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Welcome to this special themed edition of *Research, Policy and Planning* (RPP). Increasing longevity and falling birth rates are increasing the numbers and proportion of older people throughout the world. The United Nations notes that the ageing of populations is ‘unprecedented, a process without parallel in the history of humanity’ (United Nations, World Population Ageing 2009, 2010, p.xxiv). Demands and expectations are both increasing and this is creating pressure on health and care systems. In the UK, the percentage of people aged 65 and over increased from 15 per cent in 1985 to 17 per cent in 2010 and by 2035 is projected to have risen to 23 per cent (Office for National Statistics, 2012). But whilst the demographics are clear the responses needed are contested and by no means universally agreed.

The shift of vision and expectation from one of dependency to independence, participation and wellbeing – with older people exercising choices and being active partners in service design – means that including older people themselves in designing, providing and delivering future services and arrangements for older people should be a key part of any solution. The need to use scarce and reducing resources more economically, efficiently and effectively emphasises the need for change.

This edition presents four principal papers reporting on projects in which the various authors have been involved and exploring a number of key issues for all who are interested in the challenges and opportunities of our ageing society.

The first paper, from **Woolham *et al.***, gives us the views of older people themselves. It draws its data from a large community survey of older people aged 55 years and over living in Coventry. It looks at the meaning of independence, inclusion and wellbeing to older people and reports that although most survey participants were able to function independently, participate in ordinary community life and enjoy reasonable physical and mental health, many others experienced a series of significant barriers to inclusion and wellbeing. The paper concludes that there is no automatic convergence between independence, inclusion and wellbeing at the level of the individual and that to address this more socially inclusive, rather than individualistic, forms of independence may be more appropriate goals for local public agencies.

In the second paper **Davis & Ritters** look at active ageing through wellbeing – the role of information in ‘that little bit of help’. Information and the ability to act on it are seen as vital parts of the choice and personalisation agendas in health and social care. This is particularly important as older people are encouraged to do more for themselves in an era of budget reductions. Understanding how, where and why people access services and information is therefore key to developing supportive policies for an ageing society. This paper describes some of the literature and focuses on two projects, in which the authors were involved, aimed at widening access and improving information. LinkAge Plus was a Department for Work and Pensions funded project, trialling a variety of different approaches to widening access. The Stratford-upon-Avon Early Intervention Project in Warwickshire, part of the Department of Health’s Common Assessment Framework for Adults Demonstrator Site Programme, trialled a digitised self-assessment process for wellbeing linked to local sources of help. The paper concludes that as the funding gap for adult social care continues to grow, and support systems become ever more complex, the need for effective information strategies becomes more urgent.

Baldauf & Lindley then address, in the third paper, the issue of active ageing and age management. Their paper mainly presents the findings of case studies on good practice in age management in health and social care organisations and local authorities which were conducted as part of the European study on Activating Senior Potential In Ageing Europe. They focus on selected dimensions of age management including recruitment, training, career development, flexible working and health promotion. They highlight good practices that relate to wider age management approaches and developments over time and end with a brief note on the results of quantitative longitudinal studies which have examined the impact of extending working lives on individuals’ health.

Lastly, the paper from **Hughes *et al.*** explores local authority commissioning and contracting arrangements for home care, staff training opportunities and the range of services provided for older people. It utilises data from a national postal survey. Implications for the development of high quality services are discussed in terms of user need, service flexibility and training for staff providing direct care.

It is suggested that within the commissioning process key drivers of the development of more personalised high quality home care services are regular dialogue with service providers, greater health and social care involvement in a joint commissioning process, alignment of contracting arrangements to reflect service outcomes, and specification of training requirements within the setting and monitoring of home care contracts.

Reviews in this issue of *Research, Policy and Planning* cover the range of publications relevant to RPP, across social services for children and for adults. Major research reports can take time to be published in book form, thus justifying an early review if the issues are topical. This certainly applies to the research commissioned a few years ago from the Social Policy Research Unit at the University of York by the Department of Health, and which has now produced its end of grant report. The research addresses government concern regarding young people with autistic spectrum conditions (ASC) still not achieving 'markers of adulthood': employment, independent living, social lives and adult relationships. In policy terms the study links to the Autism Act 2009 and the Autism Strategy 2010 and it investigated the problematic issue of transition from children's social care and educational services to services for adults. Our reviewer has, as she indicates, some direct experience of the issues.

Another type of publication is the conference report. The review of contributions to a 2009 conference, as edited and supplemented for publication three years later, gives a mixed verdict. The topic – service user involvement in social care – is of longstanding interest and current policy concern, but its treatment here is seen as somewhat partial and essentially retrospective. An historical perspective on current practice and policy concerns can turn out to be very timely. This is the case in the review of the study which revisits Professor Peter Townsend's research in the late 1950s on residential homes for older people. The book links the earlier research with a 2005-6 follow-up, and with substantive conclusions setting both studies in a context of other research on care for older people.

An analytical perspective on a current policy phrase – children's wellbeing, supplemented by limited but focused empirical research, provides the basis for our reviewer's recommendation of a study that deserves to be influential despite the passage of a few years and major children's policy shifts in the meantime. Textbooks for researchers and students are bread and butter for publishers but RPP readers can also be helped by their advice and illustrations of good practice. They can even help remind us of the limitations of some research in social services. The two reviewed here evidently try hard to reach their audience and are well established examples of the genre.

Finally, we have been asked to add a few words to provide some clarity to readers and subscribers about a potential move to author charges and to request feedback from members. Many readers will be aware that the Finch Report recommended that academic journals move from 'pay-to-view' arrangements to open access, with costs being met by researchers who will be expected to pay to have their work published. Currently, all but the latest three editions of RPP are freely available from SSRG's website, with the most recent editions being available to members only. Editorial Board members have discussed how RPP should respond to the Finch recommendations and have recommended that, for the time being at least, no changes be made, though they will continue to assess if changes would be in the best interests of the journal, its authors and its readers. The Editorial team would be very interested in the views of readers about how RPP should respond to the Finch report and would welcome any feedback.

We are sure that the challenges and opportunities of ageing societies will provide many more occasions for discussion and for highlighting good practice. We hope you find this edition an interesting and useful contribution. In closing, we would like to add our thanks to the RPP team for their help in getting this edition off the ground.

Howard Davis and Katrina Ritters

August 2013

The relationship between independence, inclusion and wellbeing: the perspective of older citizens living in Coventry, UK

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Abstract

Independence, inclusion and wellbeing are commonly seen in a complementary relationship in policy and research literature. This paper examines the meaning of these terms for older citizens living in Coventry and the implications for policy implementation. The data presented, obtained from a large community survey of citizens of 55 years and over living in Coventry, found that although most survey participants were able to function independently, participate in ordinary community life and enjoyed reasonable physical and mental health, many others experienced a series of significant barriers to inclusion and wellbeing.

The paper concludes that there is no automatic convergence between independence, inclusion and wellbeing at the level of the individual citizen and that to address this issue, more socially inclusive rather than individualistic forms of independence may be more appropriate goals for local public agencies.

Keywords: older people, citizenship, inclusion, independence, wellbeing

Introduction

Three important policy objectives, amongst others, shape the creation and delivery of services and support for older citizens in England at the present time. The first is the objective of supporting the *independence* of older people. Although this has been ubiquitous in UK social policies relating to older people for many years, the idea that this is best achieved through the creation of services and support that enhance choice and control – for example, through personal budgets – is arguably more recent. The second is *inclusion*, or enabling of older citizens to participate fully in economic, educational, social and community activities. The third, which is the pursuit of *wellbeing*, is an even more recent addition to social policy lexicon, and draws attention to the importance of good physical and mental health in old age.

This paper will report on the perspectives of older people about these policy objectives, using data collected from a large community survey of people aged 55 and older who lived

in Coventry in 2010, and on behalf of the Coventry Older People's Partnership which comprised the City Council, local Primary Care Trust (NHS) and a range of third sector organisations including Age UK. It was designed to find out about the lifestyles, aspirations, and concerns of people aged 55 and over to inform the City Council's 'Promoting Independence' Framework – a local strategic plan for older people in the city over the next decade.

Much research and information collected on or with older people in the UK focuses upon their health and social care needs to support the planning of NHS and social care services. A distinctive feature of this survey is that the brief given to the research team was much wider: our objective was to obtain a more general idea of what older citizens wanted from their local services and community and on issues and areas of concern for them. The full report can be accessed at <http://wwwm.coventry.ac.uk/researchnet/SISC/Documents/55+%20Survey%20Full%20Report.pdf>.

A specific aim of this paper is to describe the perceptions of older citizens of their own levels of independence, inclusion and wellbeing and assess what implications these perceptions may have for these policies and the relationship between them. Our contention is that there is no automatic convergence of independence, inclusion and wellbeing at the level of the individual citizen.

The rest of the paper is organised into five sections. In the section immediately below, the policy context will be summarised, which will be followed by a description of the methods used to collect the data. A third section presents the findings of the survey. These are then discussed within the context of English policies relating to older people. Finally, the paper offers some conclusions.

Independence, inclusion and wellbeing: the policy context for key issues

Independence, choice and control

The maintenance, or restoration of independence, and the prevention of 'dependency' are long standing policy objectives, seen as essential to prevent unnecessary admission into hospital, or residential care, at a time when the proportion of older people in the general population is rising and because of the need to reduce spending because of the austerity programme of the present Government. The provision of choice to enhance control over services has more recently been seen as the means by which independence can best be achieved.

Given the degree of importance attached to the promotion of choice in public sector services, the equivocal support for enhanced choice in social care, especially in relation to older citizens, is noteworthy. Some commentators have suggested that personal budgets – the main instrument by which choice and therefore greater control is achieved – may not always be the best way of providing services for older people (Daly, 2009; Orellana, 2010; Barnes, 2011;

Woolham & Benton, 2012). Barnes, for example, commenting on *Putting People First* (DH, 2007) (a policy document that arguably has been particularly influential in promoting independence and inclusion in social care), notes that although there is some recognition of the importance of *inter-dependence* in people's lives, the focus in policy discourse is more commonly on individuals whose needs and interests may be opposed to each other in a competitive market situation rather than on the relationships within which care and support is provided. A related observation is made elsewhere by Plath (2007) who argues that independence confers both benefits and disadvantages and draws attention to the fact that older people in her study identified two distinct variants of 'independence': one rooted in individual values and emphasising the need to do things alone, the other relating to feeling valued and feelings of connectedness to others.

Participation and inclusion

The participation of older citizens – economically, educationally and in social and community life – thereby promoting their inclusion in the fabric of society, is the second policy objective on which this paper focuses. For convenience, in this paper, we have structured our summary of this issue into two sections, dealing with economic and educational participation, and social and community participation, respectively.

a. Economic and educational participation

Whilst 6.7 million people over 50 were in paid work in the UK in 2004, there were additionally approximately half to one million older people who could be considered as potential additional workers, since not all older people who want to work, or who are able to work, are currently employed (O'Neil & Welsh, 2006). In addition, older people seeking work remain unemployed for longer than younger workers (Age Concern, 2008).

A significant policy objective of the previous Labour Government, therefore, was to increase the opportunities for older people to

re-enter employment or to remain in work as they grow older (HMG, 2005; ODPM, 2006), a direction of policy continued by the current Coalition Government (HMG, 2010). There are a number of reasons for pursuing this direction. Not least are demographic changes (see Demakakos, 2008). These mean that there will be an increasing number of older people relatively and absolutely. Therefore, in order to sustain economic progress, a greater proportion and number of people over 50 years will need to be in employment, including a greater number and proportion working past the statutory pension age.

The therapeutic benefit of participation in learning for older people – both in formal educational settings and less formal opportunities to acquire new knowledge or skills – has been comparatively overlooked until recently. A recent report offers clear evidence that such participation is associated with higher wellbeing (Department for Business, Innovation and Skills, Nov. 2012).

b. Social and community participation

The Government and others (notably Curry, 2006; Wistow *et al.*, 2003) have also recognised and sought to address issues of social exclusion experienced by older people (ODPM, 2005; 2006; Daly, [DWP], 2009). Other agencies have indicated the scale of the problems faced by older people in the UK today. Help the Aged (2008, p.6) reported that ‘one third of older people report feeling out of touch with modern life and a further one in eight say they are often or always lonely’. According to the Joseph Rowntree Foundation, we are witnessing a perceived decline of community: ‘communities are weak and people are increasingly isolated from their neighbours, as people tend to see themselves as individuals and not as part of a wider society, leading to selfishness and insularity’ (JRF, 2008, p.1). Age Concern (2008) has attempted to quantify the scale of the phenomenon in stating that 1.2 million people over 50 years of age face multiple exclusions with the likelihood of social exclusion intensifying in later life.

Health and wellbeing

A third, more recent policy strand, refers to the health and wellbeing of older people, and has been a major theme of frequently cited analyses of demographic pressures facing the NHS (Wanless, 2003) and local authority Social Services Departments (Wanless, 2006) as well as in legislation and guidance, as exemplified in a number of policy documents (Hayden & Boaz, 2000; ODPM, 2000; 2005; 2006; DH, 2001; 2004; 2005; 2006a; 2006b; 2008; Audit Commission, 2002; DWP, 2002; ADSS/LGA, 2003; HMG, 2005; 2007).

The direction of policy has included an emphasis on prevention and on ‘upstream’ activities that promote older people’s health and wellbeing (see: Curry, 2006; Daly, 2009; JRF, 2005). The broad thrust of much of this is for action to encourage citizens to remain independent by taking more responsibility for their own health, to reduce demand for NHS and social care services arising from obesity, alcohol misuse and smoking which cause illnesses such as diabetes, heart disease, stroke, or COPD, and result in life-limiting and often avoidable impairments.

Relationships between independence, inclusion and wellbeing

The Oxford Shorter Dictionary offers four meanings for the noun independence, which are, briefly: ‘freedom from outside control’, ‘not depending on another for livelihood or subsistence’, ‘capable of acting and thinking for oneself’ and, finally, ‘not connected with another or with each other’. This fourth meaning is perhaps one with which some policy makers may be less familiar and is at odds with definitions of the noun ‘inclusion’ which is defined in the same dictionary as ‘the action or state of including or of being included within a group or structure’. Finally, wellbeing is described as ‘the state of being comfortable, healthy, or happy’. In policy terms, although independence and social inclusion are seen as desirable objectives in their own right, they are rarely defined as contradictory objectives in the UK literature,

though the paper has already drawn attention to the work of commentators who have expressed concerns about the values that underpin the delivery of choice and control to achieve independence. Independence and inclusion are also associated with enhanced wellbeing in both national policy guidance (DH, 2005) and locally in health and wellbeing strategies in England.

Method

Data was collected through a self-completion questionnaire which was developed by the authors in consultation with the partnership group. The final questionnaire's content and design was a compromise between the needs and requirements of local stakeholder organisations and the desire of the university team for rigour through the use of, for example, validated scales. To keep the survey manageable whilst addressing the expectations of stakeholders, questions were 'home grown', though informed by other community surveys. Care was taken over layout and design to make it easy to read and complete. This included printing the questionnaire on pale yellow paper, the use of a non-serif font and a relatively large font size (14 point). A final draft version of the questionnaire was cognitively tested by a member of the research team who led a discussion with older people who attended a local Day Care Centre. In addition, a meeting was held with members of the Older People's Forum in Coventry who received copies of the questionnaire and gave feedback about content and design. Minor amendments were made based on the feedback received.

The final questionnaire contained 57 predominantly closed questions, and was 23 pages long. Questions focused on a wide range of issues, including home and neighbourhood, use of technology, participation in leisure, learning, employment and life, general health and wellbeing, use of health, social care and voluntary organisations, mobility and transport, social life and activities, and economic participation. Eligibility criteria were that

participants had to be aged 55 or over, resident in Coventry or registered with a Coventry based GP Practice.

Data collection

Three methods of data collection were used. The first was a postal survey. Contact details of local residents came from three sources: first, a database of people living in sheltered and very sheltered housing dwellings in Coventry made available by the City Council, second, two databases of older residents who had used advice or information services provided by Coventry Age UK over the previous 12 months and, third, older people who had used Coventry Social Services over the previous 12 months. This data was combined and cleaned by removing incomplete addresses, people who did not meet the survey's eligibility criteria, and people whose details appeared on more than one of the lists. Checks were also made with the organisations that had provided the contact details to delete people recently deceased from the mailing list. From a combined survey population of 7,653, a random sample of 1,626 was selected. The size of the sample was based on an assumed response rate of 40% which would generate an overall confidence interval of +/- 4%. A single reminder letter was sent out a fortnight after the first mail-shot to non-respondents. On both occasions, members of the sample were sent a covering letter, questionnaire and pre-paid self-addressed envelope.

The second method of data collection was an online version of the questionnaire prepared using 'survey monkey' software. This was advertised widely through the city via local stakeholder agencies.

Finally, questionnaires, pre-paid envelopes and posters were used with 'ballot boxes' left in a wide range of public buildings likely to be used by older citizens, including libraries and day centres.

Ethical approval for the study was obtained from both Coventry City Council and Coventry University before it commenced.

Table 1. Responses by source

Postal Survey	638 (41%)
Questionnaires left in public buildings in Coventry	749 (48%)
Online questionnaire	169 (11%)
TOTAL	1558 (100%)

As can be seen in **Table 1**, over 1500 people took part in the survey - 2% of the population of people aged 55+ living in Coventry. The average age of those who took part was 70.6 years. Two thirds were female and 94% described their ethnic origin as White. As might be expected, most were retired. Just under a fifth said they were caring for someone (the majority were caring for another adult) and in many cases, a significant amount of time was spent caring: the average amount was over 50 hours per week. Males and people from BME groups were slightly under-represented amongst respondents. People from lower socio-economic groups may also have been under-represented but comparative population wide data could not be found to confirm this.

Collected data was entered into an SPSS database for analysis.

Findings

Key findings from the survey are presented under three thematic headings: choice, control and levels of independence, economic, educational, social and community participation, and health and wellbeing.

1. Choice, control and levels of independence

Direct payments for future care needs

The present and previous governments have been keen to promote the use of personal budgets, preferably in the form of direct payments, to enable people who use social care services to purchase the care they need (Department of Health, 2010). Advocates of this approach to care delivery (see, for example, Leadbeater, 2004; Leadbeater *et al.*, 2008; Poll *et al.*, 2006) claim that it promotes choice and enhanced control over services, and therefore empowers and promotes inclusion (through purchasing power); independence (as people are able to act autonomously in choosing their care and support); and wellbeing (as care is more personalised and more likely to enable people to achieve their goals and outcomes).

Figure 1. Question: as we get older, some of us will need help to enable us to live as independently as possible. You may receive care or support, or know someone who does. We are interested in knowing your views on how we should best provide this help. Given the choice, which of the following would be your preferred way of getting care and support should you need it? (X^2 31.609 p=0.000)

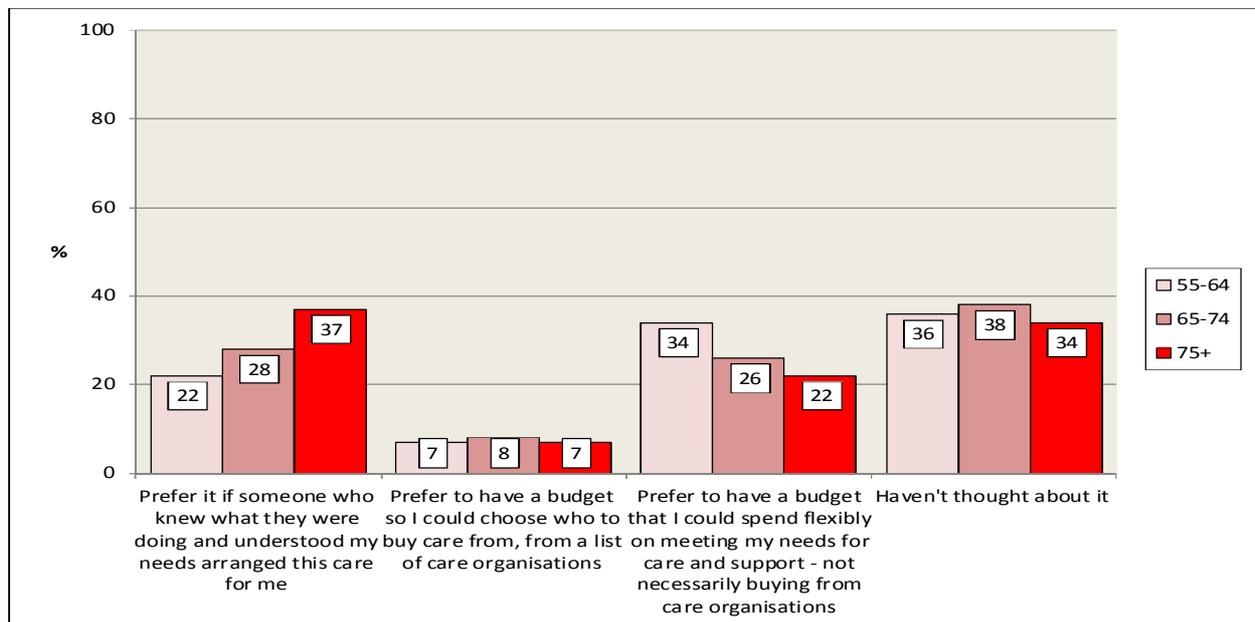


Figure 1 shows that not all survey participants were keen on the idea of having their own budget, and that the proportion of those willing to consider a personal budget declined – and the proportion who said they would prefer their care to be organised by someone else – increased with age.

Staying put or moving to better adapted housing

There is increasing recognition of the importance of ‘ageing in place’ (Sixsmith & Sixsmith, 2008) and the need to prevent unnecessary admission into institutional care. The survey asked where people would like care and support to be provided if or when it became needed.

Overall, over two thirds of respondents indicated that their preference would be to remain living in their current accommodation. Only 2% stated a preference to move into residential or nursing care, and the proportions of people who would countenance a move into housing with support schemes – low support schemes such as ordinary sheltered housing or high support – such as ‘Extra Care’ or very sheltered housing – were also very low. Reasons for these findings have been explored in other studies and include familiarity with local

area, and preservation of local social and friendship networks (O’Byrant, 2008). Respondents clearly saw living in their own home as the best way to maintain their independence and avoid exclusion (through perceived institutionalisation). The older people were, the more likely they were to say they wished to remain living at their current address.

2. Economic, educational, social and community participation

a. Economic and educational participation

Economic participation

As might be expected, the survey confirmed that the majority of respondents (67%) were retired, whilst 18% were ‘economically active’. People aged 75 and over were much less likely to be working than those aged between 55 and 64.

Money worries

Just over a third of respondents said they had no money worries, and a similar proportion said they could only manage if they budgeted carefully. By contrast, a large minority of respondents were not financially secure.

Figure 2. Question: as we get older, some of us will need help to enable us to live our lives and be as independent as possible. If you needed care and support, which of the following statements best describes what you might prefer? (n=1485, X^2 52.044 p=0.000)

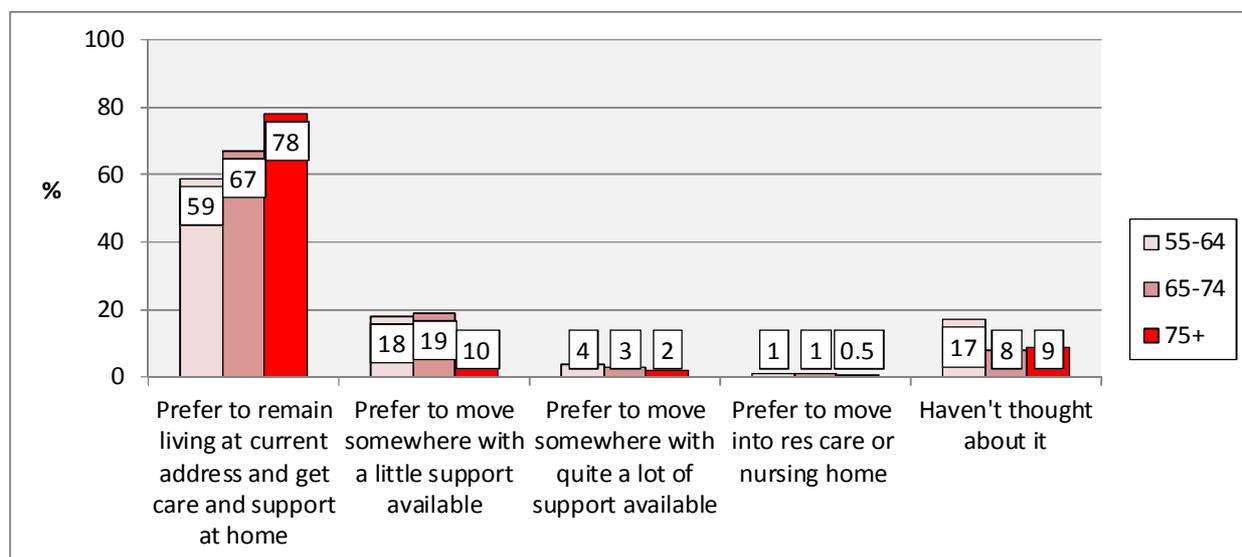
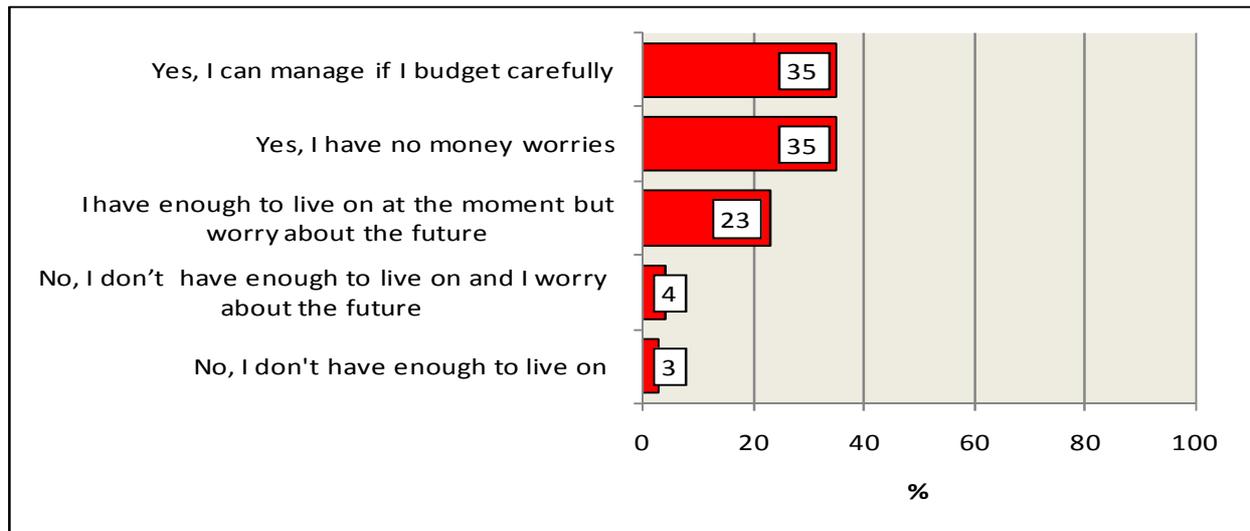


Figure 3. Question: do you have enough money to live on at the present time? (n=1480)

7% of respondents admitted to not having enough to live on (and worrying about this), but almost a quarter were managing but worried. These are concerning figures given the age of the group and the fact that the majority were retired or coming to the end of their working lives. People who were still working full-time were more likely to say that they had enough to live on (67/47%) compared to people who had retired (361/36%).

Barriers to getting help with money worries

Commenting on reasons why people might find it difficult to seek advice about their finances, people said that they did not know who to trust, or that, based on previous experiences, they did not trust advice offered by 'independent advisors' or had (perhaps more recently acquired) a general lack of confidence in the banking system.

Given the shortcomings of different sources of advice, even though people may have lacked detailed knowledge or understanding of financial issues, responses suggested that because financial advisors could not be trusted, respondents 'self-excluded', preferring to rely purely on their own judgements.

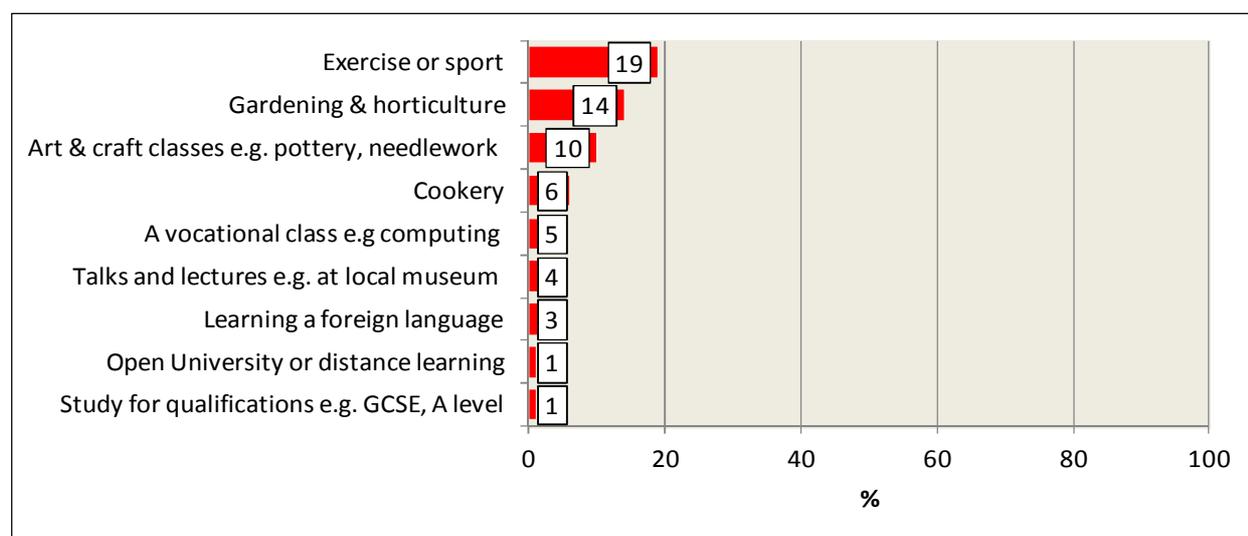
Interests in, and impediments to, participating in educational and leisure activities

Over half - 908 (59%) of respondents did not answer a question intended to find out more about the extent of participation in a range of leisure time activities, including educational participation – suggesting either that many people who responded had few hobbies or interests, or that those included in the survey were insufficiently broad to capture the diversity of pursuits and activities in which people were engaged.

Amongst those who replied, as can be seen in **Figure 4**, the most popular form of recreational activity was 'exercise or sport', followed by 'gardening & horticulture'. Almost a quarter of those who replied said they had taken part in some form of educational activity over the previous year, including art and craft classes, a vocational class of some kind, talks and lectures, learning a foreign language, distance learning or studying for an academic qualification.

Respondents were also asked to describe any barriers or obstacles that prevented them from taking part in learning and leisure activities, or made it difficult. Over 600 people did respond to this question. Following analysis a small number of issues seemed to predominate from responses.

Figure 4. Question: have you been involved in any of the following kinds of learning or leisure activities in the past year?



The first was disability or illness, which made it hard or impossible for people to take part because of physical impairments, reduced mobility which made it hard for the person to get in and out of buildings, or forgetfulness. These were by far the most frequently mentioned barriers to participation amongst those who answered the question.

The second was mobility – in the form of access to appropriate transport and the route taken by public transport – also very frequently mentioned as an obstacle:

Nothing is easily accessible by public transport during the day.

Cost was another barrier:

I'm not eligible for support but as I work only part-time and my husband is unemployed and with a small works pension money is tight.

Concerns for personal safety, specifically in getting to and from an activity, were also mentioned frequently:

Not safe to go out alone, especially after dark.

Other obstacles mentioned included the timing of the activity (a number of respondents noted that they preferred events to be available during the day rather than the evenings) and an inability to go out easily because of their role as a carer – for a disabled husband or wife but also grandchildren.

b. Social and community participation

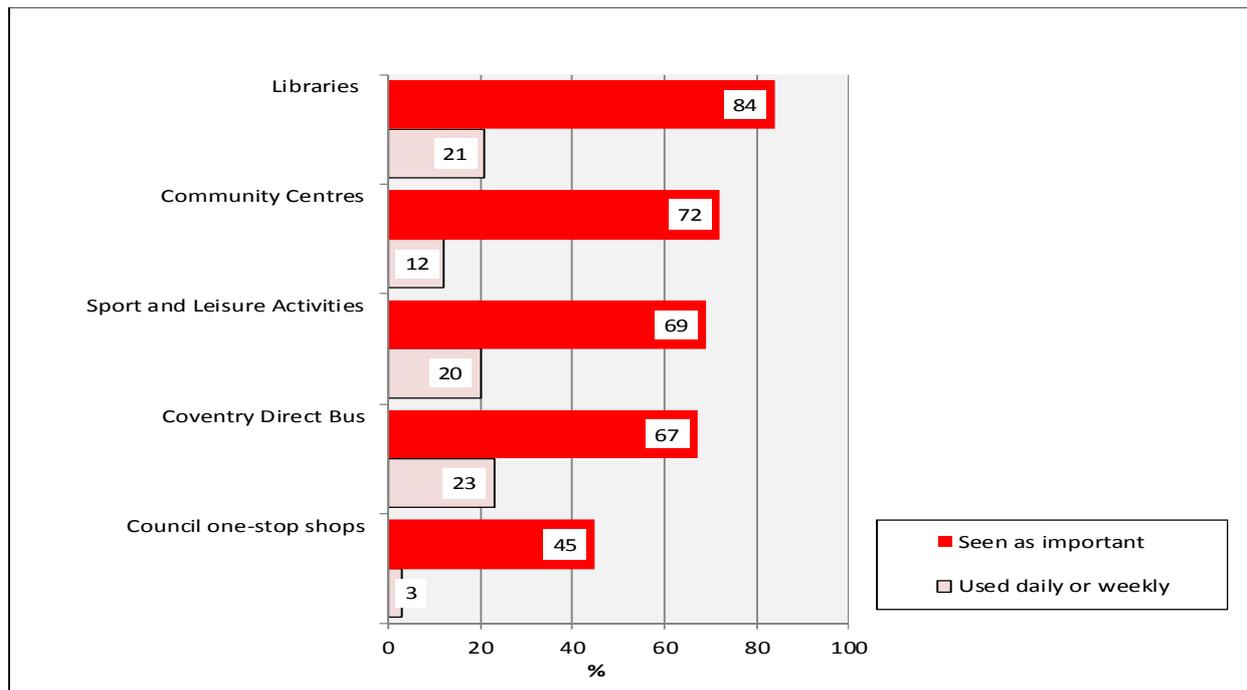
Loneliness and isolation

Just under half (46%) of respondents said they lived alone. Older people (aged 75+), women, and White respondents were most likely to live alone. 18% also said they were not able to see friends or relatives, or keep in touch with them as often as they would like to, and 16% admitted to feelings of loneliness either 'most' or 'some' days. Possible causes and consequences of loneliness are explored by the authors elsewhere (Woolham, Daly & Hughes, forthcoming 2013).

Use of community resources

Questions about use of mainstream services were also included in the survey to gauge how much they used them and what they most valued.

Figure 5. Locally valued services compared with use of these services



The survey found that although local community services and resources were all regarded as very important and valued by respondents, only a minority of respondents used them regularly. There appeared to be a number of reasons for this. Access to transport, general levels of mobility and fitness, and concerns about the safety of the external environment all affected the extent to which people were included or excluded from using these services.

Barriers to participation

Problems with walking and personal mobility were most frequently cited as barriers to being able to take part in everyday social activities, followed by the costs of participating.

Lack of information about what was ‘going on’ in Coventry was cited as an issue by just under a quarter of respondents. The absence of a companion to do things with was also mentioned by 15% of respondents.

Transport

Access to transport, the accessibility of this transport, and personal mobility were

important factors in supporting community participation and social inclusion. Given the relatively high proportion of respondents who said they had poor personal mobility, it was perhaps unsurprising that 6% of respondents said that they never left their home and only 12% said that they would walk short distances within Coventry. In fact, 38% of respondents said that their usual form of transport over short distances within Coventry was the ‘bus service, followed by 37% who said they usually travelled by car. Younger respondents (55-64) were more likely to walk or travel by car: older respondents (75+) were more reliant on the local ‘bus service.

Feedback on what would improve the ability of respondents to get out and about was also obtained.

Rapid repairs to pavements was the most frequently mentioned issue followed by a desire for better facilities for people with impaired mobility.

Figure 6. Top 5 barriers to participation in everyday activities

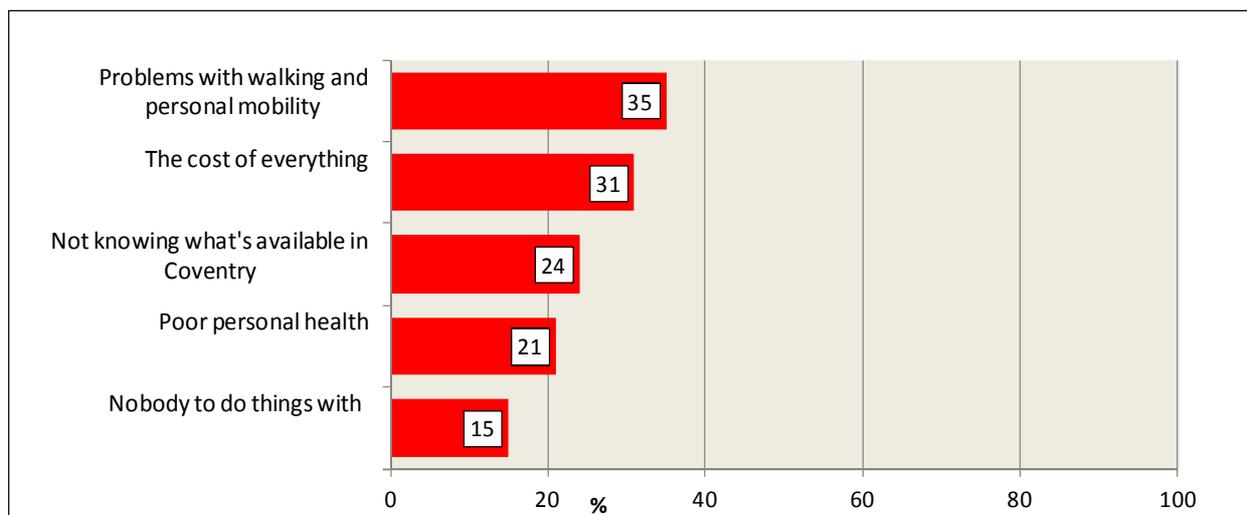
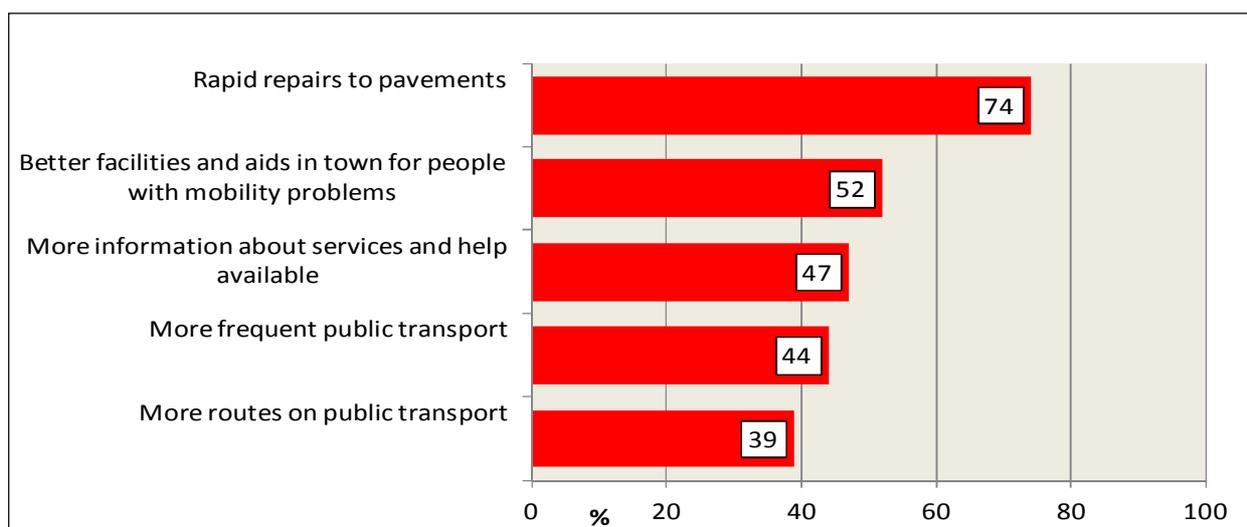


Figure 7. Top 5 things respondents said would improve their ability to get out and about in and around Coventry



Access to modern technologies of communication

Large proportions of those who took part in our survey seemed to be in danger of being left behind by the rate of technological change. Over a quarter (28%) said they rarely or never used a mobile telephone, and 46% said that they ‘rarely’ or ‘never’ used a personal computer, or the internet. A quarter of respondents also indicated that they ‘rarely’ or ‘never’ had access to a TV which had ‘free-view’ channels.

The proportion of people who did *not* use mobile phones, personal computers or the internet increased sharply with age. 10% of people aged 55-64 said they never used a mobile phone compared to 32% of the 75+ group. Personal computers were not used by 21% of the 55-64 age group but 69% of those aged 75 and over, and whilst 23% of the 55-64 age group did not use the internet, the corresponding figure for the 75+ group was 71%. (X^2 206.409 $p=0.000$). The proportion of people who never used a TV set with ‘free-view’ was 18% for the 55-64 group and 32% for those aged 75+. (X^2 53.548 $p=0.000$)

3. Health and wellbeing

Reported health status and enjoyment of life

Exactly half of respondents in the Coventry survey described their health as ‘excellent’ or ‘good’. Just over a fifth said their health was poor or very poor.

People aged over 75, and people from BME groups were more likely to report poorer health. Impaired sight, hearing and mobility reportedly ‘very much’ affected between 11 and 29% of respondents.

The questionnaire also asked people if they were enjoying their lives. Well over half said they found life enjoyable. Just over one fifth either did not feel their life was as good as they would have liked it to be, or were not

enjoying it. The age of respondents did not make a significant difference to how much, or little, people seemed to enjoy their lives.

Keeping fit and lifestyle changes

A series of questions asked respondents about exercise and lifestyle related to the maintenance of health, independence and wellbeing.

Large numbers of respondents remained physically active through walking, housework and gardening. The older respondents were, the less likely they were to take any form of exercise.

Table 2. Do you use any of the following kinds of technology?

	Often	Sometimes	Rarely	Never
A mobile phone	562 (39%)	406 (29%)	201 (14%)	256 (18%)
A personal computer	501 (42%)	151 (13%)	59 (5%)	492 (41%)
The internet	477 (40%)	167 (14%)	52 (4%)	507 (42%)
A TV with ‘freeview’	850 (62%)	178 (13%)	45 (3%)	301 (22%)

Figure 8. All in all, how much are you enjoying your current life? (n=1504)

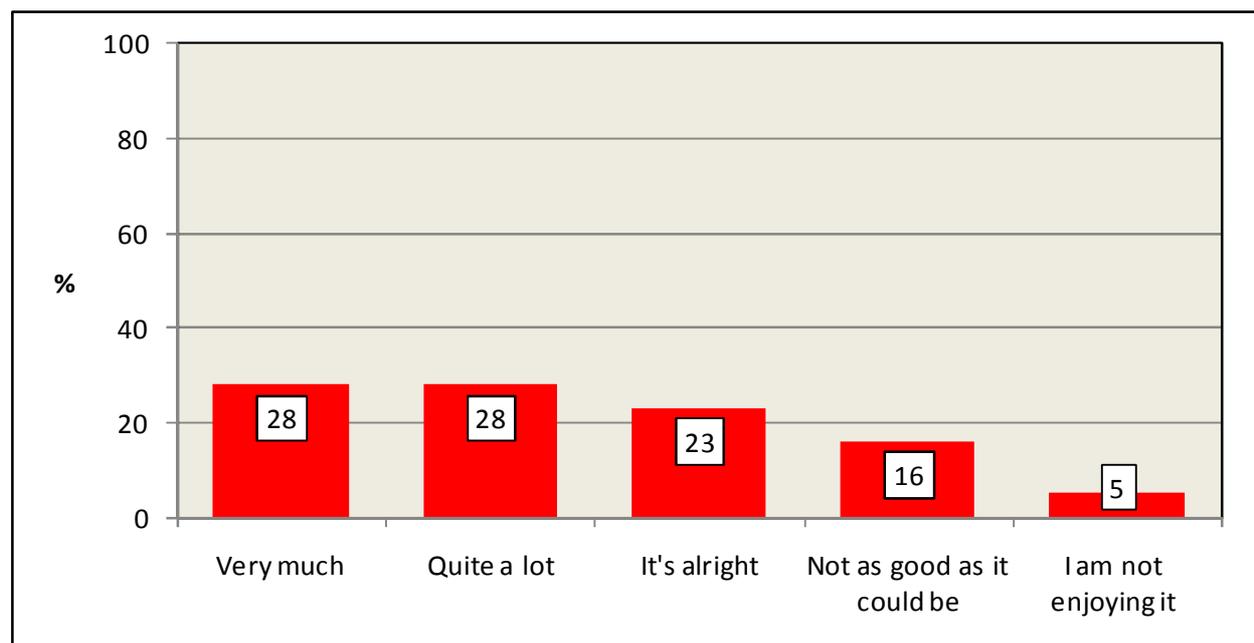


Figure 9. Question: as we get older, it may be less easy to keep fit by exercising regularly. How often do you do any of the following kinds of exercise vigorously enough to be slightly out of breath?



Respondents who rarely or never exercised were asked about reasons for this.

Table 3. Top five reasons respondents gave for not taking regular exercise

An illness or disability prevents me	544 (35%)
I have not got the energy	238 (15%)
Other ways of spending my time are more important to me	205 (13%)
I'm worried about hurting myself	142 (9%)
I have no-one to exercise with	139 (9%)

From a range of possible reasons, illness or disability and lack of energy were the most frequently cited reasons.

This is not to say, however, that people were uninterested in improving their health.

Table 4. Top five lifestyle changes respondents said they would like to make

Lose, or gain weight	608 (39%)
Take more exercise	448 (29%)
Get out of the house more	357 (23%)
Have more social contact with people	329 (21%)
Improve my diet	304 (20%)

As can be seen in **Table 4**, well over a third of respondents said they wanted to lose or gain weight, over a quarter wanted to take more exercise and a fifth wanted to improve their diet.

Information

One precondition for those wanting to maintain or improve their health and wellbeing might be access to appropriate information about how to do so. The questionnaire asked people if they knew where to advise a third party to go for help for a range of health issues.

Table 5. Respondents who said they did *not* know where to advise people to go for help in relation to a range of health issues: the top 5 issues

	Did not know where to access information
Protecting people from abuse	692 (62%)
Making more social contacts	646 (57%)
Sexual health issues	634 (57%)
Help with drug misuse	633 (55%)
Mental/emotional issues	570 (50%)

Although respondents felt they knew where to advise people to go for help with issues such as smoking cessation or alcohol misuse, as can be seen in **Table 5**, fewer than half said they knew where to advise people to go (and, by extension, would not be able to seek advice for themselves) for help with a range of other issues.

Discussion

Limitations

The data on which this paper has been based has a number of limitations. Postal surveys suffer from the inherent weakness of poor response rates, and potential response bias as respondents whose first language is not English, or who have poor literacy skills, are sometimes disadvantaged. Though the response rate to our postal survey was comparatively high for community surveys of this kind (a similar kind of community survey carried out in Oldham in 2006 achieved a response rate of 25% (Oldham Council, 2006)), males, and people from non-white ethnic groups were a little under-represented, and it seemed likely that there was some under-representation of people from lower socio-economic groups – though this could not be confirmed. There is also a very small possibility of multiple responses from the same person due to the variety of different methods of data collection. Finally, the questionnaire was large, validated scales were not used and thorough validation of questions that were included was not possible. However, the response rate suggests that size did not seem to be an obstacle – and that the issues on which the survey focused were ones about which older residents wanted to engage.

The number of responses and the time and care many respondents took to provide us with additional information suggests that our questions were appropriate for those we invited to take part, and participation was seen as worthwhile by many of Coventry's older residents. It would have been useful to have undertaken some qualitative interviews

with a purposive and representative sample, but this was also beyond the resources and remit of the study.

Choice, control and independence

Independence amongst people who use social services is commonly defined by opportunities to exercise choice, and to exert control. Two questions from the survey focused on this. The first was about the attractiveness of personal budgets. The older the participants in our survey were, the less likely they were to feel enthused by the idea of managing a Personal Budget, and the more likely they were to express a preference for someone else to arrange care and support for them. This is consistent with studies of uptake of personal budgets - particularly as Direct Payments - elsewhere (ADASS, 2011; Hatton *et al.*, 2011). A problem for policy makers has been to determine the causes of low uptake: differences in uptake amongst local authorities has led some to suggest that the problem lies with social workers not informing people about personal budgets and Direct Payments. However, the size of the budget available (Beresford, 2009a; 2009b), the amount, and quality of support available to budget holders (and the degree of permanence of this support) may make budget ownership less attractive to many older people, who may not wish to take on responsibility for managing a budget and, whilst valuing their independence, would prefer someone else to take on the main burden of responsibility. Our survey found that many older respondents seemed happier to relinquish some control providing a competent person, who understood their needs, arranged their care. These preconditions are important and suggest a willingness, or desire, to share control over care with another person providing this person could be entrusted with this responsibility.

Perhaps less surprising than responses to personal budgets is that the overwhelming majority of respondents did not wish to move into different accommodation to obtain care

or support. This is consistent with earlier research (Townsend, 1962; Sinclair, 1986; Sinclair *et al.*, 1988). Reasons for these findings have been explored elsewhere and include familiarity with local area, and preservation of local social and friendship networks. Respondents clearly saw living in their own home as the best way to maintain their independence and avoid exclusion (through perceived institutionalisation).

In relation both to preferred ways of arranging personal care, and in relation to preparedness to move to a form of housing that might be better adapted to their needs, the importance of social relationships are salient: either in respect of having a relationship of trust with another person, or prioritising the maintenance of social and friendship networks. This suggests, perhaps, that older respondents attached more importance to *inter-dependence* than independence.

Economic, educational, social and community participation

Inclusion is usually defined by the ability of people to take part, or participate, in their local community or wider society. Inclusion in economic, educational, social and community activities are affected by a range of factors.

Economic participation

Only a minority of respondents said they had no money worries. For the majority, careful managing of household finances was essential and at the other end of the spectrum a significant minority were experiencing economic hardship, or were concerned about the prospect of hardship. There was a widespread distrust of financial institutions that might offer advice. Financial hardship is one very significant form of social exclusion (ODPM, 2005; 2006): without financial resources, participation in many other educational social and community activities becomes impossible unless these are free at the point of use. Although the policy

direction may be toward encouraging older people to become economically active, this became increasingly less likely with age amongst the survey's respondents. Lack of money and lack of trustworthy advice placed limits on economic participation amongst respondents, and precluded choice.

Educational participation

Large numbers of respondents did not provide any information about involvement in formal or informal learning, suggesting that participation was not high amongst older people in the city. In part, this seemed to be due to a small number of barriers that excluded many respondents, including lack of access due to an absence of affordable or accessible transport, the financial cost of learning and lack of information about available educational activities. Arguably, many respondents found themselves unable to take part due to an absence of support from within their local community to enable this. For example, a lack of affordable transport, unaddressed safety concerns, or the absence of subsidies, and discounts on educational activities for older citizens may have prevented participation in otherwise valued activities.

Social and community participation

Almost half of participants in this survey lived alone and a substantial minority admitted to feelings of loneliness at least 'occasionally'. The survey also revealed significant barriers to social and community participation, including poor mobility, lack of confidence to participate, the absence of a companion to do things with and low income. As with barriers to educational participation, these excluding factors could often not be resolved through the exercise of independent activity: impeding factors were beyond the immediate control of individual respondents: support from institutions and other individuals would be needed to overcome them. Support, or some degree of companionship or connectedness to others, and being 'valued' by the wider community, arguably might also offer more effective ways

of supporting inclusion and independence than pursuing these activities in a solitary fashion.

The paper has already drawn attention to the 'digital divide': the oldest survey participants were also much less likely to regularly use the internet, and some seemed effectively cut off from community life by a lack of information about opportunities to participate. Many respondents were undoubtedly excluded from knowledge by a lack of access to newer social media.

In relation to educational, social and community participation, inclusion seemed to be dependent to some extent on the presence of a wider societal infrastructure (for example, the availability of regular and conveniently located bus services, adequate disabled access, the availability of the local service and its cost) and not just the respondent's physical capacity, ability to drive or income. The withdrawal, either of services, or subsidy to service operators, because of the present government's austerity programme may make it harder for some older people to participate and this may lead to more exclusion.

Health and wellbeing

Although the majority of respondents in the survey felt their general level of health was good, and they were enjoying life, the number of people who said they were in poor or indifferent health increased with age. However, lack of enjoyment of life, and therefore poor wellbeing, was more closely associated with illness, disability, loneliness and isolation than age – all factors likely to lead to social exclusion.

Maintaining or improving health - an important way of remaining more independent - also seemed to be problematic for many respondents. The numbers who took exercise declined with age: something often associated with illness or disability. Many respondents were keen to make changes to their lifestyle to improve their overall level of

health and fitness, but were effectively excluded by being unable to overcome barriers, both real and sometimes perceived, to doing so.

Knowledge of where to get advice for health-related issues was variable. Although some respondents knew where to seek advice for a range of health and wellbeing related issues, they were unclear about others: for example, how to protect others (and by extension, themselves) from abuse. Clear, accurate, accessible and timely information is likely to be a precondition to enable older citizens to fully participate in their community and wider society: the absence of information (or more properly the knowledge this confers), may lead to greater levels of exclusion. The widespread lack of access to new technologies such as mobile telephones, computers and the internet added to these risks.

Conclusions

This paper has explored the views of older citizens living in Coventry, UK, about their independence, inclusion and wellbeing and the relationship between these themes. Findings presented in the paper have suggested that whilst most older citizens were independent, able to participate in everyday community activities and were reasonably healthy, happy and comfortable, there were a number of issues that created significant barriers to inclusion and which threatened wellbeing. These included impaired mobility, lack of access to affordable or accessible transport, a lack of financial resources, impaired social networks, ill-health and lack of access to information. The prevalence and salience of these issues often increased with age, but age did not itself seem to be their primary cause. Our findings also suggest that the twin aims of independence and inclusion do not automatically converge. Independence for many older people did not seem to be highly valued if it meant the solitary pursuit of activities or tasks such as, for example, taking on responsibility for spending a personal budget. Inclusion, on the

other hand, was highly valued but difficult for many older people to achieve. To address this policy problem, more socially inclusive, rather than individualistic forms of independence (Plath, 2007), or 'inter-dependence', may be a more appropriate goal for public agencies to pursue.

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Active ageing through wellbeing – the role of information in ‘that little bit of help’

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Abstract

Information and the ability to act on it are seen as vital parts of the choice and personalisation agendas in health and social care. This is particularly important as older people are encouraged to do more for themselves in an era of budget reductions. The right information given at the right time can give access to that ‘little bit of help’, first described by the Joseph Rowntree Foundation (2005), to help keep people independent and out of health and care systems for longer. Understanding how, where and why people access services and information is therefore key to developing supportive policies for an ageing society. This paper describes some of the literature and focuses on two projects aimed at widening access and improving information. LinkAge Plus was a £10million government funded project, trialling a variety of different approaches to widening access. The Stratford-upon-Avon Early Intervention Project trialled a digitised self-assessment process for wellbeing linked to local sources of help. This paper stresses the importance of social networks and describes how outreach work in Tower Hamlets, one of the LinkAge plus pilots, was working to improve these.

Keywords: older people, ageing society, information, independence, wellbeing

Introduction

Major policy shifts taking place in relation to older people depend on effective information and access to services. The choice and personalisation agendas in health and social care, attempts to shift away from high cost services and interventions and towards people being able to do more for themselves, are all dependent, to one degree or another, on older people being aware of their options to improve health and wellbeing, and being in a position to take advantage of them.

Information and the ability to act upon it has been shown to be vitally important for older people in maintaining their independence and quality of life. Sykes *et al.* (2008, p.27) refer to an important correlation between access to information and access to services, and between access to services and quality of life for older people. Gilroy, 2005 (cited in Sykes *et al.*, *op cit.*, p.27) also found that older people place a higher value on information than other groups of the population.

Like many countries around the world the population of the UK is ageing (United Nations, 2010; Office for National Statistics, 2012.) This, together with the significant public service budget reductions since 2010, has emphasised the need for a new approach. With tighter resources and rising needs, demands and expectations, new ways of looking at services are needed. Most older people continue to contribute to their communities and families, adding value to society, but much of the attention in policy, research and practice – and in service funding – has been, and is, focused on frail older people – yet they constitute only a small proportion of the older population.

The funding gap for adult social care is growing and it is widely acknowledged that current systems for funding and accessing adult social care are confusing, complex and not sustainable in their present form. Information from the Association of Directors of Adult Social Services (ADASS) indicates that in the three years since the start of the

current UK government's austerity programme 'some £2.68 billion savings will have been made by adult social care – 20 per cent of net spending' (ADASS, 2013, p.1). 50 per cent of ADASS members think that fewer people will be able to access adult social care services in two years' time (*ibid*, p.2) and 83 per cent of councils have set their eligibility thresholds for 2013-14 at substantial or above (*ibid*).

As authorities are finding that they are increasingly having to focus their ever more limited resources on vulnerable people and groups, the general population of older people is increasingly expected to do more for itself. Measures to help promote and maintain independence and wellbeing therefore have a potentially key role to play in future approaches to service delivery – what the Joseph Rowntree Foundation (2005) has referred to as 'that little bit of help'. Keeping people out of the costly parts of the health and care systems for as long as possible are key aims. Seamless signposting and information is likely to have a key role to play in this.

In this paper we will explore issues around information for older people, using the experience of two studies in which we were actively involved. These projects were the LinkAge Plus pilot programme for the Department for Work and Pensions, 2006-9, and the Stratford Early Intervention Project (EIP), 2011-12. The latter formed part of the Department of Health's Common Assessment Framework for Adults Demonstrator Site Programme. Both projects involved older people actively in focusing on the issues of concern to them, both contained action research as well as evaluation, both had people-centred services at the heart of what they were aiming to do. Both projects had helping older people to maintain and sustain their independence at the heart of what they were trying to achieve, but the projects each took a different approach to the provision of information for older people.

In the following sections we firstly set out some background on the two projects. We

highlight the example of urban outreach in Tower Hamlets, from the LinkAge Plus pilot programme. The Stratford EIP is then used to highlight issues concerning the use of internet and internet-based service approaches for older people. We then go on to look at the question of age and information more generally – and what older people want/need to know. From here we discuss issues concerning access to information and look at the importance of social networks.

We conclude that the evidence from our work on LinkAge Plus and the Stratford EIP is that social networking and face-to-face communication are still key, but that pressures on budgets are limiting the opportunities for older people to have this kind of contact. Older people are becoming more comfortable with the internet but the situation is dynamic and changing rapidly. The need for effective information strategies – getting the right information to the right people, in the right way, at the right time – is becoming ever more pressing.

LinkAge Plus

LinkAge Plus was a £10 million programme led by the Department for Work and Pensions (DWP). The programme had its roots in Opportunity Age (HM Government, 2005) and Sure Start for Later Life (ODPM *et al.*, 2006) which set out a vision for tackling social exclusion for older people through a universal service that actively reaches out to older people at risk of isolation. At the heart of the LinkAge Plus vision was a strategic, whole systems approach to older people, one which aimed to put older people at the centre of policy making and service delivery.

The programme sought to develop and deliver services which were accessible, relevant and tailored as far as possible to individual needs and offered support of up to £1 million to develop locally relevant services for older people across a range of urban and rural areas, building on LinkAge Plus principles and testing out a proof of concept. The projects were individually assessed by local

evaluators and the programme as a whole was nationally evaluated (Davis & Ritters, 2009).

The national evaluation worked alongside the projects as they developed locally applicable improvements to their services for older people. Principally these improvements were around joining up services, improving referrals and reaching out more widely to those older people currently being missed by the system. Evaluators visited the pilot sites, interviewed project leaders and stakeholders involved in the pilots at local level, as well as local opinion formers and service managers. They also worked with local evaluators who carried out research with programme participants and engaged with local residents. Evaluation workshops brought together local and national evaluators and project leads at various points in the project, and project managers regularly met with each other and with DWP project leads. A steering group linked all this work with the views of national opinion formers.

Eight pilot areas took part in the programme – Devon, Gateshead, Gloucestershire, Lancaster, Leeds, Nottinghamshire, Salford, and Tower Hamlets – together with two additional sites focused on streamlining the assessment of attendance allowance applications with social care assessment – namely Greenwich and Lewisham.

LinkAge Plus went further than purely testing out various means of getting information to older people, nevertheless it recognised that the effective provision of information was a key part of empowering older people and ensuring that existing resources were utilised to their fullest extent. The approaches to widening access through LinkAge Plus broadly fell into four categories – outreach, working through others, enhancing telephone and contact centre activities, and specialist advice and information services.

In one of the pilot areas, Tower Hamlets, outreach approaches were used to increase take up of local community centre activities, making the centres themselves more vibrant

and reducing the social isolation of those who took part. In a rural setting, Gloucestershire developed a ‘village agents’ scheme to improve access through referrals to local services. Schemes like Nottinghamshire’s First Contact worked at increasing awareness of what local services were able to offer to older people and to encourage cross-service referral. A simple checklist was used to assess likely need and the system was underpinned by effective follow up. These are all reported on in Davis & Ritters, 2009, *op cit*. A number of local authorities used the programme to build on work to enhance local call centre offerings by partnering with older people’s organisations, such as Age Concern, and by offering extra services such as benefit checks. Some authorities set up or built on specialist information and advice services in areas such as employment and volunteering or around housing options (helping older people to downsize or relocate to accommodation more suited to their current needs).

In this paper we particularly draw upon those aspects of LinkAge Plus that related to the role of information in the effective engagement and empowerment of older people.

The Stratford Early Intervention Project

The Stratford Early Intervention Project (EIP) took place in Stratford-upon-Avon, Warwickshire, 2011-12 and formed part of the Department of Health’s Common Assessment Framework for Adults Demonstrator Site Programme. The Joint Strategic Needs Assessment for Warwickshire (JSNA) (Warwickshire County Council & NHS Warwickshire, 2011) highlights ‘old age’ as one of its five key themes – themes having been chosen by virtue of the magnitude of the issue, poor outcomes being achieved and/or worsening situation. The JSNA notes the projections for a particularly high rate of increase in the number of people aged 65 and over living within the county. This is particularly noticeable in the Stratford-on-Avon District where the projections are for an already

higher than average older population to continue to increase – with the number aged 65 and over projected to reach almost one third of the local population by 2033 (*ibid*).

The EIP aimed to test out the acceptability of an electronic self-assessment for use by older people, to test wellbeing, give pointers for improvement and signpost to sources of help. Evaluators worked alongside project staff as it developed, attending group meetings to monitor progress. They conducted interviews with project stakeholders to test the impact and effectiveness of the scheme and how far it might contribute to the goals of stakeholder organisations. They also worked directly with older people as they trialled the tool at a number of events across Stratford-upon-Avon. A structured evaluation questionnaire was produced to sit alongside the self-assessment and this was completed by participants once they had trialled the tool itself.

The EIP made use of the existing Easy-Care Standard Instrument, seeking to digitise that instrument and test how far older people might engage with a computer based self-assessment process. Easy-Care was originally developed, 1990-94, as a World Health Organisation (WHO) project and formed part of the European Commission's research and development programme. The framework for the development of the Easy-Care instruments was agreed by a WHO (Europe) expert working group in 1993, which in turn led to a number of pilot studies in the UK, Finland and Spain between 1994 and 1996 (Davis, Philp & Ritters, 2011). Between 1998 and 2001 further development and validation of Easy-Care instruments took place as part of a European Union funded project and, since 2009, the use of Easy-Care instruments has been broadened from mainly European use to global use – with more than thirty countries using common protocols. This latter work was facilitated by a non-promotional grant from Pfizer (*ibid*).

Key to Easy-Care is its structure of seven domains, developed to provide a holistic

framework for the assessment of older people's health and wellbeing, and which can also be developed into practical plans to address the most serious priorities as identified by the user. These domains are structured around the most significant threats to health, independence and wellbeing in older age namely:

- Seeing, hearing and communicating
- Looking after yourself
- Getting around
- Your safety
- Your accommodation and finance
- Staying healthy
- Your mental health and wellbeing.

In the Stratford EIP this was developed into a digitised self-assessment questionnaire, using these seven domains, which then signposted to appropriate resource settings through a database with links specific to the Stratford-upon-Avon area.

The self-assessment tool was then trialled with older people in a variety of settings. For self-assessment, the tool was put onto the internet, to enable it to be accessed from any computer with an internet connection. It was also made available in settings where it was thought older people might be encouraged to try it. These included the local library, the reception in the District Council's main office, and in a busy local medical centre. It was also used in an assisted setting with a local pharmacist, a practice nurse, Age UK case workers and at special events across the Stratford (coffee mornings, lunch clubs, garden centres, and in sheltered housing). In Stratford the tool was used to bridge into the health and social care system, not starting with the professionals as such. As ageing is a process rather than an event, the system was also seen as potentially having value to individuals as a repository for their information over time.

Over the period of the trial 84 people completed the online assessment and 32 of these completed our evaluation questionnaire. There are therefore caveats and words of

caution that should need to be stated in relation to our results. Firstly, it proved more difficult than had been anticipated to get older people to take part in the trial and therefore our sample size is small. Secondly, Stratford-upon-Avon District is relatively more affluent than some other parts of Warwickshire. Levels and acceptability of internet use in this setting may therefore be higher than average.

Having set out above the nature of the two programmes whose experience we describe and draw upon in this paper, we now move to look more specifically at the use of urban outreach in the Tower Hamlets LinkAge Plus pilot and the use of internet-based self-assessment in Stratford-upon-Avon.

Urban outreach in Tower Hamlets

The LinkAge Plus pilot in Tower Hamlets sought to build on the idea of developing social networks through its urban outreach and other support for local network centres. Tower Hamlets is an inner London borough with a great deal of population churn and social mobility. Younger families with children have moved away due to high housing costs in the capital, leaving older relatives in social housing increasingly isolated and without the networks of family and neighbours they grew up with to support them.

However, a particular feature of Tower Hamlets is the number of voluntary organisations active in the borough, with hundreds of organisations active in the area. The priority for the LinkAge Plus pilot was therefore felt to be to co-ordinate activity and to work to connect older people into services that were already available. Partnership working between voluntary and community organisations and statutory services was already strong due to work on previous bids for project-based funding.

The borough had a good network of community and day centres, but some of these needed to be made more vibrant by drawing more people in and enabling them to

put on more attractive activities and events for older people. There was work to be done to encourage the plethora of voluntary sector organisations working with older people to coordinate their activities better and for community facilities to produce joint activities and events for older people.

LinkAge Plus pilot helped to establish network coordinators and outreach staff at five network centres across the borough. Typically this involved a network coordinator and two to three outreach workers (either full or part time) managed by the network coordinator. Outreach staff primarily worked to identify and connect with socially isolated people but also had a role in developing and organising activities in the centres themselves.

The outreach workers linked in with other community workers, such as wardens in sheltered housing complexes, and with anyone in the wider community, to identify those at risk of isolation:

I've been going to the doctors' surgeries and chemists and hairdressers where I feel there are older people to tell them what we do and I say, "well if you recognise somebody that wants to come out or that's on their own, please refer them to us or give them one of our leaflets and they'll call us." (LinkAge Plus outreach worker)

They would befriend those identified as being at risk of social isolation and encourage them to come along to day centre activities, perhaps accompanying them on the first few visits. For older people this enabled them to establish or perhaps re-connect with social networks, to participate in healthy living activities, and to access advice, information and sources of help to improve their wellbeing. Outreach workers could also talk to older people about their needs and possible sources of help. The way in which outreach work linked to the network centres is set out diagrammatically (**Diagram 1**, p.29).

The support of the outreach worker in giving people the confidence to attend, and the quality of the experience at the centres once there, began a virtuous cycle in which the availability and positive experience at the centres was spread by word of mouth and more and more people were encouraged to attend.

LinkAge Plus seed funding was used to encourage voluntary sector organisations to work collaboratively rather than in competition as had sometimes happened in the past. For example, centres compared events timetables to ensure that two similar classes were not held on the same day, they started to cross refer to each other to encourage older people to attend more than one centre. Local school buses were utilised outside normal times to ferry people from day centres to local leisure facilities. Because local centres worked together, with the possibility of easier transport, local leisure centres had sufficient take up to justify specialist services such as women only sessions at the local swimming pool.

For community and day centres, wider attendance enabled them to put on more meaningful and interesting activities. Their ability to evidence increased footfall, particularly in relation to key target groups, supported applications for local funding and also enabled them to draw in other local groups, such as drama and arts groups to work at the centres. This then led to further evidence that older people liked, trusted and used the centres.

For local services, having a local access point that was vibrant, trusted and well attended by their target groups made it viable for them to put on specialist information sessions, such as healthy eating events, that supported wellbeing. It also justified the centre's role as a portal for information and advice about local services:

Without the network centres there's no natural place for older people to meet – it's absolutely the right group for preventive messages. (LinkAge Plus national evaluation interview, PCT worker)

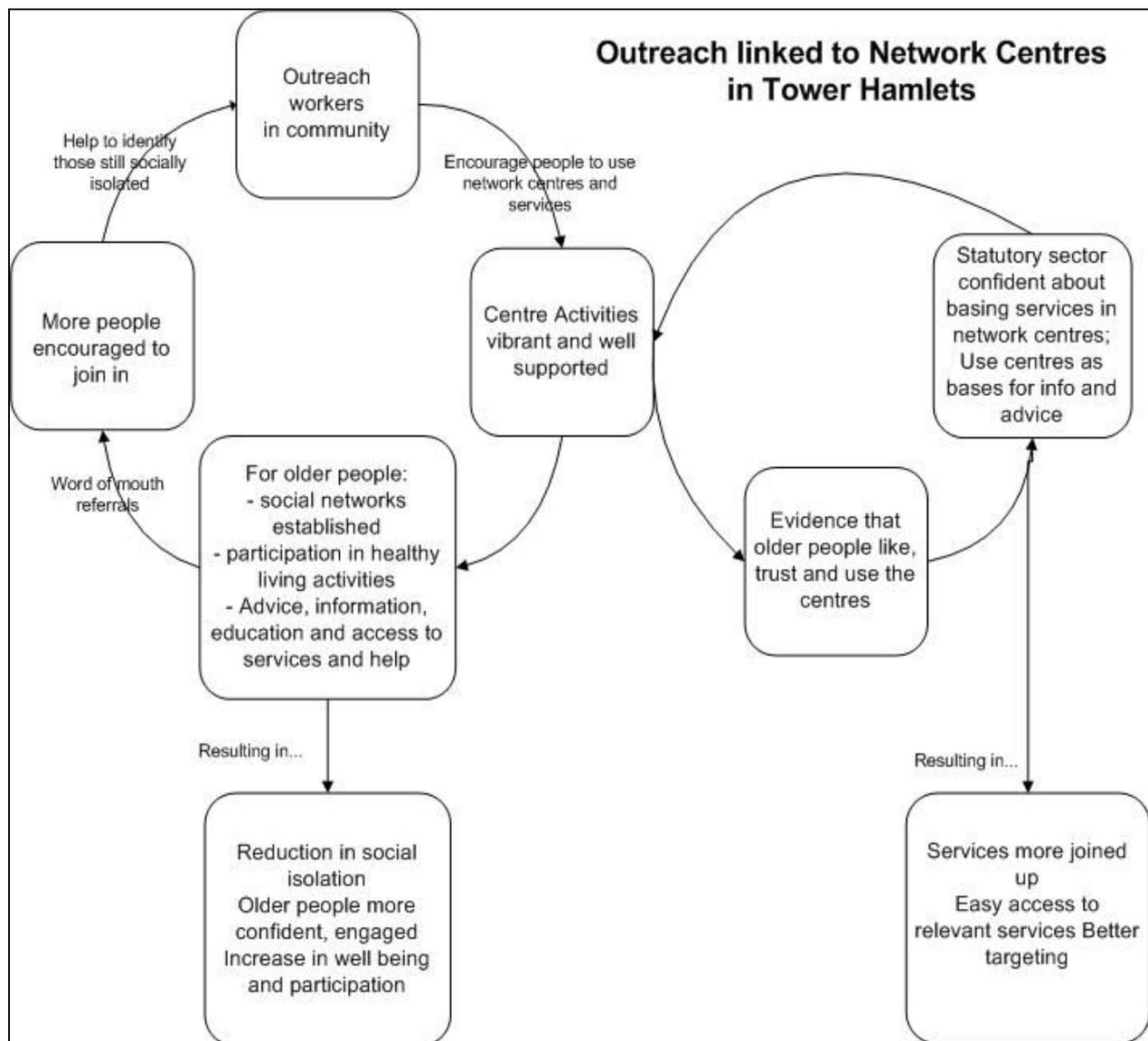
For those older people attending the centres, strengthened social networks had the potential to increase confidence, engagement and participation in local life.

When viewed purely from the point of view of access to services and the provision of information, it would seem that the outreach model is resource intensive, when compared say with an access model based on enhancing existing contact centre facilities. However, it is important to recognise that the primary purpose of the centres is to provide an area where older people can meet and socialise and take part in a range of activities. Help in accessing services and information provision is not the primary purpose of outreach in this model, although it may be a valuable spin off.

The role of the internet

A key question, for both the LinkAge Plus pilots and the Stratford EIP, was how older people would react to internet-based sources of information, assessment and advice.

In LinkAge Plus a number of the pilots reported that their web-based information resources were being used to help signpost older people into relevant services by GPs and people from the voluntary and statutory sector working with older people. However, particularly amongst the oldest old, internet-based sources of information can present a barrier to use. For example, the vast majority of respondents in the Leeds survey (Whyles, 2007, p.6) did not use the internet to find information and did not indicate that they might wish to use it in the future.

Diagram 1. Outreach model

The EIP in Stratford-upon-Avon was promoted as the 'Stratford Early Intervention Project Help and Information Service' and headlined 'Helping you to help yourself' – 'by finding out what's important to you and putting you in touch with local help and information' (Warwickshire County Council & NHS Warwickshire publicity leaflet, 2011). The welcome screen of the digital tool explained that: 'This service offers help and information on health and wellbeing for older people in Stratford-upon-Avon' and that 'By answering a few simple questions we will be able to connect you to the most appropriate local help and information on the topic giving you the most concern at the moment'.

In the Stratford EIP project, 66 per cent of users completing our evaluation had access to a computer at home or through a family member, one third used a computer every day, and 60 per cent used a computer at least once a week – although it has to be acknowledged that the numbers were small (32 respondents). Over half (56 per cent) were able to complete the self-assessment on their own, the remainder with help. When asked what they would prefer to use to fill it in if they were to complete the assessment again, just 44 per cent opted for pen and paper. 72 per cent of respondents said they would be happy to complete the assessment

again on their own, with 28 per cent saying that they felt they would need help.

The Stratford EIP internet-based self-assessment for older people

Results showed that once they had tried it, older people liked the electronic tool and the responses it generated. 87 per cent (n=28) of older people answering our questions found it very easy or easy to complete, 75 per cent would be happy to recommend the assessment to people they know, and 75 per cent found the information given either very or quite useful.

From those that tried the system there was a range of motivations for doing so. Some had a genuine interest in finding out more about health and wellbeing:

Control of one's life. Helping to manage a disability. Self-determination.

My approach is different to most people but the single word is curiosity.

For some, the technology itself was an incentive:

Curious as to using a computer. Thought this might show more about the assessment.

Others responded to peer or family pressure, or to publicity:

Absolutely simple – wife is always complaining about me not doing what I am supposed to do so I thought I would try it.

Of the seven Easy-Care domains used by the EIP (and set out earlier in this paper), those found to be most useful were the domains on 'seeing, hearing and communicating' and on 'getting around'. These were followed by the domains on 'looking after yourself' and 'staying healthy'. The domains covering safety, accommodation and finance, and mental health and wellbeing were less popular.

Stakeholders were generally supportive of the EIP as a project, as an idea, and in terms of the potential of the system itself to help them meet the objectives of their own part of the health and social care system. However, these objectives differed. Most saw the tool as a means of empowerment for older people, enabling them to make choices and to help them manage their old age. But for some, the test of whether funding should continue to develop the tool was whether it would lead to reduced future demand for their services and relieve pressure on budgets.

We wanted to explore whether, in answering independence and wellbeing assessments older people might answer in relation to an anticipated rather than a current need. In the evaluation we therefore asked specifically about the need for information. 35 per cent of respondents (n=11) were interested in information to meet a current need and over half wanted to find out about needs they may have in the future.

In terms of benefits of trying the assessment, most users (53 per cent) felt that the most important benefit was to help them think about their health and wellbeing. Other benefits were prompting them to make changes for a healthier lifestyle (9 per cent), as a tool to help them talk to friends, family, carers and doctor about their health and wellbeing (9 per cent), or to keep as a record of how they were feeling on a particular day (9 per cent).

For those who were encouraged to try the web-based assessment, these results would therefore suggest that the experience seems to have been positive. However, they must be treated with caution because of the low sample size and perhaps a tendency for those older people more interested in wellbeing and/or computing to put themselves forward for the assessment.

We now move to look at how age itself may affect the kind of information that older people require and how they prefer to access it.

Age and information

In developing strategies for informing and empowering older people, our research has suggested that a key variable is the age of the older person in question. This supports the findings of other researchers, but there are differing opinions as to where the line should be drawn. For example, research for the Central Office of Information (COI) (cited in Sykes *et al.*, 2008) concluded that there were two key age-related sub-groups amongst the over 50s – those aged 50-75, and those aged 76 and over. Sykes *et al.*, 2008, *op cit.*, recognised three important sub-groups – those aged 50 to state pension age (SPA), those between SPA and 75, and the over 75s. It was felt that these stages were distinguished from one another by factors such as employment, family life stage, relative incidence of health problems and disability, and the extent of friendships and family support networks. In Leeds, however, the Older, Better strategy (Leeds Older People's Modernisation Team & Healthy Leeds Partnership, 2006) employed slightly differing sub-groups, mainly on the basis of healthy life expectancy and differences in attitudes, expectations and needs. The sub-categories employed by Leeds were 50-65, 66-79 and 80 years and over.

Age is also a factor in determining the attitude of the person seeking information, which may affect how likely they are to access the information and then in turn to act upon it. Sykes *et al.*, 2008, *op cit.*, suggested that the attitudes of older people in accessing information varied depending on whether the person was born before the Second World War ('Old Society') or afterwards ('New Society'). 'Old Society', it was suggested, was more likely to see independence as a virtue and to be resistant to the idea of state support whereas 'New Society' was more likely to embrace state help and to be resistant to the idea of ageing.

Our own interviews for LinkAge Plus suggested that some commissioners of adult social care were also already starting to think

about, what we might term 'Next Society', i.e. the needs of the coming generation of older people. This group, it was felt, were likely to be more comfortable with the idea of being consumers in relation to social care, to be happy to use the internet, and to use a wider range of information sources to choose the type of provision and providers to meet their needs. This vision of how older people of the future will be able to use and work with information fits with the choice, personal responsibility and personalisation agendas for services. Nevertheless, there are, of course, always unknowns and a key unknown here is whether this 'Next Society' generation will actually feel the same way about such issues when they themselves are, say, aged 80 plus.

What do older people want/need to know – and how do they access it?

This section discusses the particular requirements that older people may have in relation to information, drawing on published and unpublished research, together with the findings of the 'Big Talk' event in Leeds (Townsend & Godfrey, 2007).

Just as with the rest of the population, it is likely that older people do not want to be bombarded with information before they perceive a need for it. Rather, they would prefer to have the confidence to know that they will be able to find out what they need to know when they need to know it. However, there are some life events that may require a sudden and immediate need for information and support, and which arguably are more likely to affect older people to a greater degree than the rest of the population. The sudden onset of illness or disability, a change in circumstances such as having to move house – perhaps into sheltered accommodation, retirement, or the bereavement of a close friend or family member.

Moving from the context of information needs, we can also see some of the specific information needs that have been highlighted by research. Sykes *et al.*, 2008, p.30, cited the

following as examples of topics about which respondents recalled wanting information about over the previous few months and reflect the differing information needs and wants of different age groups of older people:

- 50-59 year olds – travel insurance; health cards for travelling abroad; services for grandchildren; locally available transport concessions; getting a pension forecast; and car tax.
- 60-74 year olds – benefits and entitlements available (and how to claim); how will manage through long retirement – financially, physically, mentally (coping with retirement); information about specific health problems; refuse and recycling; transport concessions, including bus passes and taxi tokens; rail fares and timetables; age law at work; energy efficiency; tax matters; age-related entitlements (other than pensions); working opportunities after SPA; flexible work after SPA; tax and NI concessions after SPA; benefits and services for carers; council tax; and a list or directory of government contacts.
- 75+ year olds – aids and support available to people with disabilities/health problems; inheritance tax; tax matters generally; health; filling in forms; drawing State Pension; finding out about/claiming Pension Credit; managing at home; age-related entitlements (other than pensions); ideas for holidays; local house prices and estate agents; and information about government services.

In addition, older people may need greater support in sorting out what might be termed ‘daily hassles’ – what to do now that the local post office has closed, that postage rates have changed due to the size of the envelope, the switch over to digital television, changes in adult social care packages, the closure of a local shop, fear of crime, etc. All may take on a greater significance for older people than for the rest of the population.

A number of studies and projects have looked not only at the kind of information older people require but also at how they prefer to access it. Darnton, 2005 (cited in Sykes *et al.*, 2008, p.28) identified a number of features of how older people said they preferred to access information. For example, there was a preference for face-to-face communication, ideally in an informal setting. Official information in hard copy was welcomed and older people were more likely to preserve this than other age groups. Telephone helplines were appreciated, but there were concerns for people with certain kinds of impairment and those with language difficulties.

In terms of channels already used by older people, Darnton (*op cit.*) found that older people watched more television per day than any other age group, peaking at around age 70. However, they had the lowest advertising recall of all the age groups studied and less interest generally in advertising. Older people listened to more radio than other age groups (again peaking around 70) but were less interested in commercial stations. One quarter of 70-74 year olds read a daily paper and Saga was the most popular magazine (read by 18 per cent of those aged 65-69).

In Leeds, one of the LinkAge Plus pilot areas, the University worked to engage with older people around how they currently received information and help. The Leeds Involvement Project (Whyles, 2007, p.6) found that most older people got information from family members (22 votes), followed by voluntary sector groups (20 votes) and their GP (13 votes).

At the Big Talk event to which we have already referred (Townsend & Godfrey, 2007, p.9), older people commented on the fragmented nature of local service provision:

Who do you fall back on? – getting an appointment with a welfare worker is harder than getting one with a dentist. Everyone is compartmented off – they pass the buck from one to another. (Participant)

When services themselves are so fragmented, it makes accessing them and understanding how their provision fits together so much more difficult for those who need to use them.

The importance of social networks

Our research indicated that social networks had an important role to play in informing older people. LinkAge Plus was at its most effective when tapping into an existing, often already successful, infrastructure and/or network of relationships, as is described in more detail below. In Stratford too, when trialling the EIP self-assessment it was important to secure the support of local GPs, day centres, social clubs, etc, in order to spread the word about the web-based tool. Once introduced to the tool in a social setting older people were very positive about it and how it might help them. However, simply putting the website onto static computers in public settings such as a local council office reception and library, and signposting via posters and static advertising, did not generate much response.

In the Big Talk event in Leeds, older people spoke of using local network centres as a venue for socialising and keeping them in touch with the wider community. There was particular appreciation for the role of neighbourhood network centres in Leeds as a safety net, anchor, source of information and access to other support. The approachability and friendliness of staff and volunteers was also felt to be important:

It was through Margaret, a friend I met there that I found out about the network – she was a volunteer. We get lots of information that I wouldn't have known otherwise. We have talks from the fire service, the police. As a single person living alone, I fully appreciate the fact that I can call on the scheme for advice or suggestions at any time. I find this most helpful. There is someone you can speak to about anything. People felt they could contact staff if they were in trouble or in

difficult times. There was someone to unburden to. (Townsend & Godfrey, 2007, p.4)

Concluding remarks

The programmes described in this paper are intended to be illustrative, rather than fully representative of the large variety of projects aimed at widening access and awareness of the options to improve wellbeing for older people. They describe a snapshot in time but it should also be recognised that the context is changing rapidly as budget reductions continue apace and also with the continuing rise of the internet, along with the skills of older people in using electronic media.

Websites and electronic signposting are now a key part of information provision. Helping older people to improve their IT skills can therefore be important. However, barriers to use of the internet do not appear as great for those at the younger end of the over-50s age spectrum. The view may also be taken that work to establish good information databases currently helps carers, families (particularly those living in areas some distance from their older relatives), and some older people who use the internet ('silver surfers'), and are also building a foundation to help older people and others access information that will be useful to them in the future.

Consumer organisations are increasingly concerned about the move by companies towards internet-based communications with their users. A press release by the 'Keep me Posted' campaign (June 2013) quoted ONS Q1 2013 data showing that 14 per cent of adults (7.1million) in the UK have never used the internet. Independent research by Opinium in May 2013 (*ibid*) found that 84 per cent of adults are unhappy when companies take away their right to choose how they are communicated with and 40 per cent of people say the removal of paper statements entirely could seriously affect their finances through the risk of missing bill payments.

From the point of view of an organisation trying to get information across, the internet has the potential to reach a large number of people in a cost-effective and timely manner. Key to keeping the websites relevant, however, is the quality and timeliness of the information on the database.

In LinkAge Plus, and in the Stratford EIP, work to develop the information base and to structure pathways into existing sources of information was time consuming but key to their success. Thinking around how to develop and maintain these sources in an up to date and sustainable way is vital, as information quickly gets out of date. One approach is that of developing a portal and linking into organisations that will ensure that their own information is up to date. The idea of an older persons' wiki has also been discussed, whereby a community of older people will add to and update information based on their own experiences.

The role of the internet will inevitably continue to increase, bringing with it access to relevant, timely and targeted information, with unprecedented levels of breadth and depth. However, it will also leave behind those without the skills or resources to access it. Budget reductions could place these individuals in a more precarious position in getting to the right information – particularly where they, as individuals, are part of the general population of older people not receiving direct support from public services.

Evidence from LinkAge Plus and the Stratford EIP suggests that social networking and face-to-face communication have a key role to play. Outreach work in Tower Hamlets, supported by investment in day centre provision was able to create a virtuous cycle of support, vibrancy, collaboration and engagement. In terms of an outlet for service and wellbeing messages, this was seen as a valuable investment both for health and social care organisations. It also strengthened the voluntary and community sector. In Gloucestershire, village agents were able to link those in isolated communities into

services on offer, and in Stratford-upon-Avon, social networks were key to persuading people to try the online self-assessment tool.

There was no single blueprint for the LinkAge Plus projects and the Stratford EIP was a stand alone, digitised self-assessment, so no firm conclusions can be drawn from their comparison. However, they did show that when older people were introduced to sources of information and help they were used and appreciated.

As the funding gap for adult social care continues to grow and support systems become ever more complex, the need for effective information strategies becomes more urgent – that 'little bit of help' delivered in the right way at the right time can make all the difference between an independent, healthy lifestyle and a decline into dependence. Systems are then put under more strain and older people lose their cherished independence. Information and access strategies have a key role to play, and understanding how older people prefer to access information will be key to their success. LinkAge Plus and the Stratford EIP worked to help local authorities and their partners develop a range of operational strategies to help older people in this regard, with a 'no wrong door' approach – but, of course, the door has to be accessible and has to be found in the first place.

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Active ageing and age management – European case studies focusing on the caring sectors and local government

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Abstract

Active ageing has been developed as a policy response to population ageing in the UK and in other parts of Europe. A key focus of this policy is the extension of working lives, yet it needs to be supported by other measures enabling and also encouraging individuals to continue working longer. Age management in organisations has an important role to play in this respect. This article mainly presents the findings of case studies on good practice in age management in health and social care organisations and local authorities which were conducted as part of the European study on ‘Activating Senior Potential in Ageing Europe’. The article focuses on selected dimensions of age management, including recruitment, training, career development, flexible working and health promotion, while highlighting good practices that relate to wider age management approaches and developments over time. It ends with a brief note on the results of quantitative longitudinal studies which have examined the impact of extending working lives on individuals’ health.

Keywords: extending working lives, age management, Europe, case study research

Introduction

The UK population, like many others in the western world, is ageing due to increased life expectancy, the baby boom after the second world war and a subsequent fall in fertility. *Active ageing* emerged about a decade ago as an overall policy approach both to dealing with these demographic changes and to re-assessing how best to enable people to flourish in later life (Walker & Maltby, 2012). The concept, mainly driven by concerns about expected shortfalls in the funding of pension systems and lack of adequate older adult care provision, promotes the extension of working lives and other forms of active participation in society, such as volunteering.

While a substantial group of workers aims for early retirement, others plan to continue working past state pension age either due to financial need or because they enjoy their work (Smeaton *et al.*, 2009). According to a recent EU survey, 56% of UK respondents would like to continue working past the age at

which they are entitled to a pension (Eurobarometer, 2012), compared to an EU27 average of a third, and nearly one in five in the UK are already working past the age of 65, compared to the EU27 average of one in ten (Eurofound, 2012). Retirement decisions are complex though, affected by individual attributes such as age, education, health, financial resources; past/current employment and organisational/institutional factors, such as opportunities for flexible working; the family situation; and the socio-economic environment (Wang & Schulz, 2010; see also Nilsson *et al.*, 2011 for an example in the healthcare sector in Sweden).

However, in order to enable the extension of working lives, the preferences and needs of older people need to be taken into account, such as requests for more flexible working, particularly among those with caring responsibilities and with individual health difficulties (Vickerstaff *et al.*, 2008; Smeaton *et al.*, 2009). Moreover, barriers need to be removed, such as those relating to negative age stereotypes, access to training and to

recruitment of older workers (OECD, 2006; Eurobarometer, 2012). Furthermore, employment conditions need to be improved in order to prevent work-related deterioration in employee health (Ilmarinen, 2005; OECD, 2006; Walker & Maltby, 2012).

Walker & Maltby (2012) argue that age management, in combination with the assessment of the work ability of the individual (Ilmarinen, 2005), supports active ageing in the workplace through prevention rather than remedial action. The concept of age management emerged about twenty years ago when researchers at the Finnish Institute of Occupational Health realised that line managers were pivotal to helping improve the work ability of the individual, a concept developed by Ilmarinen and colleagues about thirty years ago to assess the balance between the resources of the individual and the demands at work through the so-called 'work ability index' derived from a short self-assessment questionnaire (Ilmarinen, 2011).

Research into good practice case studies of age management in Europe began in the mid-1990s, initially commissioned by the European Foundation for the Improvement of Living and Working Conditions (Eurofound) (see e.g. Walker, 1997; Walker & Taylor, 1998). Other European studies include Lindley & Düll (2006) and www.esfage.eu/. Naegele & Walker (2006, p.3) defined good practice in age management 'as those measures that combat age barriers and/or promote age diversity' in one or more dimensions of practice that relate to the employment cycle. These are, in particular, recruitment; initial induction, training and lifelong learning; career development; flexible working time practices; health protection and promotion, and workplace design; redeployment; employment exit and ultimately the transition to retirement. Moreover, organisations may adopt a more holistic human resources (HR) policy that addresses several key dimensions.

Table 1. Typology of age management practices

Level of organisational preparedness (A)	Age awareness of HR policies (B)	Typologies of age management practices – based on the combination of (A) and (B)
Proactive	Equal opportunity / individual accommodation of requests and needs	V. Life-course approach – HR policies apply to all employees to ensure flexibility over the life-course (3rd generation of AMP*)
Proactive	Ageing as an opportunity	IV. Focus on intergenerational learning that offers a two-way knowledge transfer and at the same time less physically demanding tasks (2nd generation of AMP)
Proactive	Ageing as a challenge	III. Focus on enhancing individual resources (e.g. through health promotion, training and lifelong learning) while also decreasing work demands (1st generation of AMP – deficit oriented approach)
Reactive	Ageing as a challenge	II. Focus on decreasing work demands (e.g. through redeployment, reduced/no shift work, additional leave or gradual retirement)
Reactive	No age awareness	I. Focus on tackling skills shortages the organisation experienced (retrospective AMP as older workers benefited from innovative solutions through recruitment and deployment to jobs that matched their needs/requests)

Source: adapted from Wallin & Hussi (2011), drawing on the Eurofound database of case studies.

* AMP: age management approach.

Recently, Wallin & Hussi (2011) developed a typology of age management practices, following a secondary analysis of published Eurofound case studies (see **Table 1**). It is based on two dimensions: level of organisational preparedness and age awareness of HR policies. At the bottom of their hierarchical typology the focus is on reaching out to older workers in an effort to tackle the organisation's immediate skill shortages (reactive stance without any age awareness). Further up the hierarchy are approaches concerned with enhancing the older worker's individual resources, while still focusing on decreasing work demands for older workers (a proactive stance seeing ageing as a challenge). The top of the hierarchy forms the life-course approach, a proactive stance accommodating individual requests throughout the life-course.

This article presents the results of recent case study research on good practice of age management, with a particular emphasis on sub-sectors relevant for the scope of this journal. Following a brief overview of the research aims and methods of the study, examples of good practice in five age management dimensions are presented in turn, providing additional contextual information for some cases. The focus then turns to age management drivers and outcomes. The article finishes with some insight into longitudinal studies which have examined the impact of extending working lives on the health of individuals and some concluding remarks.

The ASPA study: research aims and methods

Conducted as part of the 'Activating Senior Potential in Ageing Europe' (ASPA) project, the case study research aimed to identify, assess and analyse examples of good practice organisations implemented in order to promote the retention, recruitment and employability of older workers and more widely all workers as they age. The fieldwork was conducted during 2010/11 in eight European countries – Germany (DE),

Denmark (DK), France (FR), Italy (IT), the Netherlands (NL), Poland (PL), Sweden (SE) and the UK. The study followed up a number of earlier good practice case studies published by Eurofound or elsewhere, and also targeted additional organisations through a range of sources. Information was gathered through semi-structured interviews with HR representatives or owners/managers in small organisations and trade union or employee representatives, typically on site. Topics covered included details about the organisation, the rationale, development and outcomes of the specific measure(s), if and how the policies or practices had changed over time and the overall age management practice.

The ASPA study draws on a portfolio of 83 case studies. They are considered to be good practice in the respective countries by stakeholders (as evidenced by awards conferred) and/or researchers and range across the typology of age management practices developed by Wallin & Hussi (2011). The focus of these initiatives is typically on older workers (here defined as 50 plus) although the actual target group may vary between organisations, with some initiatives targeting people at an earlier age in order to enhance the person's employability in the longer term.

While the portfolio includes large employers and SMEs from a range of economic sectors, the selection was not intended to be representative (for details see Frerichs *et al.*, 2011).

Sectoral scope

Given the remit of this journal, particular attention is paid to fifteen cases from the health and social care sector (ten cases from five countries) and local authorities (five cases from five countries), which have responsibility for social services and in England for public health at local level (as of March 2013). Cases also include some co-operatives, which are of interest, given the new models of in-house delivery, such as

social enterprises, staff mutuals or co-operatives that may gain more prominence in England through the impact of the Localism Bill. Moreover, the workforces in both social care and the local authorities have high shares of workers aged 50 plus (Hussein & Manthorpe, 2011; Local Government Association Analysis and Research, 2010), therefore these case studies have a particular relevance for active ageing.

Results are presented for five age management dimensions in turn: (i) recruitment; (ii) training, lifelong learning and knowledge transfer; (iii) career development and mobility management; (iv) flexible working practices; and (v) health promotion and workplace design. However, these dimensions are not entirely clear cut as there can be some overlap between them. These were the five dimensions most often found in the case studies of health and social care organisations and local authorities. Similar findings emerged among the overall portfolio of case studies, although here initiatives concerned with employment exit and the transition to retirement were more prevalent than recruitment measures. **Table 2** shows the measures found among the case

studies as a whole and **Table 3** lists the core cases covered in this article.

While the interview topic guide contained questions about the gender dimension of the measure, the data are in fact too patchy for an analysis. Information on the participation in the measure by gender could be inferred, where the respective organisation has a female or male dominated workforce (e.g. social care), but not where it is more gender balanced (e.g. local authorities).

Rather than being named, case studies will be referred to using a combination of the country acronym, the case study number and the sector in which they operate (e.g. UK03 Care).

Recruitment

Seeking to re-enter the labour market at an older age often poses significant challenges (see e.g. Green *et al.*, 2012) as may changing employers in later life. Research on employer policies has also shown that there is a greater focus on retaining older workers than on recruiting them (Loretto, 2010).

Table 2. Overview of the case studies per dimension of good practice

Number	Dimension	Number of cases
1	Job recruitment	30
2	Awareness-raising, changing attitudes and diversity	20
3	Training, lifelong learning and knowledge transfer	59
4	Career development and mobility management	40
5	Remuneration	2
6	Flexible working practices	45
7	Health protection and promotion and workplace design	45
8	Redeployment and retention	25
9	Employment exit and the transition to retirement	37
10	Comprehensive approaches	15

Source: Frerichs *et al.*, 2011.

Table 3. Overview of the case study organisations in the health and social care sector and local authorities: background details and type of measure

Organisation	Legal form	Branch of economy ¹	Size ²	Dimension of good practice ³	Long-standing case ⁴
DK04 Care	Public	RCA	29	2, 3, 4, 6, 7	No
DK09 Care	Public	RCA	90	2, 4, 7, 9	Yes
FR06 Care	Public	RCA, SWA	102	1, 3, 4, 6, 7	No
IT01 Care	Non-profit co-operative	SWA, RCA	350	1, 6	Yes
IT03 Social	Non-profit co-operative	SWA	101	1, 3	No
IT08 Social	Non-profit co-operative	Other SWA	13	1	Yes
PL07 Co-op. A	Co-operative	SWA	7	1, 2, 3, 6, 7, 8	Yes
UK03 Care	Public	RCA	67	10	Yes
DK07 Hospital	Public	HHA	128	6, 7	Yes
IT11 Hospital	Public	HHA	1,871	3, 9	No
DK06 Municipality	Public	Public Administration	284	6, 7	No
DE03 Administration	Public	Public Administration	1,440	2, 3, 4, 6, 7, 9, 10	Yes
IT05 Municipality	Public	Public Administration	1,540	1, 6, 8	Yes
NL12 Municipality	Public	Public Administration	483	3, 4, 5, 6, 7, 9	No
UK10 Council	Public	Public Administration	8,100	10	Yes

Legend:

¹ Number of employees

² RCA: residential care activities; SWA: social work activities; HHA: human health activities

³ See Table 2 for the list of numbered dimensions

⁴ Measure(s) in place for more than three years.

Coding to this category of age management practice either meant that organisations had age-neutral recruitment policies or practices in place, or aimed at attracting (more) older people in response to different drivers. While larger organisations may have written equality and diversity policies, including some relating to age, and procedures supporting it, e.g. requesting date of birth for equality monitoring purposes only, smaller ones may be more likely to have relevant practices than policies, unless they are part of a larger organisation (e.g. UK03 Care). Some organisations were still recruiting substantial

numbers at the beginning of the economic downturn, including older workers (e.g. UK10 Council, where 14% of those recruited within the last 12 months were aged 50 plus).

An example of a recruitment initiative that is part of what Wallin & Hussi (2011) termed a life-stage age management approach is UK07 Call Centre. Having a predominantly younger workforce, the company aims at increasing its mature workforce (50 plus) from currently 8% to 10% through innovative recruitment campaigns, targeting people at both ends of the age spectrum (rather than primarily the

young) through different recruitment channels, while also working to improve the appeal of call centre work through better career development opportunities. Moreover, the company is also attracting mature people through its work with an intermediary organisation helping people back into work, including unemployed people seeking a career change, with job-related training being offered pre and post recruitment.

Other organisations sought older unemployed people and retirees because they found a pool of labour that was well suited to meeting the organisation's immediate skill needs. The co-operative IT01 Care, for example, has recruited older unemployed people and retirees since its establishment in the early 1990s when the labour market was tight. Initially, it offered older nurses (mainly women) management posts in care homes on a part-time basis and thus flexible work they had failed to find elsewhere. Since the initiative led to positive outcomes (including reduction of sickness absence rates), the organisation started to employ mainly older men (often on low retirement incomes) as tutors for young people and those with mental health problems.

Some organisations were set up by older people helping themselves (and others) to pursue paid work they had failed to find elsewhere (PL07 Co-operative A and IT08 Social, also a co-operative). While these initiatives generated paid work, much of it was work that is typically low paid, such as care services or cleaning. However, the Polish co-operative also offered other benefits as it acted as a support network for its members who were all women who had been affected by serious illness. The women, it was argued, would have faced great difficulties returning to the regular labour market due to the combination of age, gender and health status.

A different type of example, more akin to a remedial active labour market policy, is IT05 Municipality. Following a regional lead by the Council of the Autonomous Province of Trento, its initiative was designed to help

combat social exclusion and prevent poverty in old age by offering some of its temporary jobs to unemployed people aged 55 and those who need a few more pensionable years to enable them to reach retirement age by the end of the three-year fixed-term job. In total, twelve people, mainly women and all selected on the basis of their skills, were recruited through the initiative during 2006-10. The recruits were reported to be highly motivated, with some also having experienced improved (mental) health. While the initiative was deemed to be successful in this respect, no cost-benefit data were available.

Training, lifelong learning and knowledge transfer

Training and lifelong learning is pivotal to the extension of working lives where fast-paced changes devalue skills within ever shorter periods of time and people may need to embark on new careers in order to adapt to changing circumstances. There are concerns though that older workers are 'overlooked' (Loretto, 2010, p.285) primarily due to stereotyping or cost-benefit considerations.

A range of case study organisations asserted that they provided training and lifelong learning opportunities irrespective of age. Some organisations offered particular measures to help increase employability more generally through an individual training budget to facilitate career development (e.g. NL12 Municipality), or more specifically to enable people to take on jobs that are better aligned to their changed capabilities, extending employability in the long run, for example through innovative ways of job rotation.

Others offered specific training to support organisational changes or restructuring, or gave financial assistance to employees to upgrade their skills at times when qualification requirements are changing. While such opportunities may be limited, they help to improve employability during mid and later life, as they strengthen the skills

base and facilitate job mobility. For example, when FR06 Care, a former hospital for older people was converted to a care home for older people, a diploma for care staff became advantageous to improve one's career. Financial support was offered to employees who were encouraged by the manager to take part in training and overall at least seven people had registered, with four having been awarded the diploma in 2009. The one-year training course option, widening skills and offering more opportunities for job mobility, was preferred by younger people whereas middle-aged people tended to opt for the course based on professional experience as they were reported to be less keen on examinations.

A special case is IT03 Social, a co-operative established to offer employment opportunities to disadvantaged groups. It encourages employees, including older workers, to engage in lifelong learning, particularly in completing qualifications they may have abandoned earlier in life, while supporting them through a range of measures, including financial incentives and flexible working hours. It was acknowledged that improved skills benefit the organisation but may also lead to external mobility. Following the initial success, there was reported to be scope to increase the uptake of training further.

Developing mentoring roles is an area of interest across occupations (including health and social care) as it allows for a two-way knowledge transfer within the organisation - with the younger worker benefiting from the experience of the older worker and the latter from the recent training and the new skills of the former. It may also provide a temporary break from physically demanding jobs. Taking an example from another sector, formalising the mentoring role, with support from trade unions, led to increased job satisfaction and morale among mentors, and was also a cost-effective way for the company to train staff (P01 Shipyards).

Career development and mobility management

Career development is usually paid particular attention during the early stages of working life, yet it needs to be kept under review throughout the life-course to facilitate adaptation to changing circumstances or capabilities. Some older workers may be looking for opportunities to downshift, while others are still searching for promotion opportunities (Smeaton *et al.*, 2009). There is also some evidence in adult social care that among those who would like to progress, older workers were just as interested as younger people (Rubery *et al.*, 2011).

In France, companies have begun to respond to new legislation requiring companies with more than 50 employees to improve the recruitment and retention of older workers through action plans in specified areas (Jolivet *et al.*, 2011). In addition to other measures, career development is being paid more attention with some case study companies beginning to establish career reviews for people aged 45 or 50 and older. This provides an opportunity to assess (future) skill needs aligned with the employee's plans for the years ahead in an effort to reverse an early retirement mentality. Most of the French case studies had an element of career development although measures were at an early stage. Similarly, organisations in other countries are putting or beginning to put more emphasis on individual development plans for older people (e.g. DK09 Care).

Opportunities for career development in nursing that involve taking on less physically demanding tasks while building on the specific skills and experience of (older) people are explored elsewhere (Jahn & Ulbricht, 2011; Roundtree, 2012). Designing new jobs to suit changed capacities of (older) workers was firmly on the agenda of one social care organisation at a time of staff shortages, but activities later on somewhat stalled due to budget deficits and organisational changes (DK09 Care).

Flexible working practices

Flexible working is an area many case study organisations are aiming to facilitate to improve the work-life-balance of employees or in response to health problems when requests meet with business needs. Some may have flexible working policies in place (covering a range of options, e.g. UK10 Council) or may offer additional flexibility informally, including working from home on occasions. Other organisations, where flexibility is more difficult to implement, may offer employees the opportunity to take a maximum number of additional days leave instead of hourly reductions of work or implement self-rostering.

How flexible working is best facilitated may differ between organisations and sectors. UK03 Care, a public sector care home, offers different contracts, but otherwise the same terms and conditions, for in-built flexibility. So-called relief contracts offer guaranteed number of hours with the option of taking on more hours and this is an option older workers may prefer, although some may be effectively working full-time. There were also specific examples of (older) employees who were granted requested changes in working patterns that suited their specific situation. At DK04 Care, a small care home, offering part-time work on request is part of the manager's retention strategy for older workers, along with other measures, such as providing scope for competence development (e.g. mentor training), interesting tasks and an engaging human resources management approach. Denmark is also a special case as it offers health and care workers in municipalities the choice between the allocation of additional government funded leave (four days at age 58, rising to six days at age 60) or an equivalent financial reward; at DK04 Care older people had a clear preference for the former.

Partly depending on the countries' welfare system, part-time work can be supported or discouraged due to the financial implications it has for the person's pension. An example of

the former is an organisation from another sector, which offered older employees reduced hours while continuing to pay full pension contributions. However, it has since developed a modified model (reduction to 30 hours for five years following five years tenure) that is age-neutral and was reported to be popular both with older workers and those with small children (DK01 IT). In contrast, at IT05 Municipality, where people aged 55 have been offered preferential access to part-time jobs on request for many years, take up has been very low, largely because pensions are based on the final salary before retirement.

Health protection and promotion and workplace design

A range of health promotion measures in these case studies benefited the entire workforce, while some organisations may offer (additional) measures targeted at older people. Depending on the industry sector, measures adopted in the case study organisations included a combination of some of the following:

- prevention of injuries or work-related illnesses and sickness absence through health and safety training (including refresher courses); using available equipment to help reduce the physical demands of the job and monitoring its compliance; investment in new equipment, or ergonomic measures leading to better working conditions;
- promoting the take-up of healthier lifestyles, e.g. through information on diseases and what individuals can do to prevent or alleviate specific illnesses; subsidies for sports activities; offering voluntary health check-ups; or,
- providing specific support to reduce musculoskeletal tensions or stress (e.g. massage or physiotherapy; counselling in crisis situations or addressing mental health issues).

In care homes, particular attention was paid to health and safety and preventing work-related injuries (DK04 Care, DK09 Care, FR03 Care and UK03 Care) by using existing - or purchasing new - moving and handling equipment (e.g. hoists, electronic profiling beds), while also monitoring compliance with health and safety regulations. At UK03 Care, the manager was supported by the local authority's occupational health department when long-term sickness occurred. There is recognition though that, while these measures help to reduce risks, some significant risks remain (e.g. pushing and pulling).

Health promotion can also be encouraged through external stimuli. For example, UK10 Council signed up to the Scottish Government's strategy aimed at improving the health of the workforce and has achieved the highest award, demanding a firm ongoing focus on health promotion issues.

Health measures may, however, need to be offered in conjunction with other measures in order to maintain effectively the work ability of (older) employees. At DE03 Municipality, the ageing of its workforce as well as health issues among older workers (50 plus) - who constituted about one third of its workforce - led to a particular course of action. Assessing the current situation, through an age structure analysis, an employee survey about work ability and employability and self-checks, provided pointers for action in a range of areas. This included health promotion, with one priority being a workplace and risk analysis and the need for new ergonomic furniture to replace outdated stock. The step-wise implementation of measures was taking place against tight budgets.

Age management drivers and outcomes

Policies and practices of age management are developed and adapted over time in response to the organisation's internal and external environment. In order to capture such journeys the ASPA project introduced the concept of 'pathways of practice', reported elsewhere in more detail (see Frerichs *et al.*, 2011; Frerichs *et al.*, 2012). Drivers of age

management policies were found to be more reactive than proactive. An example of the former are responses to immediate recruitment or retention problems, and an example of the latter, assessing the need for a strategic response to an ageing workforce or a potential future shortage of skilled workers.

While in some cases policies have been developed top-down, in many others a participative approach - involving key stakeholders, including older workers and trade unions - has been crucial to the success of the measure. A number of organisations have also recognised the need to sensitise management to the needs and requests of an older workforce (e.g. DK09 Care) or to offer support for managers on request (e.g. UK10 Council). Wider ranging initiatives took time to develop, adapt and embed, and some case studies, particularly in Germany, benefited from external consultancy. Naegele & Krämer (2002) found in their work that, while models of good practice of age management were useful for organisations, solutions needed to be developed in response to the particular circumstances and challenges the organisation was facing.

There has been a shift in a number of organisations from a policy for older workers to an age-neutral life-stage policy, driven by concerns over age discrimination or insight gained that retention measures need to be improved across all age groups (e.g. at DK06 Municipality through work-life balance and skills development measures). Moreover, there was also an explicit recognition among some managers that older people are a diverse group with different interests and needs. Also, the badging of measures as those for older people led to a low take-up in some cases as particularly the younger cohort among this group felt stigmatized or not affected. In a similar vein, Timmons *et al.* (2011) in their US study on good practice advocate a 'universally designed workplace' that suits people of all ages.

Age management measures had some success in facilitating the extension of working lives.

This can be illustrated using particularly striking examples. UK10 Council introduced its flexible retirement policy in the middle of 2000 in an effort to become an employer of choice and also with demographic changes in mind, and now has 2% of its workforce working beyond the age of 65. When management at a case study organisation in another sector (DK05 Construction) became aware of negative attitudes towards older workers, the measures put in place to address this led to a substantial increase of older workers staying with the company for longer (estimated to be 10% – 20% five years after the initiative began).

Working longer and the impact on health – some results from the literature

The above focuses on how some organisations have sought to enable older workers to prolong employment, but what would be the impact on physical and mental health in later life if measures designed to extend working lives were indeed successful? The case studies were not designed to provide such answers. While it seems straightforward to ask this question, few longitudinal datasets exist that would allow us to answer it. Moreover, those that are available tend not to capture the dynamics of *changing strategies* in the light of circumstances that differ from earlier expectations. This final section encompasses a brief account of some pertinent evidence deriving from recent UK and US quantitative studies that are based on longitudinal data of individual activity and health.

Seeking relevant evidence, it is quite natural to turn to the US in this context because of the quality of their data, as exemplified by the Health and Retirement Study. Mandal & Roe (2008) and Zahn *et al.* (2009) provide evidence of some health benefits from extending working lives before and after retirement respectively, although their studies are based on earlier periods (1992 up to 2002), and the results of the latter study may not be directly transferable to the UK due to differences in social security systems.

Mandal & Roe (2008) showed that involuntary job loss among older Americans (particularly women) has a negative impact on their mental health. However, re-employment was shown to help to regain their previous level of mental health, after controlling for a number of variables.

When investigating the growing phenomenon of bridge employment in the US, Zahn *et al.* (2009) found that those who engaged in a bridge job (i.e. paid work after retirement before complete withdrawal from the labour market) and those who continued to work in their job experienced fewer major diseases and functional limitations, compared to those who retired fully. However, only those who worked in a career-related bridge job and, less so, those who continued to work in their job, experienced better mental health than those who fully retired. Those with a non-career related bridge job, the authors suggest, may not benefit from improvements in mental health because they had to adapt more or were working more for financial rather than other reasons. Results had been controlled for the individual's health before retirement and the number of working hours.

Somewhat more limited evidence exists for the UK. An analysis of the Whitehall II study - a large-scale longitudinal survey of civil servants working in London - by Mein *et al.* (2003) found no differences in physical health between people aged 54-59, who were still working about three years later, and those who retired at age 60. However, improvements in mental health were found among the retired group - albeit only for those at the highest levels in the occupational hierarchy. It was thought that the removal of work-related demands and stress at a time of substantial reorganisation played a role. In a later analysis of the Whitehall II study, covering a 15 year period, Jokela *et al.* (2010) found that mental health and to (a lesser degree) physical functioning of voluntary early retirees and statutory retirees was better compared to those still working at age 60 - while at age 65 differences in mental health

had disappeared due to the improved mental health of those still working.

These studies indicate that factors that influence how health outcomes turn out include experience of unemployment or redundancy in later life, or the nature of the work in relation to previous occupation/career or the reasons for extending working life beyond what was apparently intended.

Concluding remarks

Case studies presented in this article are not intended to be representative but rather to be suggestive of the measures and initiatives which organisations in eight European countries have introduced to facilitate the recruitment, retention and employability of older workers. The particular emphasis has been on health and social care organisations and local authorities within a wider portfolio of cases encompassed by the overall project.

Age management measures that emerged in the social care sector with its physically demanding jobs included age-unspecific health promotions to prevent work-related illnesses and opportunities to reduce work demands temporarily or permanently. This was facilitated by responding positively to requests for part-time work or by finding individual solutions when capacities change, either at the time when it was occurring or more in anticipation as part of regular staff development talks. An important measure to help retain older care workers was through opportunities for competence development - while respecting preferences among some employees for minimal engagement in training. In one small care home the culture and environment was a particularly important factor that fostered the retention of older workers, demonstrating that, contrary to some expectations, smaller care organisations can have better HR practices than larger ones (see Rubery *et al.*, 2011).

The case studies in local authorities are rather too diverse for many commonalities to emerge. However, local authorities across the

five countries shared an ageing workforce, operated in a tight financial environment and were more likely to foster a life-stage or comprehensive approach.

Overall, age awareness was an important issue that emerged in a number of case studies: awareness of managers to the requests and needs of an ageing workforce and awareness of the individual in terms of opportunities and challenges in later life.

Finally, while some quantitative studies based on longitudinal data show that there are benefits of working later for the individual's health, the evidence is more mixed than its advocates might like it to be.

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Home care services for older people: findings from a national survey of social care commissioners

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Abstract

This paper explores local authority commissioning and contracting arrangements for home care, staff training opportunities and the range of services provided for older people utilising data from a national postal survey with a 74 per cent response rate. Local authority provision focused on intermediate care services. Joint commissioning of this with health was common but less likely for specialist mental health services. Most home care was commissioned from and provided by independent sector providers with contractual requirements identified as a means of influencing and monitoring training opportunities. A range of services were provided for users, additional to personal care. Local authority training was sometimes available to independent providers, focused on statutory requirements rather than user needs. Implications for the development of high quality services are discussed in terms of user need, service flexibility and training for staff providing direct care. It is suggested that within the commissioning process key drivers of the development of more personalised high quality home care services are: regular dialogue with service providers; greater health and social care involvement in a joint commissioning process; alignment of contracting arrangements to reflect service outcomes; and specification of training requirements within the setting and monitoring of home care contracts.

Keywords: personalisation, older people, domiciliary care, quality

Introduction

Personalisation and related constructs have been identified as a cornerstone of the transformation of public services in England. For users in receipt of home care, this requires that services are of high quality and promote independence, wellbeing and dignity and that they have choice and control over how that support is delivered (Cm 8378, 2012). To promote the latter guidance has required that the allocation of resources to individual users become a more transparent process. Personal budgets were identified as the mechanism to achieve this (Department of Health, 2008). Responsibility for the construction of the associated care plan may be with the older person or a family member, who receive a cash payment and negotiate with providers directly about the assistance they require. Alternatively, a professional

may do this on the user's behalf. Thus home care providers operating within the contractual framework provided by local service commissioners are challenged to respond to both care managers' commissioning services on behalf of users and carers and direct requests from users, or family and friends acting on their behalf.

Home care services have long been part of the fabric of the Welfare State with their development characterised by evolutionary change in response to national policy initiatives, local circumstances and existing service configurations. In 1971 responsibility for their planning and provision was transferred from the public health department to a social services department within local government. Increasingly these services were caring for a more disabled and frail clientele; providing help with activities of daily living

rather than domestic assistance; and assistance at weekends and evenings as well as during the day. In short, more intensive personal care provision for people as an alternative to admission to residential or nursing care. It was recommended that the home care service should change to one which was more professional, flexible and targeted. To achieve this required both the revision of the core tasks undertaken and the provision of training for home carers (Department of Health and Social Security/Social Services Inspectorate, 1987). The community care reforms confirmed the commitment to enabling people to remain at home and receive the care they need to maximise their independence if possible and the development of home care services was integral to this (Cm 849, 1989).

Following the recommendation of the Griffiths report (1988) that local authorities should become 'enabling agencies' focusing on the commissioning of services rather than their provision, home care has become increasingly but not exclusively provided by the independent sector, with planning about its scale and content within the remit of the commissioning function undertaken by local authorities (Cm 849, 1989). The subsequent introduction of the concept of *Best Value* into local authority commissioning and contracting processes, also influenced the relative balance of home care provided by the independent and local authority sectors and the development of specialist services. *Best Value* was defined as 'a duty to deliver services to clear standards – covering both quality and cost – by the most effective, economic and efficient means available' (Cm 4169, 1998, p.113). These principles provided an incentive for local authority sector home care provision to focus on specialist services such as those for older people with mental health problems. Another incentive for the development of specialist home care services, together with a more general requirement for their development, was provided by the *Fair Access to Care Services* guidance. It confirmed the duty placed on councils to have services in place to meet eligible needs, with

the caveat that specialist services for groups of users, such as people with mental health problems, should be developed where there was justification for such (Department of Health, 2002). Subsequently, local authorities have been required to demonstrate an investment in prevention, early intervention/re-ablement, and provision of intensive care and support for those with high-level complex needs, including older people with mental health problems (Department of Health, 2008; 2009a; 2009b). The facility for commissioning to be undertaken jointly with other agencies was established subsequently influencing the development of specialist home care services (Cm 4169, 1998). Mechanisms to promote this and joint service provision were enacted in 2000 – pooled budgets, lead commissioning and integrated provision - endorsed by subsequent policy guidance and legislation (Cm 4818-I, 2000; Cm 6499, 2005; Cm 6737, 2006; Cm 8380, 2012). Key areas for the joint commissioning of specialist home care related to old age mental health services, particularly for services users with dementia, and within the intermediate care sector, for patients discharged from acute hospitals (Department of Health, 2001; 2003; 2009a; 2009b). The aim of this paper was defined in this context: to explore commissioning arrangements for home care services for older people. More specifically:

- How and what types of services are commissioned?
- To what extent are training opportunities specified within the contract setting process?
- What services are available from home care providers?

Method

Findings from a postal survey of English local authorities undertaken in 2008 are described. Its purpose was to explore the nature of local authority commissioning and contracting arrangements for older people's services. Approval was received from the Association of Directors of Adult Social

Services Research Group and the university research ethics committee. Following the initial distribution of the questionnaire, non-respondents were contacted twice by telephone and replacement questionnaires were sent. The principal respondents were service commissioners although some were operational managers or had project management responsibilities.

The development of the questionnaire was informed by a relevant, purposive review of policy and literature. In the former there was an emphasis on developments following the White Paper: *Modernising Social Services: Promoting Independence, Improving Protection, Raising Standards* (Cm 4169, 1998). The inclusion criteria for the latter are specified in **Table 1**. In addition, meetings were arranged with senior managers in two local authorities to develop a greater understanding of the issues relating to the interrelationship between commissioning, contracting and care coordination arrangements. Questions were constructed that related to these three domains of activity, focusing particularly on home care services and care home provision for people aged 65 and over, including those with mental health problems. The format of the survey was structured, with some opportunities for respondents to provide additional comments. Both are incorporated into the findings and discussion. Some data is presented in the form of figures and tables and some solely as text.

Findings

Almost three-quarters of English local authorities returned completed questionnaires.

Commissioning and contracting arrangements

Nearly all authorities (92 per cent) commissioned older people's home care services and about half (49 per cent) commissioned specialist services for older people, including those for ethnic minority groups or with specific health conditions

including dementia. A significant investment in joint commissioning with commissioners of primary care services was also reported in respect of intermediate care and old age mental health services. Over three-quarters of authorities jointly commissioned home care with their local primary care service to facilitate early supported discharge from hospital (78 per cent) and rehabilitation at home following illness (77 per cent) and four fifths to prevent hospital admission (80 per cent). On the other hand, just under a third of authorities (32 per cent) jointly commissioned specialist home care services for use within old age mental health services. Thus, whilst joint commissioning of home care services with the NHS was a feature of the intermediate care sector, it was less likely to be so within old age mental health services. Developments within the intermediate care sector reflected implementation guidance which accompanied the *Community Care (Delayed Discharges etc.) Act, 2003*. One of its principal aims was to encourage the development of new services to facilitate patient transfer to community settings which promote independence or prevent unnecessary hospital admission (Department of Health, 2003).

A large proportion of home care services were provided by the independent sector. Just under three-quarters of local authorities (71 per cent) allocated over 60 per cent of their expenditure on home care to independent providers, with nearly two-fifths (37 per cent) allocating over 80 per cent. **Table 2** provides details of local authority contracting arrangements for independent sector home care. Home care was most likely to be purchased using a fixed term contract, most typically two to three years in length. Roll on contracts and those of duration of up to a year were less common. Other types of more flexible arrangements were derived from the coding of 'other' response categories, and therefore possibly underrepresented, but included spot purchase and cost and volume contracts.

Table 1. Literature review: inclusion criteria

Participants/ service recipients	Primarily older people (65+) ¹
Service	Community-based social care ² or social services including intermediate care and old age mental health services
Location	United Kingdom
Dates	Data collected after 1991
Design/study type	Any empirical study
Focus of study	Commissioning, contracting and care management arrangements for older people

¹ Relaxation of this inclusion criterion to include all adult groups for Direct Payments and Individual Budgets due to the newness of these concepts and their centrality to the study.

² Social care was defined as services provided, commissioned, funded or facilitated by the lead social services agency in the locality.

Table 2. Contracting arrangements: independent sector domiciliary care

	No.	%
Length of contract (n=104)		
Up to one year	5	5
Two to three years	54	52
Four years and over	45	43
Type (n=103)		
Fixed term	74	72
Roll on	20	19
Flexible arrangement	9	9

Whilst under two-fifths of authorities (37 per cent) did not have a block contract for independent sector home care, just over two-fifths of respondents (41 per cent) reported block contracting for more than 60 per cent of the home care hours purchased from this sector. This suggests that where block contracts were in place, this tended to be for the majority of home care provision. Differences in contract types are important, as it is reasonable to consider that fixed longer term contracts for a specified level of service associated with block contracting might provide more stability for providers and their employees. This may encourage investment in the training of care workers, and permit the provider to commit to planning patterns of staff deployment over a longer time frame. The challenge, however, is to promote staff training within the contracting framework and responsiveness to user need at the point of service delivery, both of which are identified

as important in the provision of more personalised care (Cm 8378, 2012).

Many local authorities indicated that they were anticipating changes to existing contracting arrangements, with the implementation of Self Directed Support cited as the main reason for this. The most frequently reported changes were moves towards outcome based contracting for home care and more flexible contracting arrangements to respond to the personalisation agenda. More specifically, the latter was expected to be achieved in time by a move from cost and volume or block contracting, towards more flexible forms of contracting: the use of approved or preferred provider lists; framework agreements; or the use of individual placement agreements or contracts. It was also noteworthy that a number of respondents anticipated greater involvement of primary care and housing

departments in contracting for home care; possibly contingent on these organisations' involvement in the commissioning process.

Training

In this section, data is reported that relates to the training opportunities for staff providing direct care to users in a variety of settings: home care services and care homes in both the independent and local authority sectors. Nearly all local authorities reported that they provided training to these staff groups. It is important to note that whilst detailing the provision of training, we have no measure of the extent to which home care workers, and particularly those in the independent sector, are able to attend such courses. Neither do we have data on training offered by independent sector providers.

In general, data in **Figure 1** suggests a much stronger local authority focus on training that is organisational, often fulfilling statutory requirements for example safeguarding adults or health and safety, rather than needs focused, such as the care of an older person with Parkinson's disease, or diabetes. Each type of training separately was more likely to be provided to local authority staff compared to those working in the independent sector. However, overall, whilst just over half of authorities (53 per cent) provided more of their training courses to local authority staff, in two-fifths these were equally available to local authority and independent sector care workers.

One means by which local authorities can potentially influence the uptake of available training for staff employed by independent providers is by making this a contractual requirement. The contract could, for example, stipulate specific training requirements which might be provided by the employer or sourced from an alternative organisation such as the local authority, a college of further education or a specialist training company. Two findings are of note in this context. First, **Figure 2** provides details of specifications in contracts relating to the training of home care

workers. Authorities were most likely to specify induction and training for new staff and staff development and appraisal. Least likely to be specified were specialist training in the care of older people with dementia and rarely was it also specified that employers should pay staff to attend training courses. The latter in particular may be an important factor influencing uptake of training amongst home care workers. Second, the most frequently reported area of review in the monitoring of home care contracts with the independent sector was staff development and training. Over four-fifths (82 per cent) of respondents specified this within their overall monitoring of human resources policies. The inclusion of specific requirements within contracts relating to staff training are important because they provide an impetus for providers to enhance the skills of their workforce and a set of formal criteria against which the performance of their organisation can be monitored.

Service focus and delivery

In this section, there is a dual focus. First, data from a strategic commissioning and contracting perspective are reported and second, data relating to service delivery are explored both in terms of the range of provision and the manner in which it is commissioned on an individual basis. The former represents the framework for the provision of more personalised care and the latter a measure of its development.

Additional to their generic provision which focused on the provision of care to older people in general (98 per cent), most local authorities in England reported that their home care services were within the intermediate care sector (84 per cent) and old age mental health (91 per cent) services. Around a fifth of local authorities (21 per cent) reported other foci including: services for specific ethnic groups; extra care housing; support to carers; and palliative care. In terms of the balance between independent and local authority provision, **Figure 3** reveals that all of these services were more likely to

Figure 1. Training availability by service sector (minimum n=100, maximum n=101)

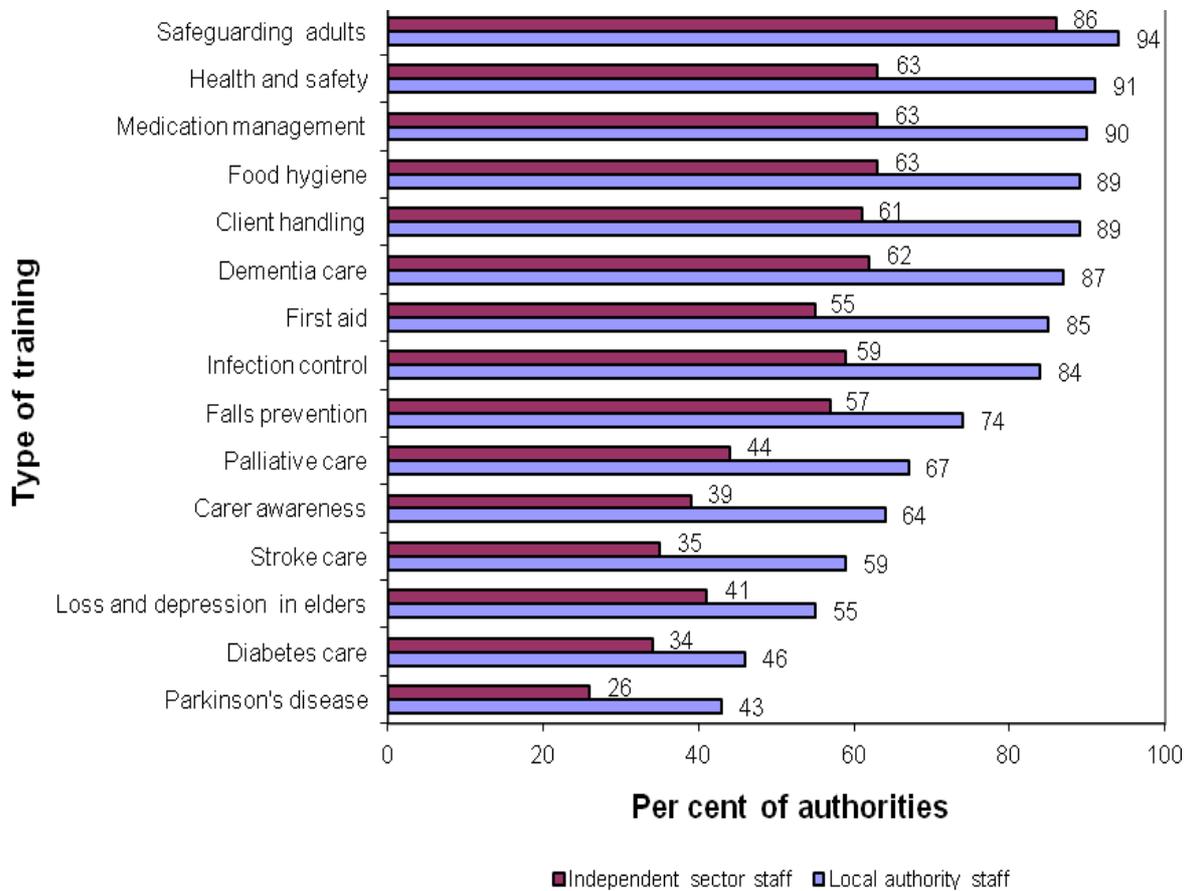


Figure 2. Contracting for domiciliary care: training specification (n=102)

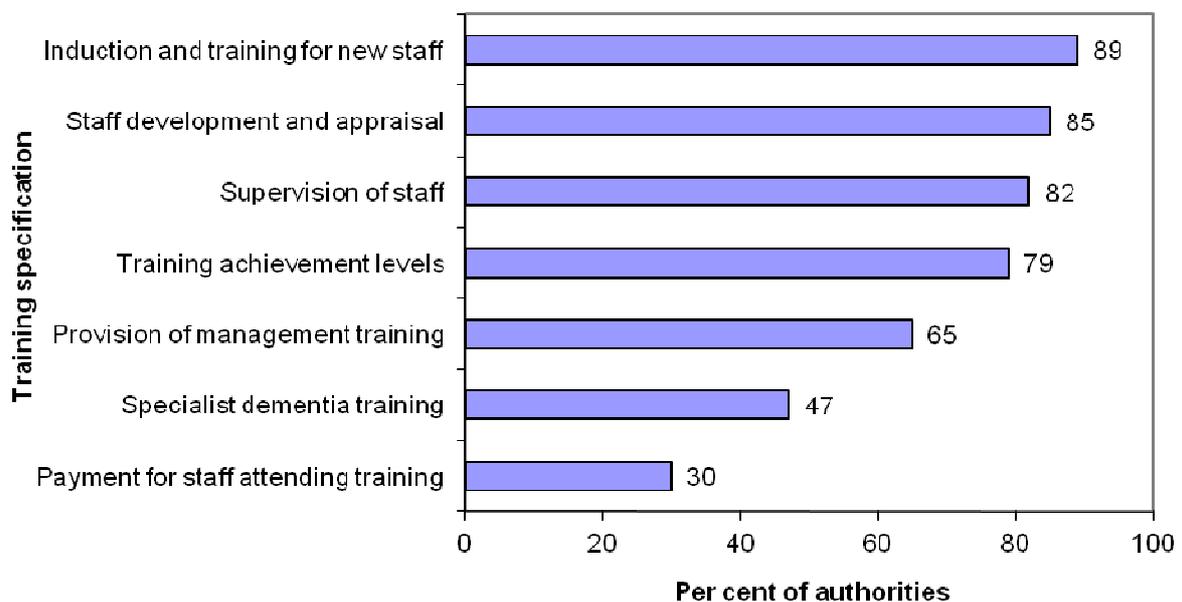
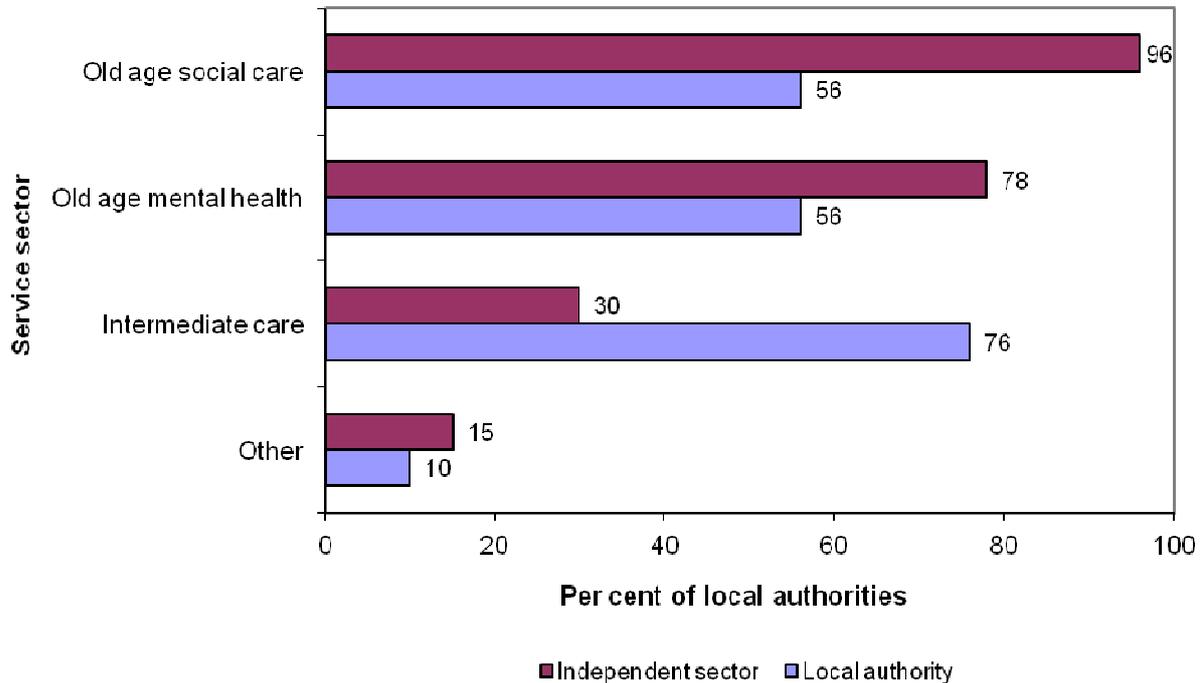


Figure 3. Foci of domiciliary care services (minimum n=101, maximum n=105)

be provided by independent care agencies, with the exception of those provided within the intermediate care sector. The latter has become the dominant area of activity for local authorities.

Nearly all authorities (95 per cent and 98 per cent respectively) reported that their local authority and independent sector providers were available daytime on weekdays suggesting that both sectors were equally likely to be providing care during this time period. By comparison, around four-fifths (79 per cent) reported that independent sector providers were available at night, and just over half of authorities (54 per cent) reported that the local authority home care service was available at this time. This implies that local authority providers were less likely to be providing night time care, which may be a reflection of this sector's specialist focus on rehabilitation within the intermediate care sector noted above.

The range of tasks undertaken by home care providers in addition to personal care is an indicator of the extent to which services are responding flexibly to individual needs.

Table 3 reveals that, as well as personal care, local authority or independent sector organisations were most frequently contracted to provide: assistance with meal preparation; shopping; and help with housework; and that these were much more likely to be provided to older people than to support informal carers in their role. The range of tasks that home care workers are expected to undertake is important, as some will require different skills to others. This may imply that workers need to be trained to do specialist tasks, or that home care providers require a workforce with a diversity of skills to meet their contractual requirements. For example, providing care to an older person, thereby offering the principal carer respite from the task, may require different qualities or skills, compared to helping an older person living alone with practical tasks for daily living.

In terms of responding flexibly to individual need, the manner in which services are commissioned for service users at the point of delivery is likely to influence the requirements for home care services specified in the contracting process. This is explored from two perspectives: the capacity of care

managers to commission services and the extent to which local authorities had arrangements in place to permit the flexible use of finance. First, only a quarter of local authorities had arrangements whereby care managers were able to commit finance to and/or allocate local authority provided services to implement a care package, without consultation with a first line manager. Second, just over a fifth of local authorities (22 per cent) reported that they routinely used bespoke arrangements to access care; examples of these were individual budgets and vouchers for carers. However, it is not clear from these data the extent to which these initiatives complement, or substitute for, home care provided through a service commissioned by the local authority and provided, for example, through a block contract. Nevertheless, together these findings provide an indication of the extent to which authorities have the capacity to tailor services to meet the specific needs of older people and their carers. They constitute a measure of the extent the provision of personalised care since they are indicators of the extent to which service users have choice and control over how that support is delivered (Cm 8378, 2012).

Discussion

This paper has provided data relating to local authority arrangements in England for the commissioning and contracting of home care services; the availability of training for 'hands on' workers; and the range of services

provided by independent agencies and local authorities. It was collected through a self completion questionnaire. A disadvantage of this approach is that responses may reflect the pre-coded choices presented to respondents rather than their actual knowledge of these arrangements (Bowling, 2002). Furthermore, the findings solely reflect the perspective of local authorities and the ways services are commissioned and contracted continually evolve in response to policy and practice guidance. With regard to the latter the rollout of personal budgets and the emphasis on the promotion of dignity and respect in the care process have been particularly important (Cm 8378, 2012). Finally, it is relevant to note that in the time which has elapsed since the survey was conducted the current period of financial austerity will have influenced the development of the home care service. Nevertheless, these data represent the views of almost three-quarters of the local authorities in England and provide an overview of home care services at a point in time. In the remainder of this paper the significance of these findings are appraised in a context in which the number of people cared for at home is expected to continue to increase with a consequent increase in the provision of home care services (CQC, 2013a; Cm 8378, 2012). It will explore the extent to which the survey findings provide insights into the main drivers for change in relation to the strategic commissioning of home care in pursuit of quality services tailored to individual need.

Table 3. Range of domiciliary care support (n=93)

	Older person		Carer	
	No.	%	No.	%
Shopping	72	77	41	44
Housework	60	65	38	41
Help with meal preparation	86	93	36	39
Teleshopping	17	18	13	14
Sitting service/respice care	5	5	9	10
Laundry	4	4	3	3
Medication prompting	3	3	1	1
Transport	1	1	1	1

Who are the principal recipients of home care?

In the management literature it has long been recognised that the segmenting and differentiating of mass markets leads to more specialised services replacing a single dominating service response (Normann, 1991). Whilst previously local authorities lacked the necessary information and infrastructure for segmentation analysis of the home care recipients, there are signs of this emerging within the service commissioning framework associated with the focus on specific groups of those with substantial needs (Department of Health, 2002). In terms of case-mix, the evidence below suggests that the needs of older people for home care fall predominantly into three groups. It is estimated that there are more than 570,000 people in England living with dementia (Department of Health, 2009a) but there is little information on the use of social care services by people with this condition. Although people have not received a formal diagnosis it is reasonable to assume that a substantial proportion of service users in receipt of home care have a degree of cognitive impairment (Challis *et al.*, 2007; 2011; Moriarty & Webb, 2000; Sutcliffe *et al.*, 2008). These constitute the first broad group who frequently require long-term support to enable them to remain in their own homes. Over and above this there is a second group comprising older people with a diagnosis of dementia and their carers who are in touch with specialist old age mental health services. There is evidence to suggest that to retain their community tenure they require specialist home care support (Challis *et al.*, 2009). However, it is only comparatively recently that the specialist needs of this group have been explicitly recognised in policy guidance (Department of Health, 2009a). Patients on discharge from hospital constitute the third group of older people with specialist home care needs. The provision of appropriate care for at home for this group and avoidance of premature admission to long-term care is a longstanding concern (Audit Commission, 1997;

Department of Health, 2001). Research has demonstrated that the provision of home care has effected a small, but significant, reduction in hospital days (Hughes *et al.*, 1997) and, for older people with undifferentiated clinical problems, support on discharge from hospital has been reported to reduce admission to long stay care (Hyde *et al.*, 2000). Typically, such provision is now located within the intermediate care sector and there is some evidence of the efficacy of these services (Cm 6737, 2006).

Evidence from our survey indicated that home care provision was aligned with intermediate care and old age mental health services suggesting that substantial resources are invested in meeting the needs of frail older people with multiple health problems and this has been confirmed subsequently (CQC, 2013b). Furthermore, other research suggests that undiagnosed morbidity is likely to be a significant component of their presenting problems (Challis *et al.*, 2004). To provide care in a timely and appropriate manner requires arrangements that permit a flexible response in terms of time and task, and a knowledge base which permits interpretation and understanding of presenting behaviours and problems. The creation of such a culture within home care services is arguably one of the biggest challenges to the implementation of the personalisation agenda (Cm 8378, 2012). Whilst our survey reported the extent to which training was prioritised within the contract setting and monitoring process, it did not provide evidence of the training opportunities afforded to home care workers.

How might a more personalised service be provided?

It was anticipated that the introduction of arrangements which permitted older people and carers to assume responsibility for their own care plans and direct negotiations with home care providers would impact on local strategic planning processes (Fernández *et al.*, 2007; Glendinning *et al.*, 2008). Commissioners were required to take account

of this and develop and deliver a strategy for home care which demonstrated both an investment in preventative services alongside those focusing on re-ablement following illness and the provision of long-term intensive care and support for older people with complex needs (Cm 8378, 2012; Department of Health, 2008). This study provided evidence of how service commissioners might promote the development of home care services to respond to these requirements. First, a number of respondents identified strong relationships with independent providers, including those from the third sector, and collaboration between providers of home care when invited to comment on the strengths of their current commissioning arrangements in free text at the end of the questionnaire. The importance of this has previously been noted in the literature (Ware *et al.*, 2001) and more recent guidance has emphasised the importance of commissioners and providers working in partnership to achieve the necessary changes in service provision that personalisation requires (Department of Health, 2009c; TLAP, 2012). Second, survey respondents identified joint commissioning or partnership working arrangements with local primary care commissioners and housing departments, as an area in which they had made progress, and which would assist in the transition to personalised care services, reflecting policy guidance (Cm 8380, 2012; Department of Health, 2008; 2009b; 2009c). However, the survey data indicated that at present joint commissioning was predominantly within intermediate care services and to a lesser extent, old age mental health. This suggests some progress with respect to an integrated approach to service commissioning for home care in advance of substantive guidance but also scope for further development (Cm 8380, 2012). Third, respondents demonstrated an awareness that decisions relating to length and type of contract were important in the development of more personalised home care services in advance of guidance relating to this (Department of Health, 2009c; TLAP, 2012). Comments of respondents in the free text at

the end of the questionnaire suggested that block contracts with home care providers might be an impediment to greater flexibility in response to individual circumstances. Experience of introducing more flexible contracting arrangements will enable local authorities to be well placed to respond to the forthcoming NICE standards for the quality of home care (Cm 8378, 2012). However, when the survey was conducted block contracts were employed by a majority of authorities.

How can commissioners promote quality services?

The quest for quality in social care services is enduring and has particular importance for home care services as they are required to demonstrate a flexible response to individual need as part of the personalisation agenda (CQC, 2013a; Cm 849, 1989; Cm 8378, 2012). Part of the vision for adult social care services in the 21st century is that they are of high quality, and delivered by a well-trained workforce, whether provided by the local authority, the NHS or another type of provider (Cm 6499, 2005; Cm 7432, 2008; Cm 8378, 2012; Department of Health, 2009d). However, survey findings indicated that whilst most provided home care services within old age mental health services and the intermediate care sector training opportunities for staff working in these settings were limited. Our findings are limited to services commissioned by local authorities but present a mixed picture in respect of specialist training for home care workers within the old age mental health and intermediate care sectors.

First, with regard to the provision of specialist dementia care training, whilst **Figure 1** indicated that was widely available, **Figure 2** indicated that its provision was less frequently specified as a requirement within the contracting process. The discretion accorded to providers with regard to the provision of specialist dementia training is of concern in the light of findings from a study of a similar sector of the workforce in care

homes. This revealed that although staff knowledge of dementia was reasonable, confidence in dealing with related situations was lower, although training could positively influence confidence in dealing with behaviour related with the condition (Hughes *et al.*, 2008). Arguably, such training would be even more valuable to home care staff who often work in isolation with users in their own homes, particularly those employed in those home care services specially commissioned to provide support for older people with mental health problems. More generally it has been noted that when home care staff understood people's illnesses they were better able to provide appropriate support and that training may aid the recruitment and retention of care workers thereby promoting a higher standard of care for older people (CQC, 2013a; Chester *et al.*, 2013).

Second, despite the fact that the majority of local authorities commission home care specifically to provide intermediate care, our data suggests that the training needs associated with this appear not to be reflected in the commissioning and contracting processes for home care, perhaps because they are not as readily identified as, for example, the need for dementia care training. The exception to this is the provision of training on the care of stroke victims, but this does not fully address the multiplicity of needs likely to emerge from home care staff providing care to vulnerable older people with undifferentiated clinical problems. Contract monitoring by commissioners is additional and complementary to the regulatory role of the *Care Quality Commission* but it has rarely been addressed in either policy guidance or literature. However, it provides a means of dialogue to overcome the often reported barriers to staff in independent home care agencies accessing training and the setting of realistic staff training targets (Balloch *et al.*, 2004; Francis & Netten, 2004; Timonen & Doyle, 2007). The monitoring of this is important because it can be construed as an indicator of the development of a more personalised service.

Our findings suggest that the degree of detail in contracts may provide the basis for their monitoring and for a more adequate ongoing dialogue between the commissioner and provider. This would permit local performance to be benchmarked against the national picture with regard to, for example, the provision of induction training, an important but often neglected issue (CQC, 2013a; Skills for Care, 2012).

Conclusion

In this paper findings of a national survey of commissioning arrangements for home care are reported. These are placed in the context of previous evolution of the service and plans for future development as identified in national policy guidance. Arrangements for commissioning and service delivery will have evolved in the interim. Nevertheless, the implications of the findings remain relevant because they provide a benchmark of practice at the inception of the changes designed to promote more personalised services and, in the context of this transformation agenda, evidence of commissioners anticipating policy directives. This momentum is a good omen for the continued service development which has characterised the home care service over time. Furthermore, study findings suggest that four aspects of the policy agenda relating to the commissioning of home care services are particularly important and could usefully be a focus of attention for commissioners. First, the development of partnership working between health and social care agencies to promote a more integrated approach to service commissioning around a local authority or clinical commissioning group (Cm 8380, 2012). Second, the specification for and monitoring of the uptake of training by hands on care staff within the contracting framework (Cm 8378, 2012). Third, greater involvement of providers within the commissioning and contracting processes (Department of Health 2008; 2010). Fourth, commissioners should regularly appraise their contracting arrangements for home care. This should include the review of the type of contract

employed and take account of nationally determined social care outcome measures (Department of Health, 2012). For the regulators, the research findings highlight the importance of ensuring that appropriate training is available to ensure service user needs are met by competent staff. Prior to the introduction of the community care reforms, there was an acknowledgement that community care was not a cheap option and twenty years later, this remains the case (Griffiths, 1988). An enduring challenge for the public sector is to provide value for money and respond to ever increasing demands for assistance both in terms of content and quality of the home care services which it commissions.

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Reviews

Exploring Concepts of Child Wellbeing: Implications for Children's Services

Axford, N.

Bristol: Policy Press, 2012, pp.272

ISBN: 978-1447305859, £19.99 (pbk.)

Many professional disciplines have jargon unique to them; a complete dictionary of phrases and meanings which are job-role specific. But what happens when disciplines overlap? When professions share some common technical language and also rely on everyday phrases to convey complex meaning? Professionals who work with children are in just this position in relation to 'child wellbeing'. Nick Axford's book, *Exploring Concepts of Child Wellbeing: Implications for Children's Services* unpicks the definition of child wellbeing in a strong mix of theoretical constructs and evidence based research.

Axford's book, based on his PhD thesis, follows a logical progression – defining child wellbeing, exploring the different professional 'lenses' through which wellbeing is assessed and measured, and then reflecting the implications of his findings for children's services. In reviewing this work it is important to establish the author's intended audience or audiences – Axford informs us that he is aiming at those who make individual level decisions about '*the need and desirability of intervention*' and also those who are responsible for '*how resources are distributed*' (page vii). So, an audience of practitioners, managers and politicians – a wide audience indeed (even without including multiple agencies). Despite accessible language, in my view, the structure of the book sometimes struggles to fully reach elements of that broad audience.

The five concepts offered as constituent elements of understanding and measuring 'wellbeing' (needs, rights, poverty, quality of life and social exclusions) are, however, well explained in Part 1 of the book. Axford

explores the political and legislative forces which influence the need for social care, education, health and related professionals to identify, assess and provide for the complex needs of a child and his or her family. 'Quality of life' is particularly well defined, and the inherent subjectivity of assessment acknowledged. Given that Axford is striving to reach practitioners as key members of his audience, a helpful additional dimension to the theoretical discourse would be case examples to illustrate the application of theory to the delivery of services and subsequent impact on children's lives. This illustration is very successful during the reporting of the research findings, where case examples positively remind the reader of the 'real children' involved in assessing 'child wellbeing'; and a similar approach in the analytical chapters would significantly increase accessibility.

Analysis of needs-led service delivery (e.g. pp.142-143) is argued well, and successfully challenges traditional service provision models. This is followed by robust theoretical explorations of the concepts of upholding rights and tackling poverty.

Two further strengths of the book are the comprehensive literature review and the thorough description of the research methods used in Axford's chosen evidence base: a study of children and families, primarily on an ethnically diverse inner-city housing estate in a London borough. However, though welcome detailed results are given, the interview schedule used in this research is not included in the book. The latter approach reflects current increased emphasis on using empirical, tested evidence in informing policy and practice decisions, both on a national level (for example in the rigorous evidence base behind the Health and Social Care Quality Standards produced by NICE), and on a local level, exemplified by judges expecting comprehensive evidence-based court statements. A minor disappointment is

that the research data are from 1998 – 2003, and the literature review ends in 2006. With a publication date for the book of 2012, these choices risk it being seen as outdated. This is particularly important as the ‘implications for children’s services’ are continually influenced by external forces, such as changes in government (and associated) policy, and increased learning regarding types of abuse and exploitation (e.g. child sexual exploitation), which can affect how we view ‘child wellbeing’. Further, the research sample is small (689 children and families) and acknowledged as not representative of England and Wales; subsets within it appear questionable (for example, a very small percentage of potentially troubled children with a recognised mental health problem).

The joyful expression of life, depicted with coloured filters on the cover of the book, and representative of the author’s description of the ‘lenses’ through which we view child ‘wellbeing’, highlights that most children have a positive experience of childhood, inconspicuously supported by universal services. However, ‘ill-being’ necessarily takes the focus in protection work, both at a policy and practice level, and therefore dominates the discussion in the text, drawing out the impact of neglect and abuse, and perhaps inadvertently skewing the balance for a backdrop of universal service delivery.

In my view, this book has earned its place as a valuable social care text. However, to better fulfil its second aim of highlighting implications for children’s services (and thereby influencing service delivery and outcomes for children), the production of an executive summary including apt case examples would widen audience appeal and strengthen the impact of the key messages. A recent example is a six page summary of work by ONS on children’s wellbeing: this has been distilled to a level that busy practitioners will read, yet is still evidenced by background research and has hypertext links to technical documents¹. In such a summary, all of Axford’s five concepts (and their role as useful ‘lenses’ with ‘which to

view and understand child wellbeing’, p.183) would need to be sharply in focus, as he argues, so that policy makers, managers and practitioners can use them all to refine service delivery and improve outcomes for children.

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¹ Beaumont, J. (2013) *Measuring national wellbeing: children’s wellbeing*, accessed at: www.ons.gov.uk/ons/dcp171766_304416.pdf

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Transition to Adult Services and Adulthood for Young People with Autistic Spectrum Conditions: Final Report Working Paper no: DH 2525

Beresford, B., Moran, N., Sloper, P., Cusworth, L., Mitchell, W., Spiers, G., Weston, K. & Beecham, J.
York: Social Policy Research Unit, February 2013, pp.193
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Available as a download from:
<http://php.york.ac.uk/inst/spru/pubs/2371/>

This research was carried out in five English local authority areas. The localities were self-identified as having developed proactive multi-agency transition planning services for young people with autistic spectrum conditions, so providing a basis for case-studies of services which were presumably beyond a minimum level. The research followed an earlier study of disability and complex health needs in some of these localities, but was not itself longitudinal.

68 managers and practitioners were interviewed: about two thirds of those approached, with education staff the largest group (14) followed by 8 from non-statutory ASC (autistic spectrum conditions) organisations and 7 from Connexions. An intended counterpart to the organisational

studies, on experiences of transition by parents and young people, and the costs and outcomes for young people, suffered from low response rates (25% and below) and lack of financial data, despite the researchers' 'persistence'. Fieldwork was undertaken in the summer and autumn of 2010, when the Act was new and the Strategy unpublished. Administrative difficulties did not help, including practical issues such as one agency's failure to send documents to their service users with the correct postage.

Of those family members interviewed (36 from 67 eligible), most (30) were mothers of young people with autistic spectrum conditions (ASC), High Function Autism (HFA) or Asperger's Syndrome (AS).

Young people with ASC, with and without learning disability, were investigated in terms of the different support mechanisms that exist; and the common needs of both groups were examined – needs that cannot be met by learning disability services on their own. How the young people had coped with this pre-transition stage was conveyed through the voices of the young people themselves, although high functioning autistic young people and those with Asperger's Syndrome were predominant. The voices of young people with both ASC *and* learning disability were not really represented: this is a weakness, as those with learning disability can in practice self-advocate to some degree.

Common issues (as in previous research) include the lack of advice to parents of young people with ASC during transition, a lack of local options - especially post-school, a lack of meaningful daytime opportunities; a lack of transition support workers with the specific skills to deal with complex transitions and work closely with families. The five transition services in the study showed examples of some things done well, and of instances where services could learn from each other. Three services had produced Transitions DVDs, giving information for families and young people. Nevertheless 'Information sharing across the sample of

managers and practitioners appeared to be dependent upon personality rather than research site, role or agency' (p.69). The five services were markedly different from one another in respect of young people with HFA or AS, for example in service eligibility, and in types of support offered, such as outreach. There were fewer service differences for those young people with learning disability who also have AS.

From a largely qualitative study one is not surprised that 'personal experiences, individual circumstances and the individual practitioners involved with the young person seemed to have a greater impact rather than wider authority policies or practices' (p.73).

Positive and negative examples were cited by parents in factors in planning for leaving school - having a key contact; timely inclusion of transition planning in annual reviews; a reliable transfer of discussion to action; feeling informed and advised about suitable post-school options; services working collaboratively; schools actively preparing the young person; the post-school options available; school exclusion. Overall, about two thirds of parent respondents were not satisfied with the transition support they had received. Looking at those students entering college, it appeared eight of the 13 who had left college had not proceeded beyond their first year.

Direct transfers of responsibilities between different services appeared problematic. A minority of ten parents reported some social care (children's or adults') support, and five a direct transfer of support from children's to adults'. Their experience of the transfer was predominantly negative. Issues were: the loss of a 'key worker' role; the shift from proactive to passive service support; the unsuitability of care environments in adult services; and identification of mental health as the main need.

Autism strategies are being developed locally. At the same time, and noted in the report, the Connexions service has been closed – though,

as reported, its provision was very variable. The overall policy picture conveyed is that there are complex challenges, but suggested responses could include low-cost solutions, taking cross-agency views on cost-effectiveness, low intensity support to parents and young people, and more creative and longer term person-centred planning.

Writing myself as a parent of a young person with ASC and learning disability who has suffered from poorly planned transition, I see real strengths in this report which struck many chords. The quotes from the young people themselves cite special problems, that need thought-out solutions. All learning and motivation is linked to our emotions, and changes should happen at the young person's pace, with less pressure on achieving all markers. The research explores transition to a new placement. In evidence to the All-Party Parliamentary Group on Autism the Royal College of Psychiatry suggested the appropriate transition strategy was to build up familiarity with new people and a new place, before staying on a trial basis¹.

However, my son's experience supports the claim by a residential school to the same Inquiry that 'It is impossible to enable a successful transition if placements are decided at the last minute, (or even later!)'². Another issue mentioned in the research is college breakdown. Being able to attend college one day a week prior to full time college attendance could reduce the likelihood of this, as suggested by a parent to the All-Party Group. Partnerships between schools and colleges could be encouraged, with planning from age 14; and I would like to see working examples, prompted by this study, as commissioners need examples to develop better models.

Comments in this study from the young person who was 'not ready to fly the nest', and from those who want normalising experiences, and/or want continued parental support, in my experience also apply to those with ASC and learning disability. My son enjoys going bowling, to the cinema and to

restaurants, along with peers with ASC and learning disability, together with same-age peers without ASC, who are actually support workers.

I look at this report, in conjunction with the Autism Act 2009 and Autism Strategy 2010, and feel that we have good enough research evidence to prevent many crises in young people's lives that drastically affect outcomes for them, their families and public expenditure. Informed action is now the imperative.

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¹ Allard, A. (2009) *The All-Party Parliamentary Group on Autism: Transition to Adulthood - Inquiry into Transition to Adulthood for Young People with Autism*, London: APPGA, p.5.

² *ibid*, p.5.

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Critical Perspectives on User Involvement

Barnes, M. & Cotterell, P. (eds.)
Bristol: Policy Press, 2012, pp.296
ISBN: 978-1847427502, £26.99 (pbk.)

This comprises contributions from academics in the field of research into health and social care issues and from 'service user activists'. The 37 named contributors include seven who identify themselves as service users, and 22 who are associated with universities. The book was prompted by a conference, held in Brighton in April 2009 and thus before personalisation policy had taken root. There is a general introduction and five page linking introductions by the editors, which supplement the 18 chapters by contributors. There is a brief, mainly autobiographical, conclusion by the editors.

The book represents an attempt to provide a stock-take of the state of service user

involvement, though its orientation is firmly to adults and to health care; and claims that it has moved 'from margin to mainstream'. The term 'service user involvement' is 'used to describe processes where the views and priorities of service users inform the delivery of services and/or research' (p.57). The book could therefore be seen as filling a gap: user involvement has been argued for and discussed over the years with relatively little theoretically informed critical engagement with the available empirical evidence. (This same general point was being made 20 years ago in the pages of *Research, Policy and Planning*, reporting on a study of Hampshire Social Services¹.) It is in three parts, with the first giving a potted history of service user involvement, and briefly describing a number of distinct service user movements. The subjects range from the local (Nottingham Advisory Group – mental health service users) to cancer services, via *Shaping Our Lives* – a national service user controlled network and organisation. The contributions are from those active in the various organisations, and tend to be brief narratives plus concluding reflections.

A more productively critical perspective would have been generated by inviting contributors to develop and differentiate the acknowledged elements of service users' experiential knowledge, addressed only at the end of this first part, in Chapter 5, and later in Chapter 11.

In the second part of the book there is an examination of 'user voice' within service delivery, and how it could change the status-quo within services. This again is quite selective, and omits any mention, for example of experts by experience – service user participation in inspection activity in health and social care. This part too tends to be descriptive. Those responsible for the Wiltshire Service User Network, draw for example on its annual reports to supplement their personal narrative. There are exceptions, though. Chapter 9 offers advice, based on a leadership development programme, on employment practice with people who have

used mental health services. That is, practice if they are engaged to undertake recruitment of staff, training, service monitoring and evaluation or service user-led research, where according to the authors 'the usual professional considerations should be applied' – though 'with additional respect for and sensitivity to the experiences that have led to their service use and involvement activity' (p.116). However, this part of the book skirts the most fundamental point. This must be the acceptance by the established social services of the fact that there will be a lot of negative experience of these services as delivered. (A contribution on NHS service planning, development and evaluation by Staniszewka *et al.* in Chapter 10 does provide evidence on this point in drawing on a systematic review of literature.) In order to change and adapt to personalisation, established services are necessarily going to have to learn and cope constructively with criticism of negative experience. The very nature of personalisation is dynamic, so for instance, what may be considered an outcome by a professional is not necessarily considered an outcome by a service user, still less a positive outcome.

The third part of the book (81 pages) mostly provides a snapshot of research, though with two chapters on the impact of involvement in research.

All of the research cited and described in this part of the book is participatory, mainly small-scale research. It ranges from young mothers, and young people in public health research, to local Age Concern collaboration with the University of Brighton. This type of research can often be mistrusted by service users, as it pays lip service to the issues that they face day after day. This is because the service users are typically given minimal input into the design, the ethics and methodology of the research. The research enquires into the what, when and where of particular issues and processes, but not how the issues make the service user feel, or affect their daily life. This in turn reflects differential power relations in research, which

are not extensively analysed in this part of the book, though touched on, for example, in Staddon's contribution (Chapter 16) on her own research in the NHS on women's alcohol use and its treatment. This includes a criticism of research publication criteria imposed by the local NHS funder. This part also raises wider issues about involvement policy. Should there be attempts to measure the impact of service user involvement? Chapter 17, based on the experience of Folk.us in Devon, cautions against ascribing measurable content to the different activities, within different contexts, that constitute 'involvement'.

One must ask: who is this book aimed at? If the readership is to be health practitioners and social work managers or practitioners, then it should carry a caveat, as this part of the book mainly concerns health research. Similar considerations apply if, as the publisher asserts, the book is aimed at social work students and presumably their teachers. In this situation it should not be used in isolation, but with additional and more recent social care material, for example, on children and young people's involvement, and derived from publications of the School for Social Care Research. The wider context could also draw from some examples of participatory research in related other fields, for example in using an advisory group of service users. (For instance, Lewis, A.L., Davison, I.W., Ellins, J.M., Niblett, L., Parsons, S., Robertson, C.M.L., Sharpe, J. (2007). The experiences of disabled pupils and their families, *British Journal of Special Education*, **34**(4), pp.189-195; Porter, J., Parsons, S., & Robertson, C. (2006) 'Time for review: supporting the work of an advisory group', *Journal of Research in Special Educational Needs*, **6**, pp.11-16.)

If the book is aimed at a service user readership, as opposed to the publisher's 'service user activists', then it is fundamentally flawed. To a service user such as me it is patronising in tone and heavy with jargon, and the limitations of its origins in an academic conference are all too clear.

Perhaps, to be more positive, before another 20 years have elapsed *Research, Policy and Planning* will carry another article on service user involvement *after* personalisation, reflecting changed patterns of research design, execution and communication styles.

Reference

¹ Lupton, C. & Hall, B. (1993) 'Beyond the rhetoric: from policy to practice in user involvement', *Research, Policy and Planning*, **10**(2), pp.6-11.

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Residential Care Transformed: Revisiting 'The Last Refuge'

Johnson, J., Rolph, S. & Smith, R.
Basingstoke: Palgrave Macmillan, 2012,
pp.304
ISBN: 978-1137265692, £19.99 (pbk.)

Julia Johnson, Sheena Rolph and Randall Smith have written a lovely book from a great study. They revisit Peter Townsend's (1962) classic *The Last Refuge: A Survey of Residential Institutions and Homes for the Aged in England and Wales*. Townsend set out to question the future of residential care through a comprehensive study largely based on visits to residential providers and residents during the late 1950s, supplemented by national statistical information on homes and institutions in England and Wales, interviews with 65 chief welfare officers in local authorities, and reports and diaries kept on the experience of working or living in a handful of homes. This was the most significant study of social care at the time in the UK. Many years later the study data were deposited in the UK Data Archive. In revisiting the data Johnson and colleagues set themselves some important research questions:

- What kinds of homes are able to continue to function from one decade to another?

- What events have precipitated closures?
- As one generation of residents and staff succeed another, what kinds of adjustments and adaptations help to sustain continuity?
- And why do policy makers and members of the general public remain ambivalent about care home provision?

These are important questions: not only because of their academic originality, but also because they encourage debate and a much needed wider perspective to the policy noise that often surrounds social care for older people.

Residential Care Transformed is organised into three parts. Chapters in the first part describe Townsend's original study, the historical and changing context of care. The authors are keen to point out that the study revisited Townsend and did not seek to replicate. The approach was unique, and drew on a team of some 100 volunteer researchers to trace the original care homes from Townsend's sample of 173 homes.

The analysis presented in part two of the book thoroughly compares and contrasts the findings over the past fifty years. Five chapters explore the characteristics of the 37 surviving and the non-surviving homes, the people who lived and worked in the homes, the living environment, people's daily lives, and care quality.

A lot of attention today is focused on the operation and development of care markets. The book provides valuable insight into how these markets are developing in the long term, and comments on their limitations. By tracing the original homes we learn about the factors shaping survival - only one in four homes survived from Townsend's study. Those homes that tended to survive were largely run by voluntary sector providers.

Readers familiar with residential care today will recognise the changing demographics of both residents and staff described in the book. Residential care offers more personal and

complex care than in the past and this is changing the nature of residential care and those who work in it. So too is the business of social care changing traditional job roles. Managers today, for example, spend less time providing frontline care than they did in the past, and much more on administration and business activities. Interestingly some of the trends in provision are leading to a more institutional feel for residential care than in the smaller private and voluntary homes of the past. Similarly, insights are given into how the built environment, space, rules and routines have changed considerably. Homes are much more accessible; but they have grown larger, employing more staff, with attention to factors such as health and safety, and this book suggests that some of the homeliness and informality of earlier residential care is being lost.

Chapter 8 describes applying Townsend's original measure of quality and the published judgements of the regulator (the Commission for Social Care Inspection) at the time of the revisit in 2005-6 to 20 of the 37 surviving homes. It is clear that the quality of care has generally improved over the last 50 years. However, some of the inequalities and restrictions on everyday activities that Townsend identified still persist today. The authors are justifiably cautious about there being evidence of a substantial improvement in residential care over the last 50 years.

In part three of the book there are two strong concluding chapters. The first reflects on methodology and approach, including research governance issues and the use of photographs of residents. The second focuses on the findings and the implications of the study, in juxtaposition to other recent research on residential care for older people. Overall the messages in the book present a mixed picture of the state of residential care in England and Wales. But the current text is much more positive about residential care than Townsend's original study. Indeed, Townsend started with the question 'Are long-stay institutions for the elderly necessary in our society, and, if so, what form should

they take?' (p.3) Townsend used photographs strongly in order to support his critique. 18 of his 31 black and white photographs were of former Public Assistance Institutions (PAIs), though these constituted only just over one quarter of the homes visited. The use of photographs from both study periods is vividly illustrative of the constantly changing world of social care.

There is no book like this, and there is lots here for providers, commissioners, policy makers and those interested in the lived experiences of people using care services to draw on and reflect upon. The book is well written throughout and takes the reader on a journey; in part historical yet contemporary in analysis. In the intervening year between hardback and paperback publication the book won the British Academy's Peter Townsend Policy Press Book Prize. And quite rightly so. It is an excellent book and I commend it.

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Understanding Research for Social Policy and Social Work: Themes, Methods and Approaches

Becker, S., Bryman, A. & Ferguson, H.
Bristol: Policy Press, 2012, 2nd edition, pp.430
ISBN: 978-1847428158, £24.99 (pbk.)

Social Research Methods

Bryman, A.
Oxford: Oxford University Press, 2012, 4th edition, pp.766
ISBN: 978-0-19-958805-3, £33.99 (pbk.)

With over 80 contributors this second edition of *Understanding Research for Social Policy and Social Work* (hereinafter Becker *et al.*) is much expanded compared with its first, doubling its number of contributions. It is published in association with the Social Policy Association, though little is made of this link in the text. It also shares an editor

(Bryman) with the author of a major text book explicitly for social science students, which is now in its fourth edition.

This review (of Becker *et al.*) concentrates on those parts most related to social services policy and social work, though *Social Research Methods* (hereinafter Bryman, with 766 pages, compared to 430 pages of Becker *et al.*) often has more extended treatment of specific methodological topics. It also addresses some of the newer issues raised in student research.

The seven chapters of the structure of Becker *et al.* form a logical sequence. First research and evidence for social policy and social work, then ethical conduct and research practice, followed by formulating research ideas – though ethical conduct might seem important in formulating ideas too.

Chapter 4 provides a route through methodological issues and debates, followed by separate chapters on quantitative and on qualitative research. Chapter 7 concludes with a discussion of research impact and knowledge transfer. Further reading is included within each of the many subsections of chapters. Within the chapters there are numbered sections, and within those sections there are often text boxes (by different authors) on specific topics. The general index copes quite well with this ordering of material, omitting some name references apparently only in Chapter 6; but the layout encourages dipping in rather than extended study. It is only a step from an electronic text with active hyper-text links. Perhaps the next edition?

For content, the academic or practitioner reader might expect textbook material to be accurate, authoritative, up to date and non-polemical. These requirements are generally met, though there is no mention of the Mental Capacity Act and its implications in the chapter on ethical conduct, so the box on gaining informed consent and other elements of the section, and box 4h in Chapter 4 need to be amended. (The issue is similarly absent from Bryman.) The national Social Care

Research Ethics Committee is discussed, in a box by Pahl, and it is regrettable that the different box illustrating confidentiality in research practice is written solely by researchers who undertook research on babies through children's social services, from the early part of the last decade – research which was not without unacknowledged design flaws, as well as having to run the perceived and criticised gauntlet of ethical approval. The claim that compliance with the approval process is becoming increasingly complex and prolonged rests upon a citation from a member of the same research team. One of Bryman's student examples (p.145) goes further, and illustrates deliberate avoidance of NHS ethics procedures in a study of childhood vaccinations, by approaching instead self-help organisations where there was apparently no formal process of assessing the ethics of prospective research.

A more general limitation in Becker *et al.* is that of space, with text in bite-sized chunks of two or three pages, and the bibliographical listings almost as long as the relevant texts. Bryman's publisher has provided an array of online additional material for students and supervisors – podcasts on specific projects, and checklists of what to do and not do in your research project. These are of course scripted, but do give a real-life flavour sometimes lacking from the more austere Becker *et al.* The latter is not so exclusively focused on student research: its section on researching within a budget ranges widely over major funding sources, which might look askance if asked to fund some of the student projects described in Bryman.

The conduct of research within and by local councils and third sector organisations is another lacuna. Research for these authors is an academic activity. The handful of pages in Becker *et al.*'s Chapter 4, on user involvement in research, encapsulate the limitations. A couple of pages by Beresford include the worthwhile point that questions and challenges to user involvement and user controlled research in particular should be put to all research. Four pages later Sempik

summarises arguments and counter-arguments about the value of user involvement, and concludes with the somewhat rhetorical question: 'Are ideological reasons sufficient for involving users in the research process or should it be based on evidence that shows it improves the quality of research?' (p.153)

In the core chapters on methodological issues and approaches examples are predominantly from areas of social policy. The initial extended example of qualitative research in social work is from New Zealand. In contrast the two pages on practitioner research, by Shaw, poses fundamental questions about fluid boundaries between social work research and practice, and he observes almost in passing that practitioner researchers seem rarely to directly involve service users – both groups similarly at risk of marginalisation from the academic mainstream.

In Becker *et al.*'s chapter on quantitative research, a leading example is provided by Baginsky's vivid description of the use of time diaries by (children's) social workers across the statutory, private and voluntary sectors, in gauging their workloads for the Social Work Task Force. This research included the decision not to use a web-based instrument, based on earlier negative experiences. (Becker *et al.*'s de Vaus is guardedly positive about the use of internet surveys in his contribution about 8 pages earlier in the book.)

The chapter on qualitative research, at 87 pages, is the second longest in Becker *et al.* The equivalent is 232 pages in Bryman, which has in addition two thoughtful chapters on mixed methods research. Both in effect acknowledge the well-reported skew towards such research among those undertaking research in social services and perhaps by students. The contributions to Becker *et al.* are resonant, if brief as required by the format, in covering the diversity of techniques and relevant literature. Website resources become mentioned more frequently, though examples of social work research are few and far between here.

Knowledge transfer examples, in the final chapter, do redress the balance somewhat, with a particularly graphic account by White of a study of the Integrated Children's System in children's social care. She concludes 'You must be willing to put your head above the parapet, secure in the knowledge that your findings are robust. You must be prepared to publish outside of the academic mainstream and to contact key individuals directly...' (p.380)

Both of these weighty books have merit as text books for their respective audiences, though they both capture only a proportion of the understandings necessary to strengthen student and non-student research in social services and social work.

It might be worth recalling that Research Governance leads in 27 councils in England commissioned work from Bangor University a few years ago specifically to strengthen their ability to *review* social care research methods in projects submitted for approval. The results were subsequently made available as a training manual¹.

Reference

¹ Iphofen, R., Krayner, A. & Robinson, C.A. (2009) *Reviewing and Reading Social Care Research: from Ideas to Findings*, Bangor University.

Paul Dolan

Reviews Editor
RPP

What are SSRG's objectives?

- to provide a network of mutual support and a forum for the exchange of ideas and information on social and health care services;
- to promote high standards in social and health care services research, information, planning and evaluation;
- encourage collaboration in social, housing and health services activities;
- to develop an informed body of opinion on social and health care services activities;
- to provide a channel of communication for the collective views of the Group to central and local government, other professional bodies and the public;
- to sponsor relevant research and identify neglected areas of research;
- to encourage and, where appropriate, sponsor high quality training in research techniques.

Who belongs?

SSRG is open to anyone who subscribes to the objectives of the Group. Members are drawn from a wide range of professional groups and organisations sharing a common interest in the work of the caring services.

How is it organised?

SSRG is run by an 'Executive Committee' (EC) which comprises elected and selected officers, elected members, co-opted members and representatives from SSRG Scotland, whose principal tasks are to promote the objectives of the group and to co-ordinate its activities.

What does it do?

SSRG publishes a Journal and a Newsletter which are distributed free to all members. It maintains working links with central government departments, the Association of Directors of Adult Social Services (ADASS) and the Association of Directors of Children's Services (ADCS) and other professional bodies and organises an annual workshop on a topical theme in social and health care services research, and occasional day conferences, for which members receive generous discounts on fees. It also co-ordinates the work of Special Interest Groups which provide members with an opportunity to contribute to the formulation of SSRG responses to national policy initiatives and current issues in the social and health care services.

Equal Opportunities Policy Aims

- To ensure that every SSRG member, user, job applicant, employee or any person working with, or in contact with, the organisation receives fair treatment irrespective of their age, colour, disability, gender, ethnic origin, marital status, nationality, race, religion, sexual orientation, responsibility for dependents, political affiliation or membership of a trade union.
- To ensure that the contribution of research, information, planning and evaluation work in social care and health is sensitive to this issue.
- To ensure that SSRG promotes the equalities agenda in all its activities.

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