

# Age Ready Britain Realising the Potential of an Ageing Society

**Ageing society policy paper**  
Policy Paper 122

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**an Ageing Society**

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## Executive summary

We are living longer. How societies adapt to being 'older' is one of the defining challenges of the 21<sup>st</sup> Century. Globally societies are having to adapt to the longer lifespans human ingenuity have made possible. By the end of the Century practically every nation on earth will have made the journey. Liberal Democrats take an optimistic view of ageing and the opportunities it presents. Taking a holistic approach that recognises ageing is about all of us, our future selves and how we want society to adapt to reflect the profound change that longer lives represent. For example, it is about reinventing retirement as a 'process' not an 'event'.

It is not the years lived (chronological ageing) rather it is the healthy years which remain (biological ageing) that guides our approach. A diverse and culturally sensitive approach will be taken because a 'one-size-fits all' policy making process will fail to recognise that the ageing population is not homogenous.

Liberal Democrats in government have been responsible for major reforms in adult social care and pensions. Breaking the deadlock on care finances by implementing the Dilnot Commission cap on catastrophic care costs. Overhauling pensions to provide a flat-rate basic state pension, auto-enrolment and fairer access to pension savings.

There is no single action or policy that will prepare the UK for an ageing society. It requires a co-ordinated approach across many areas of public policy to create an age-friendly country.

## Promoting wellbeing

Liberal Democrats believe that wellbeing is central to creating resilient, thriving and sustainable communities and identifying and tackling the causes of inter and intra-generational inequalities.

We propose that:

- Promoting wellbeing should be a specific goal of Government in general and the NHS and education in particular (1.4.1)
- Securing age-friendly communities should become an explicit goal for Government (3.1.2)
- Public Health England should lead a national wellness programme (1.3.10)
- Health and Wellbeing Boards lead the local partnership working to develop wellness services. Pooling health and care budgets will enable Boards to prioritise services with an emphasis on promoting wellbeing (1.3.9)
- The public health, adult social care and health outcome frameworks should be combined into a single national wellbeing outcomes framework to ensure that the NHS and local government work together to achieve common goals (1.4.3)
- Health and Wellbeing Board should identify and address social isolation and loneliness (1.2.1)
- Employers should be encouraged to provide group-volunteering opportunities both for older and younger employees as part of their corporate social responsibility programmes (1.2.4)

## The economics of ageing

Liberal Democrats believe that financial security in later life requires action across the life span to ensure intergenerational fairness. Simply taking a snapshot of the position of different generations at any one moment in time obscures the income, wealth, health status, educational attainment, gender, ethnic and geographical inequalities within each generation that are much more likely to determine how well we age.

We propose that:

- The Office for Budget Responsibility report annually to Parliament its assessment of the intergenerational implications for pensions, taxation, retirement ages, demand for health and care services of forecasts for life expectancy and economic prosperity (2.3.1)
- The Treasury should review the impact of longevity risk on the functioning of financial markets. This review would include a cost benefit analysis of the introduction of longevity bonds to underpin the development of markets (2.0.4)
- Access to Work (AtW) is overhauled to support longer working lives (2.2.5)
- Working with National Institute for Adult and Continuing Education (NIACE), employers and employees organisations and the National Careers Service to roll out and promote mid-life career reviews (2.2.8)
- The potential for establishing a savings and loans mutual to operate as the 'UK Skills Investment Bank' is explored (2.2.11)
- Care services are recognised as a key part of our economic infrastructure – not just enabling older and disabled people to live independently with dignity but

in supporting their families to combine work and caring  
(4.0.1)

## Valuing carers

Liberal Democrats believe that just as public services, communities and workplaces have seen a shift in how families are supported to balance childcare responsibilities with busy working lives, we need to see a similar societal shift to respond to growing eldercare responsibilities.

We propose that:

- Carers Allowance is improved by paying a ‘Carers Bonus’ annually as a contribution towards the extra costs such as taking a break by arranging for respite care. We would set this at £125, aiming to double it to £250 no later than 2020 (2.5.1)
- Every Government Department model good practice in support for carers and sign up to Employers for Carers as active members (2.3.5)
- Carers who need additional flexibility to care for a close family member have 5 days of paid additional ‘care leave’ a year, making it a statutory right for carers employed in large businesses (2.3.6)
- The NHS is given a legal duty to identify carers to ensure that they get the support they need (4.1.1)
- An NHS ‘carers passport’ scheme be developed to inform carers of their rights in the NHS, assert their role as ‘expert partners in care’ and gain access to support like free hospital parking (4.1.3)
- A review of longer-term leave options is commissioned (2.3.9)
- A new carer’s return to work programme is established by Jobcentre Plus with care co-ordinators for carers wishing to get back into work. This would include



access to pre-vocational training and learning for carers wanting to return to the labour market after years of caring (2.3.10)

- So that working carers can keep more of what they earn we will increase the carers allowance earnings disregard from £100 to £150 a week (after tax, NICs and allowable expenses, which include care costs while at work and 50% of pension payments) (2.5.1)

## Pensions and benefits

Liberal Democrats, led by Pensions Minister Steve Webb, have undertaken the most comprehensive overhaul of the pension system since its inception under Lloyd George. It will boost savings and lift millions of people out of inadequate retirement incomes.

We propose that:

- The ‘triple lock’ indexation of the state pension is put into legislation, helping to ensure that those who have saved see the benefits of their savings, and to reduce the risk of people needing to depend on means-tested benefits in retirement (2.4.8)
- Pension savings are boosted by extending the principle of auto-enrolment by increasing the employee contribution made towards their pension every time they receive a pay rise (2.4.6)
- People get value for money from their pension contributions by maintaining the pressure on pension scheme charges and implementing a ‘pot-follows-member’ policy so that small pension pots are no longer left ‘stranded’ when people change job (2.4.6)
- People have access to good quality independent face-to-face guidance including a health and wealth

- ‘resilience score’ before making decisions about their pension savings (2.4.9)
- A review is established to consider the case for introducing a single flat rate of tax relief for pensions, which would be designed to be simpler and fairer and set more generously than the current 20% basic rate relief (2.4.11)
- Winter Fuel Payments and free TV licences are withdrawn for higher rate taxpayers (2.5.5)
- Concessionary travel should be maintained (2.5.6)

## **Housing and the environment**

Accessible, warm, decent housing enables people to remain living well and independently. The physical and social environment around where we live impacts on how we live and our sense of identity. Architects, town planners and local authorities should be future proofing public spaces to promote active ageing.

We propose that:

- Government should set a goal to increase the supply of lifetime general housing so that people can remain in the same home and a full range of housing with care so people have positive alternatives (3.0.2)
- The Housing Strategy for England be updated to mainstream meeting the needs of an ageing society by including measures to increase the choice for people planning for later life who want to ‘right-size’ to a new home (3.0.3)
- Local authorities pilot alternative ways of delivering low or no cost help with removals, negotiating with energy suppliers, redirecting mail, selling unwanted goods,

dealing with administrative and legal issues and post-move support (3.0.7)

- In areas with two-tier local government both housing authorities and local planners are fully engaged with their local Health and Wellbeing Boards (3.0.11)
- My Home Life and similar programmes aimed at equipping the care workforce with the skills needed to deliver relationship based care and support should be expanded (3.0.13)
- Public health considerations should be integrated in planning policies to ensure that the built environment adapts to support the goals of making our towns and cities age friendly (3.1.1)
- National Planning Practice Guidance and Local Plan guidance make clear the benefits of safe and attractive streets and open spaces (3.1.3)

## Health and care

The Care Act 2014 marks a radical shift of emphasis in the care and support system in England. The Act makes the promotion of wellbeing the new purpose for adult care and support and gives family carers equal rights for the first time. The Act puts in place the cap on catastrophic care costs and deferred payment scheme recommended by the Dilnot Commission. The reform of the funding of care costs in England is the biggest change in the arrangements for paying for care since the National Assistance Act was passed in 1948 and will mean that no one will have to sell their home in their lifetime or face unlimited and catastrophic care costs.

We propose that:

- A review of the impact of the age discrimination ban in health and care is commissioned, reporting in 2017.

(4.0.3)

- The NHS match the best of Europe on dementia diagnosis rates and care (4.4.6)
- The UK become the global leader in dementia research, with the goal of doubling the research spend to £132 million by 2020 (4.4.5)
- Every domestic Government department develop plans to ensure their services and programmes are dementia friendly and support the goal of creating dementia friendly communities (3.1.2)
- Mental Health Champions are appointed to care homes (4.4.3)
- Free end of life social care is made available for those placed on their local end of life register (4.6.1)
- Patients receive education and tools to confidently self-manage conditions as far as possible, 'handing over' as little control of their care to clinicians as necessary so individuals have the choice and means to manage their conditions out of hospital (4.2.3)
- Patients with more than a set number of drugs prescribed will have an annual medication report given to them by their GP (4.2.7)
- Progress towards eliminating the inappropriate use of anti-psychotic drugs in the 'management' of people with dementia is audited (4.4.7)
- General Practice Federations and Networks are supported to scale up. More GP surgeries should be co-located within urgent care centres, so patients are triaged by clinicians and can access treatment in the most appropriate setting (4.2.5)
- All patients in receipt of NHS care are issued with a 'care footprint' to raise awareness of the cost of care and empower people (4.3.5)
- The amount of geriatric training that medical students receive is increased, so that more are encouraged to specialise in this field, and more are better prepared to

deal with the needs of older people in clinical settings  
(4.5.4)

## **Making Britain age ready**

There is no single action or policy that will prepare the UK for an ageing society. It requires a co-ordinated approach across many areas of public policy to create an age-friendly nation.

We propose that:

- A Cabinet Committee on wellbeing and ageing is established chaired by the Chief Secretary to the Treasury (5.0.3)
- A Minister for Ageing is appointed (5.0.3)
- A statutory independent Older People's Commissioner is established (5.0.4)
- Two independent cross party commissions are established – one to examine options for supporting longer working lives, including life-long learning, pension saving and later life planning; and the other to analyse future demand for health and social care and make recommendations for how best to meet the needs of an ageing society (5.0.2)
- The capabilities and capacity of Health and Wellbeing Boards are strengthened to realise their potential to be a powerful engine for increased integration between different parts of public services (5.0.6)

# Introduction

How societies adapt to being 'older' is one of the defining challenges of the 21<sup>st</sup> Century. By the end of the Century practically every nation on earth will have made the journey. Today there are more people over the age of 65 in the UK than there are children under 15<sup>1</sup>. This change is a triumph of human ingenuity. Liberal Democrats take an optimistic view rejecting negative stereotyping of ageing.

There has never been a society where so many people have lived such extended lifespans. Life expectancy in the UK is increasing by five hours a day, every day.<sup>2</sup> In developing our policy for an ageing society we start with the simple idea that the challenge is not just about the old, it is about all of us, our future selves and how we want society to function for us in our later years. It is about reinventing 'retirement' as a process not an 'event'. In 2010, the net contribution to the UK economy by the ageing population was £40 billion. This will rise to £77 billion by 2030.<sup>3</sup>

It is not chronological age (years lived), but biological age (healthy years which remain) and how the individual's body and mind are ageing which determines how 'old' a person feels. Neither is it their health status alone but a wider concept of wellbeing. Just 6% of over 65s see themselves as 'old'<sup>4</sup> while others think youth ends at 41 and old age starts at 59!<sup>5</sup> Our concept of what constitutes 'old age' must change. Older people are healthier than earlier generations and are

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<sup>1</sup>National Population Projections. ONS (2010).

<sup>2</sup> Rejuvenating Ageing Research. The Academy of Medical Sciences (2009)

<sup>3</sup> Gold age pensioners: Valuing the Socio-economic contribution of older people in the UK (2011).

[http://www.royalvoluntaryservice.org.uk/Uploads/Documents/gold\\_age\\_report\\_2011.pdf](http://www.royalvoluntaryservice.org.uk/Uploads/Documents/gold_age_report_2011.pdf)

<sup>4</sup> YouGov Poll reported on BBC Website, (2013).

<sup>5</sup> A snapshot of ageism in the UK and across Europe, Age UK (2011).

## Age Ready Britain

living longer. This, rather than chronological age, is crucial to behaviours and attitudes.<sup>6</sup> Chronological age is a poor measure of 'burden'.

Neither is the ageing population homogenous. From 2016 to 2051 the number of BAME's over 50 in England and Wales will treble<sup>7</sup>. Their different aspirations and cultures will need to be considered by policymakers. Migration is increasing diversity. The consequences are poorly understood and needs more research.

There are over 10 million disabled people in Britain, 70% are of working age; 19% of the working population. The number of older people living with learning disabilities is also growing, facing the 'double jeopardy' of age and disability discrimination. When designing and delivering services for an ageing population we will ensure that diversity and cultural sensitivity, and both learning and physical disabilities are recognised and reflected.

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<sup>6</sup>347;f6598. BMJ (2013).

<sup>7</sup><http://www.runnymedetrust.org/uploads/publications/pdfs/TheFutureAgeingOfTheEthnicMinorityPopulation-ForWebJuly2010.pdf>

# 1. Wellbeing and ageing

1.0.1 In policy paper *A New Purpose for Politics: Quality of Life* (2011) we stated “policy-making and other activities of government should be re-oriented towards supporting individuals to maximise their own wellbeing.” How we adapt to longer life spans will depend on how successful we are at adopting wellbeing as a national goal.

1.0.2 Wellbeing is central to creating resilient, thriving and sustainable communities. Wellbeing can be defined as ‘feeling good and functioning well’. **Wellbeing should be a specific goal, focusing on the capabilities, assets, experiences and potential of individuals and communities.**

1.0.3 Liberal Democrats believe that communities flourish when they have control and genuine opportunities to influence decisions, regular contact with neighbours and confidence in their capacity to manage their own circumstances.<sup>8</sup> **We will test policy options for their contribution towards building social and mental capital, maintaining independence and preventing or postponing the loss of physical and mental capabilities.**

## 1.1 Promoting wellbeing across the lifespan

1.1.1 Approaching ageing as the summation of our life choices and chances shifts the focus from chronological ageing to root causes. Poorer people have poorer health, age faster and die younger. Social class and location impact life expectancy too.

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<sup>8</sup> Bacon N. and Mguni N, Taking the Temperature of Local Communities: The Wellbeing and Resilience Measure – WARM. The Young Foundation (2010).



1.1.2 Programmes tailored to support parental nurturing and child development and nutrition profoundly impact educational attainment and behaviour. This has been recognised in the work led by the Deputy Prime Minister to promote social mobility<sup>9</sup> and to re-introduce free school meals for all 5-7 year olds. Early years intervention is important and with life-long benefits. The introduction of the Liberal Democrat policy of a pupil premium targeting additional funding on children from disadvantaged backgrounds is aimed at closing the attainment gap and supporting social mobility.

**1.1.3 We will re-introduce Ofsted reporting on pupils' wellbeing within their reports on schools and the Tellus Survey which included important questions about children's wellbeing.**

## **1.2 Relationships and social connectedness**

1.2.1 Close relationships are health assets.<sup>10</sup> Two of the greatest challenges currently facing older people are social isolation and loneliness. Social isolation is the objective state of lacking connections to one's neighbours and options for socialising and interacting with the larger social world. It can be addressed by improvements in design of the built environment. Loneliness, by contrast is a subjective, negative feeling caused by factors such as lack of companionship, relationship breakdown or loss and bereavement. To tackle loneliness, environmental, physical and mental health resources need to be taken into account – increasing social interaction or social participation is not enough. **Local Health and Wellbeing Boards should identify and address social isolation and loneliness as part of their Joint Strategic**

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<sup>9</sup> Opening Doors, Breaking Barriers: A Strategy for Social Mobility. Deputy Prime Ministers Office (2011).

<sup>10</sup> When I'm 64. Relate and NPC (2013).

**Needs Assessments (JSNA) and ensure it features in the work of Directors of Public Health and the commissioning plans of both clinical commissioning groups and adult social services.**

1.2.2 Within the elderly LGBT+ community isolation and loneliness is particularly prevalent. Where elderly friends die some are left lonely, without community support and can be fearful about asking local authority and other agencies for help. For example, care services do not always cater well for LGBT citizens in general, many cannot be themselves in care homes and sheltered housing where their sexuality is something that cannot be discussed or understood. There is good practice such as Anchor Housing's LGTB group.<sup>11</sup> **We believe that in ensuring there is a diverse range of quality care and support services available to meet the needs of their population local authorities and service providers should engage with LGBT groups.**

1.2.3 Having weak social connections has been shown to be a health risk equivalent to smoking 15 cigarettes a day, being an alcoholic, or not exercising.<sup>12</sup> Special attention needs to be given to the social inclusion of those over 85. A recent report has shown they are at greater risk due to the death of a partner, and increasing physical immobility worsened by geographical separation from family.<sup>13</sup> **Further prospective research should be commissioned into the impact of social isolation and loneliness focussing on solutions.**

1.2.4 Longer working lives and more 'sandwich' caring (for grandchildren and aged parents in the same family) will impact on patterns of volunteering. In policy paper *Community Futures: Policies on the Voluntary Sector and*

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<sup>11</sup> <http://www.anchor.org.uk/why-anchor/diversity/lesbian-gay-bisexual-trans-group>

<sup>12</sup> Bolton M, Loneliness – the state we're in, Age UK in Oxfordshire (2012).

<sup>13</sup> Ageing alone: Loneliness and the 'oldest old'. Centre Forum (2014).

*Volunteering* (2011) we set out our vision for an independent, voluntary and citizen-led community sector working in partnership with government and the private sector to build safe, sustainable communities in which all can thrive.

**Employers should be encouraged to provide group-volunteering opportunities both for older and younger employees as part of their corporate social responsibility programmes. We will also put in place schemes for younger people to benefit from the mentoring and support from older workers. We will remove barriers to volunteering in later life,** for example, insurance policies that set arbitrary age bars on volunteering.

1.2.5 Research by Ofcom<sup>14</sup> shows that the number of people aged 65 and over accessing the internet rose by more than a quarter in 2013, driven by a three-fold increase in the use of tablet computers to go on line. By using inclusive design principles, which suit the needs of older people, government, third sector and business organisations can help to spread adoption of technology and use of online services.

**National and local government should embed this approach into procurement of government services. By simplifying the way people interact with technology, designing it to be intuitive for users and adapt to user needs it should require little or no training.**

## 1.3 Promoting resilience

1.3.1 We all face challenges as we grow older: decreased senses and mobility, bereavement and loneliness. Policy and practice need to focus on giving people of all ages the options and resources to be resilient in the face of life's inevitable setbacks.

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<sup>14</sup> Adults' Media Use and Attitudes Report. Ofcom (2014).

1.3.2 'Resilience' is the ability to bounce back, to respond positively to internal and external stresses, whether family, work or relationship-related. Resilience is a key component of wellbeing, and a key component of resilience is individual choice and empowerment. In education, policymakers are increasingly recognising the importance of teaching children to be resilient.<sup>15</sup> Improving resilience will help older people manage declining function and loss of personal autonomy.

1.3.3 A study of the role of the public sector in influencing 'resilient relationships' emphasised interventions that strengthen social relationships within families and communities and build social support, social networks and social capital within and between communities.<sup>16</sup> The traditional 'deficit' approach of public services concentrates on the problems, needs and deficiencies in a community such as deprivation, illness and health-damaging behaviours. This approach can be disempowering to communities and increases dependency.

1.3.4 An alternative asset- or strength-based approach<sup>17</sup> focuses on the resources and capacities that people have which positively impact on their physical health and mental wellbeing. Resilient people can understand the situation they are in, have reasons to improve their health and have the power and resources – material, social or psychological – to

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15 Character and Resilience Manifesto, Chris Paterson, Claire Tyler and Jen Lexmond The all-party parliamentary group on Social Mobility, Centre Forum (2014).

16 Friedli L (2009a), Mental health, resilience and inequalities, WHO and Friedli L (2009b) Resilient relationships in the North West: what can the public sector contribute?, NWPFO (2009).

17 The theory of salutogenesis which highlights the factors that create and support human health and wellbeing, rather than those that cause disease. Salutogenesis (2005). Lindstrom & Eriksson; Journal of Epidemiology and Community Health, (2005).

cope. This model has given rise to a movement supporting asset-based approaches.<sup>18</sup>

1.3.5 Asset-based approaches value a community's capacity, knowledge and connections. Such an approach counters the deficit approach to ageing where services fill gaps, fix problems and turn people into passive recipients of services, rather than active shapers of their own lives.<sup>19</sup>

1.3.6 Until recently the NHS has been entirely focused on disease, diagnosis and treatment. Wellness services combine and give parity of esteem to both mental and physical health to improve a person's overall wellbeing. They can reduce the need for medical interventions by increasing choice, and may be much cheaper. For example, 'social prescribing'<sup>20</sup> can connect people with non-medical services and support available in the wider community and contact with others facing similar challenges, providing opportunities to learn from others' coping strategies.

1.3.7 The Liverpool Public Health Observatory report<sup>21</sup> found wellness services could provide an effective response to frequent attendees in primary care, while tackling the underlying causes of their visits. Wellness services include buddying schemes, community navigators, peer support, smoking, weight, and alcohol management, physical activity pathways, health trainer provision and psychological wellbeing.

1.3.8 At present, wellness services are not available to all those who could benefit from them, so the potential

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<sup>18</sup> <http://www.abcdinstitute.org/>

<sup>19</sup> A Glass Half-Full - How an Asset Approach Can Improve Community Health and Wellbeing, I&DeA. Foot J. and Hopkins T (2010).

<sup>20</sup> <http://www.ncbi.nlm.nih.gov/pmc/articles/PMC2688060/>

<sup>21</sup> Wellness Services – Evidence based review and examples of good practice Liverpool Public Health Observatory, Lyn Winters, Marie Armitage, Jude Stansfield, Alex Scott-Samuel and Alison Farrar (2010).

population health benefits are being lost.<sup>22</sup> There are currently few mechanisms that reward these sorts of approaches; therefore, there is little incentive for health and care services to invest in equipping patients with the skills to make informed decisions about their lifestyle, change their behaviour and prevent illness.

1.3.9 Health and Wellbeing Boards are best placed to lead the partnership necessary to develop wellness services. As a result of leadership by Liberal Democrat Health Ministers<sup>23</sup> from April 2015 Health and Wellbeing Boards will have responsibility for a budget pooled between the NHS and local government, known as the Better Care Fund.<sup>24</sup> Its purpose is to support investment in innovative services that prevent and/or postpone the need for healthcare and further ensure that when care is required it is co-ordinated around the individual. Pooling health and care budgets will allow Health and Wellbeing Boards to prioritise services with an emphasis on promoting wellbeing.

**1.3.10 Public Health England should lead wellness service development as a new way of working, review existing voluntary sector, local government and NHS programmes, and identify what each sector is contributing in order to improve integrated working.**

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<sup>22</sup> [www.hsj.co.uk/resource-centre/best-practice/individual-wellness-at-the-centre-of-new-public-healthapproach/5025301](http://www.hsj.co.uk/resource-centre/best-practice/individual-wellness-at-the-centre-of-new-public-healthapproach/5025301)

<sup>23</sup> Paul Burstow MP, Minister of State for Care Services 2010-2012, Norman Lamb, Minister of State for Care Services 2012- present.

<sup>24</sup>

<http://www.local.gov.uk/documents/10180/12193/Developing+plans+for+better+care+fund+guidance.pdf/734c155e-7820-4761-976a-6c56053c0e78>

## 1.4 Making wellbeing a goal and measuring it

1.4.1 One of the reasons past attempts at shifting the focus onto wellbeing and community have failed is that when resources are under pressure, practice defaults to the minimum requirements of the 1948 National Assistance Act. Leadership by Paul Burstow as Care Minister has meant that the Care Act 2014 establishes a new mission for social care: the promotion of individual wellbeing. **However, the promotion of individual wellbeing is not an explicit goal of the NHS or of our education system. We believe that it should be, and it should be measured too.**

1.4.2 In *A New Purpose for Politics* we argued that wellbeing should provide a common metric to help policy makers shape and compare the effects of different policies. Measuring, tracking and promoting wellbeing can be useful to public agencies, civil society organisations and private organisations. **The publication of measures of national wellbeing by the Office for National Statistics is a positive step but we believe that the approach should be extended to include the adoption of subjective wellbeing in the evaluation of public policy.**<sup>25</sup>

1.4.3 Local leadership should ensure these activities are prioritised. **Nationally, we will combine the public health, adult social care and health outcome frameworks into a single national wellbeing outcomes framework to ensure that the NHS and local government work together to achieve common goals.**

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<sup>25</sup> Wellbeing and Policy. Legatum Institute (2014).

## 2. The economics of ageing

2.0.1 Managing the economic implications of an ageing society is about overall economic performance and not just about the circumstances of older people. The economics of ageing go beyond the direct costs associated with specific groups, such as pensions and health care. As populations age, older people have a key role in the level of aggregate demand for goods and services.

2.0.2 Simply, the more people there are with small and/or fixed incomes in a society, the fewer goods and services they will buy and the fewer jobs there will be for people of any age. It is why older people need to be able to move in and out of the labour market as the demand for labour changes, and why retirement should be treated as a process rather than an event.

2.0.3 Financial security and savings relate to the development of financial services products, including in pension savings, insuring against long-term care needs, equity release for different levels of need, and inter-generational transfers. The problem for the financial industry (particularly for re-insurers) is that it is very difficult to proof products against longevity risk, adverse selection, long tail issues, and unacceptable windfall profit levels. At 60, for instance, a person might well have a better idea than an insurer of their likelihood of gaining from a product.

**2.0.4 We believe the Treasury should commission a review of the impact of longevity risk on the functioning and failure of markets in financial products. This review would include a cost-benefit analysis of the need to develop new financial instruments such as Longevity Bonds to underpin the development of**



**markets.**<sup>26</sup> Longevity bonds would potentially allow longevity risk to be shared efficiently and fairly between generations. Longevity bonds could lead to a more secure pension savings market resulting in less means-tested benefits and a higher tax take. The review would also look at what steps the government could take to kick start a capital market in private sector longevity-linked instruments.

## 2.1 Intergenerational equity

2.1.1 An ageing society is not just about the old, it is about all of us, and it is about our future selves. Viewing intergenerational equity simply in monetary terms with a balance sheet listing financial contributions and withdrawals loses sight of a much richer, more complex picture. Each generation passes through the life cycle from birth to death, so it makes sense to consider the whole life experience of a generation rather than taking a snap shot at any one point in time. Taking a snapshot of the position of different generations at any one moment in time obscures the income, wealth, health status, educational attainment, gender, ethnic and geographical inequalities within each generation that are much more likely to determine how well we age.<sup>27</sup>

2.1.2 Taking a view across the life span paints a different picture. This is one of the reasons Liberal Democrats believe it is necessary to take action to ensure fairness between the fortunate and the less fortunate across generations. Our *Fairer Taxes* policy paper (2013) sets out our vision for a focus on the taxation of wealth rather than income. This will over time reduce tax as a disincentive to work and ensure a fairer taxation system where those who can afford to pay do so.

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<sup>26</sup> DISCUSSION PAPER PI-1002, Sharing Longevity Risk: Why Governments Should Issue Longevity Bonds. Pensions Institute (2010) and <http://www.actuaries.org.uk/research-and-resources/documents/longevity-bonds>

<sup>27</sup> Intergenerational and Intergenerational Equity. Jonathan Portes, NIESR (2014).

These measures as a package will mean the fortunate in any generation pay their fair share, and reduce the burden on those less fortunate both in their generation and in other generations.

2.1.3 We recognise the risks in setting long-term policies. Policies on ageing are based on forecasts for life expectancy and economic prosperity. Modest changes to this equilibrium can have significant implications for pensions, taxation, retirement ages and the availability of healthcare in the future. We will reflect this in the mandate of the Office for Budget Responsibility. **Giving the OBR responsibility for reporting annually to Parliament forecasts of the life expectancy and economic prosperity and commentary on the long-term fairness between the generations and within generations.**

2.1.4 **We believe that making the promotion of wellbeing a measurable goal of Government will better serve the common good as will efforts to identify and tackle the causes of intra-generational inequalities.**

## 2.2 Labour market

2.2.1 According to the Department of Work and Pensions 1 in 6 men and 1 in 4 women who had recently reached State Pension age had not worked since at least age 55.<sup>28</sup> Steve Webb set out the Government's approach to promoting fuller working lives in June 2014.<sup>29</sup> Labour market exit remains a problem, with around 2.9 million people currently out of work aged between 50 and State Pension age. Over half of men

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<sup>28</sup>[https://www.gov.uk/government/uploads/system/uploads/attachment\\_data/file/319716/fuller-working-lives-infographic.pdf](https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/319716/fuller-working-lives-infographic.pdf)

<sup>29</sup> Fuller working lives – a framework for action. Department for Work and Pensions (2014).

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and women have already stopped working before they reach State Pension age.

2.2.2 Sickness absence rates increase with age. The UK Foresight Project on Mental Capital and Wellbeing<sup>30</sup> highlighted the importance of addressing increased workplace stress and anxiety and the benefits such action would have for business productivity. In Government we are establishing a Health and Work Service (HWS) following the *Health at Work – an independent review of sickness absence report*<sup>31</sup>.

2.2.3 We believe that the Health and Work Service (HWS) provides a foundation for supporting employers and employees to improve health in the workplace. **To be effective, referrals to HWS by GPs will need to become an automatic feature of the system and a face-to-face assessment will need to be available in cases where a telephone consultation is not appropriate.**

2.2.4 **We would establish a time-limited Challenge Fund to provide SMEs with access to a pool of consultants who can advise on introducing practical wellbeing programmes in companies, including helping to introduce flexible working.** This fund would receive 1/3 of its funding from employers, 1/3 from participating consultants and 1/3 from central government.

2.2.5 We will overhaul Access to Work (AtW) by:

- Extending it beyond state pension age.
- Widening coverage to include people working less than 16 hours a week.

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<sup>30</sup> Mental Capital and Wellbeing, Foresight Programme (2008).

<sup>31</sup> Sickness Absence in the Labour Market. ONS (2012).

- Examining the costs and benefits of extending the scheme to people undertaking voluntary work.
- Making it mandatory for employers to implement AtW assessor recommendations where they are fully funded by AtW.
- Piloting the introduction of a leasing scheme to reduce the cost to employers where an adaptation is not fully funded by AtW.

**2.2.6 We will work with employer's organisations and disability groups to reform AtW to ensure that where equipment is purchased to enable a person to work that the equipment can be transferred from one employer to another.** So that employees do not have to go through the assessment and procurement process again and again.

2.2.7 There is significant evidence that working into later life – in a range of roles and industries – can be good for mental and physical wellbeing. For example, research in Japan, found that retired women who worked, even for only a handful of hours a week, were much healthier than their counterparts.<sup>32</sup>

2.2.8 Extending people's working lives requires planning, preparation and management by them and their employers to enable them to achieve the full financial and wellbeing benefits. In Government we have supported the National Institute for Adult and Continuing Education (NIACE) to pilot mid-life career review.<sup>33</sup> **We will work with NIACE, employers and employees organisations and the National Careers Service to roll out and promote mid-life career reviews.**

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<sup>32</sup> <http://solidarityeconomy.web.fc2.com/en/seinjapan01-ooe.html>

<sup>33</sup> [http://shop.niace.org.uk/media/catalog/product/m/l/midlife\\_career\\_review\\_-\\_final.pdf](http://shop.niace.org.uk/media/catalog/product/m/l/midlife_career_review_-_final.pdf)

2.2.9 According to the UK Workplace Employment Relations Survey (2011) people over 50 report receiving less days of training than their younger counterparts.<sup>34</sup> According to the National Audit Office the 'shelf-life' of training is two to three years. **We propose a routine skills health check should be offered as part of a mid-life career review.**

2.2.10 We proposed in our policy paper *Learning for Life* (2013) the establishment of Lifelong learning accounts with automatic enrolment for every adult on their 25<sup>th</sup> birthday. The mid-life career review could be linked to a learning entitlement at 50. In Canada, Lifelong Learning Plans allow people to withdraw a set sum each year tax-free from their pension plan to enrol in full-time education until the age of 71. This is repaid within 5 years of graduation. **We believe this approach should form part of the funding reforms to make lifelong learning accounts a reality.**

2.2.11 **We would also investigate the potential to create a savings and loans mutual to operate as the 'UK Skills Investment Bank' through which every person in the UK can save to fund future skills acquisition and can access these savings and additional loan funding when they want to develop their professional expertise.**

## 2.3 The workplace and carers

2.3.1 Just as public services, communities and workplaces have seen a shift in how families are supported to balance childcare responsibilities with busy working lives, we need to see a similar societal shift to respond to growing eldercare responsibilities. Labour market participation of older women has increased over the last three decades. However, this can be restricted by barriers, including a lack of suitable training

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<sup>34</sup>[https://www.gov.uk/government/uploads/system/uploads/attachment\\_data/file/210103/13-1010-WERS-first-findings-report-third-edition-may-2013.pdf](https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/210103/13-1010-WERS-first-findings-report-third-edition-may-2013.pdf)

opportunities, and inflexible working arrangements making it harder to juggle caring responsibilities which often fall to women. This gender gap in opportunities and pay impacts savings and pension income in later life.

2.3.2 Seventeen percent of unemployed women left their last job to care for someone, compared to only 1% of men. Low-income older women stand out in these figures.<sup>35</sup> Four out of ten carers say the trigger for them quitting work was a lack of reliable, quality, affordable household services.<sup>36</sup> Help with gardening, cleaning, and housekeeping can be the difference between someone feeling able to juggle work and caring responsibilities and not.

2.3.3 Unless carers can access more support, remaining in work can prove impossible. Already, caring is a major contributor to early retirement and permanent exit from the labour market for the over-50s. The Census shows that 1 in 5 people aged 50-64 (1 in 4 women and 1 in 6 men) are carers.<sup>37</sup>

2.3.4 Liberal Democrats believe that growth in the provision of quality affordable care and support is essential to achieving a stronger economy and fairer society. The Care Act 2014 places new market shaping duties on local authorities to ensure there is a diverse market of care and support services. The growth of the care and support market should not be seen as a niche issue left to local authority social service departments and the sponsorship of the Department of Health. Growth in the sector<sup>38</sup> will be essential to support

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<sup>35</sup> Older Workers Employment: Preferences, Barriers and Solutions. Policy Studies Institute (2009).

<sup>36</sup> State of Caring. Carers UK (2013).

<sup>37</sup> <http://www.ons.gov.uk/ons/guide-method/census/2011/census-data/2011-census-data-catalogue/census-data-quick-view/index.html>

<sup>38</sup> Research for Skills for Care has estimated the direct and indirect economic contribution of adult social care sector in England to be £43.2 billion including

economic growth in the whole economy as the population ages. Both the Business and Skills Department and Local Economic Partnerships (LEPs) should be fully engaged supporting the sector to realise its potential.

2.3.5 Supporting carers to stay in work makes financial sense for employers. As Employers for Carers highlight, stress-related absence has been reduced by 26% through flexible working alone, while the cost of a few days emergency leave pales in comparison to the significant costs of recruitment.<sup>39</sup> The LSE has estimated that the hidden cost to the economy of carers having to give up work puts the cost at £1.3 billion a year in lost tax revenues and Carer's Allowance costs.<sup>40</sup> **We will require every Government Department to model good practice in support for carers and sign up to Employers for Carers as active members.**

2.3.6 **We will introduce 5 days of paid additional 'care leave' a year for carers who need additional flexibility to care for a close family member, making it a statutory right for carers employed in large businesses.** We will consult employers' organisations, trade unions and carers' organisations about the design and implementation of this proposal including how it should link to the right to request flexible working. Our proposal would entitle carers to take time off to attend hospital appointments or other planned, but unavoidable events, preventing carers from having to use annual leave or take sick leave in these instances. The qualifying conditions for this new employment right would mirror that for carer's allowance. Flexible working and leave policies provide critical support to those balancing work and

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supporting 2.8 million jobs. The economic value of the adult social care sector in England – Final Report. ICF GHK for Skills for Care (2013).

<sup>39</sup> <http://www.employersforcarers.org/resources/research/item/808-supporting-working-carers-the-benefits-to-families-business-and-the-economy>

<sup>40</sup> <http://blogs.lse.ac.uk/healthandsocialcare/2012/04/25/dr-linda-pickard-public-expenditure-costs-of-carers-leaving-employment/>

care responsibilities and opportunities for people to extend their working lives, which is increasingly important as the state pension age rises.<sup>41</sup> Many employers already offer a few days paid care leave.<sup>42</sup>

2.3.7 Liberal Democrats recognise that what employers want to see in return for new statutory rights are public services that work really well from both a business and a family point of view. **To support this we will work with private sector organisations<sup>43</sup>, NHS England and Local Government Association (LGA) to draw up a Work Compact for Care** – which would make clear what support family carers are entitled to.

2.3.8 **We would also make provision for up to a three-month bloc of unpaid leave for employees to deal with a particularly intensive period of caring.** This leave would be modelled on parental leave, to be taken in minimum blocs of one week and Carer’s Allowance would be provided, with additional remuneration at employer’s discretion. While the carers of young children have the legal right to 18 weeks of unpaid parental leave per child under five, there is no corresponding provision for carers of the elderly, sick or disabled, who fill an equally important role in society. Moreover, leave of this sort can help protect employment among carers – usually women – who can find themselves forced to give up work to provide care and subsequently find it difficult to re-enter the labour force.

2.3.9 **We will conduct a review of longer-term leave options, including the proposals in our policy paper *A balanced working life* (2013) of up to six months unpaid care**

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<sup>41</sup> The challenge of caring now and in the future: learning lessons from across the world. University of Leeds (2014).

<sup>42</sup> The Case for Care Leave. Carers UK (2013).

<sup>43</sup> Such as Employers for Carers.



**leave.** This would also include the possibility of families sharing leave entitlements across generations. Working with public bodies and business we would test options for supporting employees with caring responsibilities.<sup>44</sup>

**2.3.10 We will establish a carer's return to work programme for Jobcentre Plus with care co-ordinators for carers wishing to get back into work.** This would include access to pre-vocational training and learning for carers wanting to return to the labour market after years of caring. To support the programme we would examine the best option for ensuring the right care support is available to enable carers to juggle work and care and will test this through a number of pilot sites.

**2.3.11** As part of our plans for a carers return to work programme **we would review what support is available to carers in order to study and train whilst they care, to prepare for when caring comes to an end.** We believe that there is a case for lifting restrictions on studying alongside receipt of carers' benefits.

## **2.4 Pensions, savings and taxation**

**2.4.1** State spending on pensions and other benefits for pensioners accounted for 6% of GDP in 2006/7 and is forecast to rise to 6.8% by 2035/36 based on planned reforms to the pension system. In 2010 the basic state

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<sup>44</sup> In particular we will draw on a scheme introduced in Germany which allows some employees to reduce their working hours to a minimum of 15 hours a week for up to two years. Employees are paid a lower income, although the reduction is less than the reduction in hours. When they return to full-time working they continue to receive reduced earnings until they have repaid the difference. Pension contributions also continue to be paid.

pension was worth 16.3% of national average weekly earnings, this is forecast to rise to 18.5% by 2035.

2.4.2 More still needs to be done to achieve pension parity between men and women. A combination of time out of the workplace for child-bearing and rearing, the gender pay gap and premature exit from the labour market to perform unpaid caring within the family disadvantages many women.

2.4.3 These factors mean women retire with smaller pension pots, and their annuities are lower because of increased longevity, pension provision and savings having to stretch over more years. Reducing the contributory years for a full state pension from 40 to 30 years only partially compensates women for this triple loss.

2.4.4 Liberal Democrats, led by Pensions Minister Steve Webb, have undertaken the most comprehensive overhaul of the pension system since its inception under Lloyd George. It will boost savings and lift millions of people out of inadequate retirement incomes. From April 2016 a new £144 a week flat-rate state pension scheme will ensure women, self-employed and many low paid workers get a better deal.

2.4.5 Our ambitious programme of auto-enrolling 10 million people into workplace pensions will increase the number of lower earners saving, but the tax relief paid will still benefit higher earners more than basic rate taxpayers. Our reforms to the pension system are expected to reduce the number of people facing inadequate retirement incomes by 1 million; increase the incomes of 73% of those facing inadequate retirement income, bringing them closer to their target incomes; and halve the proportion of future pensioners who will retire with no private income at all from 27% to 12% in 2050<sup>45</sup>.

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<sup>45</sup> Automatic Enrolment Evaluation Report. Department of Work and Pensions (2013).

**2.4.6 To ensure that more people can retire with a decent standard of living we will extend the principle of auto-enrolment by increasing the contribution made by employees towards their pension every time they receive a pay rise.** Some employers have already introduced an auto-escalator into their pension arrangements and have achieved a high level of coverage. Over time such an escalator would significantly boost the pension pots of people on low incomes. **We will also make sure that people get value for money from their contributions by maintaining the pressure on pension scheme charges. To support a flexible labour market we will implement a ‘pot-follows-member’ policy so that small pension pots are no longer left ‘stranded’ when people change job.**

2.4.7 The new ‘Defined Ambition’ legislative framework introduced by the Pensions Minister Steve Webb will provide for new forms of risk-sharing and risk-pooling in pensions, learning from the best pension systems around the world.

2.4.8 We will build on the new freedoms announced in the 2014 Budget for people to convert their pension savings into cash if they wish. **To support this, we will put the ‘triple lock’ indexation of the state pension into legislation, to ensure that those who have saved see the benefits of their savings, and to reduce the risk of people needing to depend on means-tested benefits in retirement.**

2.4.9 As part of the new pension freedoms we are introducing we will ensure that people have access to good quality independent face-to-face guidance before making decisions about their pension savings. **We will develop and test, as part of the guidance offer, a health and wealth**

**'resilience score'**.<sup>46</sup> This would support people in making choices about their lifestyle and finances in retirement. The score could be an aid to later life planning helping people to identify actions they can take to increase their resilience.

2.4.10 From October 2015 we will provide extra help for current pensioners by introducing a new state pension top-up scheme which allows pensioners to buy an extra £25 a week of state pension from next year, for around half the price of an annuity. The scheme will be available for existing pensioners and those who reach state pension age before 6 April 2016 – women now aged 61 or over, and men aged 63 or over.

2.4.11 In our policy paper *Fairer Taxes* (2013) we set out the steps Liberal Democrats have taken to reduce the excessively generous pension tax relief granted by Labour and set out our proposal to restrict the lifetime allowance limit to £1 million. The current system of tax reliefs after taking account of auto-enrolment costs £35 billion a year. Liberal Democrats believe that the system should be simplified to make sure that the benefits of pension tax relief are shared more fairly by giving all pension savers tax relief at a flat rate, *higher* than the current standard rate of income tax. **We would establish a review to consider the case for introducing a single flat rate of tax relief for pensions, which would be designed to be simpler and fairer and set more generously than the current 20% basic rate relief.**

2.4.12 **To support saving for later life and long term care costs outside of the cap we will consult on the details of a new Personal Care Savings Bonds (PCSBs)**<sup>47</sup>. Similar to

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<sup>46</sup> International Longevity Centre UK is currently developing proposals for such a resilience score.

<sup>47</sup> Personal Care Savings Bonds - a new way of saving towards social care in later life, by Les Mayhew and David Smith. Cass Business School. University of London and ILC-UK (2013).

the Premium Bond, PCSBs could be bought by any adult at a nominal value of £1. As well as paying monthly prizes, they would also accumulate interest and could only be cashable when the owner passes a social care assessment or upon death. Research by the Cass Business School notes the fully-mature fund could be worth up to £80 billion, contributing over £2.5 billion to the UK care economy, with annual prize money worth £700 million.

## 2.5 Benefits

2.5.1 We know that many carers are offended by the limited financial support offered by Carers Allowance. The Carers Allowance is £59.75 pw<sup>48</sup>. **We propose that carers be paid a ‘Carers Bonus’ annually as a contribution towards the extra costs, for example, to take a break by arranging for substitute or respite care.** We would set this at £125, aiming to double it to £250 by no later than 2020. So that working carers can keep more of what they earn **we will increase the earnings disregard from £100 to £150 a week (after tax, NICs and allowable expenses, which include care costs while at work and 50% of pension payments).**

2.5.2 We will explore how to achieve greater coherence between disability-related benefits like Employment and Support Allowance (ESA) and Disability Living Allowance (DLA)/Personal Independence Payment (PIP), with strictly age-related benefits, especially given changes to the state pension age. However, we would not expect any review to take place until both Universal Credit and PIP are fully operational.

2.5.3 Currently, even with the streamlining effect of Universal Credit, different age and disability benefits have

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<sup>48</sup> DWP, 2014/15 rate.

different components (eg mobility or contributory components). Older claimants both pre and post retirement ages can find themselves going through multiple assessment processes, so a single gateway approach might be more efficient and reduce stress for claimants. **We will examine the options for adopting a single gateway approach to assessing different levels of entitlement for different disability benefit components;** a common assessment framework across Department of Work and Pensions processes would ensure the same information from claimants is not required on every occasion. Initially, we will ensure that the timings of reassessments for ESA and PIP are monitored so people are not forced to go through multiple assessments close together.

**2.5.4 Based on recent studies<sup>49</sup> we would consult on proposals for reforming Attendance Allowance (AA) to create a benefit with the goal of promoting individual wellbeing and maintaining a person’s independence.** We would include enabling AA data sharing between local authorities, clinical commissioning groups and health and wellbeing boards, to help identify unmet need and forecast local demand for care and support.

2.5.5 A review of benefits cannot overlook the universal age-related benefits, the Winter Fuel Payment (WFP) and Free TV licence at 75. The WFP is an anomaly, costing over £2 billion a year and covering 12 million people. It targets many who do not need assistance for heating and it fails to properly help those who do.<sup>50</sup> Research reveals only 12% of the WFP money is actually spent on fuel.<sup>51</sup> Furthermore, there are as many recipients of WFP in the top income decile as there are

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<sup>49</sup> <http://www.strategicsociety.org.uk/wp-content/uploads/2013/06/Attendance-Allowance-in-England.pdf>

<sup>50</sup> <http://www.if.org.uk/archives/1590/the-winter-fuel-allowance-why-young-people-should-get-hot-under-the-collar>

<sup>51</sup> [http://www.reform.co.uk/resources/0000/0282/Old\\_and\\_broke\\_final.pdf](http://www.reform.co.uk/resources/0000/0282/Old_and_broke_final.pdf)

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in the bottom. Over 100,000 households earning over £100,000 receive WFP.<sup>52</sup> **We would withdraw eligibility for the WFP and free TV licence from pensioners on the higher rate of income tax.**

2.5.6 We have also considered the cost and value of the concessionary bus travel scheme. In our view given the importance of maintaining social connectedness and tackling social isolation the principle of concessionary travel should be maintained.

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<sup>52</sup> Policy Exchange, Cold Comfort: Fuel Poverty and the Winter Fuel Payment (2010).

## 3. Housing

3.0.1 The fastest growing pressure for housing over the next 20 years is amongst the 65-74 and over-85s. Accessible, warm, decent housing enables people to remain living well and independently. Our goal is to increase the supply of acceptable general housing so people can remain in their family home if they wish. In addition we will promote the development of adaptable lifelong housing which can equally accommodate the young or old easily. **We will make the optional building regulations covering accessibility for older and disabled people<sup>53</sup> mandatory to ensure that future housing stock is age ready and built to lifetime standards.**

3.0.2 The age shift means house-building must shift too. The goal should be to increase the supply of adaptable general housing so that people can remain in the same home and a full range of purpose built accommodation so people have positive housing with care options.

3.0.3 **We will update the Government's Housing Strategy for England to mainstream meeting the needs of an ageing society** by including measures to increase the choice for people planning for later life who want to 'right-size' to a new home. In particular we would:

- ensure that the Homes and Communities Agency reflect HAPPI<sup>54</sup> principles in its work;
- require Local Plans to include sufficient housing provision to meet the needs of the ageing population;

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<sup>53</sup> <https://www.gov.uk/government/news/stephen-williams-announces-plans-to-raise-housing-standards>

<sup>54</sup> <https://www.homesandcommunities.co.uk/ourwork/happi>



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- use the community infrastructure levy (CIL) and Section 106 Agreements to incentivise private and social providers to design and build HAPPI-standard schemes;
- require Health and Wellbeing Boards to identify the role of housing in their needs assessments (JSNAs) and reflect the contribution of housing in preventing and postponing the need for health, care or support services.

**3.0.4 We will provide access to impartial advice about housing options whether moving or staying put.** This could include information about housing options such as Shared Lives where an older person living in a larger property shares their home or co-housing where a group of people buy or build on a mutual basis to meet their housing needs.

3.0.5. It is estimated that the NHS spends £192 million each year treating illnesses caused by people living in cold homes.<sup>55</sup> Fuel poor households are economically disadvantaged and they generally need to spend more on fuel, in absolute terms, to achieve a warm and healthy living environment. We set out our approach to fuel poverty and affordable warmth in *Green Growth and Green Jobs: Transition to a Zero Carbon Britain* (2013) and *Decent Homes for All: Policies on Housing* (2012).

**3.0.6 We would incentivise intergenerational home sharing schemes by uprating the rent a room tax free allowance – which has not been increased since 1997 – for those taking part in the scheme.** Currently, this would increase the allowance from £4,250 to £6,570, equating to a maximum of £550 per month thereby providing both additional income for those whose wealth may be tied up in their property, and greater access to affordable rents for younger generations.

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<sup>55</sup> The health costs of cold dwellings. BRE and CIEH (2011).

3.0.7 We will enable people to have a real choice of moving in a planned way to secure a better life, rather than as a result of a crisis triggered by deteriorating health, bereavement or other events. One reason for not moving is the task itself. **We will pilot with local authorities alternative ways of delivering low or no cost help with removals, negotiating with energy suppliers, redirecting mail, selling unwanted goods, dealing with administrative and legal issues and post-move support.** This could take much of the stress away from older people considering a move, particularly those who do not have any family support.

3.0.8 Certain BAME communities are overrepresented among the homeless and are more excluded in accessing quality housing help. ETHNOS revealed BAME homelessness is three times that of the white population.<sup>56</sup> **We believe more culturally sensitive supported housing and care homes for different communities are needed.** Work by Jewish Care<sup>57</sup> and the Policy Research Institute on Ageing and Ethnicity offers a guide to good practice.<sup>58</sup>

3.0.9 **We will build upon the recently introduced private-sector accreditation scheme, proposed as part of the current Communities and Local Government review of property conditions in the private rented sector, to ensure that the wellbeing of all older people is given the necessary regulatory protection.** We would develop a Model Tenancy Agreement.

3.0.10 Over a third of private rented homes fail to meet the current Decent Homes Standard.<sup>59</sup> We will review the Decent

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<sup>56</sup> [http://www.ethnos.co.uk/pdfs/3\\_Full\\_research\\_report\\_ODPM.pdf](http://www.ethnos.co.uk/pdfs/3_Full_research_report_ODPM.pdf)

<sup>57</sup> <http://www.jewishcare.org/home>

<sup>58</sup> <http://www.priae.org/index.php>

<sup>59</sup> Shelter (2014).

Homes Standard to ensure that they deliver measurable improvements in people's wellbeing. **We will also undertake a review of the Exempt Accommodation rules so there is consistent treatment for all, and funding would be based on services provided, not type of provider.**

3.0.11 Liberal Democrats in Government introduced statutory obligations for adult social care services and housing departments to work together. However, we believe that in areas with two-tier local government, we must ensure both housing authorities and local planners are engaged with their local Health and Wellbeing Boards.

3.0.12 The Demos Commission on the Future of Residential Care, is expected to report in September 2014.<sup>60</sup> Led by former Carer Services Minister, Paul Burstow MP, it is exploring how residential care must change.

3.0.13 The Coalition's Care and Support White Paper<sup>61</sup> identified the critical role played by Care Home Managers in setting the right culture and advocated steps to include care homes in the communities in which they operate. **We would support the expansion of My Home Life<sup>62</sup> and similar programmes** aimed at equipping the care workforce with the skills needed to deliver relationship based care and support. Drawing on the experience of Community Visiting<sup>63</sup> and Friends and Neighbours (FaNs)<sup>64</sup> in Essex **we would work with Care England and other bodies representing care providers and Think Local, Act Personal to roll out similar approaches for all forms of housing with care.**

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<sup>60</sup> <http://www.demos.co.uk/projects/corc>

<sup>61</sup> Caring for our future: Care and support White Paper (2012).

<sup>62</sup> <http://myhomelife.org.uk/>

<sup>63</sup> <http://www.essex.ac.uk/cps/documents/independent-evaluation-MHLECA-community-visitor-pilot.pdf>

<sup>64</sup> <http://www.mhle.org/about/fans>

### 3.1 Age friendly communities

3.1.1 The physical and social environment around where we live impacts on how we live and our sense of identity. Architects, town planners and local authorities should be future proofing public spaces to promote active ageing. The built environment of villages, towns and cities should adapt so that public spaces become multifunctional, encourage sociability, are easy to access and safe. **The goal should be to ensure that the built environment adapts to support the goals of making our towns and cities age friendly.** In its report *City Health Check: How design can save money and lives*<sup>65</sup> RIBA argues that **councils should integrate public health considerations into planning policies. We agree.**

3.1.2 There is no single action or policy that will prepare the UK for an ageing society. It requires a co-ordinated approach across many areas of public policy to create an age-friendly nation. The WHO Age Friendly Cities programme<sup>66</sup> offers a practical model for developing solutions. The approach chimes with the wellbeing approach to ageing we describe earlier in this paper. **We will make securing age-friendly communities a goal for Government promoting the adoption of this approach throughout the UK. We will ensure that a central strand of this work is making our communities dementia friendly too.**

3.1.3 **We will ensure National Planning Practice Guidance and Local Plan guidance make clear the benefits of safe and attractive streets and open spaces. Local authorities can lead change by developing Healthy Infrastructure Action Plans (HIAPs) as part of their Local Plans. Developers would be required to demonstrate how**

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<sup>65</sup><http://www.architecture.com/Files/RIBAHoldings/PolicyAndInternationalRelations/Policy/PublicAffairs/RIBACityHealthCheck.pdf>

<sup>66</sup> [http://www.who.int/ageing/age\\_friendly\\_cities\\_guide/en/](http://www.who.int/ageing/age_friendly_cities_guide/en/)

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**their proposals support the local HIAP as part of the Design Access statement they must make when applying for planning permission.**

## 4. Health and care: prevention and co-ordination

**4.0.1 Liberal Democrats recognise funding for social care as an investment, in preventing future need and pressure on social care and NHS services and in enabling families to care healthily.** Similar to childcare this also means recognising care services as a key part of our economic infrastructure – not just enabling older and disabled people to live independently with dignity but in supporting their families to combine work and caring.

4.0.2 Limited access to affordable care and support also has a wider economic impact, in lost productivity in the workplace and lost tax revenues as carers are forced to reduce or give up working. Additional investment in support for older people, widening access to care services – particularly preventative services and improving quality and affordability will also pay dividends for younger generations, in enabling them to better combine work and caring and in improving workforce participation.

4.0.3 The Care Act 2014<sup>67</sup> marks a radical shift of emphasis in the care and support system in England. As a result of the leadership of Paul Burstow and Norman Lamb the Act not only sets the promotion of individual wellbeing as the new purpose for adult care and support it gives family carers equal standing and rights for the first time. The prevention and postponing of need for care and support becomes a legal duty for the first time.

4.0.4 The Act puts in place the cap on catastrophic care

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<sup>67</sup> <http://www.legislation.gov.uk/ukpga/2014/23/contents/enacted/data.htm>

costs and deferred payment scheme recommended by the Dilnot Commission.<sup>68</sup> The reform of the funding of care costs in England is the biggest change in the arrangements for paying for care since the National Assistance Act was passed in 1948 and will mean that no one will have to sell their home in their lifetime or face unlimited and catastrophic care costs.

4.0.5 Age Discrimination in the NHS has been outlawed since October 2012.<sup>69</sup> As Care Minister, Paul Burstow took the decision that there should be no exceptions for health or care services from the ban. This means that age cannot be used arbitrarily to determine access to treatment, it must be based on evidence. There is still more to do. For example, age cut-offs are still routinely used in reporting cancer survival rates. **We will commission a review of the impact of the ban on age discrimination in the NHS and care services reporting to Ministers in 2017.**

## 4.1 Informal care

4.1.1 **To ensure that carers get the support they need we will take steps to increase the numbers of carers routinely identified. We would match the carer identification duty placed on local authorities in the Care Act 2014 with a duty on the NHS.** This would reinforce the importance attached to identifying carers and signposting them to sources of support, so that that they get the right information and advice to help them balance care with other responsibilities.

4.1.2 Government agencies could make life easier when a person takes on a caring role, by making it an automatic

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<sup>68</sup><http://webarchive.nationalarchives.gov.uk/20130221130239/https://www.wp.dh.gov.uk/carecommission/files/2011/07/Fairer-Care-Funding-Report.pdf>

<sup>69</sup> <https://www.gov.uk/government/news/new- armour-to-stop-age-discrimination-in-the-nhs>

trigger to information. Many carers miss out on advice. If a carer applies for Carer's Allowance, we will ensure they get information about local authority assessments and self-assessments so that they get signposted to better information and advice. **We will undertake a rapid review of how government bodies, local and national, can connect more to support carers.**

4.1.3 To support carers **we would work with NHS England to develop an NHS 'carers passport' scheme to inform carers of their rights in the NHS, assert their role as 'expert partners in care' and gain access to support like free hospital parking.** A few NHS Trusts have started to develop these schemes. This would build on the NHS Commitment to Carers launched in May 2014.<sup>70</sup> To support the local development costs, **we would provide start-up fund of £3 million.**

4.1.4 **We would aim to have every NHS organisation participating in the 'carers passport' scheme by 2018.** We would consult on extending the scope of the passport to include priority medical appointments and treatments, recognising that if the carer does not get treated, the person they care for will need more support from the NHS and social care.

4.1.5 An alternative to home care and care homes for disabled adults and older people is Shared Lives. In Shared Lives, a carer and someone who needs support get to know each other and, if they both feel that they will be able to form a long-term bond, they share family and community life. This can mean that the individual becomes a regular daytime or overnight visitor to the carer's household, or it can even mean that the individual moves in with the carer.

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<sup>70</sup> <http://www.england.nhs.uk/ourwork/pe/commitment-to-carers/>



4.1.6 It is currently used by around 12,000 people in the UK. Carers are recruited, vetted, trained and supported by local Shared Lives schemes, who have to be registered with the CQC. Carers receive a payment to cover some of their time and expenses, but are not paid carers. A 2013 report sets out a savings case based on detailed cost comparisons. It proposed a social impact bond based on cashable savings of on average £26,000 per person pa for people with learning disabilities and £8,000 pa for people with mental health problems, when the individual moves out of another form of regulated care (typically residential care or supported living) into Shared Lives.<sup>71</sup> **We will make consideration of Shared Lives part of the planning guidance for future rounds of the Better Care Fund.**

## 4.2 Primary care

4.2.1 Care should be provided “in the community where possible, in hospital only when needed.”<sup>72</sup> If we can identify the people who are at higher risk of hospital or care admissions due to chronic disease, disability, isolation or other factors, we can take steps to improve their quality of life and reduce the impact on health and care services. We will encourage and build on the work by Integration Pioneers in this area.

4.2.2 **Financial incentives across health and social care, including those for GPs, should be aligned around a health and wellbeing agenda**, and more investment should be earmarked to make 24/7 community care a reality. This will promote a preventative focus in caring for older patients, particularly those with long-term conditions.

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<sup>71</sup> Investing in Shared Lives. Social Finance (2013).

<sup>72</sup> Accountable Care: Focusing Accountability on the Outcomes That Matter, WISH (2013).

4.2.3 Patients will receive education and tools to confidently self-manage conditions as far as possible, 'handing over' as little control of their care to clinicians as necessary. **We will incentivise meeting personalised 'self-care outcomes' for chronically ill patients in the Wellbeing Outcomes Framework (drawing together the NHS, Public Health and Adult Social Care Outcomes Frameworks)**, so individuals have the choice and means to manage their conditions out of hospital.

4.2.4 In order to deliver excellent primary care to vulnerable older people, **commissioners will be supported to frontload costs to invest in community and social care.**

4.2.5 **We support the scaling up of general practice federations and primary care networks.** The latter should include pharmacy providers, mental health, community and voluntary sector services. This will allow primary care to move into a model of care that is innovative, proactive and able to tackle the demographic challenges facing all communities. GPs should work with all organisations in their area to improve urgent and unscheduled care services, based on their understanding of local resources and needs.

4.2.6 **We believe there should be more use within general practice of patient profiling and segmentation.** This mechanism helps to identify those most likely to develop a particular illness or suffer deterioration in an existing condition. It can act as a powerful tool for early intervention across mental and physical health, supporting broader initiatives to reduce demand for urgent and emergency care in the medium and long term.

4.2.7 **Patients with more than a set number of drugs prescribed will have an annual medication report given to**

**them by their GP.** This will be provided in written form and be accessible online and via apps, as is the case with 'My Medication Passport'.<sup>73</sup> Our medication report goes further: It names which doctor is actively reviewing each medication, so other doctors concerned about that drug can easily contact them. It will explain why and when each drug was started (in both medical and patient-friendly language) and what doses are currently prescribed. The patient will also be able to write in the *actual* doses they take, for review by their doctor. This will allow patients and their families to understand the reasons behind the medication they are taking. It will reduce drug errors on admission/discharge and cut spend on unused medications. **We also believe that there should be an automatic review of medications where a person over 75 is prescribed more than four medicines at any one time.**

4.2.8 A hearing loss screening programme for people at 65 would ensure effective treatment is offered before people lose the skills and drive for it to work, which could save the NHS up to £2 billion. **We will fund a randomised controlled trial.**

## 4.3 Dignified care

4.3.1 The commissioning of dignified care for older people should be a key objective for NHS England and an ambition championed by the Secretary of State for Health.

4.3.2 **Health 'MOT' checks conducted for all adults when they reach their 65<sup>th</sup> birthday should include a discussion about their potential future social care needs, on-going chronic conditions and how they can maintain their health**

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<sup>73</sup> <http://www.clahrc-northwestlondon.nihr.ac.uk/research-projects/bespoke-projects/my-medication-passport>

**and wellbeing for the future.**

4.3.3 Patients in hospitals or care home have not always received adequate food, water, or assistance with eating.<sup>74</sup> Reports by the Nutrition Action Plan's Delivery Board and by Age UK have revealed that despite improvement, challenges remain. This is unacceptable.<sup>75 76</sup> **In setting future mandates to NHS England the Secretary of State for Health will ensure these basic needs are adequately met through effective, co-ordinated initiatives.**

4.3.4 **We will incentivise the co-location of GP surgeries within urgent care centres, so patients are triaged by clinicians and can access treatment in the most appropriate setting.**

4.3.5 **We will issue all patients in receipt of NHS care with a statement of their care costs – a 'care footprint'.** This would be an 'information-only' letter or email, to raise awareness of the cost of care and empower people to make decisions about their present and future treatment. Redbridge NHS have pioneered such an approach with a Chronic Obstructive Pulmonary Disease checklist.<sup>77</sup>

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<sup>74</sup> Age Concern (2002) and the British Association for Parenteral and Enteral Nutrition (continuing).

<sup>75</sup> Delivery Board Chair, Lishman. Department of Health (2008 and 2009).

<sup>76</sup> The Jeffreys Report. Age UK (2012).

<sup>77</sup><http://www.innovationunit.org/sites/default/files/COPD%20Care%20Checklist%20Report.pdf>

## 4.4 Mental health and dementia

4.4.1 Older people are under-treated for psychiatric problems.<sup>78</sup> **We will ensure that appropriate services are provided, covering continued services for people with pre-existing conditions, action to address prejudice and discrimination in services, training for health and social care professionals and community support.**

4.4.2 People living with mental illness and dementia face stigma. This is a consequence of ignorance but where levels of awareness of conditions such as Alzheimer's disease have improved, levels of stigma have reduced. Timely diagnosis of these conditions is important as is funding to community organisations to provide additional support where required.

4.4.3 Depression and suicide are over-represented in the older population. Their symptoms may be assumed to be part of the ageing process rather than a treatable condition. Staff and family members need training on picking up the signs of depression. **We will introduce Mental Health Champions to care homes.** Key staff members will be trained as a champion, educating their peers and families on how to spot the signs of mental health problems and to promptly refer such cases to a GP or old age psychiatrist.

4.4.4 Depression in later life can be caused by factors including bereavement, changes in family circumstances, poverty, isolation, bad housing and security fears. There is a link between the onset of dementia and depression both for the patient and their carer. **We will review how to improve the training and support of carers on mental health issues.**

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<sup>78</sup> Promoting Mental Health & Wellbeing in Later Life. Age Concern (2006) and Improving Services and Support for Older People with Mental Health Problems. Age Concern (2007).

4.4.5 Dementia is the most feared disease amongst people over 50.<sup>79</sup> There are 820,000 people living in the UK with dementia and this will rise.<sup>80</sup> The Government is delivering the Liberal Democrat 2010 manifesto commitment to double dementia research spending by 2015; it should reach £66 million. **We will make the UK the global leader on dementia research, with the goal of doubling the research spend to £132 million by 2020.**

4.4.6 But research needs to be augmented by action to enable those living with dementia today enjoy a quality of life that has been denied to them in the past. The Coalition's dementia strategy has helped significantly; **we will continue that work, particularly to promote the concept of dementia friendly communities, tasking all government departments to develop their own strategies to support those living with dementia** and reporting to the Cabinet Sub-Committee on Ageing and Wellbeing which we propose elsewhere in this paper. **We will match the best of Europe on dementia diagnosis rates and care.**

4.4.7 While good progress has been made on reducing the over-use of anti-psychotic drugs in the management of dementias, the evidence of the life shortening consequences of their long term use demands sustained action to limit their use. **We will continue to audit progress towards the goal of eliminating the inappropriate use of anti-psychotic drugs.**

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79 YouGov survey results (Cambridge: Alzheimer's Research Trust; London: YouGov); respondents aged 55 and above said they feared dementia more than cancer, stroke and heart disease. Among younger people, however, cancer was still feared more than dementia.

<sup>80</sup> <http://www.alzheimersresearchuk.org/dementia-statistics/>

## 4.5 NHS recruitment and training

4.5.1 In professional training, there is limited recognition that staff will be working more so with older people facing multi-morbidity, and that well-intentioned interventions may threaten their resilience. Staff must be trained so they are alert to the dynamic relationship between ‘old’ and ‘age’ as life expectancy continues to rise. Patient and carer involvement in this is crucial, so professionals can learn from real-life experiences.

4.5.2 There is a need for more hospital ‘medical generalists’ and GP’s with broad-based skills. This will enable patients with multi-morbidity to be assessed in the community (e.g. at home, day assessment centres, group GP practices or non-acute community hospitals). These centres would have multidisciplinary specialist advice from pharmacists, physiotherapists and occupational therapists, and community nurses available.

**4.5.3 We will explore with the Royal Colleges how to improve recruitment and retention of old age physicians and old age psychiatrists. We will consider introducing part-time community-based contracts,** potentially linked to the GP group practices/community hospitals mentioned above.

**4.5.4 We will work with the Royal Colleges, the BMA and leading medical schools to aim to increase the amount of geriatric training that medical students receive,** so that more are encouraged to specialise in this field, and more are better prepared to deal with the needs of older people in clinical settings.

4.5.5 In the patient-centred NHS, hospital and GP services

should be available every day. To work, this must extend throughout the sector, covering diagnostics and imaging, discharge professionals and social care, community and mental health services.

## 4.6 End of life care

**4.6.1 We will introduce free end of life care for those placed on their local end of life register.** This would support people in choosing where they die, ensure that they and their families receive timely practical support, and reduce the number of people who die in hospital despite their desire to die at home.

**4.6.2** The House of Lords report on the Mental Capacity Act 2005 has proposed broadening the current Independent Mental Capacity Advocates into ‘patient advocates’, making it available to more people.<sup>81</sup> Similar ‘Patient Advocates’ could work with individuals likely to experience declining health from chronic conditions, by compassionately supporting them to discuss and express their wishes about their future care *earlier*, just in case the individual were unable to make decisions.

**4.6.3 We will work with the Royal Colleges to improve communication skills in discussing end of life care and advance decisions with families and patients, including the development of appropriate ‘decision aids’.**

**4.6.4** The Gold Standards Framework is currently used by GPs and care homes to offer a care programme to those at risk of dying in the next year. **We will review if a similar framework, encouraging individuals to forward plan,**

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<sup>81</sup><http://www.publications.parliament.uk/pa/ld201314/ldselect/ldmentalcap/139/139.pdf>



**should be extended to those whose risk of dying is beyond the next year.**

4.6.5 ‘Do not attempt resuscitation’ (DNAR) orders are usually initiated by healthcare professionals when the patient is in a critical state and not expected to survive. They aim to avoid futile treatment and so, avoid distress to patients, as well as guiding staff on how to manage the patient appropriately if they deteriorate.

4.6.6 DNAR orders must always be pre-discussed with patients (and family as appropriate), but occasionally may not be. Discussions may also have been misunderstood or forgotten. **They should be replaced, in time, by patient-initiated advance decisions to refuse treatment – placing the patient at the driving seat of their care.**

4.6.7 **We will commission a review by Health Education England and Skills for Care of how to improve the training of GPs, hospital, and care home staff on end of life care.** We will explore introducing a ‘in service’ qualification to recognise this work professionally and remuneratively. The development of excellent communication skills should be seen on par with technical competency.

## 5. Making it happen

5.0.1 In their report the House of Lords Committee on Demographic Change recommended that “Government should set out their analysis of the issues and challenges, and their vision for public services in an ageing society”.<sup>82</sup> We agree and this paper is a Liberal Democrat contribution to that process. The Government Office for Science is engaged on a project ‘Analysing the Challenges and Opportunities of an Ageing Society’.<sup>83</sup> This aims to deliver its interim outputs in the second half of 2014. However, after the General Election we believe that the incoming administration will need to take steps to complete the analysis recommended by the House of Lords and set out in a White Paper its long term approach.

**5.0.2 In Government we would establish two independent cross party commissions – one to examine options for supporting longer working lives, including life-long learning, pension saving and later life planning; and the other to analyse future demand for health and social care and make recommendations for how best to meet the needs of an ageing society.** The commissions would be expected to engage extensively with the public, civil society organisations, public and private sector organisations, leading a national debate on how we make the UK age ready.

5.0.3 To ensure that Government take the long-term and co-ordinated approach necessary to ensure that the UK is age ready we will strengthen the machinery of Government. **We will establish a Cabinet Committee on wellbeing and ageing chaired by the Chief Secretary to the Treasury and**

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<sup>82</sup> Ready for Ageing. Select Committee on Public Services and Demographic Change, HL Paper 140 (2013).

<sup>83</sup> Foresight are running a Policy Futures project looking at the implications of demographic change for the UK Government.

**appoint a Minister for Ageing.** Appointing a senior Treasury Minister to chair the committee should ensure it has the reach and the clout necessary to secure the departmental support necessary to delivering results.

5.0.4 As well as improving Government structures for a more joined-up approach to ageing **we will create a statutory independent Older People's Commissioner to champion the contribution of older people and to ensure that older people are provided with the tools necessary for improved wellbeing.** This should include ensuring that policy makers take account of the need for stronger, more resilient and connected communities that can help tackle and alleviate loneliness.

5.0.5 An Older People's Commissioner for England with effective statutory powers would help the government address many of the challenges and opportunities that an ageing society presents.<sup>84</sup> In designing the remit for a Commissioner in England we would draw on the experience of the Welsh and Northern Ireland administrations. Specific responsibilities that would fall under this remit include: promoting positive images of ageing and older people and challenge negative stereotypes; an advocate on issues affecting older people – with the powers to investigate complaints and effect change; championing the take up across government and civil society of the UN Principles for Older Persons and the recommendations of the UN's International Plan of Action.

5.0.6 We believe that Health and Wellbeing Boards have the potential to be a powerful engine for increased integration between different parts of public services, and in the interests of the 'whole citizen', rather than simply treating individual

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<sup>84</sup> Giving Older People a Voice: The case for an older people's commissioner in England Centre Forum (2013).

conditions or needs in isolation. In this paper and in policy paper *Protecting Public Services and Making Them Work For You* (2014) we set out how the role of local Health and Wellbeing Boards should develop. Including:

- Increase the funding channelled through the Better Care Fund;
- Linking the commissioning of different types of services for the same person;
- Leading the cross sector collaboration necessary to develop wellness services, influencing and linking up other parts of public services;
- Identifying and addressing social isolation and ensuring it features in the work of Directors of Public Health and the commissioning plans of CCGs and adult social services;
- Engaging housing authorities and local planners and including the contribution of housing and the built environment to preventing and postponing the need for health and care services;
- Where robust and democratically accountable governance is in place taking responsibility for commissioning primary care;
- Commissioning and holding provider organisations to account for achieving outcomes.

5.0.7 To further develop the capabilities and capacity of Health and Wellbeing Boards **we will review the current arrangements for commissioning support organisations and the training and support available to Boards and their members.**

## 6. Conclusions

6.0.1 How societies adapt to being 'older' is one of the defining challenges of the 21<sup>st</sup> Century. By the end of the Century practically every nation on earth will have made the journey. Liberal Democrats take an optimistic view. A combination of State and private actions are required to ensure that Britain is age ready. In Government Liberal Democrat Ministers have already laid the foundations in pensions and care reform.

6.0.2 Age Ready Britain is not simply about today's older people it is about all of us. There is no single action or policy that will prepare the UK for an ageing society. It requires a co-ordinated approach across many areas of public policy to create an age-friendly nation. By making wellbeing a measurable goal of Government and an organising principle for public services we can set in motion the changes needed to realise the potential of an ageing society.

## **Age Ready Britain Realising the Potential of an Ageing Society – Policy Paper 122**

This paper has been approved for debate by the Federal Conference by the Federal Policy Committee under the terms of Article 5.4 of the Federal Constitution. Within the policy-making procedure of the Liberal Democrats, the Federal Party determines the policy of the Party in those areas which might reasonably be expected to fall within the remit of the federal institutions in the context of a federal United Kingdom. The Party in England, the Scottish Liberal Democrats, the Welsh Liberal Democrats and the Northern Ireland Local Party determine the policy of the Party on all other issues, except that any or all of them may confer this power upon the Federal Party in any specified area or areas. The Party in England has chosen to pass up policy-making to the Federal level. If approved by Conference, this paper will therefore form the policy of the Federal Party on federal issues and the Party in England on English issues. In appropriate policy areas, Scottish, Welsh and Northern Ireland party policy would take precedence.

### **Working Group on Age Ready Britain**

Note: Membership of the Working Group should not be taken to indicate that every member necessarily agrees with every statement or every proposal in this paper.

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