns, focusing on Greater London. Urbanisation and population ageing are two of the great social forces of our time, and it is essential that cities adapt their structures and services to be more age-friendly (WHO 2007).

London's ageing population

While London is often thought of as a city for the young, it faces an ageing population, with the number of residents over the age of 65 predicted to top 1 million by 2026. Our research has identified a number of important characteristics of London's ageing population:

- It is the over-90 group that is growing particularly strongly. This has implications for the services that will be required – for example, the risk of dementia increases rapidly at this age.
- There is a greater increase in ageing among London's ethnic minority populations. This suggests services for older people will have to adapt to the specific cultural needs of these groups.
- The 'longevity gap' between men and women is narrowing. This means services will have to be better designed for the needs of older men, and there are likely to be proportionately fewer single-person households headed by women.
- Population ageing varies across the London boroughs. Outer London boroughs have a greater proportion of older people than inner London, suggesting they face the greater challenge.

As well as a difference in the rate of ageing across the capital, there is also a variation in the outcomes that services deliver. For example, our research identified large differences in the success of reablement schemes which help older people to settle back into their home after a spell in hospital. In some boroughs, over 95 per cent of older people going through reablement are still living at home three months after being discharged from hospital, whereas in others the success rate is under 65 per cent. This variation suggests the GLA should play a greater role in coordinating health and social care across the capital.

Four policy priorities

Our in-depth research in the areas of home care, dementia care and social isolation has provided evidence on how service providers and policymakers can adapt to the needs of London's oldest residents. Four priorities for public policy emerge from our findings:

1. Unlock resources from big institutions

There is a growing appreciation that problems associated with ageing – including dementia, social isolation and disability – cannot be solved by a visit to a hospital or government department to receive a one-off intervention. These problems require people to change the way they live, constant levels of small support, and regular contact.

There is therefore a disconnection between our current institutions and the needs of an ageing population. London has too many resources locked up in large institutions, such as hospitals, and relies too heavily on 'transactional' services such as GP visits. These services cannot tackle the problems many older people face, except by treating them at crisis point. Their resources therefore need to be unlocked and instead shifted into community-based services such as home care, reablement and peer support networks.

The best way to achieve this would be to pool budgets between health and social care, for example by jointly commissioning professionals ('supercarers') who can carry out both health and care tasks in the home.

2. Create a functioning market for social care
The introduction of the 'choice and personalisation' agenda has opened up care services to a range of providers and put budgets directly into the hands of older people, on the assumption that they are best placed to decide which services that money should be spent on. The current government has announced an expansion of this approach to create a market in social care.

This is a welcome move away from the institutionalised care of the past, but it is dependent on two things. First, it requires an adequate supply of information about what is available. At present, many older people cannot make good decisions about which services to use because they do not have the right information. An improved community information infrastructure needs to be created, based on face-to-face advice, peer support and web technology. Second, it requires a range of care providers for older people to choose from. The endemic lack of funding in social care means there are too few providers in the market, leaving personal budget holders without genuine choice.

3. Improve assessment and referrals
A recurring theme throughout our research is difficulty in identifying older people who need support, with almost 30 per cent of people over the age of 80 being isolated from basic services. This is a particular problem in the area of dementia care, given that just a third of the capital's GPs believe they have received sufficient training to diagnose and manage the condition (CSL 2009). It is clear that many people are not having their needs assessed early enough and are not being referred between services. A growing patchwork of providers – while important for stimulating innovation – brings with it the danger that some older people 'fall through the cracks' between providers.

An improved system of assessment and referrals needs to be put in place to ensure that the first point of contact a person has with any service results in their wider needs being assessed and provided for. This will require services to put in place data-sharing agreements and frontline professionals to conduct short assessments for issues that are beyond their particular remit, as well as improved training for medical staff to diagnose and manage conditions such as dementia.

4. Make home-based care a strategic priority
At a time of reduced public spending, the government has to make strategic decisions about which services to invest money in, balancing the demands for spending across a number of policy areas. This paper has argued that home-based social care should be a strategic priority for government investment. This is because the costs of the state not caring for older people far exceed the costs of extra investment.

First, it means that older people end up being cared for in costly institutions such as care homes and hospitals, rather than in their homes. A lack of resources means that 165,000 older Londoners are already unable to access the care support they need, prompting fears of a costly bed-blocking crisis in the NHS (Age UK London 2009).

Second, without a care service in place younger people are drawn out of the labour market to look after elderly relatives, which in turn weakens the tax base of the country (Esping-Anderson 2009).

Third, the private market is unable to fund care for older people. The inherent uncertainty in the cost of care has prevented people from being able to save towards – or insure themselves against – the cost of social care. Private providers have struggled to operate without public funds.

The Dilnot Commission has suggested a way for the government to make the required investment in social care. It has proposed that the state covers the cost of an individual's care if it exceeds a total of £35,000, thus balancing the need for state investment and individual contribution. These proposals would represent a strategic form of government investment – putting money into social care in order to make savings in acute care costs, support the tax base and provide the market stability that is necessary for individuals to save towards the cost of their own care.

Summing up: invest and reform

The evidence presented in our report shows that the country cannot afford not to invest in social care. The design of our health and care system is placing unnecessary pressure on acute services and expensive institutions; a reliance on private support is placing too big a burden on individual families; and an unreformed care workforce is characterised by low productivity rates. It is these problems that put pressure on the public purse.

Investing more money in social care is therefore of paramount importance, but it must be accompanied by reform of the system. Without this reform, there is a danger that more money will be spent while structural problems – including low productivity, the divide between health and care services, and poorly designed services – are not resolved. This research has identified a number of areas where government, commissioners and service providers can start on this journey of reform.

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