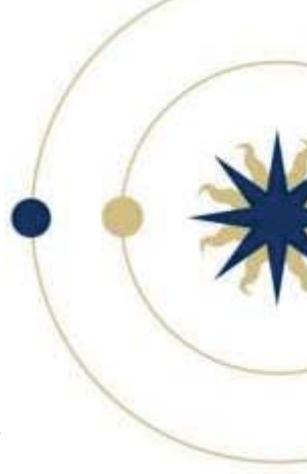




GREEN TEMPLETON COLLEGE | OXFORD



**Social Care and Older People in Home and
Community Contexts:
A Review of Existing Research and Evidence**

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Social Care and Older People in Home and Community Contexts: A Review

1. Introduction

This report presents the findings of a state of the art interdisciplinary review of the literature on social care for older people in the UK, paying particular attention to home-based and community care. The purpose of the review was to identify key evidence, synthesise that evidence and identify gaps in the evidence, with the aim of developing a cutting-edge research agenda, under the leadership of Professor Mary Daly. The review was conducted by a single researcher, taking a qualitative approach, drawing upon both academic and grey literature. For full details of all current/recent UK researchers in this area, see Appendix One.

The UK, has, like the majority of Europe, an ageing population, with more people living for longer, and into ‘older old’ age (Creighton, 2014). Morbidity is becoming ‘compressed’ (Fries, 1980) into (later) older age, with older people being more likely to develop chronic and ongoing ill health and multiple long-term conditions necessitating support from others to maintain their daily living and personal care (Falkingham et al, 2010). Often that support will be highly specialised/medicalised. The numbers of functionally disabled older people in England are projected to grow from approximately 2.3 million in 2002 to approximately 4.6 million in 2041, i.e. almost double (Commas-Herrera et al, 2006). Among high-income regions in the world (which includes the UK) older people amount for nearly half the burden of chronic diseases (Prince et al, 2015) with associated cost implications for healthcare and social care systems (Wittenberg et al, 2011 and 2012). This is predicted to increase, making preventative health interventions of paramount importance (Prince et al, 2015).

Dementia, which is age-related (Knapp, 2007), is also a concern (Alzheimer’s Disease International, 2013). In the UK, the number of people with dementia is forecast to increase to 1,142,677 by 2025 and 2,092,945 by 2051 (Prince et al, 2014). Dementia increases with age: one in every 14 people over 65 years has dementia as do a third of people aged over 95. Women are disproportionately affected by dementia: individuals aged over 80 living with dementia are twice as likely to be women as men, and individuals reaching 100 who are living with dementia are four times as likely to be women as men (Alzheimer’s Disease International, 2015). The total annual current cost of dementia in the UK is £26.3 billion (Prince et al, 2014). This is made up of the following sets of expenditure: £4.3 billion on healthcare costs; £10.3 billion on social care (publicly and privately funded); and an estimated £11.6 billion through the contribution of unpaid carers of people with dementia. Over two-thirds of older people in care homes have dementia (Prince et al, 2014). In the final stages of symptoms people with dementia require 24 hour care, often involving high levels of nursing care.

According to Comass-Herrera et al (2006: 1), based on current models of health and social care provision in the UK, this ageing and dementia-related demographic has the following implications for health and social care provision:

- To keep pace with demographic pressures over the next 40 years, assuming unchanged rates of functional disability, residential and nursing home places would need to expand by around 115% and numbers of hours of home care by around 100%.
- The numbers of staff working in social care for older people would need to increase by around 110% between 2002 and 2041 to provide this increased level of services.
- Long-term care expenditure would need to rise by around 325% in real terms between 2002 and 2041 to meet demographic pressures and allow for real rises in care costs of 2% per year for both social care and health care.
- Long-term care expenditure would need to increase from 1.4% of GDP in 2002 to 2.6% of GDP in 2041 to meet demographic pressures, assuming annual increases in GDP in line with HM Treasury assumptions.

In effect, there is an increasing gap between care needs and care expenditure. This is because of increasing numbers of older people living for longer with high care and support needs at the same time as informal and formal care resources are diminishing. The hypothetical social care tax which has been mooted local authorities might raise is predicted to fall far short of meeting demand (Franklin, 2015).

There are particular concerns about a lack of specialist residential care provision for people with dementia, over half of whom spend their final years in such provision (Macdonald & Cooper, 2007). There are increasing inequalities in housing for older people: 'there are two nations in old age and they are increasingly polarised by housing wealth' (Department for Communities and Local Government, 2008: 13). This is within the wider context of housing challenges for older people: over the next 20 years, it is estimated that the stock of specialist older age-specific housing will need to grow by between 40 and 70% (Pannell, Aldridge & Kenway, 2012). These predictions are based on the current model of 'informal' and 'formal' social care and the relationship between 'informal' (unpaid family and friendship) care (Agree & Glaser, 2009) and 'formal' (free and/or paid services from the voluntary sectors and/or paid-for services from the private and/or public sectors) care.

Family carers are the backbone of any long-term care system. Across the OECD [the Organisation for Economic Co-operation and Development], more than one in ten adults aged over 50 years provides (usually unpaid) help with personal care to people with functional limitations. Close to two-thirds of such carers are women (Francesca et al, 2011: 13).

A decline in the availability of informal care for older people would lead to an even greater increase in demand for formal services (Pickard et al, 2012). It is just such a decline which is being predicted:

The supply of care to older people with disabilities by their adult children in England is unlikely to keep pace with demand in future... Demand for unpaid care will begin to exceed supply by 2017 and the unpaid 'care gap' will grow rapidly from then onwards. (Pickard, 2015: 96)

This predicted gap in unpaid care is due in some part to 'the decline in co-residence of older people with their children and the continuing rise in labour market participation by mid-life women' (Pickard, 2015: 97). While there may be an increase in spouse carers (Colombo et al, 2011a and 2011b; Haberkern et al, 2011) this will not compensate for reduced intergenerational support. This is especially because, among the 'oldest old', individuals are likely to be rendered single by bereavement and/or both members of a couple will both be at

increased need of care and support and less likely to provide it for one another (Pickard, 2015: 38). Moreover the levels of care and support required by someone in the advanced stages of dementia will go beyond that which can be provided by even the most dedicated ‘informal’ care providers (Glaser et al, 2008: 347). An ageing population has major financial implication for local governments, which are required to meet (major) unmet needs of older people (Audit Commission, 2009). In a wider context, it coincides with growing austerity measures and reduced funding for formal social care provision (Ismail, Thorlby & Holder, 2014), with a third fewer older people receiving formal social care services in 2012/13, compared with 2005/6 (Fernandez, Snell & Wistow, 2013).

2. Method

The purpose of the review was to identify key evidence, synthesise that evidence and identify gaps in the evidence, with the aim of developing a cutting-edge research agenda relating to older people and social care. The review was conducted taking a qualitative approach, drawing upon both academic and grey literature. The research focused on literature published between 2005 and 2015, with earlier documents included if they had particular significance/saliency. International academic databases were sourced with Oxford SOLO (Bodleian Library) as a primary resource. In addition, targeted website searches and independent/ free text internet searches were also conducted. Both academic and grey literature was accessed. ‘Grey’ literature comprised: discussion papers; green papers; white papers; working papers; government enquiries/reviews; ‘think-tank’ reviews; policy documents; policy reports; policy guidance; policy statements; position statements. Initial searches were conducted using multiple combinations of the following search terms:

- *age; ageing; agency; agenda; assets; autonomy; care; carers; change; choice; client; commission(er/ing); community; concept/s; conceptualising; control; cost/s; dementia; development/s; dignity; diversity; domiciliary; elderly; end-of-life; environment; health; health capital; home; housing; housing trajectories; gaps; need/s; older people/person; paradigm; paying; personal budget/s; policy; political; practice; provider/s; provision; quality; service/s; resources; social; social capital; standards; strategy; support; support; theories; theorising; theory; trend/s; welfare.*

Secondary searches were conducted using: citation searches, i.e. tracking articles which had cited a key article, and snowball searching/reference harvesting, i.e. scanning the reference lists of all relevant literature. Documents were selected for their relevance to the UK context of social care provision for older people. Non-UK literature was selected if it added value to the quality of the review and/or described innovative models of interest. A trawl of all of the relevant UK academic institutions as well as the major funding organisations (e.g. The Economic and Social Research Council (ESRC), National Institute for Health Research (NIHR), etc.) was conducted, in order to identify recent/current relevant research.

3. English Social Policy Context

3.1. From provision to prevention agendas

Successive English governments have, since the turn of the century, shifted the focus of law and social policy from issues of care provision¹, adult protection and social care standards (Department of Health, 2000) to issues of health promotion and the prevention/delay of the need for formal social care (Secretary of State for Health, 2012; Department of Health, 2010a) in a desire to promote ‘ageing well’ to offset resultant health and social care costs (Burton, Mitchell & Stride, 2011; Means & Evans, 2012). The prevention agenda,

... has meant that authorities across England have invested in services such as reablement and telecare, as well as low-level advice, information and befriending services that aim to improve quality of life and prevent the need for more intensive packages of care (van Leeuwen et al. 2011: 105).

The *National Service Framework for Older People 2001* (Department of Health, 2001) made explicit commitments to services that promote health, independence and prevent unnecessary hospitalisation. While setting out standards for person-centred care and intermediate care and support, the framework also emphasised ‘the importance of the promotion of health and active life in older age’ (Standard Eight). The Wanless report (2002) highlighted the need to improve the health of ageing populations in order to reduce health and social care needs and unsustainable demands upon the health and social care systems. The Labour government’s 2005 *Independence, Well-Being and Choice* (Department of Health, 2005) and 2006 White Paper *Our Health, Our Care, Our Say* (Department of Health, 2006) marked a new direction for community services with an emphasis on health and social care services to provide better prevention services and earlier intervention.

Under the Conservative/Liberal coalition government (2010-2015) austerity measures led to ‘funding cuts and an ongoing emphasis on a preventative agenda’ (Dickenson et al 2012: 6). The White Paper *Open Public Services* (HM Government, 2011a) set out a commitment to devolve power and responsibility for public services to those working in them and using them. The coalition government also published two health strategies, which placed emphasis on localised services and support: the 2010 *Healthy Lives, Healthy People: Our Strategy for Public Health in England* (Department of Health, 2010a) and the 2011 *Healthy Lives, Healthy People: Update and Way Forward* (HM Government, 2011b). Around the same time, the coalition government published, in 2010, *A Vision for Adult Social Care: Capable Communities and Active Citizens* (Department of Health, 2010b) which laid out seven principles: 1) Prevention (empowering communities ‘to help people retain and regain independence’); 2) Personalisation (‘individuals control their care through good quality information, and personal budgets, preferably as direct payments’); 3) Partnership (‘care and support is delivered as a partnership between individuals, the voluntary and independent sectors, the NHS and local authorities’); 4) Plurality (‘a broad market of high quality providers meets people’s diverse needs’); 5) Protection: (‘sensible safeguards against the risk of abuse or neglect are in place, but risk is no longer an excuse to limit freedom’); 6) Productivity (‘greater local accountability and published information drives up standards’);

¹ The NHS and Community Care Act 1990.

and 7) People ('a skilled and compassionate workforce from all disciplines works alongside users and carers to lead change'). Chapter Three of the coalition's 2012 White Paper *Caring for our Future* (Department of Health, 2012) also emphasise strengthening communities in order to support older people to live in their homes for as long as possible. The coalition's Care Act 2014, built upon previous legislation² and social policy which afforded increasing rights and supports to informal carers (Department of Health, 2007; Department of Health, 2008; Department of Health, 2010c) by creating an entitlement to care and support for carers in their own right. It also emphasised: promoting individual well-being; preventing needs for care and support; and promoting integration of care and support with health services.

In 2015 Public Health England published *Improving Health Literacy to Reduce Health Inequalities* (Public Health England, 2015). The document took a highly preventative approach to health and well-being, defining 'health literacy' as 'people having the appropriate skills, knowledge, understanding and confidence to access, understand, evaluate, use and navigate health and social care information and services'. The document linked high literacy with healthy lifestyles and behaviours and low literacy with the opposite, and laid out a range of strategies to improve health literacy levels.

3.2. 'Personalisation'

The Community Care (Direct Payments) Act 1996 allowed local authorities to give cash payments ('Direct Payments') to service users instead of providing services to them, in order that the service users could purchase preferred services themselves. In 2007 the Labour Government published *Putting People First: A Shared Vision and Commitment to the Transformation of Adult Social Care* (Department of Health, 2007c), which heralded the personalisation agenda and the idea of care recipients as consumers able to exercise choice and control through independently purchasing the commodity of care. The Labour governments' agenda expanded the possibilities of the 1996 Act to enable to purchasing of care through 'personal budgets', i.e. the sum of money allocated to a service user, following assessment of needs, which could either be taken in the form of cash payments or used by the service user to direct a care package commissioned on their behalf by the local authority (Department of Health, 2010).

3.3. The prioritisation of housing

The Labour government published, in 2008, *Lifetime Homes, Lifetime Neighbourhoods: A National Strategy for Housing in an Ageing Society* (Department for Communities and Local Government, 2008: 6) which was strongly influenced by the WHO's age-friendly cities initiative (Buffel, Phillipson & Scharf, 2012) and noted that,

Most of our homes and communities are not designed to meet people's changing needs as they grow older. Older people's housing options are too often limited to care homes or sheltered housing. Put simply, we need more and better homes for older people now... This strategy sets out our response to the global challenge of ageing. It also outlines our plans for making sure that there is enough appropriate housing available in future to relieve the forecasted unsustainable pressures on homes, health and social care services.

2 Carers (Recognition & Services) Act 1995; Carers and Disabled Children Act 2000; Carers (Equal Opportunities) Act 2004.

The 2008 report (p. 132) also acknowledged the unmet housing needs of many older people, particularly those from minority backgrounds:

The research we have commissioned shows that there are legitimate concerns amongst older groups, including BME communities, disabled and lesbian, bi-sexual, gay and transgender (LGBT) older people, that specialised housing is not always sensitive to their needs. Specialised housing can adapt to a much more diverse market and is also duty bound to tackle discrimination against these groups.

The report heralded the increasing linkage in policy and policy commentaries between housing and the promotion of well-being in later life (Institute for Personal Care (IPC) and Oxford Brookes University, 2012a and 2012b). This was reflected in the Labour government's overall ageing strategy, *Opportunity Age* (HM Government, 2005), as well as the shift in government policy from an emphasis on supporting older people in residential care homes to supporting them in living in their own homes wherever possible (Barnard et al, 2007). This shift related not only to accommodation but also the provision of care, the two often overlapping (Office for Disability Issues, 2008).

The succeeding coalition government made clear its aim to 'help elderly people live at home for longer through solutions such as home adaptations and community support programmes' (HM Government, 2010: 25). Its 2011 housing strategy *Laying the Foundations* (Department for Communities and Local Government, 2011), set out a package of reforms to improve housing options for older people which reflected the position of the All Party Parliamentary Group on Housing and Care for Older People report *Living Well at Home* (Porteus, 2011) which highlighted the role played by an older person's own home in enabling longer independence, preventing the need for residential care and reducing accidents and hospital admissions.

3.4. Asset-based approaches

There has been an increasing emphasis on asset-based approaches in government policy and social policy commentaries. One of the key messages from the NHS National Colloquium's *Co-Production for Health* (National Colloquium, 2012: 4) was the need to 'to promote an asset based approach to communities to understand and harness their assets and resources'. The 2012 public health outcomes framework for England, *Improving Outcomes and Supporting Transparency* (Department of Health, 2012) recommended an indicator for 'social connectedness' and that needs assessments should include information on assets and strengths (Hopkins & Rippon, 2015: 11). The Department of Health's *Wellbeing: Why It Matters in Health Policy?* (Department of Health, 2013) also makes the case for a stronger focus on action for wellbeing to improve health outcomes. Guidance from The National Institute for Health and Care Excellence (NICE) (2007) recommends interventions and programmes that 'identify and build on the strengths of individuals and communities and the relationships within communities' and which help individuals 'feel positive of the benefits of health-enhancing behaviours and changing their behaviour' and 'recognise how their social contexts and relationships may affect their behaviour' (Principle 2).

The King's Fund's *Commissioning for Better Outcomes* (Buck & Gregory, 2013) emphasises building strong communities, wellbeing and resilience. The Health Services Management

Centre and Institute of Local Government Studies' (2015) document of the same name makes reference to 'A positive approach, which highlights what people who use services can do and might be able to do with appropriate support, not what they cannot do' (p4). Two of the sections in The National Voices' (2015) document *Person Centred Care 2020* explicitly shift accountability from the state to communities:

.... Statutory services cannot fix everything. It is time to work in equal partnership with citizens, carers, volunteers, the voluntary and community sector and communities to help individuals and shape services. This requires a shift in mind-set, behaviours and processes. (Sections 4 and 5)

The King's Fund's 2013 document *Improving the Public's Health* (Buck & Gregory, 2013) identifies 'strong communities, wellbeing and resilience' as one of the nine priorities for local action, stating that 'There is growing recognition that although disadvantaged social groups and communities have a range of complex and inter-related needs, they also have assets at the social and community level that can help improve health, and strengthen resilience to health problems' (ibid: 8).

3.5. Dementia

There are a number of inter-related and enduring policy issues relating to the care of people with dementia. The first is under-diagnosis (in some parts of the country less than 50% of people with dementia receive a diagnosis) with consequent lost opportunity for early intervention, particularly informal carer support (National Audit Office, 2007; House of Commons, Committee of Public Accounts, 2008; Department of Health, 2008). Very often carers have reached breaking point before they, and the person with dementia, come to the attention of formal health and social care providers. It is estimated that a third of people with dementia live alone. People with dementia living alone are often only diagnosed when their symptoms are so severe that they are then removed from home directly into residential/nursing home provision (Miranda-Castillo, Woods & Orrell, 2010).

Early diagnosis and intervention is at the heart of the National Dementia Strategy for England (Department of Health, 2009) which was launched by the Labour government in 2009 and led to the establishment of a national network of memory clinics. Under the succeeding coalition government, the 'Prime Minister's challenge on dementia' (Department of Health, 2012) was launched in March 2012 and aimed to drive improvements in health and care; create 'dementia-friendly communities'; and improve dementia research. The 'challenge' specifically aimed for at least two-thirds of people with dementia to be receiving a diagnosis by 2015 (Prince et al, 2014).

4. Housing Context

Housing is of particular relevance to older age and is inter-implicated with care issues:

Housing and health are related and a key challenge of living independently and healthily in later life is fuel poverty. Older people living in cold, damp homes are at greater risk of a range of conditions including arthritic symptoms and rheumatism, which can result in prolonged immobility, making it even more difficult to keep warm; domestic accidents and falls, including fatalities; social isolation; and mental health problems. (Evandrou et al, 2015: 6).

There is growing appreciation that quality of life in older age is informed by the interaction of older people with their homes and local communities (Peace, Holland & Kellaher, 2011; Wiles et al 2011; Andrews, Evans & Wiles, 2013) which takes on increasing salience as more time is spent at home and/or in the locality due to reduced mobility in 'older older' age. In particular,

Familiar and personalised places provide a sense of identity, privacy, attachment, comfort, security and safety, and supportive environments enable older persons to remain mobile, independent and in control of everyday routines (van Leeuwen et al. 2014: 105).

This understanding has led to a growing emphasis in the literature on 'ageing in place' (Means, 2007; Vasunilashorn et al, 2012). 'Ageing in place' is sometimes understood as older people remaining in the homes that they were living in as they aged (Wiles et al 2011) and it can also mean 'remaining living in the community, with some level of independence, rather than in residential care' (Davey et al 2004: 133). Discourse on ageing in place has tended to focus on housing and care, although recently there has been a growth in interest in the environment, especially the built environment (Oswald et al, 2007), and in assistive technologies.

However, as several authors have pointed out, ageing in place is not always desirable for all older people:

Aging in place is... an ambiguous position, signifying rootedness as well as rigidity. As people grow older, they may be grounded by their area of residence or they may be trapped by it (Gilleard, Hyde, & Higgs, 2007: 592).

4.1. Types of specialist housing in which older people are living

There is an expanding range of types of housing for older people in the UK (Croucher et al, 2007; Barac & Park, 2009; Institute for Personal Care (IPC) and Oxford Brookes University (2012a and 2012b; Tinker et al, 2013) and an even wider range of older age housing internationally, with considerable overlaps between terms for particular types of housing (Howe, Jones & Tilse, 2013; Glass & Skinner, 2013). This diversification is informed by the growing recognition that 'a "one size fits all" approach may not be best because at-homeness is an individualized construct' (Molony et al, 2011: 504), and different older people want different kinds of housing:

British social-housing and social-care policy makers and providers are increasingly aware that housing and care-services for older people have, for many decades, been provided in a framework that fosters dependency, and which has also been ageist in conception and execution. Today, more flexible, innovative and inclusive approaches designed to empower, to provide choices for, and to promote the autonomy of older people are being explored and encouraged... Guidance, fact sheets, networks and other resources have proliferated, and policy and research interest in the broad arena of 'housing with care' for older people has rapidly expanded (Bernard et al, 2007: 555).

In the UK, there are now a wide variety of housing options for older people. In a recent review of the literature on the health benefits of dedicated retirement housing for older people (across the spectrum of retirement communities, sheltered housing, assisted housing, extra care housing) the Institute for Public Care (IPC) IPC and Oxford Brookes University (2007a: 27) concluded:

Although the number of research studies with a control group, ie, comparing a range of sample populations in the community with those in retirement housing is limited, the weight of evidence through case studies, audits and research, shows that there is an unequivocal health gain to be made through the provision of all forms of retirement housing.

None of the studies showed there was either a health deterioration or even a standstill in people's health and well-being when they moved to this form of provision. Instead the evidence is that for many people there was a substantial improvement in health, a diminution in the volume of care and support required and a greater sense of security and well-being.

4.1.1. Retirement communities

There is a lack of agreement about what constitute retirement communities, although they are being widely promoted in the United Kingdom 'as an alternative to traditional forms of residential-home and nursing-home care...and they are seen as suitable for both fit and frail older people (Bernard et al, 2012: 556). Kingston et al (2001) have suggested that retirement communities are distinctive in the following ways:

- A retirement element – the residents are no longer in full-time employment and this affects their use of time and space.
- A community element – they accommodate an age-specified population that lives in the same area.
- A degree of collectivity – with which residents identify and which may include shared activities, interests and facilities.
- A sense of autonomy with security. (Cited in Glass and Skinner, 2007: 67)

Emerging research on retirement communities in the UK would suggest that while they are popular with the people who live there, they not only replicate, but also exacerbate social divisions, especially class divisions (Atkinson & Flint, 2004; Bernard et al, 2012) Retirement communities have been constructed within 'ageing well' discourse in two opposing ways: as older-age affirmative spaces of security, sanctuary, solidarity and mutual support (Croucher et al, 2007: 28); alternatively as sites of exclusion from mainstream society wherein older people are hidden away (Bernard et al 2007: 558).

4.1.2. Sheltered housing

'Sheltered' or 'supported' housing, where older people live in a small age-specific complex of bungalows and/or flats, with all external maintenance taken care of, usually with a 'careline' to call in emergencies and with a warden (sometimes full-time, sometimes part-time, sometimes living on-site, sometimes off-site).

4.1.3. 'Assisted living' housing

Assisted housing is like sheltered housing, but some meals are also provided in a central dining room and/or housekeeping services are also provided. A key criticism of assisted living is that it can often end up being only a transitional measure, a temporary stop-gap before extra care housing and/or residential care (Dubuc et al, 2014).

4.1.4. 'Extra care housing'

Extra care housing (Garwood, 2010; Netten et al, 2011) is an extension of sheltered/assisted living housing, which may also include extra adaptations for people with major disabilities and which provides social and/or nursing care on site. Some extra housing schemes offer gradations of support, with the older person able to access increasing levels of support when/if they are required. Extra-care housing has emerged as a model for independent living which is promoted and funded by the government as a purpose-built, community-based alternative to residential care for older people (Callaghan & Towers, 2014). A wide range of recent research has found that extra-care housing delivers positive outcomes for older people (Croucher et al, 2007; Bäumker, Netten, & Darton, 2008; Kneale, 2011; Netten et al, 2011). Extra care housing costs more than mainstream provision, but there has been little research which takes comparative trajectories into account: 'A before-and-after approach, as adopted in this study, raises the question of what would have happened otherwise: would needs have remained unmet, costs risen by as much or more, or combinations of these?'(Bäumker, Netten, & Darton, 2008:50). Although 'housing with care' can be used synonymously with 'extra care' housing, it can also refer to all types of housing with care, ranging from living in one's own home with extra care and support, all the way through to residential/nursing home care provision.

4.1.5. Residential social and/or nursing care

Residential care homes comprise housing with full board, all maintenance and housekeeping provided, and 24 hour care, for older people with severe physical and/or cognitive disabilities. Sometimes homes are registered to provide complex nursing care (for example 'nursing homes'). Recent research in seven European countries, including England, found older people consistently regarded care homes as the least preferred places to die (Calanzani et al, 2014).

4.2. *Co-housing*

There has been a growth in co-housing movements in America and Europe in recent years, many intergenerational, some specifically involving older people. Although this has not yet been reflected in the UK, there are signs that some co-housing projects involving older people may support a shift from thinking about individualised 'successful ageing' to thinking about 'ageing in community' (Thomas & Blanchard, 2009), particularly 'intentional communities', which are:

Planned residential groupings, usually founded on similar spiritual, social, or political beliefs or other shared values or goals. Resources and responsibilities are often shared, although the degree varies significantly among different community models. Intentional communities include cohousing, communes, eco-villages, ashrams, kibbutzim, and cooperative housing. (Thomas & Blanchard, 2009: 150)

There are five defining characteristics to co-housing (Chiodelli & Baglione, 2014: 21-22): 1) communitarian multi-functionality; (2) constitutional and operational rules of a private nature; (3) residents' participation and self-organisation; (4) residents' self-selection; and (5) value characterisation. Ruiu (2015) distinguishes between (gated) retirement communities and co-housing co-operatives involving older people in four main ways. First, in terms of safety,

gated communities seek to keep ‘dangerous’ others out, while co-housing communities are based on mutual trust and reciprocity. Second, there are differing degrees of closure to the outside: gated communities seek to keep their resources to themselves, while co-housing communities seek to welcome in the wider community. Third, in terms of a sense of community, in a gated community the sense of community is a secondary aim, whereas in co-housing a cooperative community is a primary aim; Fourth, their values differ: gated communities tend to be class-driven and reinforcing of class divisions; co-operative co-housing is very much based on egalitarian principles, in theory, if not always in practice (Vestbro & Horelli, 2012).

There is increasing interest in the potential benefits of co-housing for older people and a recognition that types of provision may vary.

There are two prevailing models of cohousing that offer older people a familiar, friendly, neighbourly environment in which to thrive in their later years. One is intergenerational, where families and singles share a cluster of buildings and the other is an age-peer group, where people of 50+ who prefer a child-free setting make their own mutually supportive community. (Burke, 2010: 15).

Co-housing communities among older people, or which include older people, wherein they provide self-organised reciprocal social and instrumental support, are increasingly popular in the USA (Glass, 2009, 2012 and 2013; Glass & Vander Plaats, 2013) and Europe (Turners, 2015), especially in northern Europe (Choi, 2004), with known projects in Denmark (Pedersen, 2015), Sweden (Sandstedt & Westin, 2015), Finland (Jolanki & Vilkkko, 2015) and Germany (Labit, 2015).

There are currently about 20 co-housing communities in England, many based on anti-capitalist principles (Jarvis, 2015) with many more under development³. As far as is known, none are age-specific (Moorhead, 2010), with the exception of the Older Women’s Housing Cooperative (OWCH)⁴ in North London and an over-50s co-housing scheme also under development in South London (Scanlon & Arrigoitia, 2015).

Co-housing fits well with the conceptual trends towards ‘social capital’ (Ruiu, 2015) and ‘empowerment’ (Brenton, 2008 and 2013) which are often mobilised in the literature. Co-housing promotes the pooling of resources and reciprocal support (Thomas & Blanchard, 2009) and encourages ‘a radical do-it-yourself approach’ (Glass 2009: 284). However, in her review of the literature, Labit (2015: 34) observed: ‘it has yet to be proved that seniors living in co-housing units are happier and healthier than those in more traditional housing and living arrangements’. Labit also reported that in the long-term co-housing communities among older people face several challenges, including: a loss of interest in community living and a retreat to privately-lived spaces and lives; conflict (over the use of communal spaces and/or funds, noise, tidiness of communal areas); the reduced capacity for active participation by community members who become physically and/or cognitively disabled. In intergenerational projects which included older people, intergenerational conflict most frequently undermined

3 <http://cohousing.org.uk/cohousing-uk>

4 <http://www.owch.org.uk/>

the success of several projects. That conflict related to the use of communal spaces and equipment, which were most often occupied and/or used by younger community members with older community members feeling unwelcome. Increasing need for care and support with ageing also led to many older members feeling marginalised.

4.3. Housing trajectories

Older people's housing choices can change over time, often affected by changes in circumstances (Peace et al 2011) which can lead to voluntary or involuntary moves to different housing in later life.

4.3.1. From independent living to retirement communities

Among those older people who move from living independently to retirement communities, reasons include (Kraut et al 2002; Croucher et al 2006; Bäumker et al 2012; Weeks et al, 2012): needing help with some aspect of deteriorating health; seeking more affordable housing; needing more services; seeking the security of onsite support and flexible continuing care; release from the burden of household upkeep and maintenance; accessible living arrangements; opportunities for on-site socialising and leisure activities (particularly important for older people without identified 'care needs'); and the desire to not become a burden on their families.

... decisions were often driven by a complex mix of different concerns and needs, including needs for accessible, affordable and secure housing, as well as access to care and support both now and in the future. Staying put was simply not an option for many people. For those with care and support needs, housing with care offered a more attractive option than other alternatives available to them (Croucher et al 2007: 28).

These studies suggest both 'go from' and 'go to' reasoning. This dichotomy was also identified, and refined, by researchers in Belgium (Smetcoren et al, 2015). They studied older people who moved from living independently to living in more supported environments, and reported:

An analysis of the movers revealed inequalities in the reasons for moving in later life and raises the question of whether a relocation is voluntary (being able to move) or in-voluntary (being forced to move). Respondents with lower household incomes and poor mental health were significantly more likely to have moved because of stressors pushing them out of their previous dwelling, whereas older people with higher household incomes or home-owners were mainly pulled towards a more attractive environment (Smetcoren et al, 2015: 1).

4.3.2. From hospital to residential/nursing home

Moves from community living to residential/nursing home are often preceded by an unplanned hospital admission (van Rensbergen & Nawrot, 2010) particularly among people with dementia (Callahan et al, 2012). Circumstances which are linked to unplanned hospital admissions in older people include (Walsh, Roberts & Hopkinson, 2007; Walsh et al, 2008; Walsh, Roberts & Nicholls, 2011; Dale et al 2013): falls, confusion and incontinence; chronic conditions which could be managed in the community, but outpatient care has broken down; and a cycle of repeated and/or protracted hospital re-admissions which leads to the breakdown of formal and informal care networks.

4.3.3. From community living to residential/nursing home

Admissions to residential care from the community are informed by gender (Glaser et al, 2009). Among heterosexual men the presence of a spouse caregiver reduced the risk of institutional care. Among single (including bereaved) women the presence of intergenerational support reduced the risk of institutional care. Single childless women predominate in long-term residential care spaces. Among those older people who move from living in the community to living in residential/nursing home provision without a precipitating hospital admission, several factors have been identified, both in the UK and overseas, as being of significance (Gaugler et al, 2007; Bowers, 2009; Luppá et al, 2009a and 2009b) including: concerns about health; cognitive and/or functional impairment; inadequate informal social support (and/or 'caregiver burden', (McFall and Miller, 1992); insufficient formal support and assistance in daily living; poor housing; limited/lack of socioeconomic resources. It is also nuanced by housing tenure: home ownership being linked with a reduced risk of admission to institutional care (McCann et al, 2011). Moves to residential care also often take place during a crisis:

Things can happen very quickly when options for support are being discussed, and points of no return (homes being sold, for example) are reached from which there is no way back. A move into care is often precipitated by a breakdown in support arrangements at home, compounded by a real as well as perceived lack of alternatives. Without information and impartial advice, people quickly become convinced that the 'last resort' (moving into care) has been reached (Bowers et al 2009: 6).

Retirement communities with different gradations of support and different kinds of on-site accommodation are generally understood to have been designed to avoid the sudden shock of moving from home to a residential care facility. However, transitions to increasing levels of support within a continuing care retirement community (which can often involving physically relocating within the community) can be as traumatic as moving into residential/nursing home care from living independently/semi-independently in the wider community (Shippee, 2009).

4.3.4. Limited choices

Despite the diversification of housing, there is still insufficient variety to meet older people's needs and/or preferences (Ham, Dixon & Brooke, 2012). Housing preferences can also be informed by cultural background and ethnicity, with people from Black, Asian and minority ethnic communities looking for housing-with-care options which reflect their cultural heritages (Croucher, 2008). People from lesbian, gay, bisexual and transgender (LGBT) communities want a choice of provision which includes LGBT-friendly mainstream (Stein & Almack, 2012), LGBT-specific and (for some older lesbians) women-/lesbian-only provision (Westwood, 2015a), which is not available in the UK (Carr & Ross, 2013).

Studies conducted with people in long-term care (which are quite limited) would appear to suggest that many residents do not want to be living there (Bowers et al, 2009). The decision for them to move into residential care is often not theirs but rather made by family members and/or health and social care agencies.

Bowers et al (2009: 6) have argued that there is a strong age-bias in such decisions:

If any of the precipitating factors outlined here had occurred at a younger age, the push into care would not happen. Outside the world of services for older people, alternative and creative support has moved on immensely. Yet person-centred approaches and support that promote choice and control remain hard to find for older people with high support needs.

It has also been suggested that class may play a role, in an inverse way: those people ineligible for council-arranged services and unable to purchase care privately ‘often struggle with fragile informal support arrangements and a poor quality of life’ (CSCI, 2008: viii).

People who fund their own care rarely have access to assessment and tend to be left without any form of independent review, advice or support. They are often given no option but to enter residential care, especially at a time of crisis, and often there is no way back as homes are sold (often very quickly) to pay for care (Bowers et al 2009: 21).

All of this suggests that access to appropriate levels of support is key in preventing deterioration and promoting rehabilitation in order to support individuals to remain living in the community. Very often that support may be complex, multi-faceted and require careful coordination (Evandrou et al, 2015).

4.4. Age-friendly environments

There is growing interest in the role of the environment in sustaining older people in their homes for longer (Burton et al 2014). Both urban and rural environments can potentially be sites of inclusion and exclusion for older people (Phillipson & Scharf, 2005). Older people living in the countryside can be at greater risk of poverty, loneliness and isolation, primarily associated with reduced mobility, distances to travel to access services and poor public transport services to rural areas) (Scharf, Williams & Roberts, 2007; Burholt & Scharf, 2013). This can be exacerbated for older people with minority identities, include BAME older people (Manthorpe et al, 2012) and lesbian and gay older people (Heaphy, 2009). On the other hand older people in urban areas can also experience isolation and social disconnection because of changing urban neighbourhoods, urban spaces which are not age-friendly, and which may be perceived by older people as unsafe (Scharf, Phillipson & Smith, 2005; Phillipson, 2007; Scharf & De Jong Gierveld, 2008).

The World Health Organization (WHO) (2007a and 2007b) has initiated a ‘Global Age-Friendly Cities Project’ involving 33 cities from 22 countries involved in developing ways to help older people remain active and engaged in their local communities. WHO has developed an 88-point checklist for what constitutes an ‘age friendly city’. ‘Age Friendly Cities’ (Liu et al, 2009, Buffel et al, 2014, Fitzgerald & Caro, 2014) have been the focus of considerable recent research. Buffel and Phillipson (2012: 598) point out:

The model of ‘age-friendly cities’ initiated by the World Health Organization (WHO) (2007a) reflects attempts to develop supportive urban communities for older citizens. These have been defined as encouraging ‘active ageing by optimizing opportunities for health, participation and security in order to enhance quality of life as people age’ (WHO, 2007a: 12). By 2030, two-thirds of the world’s population will be residing in cities, with – for urban areas in high-income countries – at least one-quarter of their populations aged 60 and over (UN-Habitat, 2010). The global ‘age friendly’ city perspective has been influential in raising awareness about the impact of population ageing, especially for the management and planning of urban environments.

Investment in environmental features may postpone or avoid the point where declining individual competences demand actions such as relocation or intensification of formal care. Van Leeuwen et al (2014) have conducted research which suggests that the three factors from the WHO environmental guidelines, which are included in the Adult Social Care Survey, could play an important role in both quality of life and enabling people to continue to live independently:

The provision of easy-to-find, personalised, up-to-date and high quality information could assist older adults and their informal caregivers to find, compare and apply for services from appropriate providers... Adapted toilets, showers, and lifting equipment have been suggested as home modifications which improve the independence and quality of life of older adults... 'going outdoors' by older adults is supported by neighbourhood and public transportation attributes such as bus stop locations, transport fares and scheduling, adequate [disabled] parking, pedestrian infrastructure, proximity to shops and services and feelings of familiarity and safety... Our results indicate that these factors have the largest influence on older adults with higher needs, less assistance and lower quality of life, further research should therefore focus on interventions targeted at older adults that are most vulnerable. (Van Leeuwen et al. 2014: 109-110).

Phillipson has pointed out that there is a need to think about 'age-friendly' social communities as much as 'age-friendly' material spaces (Phillipson, 2011). Central to this social dimension and to enabling older people to remain in their homes and communities for longer is appropriate social care and support.

5. Older People and Social Care

5.1. Social care: definitions

Care, at its simplest 'refers to looking after those who cannot take care of themselves' (Daly 2002: 252). 'Social care' is 'a multi-dimensional concept' (Daly & Lewis, 2000: 285) which includes: care as labour, care as a norm or ethic and care 'as an activity with costs, both financial and emotional, which extend across public/private boundaries'. 'Care as labour' in particular,

... draws attention to the conditions under which it is carried out. This in turn makes an analysis of the role of the welfare state indispensable and leads especially to consideration of whether care is paid or unpaid, formal or informal, and the state's role in determining these and other boundaries. (Daly and Lewis, 2000: 285)

'Social care' is often used as shorthand for care provided by the state:

There is no simple definition of social care, although it is generally used in the UK to describe a wide range of services provided by local authorities and the independent sector, to people with assessed needs for social care, either in their own homes or in a care home. It also covers short-break or day-centre care. The support includes assistance with personal hygiene, dressing, going to the toilet, feeding, provision of meals, social and leisure activities, home care and shopping. Often, people pay for these themselves, or their payments are means-tested. Clients or users include those with physical and/or sensory impairments, learning disabilities and mental health problems including dementia. (Bowling, 2014: 1)

5.2. *Older people and the social care 'market'*

5.2.1. Health and social care distinctions

In England, there is a binary divide between 'health' and 'social' care, although there are ongoing efforts to integrate the two (Iliffe & Manthorpe, 2014) (addressed in the social policy section below). Publicly-funded social care is available through local authorities on a means-tested basis; by contrast nursing care is provided without charge by the National Health Service. There are significant geographical variations in social care for older people both across the devolved UK and specifically England (Brand, Hughes & Challis, 2012). These especially relate to what is considered to be 'unmet needs', what level of unmet needs warrants state intervention, and what that intervention will be (van Leeuwen et al, 2014).

5.2.2. The social care 'marketplace'

There has been a dramatic shift in the shape of formal adult social care in recent years (Newman, Glendinning & Hughes, 2008) and central to that shift has been the marketization of care (Brennan et al, 2012). As part of that shift, local authorities, while retaining statutory obligations to assess care needs and ensure certain levels of need are met, have moved from providers of social care services to commissioners of social care services from other providers. This is sometimes done directly, on behalf of service users, but increasingly through allocating funds in the form of personal budgets with which individuals or their informal carers purchase (theoretically) personalised care from (theoretically) a range of care providers. Some local authorities have sub-divided organisationally, so that they are both commissioners and providers, with the provider arm bidding for tenders to provide social care services (e.g. domiciliary care; day care; carer support), with the tenders put out by the commissioning arm. However, in the new social care marketplace, there is now considerable competition for those tenders from a wide range of potential providers, including local charities and not-for-profit organisations, for-profit individuals and organisations, particularly, in terms of domiciliary care and specialist care agencies. See Table 1 overleaf for an outline.

Although all local authorities fund home care, they do not all fund it sufficiently, and current funding levels are considered unsustainable (United Kingdom Care Home Association, 2015). Personal Budgets (Individual Budgets in Scotland) marked a sea change in the provision of social care in the UK (Glendinning et al, 2008; Forder et al, 2012; Netten et al, 2012; Baxter, Rabiee & Glendinning, 2013). However if services are costed too low, people's budgets will not be sufficient to pay for the services they need. As subsequent sections will highlight, the low pay for domiciliary care workers (Bode, Gardin & Nyssens, 2011) is putting enormous strain on the provision of appropriate levels and quality of care (Lewis & West, 2014). Cost is also an issue for people who because of tests of means are required to pay for their own care: while relatively affluent older people can buy in their own care, and those on limited means will have access to personal budgets, people in the middle may neither be poor enough for personal budgets nor wealthy enough to be able to purchase decent care: they are thus caught in the middle. Although the Dilnot report (see below) recommended a cap on care costs, which the coalition government approved, the current Conservative government has deferred imposing the cap until 2020.

Table 1: Key players in provision of community-based social care for older people

| Informal Care (National Audit Office (2014)) | Local Authority (National Audit Office (2014)) | Private Sector | 'Third Sector' (Dickinson et al, 2012) |
|---|---|--|--|
| <ul style="list-style-type: none"> • Unpaid family, friends and neighbours | <ul style="list-style-type: none"> • Local government social services (sometimes in conjunction with health services) | <ul style="list-style-type: none"> • Commercial, for-profit providers | <ul style="list-style-type: none"> • Voluntary Organisations • Community Organisations • Charities • Social Enterprise schemes |
| <ul style="list-style-type: none"> • Emotional support • Personal care • Practical help • Coordinate formal services | <ul style="list-style-type: none"> • Assessment of care needs and entitlement to services (Care Act 2014). • Direct provision of services or, more often, provision of funding for the purchasing of services, either by older person/informal carers or brokerage. • Sometimes provide brokerage directly; otherwise commission brokerage services from third sector. | <ul style="list-style-type: none"> • Home care and support agencies • Residential care homes providing respite care services | <ul style="list-style-type: none"> • Home care and support services • Day centre services • Befriending services • Welfare information and advice • Care brokerage • Advocacy • Respite care services |
| <ul style="list-style-type: none"> • Self-funding/ supporting and/or with (variable) support from local authorities and/or carer support agencies. | <ul style="list-style-type: none"> • Funded by (diminishing) monies from central government. • Hypothetical social care local tax has been proposed. | | <ul style="list-style-type: none"> • Local authority commissioned (fully funded) • Local authority assisted (partially funded) • Self-funded |

5.2.3. The costs of social care for older people

The majority of adult social care costs are attached to older people. Gross expenditure on adult social care in England in 2013-14 was £17.2 billion (Health and Social Care Information Centre, 2014: 5), just over half of which was allocated to social care provision for older people, i.e. those aged 65 and over. In terms of domiciliary and day care, expenditure on older people was over £3.2 billion in 2012-13 and 2013-14 billion (Health and Social Care Information Centre, 2014, p25). The cost of residential care provision for older people was almost £5 billion in those same periods billion (Health and Social Care Information Centre, 2014: 10).

5.3. Older people and the 'need' for social care (home and community)

5.3.1. Social care model

Older people comprise the bulk of users of both social care and health care. In the UK, 50% of older people over 85 are in residential care and 25% are in receipt of domiciliary care at home (Wittenberg, et al, 2012). For several decades now the model of social care in the UK has been predicated upon the notion that formal social care services would only intervene once supplies of informal social support (family, friends, neighbours, voluntary sector) were exhausted and/or stretched beyond capacity (Bernard & Phillips, 2000; Grundy & Read, 2012). Not all older people require additional social care, indeed the story of ageing is really now a story in two halves,

Increasingly, the picture on offer as longevity increases is, for many people, a two-tier old age. On the one hand an early, immediate post-retirement, period of comparative health and prosperity, followed by an older old age where there is a greater risk of increased physical and mental infirmity, of owning a property that becomes increasingly hard to manage and sadly for many, either the death of a lifelong partner or one family member caring for another. (IPC and Oxford Brookes University, 2012b: 5)

In a recent UK study with older people in receipt of formal care and support services, the ways in which they felt those services helped them most were⁵: 'personal care (68%), feeling safe and secure (55%), meals (54%), keeping my home clean and comfortable (51%), to have control over daily life (49%), social contact with people I like (42%), and doing things a value and enjoy (33%)'.

5.3.2. The assessment of 'need'

When older people do require support, formal intervention is based on assessed 'need':

The provision of state funded social care for older adults in the UK is driven by the concept of 'need', with individuals who have care requirements that surpass a certain threshold being eligible to receive care. A wide range of methods are used to ascertain need, but the ability to conduct simple Activities of Daily Living (ADL), such as bathing and dressing, is often used (University of Southampton, 2015: 4).

The threshold for the level of need which triggers services has been raised repeatedly by local authorities during recent times of austerity. Local authorities now only provide/fund services for those whose levels of need are assessed to be 'substantial' or 'critical'. As a consequence, according to Age UK, 'of the 2.8million older people with care related needs, 900,000 currently do not receive any formal support' (Age UK, 2015: 14). There is now growing discourse in research about 'unmet need' in relation to social care and older people:

Recent spending cuts in the area of adult social care have given rise to concerns regarding the proportion of older people whose need for social care is not being met... in relation to specific Activities of Daily Living (ADLs) and Instrumental Activities of Daily Living (IADLs) (University of Southampton, 2015: 4).

5 Personal Social Services Adult Social Care Survey, England - Provisional 2010-11, quoted in Age UK (2015) *Later Life in the United Kingdom October 2015 Factsheet*, September 2015 update: http://www.ageuk.org.uk/Documents/EN-GB/Factsheets/Later_Life_UK_factsheet.pdf?dtrk=true

The growing numbers of older people living for longer but with higher support needs, the comparative reduction in informal social care availability, and current austerity measures, means that there is a growing care crisis in the UK:

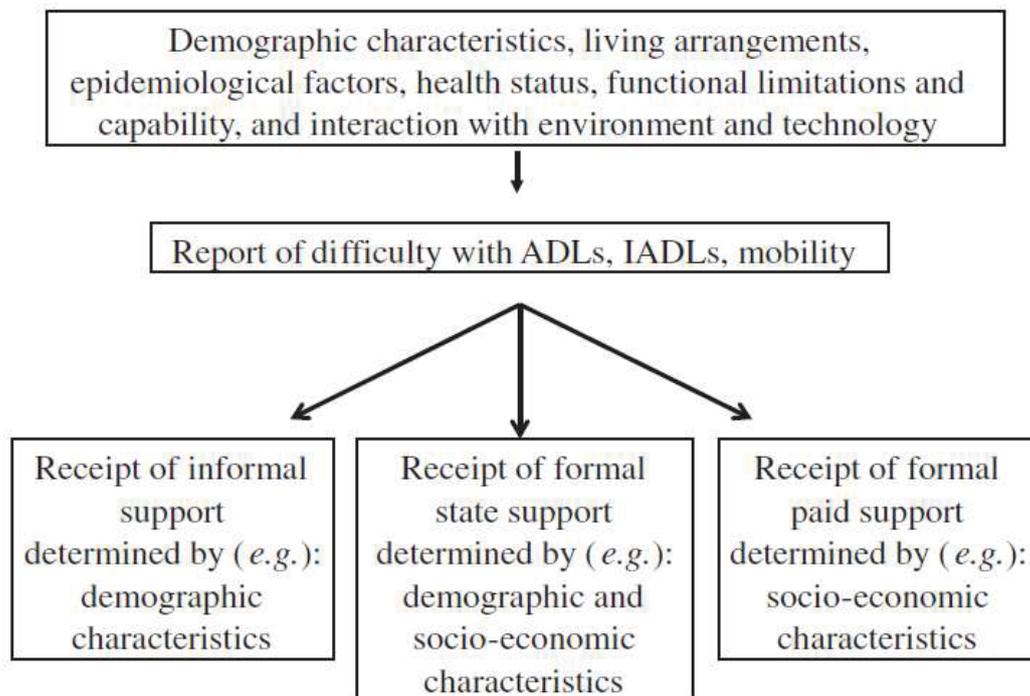
Formal social care for older people is a system in upheaval: We are facing a major crisis in the funding of public sector services, particularly in social care’ (Blood, 2013: 5).

As noted in the Introduction, although there are growing numbers of older people living for longer, with chronic, often multiple, health conditions, UK state spending on care for older people has reduced by almost a third in the past decade. This has particular saliency for women, who are more likely to be care recipients than men and who are more likely to be providers of informal unpaid care and formal (low) paid care (European Commission, 2012).

5.3.3. Factors contributing to a ‘need’ for social care

The need for social care (Manthorp, 2012) involves the dynamic interaction of multiple factors ‘including an individual’s demographic and socio-economic characteristics, and the extent to which individuals can use technologies in their home environment to compensate for disabilities’ (Vlachantoni et al, 2015: 324). Vlachantoni et al (2015) have recently designed a simple flow chart demonstrating this dynamic (see Figure 1 below).

Figure 1 Conceptualising the receipt of social care support in later life. [ADLs: activities of daily living; IADLs: instrumental activities of daily living] ((Vlachantoni et al, 2015: 326)



As Figure 1 demonstrates, a complex set of mutually interactive factors informs the receipt of in/formal social care. These include the following:

- *Demographic*: gender, age group, legal marital status or co-habitation, having any children in the household, number of children outside the household and number of household members;
- *Socio-economic*: income and wealth, access to a car, housing tenure;
- *Physical health*: self-reported general health, self-reported eyesight, self-reported hearing, self-reported pain, and doctor's diagnosis of arthritis, chronic lung disease, Parkinson's disease or high blood pressure;
- *Mental health*: doctor's diagnosis of depression or dementia, number of errors in orientation in time;
- *Disability/functional limitations variables*: self-reported number of mobility limitations, ADLs and IADLs one has difficulty with, difficulty with walking a quarter of a mile, report of limiting long-standing illness (LLSI);
- *Environment/technology*: home with an adaptation e.g. hand rails, retirement housing, current use of cane/walking stick, zimmer frame/walker, manual or electric wheelchair, buggy/scooter, personal alarm or elbow crutches); and receipt of support/use of services variables (self-report of receipt of informal, state, paid-for or 'other' support, whether ever attended a lunch club or day care centre, has ever used meals-on-wheels, is currently using the services of an occupational therapist/physiotherapist, chiroprapist or is engaging in exercise therapy.

5.3.4. Social care quality

A recent review by the Equality and Human Rights Commission (2011) found substantial deficits in the quality of formal home based care provided to older people, to the extent that very often their human rights were breached, although this frequently went unchallenged. The report stated: 'The cumulative impact on older people can be profoundly depressing and stressful: tears, frustration, expressions of a desire to die and feelings of being stripped of self-worth and dignity – much of which was avoidable' (EHRC, 2011: 4). These failings in care were attributed to 'the way home care is commissioned [and] the way home care contracts are procured and monitored' (ibid: 4). Specifically,

The way home care is commissioned by local authorities may be increasing the risks of older people suffering human rights abuses. In particular, the rates that some local authorities pay care providers do not always appear to cover the actual costs of delivering care, a significant proportion of which is workers' wages which should include travel time. Poor working conditions may lead to a high turnover of staff and increase the risks to the human rights of older people (EHRC 2012: 6).

The public inquiry into the serious failings at the Mid Staffordshire NHS Foundation Trust also found a health system which was fundamentally deficient and which failed to address repeated concerns expressed by patients and/or their family members. The inquiry's final report (Francis, 2013: 4) determined that this had a number of inter-connected causes which included:

- A culture focused on doing the system's business – not that of the patients;
- An institutional culture which ascribed more weight to positive information about the service than to information capable of implying cause for concern;

- Standards and methods of measuring compliance which did not focus on the effect of a service on patients;
- Too great a degree of tolerance of poor standards and of risk to patients;
- A failure of communication between the many agencies to share their knowledge of concerns;
- Assumptions that monitoring, performance management or intervention was the responsibility of someone else;
- A failure to tackle challenges to the building up of a positive culture, in nursing in particular but also within the medical profession;
- A failure to appreciate until recently the risk of disruptive loss of corporate memory and focus resulting from repeated, multi-level reorganisation.

There is also a lack of culturally sensitive support for older Black, Asian and ethnic minority individuals and their networks (Bowes & Wilkinson, 2003; Katbamna et al, 2004; Bowes, 2006; Moriarty, 2008; Manthorpe et al, 2010; Moriarty, Sharif, & Robinson, 2011; Desai, 2012) and LGBT people, particularly those with dementia (Price, 2008 and 2010; Ward, Pugh & Price, 2011; McGovern, 2014, Westwood, 2015a and 2015b; Westwood & Price, 2016).

5.4. Social care and quality of life (QoL)

Various tools have been developed which are intended to measure social care-related quality of life (SCRQoL) (Gabriel & Bowling, 2004; Bowling & Stenner, 2011; Bowling et al, 2013) among older people and to evaluate outcomes of social care intervention (Malley & Netten, 2009; Netten, 2011). Some tools have been based on quality of life as defined by older people themselves (Bowling et al, 2013), others by policy documents. These tools include: 1) The Adult Social Care Outcomes Toolkit (ASCOT) (Malley et al, 2012; Netten et al., 2011 and 2012), which measures SCRQoL but covers domains which are more generally relevant for older people, including ‘personal safety’, ‘accommodation cleanliness and comfort’ and ‘control over daily life’; and 2) The Adult Social Care Survey (ASCS) which includes the ASCOT as well as information about three of the areas from the WHO’s ‘Age-Friendly cities’: accessibility of information and advice; design of the home; and accessibility of the local area (Van Leeuwen et al, 2014).

Other quality of life measures which also measure social care/support include:

- The Camberwell Assessment of Need for the Elderly (CANE) which evaluates social, psychological, physical, and environmental needs (rated as no need, met need or unmet need) and also asks about formal and informal support (Reynolds et al, 2000);
- The Physical Self-maintenance Scale (PSMS) and Instrumental Activities of Daily Living Scale (IADL) which measure an individual’s abilities to perform everyday activities (Lawton & Brody, 1969);
- The ICEpop CAPability index (ICECAP-O) (Coast, Flynn, et al, 2008; Coast, Peters, et al, 2008) which measures attachment, security, role, enjoyment and control;
- The OPQOL (Bowling & Stenner, 2010) which measures overall quality of life, health, social relationships and participation, independence, control over life, freedom, home and neighbourhood, psychological and emotional well-being, financial circumstances and (sometimes) religion/culture;

- The CASP-19 (Control, Autonomy, Self-realisation and Pleasure) (Hyde et al, 2003), which measures control, autonomy, pleasure, and self-realisation;
- The WHOQOL-Old (Power, Quinn & Schmidt, 2005) which measures: sensory abilities; autonomy; past, present and future activities; social participation; attitudes towards death and dying, and intimacy;
- The Practitioner Assessment of Network Typology (PANT) (Wenger, 1994). This was developed to assess older people's support networks. The instrument comprises 8 items about three main features: availability of local close kin, level of involvement of family friends and neighbours, and the level of interaction with the community and voluntary groups. Thus, networks are characterised into five main types: Local family dependent support networks (which comprise close local family ties with a few peripheral friends and neighbours); locally integrated networks (local family, friends and neighbours); local self-contained support network (neighbours and distant relatives); wider community focused (local friends and distant kin); private restricted support network (no local support and distant kin).

5.5. Strategies to prevent deterioration/ heightened need for care and support

In addition to age-friendly environments (Section 4.4) and an increased interest in informal carer support, there has been a recent growth of interest in formal preventative strategies intended to support older people to live longer in their own homes.

5.5.1. The Partnership for Older People Projects (POPP)

The Partnership for Older People Projects (POPP) were funded by the Department of Health 'to develop services for older people, aimed at promoting their health, well-being and independence and preventing or delaying their need for higher intensity or institutional care' (Windle et al 2008: 2). Based on the increasingly popular Kaiser Permanente model of care and support (see Appendix Two), it ran between 2006 and 2009 and involved pilot sites in 29 local authorities. Pilot sites initiated a range of different interventions to improve wellbeing, implement proactive care coordination and rehabilitation and increase carer support. The POPP final evaluation concluded that the various interventions resulted in cost savings associated with reduced emergency hospital admissions, reduced overnight stays in hospital and reduced use of out-patient services. The evaluation also reported that there was improved reported quality of life, varying between the different projects on offer.

5.5.2. Early intervention

Chen and Thompson (2010) have suggested that early intervention improves the chances of older people remaining in the community, rather than later interventions when an older person is already experiencing difficulties in daily living skills. In a recent review of the literature, Walsh et al (2015: 61) recently reported that 'admission avoidance interventions have failed to reduce unplanned hospital admissions in older people'. This echoes previous reviews (Health Services Management Centre, 2006; Wanless et al, 2007; Comptroller & Auditor General, 2013). The study reported that professionals thought that there was a lack of expertise among health and social care providers about complex and intersecting needs among

‘frail’ older people; that the health care system is geared towards discrete acute events rather than recurrent intersecting chronic ones; that the health and social care system itself is complex, fragmented and difficult to navigate.

5.5.3. Identifying older people ‘at risk’

Various tools have been developed to identify older people ‘at risk’. These include:

- Billings et al (2006) developed a tool which would identify patients most at risk of rehospitalisation (‘the patients at risk for re-hospitalisation (PARR) algorithm’), and which was designed for all patient groups, not just older people. It was limited by the complexity of the factors (physical, psychological and social) which were involved, although it has since been used with a variety of patient groups, including older people. However, in an NHS review, it was not found to be effective in reducing hospital admissions among older people (Gravelle et al, 2011).
- In the USA, Drubbel et al (2013a) developed a ‘Frailty Index’ (FI), based on routine health care data, to predict healthcare outcomes among older people. In the Netherlands, Steverink et al (2001) developed the Groningen Frailty Indicator (GFI). Both are used as indicators which flag older people living in the community who are in need of increasing levels of combined health and social care (Slaets, 2006; Drubbel et al, 2013b).
- In the UK, Knighting et al (2015) have developed a ‘Carers’ Alert Thermometer’ (CAT) to identify family carers struggling with caring for someone who is nearing the end of their life at home, with the aim of offering them increased support, thereby preventing ‘potentially avoidable’ hospital admissions.

5.5.4. Intermediate care

A recent systematic review (Phelp et al, 2013) of the literature on intermediate care reported that effective care coordination, preventive health checks and specialist in-hospital services for older people reduced the risk of repeat hospital admissions and duration of stay. Timely and sufficient support during the transition from hospital to home would appear to be crucial in enabling older people to be able to continue living in their homes after a hospital admission. Various housing associations now work with health and social care agencies and assistive technology providers to use the provision of telecare, for monitoring and support, to enable a person to return and maintain themselves at home after a hospital admission. Housing 21 piloted a project, reported by Housing Lin (Leng, 2011), whereby those of its housing services which provide extra care and accommodation supported the residents while in hospital, by providing advocacy and ongoing visits, in order to promote their chances of a successful return home. A key issue was who should pay for this work, with Housing 21 seeking to charge the NHS because of the perceived cost benefits (earlier and more successful discharge), and the NHS reluctant to pay for such services (Leng, 2011: 7).

In 2010, Alliance Homes, Age UK Somerset, North Somerset Care & Repair, Rethink/Reconnect and Brunel Care, funded by North Somerset Council, set up a joint project to facilitate the return home of older people who have gone into hospital:

A partnership representative is in every hospital, working closely with the discharge teams and ward staff to process referrals, carry out bedside assessments, arrange home visits and support patients. A single referral process has been introduced to ensure a consistent approach. The service is particularly for individuals who do not meet Fair Access to Care criteria for social care or do not have family or friends to support them (Leng 2011: 8).

Preliminary indicators were that this was proving an effective organisational strategy, however, it is not clear whether the project is still being funded. Since 2009 Bournemouth Churches Housing Association's (BCHA's) had delivered a Leaving Hospital Support Service (LHSS) to patients from the Royal Bournemouth Hospital, providing advocacy and support to facilitate prompt discharges from hospital and prevent hospital re-admissions (Leng 2011: 10). Patients not meeting the eligibility criteria (i.e. non-stroke patients) could self-fund access to the service. However, 'Funding pressures mean the service is currently not available at weekends and on bank holidays, so there's a risk people will return home without the correct care in place' (Leng 2011:12).

For some older people an interim rehabilitation placement in a care home can be helpful. 'Breathing Space' projects have been set up by residential care homes for older people, to offer transitional spaces for people after difficulties at home and/or a hospital admission, with a view to them returning home in the longer term. These paid-for services are funded by local authorities and/or individual's personal budgets. A key issue appears to be, again, who is willing and able to pay for it. One such project in Bradford found that a lack of funding for intermediate care placements was leading to delayed discharges (Leng 2011: 19).

6. Alternatives to Formal Care

6.1. Unpaid carer support

There is ongoing research interest in informal (family and friends) carer support, with the aim of supporting carers to be able to support older people in their homes for longer. This has focussed not only on the provision of respite care (see above) but also interventions which enable carers to remain in work for longer. However, many carers (most often women) find they have to leave the job market when a family member they are supporting develops high support needs. This can also be to the detriment of their own health. It can subsequently be difficult for carers (especially older carers) to re-enter the job market when their caring role has come to an end. The tensions between work and caring (Kröger & Yeandle, 2014), and to what extent informal carers (usually women) 'choose' to leave the job market, or feel they have no choice in doing so have been the subject of considerable recent debate (Yeandle, Kröger & Cass, 2012; Larkin & Milne, 2014). In addition to varying by gender, this is also shaped by other social positions. Carers of BAME older people often feel there is a lack of culturally sensitive care and support, as attested to by a small but growing body of research in this regard (Giuntoli & Cattan, 2012). Older LGBT carers can feel under-recognised and under-supported, and again there is a small but relatively constant flow of research in this regard (Willis, Ward & Fish, 2011; EHRC, 2011; Willis, 2014).

6.2. Assistive technology

There is increasing research interest in how new technologies might enable older people to remain in their own homes for longer (Kachouie, et al, 2014; Greenhalgh et al, 2013; Allen & Glasby, 2012) ‘either by reducing demand for unpaid care or by improving efficiency in the provision of care’ (Pickard 2015: 117). At its simplest, assistive technology might just be the use of IT to maintain contact with family and friends. A significant number of old people, especially the very old, do not use computers, creating a digital divide not only between older and younger people but also among older people of different ages (Berry, 2011). Age UK has initiated ongoing local programmes which help older people to learn how to use a computer, particularly email and Skype, to help reduce loneliness and isolation (Age UK, 2011). However, there is a need not only to help older people to catch up with technology but also to help older people keep up with rapidly developing new technologies, in order to avoid a generational digital divide (Damant & Knapp, 2015).

More advanced assistive technologies. i.e. devices or systems that support a person to maintain or improve their independence, safety and wellbeing, (Department of Health, 2013) are being promoted by local government⁶. Those which are used to support older people include: telehealth (health services via the telephone and/or online), telemonitoring (remotely monitoring patient health and/or activities), telecare (direct call lines for emergency assistance) (Sinclair & Creighton, 2015) and telecare befriending (Hepworth, Olphert & Bartle, 2013).

Devices which can be of particular assistance to older people with dementia include (Alzheimer’s Society, 2015: 5-10):

- Automated prompts and reminders, e.g. a specifically located pre-recorded voice prompt (reminding someone to lock a door, or turn the oven off); a timed reminder to prompt someone to take their medication or to remind them that they have an appointment;
- Personal prompts, e.g. tablets which friends/family members can use to remotely prompt the person with dementia about appointments and activities (page5);
- Clock and calendar apps to help keep the person with dementia orientated to time (and place if needed);
- Time-programmed automated medication dispensers which can be remotely monitored;
- Locators such as tags on items (e.g. purse, glasses, keys) which if lost can be located via smartphone;
- Communication aids such as touch screen Smartphones, tablets and laptops, with easy access devices to contact/be contacted by family members/friends using Skype, etc;
- Safety devices which can be linked to telecare systems such as:
 - Automatic lights which come on as the person is moving around, which can reduce the risk of falls;

⁶ http://www.oxfordshireccg.nhs.uk/wp-content/uploads/2015/04/OCC_Jigsaw-Poster-PRINT-2-2-2.pdf

- Automatic shut-off devices for gas hobs left on, taps left running, baths about to overflow, bathwater which is too hot;
- Falls' sensors;
- Telephone call blockers (to prevent cold callers);
- Alarm systems if the person with dementia leaves a certain area (e.g. goes outdoors, or out of their garden);
- Tracking devices.

The general benefits of assistive technology for older people purportedly include (Beech and Roberts, 2008: 12): increased choice and independence and sense of control; increased safety; reduced accidents and falls; and reduced carer burden. There is a need for further research in this area (Steventon et al, 2013; Haberken et al, 2011). Additionally, the market for the provision of assistive technology is highly fragmented, raising a number of ethical concerns, particularly in relation to the involvement of an under-regulated private sector (Gibson et al, 2014). Other ethical issues raised include the tension between surveillance and autonomy (Stowe & Harding, 2010) and the concern that new technologies 'risk destroying some of the already diminished social capital resources available to vulnerable older people by taking away their care-based networks and some of the human interactions they treasure' (Sanders et al: 220). However, a recent review of the literature on the ethics of assistive technologies in relation to older people observed that there is only limited attention being given to such ethical concerns (Zwijssen, Niemeijer, & Hertogh, 2011).

The most recent, and ethically challenging, assistive technology is the care robot, already much-used with older people in Japan. There is growing research interest in care robots as nursing assistants in clinical settings (van Wynsberghe, 2013) and also more specifically in the context of 'social' care of older people in their homes (Broekens et al, 2009; Mast et al, 2012). Researchers are currently trying to develop medical machines (Vallverdú & Casacuberta, 2015) and socially assistive robots which can emulate empathy (Tapus and Mataric 2007; Leite et al 2013). Socially assistive robots are currently being used in Japan to monitor physical safety, provide 'a customized help protocol through motivation, encouragements, and companionship' (Tapus et al 2009a: 924) as well as 'music therapy' (Tapus et al 2009b) to people with dementia.

Several authors have raised ethical concerns (Vallor 2011; Sharkey & Sharkey 2012a; Frennert & Östlund, 2014; Sorell & Draper, 2014) in relation to the likely growth of robot care for older people. These concerns cohere around (Sharkey & Sharkey 2012b): the potential reduction in the amount of human contact; an increase in the feelings of objectification and loss of control; a loss of privacy; a loss of personal liberty; and the potential for deception and infantilisation. By contrast car robots can also be seen as ways to enable older people to maintain their independence for longer.

Despite the emerging debate about the advantages, disadvantages and ethical challenges of social robots, technology is a long way from being able to create robots which can provide personal care (i.e. help to wash, bathe, go to the toilet, dress, etc) (Bedaf, Gelderblom & De Witte, 2015). It is these tasks with which older people very often need assistance in later life

in order to remain living in their own homes, and so the potential for social robots to rescue an overwhelmed health and social care system should not be over-estimated.

6.3. *Asset based approaches*

Asset based discourse is emerging as a strong conceptual field, both internationally and in the UK (Harrison et al, 2004; Morgan & Ziglio, 2010; Foot & Hopkins, 2010; Friedli 2013; Stead, Arnott & Dempsey, 2013) in relation to health and well-being. Asset based approaches.

... recognise and build on a combination of the human, social and physical capital that exists within local communities. They acknowledge and build on what people value most and can help ensure that public services are provided where and how they are needed (GCPH 2012b: 3).

The aim of asset-based practice is to ‘promote and strengthen the factors that support good health and wellbeing, protect against poor health and foster communities and networks that sustain health’ (Hopkins & Rippon, 2015: 3).

The notion of assets is also used alongside and/or interchangeably with ‘strengths’ discourse, particularly in relation to reducing dependency and costs and promoting independence and via self-directed support and self-management of long-term health conditions (Pattoni, 2012). Assets have also been (re-)framed in terms of adapted versions of Bourdieu’s framework of capital(s) (Pitkin & Varda, 2009) particularly social capital (Forsman et al, 2013; Muckenhuber, Stronegger & Freidl, 2013; Nyqvist et al, 2013; Roberts & Gannon, 2014; Koutsogeorgou et al, 2014; Knapp, 2015) in terms of: community, family, health (Bergland & Slettebø 2015); human, housing, neighbourhood (Carpiano, 2006); and environment, financial, social, cultural and political capitals (Lynch, 2010). Asset-based approaches are informed by three sets of ideas: salutogenesis, asset-mapping and by the idea of asset-based community development (ABCD).

The concept of salutogenesis was developed by the medical sociologist Aaron Antonovsky (1979, 1987) over 25 years ago. Antonovsky argued that it was important to focus upon an individual’s strengths rather than their weaknesses:

According to Antonovsky’s original idea it was more important to focus on peoples’ resources and capacity to create health than the classic focus on risks, ill health, and disease. The key elements in the salutogenic development are, firstly, the orientation towards problem solving and, secondly, the capacity to use the resources available (Lindström, & Eriksson, 2005: 440).

Antonovsky (1993) developed a 29-item ‘life orientation’ scale (SOC) and subsequently a shorter 13-item scale. Both have been used internationally, although the reliability and validity of each is less than certain (Eriksson, 2005). Despite Brooks (1994) suggesting over 20 years ago that the concept could be linked to successful ageing, only a very limited amount of research has been conducted in this area. In a review of the literature Tan et al (2014) suggested that there is potential to enhance the internal and external resources of older people, and proposed that salutogenesis might have much to offer policy makers and service providers.

More recently, salutogenesis has also been linked to an asset-based approach to well-being in relation to women’s health (Bull et al, 2013), but not, as yet, to well-being in older age.

However, studies of QoL among older people, using the salutogenic model as an assessment tool have been conducted in Spain (Giglio et al, 2015) and Norway (Söderhamn et al, 2015). It has also been used as part of a Danish study of a nursing intervention to enhance a ‘sense of coherence’ among people with dementia living in residential care (Lillekroken et al, 2015) and a trial protocol to determine if a self-care program in Singapore enhances quality of life in people aged over 65 years (Tan et al, 2015).

Asset mapping (Kretzmann & McKnight, 1993) is closely linked to asset-based approaches. It has been described as ‘a process of building an inventory of the strengths and gifts of the people who make up a community prior to intervening’ (Morgan & Ziglio, 2007: 4). An Asset-Based Community Development (ABCD) approach was first developed in Canada and the USA (Mathie & Cunningham, 2003). It is,

...a method of community and network building that starts by locating the assets, skills and capacities of citizens and local organisations, rather than focusing on their needs and deficits. The aim is to help people to improve their resilience, independence and wellbeing by focusing on what can be done through communities working together (ibid: 4).

Asset-based approaches have been critiqued for being ‘a capitulation to neoliberal values of individualization and privatization’ (MacLeod & Emejulu, 2014: 430) and for masking ‘the retreat of statutory, state provision of both public services and public health’ (Friedli, 2013: 140). Moreover, in terms of building social networks, or social capital, several authors have argued that this cannot be separated off from economic capital:

Social capital cannot be conceived in isolation from economic and political structures, since social connections are contingent on, and structured by, access to material resources (Wakefield & Poland, 2005: 2820).

6.4. Community capital

There is a growing research and policy discourse about ‘community capital’

Current debates in many countries about the sustainability of public commitments include discussion of the adequacy and affordability of collective health and social care responses to the rapidly growing needs of ageing communities. A recurrent theme in England is whether communities can play greater roles in preventing the emergence of social care needs and/or in helping to meet them. A number of approaches have been suggested, employing a range of concepts and terms, including community development, community capacity-building and creating social capital. (Knapp et al, 2013: 313).

Knapp et al have suggested that investment in community programmes could be highly cost-effective. Community capital is in turn linked to the concept of social capital. Social capital has been linked to reducing social isolation and loneliness among older people and contributing to the promotion of help and well-being in later life (Sirven & Debrand, 2012; Nyqvist & Forsman, 2015). Increasing community capital and/or social capital is being heralded as the solution to the reductions in local authority social care provision (Bowers et al, 2013) and as a way of moving away from dependency narratives about older people to ones which engaged with reciprocal support. Such projects include: mutually supportive relationships; mutually supportive communities (including KeyRing Networks); cohousing; Homeshare; Shared Lives; time banking; Circles of Support; face-to-face and virtual

volunteering schemes; self-help and peer support networks. However, there is at present only limited research into the actual outcomes of such community projects.

6.5. *Community projects with older people in the UK*

Asset based projects with older people which have so far been reported in the literature include (Buck & Gregory, 2013): supporting volunteering by older people in order to reduce loneliness and isolation and promote wellbeing and community engagement (Bernard & Perry, 2013); developing befriending schemes for older people (Lester et al, 2012; Cattan, Kime & Bagnall, 2011); developing innovative social network promotion schemes, based on interests, such as the *Men in Sheds* projects (Wilson & Cordier, 2013); and targeted activities, such as chair-based exercise classes (Clegg et al, 2014). Outlined below are a few of the most recent projects:

6.5.1. Older People for Older People (O4O)

One of several local pilot projects in Scotland was ‘Older People for Older People (O4O)’⁷ in the Highlands, where older people supported one another through the provision of community transport, ‘helping’ and ‘befriending’ schemes, and local social and cultural activities. The project also developed a toolkit to enable other communities to develop similar projects (Hill, Whitelaw & Stokes, 2010).

6.5.2. The Shine Project

The Shine project in Fife (Health Foundation, 2014) also developed a local assets based project to support older people in their local communities the aim being ‘to build on peoples’ interests, skills, networks and contacts to enable them to remain socially engaged and minimise unnecessary dependency on services and formal support’ (Hopkins & Rippon, 2014: 42) by ‘stimulating a “co-productive” way of working with each person, involving their natural networks to allow highly effective individual solutions to emerge and support new micro-providers based in local neighbourhoods to deliver aspects of individual support’. Outcomes are providing difficult to measure and evaluate, due to the highly personalised situation of individual older people (Petch, 2012).

6.5.3. The Third Age Foundation (TAF)

The Third Age Foundation (TAF) is a charitable project in a small village in rural Ireland whose goals are: changing perceptions of ageing and older people; developing opportunities for older people; reaching out to marginalised people; representing older people; influencing policy makers; supporting and assisting older people. An evaluation of TAF is that is ‘creates a participatory environment which invigorates and empowers citizens in equal measure, overcoming the restrictive material aspects of place to enhance individual well-being, community, social cohesion and social capital’ (Walsh & O’Shea, 2008: 803). However, there is a need for more robust empirical research to identify the precise benefits of the project.

⁷ <http://www.o4os.eu/about-o4o.asp>

6.6. *Asset-based community projects with older people outside the UK*

6.6.1. The NORC supportive services program (USA)

The NORC Supportive Services Program (NORC-SSP) (Bedney, Goldberg & Josephson, 2010) is

A community-level intervention in which older adults, building owners and managers, service providers, funders, and other community partners create a network of services and volunteer opportunities to promote aging in place among older adults who live in ‘naturally occurring retirement communities,’ housing developments and residential areas not planned for older adults but in which large numbers of older adults reside. Because they promote aging in place as well as leadership and self-determination among older adults, NORC-SSPs can be simultaneously conceptualized as a service delivery mechanism, public policy strategy, and means to rewrite cultural meanings of aging (Ibid: 304).

NORC is located within the very differently structured provision of welfare in the USA, and has a strong charitable basis to it, which is common to many projects for older people in the USA, which funded partly at a federal/state level, supplemented by donations. What makes the various NORC model (and its local variants) of particular interest (Bookman 2008: 424) is its model of joined up local services, led by communities by specific (health and social care) agencies, and its engagement with older adults themselves in the design, implementation and delivery of services, which can include ‘transportation, housekeeping, adult day care, congregate and home-delivered meals, and information and referral services’ (Bedney, Goldberg & Josephson, 2010: 308-9).

6.6.2. The CAPABLE programme (USA)

The Community Aging in Place, Advancing Better Living for Elders (CAPABLE), also in the USA, and again located within the USA’s welfare model, provides coordinated occupational therapy, nursing, and handyman visits with aim of reducing/ preventing deterioration in everyday living skills (Szanton et al, 2011). While this may not sound particularly remarkable what is significant is the provision of instrumental support which is different from ‘social care’ (involving meals, shopping and personal care) and which focuses on maintaining everyday living skills rather than intervening to substitute them when they have deteriorated. It is, in effect a preventative home-based intervention designed to reduce/ defer the need for more intensive support.

6.6.3. Alternate housing models (AHMs) (Canada)

Alternate housing models (AHMs) in Canada, ‘allow private and community organisations to offer housing services within the framework of a partnership with public health-care services’ (Dubuc et al 2014: 1575). In other words, a single organisation is the provider of both home/ community care services *and* residential care provision. This links in with suggestions by UK policy groups that residential care homes should become ‘community hubs’:

... the idea of the care home as a ‘community hub’, whereby a range of services is collected under one roof or within a series of closely integrated neighbourhoods. Within the community hub care homes could potentially be considered less as a series of physical buildings and more as a model for delivering specialist care but within a wider community – the driving forces

being the status of individuals and the types of services they require. These services would be supplemented by a range of new and developing technologies (Mason, 2012: 5).

Creating community hubs for older people would provide joined up continuity of care and support in their own homes and/or in supported housing. It would also bring the community in to those older people who are often excluded and marginalised in current models of residential care (Keady et al, 2011). Instead, there would be a two way flow of community-based care and support.

6.6.4. Integrated Service Areas (ISAs) (Europe)

A new project started in northern Europe (Singelenberg et al, 2014) has developed an Integrated Service Areas (ISAs) model of housing and support for older people which is integrated into local communities, and which preliminary research suggests leads to improved QoL and prolonged housing independence among older people living in ISAs:

The ISA (Integrated Service Areas) network⁸ began in 2009 with representatives from Germany, the Netherlands, Switzerland and Denmark identifying various types of housing and service arrangements in their country... criteria included housing that was clearly integrated into the local community, with systems of support that were multidisciplinary and coordinated across areas of support (i.e. physical health as well as social support services) and included the active participation of local citizens and local governments. They called these projects 'Integrated Service Areas' because they included provision of housing, social and physical support services and various levels of care. These ISAs focused on residential areas of towns or municipalities where all generations lived together... [they] may well address the issue of social isolation among elders (Singelenberg et al, 2014: 72).

ISAs differ from the USA models in that they focus on intergenerational integration rather than age-specific reciprocal care support. Some form of integrated model is being increasingly advocated by researchers in the UK:

... a more integrated approach to address demographic change where housing, support and healthcare are all considered... housing is connected to health and therefore has the potential to complement health and care systems; where this is not the case, it can create health problems rather than solve them (Evandrou et al, 2015: 28).

7. Conclusion

This report has provided an overview of current research on older people and social care. There is a growing care gap in relation to need for care and support and diminishing resources, in terms of both informal and formal supplies. The trend towards an asset-based approach will only be effective if there are additional informal assets which can be mobilised, i.e. if there is more volunteer time which can be mobilised and if there is the economic capital available to fund volunteer activities, including transport. Increasing reliance upon informal care and support when there is already a shortfall may not be realistic. It may add to the burden on women's unpaid care work (Exley & Allen, 2007)

In terms of using voluntary sector organisations as assets to support older people, those organisations are themselves under increasing financial pressures and are in turn having to

⁸ www.isa-platform.eu

marketise their services. Indeed, many are now commissioned to provide services by local authorities. Under these conditions it is highly unlikely that the charitable sector will be able to provide additional, and free, social care. The question about assets, then, is from where they will be resourced. A shift from 'needs' to assets discourse will not prevent there being unmet needs among older people with insufficient 'assets'.

The emphasis on increasing social assets in the community is a preventative measure which may well be successful in enabling 'younger older' people to remain in their communities for longer. However, building on community assets is not a straight exchange for social care. Older people, especially those in the upper age range, particularly those with co-morbidities, will still need help with everyday living which includes shopping, cooking, cleaning and, for many, help with washing and dressing, and with continence issues. There are several dangers associated with the conflation of community support and social care, not least of which will be the 'reading' by government of them being one and the same, and an underestimation of the ongoing need for formal social care provision. A further danger is that there could be an increasingly reliance on informal community supporters to also provide more specialised social care (Mountain et al, 2015), and even health care, as can be the case for family carers.

Observers have also noted that care is becoming increasingly technologised, and that many people being cared for in the community have highly complex needs. Recent studies report that the activities undertaken by family carers range from personal care through to highly technical activities, such as renal dialysis and fistula care. (Exley & Allen, 2007: 2319).

Turning to community volunteers to act as substitutes for professional care would raise the potential for unregulated social care for older people. With that lack of regulation would come issues of standards, consistency and safety.

Aspirations for self-governance are also not easily reconciled with hierarchical governance regimes that emphasise consistency, standards, accountability and protection... As Direct Payments and Individual Budgets become more firmly established, with groups of service users sharing their resources to purchase services in common or employing personal assistants from beyond the traditional social care workforce, hard questions will need to be asked about the place of standards and the role of regulation in ensuring equity and accountability. (Newman, Glendinning & Hughes, 2008: 548)

Using untrained volunteers also raises issues in regard to the abuse of older people, particularly as the majority of older people are abused in their own homes (Milne et al, 2013). It would also shift the reciprocity of care model to one of dependency and risk exploiting informal caring relationships (Rummery, 2011). While asset-based approaches to social care for older people may be appealing, they may not be the cure-all it is hoped that they will be.

More broadly, there is a significant research gap in critically interrogating the conceptualisations and strategic mobilisations of 'care needs', 'met care needs' and 'unmet care needs' (Fernández & Snell, 2012), particularly in relation to older people. Despite its significance, the concept of 'need' itself remains surprisingly critically under-interrogated (Reader & Brock, 2004; Tay & Diener, 2011; Schuppert, 2013; Dean, 2014) as is the emphasis on everyday living 'needs' rather than broader concepts of wellbeing (Forder & Fernandez, 2015; Kar, 2015), the idea that love, care and solidarity are basic human needs (Lynch et al, 2009) or, taking a capabilities approach (Nussbaum, 2003; Sen, 2005;

Entwistle, & Watt, 2013) more complex understandings of need in relation to human flourishing. Given the increasing reliance upon the concept of need in social policy relating to care for older people, a research project which engages with this conceptually may have an important role to play in problematising how 'need' is used as a gatekeeper for care services together with both the efficacy and ethics of doing so.

There remains the pressing and unresolved issue of how to fund the growing care needs of older people, particularly during times of austerity. It may be that only a significant cultural shift, which supports systems and practices which prioritise, value and promote the provision of care (both formal and informal), will resolve the growing gap between care needs and available care support. Our society as a whole may need to become re-orientated so that care becomes central to its operating values and social norms, rather than merely adjunct to them.

REFERENCES

- Age UK (2011). *Technology and Older People Evidence Review*. London: Age UK. http://www.ageuk.org.uk/documents/en-gb/for-professionals/computers-and-technology/evidence_review_technology.pdf?dtrk=true
- Age UK (2015). *Later Life in the United Kingdom October 2015 Factsheet*: http://www.ageuk.org.uk/Documents/EN-GB/Factsheets/Later_Life_UK_factsheet.pdf?dtrk=true
- Agree, E. M., & Glaser, K. (2009). Demography of informal caregiving. In Uhlenberg, P. (ed.). *International handbook of population aging* (Vol. 1) (pp. 647-668). Netherlands: Springer.
- Allen, K., & Glasby, J. (2012). 'The billion dollar question': Embedding prevention in older people's services - Ten 'High-Impact' Changes. *British Journal of Social Work*, 43, 904–924.
- Alzheimer's Disease International (2013). *The Global Impact of Dementia 2013-2050*. London: Alzheimer's Disease International.
- Alzheimer's Disease International (2015). *Women and Dementia: A global research review*. London: Alzheimer's Disease International.
- Alzheimer's Society (2015). *Assistive Technology – devices to help with everyday living*. London: Alzheimer's Society.
- Andrews, G. J., Evans, J., & Wiles, J. L. (2013). Re-spacing and re-placing gerontology: relationality and affect. *Ageing and Society*, 33(8), 1339-1373.
- Antonovsky, A. (1979). *Health, Stress and Coping*. San Francisco: Jossey-Bass.
- Antonovsky, A. (1987) *Unraveling the Mystery of Health. How people manage stress and stay well*. San Francisco: Jossey-Bass
- Antonovsky, A. (1993). The structure and properties of the sense of coherence scale. *Social Science & Medicine*, 36(6), 725-733.
- Atkinson, R., & Flint, J. (2004). Fortress UK? Gated communities, the spatial revolt of the elites and time–space trajectories of segregation. *Housing Studies*, 19(6), 875-892.
- Audit Commission (2009). *The Financial Implications for Local Authorities of an Ageing Population: Policy and Literature Review*. London: The Audit Commission.
- Ayres, S. (2013). *Can Online Innovations Enhance Social Care? Exploring the challenges of using digital technology to develop new models of support for older people*. Oxford: Nominet Trust.
- Barac, M. & Park, J. (2009). *HAPPI. Housing our Ageing Population: Panel for innovation*. London: Homes and Communities Agency.

- Bäumker, T., Callaghan, L., Darton, R., Holder, J., Netten, A., & Towers, A. (2012). Deciding to move into extra care housing: residents' views. *Ageing and Society*, 32(7), 1215-1245.
- Bäumker, T., Netten, A. & Darton, R. (2008). *Costs and Outcomes of and Extra-care Housing Scheme in Bradford*. York: Joseph Rowntree Foundation.
- Baxter, K., Rabiee, P. & Glendinning, C. (2013). Managed personal budgets for older people: what are English local authorities doing to facilitate personalized and flexible care? *Public Money & Management*, 33(6), 399-406.
- Bedaf, S., Gelderblom, G. J. & De Witte, L. (2015). Overview and categorization of robots supporting independent living of elderly people: What activities do they support and how far have they developed?. *Assistive Technology*, 27(2), 88-100.
- Bedney, B. J., Goldberg, R. B., & Josephson, K. (2010). Aging in place in naturally occurring retirement communities: Transforming aging through supportive service programs. *Journal of Housing for the Elderly*, 24(3-4), 304-321.
- Beech, R., & Roberts, D. (2008). *Assistive Technology and Older People*. London: Social Care Institute for Excellence (SCIE).
- Bergland, A., & Slettebø, Å. (2015) Health capital in everyday life of the oldest old living in their own homes. *Ageing and Society*, 35, 2156-2175.
- Bernard, M. & Phillips, J. (2000). The challenge of ageing in tomorrow's Britain. *Ageing and Society*, 20, 33-54.
- Bernard, M., Bartlam, B., Sim, J., & Biggs, S. (2007). Housing and care for older people: Life in an English purpose-built retirement village. *Ageing and Society*, 27(04), 555-578.
- Bernard, M., Liddle, J., Bartlam, B., Scharf, T. & Sim, J. (2012). Then and now: Evolving community in the context of a retirement village. *Ageing and Society*, 32(01), 103-129.
- Bernard, S., & Perry, H. (2013). *Loneliness and Social Isolation among Older People in North Yorkshire*. Social Policy Research Unit, York: University of York.
- Berry, R. (2011) *Older People and the Internet. Towards a System Map of Digital Exclusion* International Longevity Centre, London.
- Billings, J., Dixon, J., Mijanovich, T., & Wennberg, D. (2006). Case finding for patients at risk of readmission to hospital: Development of algorithm to identify high risk patients. *British Medical Journal*, 333(7563), 327.
- Blood, I. (2013). *A Better Life: Valuing Our Later Years*. London; Joseph Rowntree Foundation.
- Blood, I. & Bamford, S. M. (2010). *Equality and Diversity and Older People with High Support Needs*. York: Joseph Rowntree Foundation.
- Bode, I., Gardin, L. & Nyssens, M. (2011). Quasi-marketisation in domiciliary care: varied patterns, similar problems? *International Journal of Sociology and Social Policy*, 31(3/4), 222-235.

- Bookman, A. (2008). Innovative models of aging in place: Transforming our communities for an aging population. *Community, Work & Family*, 11(4), 419-438.
- Bowers, H. (2009). *Older People's Vision for Long-Term Care*. York: Joseph Rowntree Foundation.
- Bowers, H., Lockwood, S., Eley, A., Catley, A., Runnicles, D., Mordey, M., Barker, S., Thomas, N., Jones, C. & Dalziel, S. (2013) *Widening Choices for Older People with High Support Needs*. York: Joseph Rowntree Foundation.
- Bowes, A. (2006). Mainstreaming equality: implications of the provision of support at home for majority and minority ethnic older people. *Social Policy & Administration*, 40(7), 739-757.
- Bowes, A., & Wilkinson, H. (2003). 'We didn't know it would get that bad': South Asian experiences of dementia and the service response. *Health & Social Care in the Community*, 11(5), 387-396.
- Bowling, A., & Stenner, P. (2010). Which measure of quality of life performs best in older age? A comparison of the OPQOL, CASP-19 and WHOQOL-OLD. *Journal of Epidemiology and Community Health*, *Journal of Epidemiology and Community Health*, 65, 273–280.
- Bowling, A., & Stenner, P. (2010). Which measure of quality of life performs best in older age? A comparison of the OPQOL, CASP-19 and WHOQOL-OLD. *Journal of Epidemiology and Community Health*, 65,273-280.
- Bowling, A., Gabriel, Z., Dykes, J., Dowding, L.M., Evans, O., Fleissig, A., Banister, D. & Sutton, S. (2003). Let's ask them: A national survey of definitions of quality of life and its enhancement among people aged 65 and over, *International Journal of Aging and Human Development*, 56, 269–306.
- Bowling, A., Hankins, M., Windle, G., Bilotta, C., & Grant, R. (2013). A short measure of quality of life in older age: The performance of the brief Older People's Quality of Life questionnaire (OPQOL-brief). *Archives of Gerontology and Geriatrics*, 56(1), 181-187.
- Brand, C., Hughes, J., & Challis, D. (2012). Towards understanding variations in social care for older people in England. *Social Policy & Administration*, 46(7), 705-726.
- Brennan, D., Cass, B., Himmelweit, S., & Szebehely, M. (2012). The marketisation of care: Rationales and consequences in Nordic and liberal care regimes. *Journal of European Social Policy*, 22(4), 377-391.
- Brenton, M. (2008). *The Co-housing Approach to 'Lifetime Neighbourhoods'*. Housing Learning and Improvement Network Factsheets No. 29, London: Housing LIN.
- Brenton, M. (2013). *Senior Co-Housing Communities – An Alternative Approach for the UK?* Joseph Rowntree Foundation Programme Paper. York: Joseph Rowntree Foundation.
- Broekens, J., Heerink, M., & Rosendal, H. (2009). Assistive social robots in elderly care: a review. *Gerontechnology*, 8(2), 94-103.

- Brooks, F. & Kendall, S. (2013). Making sense of assets: what can an assets based approach offer public health? *Critical Public Health*, 23(2), 127-130.
- Brooks, J.D. (1994). Salutogenesis, successful aging and the advancement of theory on family caregiving. In H.I. McCubbin, E.A.Thompson, A.I.Thompson & J.E. Fromer (Eds.). *Stress, Coping, and Health in Families: Sense of Coherence and Resiliency. Resiliency in Families Series* (pp. 227–248). Thousand Oaks, CA: Sage.
- Buck, D. and Gregory, S. (2013). *Commissioning for Better Outcomes: A Route Map*. London: The King’s Fund.
- Buck, D. and Gregory, S. (2013) *Improving the Public’s Health*. London: The King’s Fund.
- Buffel, T., McGarry, P., Phillipson, C., De Donder, L., Dury, S., De Witte, N., Smetcoran, A-S. & Verte, D. (2014) Developing age-friendly cities: Case studies from Brussels and Manchester and implications for practice. *Journal of Aging & Social Policy* 26(24), 52-74.
- Buffel, T., Phillipson, C. and Scharf, T. (2012). Ageing in urban environments: Developing ‘age-friendly’ cities. *Critical Social Policy*, 32(4), 597-617.
- Bull, T., Mittelmark, M. B., & Kanyeka, N. E. (2013). Assets for well-being for women living in deep poverty: Through a salutogenic looking-glass. *Critical Public Health*, 23(2), 160-173.
- Burholt, V., & Scharf, T. (2013). Poor health and loneliness in later life: The role of depressive symptoms, social resources, and rural environments. *The Journals of Gerontology Series B: Psychological Sciences and Social Sciences*, DOI: 10.1093/geronb/gbt121
- Burke, S (2010) *A Better Life: Alternative Approaches from the Perspective of Families and Carers of Older People with High Support Needs*. JRF programme paper. York: Joseph Rowntree Foundation.
- Burton, E. J., Mitchell, L., & Stride, C. B. (2011). Good places for ageing in place: development of objective built environment measures for investigating links with older people's wellbeing. *BMC Public Health*, 11(1), 839.
- Callaghan, L., & Towers, A. (2014). Feeling in control: comparing older people's experiences in different care settings. *Ageing and Society*, 34(08), 1427-1451.
- Callahan, C. M., Arling, G., Tu, W., Rosenman, M. B., Counsell, S. R., Stump, T. E., & Hendrie, H. C. (2012). Transitions in care for older adults with and without dementia. *Journal of the American Geriatrics Society*, 60(5), 813-820.
- Carpiano, R. M. (2006). Toward a neighborhood resource-based theory of social capital for health: Can Bourdieu and sociology help? *Social science & medicine*, 62(1), 165-175.
- Carr, S. & Ross, P. (2013). *Assessing Current and Future Housing and Support Options for Older LGB People*. York: Joseph Rowntree Foundation.
- Carr, S. (2014). *Social Care for Marginalised Communities: Balancing Self-organisation, Microprovision and Mainstream Support. Policy Paper, 18*. Birmingham: University of Birmingham.

- Carter, M. R., & Barrett, C. B. (2006). The economics of poverty traps and persistent poverty: An asset-based approach. *The Journal of Development Studies*, 42(2), 178-199.
- Cattan, M., Kime, N., & Bagnall, A. M. (2011). The use of telephone befriending in low level support for socially isolated older people—an evaluation. *Health & Social Care in the Community*, 19(2), 198-206.
- Chen, Y. M., & Thompson, E. A. (2010). Understanding factors that influence success of home-and community-based services in keeping older adults in community settings. *Journal of Aging and Health*, 22(3), 267-291.
- Chiodelli, F & Baglione, V. (2014). Living together privately: For a cautious reading of cohousing, *Urban Research & Practice*, 7(1), 20-34.
- Choi, S. J. (2004). Evaluation of community planning and life of senior cohousing projects in Northern European countries. *European Planning Studies*, 12(8), 1189–1216
- Clegg, A., Barber, S., Young, J., Iliffe, S., & Forster, A. (2014). The Home-based Older People's Exercise (HOPE) trial: a pilot randomised controlled trial of a home-based exercise intervention for older people with frailty. *Age and Ageing*, 43(5), 687-695.
- Coast, J., Flynn, T. N., Natarajan, L., Sproston, K., Lewis, J., Louviere, J. J., et al. (2008). Valuing the ICECAP capability index for older people. *Social Science & Medicine*, 67(5), 874-882.
- Coast, J., Peters, T. J., Natarajan, L., Sproston, K., & Flynn, T. (2008). An assessment of the construct validity of the descriptive system for the ICECAP capability measure for older people. *Quality of Life Research: An International Journal of Quality of Life Aspects of Treatment, Care and Rehabilitation*, 17(7), 967-976.
- Collom, E. (2008). Engagement of the elderly in time banking: The potential for social capital generation in an aging society. *Journal of Aging & Social Policy*, 20(4), 414-436.
- Colombo, F., Llana-Nozal, A., Mercier, J. & Tjadens, F. (2011) *Help Wanted? Providing and Paying for Long-term Care Policy Brief*. Paris: OECD.
- Comas-Herrera, A., King, D., Malley, J., Pickard, L., Wittenberg, R., & Darton, R. (2006). *Thirty-five Years On: Future Demands for Long-term Care in England*. London: London School of Economics and Political Science (PSSRU).
- Comptroller & Auditor General (2013) *Emergency Admissions to Hospital: Managing the Demand*. London: National Audit Office.
- Creighton, H. (2014). *Europe's Ageing Demography*. London: ILC-UK.
- Croucher, K. (2008). *Housing Choices and Aspirations of Older People: Research from the New Horizons Programme*. London: Department for Communities and Local Government.
- Croucher, K., Hicks, L., & Jackson, K. (2006). *Housing with Care for Later Life*. York: Joseph Rowntree Foundation, University of York.
- Croucher, K., Hicks, L., Bevan, M., & Serson, D. (2007). *Comparative Evaluation of Models of Housing with Care for Later Life*. York: Joseph Rowntree Foundation.

- CSCI (Commission for Social Care Inspection) (2008) *State of Social Care in England 2006–07*, third annual report to Parliament. London: CSCI.
- Dale, C.E., Bowling, A., Adamson, J., Kuper, H., Amuzu, A., Ebrahim, S., Casas, J.P. & Nüesch, E. (2013). Predictors of patterns of change in health-related quality of life in older women over 7 years: evidence from a prospective cohort study. *Age and Ageing*, 42(3), 312-318.
- Daly, M. & Lewis, J. (2000). The concept of social care and the analysis of contemporary welfare states. *The British Journal of Sociology*, 51(2), 281-298.
- Daly, M. (2002). Care as a good for social policy. *Journal of Social Policy*, 31(2), 251-270.
- Damant, J. & Knapp, M. (2015). *What are the Likely Changes in Society and Technology which will Impact upon the Ability of Older Adults to Maintain Social (extra-familial) Networks of Support now, in 2025 and in 2040?* London: Government Office for Science.
- Davey, J., Nana, G., de Joux, V., & Arcus, M. (2004). *Accommodation Options for Older People in Aotearoa/New Zealand*. Wellington, New Zealand: NZ Institute for Research on Ageing/Business & Economic Research Ltd, for Centre for Housing Research Aotearoa, New Zealand.
- Dean, H. (2014). *Understanding Human Need (Understanding Welfare: Social Issues, Policy and Practice)* Bristol: Policy Press. Kindle Edition.
- Department for Communities and Local Government (2008). *Lifetime Homes, Lifetime Neighbourhoods: A National Strategy for Housing in an Ageing Society*. London: Department for Communities and Local Government.
- Department for Communities and Local Government (2011). *Laying the Foundations: A Housing Strategy for England*. London: The Stationery Office.
- Department of Health (1999a). *Better Care, Higher Standards: A Charter for Long Term Care*. London: The Stationery Office.
- Department of Health (1999b). *National Service Frameworks Mental Health*. London: The Stationery Office.
- Department of Health (2000). *No Secrets: Guidance on Developing and Implementing Multi-agency Policies and Procedures to Protect Vulnerable Adults from Abuse*. London: The Stationery Office.
- Department of Health (2001). *National Service Framework for Older People*. London: The Stationery Office.
- Department of Health (2003). *Care Homes for Older People: National Minimum Standards and the Care Homes Regulations: Third Edition (revised)*. London: The Stationery Office.
- Department of Health (2005). *Independence, Well-Being and Choice: Our Vision for the Future of Social Care for Adults in England*. London: The Stationery Office.
- Department of Health (2006). *Our Health, Our Care, Our Say: a new direction for community services*. London: The Stationery Office.

- Department of Health (2007a). *Who Cares? Information and Support for the Carers of People with Dementia*. London: The Stationery Office
- Department of Health (2007b). *Putting People First: A Shared Vision and Commitment to the Transformation of Adult Social Care*. London: The Stationery Office.
- Department of Health (2008a). *Transforming the Quality of Dementia Care: Consultation on a National Dementia Strategy*. London: Department of Health.
- Department of Health (2008b). *Carers at the Heart of 21st Century Families and Communities*. London: The Stationery Office.
- Department of Health (2009). *Living Well with Dementia: A National Dementia Strategy for England*. London: Department of Health.
- Department of Health (2010a). *A Vision for Adult Social Care: Capable Communities and Active Citizens*. London: The Stationery Office
- Department of Health (2010b). *Healthy Lives, Healthy People: Our strategy for public health in England*. London: The Stationery Office
- Department of Health (2010c). *Essence of Care: Benchmarks for the Fundamental Aspects of Care*. London: The Stationery Office.
- Department of Health (2010d). *Recognised, Valued and Supported: Next Steps for the Carer's Strategy*. London: The Stationery Office.
- Department of Health (2012a). *Caring for our Future: Reforming Care and Support*, White Paper. London: Department of Health.
- Department of Health (2012b). *Improving Outcomes and Supporting Transparency Part 1A: A Public Health Outcomes Framework for England, 2013-2016*. London: The Stationery Office.
- Department of Health (2012c). *Prime Minister's Challenge on Dementia: Delivering Major Improvements in Dementia Care and Research by 2015*. London: Department of Health.
- Department of Health (2013a). *Research and Development Work Relating to Assistive Technology 2012-13*. London: The Stationery Office.
- Department of Health (2013b). *Wellbeing: Why it Matters in Health Policy?* London: The Stationery Office.
- Desai, S. (2012). Will it ever change? The continuing unmet needs of older black and ethnic minority people and social care. *Diversity and Equality in Health and Care*, 9, 85-87.
- Dickinson, H., Allen, K., Alcock, P., Macmillan, R., & Glasby, J. (2012). *The Role of the Third Sector in Delivering Social Care*. London: NIHR School for Social Care Research, London School of Economics and Political Science.
- Drubbel, I., Bleijenberg, N., Kranenburg, G., Eijkemans, R. J., Schuurmans, M. J., de Wit, N. J., & Numans, M. E. (2013). Identifying frailty: do the Frailty Index and Groningen Frailty Indicator cover different clinical perspectives? A cross-sectional study. *BMC Family Practice*, 14(1), 64.

- Drubbel, I., de Wit, N. J., Bleijenberg, N., Eijkemans, R. J., Schuurmans, M. J., & Numans, M. E. (2013). Prediction of adverse health outcomes in older people using a frailty index based on routine primary care data. *The Journals of Gerontology Series A: Biological Sciences and Medical Sciences*, 68(3), 301-308.
- Dubuc, N., Dubois, M.F., Demers, L., Tourigny, A., Tousignant, M., Desrosiers, J., Corbin, C., Trottier, L. and Raiche, M. (2014). Alternate housing models for older people with disabilities: Their clientele, structures and resources in relation to the quality of and satisfaction with care delivery. *Ageing and Society*, 34(9), 1575-1600.
- Durie, R., & Wyatt, K. (2013). Connecting communities and complexity: a case study in creating the conditions for transformational change. *Critical Public Health*, 23(2), 174-187, p174.
- Entwistle, V. A., & Watt, I. S. (2013). Treating patients as persons: A capabilities approach to support delivery of person-centered care. *The American Journal of Bioethics*, 13(8), 29-39.
- Equality and Human Rights Commission (EHRC) (2011) *Close to Home: An Inquiry into Older People and Human Rights in Home Care*. London: EHRC.
- Eriksson, M., & Lindström, B. (2005). Validity of Antonovsky's sense of coherence scale: a systematic review. *Journal of Epidemiology and Community Health*, 59(6), 460-466.
- European Commission (2012) *Long-Term Care for the Elderly: Provisions and Providers in 33 European Countries*. Luxembourg: European Commission.
- Exley, C., & Allen, D. (2007). A critical examination of home care: End of life care as an illustrative case. *Social Science and Medicine*, 65(11), 2317-2327.
- Falkingham, J., Evandrou, M., McGowan, T., Bell, D., & Bowes, A. (2010). *Demographic Issues, Projections and Trends: Older People with High Support Needs in the UK. JRF Better Life Paper*. Southampton: ESRC Centre for Population Change, University of Southampton and University of Stirling. [http://eprints.soton.ac.uk/338999/1/JRF_report Falkingham 2010.pdf](http://eprints.soton.ac.uk/338999/1/JRF_report_Falkingham_2010.pdf) - at present you are listing the URL selectively – either do it for all or none
- Fernández, J. L., & Snell, T. (2012) *Survey of Fair Access to Care Services: (FACS) Assessment Criteria among Local Authorities in England*. London: Personal Social Services Research Unit, London School of Economics.
- Fernandez, J. L., Snell, T., & Wistow, G. (2013). *Changes in the Patterns of Social Care Provision in England: 2005/6 to 2012/13*. Personal Social Services Research Unit PSSRU Discussion Paper 2867 Canterbury and London: University of Kent and London School of Economics.
- Fitzgerald, K. G., & Caro, F. G. (2014). An overview of age-friendly cities and communities around the world. *Journal of Aging & Social Policy*, 26(1-2), 1-18.
- Foot, J., & Hopkins, T. (2010). *A Glass Half-full: How an Asset Approach Can Improve Community Health and Well-being*. London: Great Britain Improvement and Development Agency.

- Forder, J., Jones, K., Glendinning, C., Caiels, J., Welch, E., Baxter, K., Davidson, J., Windle, K., Irvine, A., King, D. & Dolan, P. (2012). *Evaluation of the Personal Health Budget Pilot Programme. Discussion Paper 2840*. London: Department of Health.
- Forsman, A. K., Herberts, C., Nyqvist, F., Wahlbeck, K., & Schierenbeck, I. (2013). Understanding the role of social capital for mental wellbeing among older adults. *Ageing and Society*, 33(05), 804-825
- Francesca, C., Ana, L. N., Jérôme, M., & Frits, T. (2011). *OECD Health Policy Studies Help Wanted? Providing and Paying for Long-Term Care: Providing and Paying for Long-Term Care* (Vol. 2011). Paris: OECD Publishing.
- Francis, R. (2013) *Report of the Mid Staffordshire NHS Foundation Trust Public Inquiry Executive summary HC947*. London: The Stationery Office.
- Franklin, B. (2015) *The End of Formal Adult Social Care: A Provocation by the ILC-UK*. London: ILC-UK
- Frennert, S., & Östlund, B. (2014). Review: seven matters of concern of social robots and older people. *International Journal of Social Robotics*, 6(2), 299-310.
- Friedli, L. (2013) 'What we've tried, hasn't worked': the politics of assets based public health. *Critical Public Health*, 23(2), 131-145
- Fries, J.F. (1980). Aging, natural death, and the compression of morbidity. *New England Journal of Medicine*, 303(3), 130-135.
- Gabriel, Z. & Bowling, A. (2004). Perspectives on quality of life in older age: older people talking, *Ageing and Society*, 24, 675–691.
- Garwood, S. (2010) *A Better Life for Older People with High Support Needs in Housing with Care*. York: Joseph Rowntree Foundation.
- Gaugler, J. E., Duval, S., Anderson, K. A., & Kane, R. L. (2007). Predicting nursing home admission in the US: a meta-analysis. *BMC Geriatrics*, 7(1), 13.
- Gibson, G., Newton, L., Pritchard, G., Finch, T., Brittain, K., & Robinson, L. (2014). The provision of assistive technology products and services for people with dementia in the United Kingdom. *Dementia*, DOI: 1471301214532643.
- Giglio, R. E., Rodriguez-Blazquez, C., de Pedro-Cuesta, J., & Forjaz, M. J. (2015). Sense of coherence and health of community-dwelling older adults in Spain. *International Psychogeriatrics*, 27(04), 621-628.
- Gilleard, C., & Higgs, P. (2010). Aging without agency: Theorizing the fourth age. *Ageing & Mental Health*, 14(2), 121-128.
- Gilleard, C., Hyde, M., & Higgs, P. (2007). The impact of age, place, aging in place, and attachment to place on the well-being of the over 50s in England. *Research on Aging*, 29(6), 590-605.
- Giuntoli, G., & Cattan, M. (2012). The experiences and expectations of care and support among older migrants in the UK. *European Journal of Social Work*, 15(1), 131-147.

- Glaser, K., Stuchbury, R., Tomassini, C., & Askham, J. (2008). The long-term consequences of partnership dissolution for support in later life in the United Kingdom. *Ageing and Society*, 28(03), 329-351.
- Glaser, Karen, et. al. (2009). *Life Course Influences on Health and Well-being in Later Life: A Review*. Equality and Human Rights Commission with Age Concern and Help the Aged: Manchester: <http://justageing.equalityhumanrights.com/wp-content/uploads/2009/10/Life-course-influences-and-well-being-in-later-life-a-review.pdf>
- Glasgow Centre for Population Health (GCPH) (2012) *Putting Asset Based Approaches into Practice: Identification, Mobilisation and Measurement of Assets*. Briefing Paper 10. Glasgow: GCPH.
- Glass, A. P. (2009). Aging in a community of mutual support: The emergence of an elder intentional cohousing community in the United States. *Journal of Housing for the Elderly*, 23(4), 283-303.
- Glass, A. P. (2012). Elder co-housing in the United States: Three case studies. *Built Environment* 38(3), 345–363.
- Glass, A. P. (2013). Lessons learned from a new elder cohousing community. *Journal of Housing for the Elderly*, 27(4), 348-368.
- Glass, A. P., & Skinner, J. (2013). Retirement communities: We know what they are... or do we?. *Journal of Housing for the Elderly*, 27(1-2), 61-88.
- Glass, A. P., & Vander Plaats, R. S. (2013). A conceptual model for aging better together intentionally. *Journal of Aging Studies*, 27(4), 428-442.
- Glendinning, C., Challis, D., Fernandez, J-L., Jacobs, S., Jones, K., Knapp, M., Manthorpe, J., Moran, N., Netten, A., Stevens, M. and Wilberforce, M. (2008). *Evaluation of the Individual Budgets Pilot Programme: Final Report* SPRU, York: University of York.
- Greenhalgh, T., Wherton, J., Sugarhood, P., Hinder, S., Procter, R., & Stones, R. (2013). What matters to older people with assisted living needs? A phenomenological analysis of the use and non-use of telehealth and telecare. *Social Science & Medicine*, 93, 86-94.
- Grundy, E., & Read, S. (2012). Social contacts and receipt of help among older people in England: Are there benefits of having more children? *The Journals of Gerontology Series B: Psychological Sciences and Social Sciences*, 67(6), 742-754.
- Haberkern, F.K., Schmid, T., Neuberger, F., & Grignon, M. (2011). The role of the elderly as providers and recipients of care. In OECD, *The Future of Families to 2030* (pp. 189–257). Paris: OECD.
- Ham, C., Dixon, A. & Brooke, B. (2012). *Transforming the Delivery of Health and Social Care. The Case for Fundamental Change*. London: King's Fund.
- Harrison, D., E. Ziglio, L. Levin, & A. Morgan. (2004). *Assets for Health and Development: Developing a Conceptual Framework*. European Office for Investment for Health and Development. Venice: WHO.

- Health and Social Care Information Centre (HSCIC) (2014). *Personal Social Services: Expenditure and Unit Costs, England. 2013-14 Final release*. London: Health and Social Care Information Centre.
- Health Foundation (2014). *Shine. NHS Fife: Micro-enterprise Care Solutions to Reduce Acute Hospital Admissions*. Available from: www.health.org.uk/areas-of-work/programmes/shine-eleven/related-projects/nhs-fife/
- Health Services Management Centre (2006). *Reducing Unplanned Hospital Admissions*. Birmingham: Health Services Management Centre.
- Health Services Management Centre and Institute of Local Government Studies (2015). *Commissioning for Better Outcomes: A Route Map*. Policy Paper, 18. Birmingham: University of Birmingham, Health Services Management Centre and Institute of Local Government Studies.
- Heaphy, B. (2009). Choice and its limits in older lesbian and gay narratives of relational life. *Journal of GLBT Family Studies*, 5(1-2), 119-138.
- Hepworth, M., Olphert, W. & Bartle, J. (2013). Co-design and navigating conflicts of interest: enabling independent living for seniors living in supported housing. *International Journal of Integrated Care*, 13(7), 1-2.
- Hill, C., Whitelaw, S. & Stoke, P. (2010) *O4O Toolkit. Older People for Older People: developing social enterprise and service delivery in remote and rural areas*. Glasgow: University of Glasgow and Crichton Publications.
- HM Government (2005). *Opportunity Age*. London: The Stationery Office.
- HM Government (2010). *The Coalition: Our Programme for Government*. London: The Stationery Office.
- HM Government (2011a). *Open Public Services*. London: The Stationery Office.
- HM Government (2011b). *Healthy Lives, Healthy People: Update and way forward*. London: The Stationery Office.
- Hopkins, T., & Rippon, S. (2015). *Head, Hands and Heart: Asset-based Approaches in Health Care*. London: The Health Foundation.
- House of Commons, Committee of Public Accounts (2008) *Improving Services and Support for People with Dementia*. London: The Stationary Office.
- Howe, A. L., Jones, A. E., & Tilse, C. (2013). What's in a name? Similarities and differences in international terms and meanings for older peoples' housing with services. *Ageing and Society*, 33(04), 547-578.
- Hyde, M., Wiggins, R. D., Higgs, P., & Blane, D. B. (2003). A measure of quality of life in early old age: the theory, development and properties of a needs satisfaction model (CASP-19). *Ageing & Mental Health*, 7(3), 186-194.
- Iliffe, S. & Manthorpe, J. (2014). A new settlement for health and social care?. *BMJ*, 349, g4818.

- Institute for Personal Care (IPC) and Oxford Brookes University (2012a) *Health, Wellbeing, and the Older People Housing Agenda*. London: Housing LIN.
- Institute for Personal Care (IPC) and Oxford Brookes University (2012b) *Identifying the Health Gain from Retirement Housing*. Oxford: IPC and Oxford Brookes University.
- Ismail, S. Thorlby, R. and Holder, H. (2014) *Focus On: Social Care for Older People. Reductions in Adult Social Services for Older People in England*. Nuffield Quality Watch. London: The Health Foundation and Nuffield Trust.
- Jarvis, H. (2015). Towards a deeper understanding of the social architecture of co-housing: evidence from the UK, USA and Australia. *Urban Research & Practice*, 8(1), 93-105.
- Jolanki, O., & Vilkkö, A. (2015). The meaning of a 'sense of Community' in a Finnish senior co-Housing community. *Journal of Housing For the Elderly*, 29(1-2), 111-125.
- Kachouie, R., Sedighadeli, S., Khosla, R., & Chu, M. T. (2014). Socially assistive robots in elderly care: a mixed-method systematic literature review. *International Journal of Human-Computer Interaction*, 30(5), 369-393.
- Katbamna, S., Ahmad, W., Bhakta, P., Baker, R., & Parker, G. (2004). Do they look after their own? Informal support for South Asian carers. *Health & Social Care in the Community*, 12(5), 398-406.
- Keady, J., Campbell, S., Barnes, H., Ward, R., Li, X., Swarbrick, C., Burrow, S. & Elvish, R. (2012). Neighbourhoods and dementia in the health and social care context: a realist review of the literature and implications for UK policy development. *Reviews in Clinical Gerontology*, 22(02), 150-163.
- Knapp, M. (2015). Reflecting on 'An economic model of social capital and health'. *Health Economics, Policy and Law*, 10(04), 411-417.
- Knapp, M., Bauer, A., Perkins, M., & Snell, T. (2013). Building community capital in social care: is there an economic case? *Community Development Journal*, 48(2), 313-331.
- Knapp, M., Prince, M., Albanese, E., Banerjee, S., Dhanasiri, S., Fernandez, J., Ferri, C., McCrone, P., Snell, T. & Stewart, R. (2007). *Dementia UK*. A report to the Alzheimer's Society on the prevalence and economic cost of dementia in the UK produced by King's College London and London School of Economics. Alzheimer's Society: London.
- Kneale, D. (2011). *Establishing the Extra in Extra Care: Perspectives from three extra care housing providers*. London: International Longevity Centre, ILC-UK
- Knighting, K., O'Brien, M. R., Roe, B., Gandy, R., Lloyd-Williams, M., Nolan, M., & Jack, B. A. (2015). Development of the Carers' Alert Thermometer (CAT) to identify family carers struggling with caring for someone dying at home: a mixed method consensus study. *BMC Palliative Care*, 14(1), 22.
- Koutsogeorgou, E., Davies, J.K., Aranda, K., Zissi, A., Chatzikou, M., Cerniauskaite, M., Quintas, R., Raggi, A. & Leonardi, M (2014). Healthy and active ageing: Social capital in health promotion. *Health Education Journal*, 73(6), 627-641.

- Kröger, T. & Yeandle, S. (Eds.) (2014) *Combining Paid Work and Family Care: Policies and Experiences in International Perspective*. Bristol: Policy Press.
- Krout, J. A., Moen, P., Holmes, H. H., Oggins, J., & Bowen, N. (2002). Reasons for relocation to a continuing care retirement community. *Journal of Applied Gerontology*, 21(2), 236-256.
- Labit, A. (2015). Self-managed co-housing in the context of an ageing population in Europe. *Urban Research & Practice*, 8(1), 32-45.
- Larkin, M., & Milne, A. (2014). Carers and empowerment in the UK: a critical reflection. *Social Policy and Society*, 13(01), 25-38.
- Lawton, M. & Brody, E. (1969). Assessment of older people: self-maintaining and instrumental activities of daily living. *Gerontologist*, 9,179-186.
- Leite, I., Pereira, A., Mascarenhas, S., Martinho, C., Prada, R., & Paiva, A. (2013). The influence of empathy in human–robot relations. *International Journal of Human-Computer Studies*, 71(3), 250-260.
- Leng, G. (2011) *On the Pulse: Housing Routes to Better Health Outcomes for Older People*. London: National Housing Federation.
- Lester, H., Mead, N., Graham, C. C., Gask, L., & Reilly, S. (2012). An exploration of the value and mechanisms of befriending for older adults in England. *Ageing and Society*, 32(2), 307-328.
- Lewis, J. & West, A. (2014). Re-shaping social care services for older people in England: Policy development and the problem of achieving ‘good care’. *Journal of Social Policy*, 43(1), 1-18.
- Lillekroken, D., Hauge, S., & Slettebø, Å. (2015). Enabling resources in people with dementia: a qualitative study about nurses’ strategies that may support a sense of coherence in people with dementia. *Journal of Clinical Nursing*, 24(21-22), 3129-3137.
- Lindström, B., & Eriksson, M. (2005). Salutogenesis. *Journal of Epidemiology and community health*, 59(6), 440-442.
- Lui, C. W., Everingham, J. A., Warburton, J., Cuthill, M., & Bartlett, H. (2009). What makes a community age-friendly: A review of international literature. *Australasian Journal on Ageing*, 28(3), 116-121.
- Luppa, M., Luck, T., Weyerer, S., König, H. H., & Riedel-Heller, S. G. (2009a). Gender differences in predictors of nursing home placement in the elderly: a systematic review. *International Psychogeriatrics*, 21(06), 1015-1025.
- Luppa, M., Luck, T., Weyerer, S., König, H. H., Brähler, E., & Riedel-Heller, S. G. (2009b). Prediction of institutionalization in the elderly. A systematic review. *Age and Ageing*, 39(1), 31-8.
- Lynch, H. (2010) *Govanhill: Community Assets and Community Ownership*. Glasgow: Centre for Community Practice Govanhill Baths Community Trust.

- Lynch, K., Baker, J., Cantillon, S., & Walsh, J. (2009). Which Equalities Matter? The Place of Affective Equality in Egalitarian Thinking. In K. Lynch, J. Baker and M. Lyons (Eds.), *Affective Equality: Love Care and Injustice* (pp. 12-34). Basingstoke: Palgrave Macmillan.
- Macdonald, A. & Cooper, B. (2007). Long-term care and dementia services: an impending crisis. *Age and Ageing*, 36(1), 16-22.
- MacLeod, M. A., & Emejulu, A. (2014). Neoliberalism with a community face? A critical analysis of asset-based community development in Scotland. *Journal of Community Practice*, 22(4), 430-450.
- Malley J, Netten A (2009). Measuring outcomes of social care, *Research Policy and Planning*, 27, 85–96.
- Malley, J. N., Towers, A. M., Netten, A. P., Brazier, J. E., Forder, J. E., & Flynn, T. (2012). An assessment of the construct validity of the ASCOT measure of social care-related quality of life with older people. *Health and Quality of Life Outcomes*, 10(1), 1.
- Manthorp, C. (2010) *Innovation and Better Lives for Older People with High Support Needs: International Good Practice*. York: Joseph Rowntree Foundation.
- Manthorpe, J., Moriarty, J., Stevens, M., Hussein, S., & Sharif, N. (2010). Black and minority ethnic older people and mental well-being: possibilities for practice. *Working with Older People*, 14(4), 32-37.
- Manthorpe, J., Moriarty, J., Stevens, M., Hussein, S., & Sharif, N. (2012). Promoting the mental well-being of older people from black and minority ethnic communities in United Kingdom rural areas: Findings from an interview study. *Journal of Rural Studies*, 28(4), 406-411.
- Mason, M. (2012) *Care Home Sweet Home: Care Home of the Future*. London: ILC-UK
- Mast, M., Burmester, M., Krüger, K., Fatikow, S., Arbeiter, G., Graf, B., Kronreif, G., Pignini, L., Facal, D. and Qiu, R. (2012). User-centered design of a dynamic-autonomy remote interaction concept for manipulation-capable robots to assist elderly people in the home. *Journal of Human-Robot Interaction*, 1(1), 96-118.
- Mathie, A. & Cunningham, G. (2003). From clients to citizens: Asset-based community development as a strategy for community-driven development. *Development in Practice*, 13(5), 474-486.
- McCann, M., Grundy, E., & O'Reilly, D. (2011). Why is housing tenure associated with a lower risk of admission to a nursing or residential home? Wealth, health and the incentive to keep 'my home'. *Journal of epidemiology and community health*, DOI: 10.1136/jech-2011-200315.
- McFall, S., & Miller, B. H. (1992). Caregiver burden and nursing home admission of frail elderly persons. *Journal of Gerontology*, 47(2), S73-S79.
- McGovern, J. (2014). The forgotten: Dementia and the aging LGBT community. *Journal of Gerontological Social Work*, 57(8), 845-857.

- Means, R. (2007). Safe as houses? Ageing in place and vulnerable older people in the UK. *Social Policy & Administration*, 41(1), 65-85.
- Means, R., & Evans, S. (2012). Communities of place and communities of interest? An exploration of their changing role in later life. *Ageing and Society*, 32(08), 1300-1318.
- Milligan, C., Roberts, C., & Mort, M. (2011). Telecare and older people: who cares where? *Social Science & Medicine*, 72(3), 347-354.
- Milne, A., Cambridge, P., Beadle-Brown, J., Mansell, J., & Whelton, B. (2013). The characteristics and management of elder abuse: evidence and lessons from a UK case study. *European Journal of Social Work*, 16(4), 489-505.
- Miranda-Castillo, C., Woods, B., & Orrell, M. (2010). People with dementia living alone: what are their needs and what kind of support are they receiving? *International Psychogeriatrics*, 22(4), 607.
- Montgomerie, J., & Büdenbender, M. (2015). Round the houses: Homeownership and failures of asset-based welfare in the United Kingdom. *New Political Economy*, 20(3), 386-405.
- Moorhead J. (2010) 'It's like a mini Centre Parcs!' : Joanna Moorhead on the growth in cohousing. *The Guardian* Sat 1st May <http://gu.com/p/2gjc7/stw>
- Moran, N., Glendinning, C., Wilberforce, M., Stevens, M., Netten, A., Jones, K., Manthorpe, J., Knapp, M., Fernandez, J.L., Challis, D. & Jacobs, S. (2013). Older people's experiences of cash-for-care schemes: evidence from the English Individual Budget pilot projects. *Ageing and Society*, 33(5), 826-851.
- Morgan, A. & E. Ziglio. 2010. Revitalising the public health evidence base: An asset model. In A. Morgan, M. Davies & E. Ziglio (Eds), *Health Assets in a Global Context – Theory, Methods, Action* (pp 3–16). London: Springer.
- Moriarty, J. (2008). *The Health and Social Care Experiences of Black and Minority Ethnic Older People*. Race Equality Foundation Briefing Paper. London: Race Equality Foundation.
- Moriarty, J., Sharif, N., & Robinson, J. (2011). *Black and Minority Ethnic People with Dementia and their Access to Support and Services*. Social Care Institute for Excellence (SCIE) Research Briefing, 35. London: SCIE.
- Mountain, G., Gossage-Worrall, R., Cattan, M., & Bowling, A. (2015). Only available to a selected few? Is it feasible to rely on a volunteer workforce for complex intervention delivery? *Health & Social Care in the Community*. DOI: 10.1111/hsc.12285
- Muckenhuber, J., Stronegger, W. J., & Freidl, W. (2013). Social capital affects the health of older people more strongly than that of younger people. *Ageing and Society*, 33(5), 853-870.
- National Audit Office (2007) *Improving Services and Support for People with Dementia*. London: The Stationary Office.

- National Audit Office (2014) *Adult social care in England: overview*. London: The Stationary Office.
- National Colloquium (2012) *Co-production for Health: A New Model for a Radically New World: Building New Approaches to Delivery to Achieve Better Health Outcomes at the Local Level*. Oxford: Solutions for Public Health.
- National Institute for Health and Care Excellence (NICE) (2007) *Behaviour Change: General Approaches. NICE guidelines [PH6]* Published date: October 2007. London: NICE.
- Netten, A. (2011) *SSCR Methods 6: Overview of Outcome Measurement for Adults Using Social Care Services and Support*. London: NIHR School for Social Care Research,
- Netten, A., Beadle-Brown, J., Caiels, J., Forder, J., Malley, J. & Smith, N. (2011). *Adult Social Care Outcomes Toolkit (ASCOT) Main Guidance v 2.1*. University of Kent (PSSRU discussion paper 2716/3). Canterbury: Personal Social Services Research Unit.
- Netten, A., Burge, P., Malley, J., Potoglou, D., Towers, A.M., Brazier, J., Flynn, T., Forder, J. & Wall, B. (2012) Outcomes of social care for adults: developing a preference-weighted measure, *Health Technology Assessment*, 16, 16. Available from: <http://orca.cf.ac.uk/37396/1/FullReport-hta16160.pdf>
- Netten, A., Darton, R., Bäumker, T., & Callaghan, L. (2011). *Improving Housing with Care Choices for Older People: An Evaluation of Extra Care Housing*. Kent: Personal Social Services Research Unit, University of Kent, Canterbury.
- Netten, A., Jones, K., Knapp, M., Fernandez, J.L., Challis, D., Glendinning, C., Jacobs, S., Manthorpe, J., Moran, N., Stevens, M. & Wilberforce, M. (2011). Personalisation through individual budgets: Does it work and for whom? *British Journal of Social Work*, 42(8), 1556-1573.
- Newman, J., Glendinning, C., & Hughes, M. (2008). Beyond modernisation? Social care and the transformation of welfare governance. *Journal of Social Policy*, 37(4), 531-557.
- Nussbaum, M. (2003). Capabilities as fundamental entitlements: Sen and social justice. *Feminist Economics*, 9(2-3), 33-59.
- Nyqvist, F. & Forsman, A. (Eds) (2015), *Social Capital as a Health Resource in Later Life: The Relevance of Context*. Berlin: Springer.
- Nyqvist, F., Forsman, A. K., Giuntoli, G., & Cattani, M. (2013). Social capital as a resource for mental well-being in older people: A systematic review. *Aging & Mental Health*, 17(4), 394-410.
- Office for Disability Issues (2008) *Independent Living Strategy*. London: The Stationary Office.
- Oswald, F., Jopp, D., Rott, C., & Wahl, H. (2010). Is aging in place a resource for or risk to life satisfaction? *The Gerontologist*, 51, 238–250.
- Pannell J, Aldridge H, & Kenway P (2012). *Older People's Housing: Choice, Quality of Life and Under-occupation*. York: Joseph Rowntree Foundation.

- Pattoni, L. (2012) *Strengths-Based Approaches for Working with Individuals*. Glasgow: The Institute for Research and Innovation in Social Services (IRISS).
- Peace, S., Holland, C., & Kellaher, L. (2011). 'Option recognition' in later life: variations in ageing in place. *Ageing and Society*, 31(5), 734-757.
- Pedersen, M. (2015). Senior co-housing communities in Denmark. *Journal of Housing For the Elderly*, 29(1-2), 126-145.
- Petch A. (2012) *'We've Got to Talk about Outcomes...': A Review of the Talking Points Personal Outcomes Approach*. London: IRISS (Institute for Research and Innovation in Social Services).
- Phillips, J., Bernard, M., Biggs, S. & Kingston, P. (2001). Retirement communities in Britain: a 'third way' for the third age? In Peace, S. M. and Holland, C. (Eds.), *Inclusive Housing in an Ageing Society: Innovative Approaches* (pp 185–204). Bristol: Policy.
- Phillipson, C. (2007). The 'elected' and the 'excluded': Sociological perspectives on the experience of place and community in old age. *Ageing & Society* 27(3), 321-342.
- Phillipson, C. (2011). Developing age-friendly communities: New approaches to growing old in urban environments. In J.L. Angel & R. Settersten (Eds.), *Handbook of the Sociology of Aging* (pp 279-296). New York: Springer.
- Phillipson, C. & Scharf, T. (2005). Rural and urban perspectives on growing old: developing a new research agenda. *European journal of ageing*, 2(2), 67-75.
- Philp, I., Mills, K. A., Thanvi, B., Ghosh, K., & Long, J. F. (2013). Reducing hospital bed use by frail older people: results from a systematic review of the literature. *International Journal of Integrated Care*, 13(4).
- Pickard, L. (2015). A growing care gap? The supply of unpaid care for older people by their adult children in England to 2032. *Ageing and Society*, 35(01), 96-123.
- Pickard, L., Wittenberg, R., Comas-Herrera, A., King, D., & Malley, J. (2012). Mapping the future of family care: Receipt of informal care by older people with disabilities in England to 2032. *Social Policy and Society*, 11(4), 533–545.
- Pitkin, D. K., & Varda, D. M. (2009). Social Capital and Health Care Access. *Medical Care Research and Review*, 66(3)2, 72-306.
- Porteus, J. (2011). *All Party Parliamentary Group on Housing and Care for Older People: Living Well at Home Inquiry*. London: The Stationery Office.
- Power, M., Quinn, K., & Schmidt, S. (2005). Development of the WHOQOL-old module. *Quality of Life Research*, 14(10), 2197-2214.
- Prabhakar, R. (2013). Asset-based welfare: Financialization or financial inclusion? *Critical Social Policy*, 33(4), 658-678.
- Price, E. (2008). Pride or Prejudice? Gay men, lesbians and dementia. *British Journal of Social Work*, 38, 1337-1352.

- Price, E. (2010). Coming out to care: gay and lesbian carers' experiences of dementia services. *Health & Social Care in the Community*, 18(2), 160-168.
- Prince, M. J., Wu, F., Guo, Y., Robledo, L. M. G., O'Donnell, M., Sullivan, R., & Yusuf, S. (2015). The burden of disease in older people and implications for health policy and practice. *The Lancet*, 385(9967), 549-562.
- Prince, M., Knapp, M., Guerchet, M., McCrone, P., Prina, M., Comas-Herrera, A., Wittenberg, R., Adelaja, B., Hu, B., King, D. & Rehill, A. (2014) *Dementia UK Update*. London: Alzheimer's Society.
- Public Health England (PHE) (2015). *Improving Health Literacy to Reduce Health Inequalities*. London: PHE.
- Reader, S. & Brock, G. (2004). Needs, moral demands and moral theory. *Utilitas*, 16, 251-266.
- Reynolds, T., Thornicroft, G., Abas, M., Woods, B., Hoe, J., Leese, M., & Orrell, M. (2000). Camberwell assessment of need for the elderly (CANE). *The British Journal of Psychiatry*, 176(5), 444-452.
- Roberts, J. & Gannon, B. (2014). *The Multidimensional Nature of Social Capital: An Empirical Investigation for Older People in Europe*. Sheffield Economic Research Paper Series (SERPS) 201401. Sheffield: University of Sheffield.
- Ruiu, M. L. (2015). The social capital of cohousing communities. *Sociology*, DOI: 0038038515573473.
- Rummery, K. (2011). A comparative analysis of personalisation: Balancing an ethic of care with user empowerment, *Ethics and Social Welfare*, 5(2), 138-152.
- Sanders, C., Rogers, A., Bowen, R., Bower, P., Hirani, S., Cartwright, M., Fitzpatrick, R., Knapp, M., Barlow, J., Hendy, J. & Chrysanthaki, T. (2012). Exploring barriers to participation and adoption of telehealth and telecare within the Whole System Demonstrator trial: A qualitative study. *BMC Health Services Research*, 12(1), 220.
- Sandstedt, E., & Westin, S. (2015). Beyond Gemeinschaft and Gesellschaft. Cohousing life in contemporary Sweden. *Housing, Theory and Society*, 32(2), 131-150.
- Scanlon, K., & Arrigoitia, M. F. (2015). Development of new cohousing: lessons from a London scheme for the over-50s. *Urban Research & Practice*, 8(1), 106-121.
- Scharf, T., & de Jong Gierveld, J. (2008). Loneliness in urban neighbourhoods: an Anglo-Dutch comparison. *European Journal of Ageing*, 5(2), 103-115.
- Scharf, T., Phillipson, C., & Smith, A. E. (2005). Social exclusion of older people in deprived urban communities of England. *European Journal of Ageing*, 2(2), 76-87.
- Scharf, T., Williams, C., & Roberts, D. (2007). *Obstacles to Using and Providing Rural Social Care*. London: Social Care Institute for Excellence.
- Schuppert, F. (2013) Distinguishing basic needs and fundamental interests. *Critical Review of International Social and Political Philosophy*, 16(1), 24-44.

- Secretary of State for Health (2012). *Caring for Our Future: Reforming Care and Support*. London: The Stationery Office.
- Sen, A.K. (2005). Human rights and capabilities, *Journal of Human Development*, 6(2), 150-166.
- Sharkey, A., & Sharkey, N. (2012). Granny and the robots: ethical issues in robot care for the elderly. *Ethics and Information Technology*, 14(1), 27-40.
- Sharkey, N., & Sharkey, A. (2012). The eldercare factory. *Gerontology*, 58(3), 282-288.
- Shippee, T. P. (2009). "But I am not moving": Residents' perspectives on transitions within a continuing care retirement community. *The Gerontologist*, 49(3), 418-427.
- Sinclair, D & Creighton, H. (2015). *Opportunity Knocks: Designing solutions for an ageing society*. London: ILC-UK.
- Singelenberg, J., Stolarz, H., & McCall, M. E. (2014). Integrated service areas: An innovative approach to housing, services and supports for older persons ageing in place. *Journal of Community & Applied Social Psychology*, 24(1), 69-73.
- Sirven, N. & Debrand, T. (2012). Social capital and health of older Europeans: Causal pathways and health inequalities. *Social Science & Medicine*, 75(7), 1288-1295.
- Slaets, J. P. (2006). Vulnerability in the elderly: frailty. *Medical Clinics of North America*, 90(4), 593-601.
- Smetcoren, A. S., De Donder, L., Dury, S., De Witte, N., Kardol, T., & Verté, D. (2015). Refining the push and pull framework: identifying inequalities in residential relocation among older adults. *Ageing and Society*. DOI: <http://dx.doi.org/10.1017/S0144686X15001026>
- Söderhamn, U., Sundsli, K., Cliffordson, C., & Dale, B. (2015). Psychometric properties of Antonovsky's 29-item Sense of Coherence scale in research on older home-dwelling Norwegians. *Scandinavian Journal of Public Health*, DOI: 1403494815598863.
- Sorell, T., & Draper, H. (2014). Robot carers, ethics, and older people. *Ethics and Information Technology*, 16(3), 183-195.
- Stead, M., Arnott, L. & Dempsey, E. (2013). Healthy heroes, magic meals, and a visiting alien community-led assets-based social marketing. *Social Marketing Quarterly*, 19(1), 26-39.
- Stein, G. & Almack, K. (2012). Care Near the End of Life: The Concerns, Needs and Experiences of LGBT Elders. In R.Ward R, I. Rivers & M. Sutherland (Eds.) *Lesbian, Gay, Bisexual and Transgender Ageing: Biographical Approaches for Inclusive Care and Support* (pp 114-134). London: Jessica Kingsley.
- Steventon, A., Bardsley, M., Billings, J., Dixon, J., Doll, H., Beynon, M., Hirani, S., Cartwright, M., Rixon, L., Knapp, M. and Henderson, C. (2013). Effect of telecare on use of health and social care services: findings from the Whole Systems Demonstrator cluster randomised trial. *Age and Ageing*, 42(4), 501-508.

- Steverink, N., Slaets, J. P. J., Schuurmans, H., & Van Lis, M. (2001). Measuring frailty: development and testing of the Groningen Frailty Indicator (GFI). *Gerontologist*, 41(1), 236.
- Stowe, S., & Harding, S. (2010). Telecare, telehealth and telemedicine. *European Geriatric Medicine*, 1(3), 193-197.
- Szanton, S.L., Thorpe, R.J., Boyd, C., Tanner, E.K., Leff, B., Agree, E., Xue, Q.L., Allen, J.K., Seplaki, C.L., Weiss, C.O. and Guralnik, J.M. (2011). Community aging in place, advancing better living for elders: A bio-behavioral-environmental intervention to improve function and health-related quality of life in disabled older adults. *Journal of the American Geriatrics Society*, 59(12), 2314-2320.
- Tan, K. K., Chan, S. W. C., & Vehviläinen-Julkunen, K. (2014). Self-care program for older community-dwellers: Protocol for a randomized controlled trial. *Central European Journal of Nursing and Midwifery*, 5(4), 145-155.
- Tan, K. K., Vehviläinen-Julkunen, K., & Chan, S. W. C. (2014). Integrative review: salutogenesis and health in older people over 65 years old. *Journal of Advanced Nursing*, 70(3), 497-510.
- Tapus, A., & Mataric, M. J. (2007). Emulating empathy in socially assistive robotics. In *AAAI Spring Symposium: Multidisciplinary Collaboration for Socially Assistive Robotics* (pp. 93-96).
- Tapus, A., Țăpuș, C., & Matarić, M. J. (2009a). The use of socially assistive robots in the design of intelligent cognitive therapies for people with dementia. In *Rehabilitation Robotics, 2009. IEEE International Conference* (pp. 924-929).
- Tapus, A., Țăpuș, C., & Matarić, M. J. (2009b). Music therapist robot: A solution for helping people with cognitive impairments. In *IJCAI Workshop on Intelligent Systems for Assisted Cognition, July, Pasadena, CA*.
- Tay, L., & Diener, E. (2011). Needs and subjective well-being around the world. *Journal of Personality and Social Psychology*, 101(2), 354.
- The National Voices (2015) *Person Centred Care 2020. Calls and Contributions from Health and Social care Charities*. London: National Voices. <http://www.nationalvoices.org.uk/person-centred-care-2020-calls-and-contributions-health-and-social-care-charities>
- Thomas, W., & Blanchard, J. (2009). Moving beyond place: Aging in community. *Generations*, 33(2), 12-17.
- Tinker, A., Kellaher, L. Ginn, J., & Ribe, E. (2013). *Assisted Living Platform: The Long Term Care Revolution*. London: King's College and Housing LIN
- Tummers, L. (2015). The re-emergence of self-managed co-housing in Europe: A critical review of co-housing research. *Urban Studies*, DOI: 0042098015586696.
- United Kingdom Care Home Association (UKCHA) (2015) *The Homecare Deficit*. Wallington: UKCHA.

- University of Southampton (2015) *The EPSRC Care Life Cycle Programme Final Report*. Southampton: University of Southampton.
- Vallor, S. (2011). Carebots and caregivers: Sustaining the ethical ideal of care in the twenty-first century. *Philosophy & Technology*, 24(3), 251-268
- Vallverdú, J., & Casacuberta, D. (2015). Ethical and technical aspects of emotions to create empathy in medical machines. In *Machine Medical Ethics* (pp. 341-362). New York: Springer.
- van Leeuwen, K. M., Malley, J., Bosmans, J. E., Jansen, A. P. D., Ostelo, R. W., van der Horst, H. E., & Netten, A. (2014). What can local authorities do to improve the social care-related quality of life of older adults living at home? Evidence from the Adult Social Care Survey. *Health & Place*, 29, 104-113.
- van Rensbergen G. & Nawrot T. (2010) Medical conditions of nursing home admissions. *BMC Geriatrics* 10, 46.
- van Wynsberghe, A. (2013). Designing robots for care: Care centered value-sensitive design. *Science and engineering ethics*, 19(2), 407-433.
- Vasunilashorn, S., Steinman, B. A., Liebig, P. S., & Pynoos, J. (2012). Aging in Place: Evolution of a research topic whose time has come. *Journal of Aging Research*, doi:10.1155/2012/120952
- Vestbro, D. U., & Horelli, L. (2012). Design for gender equality: The history of co-housing ideas and realities. *Built Environment*, 38(3), 315-335.
- Vlachantoni, A., Shaw, R. J., Evandrou, M., & Falkingham, J. (2015). The determinants of receiving social care in later life in England. *Ageing and Society*, 35(02), 321-345.
- Wakefield, S. E., & Poland, B. (2005). Family, friend or foe? Critical reflections on the relevance and role of social capital in health promotion and community development. *Social Science & Medicine*, 60(12), 2819-2832.
- Walsh, B., Lattimer, V., Wintrup, J., & Brailsford, S. (2015). Professional perspectives on systemic barriers to admission avoidance: learning from a system dynamics study of older people's admission pathways. *International Journal of Older People Nursing*, 10(2), 105-114.
- Walsh, B., Roberts, H. C., & Nicholls, P. G. (2011). Emergency hospital admissions of older people due to ill-defined (R-coded) conditions: retrospective analysis of hospital admissions data. *BMC Geriatrics*, 11, 62.
- Walsh, B., Roberts, H. C., Nicholls, P. G., & Lattimer, V. A. (2008). Trends in hospital inpatient episodes for signs, symptoms and ill-defined conditions: observational study of older people's hospital episodes in England, 1995–2003. *Age and Ageing*, 37(4), 455-458.
- Walsh, B., Roberts, H., & Hopkinson, J. (2007). Emergency hospital admissions for ill-defined conditions amongst older people: a review of the literature. *International Journal of Older People Nursing*, 2(4), 270-277.

- Wanless, D. (2002). *The Wanless Report. Securing our Future Health: Taking a Long-Term View*. London: HM Treasury.
- Wanless, D., Appleby, J., Harrison, A. & Patel, D. (2007). *Our Future Health Secured? A Review of NHS Funding and Performance*. London: King's Fund.
- Ward, R., Pugh, S. & Price, E. (2011). *Don't Look Back? Improving Health and Social Care Service Delivery for Older LGB Users*. London: Equality and Human Rights Commission.
- Weeks, L. E., Keefe, J., & Macdonald, D. J. (2012). Factors predicting relocation among older adults. *Journal of Housing for the Elderly*, 26(4), 355-371.
- Wenger, G.C. (1994) *Support Networks of Older People: A Guide for Practitioners*. York: Joseph Rowntree Foundation.
- Westwood, S. (2015a) Dementia, women and sexuality: How the intersection of ageing, gender and sexuality magnify dementia concerns among older lesbian and bisexual women. *Dementia: The International Journal of Social Research and Practice*, 1471301214564446.
- Westwood, S. (2015b) 'We see it as being heterosexualised, being put into a care home': Gender, sexuality and housing/care preferences among older LGB individuals in the UK. *Health and Social Care in the Community* doi: 10.1111/hsc.12265
- Westwood, S. & Price, E. (eds) (2016) *Lesbian, Gay, Bisexual and Transgender (LGBT) Individuals Living with Dementia: Concepts, practice and rights*. Abingdon: Routledge.
- Whiting, L. S., Kendall, S., & Wills, W. (2013). Rethinking children's public health: the development of an assets model. *Critical Public Health*, 23(2), 146-159.
- Wiles, J. L., Leibing, A., Guberman, N., Reeve, J., & Allen, R. E. (2011). The meaning of "ageing in place" to older people. *The Gerontologist*, 52(3), 357-366.
- Willis, P., Maegusuku-Hewett, T., Raithby, M. & Miles, P. (2016). Swimming upstream: the provision of inclusive care to older lesbian, gay and bisexual (LGB) adults in residential and nursing environments in Wales. *Ageing and Society*, 36(02), 282-306.
- Willis, P., Ward, N. & Fish, J. (2011). Searching for LGBT carers: Mapping a research agenda in social work and social care. *British Journal of Social Work*, 41, 1304-1320.
- Wilson, N. J., & Cordier, R. (2013). A narrative review of Men's Sheds literature: reducing social isolation and promoting men's health and well-being. *Health & social care in the community*, 21(5), 451-463.
- Windle, K., Wagland, R., Dickinson, A., Knapp, M., Forder, J., Wistow, J., Henderson, C., Beech, R., Roe, B. & Bowling, A. (2008). *National Evaluation of the Partnerships for Older People Projects*, Bulletin 18, October. London: Personal Social Service Research Unit, LSE.
- Wittenberg, R., Hu, B., Comas-Herrera, A., & Fernandez, J. L. (2012). *Care for Older people: projected Expenditure to 2022 on Social Care and Continuing Health Care for England's Older Population*. London: The Nuffield Trust.

- Wittenberg, R., Hu, B., Comas-Herrera, A., & Fernandez, J. L. (2012). *Care for Older People*. London: Nuffield Trust.
- Wittenberg, R., Hu, B., Hancock, R., Morciano, M., Comas-Herrera, A., Malley, J., & King, D. (2011). *Projections of Demand for and Costs of Social Care for Older People in England, 2010 to 2030, under Current and Alternative Funding Systems*. Personal Social Services Research Unit. PSSRU Discussion paper 2811/2. Kent: University of Kent (PSSRU).
- World Health Organization (2007a) *Global Age-Friendly Cities: A Guide*. Geneva: WHO Press.
- World Health Organization (2007b) *Checklist of Essential Features of Age-Friendly Cities*. Geneva: WHO Press.
- Yeandle, S., Kröger, T., & Cass, B. (2012). Voice and choice for users and carers? Developments in patterns of care for older people in Australia, England and Finland. *Journal of European Social Policy*, 22(4), 432-445.
- Zwijzen, S. A., Niemeijer, A. R., & Hertogh, C. M. (2011). Ethics of using assistive technology in the care for community-dwelling elderly people: An overview of the literature. *Aging & Mental Health*, 15(4), 419-427.

APPENDIX ONE

RELEVANT UK RESEARCH ORGANISATIONS AND NETWORKS

1. Ageing and social care research centres in UK

Brunel Institute for Ageing Studies, Brunel University, England

Leading members: Prof Mary Gilhooly; Professor Christina Victor

Research areas:

- Broad ranging interdisciplinary research relating to ageing. May lack a particular focus at present, and perhaps be in a state of flux.
- Christina Victor has a particular interest in ageing and loneliness.

Centre for Ageing Research, Lancaster University, England

Leading member: Prof Christine Milligan

Research areas:

- ‘How best to address the needs of older people and their carers in ways that are both proactive and conscious of the need to place dignity, choice and independence at the forefront of care and support for older people.’
- Research examples:
 - ‘Men in Sheds and other gendered interventions for older men’;
 - EPOCH: The experiences and expectations of older people resident in care homes, their carers and professionals of end of life care and symptom relief needs: a prospective study (with the University of Hertfordshire);
 - EFORRT Remote care interventions: ethics, gender and governance of new technologies of elderly care at home (Comparative study with the UK, Netherlands, Norway and Spain).

Centre for Innovative Ageing, Swansea University, Wales

Research leads

Professor Vanessa Burholt

Professor Judith Phillips

Research areas:

- Civic and social engagement and participation of older people
 - Intergenerational relationships; social and support networks; civic participation and the disruption of these types of engagement based on personal (e.g. migration, psychological resources) and structural (e.g. multiple disadvantage, discrimination, national or local policies, transport) factors.
- Environments of ageing
 - Natural and built physical space; functional design; community; housing; climate change and extreme emergencies caused by natural and human-made events.
- Care provision for older people
 - Social care; health care; intermediate care; residential care; palliative and end of life care.
- Chronic conditions, falls and prevention in old age
 - Falls; stroke; cancer; dementia; depression; health promotion.

Centre for Research on Ageing, University of Southampton, England

Director: Professor Maria Evandrou

Research areas:

- Ageing in developing and transitional societies
- Diversity in later life and ethnic minority ageing
- Gender and pension reform
- Income, pensions and inequality
- Health and social care
- Paid work and informal caring
- Retirement prospects of future generations of elders
- Social networks and informal support

Centre for Research on Ageing and Gender, University of Surrey, England

Co-Directors: Professor Sara Arber and Dr Andrew King

Most of the CRAG team have retired/are in process of retiring (including Professor Arber). Its future direction, indeed whether it has a future at all, is unclear. It has no research students or staff and only one current research project: the SAFE (Secure, Accessible, Friendly, Equal) Project is investigating housing provision and options available to older LGBT people.

Institute of Gerontology, King's College, London, England

Director: Professor Karen Glaser

Research themes:

- Ageing policy, health & healthcare
- Communities, work & family life
- Global ageing

Irish Centre for Social Gerontology, University of Galway, Northern Ireland

Director: Professor Thomas Scharf

Research themes:

- Economics of ageing
- Social policies for ageing societies
- Ageing and place
- Health and well-being in later life
- Ageing and the lifecourse.

Manchester Institute for Collaborative Research on Ageing, University of Manchester, England

Executive Director: Professor Chris Phillipson

Research areas:

- Social and cultural change in later life
- Later life working, retirement and pensions inequalities,
- Health and well-being
- Engineering, environment and technology
- Public policy and care provision
- Frailty, cognition and dementia
- Physical decline and tissue regeneration

- Biology of ageing and the life span

School for Policy Studies, University of Bristol

Ageing and the life course research programme, researching:

- Policies on long-term care and informal care
- Community and social care practices with older people
- Housing and intergenerational relations
- Residential care: past, present and future
- End of life issues
- Disability issues
- Exercise/physical activity, nutrition and health
- Mental health
- Poverty and social exclusion

2. Other ageing research centres

Oxford Institute for Population Ageing, University of Oxford, England

- Conducts research into the implications of population change. Researchers work in Africa, Latin America, Asia and Europe. Runs the Population Networks AFRAN (Africa) LARNA (Latin America) EAST (Eastern Europe).

3. Dementia research centres

Dementia Services Development Centre (DSDC), University of Stirling, Scotland.

Research areas:

- Outcomes for people with dementia
- Decision making for care provision
- Innovations in care
- The roles of community-based care professionals
- The importance of the dementia-friendly neighbourhood

School of Dementia Studies, University of Bradford, England

Research areas:

- Living Well with Dementia
- Improving the Quality of Care for People with Dementia (Dementia Care Mapping)

Association for Dementia Studies, University of Worcester

Research areas:

- Home, communities, public health and diversity: living well post diagnosis
- Skilled care, assessment and leadership in services for people living with dementia and complex needs
- Enriching lives in dementia through creativity, arts, nature and sport
- Dementia friendly person-centred design & technology.

4. Other relevant social policy/social care research centres

Care-Connect Social Care Innovation Hub, University of Leeds

Director: Dr Andrea Wigfield

- ‘[We] use research to inform policy and practice, with the ultimate objective of supporting the creation and sustainability of caring, connected communities.’
- About to relocate to University of Sheffield.

Centre for International Research on Care Labour and Economics (CIRCLE), University of Leeds

Director: Professor Sue Yeandle. *Deputy Director:* Dr Andrea Wigfield

- Research, evaluation and bespoke consultancy on contemporary issues and debates in three key areas: Care; Labour; and Equalities.
- About to be relocated to University of Sheffield.

Economics of Social and Health Care Research Unit (ESHCRU)

- A joint collaboration between the Centre for Health Economics (CHE) at the University of York and the Personal Social Services Research Unit (PSSRU) at the London School of Economics and the University of Kent.
- The aim of the ESHCRU is to inform and guide policy-making in the health and social care sectors by undertaking high quality, robust and policy-relevant research, based on the discipline of economics.

King’s Fund

- Independent charity working to improve health and health care in England, shaping policy and practice through research and analysis

Nuffield Trust

- ‘Authoritative and independent source of evidence-based research and policy analysis for improving health care in the UK.’
- Also host to the [Centre for Policy on Ageing](#).

International Longevity Centre – UK (ILC-UK)

- An independent think-tank dedicated to addressing issues of longevity, ageing and population change in relation to ‘everything from pensions and financial planning, to health and social care, housing design, and age discrimination.’

Joseph Rowntree Foundation

- Independent social policy research and development charity that funds a UK-wide research and development programme.
- It seeks to ‘understand the root causes of social problems’, identify ways of overcoming them, and show how social needs can be met in practice.

Personal Social Services Research Unit (PSSRU), England

- Collaboration between University of Manchester, University of Kent and the London School of Economics and Political Science, England.

- The PSSRU carries out policy analysis, research and consultancy in the UK and abroad. Current research programmes focus on needs, resources and outcomes in social care, across age spectrum.

Quality and Outcomes of Person-centred Care Policy Research Unit (QORU)

Director: Professor Julien Forder, University of Kent (PSSRU). *Assistant Directors:* Dr José-Luis Fernández, London School of Economics and Political Science (PSSRU), and Professor Ray Fitzpatrick, Department of Public Health and Primary Care and Nuffield College, University of Oxford.

- A collaboration involving researchers in health and social care from the Universities of Kent, Oxford and the London School of Economics and Political Science (LSE), funded by the Department of Health in England (from January 2011 for seven years) to ‘support government policy in health and social care on achieving outcomes’.
- *Research themes:*
 - Application: Understanding how information about care-related needs and quality of life can be used to optimally achieve person-centred goals for commissioning, regulation etc.
 - Engagement: Developing methods to improve participation of ‘hard-to-engage’ and ‘seldom heard’ people in research and so enable their experiences to be reflected in the evidence base.
 - Measurement: Finding ways to identify and best measure the needs, quality of life, well-being and health of people in way that is relevant to how they experience services and support.
 - Service Delivery: Developing the evidence-base about which specific interventions succeed in delivering person-centred outcomes.

Social Care Institute for Excellence (SCIE)

- Independent charity which aims to improve the quality of care and support services for adults and children by:
 - ‘identifying and sharing knowledge about what works and what’s new’;
 - ‘supporting people who plan, commission, deliver and use services to put that knowledge into practice’;
 - ‘informing, influencing and inspiring the direction of future practice and policy.’

Social Care Workforce Research Unit (SCWRU), King’s College, University of London

Director: Professor Jill Manthorpe

- ‘The Unit exists to develop research knowledge and to disseminate the findings to policymakers, service providers, employers and social care service user and carer groups.’
- Large volume of well-respected research.

NICE Collaborating Centre for Social Care (NCCSC)

- Consortium led by the Social Care Institute for Excellence (SCIE) with: Research in Practice; Research in Practice for Adults; Evidence for Policy and Practice Information and Co-ordinating Centre (EPPI-Centre); and Personal Social Services Research Unit (PSSRU).
- Develops guidance about social care for children and adults on behalf of the National Institute for Health and Care Excellence (NICE).

- Helps to ensure that people who commission, provide and use care services know about the NICE guidance and related quality standards and are supported to put them into practice.

NIHR School for Social Care Research (SSRC)

- One of leading funders of research into adult social care practice in England, aims to improve practice in England through conducting and commissioning research.
- SSRC is a partnership of 6 research centres:
 - Personal Social Services Research Unit, London School of Economics (LSE)
 - Personal Social Services Research Unit, University of Manchester
 - Social Policy Research Unit, University of York
 - Personal Social Services Research Unit, University of Kent
 - School for Policy Studies, University of Bristol
 - Tizard Centre, University of Kent

Social Policy Research Unit (SPRU), University of York, England

- Research in social policy, especially health and social care, poverty, welfare and social work, across age spectrum.

5. Other relevant organisations and/or networks

Age NI (Northern Ireland)

- Network of organisations representing interests, issues and concerns of older people in Northern Ireland; also part of Age UK.
- Provides range of services to older people in Scotland.

Age Scotland

- Network of organisations representing interests, issues and concerns of older people in Scotland; also part of Age UK.
- Provides range of services to older people in Scotland.

Age UK

- Federal network of organisations representing interests, issues and concerns of older people in the UK.

Age Wales/Age Cymru

- Network of organisations representing interests, issues and concerns of older people in Wales; also part of Age UK.

Ageing without Children

- Campaign organisation aiming to help people ageing without children live a later life free of the free fear of ageing alone and being without support.

Alzheimer Scotland

- Provides a range of specialist services for people with dementia and their carers in Scotland, including personalised support services, community activities, information and advice. Affiliated with Alzheimer's Society (UK).
- Campaigns for the rights of people with dementia and their families

Alzheimer's Society

- Provides a range of specialist services for people with dementia and their carers in England, Northern Ireland and Wales, including personalised support services, community activities, information and advice. Affiliated with Alzheimer Scotland.
- Campaigns for the rights of people with dementia and their families.
- Funds research on dementia and dementia services.

Carers UK

- UK carers' support network and campaign organisation representing carers' interests.

Carers Trust

- Network of support, information, advice and services for carers in England.
- Affiliated with: Carers Trust Northern Ireland; Carers Trust Scotland; and Carers Trust Scotland.

Carers Trust Northern Ireland

- Providers of support services for family carers in Northern Ireland
- Affiliated with Carers Trust.

Carers Trust Scotland

- Network of carers support services in Scotland.
- Affiliated with Carers Trust.

Carers Trust Wales

- 'Provides action, help and advice to carers throughout Wales'.
- Affiliated with Carers Trust.

Dementia UK

- Provide Admiral Nurses, specialist dementia nurses who give practical and emotional support to families affected by dementia.

The Campaign to End Loneliness

- UK Campaign organisation aiming to end loneliness in older age.

6. UK Government departments

England

- [Care Quality Commission](#)
- [The College of Social Work](#)
- [Department for Education](#)
- [Department of Health](#)
- [Health and Care Professions Council](#)
- [Skills for Care](#)
- [Think Local Act Personal](#)

Northern Ireland

- [Department of Health, Social Services and Public Safety](#)
- [Northern Ireland Social Care Council](#)
- [Regulation and Quality Improvement Authority](#)

Scotland

- [Social Care and Social Work Improvement Scotland](#)
- [Institute for Research and Innovation in Social Services](#)
- [Scottish Social Services Council](#)

Wales

- [Care Council for Wales](#)
- [Social Services Improvement Agency \(SSIA\)](#)

APPENDIX TWO

Comparison of asset-based and deficit-based approaches to health and well-being (Buck & Gregory, 2013).

Table Two. Comparing deficit and asset-based models (Kings Fund 2013)

| Table 1: Comparing an asset-based approach to a deficit approach | |
|--|---|
| Deficit approach | Asset-based approach |
| Start with deficiencies and needs – what a community needs | Start with strengths and potential – the assets of individuals and communities |
| Treat the illness and symptoms | Promote wellbeing and positive health Treat the whole person |
| React to problems | Foster strengths and assets to prevent problems |
| Do to | Work with |
| People are consumers of health services | People are co-producers of health outcomes |
| Emphasise the role and knowledge of professionals and agencies | Emphasise the role and knowledge of communities, networks and neighbourhood organisations Citizens act as peers and agents in their own health and work alongside professionals |
| Fix broken people | Empower people to take control of their lives and health Act as brokers, facilitators, catalysts, collaborators |
| Deliver intervention programmes | Work with local people to support their ideas, potential and priorities |
| View the social causes of ill health and inequality as outside the remit of health and care services | Work with citizens to tackle the social, economic and environmental determinants of health and challenge health inequalities |
| Focus on what a community does not have | Focus on what a community has and could have Collaborate and work alongside people to mobilise community, family and local care and support networks and resources Self-organisation and community organisation Support peer groups, social prescribing and local networks |
| Consult residents about health services | Work alongside citizens to improve health and care outcomes |