DEVON OLDER PERSONS' HOUSING STUDY

Old age is no place for sissies – **Bette Davis**
Old age is not a disease, it is strength and survivorship – **Samuel Johnson**
The most common way people give up their power is by thinking they don't have any – **Alice Walker**

A pilot study by the
WHO Collaborating Centre for Housing Standards and Health

THE UNIVERSITY OF
WARWICK

INTRODUCTION

A consortium including Devon Private Sector Housing Group, Plymouth City Council, Exeter City Council, Torbay Council, and Devon Housing Options, commissioned this pilot study, the main objectives of which were to –

- develop a local evidence base to improve knowledge and to inform policy and action with the prime focus on older people strategies within the Devon Local Authorities
- identify the barriers which exist in achieving independent living for older people and the opportunities to provide an holistic approach to housing options through improved and/or innovative solutions to housing needs across all tenures

It was accepted that any recommendations based on the findings should have a reasonably long 'shelf-life'. In particular, it was recognised that in the current economic climate and period of policy change, a negative affect on the provision of services and support provided by the public, the private and the voluntary sectors is highly likely. So the emphasis of the study was on the 'problems' as experienced by those older people who have needed some form of help and assistance to remain 'independent' and in their own homes, and potential 'solutions' to the problems raised.

We are grateful for the help and assistance given by those commissioning this study, and in particular the help given through Eve FitzGerald and Keith Williams of Exeter City Council.

Thanks also to Amanda Winn for help with the analyses. We also thank all those who agreed to be interviewed, those who provided information, and the administrative support from the Institute of Health at Warwick.

Peter Ambrose, John Bryson, Stephen Battersby, and David Ormandy
Warwick University, July 2011.

CONTEXT

AN AGING POPULATION

The 'problems' experienced by older people wanting to remain 'independent' in their own homes will persist and, with an ageing population, will grow in scale. According to Office of National Statistics (http://www.statistics.gov.uk/cci/nugget.asp?ID=949) the population of the UK is ageing. Over the last 25 years the percentage of the population aged 65 and over increased from 15% in 1985 to 17% in 2010, an increase of 1.7 million people. Over the same period, the percentage of the population aged under 16 decreased from 21% to 19%. This trend is projected to continue, so that by 2035, 23% per cent of the population is projected to be aged 65 and over compared to 18% aged under 16.

The fastest population increase has been in the number of those aged 85 and over, the "oldest old". In 1985, there were around 690,000 people in the UK aged 85 and over. Since then the numbers have more than doubled reaching 1.4 million in 2010. By 2035 the number of people aged 85 and over is projected to be 2.5 times larger than in 2010, reaching 3.6 million and accounting for 5 per cent of the total population.

HOUSING, HEALTH AND HOME

A prime function of a house is to provide shelter and refuge from the outside world. It is a physical and psychological envelope enabling individuals to become themselves. The 'house' is the physical structure, and the 'home' is the economic, cultural and psychological structure created by the household. Feeling secure in one's own home, whether owned or rented, gives a feeling of social belonging, and allows the development of supportive and mutually helpful social bonds.

Being able to stay in one's own home is important for a feeling of well-being, a feeling of worth, and maintains the sense of individuality. Losing one's home can result in a range of psychological consequences, as can the fear of being unable to cope and the prospect of having to leave it.

The provision of advice, support, and assistance to help people remain in their own home has major benefits for their quality of life and psychological well-being. It can also have cost benefits to society.

> *"Postponing entry into residential care by just one year through adapting peoples' homes saves £28,080 per person"*
>
> *"We believe the time is right, with the spotlight now on the nation's growing requirements for care services, to recognise the value of housing in preventing the need for institutional care, in easing pressures on the health service and in enabling more of us to "live well at home" as we all grow older."*
>
> Living Well at Home Inquiry: All Party Parliamentary Group on Housing and Care for Older People, July 2011

THE FOCUS OF THE STUDY

The study focused on those older people who need some degree of support to continue to live independently, recognising that the degree of any support needed may rise and fall. What constitutes 'older people' has not been age-defined (although those involved have been at least 60 years old) but rather situation-defined.

The original intention was to interview members of three groups, those who –

a) are approaching the point when they realise they can't manage in their home without support or home adaptations and that such support or adaptation would help prolong their independence
b) have recently been provided with support or home adaptation
c) have recently moved into care

The plan was to get information from group (a) on 'What services or facilities would enable you to prolong your independence?'; from group (b) on 'What services or facilities made it possible for you to continue living in your home?'; and from group (c) on 'What services or facilities would have made it possible for you to continue living in your home?'

For a number of reasons (outlined below), it was not possible or practicable to interview representatives from all three groups. In the end, the interviews were limited to those older people who have had some support and/or adaptation, and because of that, have been able to remain in their own home and 'relatively independent'.

APPROACH

To meet the first objective a brief review was made of some of the relevant literature. However, it became clear that there is considerably more literature and information locally, nationally, and internationally than could be reviewed within the terms of this project, and was decided that it was not appropriate to produce a comprehensive database of material.

However, from the brief review undertaken, and from enquiries made of a number of agencies and organisations at the beginning of the study, it appears that the approach adopted for this study does not duplicate previous work. It is hoped, therefore, that the findings will make a valuable contribution to this topic.

Various people were contacted directly to discuss possible routes to identifying individuals falling within the three groups who could be approached for interview. Agreement was reached with one contact that they would send out letters to individuals who had asked for support and/or adaptations requesting an interview. Unfortunately, circumstances affecting that organisation meant that this agreement fell through. This has caused some delays, however, arrangements were made for the letters to be issued through the commissioning bodies.

Letters drafted were aimed at two groups – those still managing and those who had recently moved out of their home. Reply forms were also drafted, to be returned (by Freepost) for those who agreed to an interview. An additional group was identified – those who have 'downsized' (ie, moved to smaller accommodation) – and interview letters have been sent out to around 30 such individuals. (Copies of the letters and reply forms are included in Annex A.) While there was no response to this second batch of 30 letters, one interviewee from the first batch had 'downsized'.

To ensure relevant basic information was collected from the interviewees in a consistent form, a semi-structured interview schedule was devised (included in Annex A).

REVIEW OF FINDINGS FROM INTERVIEWS

Details of the analyses of the information gathered from the interviews are given in Annex B, but here we summarise some of the findings. The nature of the approach and the characteristics of those interviewed allows for the findings to be illustrated with anecdotal evidence.

A total of 32 households were interviewed, comprising 56 individuals with an average age of just over 73 years. 55% were registered disabled, and 50% were suffering from a long-term illness, many falling into both categories. 22 households had the use of a car, and of these 4 had had adaptations made to the car.

HOUSING

Of the 32 households, 69% were owner-occupied, 28% rented from the public sector, and 3% from the private sector. Half of the households, 16, were in urban areas, and a further 10 in villages – 37% in cities, 12% in towns, 31% in villages, and 19% in rural areas.

All the households wanted to stay in their own home, even though 10 thought their home was too big for them to manage. Of all the households 3 were not sure that they would be able to stay in their home even though they wanted to do so. There were lots of comments such as *'God willing'*, *'As long as I have my health'*, and *'They'll have to carry me out in a box'*. However, many qualified their response by saying that it really depended on the help they were receiving (in particular from their children and grandchildren).

The one person who had 'downsized' had received a £1,000 rent allowance as an incentive and she said that she was delighted with the two-bedroomed bungalow in a small development with a warden service.

14 households had had adaptations, mainly walk-in showers, stairlifts, changes to steps, and grab handles. Most were very pleased with the adaptations, but many mentioned long waiting periods (up to two years in one case). In a few cases, the provision of a downstairs toilet would make a very material difference (the alternative of a commode was regarded as a poor substitute). The majority of these adaptations were carried out with Disabled Facility Grant assistance.

INFORMAL SUPPORT

Friends provided support in a number of ways, including doing small jobs in the home and garden, lifts to the hospital or the doctor, help in emergency situations, shopping trips and general trips out, 'keeping a look out' and painting and decorating. However, only 9 said that friends were very important in helping them stay and in their decision to stay in their own home, and 4 that they were not important at all.

In contrast, of the 24 who had relatives within 30 minutes (by car), 15 said that it was relatives that were very important in helping them stay in their home, and a further 9 that they were of some or a little importance. The relatives, particularly children and grandchildren, provided similar support to that given by friends. They also helped by keeping in close touch by phone, providing some meals, looking after financial affairs, communicating with doctors and other resource people, and with occasional gifts such as a television.

SUPPORT SERVICES AVAILABLE AND USED

Table 1 sets out available support services, and whether the older people knew about, and used, them.

Service	Known	Used
1. Aids and adaptations	25	25
2. Meals Service	2	2
3. Care at home	7	7
4. Ring a ride schemes	0	0
5. Community alarms	3	3
6. Telecare	0	0
7. Search 4 services	1	1
8. Medicines support	1	1
9. Social care re-ablement	0	0

Table 1 – Support Services Known and Used

It seems that, other than adaptations, information on the availability of services that could help and support people in their home is not reaching those who took part in this study. And, there is no reason to suppose our sample is less competent than others to access services if they had known about them – perhaps the reverse, since they responded positively to our letter. As can be seen from the Table, when a service is known about, it is used.

There were two additional services mentioned by the interviewees – Chiropody (by 2) and assistance with completing forms (by 5). These services appeared to have been located and accessed by the interviewees themselves.

SUPPORT SERVICES THAT COULD HELP

Asked what would help them maintain their independence, the following is list of the services and support suggested (not in order of their perceived importance) –

- Advice on benefits and entitlements, and advice on and help with completing forms (this from many respondents)
- Lists of local people who might do cleaning
- Lists of local people who might do jobs around the home and garden
- Knowledge of chiropody services
- Help with accessing veterinary services (pets were seen as very important companions)
- Companionship
- Help with managing medication (particularly the need for more legible labelling and instructions)
- More flexibility in the Meals on Wheels service (such as for weekends only)
- Sensible placing of things in the home (such as energy supply meters and fuse boxes)
- More generally available shopping online with deliveries
- Police advice on what to do when ‘con men’ come to do jobs

- A personal alarm for everyone living alone or who needs one for other reasons
- Advice on maintaining indoor heat to right level
- Exterior lights to make trips to the dustbin safer

While the current bus services in Devon were felt to be very good among those with no access to a car, several mentioned that wheel-chair friendly buses would make a huge difference.

DISCUSSION

It is important to acknowledge that those interviewed cannot be considered a representative sample of older people in the Devon area. The prime reason being that the individuals contacted were all known to the commissioning bodies. This means that the interviewees had already made enquiries or received help. One implication of this is that there are probably many older people in the area who may need help and advice, but are unaware of the services available. We suggest, therefore, that this report under-states the scale of the problem.

The impression gained from the interviews was that it was the informal support from relatives that was the most important factor in the decision to stay (25 of the 32), even though one person reported that they remained independent despite advice to the contrary from relatives. In only a few cases was it friends or other support (4 and 3 respectively) that influenced the decision.

While it is apparent that it is support that the interviewees are receiving that means they can stay in their homes at present – *'I don't know what I would do without my son'* (or daughter, or niece) – what is not clear is whether continuing to stay in their homes will depend on additional support or adaptations. Although all the households said they wanted to stay in their own home, the reasons why 3 of them were not sure they would be able to do so were not investigated.

It seems that people would welcome many of the services available and that these services would materially help to them maintain their independence. But because they don't know about the existence of the services they can't relate the potential benefit of using them to their own situations. When asked if it would help if services were available more locally, only 4 said it would; whether this reflects a lack of appreciation of the benefits, or that where the service base is located is irrelevant is not clear.

The general impression given by those taking part in this study was the high degree of determination to remain independent. What was surprising was the lack of knowledge/awareness of the many of the support services (other than for adaptations) that we found, even though these were people who had had contact with one or other of the agencies. If a service is not known about it cannot be accessed, so this lack of awareness should be seen as a form of failure of provision.

This population have considerable skills and experience, and represents a resource that should be tapped. This is a valuable but currently under-used resource which should be 'released' for general advantage.


WELCOME TO
WILLAND
30

CONCLUSIONS AND RECOMMENDATIONS

Supporting and helping people remain independent and in their own home not only gives them a feeling of worth and well-being (things difficult to quantify), but also represents a cost benefit to society. The determination of the interviewees suggests that the development of locally based networks, releasing the skills and energies found in this population should be the focus of local government and non-government organisations; this population should be seen as a resource and not as a group needing to be helped along.

Some of the recommendations made here may not fall within the responsibilities of the commissioning group. Nonetheless, we believe it is important for there to be close cooperation between all the various bodies to avoid duplication, but more importantly, to avoid gaps.

A COMPREHENSIVE AND HOLISTIC APPROACH

It is vitally important to make sure people are aware of the full range of services available. It should be recognised that people will probably not be aware of the services until they need them, and it may be only one particular need that prompts them to investigate. Whatever the particular need is, they should be made aware of the other services.

Here, we discuss a range of models and options that are not necessarily mutually exclusive. However, we wish to stress that the over-riding objective should be to meet the needs of the older population.

The most obvious solution to meet this need is **a 'one-stop shop' free-phone number**. We are aware that the County Council has a customer service centre which operates as **My Devon** and, as a part of that, has **Care Direct** which deals with enquiries from older persons. We also understand that considerable effort was given to advertising this service when it was launched. However, hardly any of the people interviewed knew of it – an indication of a lack of adequate promotion. Bearing in mind these interviewees were the very type of person who would probably need to access this customer service it would seem that some **greater and continuing effort on marketing is required**. To ensure the promotion and marketing is reaching the right audience and gives sufficient useful information, it is important that it is closely **monitored**.

As the customer service centre is primarily a 'sign-posting' one, we recommend that consideration be given to supplementing this with an additional service such as **FirstStop** (http://www.firststopcareadvice.org.uk/). FirstStop provides an independent, free service offering advice and information for older people, their families and carers about housing and care options in later life. It is led by the charity Elderly Accommodation Counsel (EAC) working in partnership with other national and local organisations.

To make the existing or an extended service known, there should be continuing very wide advertising of this number (leaflets, buses, local newspapers, day-time television, local radio, doctors' surgeries, libraries etc).

As well as responding to the particular enquiry, the 'one-stop-shop' service should also include a check on whether other services could be of help. There appears to be no systematic way in which people can become aware of their entitlements except by chance. We suggest that there should be simple and easy **access to expert money/benefit advice.** In addition, virtually all those who had accessed help that required form-filling commented on the unnecessary complexity and length of the forms. **Simplification of forms** would help considerably in ensuring a higher take-up rate of benefits and entitlements.

Overall, there should be **a more holistic appreciation of the issues**. Many households had been equipped with adaptations, about which they were mostly very positive. But many expressed other needs in relation to companionship, connectedness with others locally, continued use of old skills and the development of new ones and generally a sense of still being useful – self-help, mutual help and educational programmes of all kinds would work to complement the already good work being done in the field of adaptations.

Many of those interviewed had had home adaptations, about which they were mostly very positive and central to that was the role of the **Home Improvement Agency** (HIA). We understand that the role of the HIA has been revised recently, and that they now provide a rather reduced service. We also understand that this revision is partly a result of a change in funding, and that the County Council now commission them solely, whereas for the previous five years the service had been jointly commissioned by the County Council, the three Devon Primary Care Trusts, and the eight local District Councils. As a result of this change, following an assessment by an Occupational Therapist, the HIA are contacted for housing options advice.

This appears to be a move away from a more comprehensive and holistic approach. Whatever the reason behind the initial enquiry triggering a visit, it is an opportunity to give advice and information on a wide range of services – on property related problems; on housing options; on completing forms; on legal and financial entitlements; on benefits and possible sources of funding; on accident prevention; on crime reduction; and on energy efficiency and reducing energy precariousness (fuel poverty). While this more comprehensive approach may increase the initial cost it could avoid money being wasted at later stages. We recommend that the eight District Councils and the County Council review the commissioning of the HIA, and consider the benefits, both internally and to the service offered to older people in Devon, of a **more holistic approach**.

None of those interviewed raised issues relating to **energy precariousness** (fuel poverty). This may be because of the way the sample was drawn (see Discussion), and, as the latest finding is that 1 in 5 households are now in fuel poverty, we suspect that this may be a problem for some of those in the older population.

Work in the North West of England on energy precariousness provides a model that could be usefully examined for its relevance to Devon. The Health, Housing and Fuel Poverty Forum (HHFPF) was established by the UK Public Health Association (UKPHA). This Forum concluded that a model of local area partnerships linking health, housing and fuel poverty services is the most effective approach for directing services to the potentially vulnerable people. The model **links those who work in the health sector with those involved in the delivery of energy efficiency measures and fuel poverty schemes**.

The UKPHA was contracted by the Department for Environment, Food, and Rural Affairs (Defra) to coordinate and facilitate the Forum and the HHFPF devised and obtained partnership funding for the Greater Manchester Fuel Poverty Initiative (GMFP) – see http://www.ukpha.org.uk/fuel-poverty.aspx.

The GMFP has a hub referral mechanism for dealing with individual cases. In this case it is AWARM (Affordable Warmth Access Referral Mechanism) which provides a holistic one-stop service, provides training for frontline professionals to identify those in need, and assists clients to access a range of interventions aimed at tackling the health and housing inequalities brought about by fuel poverty. It works alongside the Energy Saving Trust Greater Manchester advice centre as well as a variety of partners, including Housing, the Fire Service, Primary Care Trusts and AgeUK. It provides a central point to which frontline staff can make referrals.

The experience in Greater Manchester is that the 'one-stop shop' central clearing house model is robust, but it became clear in the project that new and innovative ways have to be found to identify and assist the vulnerable fuel poor. In Greater Manchester the GP IT referral systems and data-overlay mapping processes between local authorities and Primary Care Trusts, have been specifically designed and developed to improve referrals. In essence, the development of data sharing and referral both individually (at the patient-GP interface) and at population level (through data-overlay mapping between local authorities and PCTs) enables evidence based targeting at a Unitary (or equivalent population size) wide level. This approach appears to fit with the current policies, particularly on localism and the role of GPs and local authorities in the proposed public health structures (and proposed public health outcomes framework).

Although the GMFP focuses on fuel poverty (energy precariousness) we believe that it could provide a template for a **Health and Housing initiative**, able to deal with the

wide range of matters, such as entry by intruders and falls, that affect or worry older people as already mentioned above. And, the aspect perhaps most relevant to Devon and the older population, and which should be investigated further is a system of 'pop-ups' for General Practitioners on their computers when patients from certain postcodes (where large numbers of energy inefficient dwellings are known to exist) attend their surgery. This is currently being piloted in Salford and Bury. The GP IT referral system is now in toolkit form and is currently being trialed in several PCTs.

Aspects of experience in Greater Manchester that should be investigated further with regard to wider housing issues for older people in Devon include:

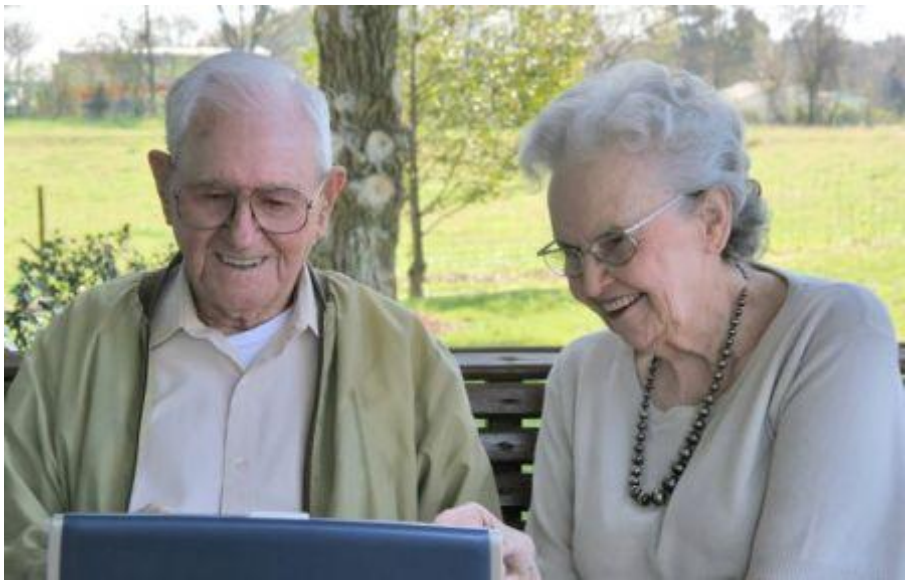
- how the model could work with and update the Single Assessment Process for older adults
- the possibility of targets within key health contracts to sustain referral rates, eg, GP Quality Outcome Framework and 'Provider Arm' Contracts (District Nurses etc)
- the use of IT systems to sustain referral rate, eg, automatic identification of patients at risk and electronic referrals from GP Patient Record Systems
- data-sharing exercises overlaying PCT data about health of older people including for example frequency of falls with local authority data about known areas of poor housing and low income

MUTUAL AND SELF HELP

There is plenty of goodwill in this population and willingness to help out with things one person can do in exchange with help for things they can't. It should be possible to build up neighbourhood-level mutual help/exchange systems. This would have not only a practical benefit but would promote self-worth, community interaction and companionship. We therefore recommend the development within the relevant local authorities of **a dedicated structure to promote mutual and self-help**. This should include designated staff with a clear remit to promote such networks at a very local level. The benefits of facilitating self and mutual help may well far outweigh the relatively small costs involved in staff time.

Mutual support networks could focus on particular services such as facilitating **help with gardening, decorating, dog walking etc.** Pets are crucially important to many older people, especially those now living alone, and, if the pet is a dog, it may be that the owner is unable to walk the dog. Many older people appreciate gardens, but may be unable to keep lawns cut and borders weed-free. Decorating may be beyond the ability of one person, either because of physical limitations or basic skills. However, within this population there will be individuals who can help with each of these services, enabling them to providing help and assistance to others will give a feeling of worth.

Computer skills and IT literacy can convey many benefits in terms of cheaper purchasing of almost all commodities (one respondent saved himself £700 by purchasing a car hoist online rather than from the recommended supplier). It also facilitates virtual contact via Skype, etc. with far-flung family members, which would be a huge boon for many isolated people. At least two respondents had both a high degree of IT literacy from their working days and a willingness to share this with others locally. At present there is no structure to encourage and facilitate this willingness, and we recommend that the development of **neighbourhood self-help schemes about IT literacy** should be one of the aims of the unit dedicated to the promotion of mutual and self help.



Self-help and mutual-help networks have been developed elsewhere, often in consultation with professional advisers, and they can be a potent factor in supporting older people to deal with a wide range of difficulties and chronic ill-health by making better use of their own resources and the resources of those around them. They can be a powerful factor in conveying a greater sense of self-determination and reducing dependence on official providers of care and assistance.

A model that exists is the Arthritis Self-Help Network (ASNET) developed in the London borough of Redbridge (http://www.arthritis-selfhelp.org/content/about-us). This began with a discussion with a local GP and has now developed into a source of support for many arthritis sufferers.

Networks of this kind can be developed in relation to other difficulties and problems faced by older residents. This might include help with tasks around the home and garden that have become more difficult with advancing age and transport to necessary venues such a for shopping and health appointments.

SURVEYS CARRIED OUT BY OLDER PEOPLE THEMSELVES

It seems evident to us that this small survey should be followed by a much more systematic assessment of the needs of the older population and on the extent to which the services apparently available are not reaching a high proportion of this population. We feel that the best people to decide what information is required to build better services, and how best to get that information, are the older people themselves. We see no reason why a survey or surveys cannot be designed and implemented largely by older members of the local community, given sufficient training and guidance from experienced researchers.

The legacy would be a growing capacity for residents and the LA in partnership to identify information needs and to mount resident-led surveys to satisfy them. This would improve provider/user understanding and co-operation and enhance user capacity.

SOME MISCELLANEOUS SPECIFIC ISSUES

There were some very specific issues raised that, while they may appear relatively minor, can have a significant impact of the quality of life of older persons. These include –

- Good foot care depends on regular check-ups and the health of the feet becomes more important with age. For example, mobility is affected if there is an interval of six weeks or longer between cutting toenails. This means that **the availability and frequency of NHS chiropody services** is essential. The NHS provision used to be at six weekly intervals, but it now appears to be nearer three months. This has meant that some respondents have paid for this service themselves (£20-25 seemed the going rate).

- There is a need for **simpler and more consistent labelling for medication.** Quite a few respondents commented on the print size on medications and prescriptions, and the continual changes of packaging. This can easily lead to dangerous confusions among older people, particularly those with failing sight.

- Several respondents said that they would like **more flexibility from the Meals on Wheels service.** They would like less than a full service, perhaps one or two days a week or just at weekends, but it seems that at present the service is available either for the whole week or not at all.

- One respondent said she had to climb on a kitchen chair to read the meter, and another said the meter was way down low under the stairs. Both positions are difficult and even dangerous for older people to access, and so there should be e**asier placing of energy meters for reading and other things that need to be looked at in the home.**

- Older people can be prey to tricksters. One respondent who had her wits about her when two young men, saying they were from the Council, offered to do the path, called the local authority to check. The authority took over an hour to respond by which time the men had gone. The authority said she should have called the police at once. The police need to make this clearer to everyone; perhaps with advice such as 'when in doubt use 999', (or the other emergency number – 112), and there should be **more systematic leafleting and advice from the Police about those dishonestly offering services.**

- Only a minority of respondents said they had a Piper Alarm (worn round the neck), which can summon help very quickly. We recommend that **personal lifeline alarms** are provided for all those at any kind of risk.

- As mentioned, pets can provide comfort and companionship, but pets cannot be kept in good health if visits to the vet are expensive and difficult to arrange. The provision of **mobile and cheap veterinary services** should be investigated and would be greatly appreciated by many older people.

WHAT NEXT?

In summary, our recommendations to the commissioners are –

- there needs to be a comprehensive and holistic approach to the provision of services for older people – this could include a well advertised and improved one-stop-shop, a review of the role of the Home Improvement Agency, and consideration of data-sharing and the use of IT referral systems
- promotion of mutual and self-help networks
- surveys of older people carried out by older residents
- greater availability of NHS chiropody services
- simplification of medication labelling
- greater flexibility of Meals on Wheels service
- sensible siting of energy meters etc
- provision of advice on dealing with potential con-men
- provision of personal alarms
- access to veterinary services

These suggestions would involve discussing the intentions and proposals with local health centres, occupational therapists and other community based health professionals, getting support from the relevant local authorities, discussions with patient groups representatives and other key organisations such as AgeUK and the Citizens' Advice Bureaux.

We would be prepared to help develop and promote some of these recommendations, in particular the mutual and self-help networks and the co-ordination of surveys.

ANNEX A

LETTER, REPLY FORM, AND INTERVIEW SCHEDULE

(THOSE STILL MANAGING IN THEIR OWN HOME)

THE UNIVERSITY OF WARWICK

	January 2010

The Institute of Health at the University of Warwick has been asked by Devon Private Sector Housing Group, Plymouth CC, Torbay BC, Exeter Council, and the Devon Housing Options to carry out a study to look at the housing choices available to older people in the Devon area.

To do this, we need to find out the following Š

- how well you manage at home,
- whether you have any help and support from friends, relatives or any services provided by the local councils, or voluntary or other agencies, and
- whether you think there is anything else that would help you to remain independent at home.

This is an important study, and whatever we find out could help inform those who make decisions on the support services for people such as you.

We hope that you will be able to help us by agreeing to an interview in your home. If you do agree, please complete the enclosed form and put it in an envelope addressed to Š

David Ormandy
School of Health and Social Studies
FREEPOST NEA14564
Coventry
CV4 7BR

Please note this is a FREEPOST service so you do not need to pay any postage.

Once we get your agreement, either John Bryson or Peter Ambrose will contact you direct to arrange a suitable time and date to see you.

Please be assured that your name will not be passed on to anyone, and that whatever you tell us will be in the strictest confidence.

Yours sincerely

David Ormandy

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Devon Area Housing Options for Older People

We hope to visit people to talk to them during the week beginning 14th February.

If you are willing and able to help us please tick the relevant boxes below

I am happy to help with this study	

Please tick which of the following seems to be closest to your situation and how you feel at the moment – tick more than one if it is appropriate

I am happily self-sufficient and in my own home	
I am in my own home because I have support from my family/friends	
I am in my own home because I have support from the local authority and/or a voluntary organisation	
I am in my own home but feel I need more support and/or some adaptations to be able to stay here	
I am in my own home but feel I may not be able to cope much longer even with support and/or adaptations	
I am in my own home, but have moved from a larger one	
I am no longer in my own home	

I can be contacted on –

Telephone number		
email		
My name and address is		
Any other comments		

As it says in the letter, please be assured that your name will not be passed on to anyone, and that whatever you tell us will be in the strictest confidence.

THE UNIVERSITY OF WARWICK

Devon Older People Housing Options Project – Still in home

Interviewer……. Interviewee number…….

Date…….. Area type (C, T, V, R)……

Post code……

A – THE HOUSEHOLD

Q1. Enter all members of the household in descending age order indicating the respondent with R

	M/F	Age	Ethnic identity	How long lived in Devon in years	Registered disabled Yes=1 No=0	Any limiting long-term illness
1						
2						
3						
4						
5						
6						

Q2. How many members in the household…….

Q3. How many room excluding kitchen and bathroom……

Q4. Persons per room……

Q5. Do you feel that the home is too big for you to manage?

Yes 1
No 0

Q6. Is the home
Owner-occupied 1
Rented from an RSL 2
Rented privately 3
Rented from an LA 4
Other 5

Q7. Do you have and can you use a car? Yes 1
No 0

Were adaptations required?
Yes 1
No 0

B – SUPPORT

Q8. Do you have friends in the locality? **Yes 1**
No 0

If Yes **between 1 and 5 friends** **1**
between 6 and 10 **2**
between 11 and 15 **3**
more than 15 **4**

Q9. How important do you feel they are for enabling you to stay in your own home?

Very 4
Some 3
A little 2
Not 1
N/A 0

Q10. If the answer is 4, 3 or 2 in what ways do friends help?

……

……

……

……

……

.....

.....

Q11. Do you have relatives in the locality? **Yes 1**
No 0

If Yes **between 1 and 5 relatives** **1**
between 6 and 10 **2**
between 11 and 15 **3**
more than 15 **4**

Q12. How important do you feel they are for enabling you to stay in your own home?

Very 4
Some 3
A little 2
Not 1
N/A 0

Q13. If the answer is 4, 3 or 2 in what ways do relatives help?

……

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.....

Q14. Which of these support services are (a) known to you and (b) being used by you:

(enter 1 in columns 2 and 4 if known about/used – otherwise leave blank)

Service	Known?	How known about?	Used?

C – THE FUTURE

Q15. How confident do you feel that you will still be in your own home this time next year?

(rank on scale of 5 = most confident down to 1 = least confident)

Confidence level…….

Q16. How much do you want to stay longer in your own home?

(rank on scale of 5 = most strongly down to 1 = least strongly)

Wish to stay level…….

Q17. What additional services would most help you to stay in your own home?

Adaptations to your home?

Yes 1
No 0

If yes, which adaptations?.....
.....
.....
.....
.....
.....

Changes in the area outside your home? (e,g to transport services)

Yes 1
No 0

If yes, which changes?.....
.....
.....
.....
.....

Additional support services that would help?

Yes 1
No 0

If yes, which additional services?.....
.....
.....
.....
.....
.....
.....

Q18. Have you made past attempts to get these adaptations and additional services

Yes 1
No 0

If yes how, and what was the result?.....
.....
.....
.....
.....
.....
.....

Q19. In general have local and easily accessible services been reduced recently?

Yes 1
No 0

Q20. Would it help you to remain independent if services were available more locally?

Yes 1
No 0

Q21. Any other comments on the issue of staying in your own home?

……

……

……

……

……

……

Thanks for your help

****

Q22. INTERVIEWER JUDGEMENT – which seems to be more significant in influencing the decision to make the move into care?

Friends	**1**
Relatives	**2**
Professional or other advisers	**3**

Any interviewer comments on the respondent's situation:

……

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NB - if the respondent clearly needs information that can be supplied by local service providers make a note of this)

……

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ANNEX B

SUMMARY OF ANALYSES

Summary of Analyses

Demographics

no of households	32
no of people	56
average age of whole sample	73.8
gender	28M 28F
% Reg. disabled	55%
% LLTI	50%
Average years lived in Devon	43.3
Use of a car	Yes 22 No 10
Adaptations to car?	Yes = 4 No = 18

Households

No		32
No of rooms (excl K and B)		104
Pphr		1.9
Tenure %	OO 69%	
	RSL 16%	
	LA 12%	
	PR 3%	
Type of area		City = 12
		Town = 4
		Village = 10
		Rural = 6
Is home too big for you to manage		Yes = 10
		No = 22
Have households had adaptations		Yes = 14
		No = 18

Preferences/confidence about the future

Want to stay in own home (5 down to 1)	5 = 31
	4 = 1
	3 = 0
	2 = 0
	1 = 0
Confident to stay in own home for 1 yr + (5 down to 1)	5 = 29
	4 = 0
	3 = 3
	2 = 0
	1 = 0

Informal support networks

Have friends in neighbourhood	Yes 28 No 4
Number of friends	1-5 = 13 6-10 = 8 11-15 = 0 More than 15 = 7 No reply = 4
How imp. are friends for staying in home	Very = 9 Some importance = 6 A little importance = 9 Not important = 4 N/A = 4
Number of relatives nearby (say 30 mins by car)	1-5 = 23 6-10 = 0 11-15 = 1 Over 15 = 0 None = 8
How imp. are relatives for staying in home	Very = 15 Some = 6 Little = 3 Not or N/A = 8
Interviewers' judgement about who most important for deciding to stay in own home	Friends = 4 Relatives = 25 Professional and other = 3

Which of the claimed available services are known about and used

Service	Known	Used
1. Aids and adaptations	25	25
2. Meals Service	2	2
3. Care at home	7	7
4. Ring a ride schemes	0	0
5. Community alarms	3	3
6. Telecare	0	0
7. Search 4 services	1	1
8. Medicines support	1	1
9. Social care reablement	0	0
10. Chiropody	2	2
11. Assistance with forms	5	5

NB – the first 9 of these are in the list provided by the Commissioners and the last
two were mentioned by respondents who had accessed them by their own actions

Would it help to remain independent if services were available more locally?

Yes = 4
No = 28

Have you made past attempts to get adaptations and services?

Yes = 7
No = 25

Have there been changes outside your home recently (e.g. bus services)?

Yes = 5
No = 27

In general have locally accessible services been reduced recently?

This was taken to mean public services such as rubbish collection which seem to be well maintained in the area.

Yes = 2
No = 30