AGE PROOFING OXFORDSHIRE

Literature Review

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Making services appropriate for everyone as we age

NHS Oxfordshire

West Oxfordshire District Council

Oxfordshire County Council
www.oxfordshire.gov.uk

Age Proofing Literature Review

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Contents

Introduction……………………………………………………p.1

Methodology…………………………………………………..p.1

Definitions……………………………………………………..p.2

Potential contribution to health and wellbeing………….p.5

Cost effectiveness……………….……………………….. p.10

Replicable initiatives…………..…………………………...p.14

Conclusions and suggested ways forward……………...p.21

Appendix A: sources of information…..…………………………….p.i

Appendix B: examples of discrimination……..……………………….p.vi

1 Introduction

This paper has been developed as part of the Age Proofing Project between Oxfordshire County Council, West Oxfordshire District Council and NHS Oxfordshire. It looked for recent UK material that either sets out the rationale for, or identifies an evidenced based process to, developing Age Proofing approaches that have a positive impact on well-being. The Project Team undertook within the review to:

- clarify what is meant by 'Age Proofing' and the extent to which it was being undertaken by partners locally;
- find out what was being done elsewhere in the country to identify any good practice Oxfordshire could learn from; and
- come up with a series of potential 'best buys', which if taken forward could remove barriers preventing people living full and active lives.

2 Methodology

The team considered almost a hundred papers, studies and reviews. These included:

- government documents and guidance;
- information on specific projects – publicity and, where possible, evaluations;
- major programme evaluations, such as the National Evaluation of Partnerships for Older People Projects, and the LinkAge Plus national evaluation.

The literature covered low intensity support services, health improvement initiatives, community involvement programmes, approaches seeking to give greater prominence to the voice of older people, projects to improve older people's use of ICT, preventative social care, and more.

The report is divided into five sections:

- Definitions of age proofing – what the literature tells us, and a suggested position for Oxfordshire.
- Age Proofing's contribution to health and wellbeing (including summaries of toolkits from elsewhere).
- Research into outcomes, including cost-effectiveness.
- Good practice initiatives that are potentially replicable in Oxfordshire.
- Suggested ways forward.

3 Definitions of age proofing

Definitions of 'age proofing' are often presumed rather than made explicit in the literature. Age Proofing can be almost anything that relates to improving acceptability or accessibility, and the literature is full of different 'takes' on the subject. There are also other concepts that are used interchangeably with 'age proofing' – terms like age-sensitivity, age-friendly or age equality. Each term has layers of features, and these terms and features overlap in a sometimes ambiguous way.[1]

Where the notion of 'age proofing' is employed by government policy and guidance it is frequently linked to combating 'ageism' and 'age discrimination' and these two notions more often attract formal definitions than 'age proofing' itself. Ageism and age discrimination are generally distinguished from one another, but also linked:

> '*Ageism is primarily an attitude of mind which may lead to age discrimination. Age discrimination, on the other hand, is a behavioural process with outcomes that may be measured, assessed and compare*d'.
>
> Centre for Policy on Ageing. 2007

Combating ageism is an essential part of age-proofing, since it can act as a major barrier to wellbeing and participation. Age-proofing involves ensuring that services are not vulnerable to charges of age discrimination, either directly – i.e. whereby discriminatory assumptions are made about their preferences or capacities which lead to differential treatment – or indirectly, whereby seemingly neutral systems that are in place within institutions to treat everyone in the same way have a tendency to disadvantage older people because they have not been properly thought through.

In contrast to care for the disabled where disability is conceptualised through a 'social model', older people "continue to be perceived as passive recipients of care first and foremost" (Bowers et al 2009, study) and have to submit to a medical model of later life if they receive health or social care services (Oldman 2002, review). Whereas the 'social model' treats the disability as residing in the disabling social treatment of the person with the impairment, the 'medical model' treats the individual's impairment as the locus of the problem. It is against this concept of 'care' (with its notions of people as passive and dependent recipients, often confined into institutions) that the concept of 'independence' has emerged – emphasising the importance of having choice and control over one's life. In this sense, age proofing fulfils a broader social objective to redress the disadvantaging of older people by various forms of disabling social treatment that limit their self-determination. Age proofing seeks to ensure that as we age we still have the necessary choice and control to go about daily life and participate equally in all its opportunities.

From a prevention perspective, age-proofing is as a way of safeguarding against the possibility that exclusion from mainstream public services contributes to a loss of independence in later life. By making sure all services are older people friendly the 'offer to the over 50s' is improved and mainstream services work to support everybody to enjoy a good quality of life as they age. In this sense age proofing has features in common with prevention approaches, which seek to maximise self-fulfilment, independence and dignity. But it involves more than this too. It is also about finding means to verify that services do not discriminate. It is thus related to elements of Equality Impact Assessments (EqIAs) around ageism.

[1] For a fuller account and definitions of the terminology involved see: *Ageism and Age Discrimination in Social Care in the United Kingdom: A review from the literature*, pp.10-11, and http://age-equality.southwest.nhs.uk/definitions-legal-framework-and-implementation.php

There is a list of values that might characteristically be associated with 'Age Proofing':

- ensuring services are designed with an older population in mind
- addressing the needs and preferences of older people as citizens and consumers
- making sure that older people receiving services are not poorly treated
- ensuring equality standards are incorporated in the delivery of services
- making sure that as people age they are still able to use universal services
- taking steps to maintain or increase the civic participation of people as they age
- taking steps to support the social participation of people as they age
- valuing the contribution older people make and tackling ageist attitudes in society
- improving the availability of information to people in later life

Having considered all these sources of information the following composite definition of Age Proofing is proposed:

The purpose of age-proofing is to promote age-sensitive improvement in the planning and delivery of goods, facilities, services and environments for older people, in relation to achieving and sustaining their independence. It is concerned with countering ageism and ensuring positive age equality, as well as promoting civic and social engagement, and integrating services.

Although the practical importance of age proofing and its effect on wellbeing is widely acknowledged, there is a tendency to discuss it at an abstract rather than a practical level. The characteristics of an age proofed society or community are readily described but the practical steps to get there are harder to pin down. For example, the Audit Commission, in its 2008 report 'Don't Stop Me Now', encourages public bodies to age proof mainstream services to ensure that their older communities are able to access universal services. Age-proofing means services being designed and delivered with an older population in mind. Ensuring older people are involved in planning, delivery and evaluation of services is another important policy strand, arising from the new Duty to Involve. This enables older people themselves to act as a form of quality control, to determine if services are doing what they ought to. 'Don't Stop Me Know' gives the example of Knowsley age-proofing waste services – the involvement of Knowlsey Older People Voice led to wheels being fitted to recycling containers and the council having an assisted collection service for people who cannot put out their bins.

A Review of progress against the National Service Framework for Older People from 2006, the mid point in that 10 year programme, found that further action is required. One of its key areas, in addition to tackling ageist attitudes, was to strengthen partnership working between all the agencies that provide services to ensure that they work together to improve the experiences of older people who use services. This desire for a more coordinated, seamless user experience is frequently highlighted by consultations with older people and has emerged as a key concept currently intrinsic to age-proofing. When service design is considered from a user perspective, the requirement for better integration of services becomes readily apparent (the confusion arising from fragmented services is a genuine barrier to uptake). For example, the current structure of the NHS, with its focus on 'specialisms', creates barriers to treating people with multiple conditions cutting across medical boundaries and care settings. As Rockwood, writing in a health context, puts it, "If we design services for people with one thing wrong at once but people with more than one thing wrong turn up, the fault lies not with the users but with the system, but all too often these people are labelled as 'inappropriate'".

Bearing all this in mind we could say that:

a) The *purpose* of age-proofing is to promote improvement in the planning and delivery of goods, facilities, services and environments for older people, to achieve and sustain their independence.
b) The *activity* of age-proofing is a mixture of countering ageism and discrimination, coupled with promoting engagement, positive age equality, and integrated services.

Designing services appropriately requires an understanding of all the barriers people may encounter as they get older. Three different categories of social barriers are described in the literature (for example in 'How to Age Proof' by Held the Aged in Wales), all of which are mutually reinforcing:

1. **Attitudinal** barriers manifested as ageism; these are based on assumptions about a person's ability, capacity, competence, risk, ability to benefit/ not benefit from an intervention due to his or her age. Such attitudes are often informed by ageist stereotypes which view people in later life as grumpy, infirm, incapable of making their own decisions; slower; always vulnerable, etc. This barrier also manifests itself in attitudes which suggest 'we have always done it this way, so why should we change?'.
   Attitudes can feed institutional and environmental barriers.
2. **Institutional** barriers manifest themselves in unjustifiable age-based policies, criteria and practices (resulting in both direct and indirect age discrimination). Chronological age can be used to restrict or confer access to services. Similarly, doing things *to* people of advanced years instead of *with* them can result in institutional discrimination.
   Institutional barriers can reinforce attitudinal barriers and shape environmental barriers.
3. **Environmental** barriers manifest themselves in the built environment in the form of poor street lighting, lack of physical access for people with mobility difficulties, those who need to use scooters, wheelchairs, etc.; sensory barriers due to lack of hearing loops or materials which use type smaller than 12 point; the removal/ lack of facilities such as public toilets or seating in public spaces or services which are provided only through digital and modern information/ communications technology.
   Environmental barriers can reinforce institutional and attitudinal barriers.

Elsewhere, barriers to service delivery are classified into 5 categories: availability, accessibility, affordability, acceptability and accommodation (Penchansky and Thomas, 1981 cited in Guagliardo, 2004). There is no consensus as to what constitutes 'appropriate' access and what indicates a high degree of access. Indeed 'access' is itself a highly ambiguous and often confused term. In general terms, good access can be said to exist when citizens can get '**the right service at the right time in the right place**' (Chapman et al., 2004 cited in Centre for Policy on Ageing – A Review from the Literature, Dec 2009). This is most likely to happen when the social barriers mentioned above have been addressed by the activity of age proofing.

4 The potential contribution to health and wellbeing

A comprehensive study of age discrimination in the first decade of the 21st century, and older people's experience of exclusion, is documented in '[Too Old: Research on Age Discrimination (RoAD), 2007]'.[2] This examines the accounts of older people and concludes that age discrimination is part and parcel of everyday experience. Reinforced by ageist language and commonplace practices, age discrimination is often invisible even though it limits opportunities to participate in activities and employment that would improve physical health, extend social contacts or improve income. This discrimination results in older people being excluded from many public spaces and social activities or placed at a severe disadvantage.

All kinds of positive impacts are seen to flow from tackling the age discrimination that is part of the fabric of our everyday lives, including:

- Policy of greater relevance to the growing numbers of older people;
- Greater uptake of mainstream services;
- Improvement in civic engagement – a stronger voice for older people;
- Enhanced social interaction and happiness (less isolation/ more independence);
- Added economic value from enhanced access to jobs and phased retirement;
- Added economic value from valuing the contribution of volunteers and carers;
- Enhanced safety and protection;
- Fulfilment of legal obligations and moral duty

The central theme underpinning age proofing is that these assorted elements generate positive effects on **life chances and wellbeing**. In addressing these benefits, age proofing has the potential to make a dramatic impact, and some of the specific improvements to wellbeing identified in the literature are set out below:

- People aged 65 to 85 years old with close family, friendship, and community ties are less likely to die from all causes than people who lack social networks.[3]
- Social connections improve mental health, and inhibit depression, low esteem, problems with eating and sleeping.[4] A sense of community engagement also boosts immune systems, lowers blood pressure, and guards against ageing.[5]
- The wealth and the sense of empowerment that comes from employment can result in less demand on services, improved sense of control and greater life satisfaction.[6]

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[2] Numerous other studies corroborate the RoAD research, including: *Patients… not numbers, People… not statistics*, The Patients Association, 2009; *Ageism: A benchmark of public attitudes in Britain*, Ray, S., Sharp, E. and Abrams, D. Age Concern/ University of Kent, 2006; *Every Day Discrimination What older People Say,* Help the Aged, 2004

[3] Aging and Well-Being in an international context' in *Politics of Aging Working Paper No 3* by Clifton, J., Institute for Public Policy Research, 2009 – and – '*Social Relationships and Mortality Risk: A Meta-analytic Review*', Holt-Lunstad J, Smith TB, Layton JB, PLoS Med 7 (7), 2010 – and – 'Differentials in mortality up to 20 years after baseline interview among older people in East London and Essex', Bowling A and Grundy E, *Age and Ageing* 38 (1), 2009, pp. 51 5

[4] *Achieving Age Equality in Health and Social Care; A report to the secretary of state for Health* by Carruthers, I. and Omondroyd, J., Crown Copyright, 2009

[5] 'From Social Integration to Health: Durkheim in the new millennium', Berkman, L., Seeman, T., Glass, T., & Brissette I. in *Social Science & Medicine* 51, 2000, pp.843-57

[6] *The Grey Market*, Age Concern England, 2008 -- and – 'Continued work employment and volunteering and mental wellbeing of adults: Singapore longitudinal aging study', Schwingel A. et al., *Age & Ageing*, 2009

- Recognising and respecting the valuable contribution that older people make as a significant part of the wider community, for example as carers of others, improves the individual and collective sense of self-reliance.[7]
- Improving opportunities for volunteering can reduce depression.[8] For instance joining a community group (when belonging to none) reduces risk of death in the next year by about the same amount as giving up smoking (and may be easier).[9]
- Ensuring people as they age can still get out and about, even when they cannot rely on the use of a private car, maintains people's capacity to live an independent life as they age. [ref]
- Improving the availability of information about services, particularly joined-up signposting and inter-agency referral processes, to ensure people find out about all available help and support makes a big difference to uptake. [ref]
- The provision of practical support – 'that little bit of help' – is an extremely valuable contributor to sustaining independence and well being.[10]
- Age discrimination can make people feel devalued, rejected, excluded, exploited, frustrated, and marginalised, all things which can effect how they interact with society and lead to isolation and in the long term cost them their independence.[11]

It is not clear from the literature how much weight should be given to each element. There is a complex, iterative and mutually reinforcing relationship between loneliness, ill health, exclusion and loss of independence. Rather than trying to prioritise any single action as the most beneficial, attempts are made to demonstrate the association between them, for example in the national ten-year strategy Opportunity Age. This seeks to improve the quality of life of all older people by creating a cycle of wellbeing through participation, leisure, education and ensuring that older people are valued in the workplace and communities. This policy direction is maintained in a raft of subsequent government guidance, most recently in the Building A Society for All Ages series of papers. Robust evidence of causality are much harder to produce and it is likely that there is a complex web of mutual reinforcement between several of these elements. Getting the balance right must ultimately be a matter for local, contextual (and political) judgement.

In short, wellbeing in later life is inextricably linked to effective social ties and opportunities for participation. Attempts to improve older people's wellbeing must tackle social isolation and exclusion by providing the resources for people to realise their life chances and be fulfilled. Improving their contact with society will enable many more older people to have their needs met, yet public services have tended work the other way round, by addressing basic care needs first in the hope that this will enable people to develop strong social ties. The challenge for local government is to encourage forms of social capital that act as a bridge between social groups, to widen social networks, to improve access to jobs and volunteering, and to maintain and sustain people's participation. Tackling exclusion and building social capital by developing new forms of

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[7] *Getting on Well Together: councils working with older people*, IDeA/ Local Government Association, 2009

[8] *Promoting mental health and wellbeing in later life*, Lee, M., Mental Health Foundation and Age Concern, London, 2006 -- and -- Rushey Green, Time Bank Evaluation Report, April 1999-May 2001

[9] Five peer-reviewed studies published in academic medical journals, referred to in *Communities, Social Capital and Public Policy: Literature Review*; David Johnson, Bruce Headey and Ben Jensen; Melbourne Institute of Applied Economic and Social Research; The University of Melbourne; Melbourne Institute Working Paper No. 26/03

[10] *The Older People's inquiry "That little bit of help",* Joseph Rowntree Foundation, November 2005

[11] *Too Old: Older people's accounts of discrimination, exclusion and rejection*, A report from the Research on Age Discrimination project (RoAD) to Help the Aged, 2006

leisure, working, socialising and learning that do not exclude older people will increase resilience and self-reliance.

Without a more responsive model for services for older people, one that reacts to the complexity of exclusion in later life, the damaging effects on older people are compounded. The council and its partners therefore need to exert the strongest possible leadership role to achieve wider change in attitudes to ageing that are the root cause of inequalities. Everyone, including older people, has the right to continue having meaningful relationships and roles throughout their lives.

Many organisations in the UK have responded to this challenge by a reliance upon the use of Single Equality Schemes to implement measures to improve equality. These schemes include age though usually in less detail than the other 'protected characteristics'. Generally any additional approaches beyond the use of Equality Impact Assessments to deliver the benefits set out above consist of work along two broad lines:

(i) a toolkit/ checklist/ self assessment style material

(ii) various mechanisms to increase involvement of older people in decision making

In addition there are some specific changes that could be replicated locally (such as the Welsh Assembly Government's consideration of using smart cards to promote multiple benefits to older citizens), which will be considered in a later section.

4.1 Examples of age-proofing tool kits include:

Age Concern England compiled an 'Age Proofing Toolkit' jointly with the EU Committee of the Regions in 2006, aimed at ensuring that organisations operating at regional level from all sectors fully consider the issues of an ageing population when preparing their regional strategies, and can age-proof their documents. Factors included are best use of demographic trends, promoting stereotype free generalisations, recognition of older people's economic contribution, improving housing choices, etc.

Help The Aged produced a publication from the 'Growing Older in Wales' initiative called 'How to Age Proof'. This approach to age-proofing covers issues of age discrimination and the promotion of age equality with reference to the United Nations Principles for Older Persons, the activity of impact assessing and reviewing current practice.

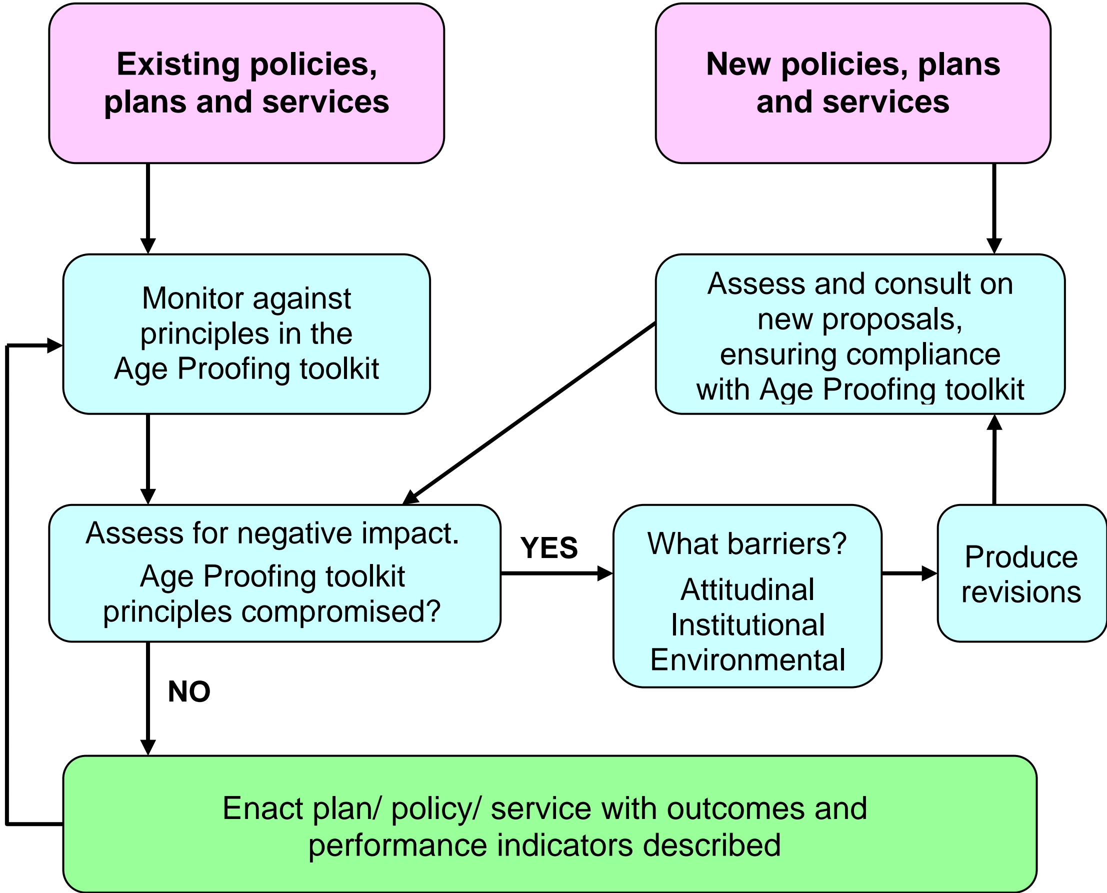
In 2007, the World Health Organisation (WHO) issued its 'Checklist of Essential Features of Age-friendly Cities' following a world-wide series of consultations into the subject. More recently, the DWP discussion paper 'Preparing for our Ageing Society 2008', talked about 'creating an age-friendly society' to change attitudes and make sure that services are well designed and accessible to people of any age.

The Age Equality in Health and Social Care review analysed evidence about the nature, extent and variability of age discrimination in health and social care services, and considered reforms to tackle age discrimination and enhance age equality. The Government responded to the review's recommendations and published a resource pack with three components: (i) an audit toolkit on age discrimination – which enables local NHS organisations and councils to undertake an audit or gap analysis and assess their preparedness for the implementation of the relevant requirements of the Equality Act; (ii) a Good Practice Guide for the NHS – which helps both commissioning and provider organisations build on the information and insight from using the toolkit and draw up action plans and identify solutions to end age discrimination and promote age equality in their organisations; (iii) an Interim Good Practice Guide for Social Care – which helps local authorities identify, formulate and promote good practice in encouraging age equality and tackling age discrimination in social work, social care commissioning and service provision.

The Local Government Group (formerly the IDeA) have produced their own self assessment tool called A good place to grow older. Though billed as simple, quick and easy to use it aims to assess an entire organisation or locality and is less amendable to use by individual service areas or managers.

Oxfordshire would benefit from a tool that could be used by both services/ functions within a council or partner agency and by managers with responsibility for the production of particular strategies or action plans. This would need to be applicable to the development of new services or strategies and to assist in 'retrofitting' existing services or strategies that pre-date the development of the tool. An illustration of how this might work is given in the diagram below.

Fig. 1 - How an Oxfordshire tool could work



Although not a toolkit as such, there are two sets of standards within the development/ built environment arena that are appropriate to include. A number of factors such as good paving, street lighting, access to suitable transport, and well designed buildings are emphasised in both the Lifetime Homes Design Criteria and at least 14/20 of the Building for Life standards. These standards support the development of '*lifetime neighbourhoods*' – places in which the infrastructure, housing and public spaces are designed to meet everyone's needs – so that a person's age does not affect their chances of having a good quality of life. This form of future proofing has strong parallels with the ambition that underpins age proofing.

4.2 Examples of increasing involvement include:

There are numerous examples from around the country of projects focused on encouraging older people to become involved with the decision-making processes in their area.

Case study: Expert Elders (Sheffield)

A network of older people was established as partners in the implementation of the POPP programme in Sheffield, and as decision makers through the local strategic partnership. Expert elders were involved in service reviews, contractor evaluations, quality assurance, and the gaining of patient user opinions on services. The network comprised over 200 people from across the City, drawn from all social backgrounds. 18% were from BME communities, 25% were carers or are cared for and over 60% were women. Participants volunteer their time but are supported by a small staffed project team. Expert Elders receive support and training to help them develop their skills and confidence, so they can influence the development and planning of services and are given information about how Sheffield's statutory and voluntary agencies work. The network meets every 6 weeks. It is claimed that services have changed as a result of Expert Elders, for example:

- Generic care workers are now being trained in hand and toe nail cutting after a network member complained that his home carer could not cut his toe nails. This initiative is known as 'Joe's Toes'.
- The job descriptions for Rapid Response nurses were changed to include mental health skills as older people felt that 'ordinary' intermediate care services did not recognise the number of older people with mental health needs.
- Expert Elders have worked with the City Council and Brunel University on the DIADEM project (Delivering Inclusive Access for Disabled or Elderly Members of the community) which aims to make online forms easier to complete[1].

Case study: Older people's Council (Brighton and Hove)

The city council ensures its 49,000 older people have the opportunity every four years to elect 9 people to form an Older People's Council to represent their interests. The OPC is supported by but independent of the City Council. Its job is to make sure that older people are treated with respect and dignity, that they receive the services and support they need and have access to opportunities to lead a fulfilling life. The OPC meets at least once a month to discuss and take action on issues of importance to older people. The nine members have each been assigned a special area of interest for which they keep up to date on developments and make representations as necessary. The OPC is represented on a large number of bodies throughout the city and works in partnership with the City Council and other large organisations, such as the National Health Service.

Similar set ups can be seen in the Senior Council in Devon, the Older Persons' assembly in Gateshead, and the older people fora in Salford. A slightly different idea has been pursued in Nottinghamshire where a group of older people were recruited and trained as researchers/mystery shoppers to find out what service users thought of their various LinkAge Plus schemes. The results were collated and fed back to further improve services. The elders council of Newcastle and Eastleigh southern parishes older people's forum have been instrumental in mapping their local areas and talking to local people to identify what needs to be done ensure that all neighbourhoods are good places in which to grow old.

5 Cost effectiveness

Most of the literature reviewed is either from the policy arena – such as government policies, setting out ambitions for the participation of older people; or from other local authorities, describing what they have done and the impacts they hope to achieve (as in the examples cited above). There are relatively few robust evaluations of the effectiveness of interventions put in place to age proof services or strategies. There is even less information about cost effectiveness. In 'Don't Stop Me Now', which gave examples of notable practice in local strategic approaches to older people's services, it was clear that even those councils funding innovative schemes had little experience of assessing costs and benefits, particularly those for prevention.

'Valuing Health' is an IDeA literature review on the health of local communities. It purports to present the beginnings of a business case for local authorities to engage in health improvement and examines seventeen thematic areas, including health promotion topics, e.g. smoking, as well as broader topics which impact on health, e.g. housing and employment. It finds the quality and extent of evidence variable; evaluations are frequently not robust; and data on costs and cost effectiveness is 'rarely collected'. Moreover, one cannot be entirely confident that the evidenced findings will always apply to other populations elsewhere in the UK. Notwithstanding these caveats, the IDeA suggests that focussing on the health and independence of older people presents the best potential for efficiency savings. In particular, it points to the impact of exercise classes on the incidence of falls and the need for care. It also promotes measures to reduce isolation/ promote inclusion with the most isolated being between 1.4 and 4 times more likely to die than those who enjoy better social support.[12]

Windle et al's extremely rigorous systematic review, PHIAC 17.14 Mental Well-being and Older People: Review of Effectiveness & Cost Effectiveness, found that despite a general shortage of robust evidence for the effectiveness and cost-effectiveness of interventions they generated six robust evidence statements (see numbers 1 to 4 relating to exercise, no.7 relating to health promotion and no.10 relating to psychological interventions (pp. 9 to 11)).[13]

Curry's literature review, 'Preventative Social Care – Is it cost-effective?', developed as a background paper to the Wanless social care review, again indicates that there is "a paucity of quantified information about the effectiveness of preventative services". [14] Information about cost effectiveness tends to relate to small scale studies and is therefore not comparable. Curry also suggests that the literature is "very disparate in terms of content, outcomes and measurements" and that this makes pulling together and summarising findings very challenging. Curry echoes Layard – concepts like happiness and independence are key to maintaining an effective health and social care system – but it is difficult to establish the cost effectiveness of services that provide them.[15] In a similar vein, OECD has reported that there is considerable evidence that policy instruments can improve the health of older people, but it is unclear which ones are cost

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[12] *Valuing Health: developing a business case for health improvement: Final report*, IDeA, 2009

[13] *Public health interventions to promote mental well-being in people aged 85 and over: systematic review of effectiveness and cost-effectiveness,* by Windle G, Hughes D, Linck P, Russell I, Morgan R, Woods R, Burholt V, Tudor Edwards R, Reeves C and Yeo S T; University of Wales Bangor, Institute of Medical and Social Care Research, Centre for Social Policy Research & Development and Centre for Economics & Policy in Health, 2008

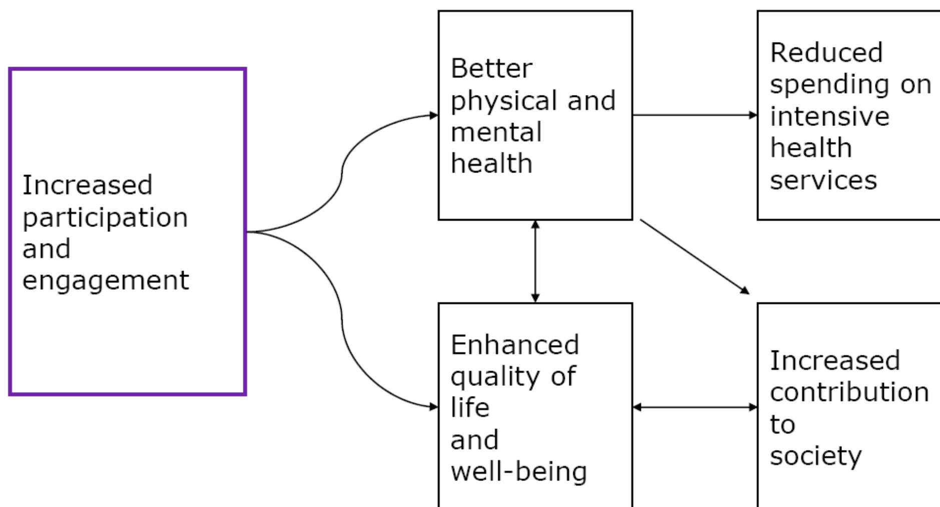
[14] 'Preventative Social Care – Is it cost effective?' by Curry, N., background Paper to *Wanless Social Care Review*, Wanless D. and J. Forder, King's Fund, 2006

[15] *Happiness: Lessons from a new science* (annexes), Layard, R., Allen Lane, 2005

effective. However, there is a “strong financial case” for reducing hospitalisation and for maintaining independence, although the “evidence as to what is effective is rarely quantitative”. Quantifying the economic benefits that might flow from upstream service developments is made harder still as they might not be discerned for several years.

Despite this absence of rigorously costed information on beneficial outcomes, Curry also suggests, similar to ‘Valuing Health’, a number of approaches that are seen as cost effective, and which might be seen to fall within the remit of Age Proofing. For example, ensuring that as people age they still avail themselves of opportunities for exercise. Curry refers to research by Munro et al. which states, “this particular evaluation found the scheme, with a cost of £854,700, to have the potential of preventing 76 deaths and avoiding 230 in-patient episodes, saving costs of around £601,000. Based on the assumption that life expectancy after 65 is ten years, the programme cost £330 per life saved (although the range was £100-£1,500).”[16]

Godfrey, another frequent contributor to the literature, similarly believes in the cost effectiveness in providing just a low level of assistance to individuals who require it to live independently, arguing that without provision of this assistance they more quickly require high intensity and high cost care. Intervening early, or in a timely manner, is intended to delay, and even reduce the intensity of this need. Additionally, increased activity and social engagement can lead to a self-reinforcing cycle of enhanced quality of life and wellbeing, enabling older people to make an increased (mutually beneficial) contribution to society. The conceptual model of successful ageing is set out in the diagram below – clearly the challenge lies in establishing the link between the implementation of a given intervention and the outcome achieved.



Source: Making life better for older people: An economic case for preventative services and activities, ODMP, 2006

The ‘Measuring Outcomes for Public Service Users’ (MOPSU) project, funded over three years (2007-2009) by the Treasury attempted to quantify the benefits of low-level preventative initiatives. Prevention is defined as upstream interventions which seek to help people maintain or improve health before it is compromised, as opposed to the traditional role of the health care system that is to restore health once it has already come under threat. The Sloppy Slipper Campaign, which encouraged older people to exchange ill fitting slippers for new ones that fit, reduced falls by 32% in the first year and 37% in the

[16] ‘Physical activity for the over-65s: could it be a cost effective exercise for the NHS?’, Munro, JF, Brazier JE, Davey R, Nicholl, JP. in *Journal of Public Health Medicine*, vol. 19, no 4, pp 397–402, 1997

second year. The basis for this scheme is that, of the 300,000 older people who go to hospital with serious injuries from falling, around 9 per cent blame their slippers (Department of Health, 2003). If this campaign were rolled out across the country, it is estimated that some £500 million could be saved in terms of reduced falls and the resulting treatment required (Office of the Deputy Prime Minister, 2006).[17]

The recent national evaluation of Partnerships for Older People Projects (POPP) schemes provides the most robust examination of preventative approaches with older people, although these are largely restricted to the social and health care arena. Pilots were focused on delivering improved outcomes for older people by providing more low level care and support in the community. Just about all POPP schemes were seen as cost effective, especially those providing practical help (98%).[18] Preventative programmes, focused on improving well-being through the provision of practical help, small housing repairs, gardening, limited assistive technology or shopping, and exercise programmes produced the best quality of life benefits – an average 12% increase.

For every £1 spent on POPP services, £1.20 was saved in spending on emergency hospital beds. Productivity gains in other areas of health service activity were indicated; for example, hospital overnight stays appeared to be reduced by almost half (47%) and use of Accident & Emergency departments by almost a third (29%). Reductions were seen in physiotherapy/occupational therapy and clinic or outpatient appointments by almost one in ten. Such change had a notable impact on costs with a reported cost reduction of £2,166 per person.[19]

"The POPP programme, set up to test preventive approaches, demonstrated that prevention and early intervention can 'work' for older people. Local authority-led partnerships, working within the context of Local Strategic Partnership and Local Area Agreements, can help to reduce demand on secondary services, providing they are appropriately funded and performance managed. Moreover, it has shown that small services providing practical help and emotional support to older people can significantly affect their health and well-being. Most of the older people using POPP services had relatively high levels of need, but they nonetheless experienced improved outcomes and reported greater satisfaction than the comparison group, as a result of using these services."[20]

In 'That bit of help' Clark et al. (1998) argue that low-level interventions are key to maintaining independence, avoiding institutionalisation and reducing isolation but the financial benefits are somewhat assumed rather than quantified. Another national evaluation claims that LinkAge Plus pilots (which focus on holistic approaches to general wellbeing rather than services that deliver intensive support) have succeeded in providing 'that little bit of help' which enables older people to retain choice and control in their lives, and that services are contributing to the improvement of older people's quality of life, healthy life expectancy and active participation.[21] Accounts of effectiveness are broad-brushed and lack detail, and benefits are described as "difficult to quantify".

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[17] *Measuring the outcomes of low-level services: Annexes to final report*, Personal Social Services Research Unit Discussion Paper 2727, June 2010, p.6

[18] *National Evaluation of Partnerships for Older People Projects: final report*, Personal Social Services Research Unit/ DH, 18 January 2010

[19] op cit

[20] op cit

[21] *LinkAge Plus national evaluation: end of project report*, Davis, H & and Ritters, K., Department for Work and Pensions Research Report No 572, 2009

However, an illustrative example to highlight the potential cost-benefit of an integrated preventative approach is constructed in the associated business case.[22] This found that some up-front investment is required but this quickly begins to deliver net savings, breaking even in the first year after the investment period. "The net present value of savings up to the end of the five-year period following the investment is £1.80 per £1 invested." The business case goes on to argue that into this framework should be added a wider perspective on money saved by decreased and delayed referrals to hospital; numbers of people moving from benefit into employment and therefore paying taxes; fewer visits to medical services as individuals regain confidence and independence and so on. "If the full breadth of the LinkAge services and these wider savings are costed in the cumulative net present value to the taxpayer per £1 invested is £2.65."[23] In addition to taxpayer savings there are benefits to older people monetised at £1.40 for every pound spent.

	Home	External Environment
Physical and Practical	Heating/insulation, Home safety/security, Cleaning, Shopping, Gardening, Equipment, Adaptations, Home Improvement Agencies, Community Alarms, Use of technology, Handyperson/repairs, Lifetime housing, Specialist housing, Benefit Take-up, Equity Release.	Transport, Personal safety, Street lighting, Built environment (pavements, dropped kerbs, disabled access), Traffic management, Community centres, Advice centres and one stop shops, Accessible shops with affordable products.

Source: PSSRU, Annexes to Final Report, 2010, op. cit., p.5

The Audit Commission states that small investment in services such as housing and leisure can reduce or delay care costs and improve wellbeing. One county saves £1 million a year on residential care costs by providing telecare services (North Yorkshire).[24] *Don't Stop Me Now* recommended an age-proofing approach to council services. Under Pressure updates this recommendation to the new economic environment that few predicted in the summer of 2008. This report challenges councils to make long-term decisions about how they will manage the impact of an ageing population.

In conclusion, cost-effectiveness is exceedingly hard to measure, partly due to the nature of the outcomes being measured and partly due to a lack of quantifiable evidence. Although the financial case for prevention needs further development, both the POPPs and LinkAge Plus national pilots have clearly shown the benefits to citizens and the state of developing alternative upstream services. Researchers often say that many of the assumptions made are conservative, and omit a large number of benefits that have not been quantified. There is a great deal of consensus within the literature that holistic, integrated upstream services contribute to an improvement in well-being for older people, all of which shape the shift towards prevention.

[22] *The business case for LinkAge Plus*, Watt, P & Blair, I., Department for Work and Pensions Research Report No 573, 2009
[23] *Benefits realization: assessing the evidence for the cost benefit and cost effectiveness of integrated health and social care*, Turning Point Centre of Excellence in Connected Care, February 2010
[24] *Under Pressure*, Audit Commission, February 2010

6 Replicable initiatives which could make a contribution to age proofing

Where does all this evidence point to in terms of action? Oxfordshire might want to focus actions where there is evidence of interventions with a well-being pay off. This section points to illustrative projects that are likely to have demonstrable benefits. The final part brings together some of the key features of the projects and a set of success criteria.

6.1 Practical help

Evidence from the preceding section suggests that funding practical services to promote wellbeing, and investing in improvements to information and signposting, may provide fewer immediate cost reductions but these services are often found to provide better outcomes in terms of quality of life compared to higher level services. Moreover, practical help to support people to remain active and independent is highly valued by older people. Research conducted on behalf of the Joseph Rowntree Foundation's Older People's Inquiry (JRF, 2005) identified a 'baker's dozen' of low level supports that older people valued because they enabled them to stay in their own homes. These initiatives, such as a 'handy help' – a scheme for small repairs around the house, and 'welcome home' – a scheme for those returning from hospital, are held up as examples of practical services that improve the quality of life of older people and help maintain their independence. There are also good examples from initiatives in Lancaster and Wigan.

Case study: Help Direct (Lancashire)

This innovative service (a key investment in Lancashire's wellbeing and prevention strategy) helps people get the right practical support or simply the right information and advice before a small problem becomes a crisis. The information and signposting component is a free service to all adult citizens (universal offer). The service is commissioned from four providers who work in partnership with each other. Each provider has been commissioned to deliver focused outreach, to find people who might be at risk and provide them with the same advice service and access to practical help (targeted offer). It is not a 'one service' offer, nor a 'one stop shop' but rather a holistic systems providing referrals, wellbeing assessments, one-to-one support, community activity, investment in social enterprises, and social inclusion schemes all through its own resources and through the growing network of partners and community based resources. The most popular outputs were information re digital switchover, handyman services, home fire safety check, home repair or minor adaptations, involvement in leisure activities, personalised services arranged (such as shopping or moving house), and benefits checks that have succeeded in customers receiving greater income.

The service aims to help people gain sufficiently in confidence for them to make a contribution to their local community through volunteering. After 12 months, 149 customers had been signed up to volunteer with local Volunteer Service and a further 77 people were recruited to volunteer specifically with Help Direct.

Case study: 'Groundwork' Gardening Project (Wigan)

In Wigan a 'garden squad' of local volunteers was developed to undertake basic gardening work for older people that did not require professional skills. A quote would be provided and the work then done once the amount had been agreed. Such work included lawn mowing, hedge cutting, and path laying and clearing. The scheme showed a 93% satisfaction rate and this was a key aspect of increasing their independence and reducing risks.

Around 35% of properties classified as 'non decent' are estimated to be inhabited by older households and there is ample evidence that poor housing exacerbates the burden of ill health and disability. Although addressing such sub-standard housing goes way beyond low levels of practical support, there is an evidence base to show that housing related solutions can offer significant and cost-effective gains in older people's independence and well-being. As keeping people in their own homes is a stated policy objective in Oxfordshire, links need to be made with planners and developers to ensure housing is brought up to standard. Relatively few new houses in the UK are currently built to Lifetime Home standards. All public sector funded housing should be built to these standards from 2011; there is a government aspiration that by 2013 all new homes will be built to the standards (see p.8 above).

6.2 Community development

A mixture of projects ranging from direct interventions targeting specific localities to projects that set up neighbourhood schemes have been undertaken to strengthen communities. The Leeds Older People's Forum was a key delivery partner for the city council's older people's strategy for 2006-11 'Older Better', and led on capacity building and networking. 41 organisations including nine BME groups benefiting from capacity building grants to invest in equipment, training, and volunteer recruitment to establish the role of older people as 'peer mentors'; and to establish an infostore website for older people (now seen as a key source of information by those working with older people). As a result older people had easier access to local community centres, participation increased, particularly by minority groups, and the quality of services improved. Across the city as a whole, almost 1,500 volunteers support the neighbourhood network schemes, and over the life of their LinkAge pilot, the number of older people volunteering rose by 16 per cent. Leeds have also worked with existing community network centres which have facilitated a variety of leisure activities, from coffee mornings to art classes, bingo, musical evenings and day excursions to tourist attractions. An increasing number of pubs are putting on pensioners' afternoons attracting lots of people that don't take part in activities organised by the council's social centres.

Case study: Somerset Active Living Centres (Somerset)

The POPP programme in Somerset established more than 50 very local Active Living Centres (ALCs) throughout the county, based within community centres, church and village halls. Each ALC became a 'hub' for the full range of preventive and well-being services already provided by statutory agencies and VCOs. The ALCs provided a café-style environment while hosting a variety of well-being activities, and providing information and referral to other locally available services. The ALCs were mainly supported by local volunteers, supporting a person-centred selection of services for maintaining independence, and were to serve as vehicles for community development and empowerment. Somerset report a " lessening of the effects of chronic health conditions, improved mobility, reduced social isolation and … a renewed sense of feeling independent, in control and being a part of the local community".

The Leeds Older People's Forum also produced a social isolation resource pack to help people work effectively with socially isolated people. The pack summarises research into social isolation goes on to describe good practice – how to target socially isolated people, how to encourage take-up of services that people are reluctant to access. There

is also a section on coping strategies for workers and good practice case studies, along with a set of questions which enables the pack to be used as a training aid. An outline of a three-hour training session for practitioners is also included. Feedback has been very good and the demand has taken producers somewhat by surprise. It is now on its third reprint.

Nottinghamshire introduced *Activity Friends* modelled on an American Senior Peer Mentoring programme designed to help people aged 50+ help others of the same age to incorporate more physical activity into their lives. People over 50 were recruited and trained as Activity Friends volunteers to reach out to their peers in their local community to encourage and support them in participating in some form of physical activity. The main aims of the scheme were to reduce mortality rates from heart disease, stroke and related diseases, improve mental health and wellbeing, and promote healthy and active lifestyles. Befriending to reduce social isolation also formed part of the scheme's activity.

6.3 Joined-up approaches

A key concept currently intrinsic to age-proofing (and prominent in the eight LinkAge Plus Pilots in 2007/08), is how to ensure access to joined-up services for older people. An example with regard to mainstream services is provided by Salford's LinkAge Plus in action referral network, which is supported by the Corporate Contact Centre. Over and above the reason for their call, callers to the centre are also offered a home fire risk assessment, a doorstop crime visit, and a pensions check or contact with a Warm Front adviser. In this way, the mainstream service of advice and signposting works proactively to the advantage of the individual older person by advising them of other relevant services, both mainstream and age specific. A similar single access gateway was introduced in Tower Hamlets.

Case study: First Contact (Nottinghamshire)

First Contact enables older people to access services through a single point of contact. One simple checklist enables people aged over 60 to receive vital services to stay safe and independent in their homes. An older person can receive a range of services without having to separately contact all of the various organisations themselves. If a worker from any of the partner agencies visits someone at home they complete a checklist in relation to that 'first contact' to find out if the older person has need of other services. Responses to the checklist are fed back to central points of contact where staff coordinate the responses of partner organisations. The relevant partner organisation(s) then follow-up with home visits to the person concerned. Services include…

- fire safety check;
- home security check;
- home repairs or mobility adaptations;
- energy saving improvements to keep warm and reduce energy bills;
- confidential advice on money entitlements;
- signposting to local voluntary and community groups and clubs;
- advice on types of housing accommodation that might be available.

The LinkAge evaluation found it to have a net present value over 5 years of £1.80 for every £1 spent.

Integration is evident in another way, in terms of the important policy strand represented by the 2008 national strategy for housing in 'lifetime homes', and 'lifetime neighbourhoods', to promote the interdependency between older people and their communities. Spaces that promote inter-generational contact and function equally well for all age groups are about more than just the built environment and infrastructure (e.g. paving and kerb design, street lighting etc) – they also come about through the way services are located, organised and delivered. Eco Towns will be used as models for exemplary design and the sharing of good practice. *Help the Aged* has proposed ten components that should be the minimum requirements for successful neighbourhoods and communities from the older person's perspective.

6.4 Information

Agencies often encounter real difficulties in ensuring that information is updated and available. And, as Godfrey and Denby recognise, there is more to giving information than handing out leaflets; "Publicising information so that it is widely accessible, including to those who are restricted to their own homes requires both use of a range of media ..... as well acknowledging that 'trusted sources' are multiple and varied"[25].

The Gloucestershire 'Village Agent' scheme and the POPP 'Wayfinders' scheme in Dorset get round this by using local older people as sources of information for local citizens. The older people in this role bridge the gap between communities and organisations that are able to offer help or support. Apart from providing high quality information, they put people in direct contact with the agencies that are able to provide the service they need, carry out a series of practical checks, and contribute to the building of communities. It is an approach particularly well-suited to rural communities (of which there are many in Oxfordshire), and reflects the assumption that 'older people are more likely to source information and access services from someone they know and trust, thereby promoting and supporting longer term independence'. 83% of people say they are happy to approach someone they know and trust in the community for health and advice.

Case study: Village Agents (Gloucestershire)

Agents refer people to services they would not have the resources to find due to their rural location. Over 31,000 contacts were made to Village Agents at a cost of £10 per contact. The contacts were primarily made at existing meetings although increasingly at home and through other stakeholders. The referrals raised by these contacts included benefits, fire safety, transport and a range of other concerns. An additional benefit is that older people have increased confidence in contacting statutory agencies as a result of this scheme. During the pilot Village Agents were responsible for an extra £6,015 in benefits uptake per week and made 150 smoke alarm referrals each year. Agents visit people in their homes and recommend falls prevention measures. During 2007 there were 148 referrals for occupational therapy; many of these were for aids such as grab rails to prevent falls. There were also 93 direct referrals to the Home Improvement Agency for minor works. Agents set up 8 Tai Chi groups which had an average of 104 attendees each week.

[25] Godfrey, M. and Denby, T. *Literature Review, Older People Accessing Information and ICTs*, Centre for Health and Social Care, Leeds Institute of Health Sciences, University of Leeds, March 2007

In addition to Gloucestershire, many of the other POPP and LinkAge projects focussed on improving access to services through the provision of better information, would be worth further examination, such as those in Nottinghamshire, Dorset, Devon, Gateshead, Lancaster and Salford. The 'AskSid' website in Salford forms part of an existing citywide web-based service information directory intended to enable service users to find the right people to talk to. It provides quick and easy 24-hour access to community information that may otherwise be difficult to find. In Nottinghamshire, outreach advisers were used to reach the isolated/ excluded, and Devon undertook a twin-track approach using broad outreach and deep outreach. The former focused on improving access to information and services and included face-to-face events, while the latter provided community mentoring for older people who were experiencing some form of downturn in their lives. Both aimed to provide a more holistic service to meet need underpinned by the principle that 'no door should be the wrong door' for an older person to knock on. In Gateshead a 'proactive information network' was established, whilst in Lancaster care navigators provide practical support on a one-to-one basis to enable vulnerable and isolated older people to access services that they need to remain active in their communities.

6.5 Time Banks

Time Banking promotes the exchange of practical help and support between members of a local community. Participants 'deposit' time, rather than money, in a Time Bank by providing practical help and support to others. They are then able to 'withdraw' their time when they need help themselves. Time Bank brokers maintain a database of participants and match up 'givers' and 'receivers'. All types of help and support are recognised, ranging from house cleaning or meal sharing to accompanying people on walks or giving lifts to the shops to teaching language lessons or providing an hour's financial advice.

Tackling depression by referring patients to community resources (Lewisham)

Rushey Green Time Bank is based in GP practice with approximately 130 members of all ages, half of whom are aged 50 and over, some of whom are older people recovering from mental health problems. It was started in 2000 by a GP who was convinced that many of his patients who had symptoms of depression and isolation could be helped by increasing their social contacts and finding a way for them to feel needed by others and useful to society. Feedback from members indicates that time banking has reduced social isolation and improved mental health and well-being.

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Time Banking is a tool that is beginning to be used in different ways to assist statutory agencies to achieve their goals and to improve social outcomes for local people at the same time. Unlike other forms of community currency, such as Local Exchange Trading Schemes (LETS), Time Banks aim to work alongside mainstream agencies like local authorities rather than trying to build an alternative economy. In Japan, they have been used to enable people to earn credits which can be spent by elderly relatives living in other parts of the country, thus preventing the need for adult children to relocate to be near their parents when they age.

Building a genuinely resident-led Housing Association (Cardiff)

The Taff Housing Association has used Time Banking to transform the way their tenant participation officers work, for an investment of only £5k p.a. Previously, they had used traditional participation methods but found they were involving the same handful of people, most of whom were over 70. Young women at their two hostels now help out by looking after plants in the house or showing a new mum how to bathe her baby. They are rewarded in time credits, which they can spend in eight local leisure centres or the Gate Arts Centre, to access training, or go on Housing Association events that include bowling, picnics, photo shoots and trips out of town. Cardiff Blues Rugby Club now accepts time credits for rugby games and events at the club. The young women are no longer just passive recipients of the housing association's services but co-producers actively involved in running the hostel. Time Banking has also changed the attitude of staff who now view service users as an even more valuable asset to the organisation.

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There are more than 150 Time Banks in operation in the UK (as of Dec 2009) with many more being developed. In Lancashire the county council builds Time Banks into its contracts with voluntary organisations to encourage them to set up additional Time Banks to support those in rural locations avoid isolation. Northamptonshire County Council use a Time Bank to support learning disability service users in the community alongside daytime support. Lehigh Hospital use a Time Bank for people leaving hospital who receive a visit from a Time Bank member; when they recover they pay back the bank by supporting another person. Sandwell's Time 2 Trade Time Bank has been giving residents access to skills and services present in their community for over seven years. It also works with local mental health service providers to deliver friendship and buddying support schemes, and with the Probation Service to utilise the "Work in the Community" team to provide decorating and gardening services to local community groups. SPICE in Wales have developed the approach where people contribute time to the community in exchange to accessing local resources such as cinemas and leisure centres.

Time Banks show positive results in terms of improved self worth, and reduced depression.[26] They characteristically attract groups that are normally socially excluded, and helpfully blur the distinction between givers and receivers. They help with creating social networks that produce healthy outcomes. There is evidence of reduced hospital emergency admissions.[27] These are low cost and hence cost effective schemes which – brokers apart – tend to rely on volunteers with time being used as the operational capital. Oxfordshire is currently investing in setting up a number of Good Neighbour Schemes. A change of approach to instead turn these into Time Banks could be very advantageous. Time Banks recognise people as assets, and are underpinned by the notion of reciprocity, the sense that giving and receiving builds trust and mutual respect. Some people are critical of such schemes for operating amongst a closed membership within a wider community, and argue that there is little sense of volunteering – merely fair trade. In this sense Good Neighbour Schemes should be seen as fulfilling complementary but different purposes. However proponents believe that TimeBanks attract people who are not attracted by conventional volunteering and that beneficiaries prefer the dignity that comes with the expectation of repaying the time in some way, as opposed to accepting help in the form of 'charity'. TimeBanks include – indeed frequently set out actively to include, and value – the contributions of those who are traditionally recipients of services.

[26] Rogers, B & Robinson, E. The Benefits of Community Engagement: A review of the evidence, IPPR, Home Office, 2004
[27] Rushey Green Time Bank Evaluation Report April 1999-May 2001

6.6 Other examples

The county council should consider using information from the registrations service to write to people on their 60th birthday to highlight their entitlements and opportunities and generally give them relevant lifecycle information (e.g. free swimming, free eye tests, free off-peak bus passes, free access to museums and galleries). Such an initiative be incorporated into an overall prevention strategy and/ or tied in with the government's Active at 60 programme aiming to increase the activity of those nearing or newly retired both mentally and physically, and to encourage them to continue these activities into later life. This programme is looking for ways to develop a Big Society approach using volunteers to build on existing community provision to help older people find out about and get involved with activities that will help them stay active, healthy and independent.

Concessionary bus passes for people over 60 often use smart card technology. These are increasingly being incorporated into a wider scheme of benefits so that the same card is used in leisure centres, libraries and for other local services. As outlined in the case studies below smartcard technology to provide all-in-one cards to give access to a range of local activities.

Smart Cards (Bracknell Forest)

In Bracknell Forest people over 60 can use the same card to access the library, free bus services, sports clubs, and get discounts from over 100 local businesses. An added benefit is that people do not need to travel into town to register for free bus travel, as was the case before. Instead, it is possible to register for any service that is available on the card at any location that uses them. This is a benefit for people with mobility problems, since it reduces the need for long journeys in order to be able to take up the opportunities that become available at age 60.

Smart Cards (Derbyshire)

Derbyshire's scheme includes discounts at over 1,400 local businesses that have signed up to using the card. In addition to this, the library service is included on the cards automatically and 20,000 people registered for the library as a result. The card, combined with communications including a magazine and regular roadshows, has helped to improve participation levels in local services. Derbyshire are looking for opportunities to expand the cards to include, for example, cycle hire or DVD rentals, as well as government entitlements.

Intergenerational work offers a further avenue of possibility. 'Building a society for all ages' commits the government to hold a grandparents summit to highlight the opportunities for inter-generational contact and to look at what extra help grandparents may need.[28] In Leeds, links between Leeds University and a local college have brought young people into the work of the neighbourhood network centres on a regular basis. This has benefited both the work of the centres and the young people.

Manchester, Derbyshire, Salford, Hertfordshire and Lancashire have all produced comprehensive older people strategies, expressing their commitment to valuing older people and articulating how they plan to make the area age-friendly. Oxfordshire could do the same.

[28] Building a Society for All Ages, HM Government, 2009, p.25

7 Where does all this lead? Conclusions and suggested ways forward

7.1 Shared statement of purpose

Public bodies such as local authorities and NHS organisations have a duty to consider what action they can take to reduce the inequalities people face. They are required to end age discrimination and promote age equality. This duty will affect how public bodies make strategic decisions about spending and service delivery. Age Proofing is a means by which these agencies can satisfy themselves that they are meeting this duty with regard to older adults. A suggested response is for all the main organisations in Oxfordshire to sign up to a commitment which can be summarised along the following lines:

Our ambition is to reframe how old age is viewed in Oxfordshire to re-establish the value of being older.

Our objective is to promote older people's autonomy and advance their wellbeing.

Our rationale is that everyone should have access to appropriate products and services – regardless of their age.

There should be a clear local vision in relation to age equality. Every provider must consider how to achieve non-discriminatory, age-appropriate services, drawing on sources of good practice, to ensure older adults are able to participate fully in society on an equal footing with other citizens and consumers. This will require changes to the way institutions, services and actions are designed in all walks of life – moving the response far beyond the usual focus on the trinity of pensions, health and social care.

7.2 Set of principles

Although, as identified earlier some of the evaluations are a little thin on detail, overall the following factors look to be important in delivering an age proofed environment for older people.

Involvement – older people must be given a voice, and their views listened to when expressed, to ensure that the user's perspective is in the 'driving seat'. Consultation when services are designed is vital and people should also be involved in giving feedback to monitor and quality assure them. It is also crucial to involve older people in assessing how well the county is doing in terms of outcomes that evidence success at promoting age equality.

Whole system working – schemes need to promote and rely upon joint working, and gaining the involvement and commitment of partners. Taking a big picture view across a range of different interests means identifying the various components of the whole system, understanding the relationship between each of these, and recognising the benefits and risks that come within that whole system (such as opportunities to share costs).

Information – providing appropriate information in ways that ensure it reaches sufficient numbers of people, including those who may be least able to get hold of information is essential to the uptake of services. People cannot benefit from services which they do not know exist.

Environment – making sure the physical aspects of our places and spaces do not impose any barriers, for example by ensuring a sufficiency of toilets, signage and seating, minimising obstructions such as steps, stairs, uneven surfaces and restricted

passages, and checking other aspects such as the safety, lighting, and cleanliness of the public realm.

Access – this can mean different things to different people and is sometimes considered to be a form of jargon. Making sure people can access services is an element of uptake and as such encompasses information (knowing about a service), the physical environment (being able to enter and use the location of the service), the appropriateness of the service (how welcoming, friendly and relevant it is) and transport (getting to a service). Thinking about transport issues means more than just how people get there, it involves considerations around co-location with other services, making sure there are alternatives to the private car, and coordinating opening hours to fit in with public transport schedules.

Staff attitudes – ageism is deeply engrained in contemporary culture such that worker's expectations of older people colours their approach to them. This can be especially, but by no means only, true in the medical profession where it can at times be challenging to disentangle the limitations that can arise from ageing from the requirement for fairness and equality in many decision-making processes. Staff must be helped to recognise the age-range and diversity of older people. Despite the gap between policy rhetoric and practice realities, and between needs and resources, it is unacceptable for customer-facing staff not to address people's needs.

Personalisation/ flexibility – coupled with dignity and respect programmes, a person-centred approach is the best guide for staff, so that at all times they see the person and not the age. Personalisation policies should fully integrate age equality requirements and be extended wherever possible into the design and delivery of services beyond the sphere of social care as a core principle for ensuring fair treatment.

7.3 Age proofing Criteria

From the information set out above, it is possible to identify a number of criteria by which organisations and services can be judged. An age-proofed service/ function will have most (if not all) of the following characteristics:

1. Managers take direct and personal responsibility for promoting greater equality and test themselves on progress by the outcomes they achieve.
2. The service has undergone a consultation/ engagement process with key stakeholders to identify what matters most to them and understands how it may previously have disadvantaged some people.
3. It has set objectives to address persistent inequalities and to narrow any gap or other area of inequality for service delivery.
4. It has thought about how people of all ages will access the service and has ensured its location and opening hours are aligned with public transport options (no point having a drop-in session after the last bus). It includes details of local public transport in all its publicity.
5. It operates in a building that is as accessible as possible, and can provide or direct people who need to use a toilet with appropriate facilities.
6. It has trained its staff to think about how they interact with people of all ages to ensure they accommodate any special needs they may have without assuming such needs may be present. Staff behave in a way that is courteous, helpful and non-patronising. Staff are alert to the dangers of elder abuse and understand how and when to use adult safeguarding procedures.

7. It takes into account Equality Impact Assessments that review service changes in policy and conducts its own EqIAs from time to time. Equality objectives are integrated into both service planning processes and procurement and contracting processes.
8. It operates in accordance with appropriate employment objectives for older people, and does not use unfair age limits in either its recruitment or delivery.
9. It operates in a joined-up way and honours a commitment to help sign-post people to other appropriate services as a matter of routine, so that people as they get older can still get the information they need easily without being passed from ‘pillar to post’.
10. Members of the public, including those who are marginalised or vulnerable, are able to challenge performance on equalities issues.
11. It uses some positive imagery of ageing within its publicity, and challenges stereotypical notions of ageing in its information and amongst its workforce.
12. It takes appropriate steps to contribute to a more cohesive local community in which mainstream services offer fulfilment for all.

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Useful websites

Centre for Policy on Ageing (CPA):
www.cpa.org.uk/cpa/cpa_news.html

Audit Tool for Achieving Age Equality (Dept of Health/ NHS South West)
http://age-equality.southwest.nhs.uk/

DH Care Networks – prevention and early intervention (replaced CSIP):
www.dhcarenetworks.org.uk/prevention/

Department of Health Equality & Human Rights Guidance:
www.dh.gov.uk/en/Managingyourorganisation/Equalityandhumanrights

Equality & Human Rights Commission:
www.equalityhumanrights.com

Audit Commission improvement tools:
www.audit-commission.gov.uk/localgov/goodpractice/olderpeople/pages/default.aspx

Communities and Local Government:
www.communities.gov.uk

The Ageing Well programme (IDeA)
www.idea.gov.uk/idk/core/page.do?pageId=20344655

Housing Learning Improvement Network (HLIN), CSIP:
www.housinglin.org.uk/index.cfm

The Housing and Older People Development Group (HOPDEV):
http://hopdev.housingcare.org/publications.html

Care and Repair (England)
www.careandrepair-england.org.uk

Joseph Rowntree Foundation:
www.jrf.org.uk/work/workarea/older-people

Care Quality Commission (CQC):
www.cqc.org.uk

WRVS:
www.giveusalift.org.uk/WRVS.aspx

Age Concern Oxfordshire:
www.ageconcern.org.uk

Forster Agency
www.forster.co.uk www.forsteragency.co.uk

50 athletes over 50
http://athletes.50interviews.com/

Time Banking UK
www.timebanking.org

Examples of indirect discrimination and disadvantage

A few examples of discrimination (outlined in participatory research or in various testimonials of older people) are outlined below.

Within the built environment and infrastructure (including transport):

- A general shortage in town centres and outlying areas of public benches, seating areas and public toilets.
- Town planning creating beautiful city centres with uneven floor surfaces (cobbles, paving).
- Poor transport links – e.g. York no taxis allowed into the centre in the middle of the day, which older people expressed as a time of day they most favoured to be out).
- New government concessionary fares on buses – no consideration to other transport for the less able to use buses.

"I accept that it may be necessary for me to inform the authorities that I am still fit enough to drive, but why do I have to pay £10 every three years [to renew my licence]*"*

"Older people have been told (by bus drivers) to get off the bus and wait outside until the driver knows if there are any seats available"

"*The drivers willingly lower the floor for obvious handicaps such as buggies and wheel chairs, but exercise their own clinical judgement for boarding or leaving older passengers*".

"There were stairs down to all the restaurants with no rails, there were little amount of seats, those that there were there were away from the entertainment. The toilets were not of a hygienic nature"

"*After lunch we walked on the costal path, we jumped a number of times, as cyclists whizzed by, me because I can't see properly, my husband because he is deaf and my sister because she is 73 and of a nervous disposition"*

(From a vignette about town changes) The poster promised al fresco eating, entertainment, a water feature, entertainment and specialist market (in the new town square). They looked in vain for the market, the square had 4 pubs, which were reported to open late and be rowdy *"it is just for the young people now; it's either too expensive or too noisy, and I wouldn't feel safe here after dark."* *"I'd have liked an old fashion market and somewhere to spend a penny"*

Advertising and the Media:

- Stereotypes and negative images or ones which ridicule older people pervade the media (reflecting and reinforcing the deeply imbedded ageist attitudes in society at large).
- Older people feel ignored in advertising, marketing and product design. Although people over 50 account for two-thirds of annual expenditure on leisure goods and services, less than 10 per cent of all marketing expenditure is aimed at them.
- Older people are under-represented on TV, with less than 3% of prime-time TV characters in the US over the age of 65.

- *"OAP Judge to head investigation"*
- *"A tea advert features a waiter running away from an older woman after she asks him to put sun cream on her".*

Within the market:

- 97% of annual travel insurance policies across the market impose an upper age limit. (More than a quarter (26%) of the annual policies examined will not cover the 9.6 million people in the UK aged 65 and over, with three quarters refusing to cover the over 75s).
- Leading fashion excludes older people
- Modern technology disadvantages older people in crowded settings and in queues, banks, shops etc.
- Advertisements, TV and films often portray older people as figures of fun.
- Cost excludes older consumers.
- Digital technology is generally not marketed to older people in a way that reflects their needs and interests.

"*You can't book online if one person is over 60*"

"I have recently reached the age of 65, and already I am having to cope with being refused admission to activities, even though my crime is simply that I have had another birthday."

"The minute you say that you are over 66 they have no cars available" (car hire).

"It turns out that their sole reason for refusing my application was because I was over 75" (on a computer payment option).

"Two for the price of one in food shops is ridiculous for someone living alone."

Employment and learning:

- Forced to retire early before they are ready
- Rejected due to age
- Compelled to go part time or take a lesser paid job
- Denied opportunities
- Bullied by younger colleagues.
- Even in voluntary work people are discriminated against.
- Confessionary fees for community education and other courses were not available to someone over 60.

"In spite of my experience and knowledge and reliability [in a specialist field for over 50 years] *I am being replaced by someone who will have none of the knowledge unique to the position, purely because the* (organisation) *deem I am too old to carry on with a job I have been doing efficiently and successfully until my birthday"*

"We don't accept anyone over the age of 57"

"The new rule will de bar me from continuing in this unpaid job, which I am happy to continue doing, just because I am over 70"

"We are never too old to learn" – a woman turned down for a course at a leisure centre as she was over 60.

Within society;

- Older people feel that family, and services feel that you cannot make your own decisions and treat them like children when they reach a certain age.
- One third of people have a difficulty in participating in public consultations.
- 76% of people who were in residential care feel they are forgotten by society.
- 65% of people feel that local communities neglect their older people who have become socially isolated.
- Older people felt they were discouraged by society from expressing their sexuality.
- Assumptions and stereotypes are common e.g. older people do not contribute to the economy – but:

– 25% of all women aged 50-54 are providing unpaid care for a family member, friend or neighbour,
– over 27% of older people aged over 65 work in voluntary work,
– 60% of childcare is provided by grandparents.
– 5% of the employment workforce are over 60.
– Many older people fund their own care.
– The amount that unpaid carers save public sector is around £22 billion a year, more than double the current annual public sector spending [3].

"Sunday newspapers that I used to enjoy are now devoid of inclusive references for me, so I don't buy them. The culture that I live in makes me feel that I don't exist"

"Sometimes it makes you feel bad when you see people who are younger. The fact of me being a sexual being wouldn't enter their heads"

In response to the sad death of an isolated old lady one commented *"Very sad but not uncommon. The forgotten old of society. Who cares for the old?"*

Within Service provision:

- 59% of people feel that many residential care homes neglect to some extent their loved ones. Around 40% of residents have depression (and older people with depression are three times more likely to experience elder abuse).
- Older people expressed concerns about how they were treated by key professionals, for example within health services, and how they were felt viewed as *"a nuisance"* or received worse care than younger people, not included about key decisions about their care or neglected.
- Only 10% of older people with clinical depression are referred to specialist mental health services, compared with about 50% of younger adults.

"If you were 72 (now) and 77 in five years. I would keep checking you. But as you are now 77 I will discharge you" – comments from a consultant surgeon.

"I was taken off their books because I was not an "ordinary" person" – from a dental list.

"It has been given to us, her family, the distinct impression that maybe a younger person would have been taken more seriously." – family of a woman who presented with months of symptoms but received very late diagnosis and died of cancer.

"It has been the worse two years of my life. I've only been out of this flat one day a week in the last two years". (Access issues in sheltered accommodation – a high step).

"*I am noticing the differences what social services will commission for home care services aged over 65 and what it commissions for people who are younger*" (A researcher)

"At one point my fathers alarm was taken away, making it difficult for him to get help when suffering through the night with severe pain"

She was told that due to being unable to use the toilet facilities [due to being immobile due to a fracture] *she should wet the bed. This was highly embarrassing for her. Even worse on one occasion, a night nurse told her off for doing this, severely enough to reduce her to tears and for her to ask me to take her home." "Eventually she was fitted with a catheter".*

"In residential homes, a variety of issues around access to information can lead to exclusion. One home had various policies printed in miniscule font and pinned high up on the wall in the home's reception area. Many homes offer no access for residents to daily newspapers, magazines, journals or phone calls. A newly admitted resident was anxious and tearful because her daughter was undergoing surgery for an aggressive cancer, and wanted to phone the hospital to find out how the operation had gone. She was denied access to a phone, and told a member of staff would ring the hospital later in the day." (Observations from visits to homes)

In all of these examples, the options offered to older people are not what they want. Those involved in planning or providing services are making false assumptions about older people, their needs, and the way they choose to live their lives.

The result?

Older people are devalued, ignored, dismissed or badly served. A causal remark or a policy set in stone – the effect is the same.