CENTRE FOR AGEING BETTER

THE WORK OF THE CENTRE FOR AGEING BETTER: CONSULTATION PAPER

MARCH 2015

CONTENTS

1.   We would be pleased to receive your reactions to this consultation paper, including:

- Any high-level comments on our vision, aims and objectives;

- Any reactions to how we will work – in particular, how we will:
    - involve older people;
    - identify the issues that matter most to people and where our capabilities allow us to bring about change;
    - manage and deliver programmes, working in partnership with other bodies;
    - evaluate and adjust our portfolio of activities;
    - and build an organisation that is fit for purpose;

- Comments on the eight potential topics in Appendix 1 – and, in particular, the key questions listed at the end of each topic paper.

2.   A summary of consultation questions can be found at Appendix 2. We would welcome your comments – to ceo@agebetter.org.uk by May 20th 2015.

SUMMARY

3.   The opportunity for a longer life is one of our society's greatest achievements – and, currently, many older people enjoy extensive benefit from this. But the inequalities in later life are striking and shocking; many other older people live shorter lives, are unhealthy for more of their later life, are poorer than they expected, are lonely and isolated, and lack meaning in their lives. There are very diverse experiences of ageing across different parts of the country and across different social and identity groups. And the discourse around an ageing society is negative; too often, ageing is seen as a problem, rather than as a great asset for society and for individuals.

4.   The Centre for Ageing Better (CfAB) aims to help many more people have a better later life by applying evidence of what works and by driving change in line with this evidence. We have a clear understanding from the evidence of what people want for a better later life and a clear analytic of where change is needed to make this possible across four key domains of better health, better finances, better relationships and better places.

5.   By the end of our ten-year period, our aim is that more people will know how to plan and prepare for a better later life - and more will do so. More organisations will know what works to support individuals and society to enjoy better later lives – and more of them will act on this evidence. And we aim to have shaped the broader conversation around an ageing society so that, as a country, England becomes more ready to celebrate longer later life and to see the benefits arising from greater numbers of older people.

6.   The Centre for Ageing Better received £50 million from the Big Lottery Fund in January 2015 in the

form of an endowment to enable it to identify what works for a better later life by bridging the gap between research, evidence and practice. CfAB is currently in start-up mode with an interim CEO and a small team undertaking the preparatory work that needs to be completed if we are to make good progress in advance of the autumn, when the Centre's Board and Permanent CEO will take decisions on the composition of its initial portfolio of activities. As part of these preparations, CfAB is keen to consult with a wide range of organisations on the Centre's vision, proposed role and ways of working - and also on a list of eight potential topics (details of which are outlined in the appendix to this document) that might form part of our initial portfolio.

A VISION FOR AGEING BETTER

7. A vision for ageing better - based on the evidence CfAB has reviewed of what older people want for themselves, and on an assessment of how the whole of society can be enriched by our ageing population – points to the need for change across four domains if more people are to benefit from a longer life:

   - **Better health** – in which lifestyle choices, environmental factors and service provision combine to give older people the maximum opportunity for physical, mental and social wellbeing as well as minimising the impact of disease and infirmity.

   - **Better finances** – in which older people develop and sustain the resources needed to give them a life more free from money worries in later life.

   - **Better psychosocial life** – in which older people feel connected and experience a sense of purpose, in which they feel valued and can live free from ageism, and in which they nurture the individual and collective capabilities that allow a resilient response to the challenges of ageing.

   - **Better places** – in which the supply, design and location of homes are appropriate for the opportunities and challenges of later life; and in which decisions around the built environment and transport, cultural and leisure services create places in which growing old is a pleasure rather than a battle.

8. More needs to be done by individuals, their families and society as a whole, as well as by public bodies, to achieve these outcomes. CfAB's analysis, and our discussions last year with stakeholders and the public around the development of our business plan, has confirmed that there is a clear need for an organisation that:

   - Adopts an entirely independent position - from which it is possible to survey the entire landscape, see the whole picture, and challenge wherever it is needed;

   - Champions the generation and use of evidence across all the domains of people's experience of ageing - and then connects the evidence base to the levers of change, using the evidence to drive change;

   - Focuses on people and their needs, rather than simply on public services; and

   - Targets relatively neglected areas – in particular, prevention and optimisation, and understanding and tackling inequalities.

9. CfAB intends to fill this gap. Our aim is to be a force for evidence-based change that helps realise the vision for ageing better across the four domains outlined above. We will do this through:

    - **Harnessing and strengthening the evidence base.** We will synthesise evidence on what works to support ageing better; and we will supplement this evidence through commissioning, funding and supporting fresh evaluation and the development of new insights - as well as through encouraging funders and research organisations to generate more and better evidence.

    - **Funding projects.** Working with other funders and providers, we will seed projects that show promise and potential for contributing to our vision of better ageing, and we will help projects with proven effectiveness to operate at greater scale.

    - **Helping bring about evidence-based change through partnership working.** We will work with a combination of individuals and their families, voluntary and community organisations, businesses and statutory bodies in order to best bring about the necessary change, based on the insights that our funding and evidence work have generated. Forming effective partnerships will therefore be an essential component of our work. In part, our role in these partnerships will be to share evidence through compelling and accessible communications. But we will also engage in a wider range of activities that can encourage, support and challenge others to secure change through the application of evidence and adoption practices that have been shown to be effective.

10. Over time as the Centre develops its understanding and capabilities it will seek to influence the generation of better evidence to improve later lives, by working:

    - with research funders to suggest where research and evidence is most needed;

    - with innovation funders to suggest where innovation is needed and that funded projects build credible evidence;

    - with practitioners (across the voluntary and community sector, clinical commissioning groups, local authorities, etc) to raise the importance of building credible evidence to improve outcomes for older people;

    - with all the above to build evidence-based business cases to show that certain actions are more likely to deliver benefits to individuals and to public policy goals. Without this it is less likely that funding will be attracted to enable the scaling of promising innovations.

11. It is in the connection between evidence and change that the Centre can add the greatest value. We have been given a clear message from the Big Lottery Fund about the importance of our being a 'do-tank' rather than merely a writer of reports; and we are fortunate that the size of our endowment provides us with opportunities to fund initiatives, rather than merely assess the initiatives of other organisations. CfAB appreciates that these opportunities must be used wisely: our funding decisions must always be based in evidence, and must also involve the capture and evaluation of data on the impact and cost-effectiveness of what we fund. Equally: our work around synthesising and supplementing the existing evidence base must never see the generation of better evidence on its own as a sufficient justification for CfAB's existence – we will need to ensure that our evidence products are trustworthy, accessible and relevant to the organisations and individuals

we wish to influence, and that those agents are motivated and enabled to act on the insights we generate. The ultimate test of all our work is whether it helps bring about better outcomes for older people: if we are unsuccessful against this standard, then we will have failed in our mission.

OUR APPROACH TO THE SELECTION, DESIGN AND DELIVERY OF PROGRAMMES OF WORK

12. Our approach will be evidence-led and programme-based, with the ability to take the long view as well as to be agile and responsive to new issues that emerge over the life of the Centre. Given the scale of our ambition, and the breadth of the canvas across which we will operate, CfAB will need to develop a portfolio of initiatives – and the design and management of this portfolio will require considerable skill if CfAB is to generate the maximum impact from its endowment. The Centre will need to be highly effective in:

   • Selecting the topics on which it will work,

   • Delivering programmes to generate impact for beneficiaries,

   • Monitoring and evaluating our activity, and

   • Adjusting CfAB's portfolio and ways of working over time.

13. Throughout this cycle of activity, CfAB is committed to ensuring that the views and voices of older people are embedded in the Centre's work. We want to select topics that reflect the priorities of older people, deliver programmes in ways that promote co-design and co-production with older people, and adopt approaches to behaviour change that reflect what we know will resonate with older people. We are exploring an exciting and innovative set of ideas for realising these ambitions: they include the establishment of an opinion-research panel and a deliberative group of older people, using older researchers to carry out our work, and involving older people in quality assurance and product feedback. CfAB is also considering how best to ensure that the views and voices of older people in their full diversity resonate throughout the Centre's governance.

HOW WE WILL SELECT TOPICS FOR OUR INITIAL PORTFOLIO

14. Using the four domains of better ageing (outlined in paragraph 7 above) as our starting point, we have prepared a list of topics for potential inclusion in the Centre's initial portfolio of work. This is the material on which we would particularly value your feedback. The topics – which are outlined in a series of short papers attached as Appendix 1 to this consultation document – are:

   1. Healthy Living for All

   2. Extending Working Lives

   3. Social Connectedness

   4. Sustaining Independence in the Home

   5. Ready for Ageing Locally: What Works?

   6. Ageism: Understanding its Perception and Impact

   7. Inequality in Ageing Outcomes

   8. The Contribution of Older People to a Better Later Life

15. The topics have been selected to illustrate all four of our domains, as well as some of the key cross-cutting issues that impact on later life. They have been developed through a process of desk research and discussions at Board level, and have been the subject of a preliminary assessment of:

- **Desirability** - considered with reference to the opportunity for CfAB to improve outcomes for older people, address deficiencies in the evidence base, work on issues where existing organisations would benefit from CfAB's support in order to achieve change, and where there is scope to achieve meaningful change within a five-year time horizon; and

- **Feasibility** - considered with reference to the level and nature of behaviour change required from organisations and individuals, the overall net cost of action, the availability of powerful partner organisations that appear willing and able to work with us to help bring about change, and the extent to which the economic and political environment is conducive to change.

16. In addition, all eight topics have been evaluated for:

- Their degree of fit with CfAB's distinctive characteristics (independent, evidence-driven, person-centred, able to take the long view, and involving attention to the preventative agenda and to inequalities), and

- Whether there is a convincing 'Theory of Change' – namely, whether the Centre can outline how a programme could help targeted individuals and organisations generate measurable outcomes that will contribute to the ultimate goals that the Centre is seeking to achieve. Each topic paper contains some initial thoughts on theories of change, and we would welcome comments from consultees on these thoughts.

17. Your views are sought on these eight topics - in particular, on the questions asked at the end of each topic paper. A summary of the questions on which we would welcome responses are set out in Appendix 2.

18. In addition to consulting with stakeholders, the Centre is also planning a process of public engagement (probably in the form of a series of focus groups and ethnographic interviews), a series of scoping reviews (to enrich our understanding of the published evidence base) and the running of calls for examples and evidence (to enrich our understanding of the wider landscape). Together, we hope that these ingredients will provide the CfAB Board with a rich basis for taking decisions this autumn on the shape of the Centre's initial portfolio, ensuring that our priorities are determined not just by our own analysis but also by discussions with older people themselves and with organisations that are devising and providing services for them.

19. When considering potential topics for its initial portfolio, CfAB may well face a position where there is a surplus of credible opportunities over available resources. In assessing the competing claims of these opportunities, the Board will give priority to programmes which generate balanced and comprehensive coverage across the four domains and which create a mix of results over the short, medium and long term.

HOW WE WILL DELIVER PROGRAMMES TO GENERATE IMPACT

20. In each case, programmes will start from a clear and compelling account of:

   • The desired impact that CfAB is looking to help bring about;

   • A set of target outcomes that will contribute towards the desired impact;

   • Which individuals and institutions can help generate these outcomes, where those agents are at the moment, and what mix of activities by CfAB and partners can help move the agents to where they need to be in order to generate the target outcomes; and

   • How to underpin this process of change with appropriate measures that will allow CfAB to track progress towards the generation of impact.

21. The mix of activities will vary across programmes: some will be focused more on evidence synthesis and generation, others more on the seeding and scaling of promising and proven practice. We will deploy a variety of tools – potentially spanning opinion research, analytical and evaluation studies, grant funding, equity financing, and partnership working – in support of the proposed mix of activities; and we will publish the results of our work. An important part of our research and analytical work will be the identification of relevant sources of evidence internationally.

22. For evidence synthesis and generation activities, CfAB will need to be a skilful commissioner of systematic reviews and evidence summaries: in making decisions between competing priorities, we will consider whether the proposed work will generate new insight, and what the likelihood is of that insight stimulating action in line with the Theory of Change. For seeding and scaling activities, CfAB will need to combine its commitment to evidential rigour with skills as a grant-maker and investor: in making decisions between competing priorities, we will consider the strength of applicants' business cases and their capability to deliver the proposed change – as well as the feasibility of using trials and quasi-experimental methods as part of independent evaluation that assesses the effectiveness of funded interventions. Across all these activities, the Centre is committed to taking risks – we will back some initiatives that have potential and promise, and which therefore have a degree of uncertainty. Not everything we do will work; but everything we do will provide opportunities for learning.

23. CfAB appreciates that even the most compelling pieces of synthesis and seeding will, at best, be necessary but not sufficient to bring about change. If our work is to generate real impact, the Centre will need not just to publish reports and highlight effective practice; it will also need to apply leading-edge thinking about how to bring about change in individuals and organisations – and, more broadly, about what it takes to create movements for social change.

24. For many of our programmes, we envisage working closely with experts from the fields of social psychology and behavioural economics, applying leading-edge approaches to facilitating behavioural change that make such change easy, attractive, social and timely for individuals. Where our work is orientated more towards the activities of institutions, we will draw on the extensive literature about how to achieve successful change in organisations. And where impact is dependent upon broader changes in social attitudes, we will work with stakeholders and carefully selected media partners to design and run campaigns around the insights generated by our work.

HOW WE WILL EVALUATE OUR PROGRAMMES

25. CfAB will ensure that each programme of work is evaluated once it has had sufficient time to achieve its target outcomes. Evaluations will focus on impact as well as on process - and on cost-effectiveness as well as effectiveness. We propose to earmark a proportion of each programme's budget to fund these evaluations – and to publish the results.

HOW WE WILL ADJUST THE PORTFOLIO – AND OUR WAYS OF WORKING – OVER TIME

26. CfAB envisages a gradual expansion of the size of the overall portfolio over the first few years of the Centre's life. In the first year, we will initiate work on up to six topics; we may then add 2-4 further topics across years two and three. By our fourth year, we anticipate that sufficient progress will have been made across the portfolio to warrant a reassessment of its shape and composition. We envisage a range of options for individual programmes: stopping work because we feel we have been successful – or because we have been unsuccessful; continuing at the same size and scale of commitment; and expanding or reducing the level of resources. In addition, as a result of these considerations, the reshaping of the portfolio may create space for new topics to be added – both for scoping work, and for programme delivery.

27. We will consider these options with reference to evidence about where we have got to and judgments about what – given the evidence of progress to date - is likely to happen in the future. Our evidence sources will include our own data on programme performance, the results of evaluation studies and stakeholder feedback. In reaching a conclusion about how to reshape the portfolio, we will consider:

    • Whether our work to date has demonstrated routes to impact and means of scaling these interventions;

    • Whether CfAB can withdraw from active involvement without jeopardising the momentum of the initiative; and

    • The opportunity cost of our choices: we appreciate that continuing with any one programme will deny resources for others – including potential new topics of work that may have emerged from discussions with older people and stakeholders, or in the overall social and public-policy environment.

Throughout this process of option appraisal, we will ensure that we remain focused on our two highest priorities – the need to be evidence–driven, and the need to generate impact for our beneficiaries.

28. Across all our work, we will strive to achieve high standards in the collection and use of evidence. For this reason, we are pleased to be part of the network of What Works Centres. We have had extensive and valuable contact with fellow evidence-driven practitioners across this network, and we look forward to drawing further on the skills and knowledge of our What Works colleagues.

29. We appreciate that the delivery of our ambitions will require outstanding capability across all dimensions of the Centre's organisation. We will need to pay close attention to:

- Governance and leadership;
- Organisation design and the establishment of CfAB's core team of staff;
- Models of partnership working.

30. CfAB has already assembled a Board with a powerful breadth of skills and experience. Its membership combines expertise (in ageing, and in the use of evidence to influence practice) and executive capability (in programme and change management, in commissioning, and in the management of resources). As well as leading on the development of the Centre's business plan, the Board has established a governance framework and completed an initial risk assessment for its work.

31. The Centre has advertised for a Permanent CEO, is about to advertise for a Director of Evidence, and hopes to make these appointments over the summer. In the interim, a small development team (headed by the Centre's Interim CEO, Greg Wilkinson) is working on the establishment of the Centre's capabilities; the team also hopes to identify a limited number of processes and activities that can be prototyped, to enable the Centre to 'learn through doing' and also to kickstart our core activity of enabling evidence-based change.

32. Alongside the CEO and Director of Evidence, the Centre will appoint a small number of high-quality permanent staff to form the Centre's core team, ensuring that CfAB acquires expertise in leading-edge research methods and techniques; and we will commission services beyond this core, buying in support to accelerate our development and assist with the design and delivery of programmes of work. We will continue to be active within professional networks across related organisations – especially the other What Works Centres, which contain extensive expertise that will be invaluable to CfAB in its work.

33. We will build partnerships to advance all aspects of our work. These will include a small number of strategic partnerships (characterised by mutuality of interest, complementarity of skills and resources, and high trust) and a wider range of delivery partnerships with organisations that can help us drive evidence-based change for individual topics. CfAB is pleased by the warm relationships it has already established with a large number of potential partners – for both strategic and tactical relationships – and is keen to use this consultation exercise to help cement partnerships over the coming months as we move towards decisions on our initial portfolio of work.

34. The pressing priorities at this stage in our existence are around consulting with stakeholders, engaging with the public, establishing the infrastructure of the Centre, building the top team, and looking to agree and then launch our initial portfolio of activity towards the end of 2015. We have not yet spent time considering what CfAB's future might be after our ten years' existence has come to an end; our current view is that we will operate as a spend-down organisation, looking to use up the resources we secure across our lifespan – and aiming to leave a legacy of having made a profound difference to the quality of later life in England through the generation of evidence-based change.

CONCLUSION

35. There is much that we can do to drive evidence-based change around ageing. Across the ten years of CfAB's life, it is realistic to aim for significant progress in key outcomes across our domains - to help create a country in which:

- More individuals and organisations have a better understanding of what works to deliver opportunities for better health, stronger personal finances, continuing participation in the world of work, more and better volunteer-based support, housing that fits changing needs, and localities that are genuinely age-friendly;

- More individuals act on this understanding, building and reinforcing the habits and behaviours that give them the best chance of a richer later life;

- Existing organisations adapt their services and offerings to reflect the evidence of what works; and

- New organisations and services come into being and, if they can prove their effectiveness, operate at sufficient scale to tackle the problems that existing provision is unable to solve – and thereby help people to live a better later life.

36. Old age will never be a period entirely without challenge and suffering. But it is now clear that human ageing is much more malleable than has been previously thought. Many more people can arrive at old age healthy and cognitively fit, and many more can enjoy states of wellbeing for longer periods of their later years: our task is to help identify and apply the evidence that makes these outcomes possible. We are excited by this task; and we are looking forward to doing the work.

NEXT STEPS

37.   We are consulting over the next eight weeks with a wide variety of stakeholders to test reactions to our proposed role and our possible work topics or programmes. The questions on which we would welcome responses are set out in Appendix 2.

38.   In addition, and fundamentally for us, we will over the Summer engage with the public in a number of ways and will do this by listening to individuals and groups across England to deepen our understanding of the diversity of views, needs and opportunities.

39.   Over the next four months we will also undertake further research to deepen our understanding of the eight potential work topics so that we have a better understanding of the changes that matter and of the evidence base that is relevant to bringing about such changes.

40.   Our present aim is to have concluded all the above processes by the autumn, so that the Board and permanent CEO can then decide on the initial work programme of the Centre.

APPENDIX 1

TOPIC 1: HEALTHY LIVING FOR ALL

SUMMARY

Habits and behaviours formed earlier in people's lives – from childhood to the middle years - have a major impact on their health in later life. Physical inactivity, poor nutrition, smoking and alcohol consumption bring about a significant diminution of the quantity and quality of later life. A key issue is what works to help people shift their behaviour to healthier lifestyles.

TOPIC OVERVIEW

WHY THIS MATTERS

Ill health in later life is closely tied to lifestyle and behavioural choices made in middle age. The four principal behavioural risk factors – smoking, alcohol consumption, lack of physical activity and poor nutrition – contribute to half the burden of illness in the developed world.[1] Research suggests that the presence of all four risk factors shortens an individual's life expectancy by up to 14 years,[2] and that up to 40% of premature deaths are a result of what individuals do to themselves, for example eating a poor diet.[3]

Changes to lifestyle choices earlier in the life-course are important in improving ageing outcomes for older people.[4] For example:

- Physical activity: One hour of physical activity each week increases the likelihood of successful ageing.[5] Physical activity in mid-life is related to reduced incidence of disability,[6] improvement in cognitive function,[7] and delayed later-life mortality.[8]

- Diet: A healthy diet throughout the life-course is linked to better ageing,[9] and reduced mortality.[10]

- Smoking: International examples have highlighted the negative effect of smoking on mobility[11] and cognitive ability.[12]

- Alcohol: There is greater likelihood of ill health among alcohol drinkers, and a greater risk of osteoporotic fractures.[13] Reduced alcohol consumption has been linked with lower risk of dementia.[14]

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1   World Health Organisation, Active Ageing: A Policy Framework, 2002.

2   Lords Committee on Public Service and Demographic Change, Ready for Ageing?, 2013.

3   McGiniss, et al, The Case for More Active Policy Attention to Health Promotion, 2002.

4   NICE, Disability, Dementia and Frailty Evidence Review, 2014.

5   Britton, et al., Successful Aging: the contribution of early-life and midlife risk factors, 2008.

6   Ibid.

7   Chang, et al, The effect of midlife physical activity on cognitive function among older adults: AGES—Reykja vik study, 2013.

8   Elwood, Healthy lifestyles reduce the incidence of chronic diseases and dementia: evidence from the Caer philly Cohort Study, 2013.

9   Samieri, The association between dietary patterns at mid-life and health in ageing: an observational study, 2013.

10   Seccareccia, et al, Vegetable intake and long-term survival among middle-aged men in Italy, 2003.

11   Agahi, Shaw, Smoking trajectories from mid-life to old age and the development of non-life-threatening health problems: a 34 year prospective cohort study, 2013.

12   Debette, Mid-life vascular risk exposure accelerates structural brain aging and cognitive decline, 2011.

13   Moayyeri, et al, Estimation of absolute fracture risk among middle-aged an older men and women: the EP IC-Norfolk population cohort study, 2009.

14   Virta, et al, Midlife alcohol consumption and later risk of cognitive impairment: a twin follow-up study, 2010. See also NICE, Disability, Dementia and Frailty Evidence Review 2, 2014: the evidence on links between alcohol and diabetes/ other conditions is less consistent.

- Cognitive activity: There is consistent evidence that cognitive activity in mid-life is related to lower risk of cognitive decline.[15]

There is some evidence that disability rates in the UK's older population are declining.[16] But a large proportion of older people still suffer from poor quality health: 5.1 million people over the state pension age have a "long-standing illness, disability or impairment which causes substantial difficulty with day-to-date activities." Of those, some 71% reported mobility impairment, and over 20% reported sensory impairment.[17] Older people disproportionately suffer from costly long-term conditions, which take up 70% of the national health budget.[18] The indicative costs to the economy of physical inactivity and malnutrition are substantial: £20bn[19] and £13bn[20] per year respectively.

The picture is starker for at-risk populations. The poorest old people are estimated to experience 28% less disability free life after 65 than the least disadvantaged;[21] are five times more likely to have poor general health; and are twice as likely to have diabetes.[22] The richest neighbourhoods have on average 17 more years disability free life than the poorest neighbourhoods.[23]

A number of risk indicators for adverse lifestyle behaviours have been highlighted in the UK population:

- Socioeconomic: The incidence of many key health behaviours "significant to the development of chronic disease follow the social gradient": e.g. 5% of people on low incomes reported skipping meals for whole days.[24] Individuals at socioeconomic disadvantage have lower expectations of longevity and are less likely to engage in healthy behaviours, judging the long-term health benefits to be minimal.[25]

- Employment: People who are unemployed have higher rates of limiting long-term illness, mental illness, cardiovascular disease and increased overall mortality.[26] "[W]orking conditions in the middle of people's working lives and the long-term effects of job strain" cause health inequalities in later life.[27]

- Education: People with no formal qualifications were five times more likely than those with higher education to participate in the four key damaging behaviours of excessive alcohol consumption, poor nutrition, lack of physical activity, and smoking.[28]

- Ethnicity: Ethnicity is an important determinant of later life health outcomes, which is tied at least in part to behavioural factors. For instance, Bangladeshi women in Britain suffer poor health relative to the average population; nutrition "plays a significant part" in explaining this.[29]

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15   *Holtzman, et al, Social network characteristics and congition in middle aged and older adults, 2004.*

16   *Joseph Rowntree Foundation, A Better Life: Demographic Issues, Projections and Trends, 2010.*

17   *Department for Work and Pensions, Family Resources Survey, 2013.*

18   *NHS, Five Year Forward View, 2014.*

19   *Designed to Move, Designed to Move: A physical activity agenda (http://www.designedtomove.org/), 2013.*

20   *UCD Institute of Food and Health, Nutrition and Health in and Ageing Population, 2010.*

21   *ONS, Life Expectancy, Healthy Life Expectancy, and Disability Free Life Expectancy at Birth, 2012.*

22   *A Coote, London: New Economics Foundation, The wisdom of prevention: long-term planning, upstream investment and early action to prevent harm, 2012.*

23   *Marmot Review, Fair Society, Healthy Lives, 2010.*

24   *Ibid.*

25   *ELSA, "Socioeconomic position and the association between anticipated and actual survival in older English adults", 2014.*

26   *Marmot Review, Fair Society, Healthy Lives, 2010.*

27   *Lords Committee on Public Service and Demographic Change, Ready for Ageing?, 2013.*

28   *The King's Fund, Clustering of unhealthy behaviours over time, 2012.*

29   *"Finding 17" in NDA Programme Handbook, Dec 2014 summary.*

Achieving even moderate changes over a sustained period of time is extremely challenging, in particular for people in vulnerable populations, who often face multiple risk indicators.[30] Awareness alone can be insufficient to encourage change.[31] Whilst incidence of risk factors declined from 33% of the population to 25% between 2003 and 2008, this occurred disproportionately in higher socioeconomic groups.[32] Uptake of past population-wide ill health prevention programmes were more quickly and commonly taken up by the middle classes and those who had positive attitudes towards health. Hence the relationship "between social conditions and health is not a footnote . . . [but] should become the main focus" of healthcare policy.[33]

Potential theory of change and outcomes sought

A robust theory of change in this area will require more detailed scoping work. It will also require the cooperation of well-funded, committed partners who can work with us to implement change: we are particularly keen to test the willingness of Public Health England, the Department of Health and the local government sector to engage with the centre around this topic. At this stage, our early view is that:

- Local service providers need to identify those groups who are most likely to engage in damaging behaviours, and whose behaviour is most difficult to change. The current evidence base around the relevant segmentation of such groups, and identifying at-risk individuals, should be synthesised and shared.

- Information about what works is vital for commissioners and policy-makers if they wish to influence behaviour change in mid-life. NICE has recently synthesised the existing evidence base, and there is a need to share more widely key findings with local authorities and health and well-being boards.

- There are substantial gaps in the evidence for what works in changing behaviour, particularly in at-risk groups, which inhibits the effectiveness of local and national programmes to change behaviour. These require incorporation of evolving international research, rigorous evaluation of what is having most impact in the UK, and funding and evaluation of innovative pilot schemes.

In addressing this topic, the Centre for Ageing Better and partners would aim to help more people in middle age to adopt healthier lifestyles, resulting in reduction of non-communicable diseases. Life expectancy and disability-free life expectancy would be increased. Interventions would be informed by evidence of what works in altering later-life outcomes across physical and mental health, creating changes to be measured through a range of additional health indicators.

Example early interventions the Centre might consider

We have held initial, high-level discussions with Public Health England, NHS England, and NICE among others. Our early view is that the Centre might:

- Provide evaluative support. There are a large number of research organisations active in this space, contributing to a growing but incomplete evidence base. The Centre could help evaluate research projects or highlight overseas pilots that might be applicable to the UK.

- Disseminate information more broadly than has been achieved to date, and highlight new research on what works. For example, there is a variation in the quality of local preventative services, with some examples of best practice not always translating effectively.[34]

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30   The King's Fund, Clustering of unhealthy behaviours over time, 2012.

31   All Party Commission on Physical Activity, Tackling Physical Activity, 2014.

32   The King's Fund, Clustering of unhealthy behaviours over time, 2012.

33   Marmot Review, Fair Society, Healthy Lives, 2010.

34   NICE, Expert Paper 8, for Disability, dementia and frailty in later life, 2014.

- Seed and evaluate pilots to fill identified gaps in the evidence of what works to change behaviour in at-risk groups. For example, run pilot schemes trialling how best to effect dietary behaviour change in at-risk population groups such as Bangladeshi women.[35]

- Fund new or evaluate existing business cases for the most effective interventions, enabling local and national organisations to make appropriate policy decisions and scale impact. For example, the Centre might commission a health economist to perform a landscape review of interventions in a specific area.

OUR KEY QUESTIONS

We welcome your reactions to the brief discussion above, and in particular your thoughts on the following questions:

1. Prioritisation. Does this topic matter for better later lives? Should it be one of the three or four priority topics for inclusion in the Centre's initial portfolio of work?

2. Landscape. Which initiatives, pieces of evidence or research are you aware of that are particularly relevant to this topic?

3. Focus. On which aspects of this topic should the Centre focus? What most needs action by the Centre on this topic – to synthesise evidence, to share it, to seed innovation, to scale proven practice, or to secure change?

4. Theory of change. The Centre aims to help promote change with evidence and other actions. What are your views on the high-level theory of change outlined in the paper?

5. Working together. If we decide to proceed with this topic, how might we work with your organisation? Which other organisations should we seek to work with?

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35   *"Finding 17" in NDA Programme Handbook, Dec 2014 summary.*

TOPIC 2: EXTENDING WORKING LIVES

SUMMARY

Many people want to work for longer and retire later, and many will need to. Working longer helps people to age better, offering health, financial and psychosocial benefits. The Centre for Ageing Better and partners would seek to help more people stay in work longer, with a particular focus on those most at risk of early exit – women employees, carers and certain groups of manual workers.

TOPIC OVERVIEW

WHY THIS MATTERS

Many older people in the UK retire earlier than they would like or need to. Only 10% of over 65s are in work;[36] over half of men and women have stopped working before they reach state pension age.[37] Some 1.1 million people below state pension age have retired involuntarily, mainly due to ill health.[38] Over the next 15 years, 7.5 million workers will reach state pension age.[39]

Early exit from the labour force can have significant consequences for the individual:

- Some 12 million people are heading for financially insecure retirements.[40] The financial impact of leaving work early can be substantial: research from ACAS found that an additional year's work can increase the average value of a pension by £4,500.[41]

- Work provides a sense of purpose, and important social connections of the sort that increase physical and mental well-being. Estimates of the causal effect vary, but research from the Institute of Economic Affairs suggests that retirement is associated with an increase in the probability of clinical depression by roughly 40%, and of having at least one diagnosed physical condition by 60%.[42]

Although our focus is on individuals, early retirement also has a substantial societal impact. The DWP estimated in 2009 that early retirement cost the Exchequer £4bn in lost tax revenue; and that if all older people were able to extend their working lives by one year, then UK GDP would increase by 1%.[43]

Potential theory of change and outcomes sought

A robust theory of change in this area will require more detailed scoping work. It will also require the cooperation of well-funded, committed partners who can work with us to implement change. At this stage, our early view is that:

- Businesses will seek to create more age-friendly workplaces when presented with the business case for doing so. This requires building and sharing an evidence-based business case for the retention of older

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36   Office for National Statistics, Labour Market Statistics, September 2014.

37   DWP, Fuller Working Lives: Background Evidence, 2014.

38   Social Finance, Using social investment to prevent involuntary early retirement, 2014.

39   Office for National Statistics, Labour Market Statistics, December 2012.

40   DWP, Fuller Working Lives: Background Evidence, 2014.

41   www.acas.org.uk (at 26 Feb 2015).

42   Chartered Institute for Personnel and Development, Age Diversity in SMEs: Reaping the Benefits, 2014.

43   Department for Work and Pensions, Fuller Working Lives, 2014. See also National Institute of Economic and Social Research, The Macroeconomic Impact from Extending Working Lives, 2011.

workers, one that quantifies the strategic and financial benefits of age-friendly policies and processes.[44]

- Employers and policy-makers need to understand the key drivers of involuntary retirement, and what works in tackling these. In particular, there appears to be limited research on interventions across diverse groups within the population, in particular those most at-risk.

- Employers will need support in implementing necessary changes. This requires evidence of what works across different types of organisation, which may require testing and evaluation of innovative policies and tools.

Large organisations (those that employ more than 250 people) in the public and private sectors employ more half of the United Kingdom's workforce. They therefore have an important role to play in enabling people to work longer and take advantage of the opportunities that such work provides. Large organisations have been targeted as a potential first target for the Centre as interventions here are able to have greater impact in extending working lives, however this does not preclude looking at other areas of employment or self-employment.

Our goals would be a reduction in the percentage of people who report leaving the workforce involuntarily, in particular before the retirement age. We would also hope to see more people wanting to stay in the workforce longer; more over-65s in work; and more organisations promoting opportunities for an older workforce. We would have a particular emphasis on at-risk populations, to close inequality gaps between older people.

Example early interventions the Centre might consider

The Centre has already discussed this area with various potential stakeholders such as Business in the Community (BITC) and the DWP; there are many potential partners we would seek to engage with. Interventions we might pursue include:

- Develop a business case for retaining older workers. For example, we could work with BITC, who are currently engaging with companies in low paid sectors or ones with significant numbers of manual workers.

- Evaluate existing efforts to retain older workers. For example, a number of large employers have demonstrated a commitment to retaining workers for longer, and have implemented a range of measures designed to encourage extending working lives. However, there appears to be little systematic evaluation of these interventions.

- Commission new research to fill identified gaps on how best to encourage extended working lives. This would likely focus on at-risk populations, and might therefore prioritise in particular low-wage or manual sectors (e.g. hospitality or construction). BITC are launching in April a report with the ILC on how to develop solutions on preventing early exit.

- Work with key partners in government – such as the DWP – to inform and develop policy on the basis of evidence of what works.

OUR KEY QUESTIONS

We welcome your reactions to the brief discussion above, and in particular your thoughts on the following questions:

1. Prioritisation. Does this topic matter for better later lives? Should it be one of the three or four priority topics for inclusion in the Centre's initial portfolio of work?

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44   *Department for Work and Pensions, Employing Older People, 2013.*

2. Landscape. Which initiatives, pieces of evidence or research are you aware of that are particularly relevant to this topic?

3. Focus. On which aspects of this topic should the Centre focus? What most needs action by the Centre on this topic – to synthesise evidence, to share it, to seed innovation, to scale proven practice, or to secure change?

    - In particular, should we focus on certain sizes of organisations? (There are 6,000 large employers in the UK who employ roughly half of the workforce, and are arguably more straightforward to "go to market".) Or on particular sectors (e.g. public, manual)?

4. Theory of change. The Centre aims to help promote change with evidence and other actions. What are your views on the high-level theory of change outlined in the paper?

5. Working together. If we decide to proceed with this topic, how might we work with your organisation? Which other organisations should we seek to work with?

TOPIC 3: SOCIAL CONNECTEDNESS

SUMMARY

Loneliness matters, especially in later life. But there is more to be done in understanding what works to prevent and reduce it – and how to finance and support effective interventions. In considering options for work on this topic, the Centre will be particularly keen to align its efforts with the work of other bodies – for example, The Big Lottery Fund's £82m Fulfilling Lives: Ageing Better programme.

TOPIC OVERVIEW

WHY THIS MATTERS

Loneliness is a subjective feeling, defined as the "discrepancy between what [people] have and what they desire" in terms of social companionship and interaction.[45] Social isolation is the objective absence of social interaction; this can vary by individual: for example, people with sensory deprivation may experience levels of social isolation even in the company of others.[46]

Loneliness can have a similar impact on mortality to smoking fifteen cigarettes per day; lonely people can be 3.5 times more likely to enter residential care, over 3 times more likely to suffer depression, and 14% more likely to suffer heart disease because of physical inactivity.[47] Higher social connectedness leads to an improved quality of life and greater sense of purpose in later life.

Research to establish the prevalence of loneliness has produced variable results.[48] Chronic loneliness is estimated by the Campaign to End Loneliness to affect between 6%-13% of older people.[49] The Growing Older project estimated that 7% of older people were often lonely and 31% are "sometimes" lonely;[50] research for AgeUK has estimated figures of 650,000-800,000.[51] Christina Victor estimates that the proportion of lonely people has remained constant over the past five decades but the absolute increase in the number of older people means some 900,000 now feel lonely "often".[52]

Social isolation affects about 1 million older people.[53] 17% of older people are in contact with friends and family less than once per week, and two fifths report that television is their principal form of company.[54]

A range of risk factors are associated (but not necessarily directly causal) with increased likelihood of loneliness among older people, including: living alone;[55] being single, divorced or never married;[56] becoming a carer;[57] living on a low income;[58] or being in residential care.[59] Loneliness "can be exacerbated

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45   Essex County Council Joint Strategic Needs Assessment, Loneliness and Social Isolation, 2013.

46   Age UK, Loneliness and Isolation Evidence Review, 2014.

47   Social Finance, A Social Impact Bond to Reduce Social Isolation… , 2013

48   Age UK, Loneliness and Isolation Evidence Review, 2014.

49   Campaign to End Loneliness, Safeguarding the Convoy, 2011.

50   ESRC, Research Findings: 17, 2003.

51   TNS survey for Age UK, 2014.

52   Victor, C. Presentation to Campaign to End Loneliness.

53   Age UK, Loneliness and Isolation Evidence Review, 2014.

54   TNS Survey for Age UK, 2014.

55   Age UK Oxfordshire, Alleviating Loneliness Among Older Adults: Possibilities and Constraints of Interventions, 2011.

56   Age UK, Growing Older in Socially Deprived Areas, 2002.

57   Age UK, Safeguarding the Convoy, 2011

58   Age UK, Loneliness and Isolation Evidence Review, 2014.

59   Age UK, Safeguarding the Convoy, 2011.

by life events … such as leaving work, health decline and bereavement."[60]

The Social Care Institute for Excellence has identified three broad types of intervention to increase social connectedness and reduce loneliness:[61]

- One to one, including befriending, mentoring, support from Community Navigators, formal and informal caring.
- Group services, such as lunch clubs and group activities.
- Wider community engagement, with programmes that support individuals to increase their social participation.

There is limited cost-benefit analysis available to identify returns on investment for interventions,[62] but research in 2010 suggested that £80 in befriending support yields £300 through reduced service use, and £480 on "Community Navigator" schemes yields c. £900.[63] More recently, Social Finance estimated ~£1,000 per person in value could be achieved by a programme of interventions in Worcestershire.[64]

Potential theory of change and outcomes sought

A robust theory of change in this area will require more detailed scoping work. It will also require the cooperation of well-funded, committed partners who can work with us to implement change. At this stage, our early view is that:

- Connectedness begins with the individual, and the views of older people can be better incorporated into planning and design of interventions around social isolation and loneliness.
- While there is some research on risk factors, there is no agreed practice of what works in identifying populations most at risk of loneliness. Localities and NGOs need the most effective tools and methods for doing so.
- The business case for interventions to tackle social isolation and loneliness needs to be enhanced. This would help funders with constrained budgets make informed decisions of which interventions to prioritise.
- Sustained impact, at the local and national level, for both the population in general and for specific at-risk groups, will require continued innovation, with robust evaluations to determine which are most effective and likely to be scalable.

Our goal in this topic is an increase in the number of people who are and feel connected in society. This would be measured through qualitative and quantitative metrics, surveying individuals directly and measuring via funders' key indicators. We would monitor implementation progress by tracking: localities' adoption into their health and well-being strategies of plans to tackle loneliness and social isolation; cooperation between NGOs and local/national government in implementing such strategies; and quality of service provision based on evidence of what works.

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60   *Essex County Council Joint Strategic Needs Assessment, Loneliness and Social Isolation, 2013.*

61   *SCIE, Preventing loneliness and social isolation: interventions and outcomes, 2011.*

62   *Essex County Council Joint Strategic Needs Assessment, Loneliness and Social Isolation, 2013.*

63   *Knapp, Building Community Capacity, 2010.*

64   *Social Finance, A Social Impact Bond to Reduce Social Isolation… , 2013.*

Example early interventions the Centre might consider

The Centre would explore working with key stakeholders in the field, both commissioners and third-sector actors such as the Campaign to End Loneliness and Age UK, to pursue potential interventions such as:

- Synthesise existing evidence of what works in alleviating loneliness, to establish highest priority interventions.
- Fund research to evaluate existing and to develop new business cases for the most successful interventions, to be shared with funders.
- Map the current state of the field, to identify what obstacles prevent scaling of best practice across localities.
- Work with select localities to support new initiatives and share lessons learned.[65]
- Work with private and third-sector funders to seed and evaluate innovative strategies to tackle loneliness and social isolation.

OUR KEY QUESTIONS

We welcome your reactions to the brief discussion above, and in particular your thoughts on the following questions:

1. Prioritisation. Does this topic matter for better later lives? Should it be one of the three or four priority topics for inclusion in the Centre's initial portfolio of work?

2. Landscape. Which initiatives, pieces of evidence or research are you aware of that are particularly relevant to this topic?

3. Focus. On which aspects of this topic should the Centre focus? What most needs action by the Centre on this topic – to synthesise evidence, to share it, to seed innovation, to scale proven practice, or to secure change?

4. Theory of change. The Centre aims to help promote change with evidence and other actions. What are your views on the high-level theory of change outlined in the paper?

5. Working together. If we decide to proceed with this topic, how might we work with your organisation? Which other organisations should we seek to work with?

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65   See for example University of Bath, An Evaluation of the LinkAge Befriending Scheme, 2014; and Bristol City Council, Health and Wellbeing Strategy, 2013.

TOPIC 4: SUSTAINING INDEPENDENCE IN THE HOME

SUMMARY

Most people wish to stay in their own home for as long as possible; a safe and comfortable home contributes significantly to well-being. Yet many homes are not suitable for people as they age. Current services for home adaptation and advice need to be better designed and delivered.

TOPIC OVERVIEW

WHY THIS MATTERS

Many older people today live in housing that is inadequate for their needs:

- 145,000 older people reported living in homes that did not meet their needs in 2008.[66]

- 1 in 4 older people felt they were unable to get around the home safely.[67]

- 22.6% of older people's housing in England is 'non-decent,' due to poor state of repair, inadequate facilities, etc.[68]

- Roughly one million people over 65 live in fuel poverty. The same number report cutting back on food to pay for bills.[69]

- Age UK estimates that in 2012/13, there were 31,000 excess winter deaths, a "vast majority of whom were older people."[70]

- Medical conditions due to or exacerbated by poor energy efficiency in homes cost the NHS £700 million a year.[71]

Adaptation of existing homes can tackle many of these challenges. Accessibility improvements physically adapt homes to changing needs, such as declining mobility or sensory impairment; these improvements range in scale and value, from carpet replacement aimed at preventing falls, through to large-scale remodelling. Energy efficiency improvements adapt houses that may be poorly insulated, inefficient and expensive-to-heat. Timely and effective information and advice play "a critical role in helping older people to identify good housing options and gain access to housing support."[72]

Another solution is the supply of new housing stock. However, this paper will not consider supply side issues, as the figures are at present too low to help the large numbers of people living in inadequate housing (some 140,000 new dwellings were built in 2013/14). The Centre may consider in the future what role it could play in helping stimulate better supply of decent housing as its programme of work evolves.

Improvements to the home are essential for preserving independence and empowering people in later life.[73] Research suggests that adults lacking necessary adaptations were between 1.5 and 2.8 times more likely to fall.[74] In a 2010 survey, 70% of older adults who received "minor changes" to their home rated their

66   Department for Communities and Local Government, Lifetime Homes, 2008

67   Papworth Trust, Home Solutions to our Care Crisis, 2013.

68   Age UK, Agenda for Later Life, 2014.

69   Ibid.

70   Ibid.

71   Roys, et al. The Real Cost of Poor Housing, 2010

72   Age UK, Agenda for Later Life, 2014.

73   Lords Committee on Public Service and Demographic Change, Ready for Ageing?, 2013.

74   e.g. Department of Health, Falls and Fractures, 2009.

quality of life as "much better" following intervention.[75] The mental health benefit of better housing is also significant, with some studies finding improvement on the SF36 scale, a profile of health and well-being.[76]

The current framework for home improvement is complex. Adaptation services are "fragmented [… involving] health, social care, housing, environmental health and the third sector".[77] Local housing authorities are under a statutory duty to provide grant aid to disabled people for adaptations to their homes, which is principally financed through Disabled Facilities Grants (DFGs) or self-funding.[78] National government develops policies to improve energy efficiency – such as the Green Deal and the Energy Companies' Obligation – with the role of local government varying by location. Local services to support independence in the home are often underpinned by Home Improvement Agencies (HIAs), non-profit organisations who support individuals requiring home adaptation. HIAs advise people on improvements to their homes, assist with applications for local authority support, and oversee work undertaken by private or in-agency contractors.[79]

Government research from 2007 found that to make suitable the homes of the 145,000 people whose accommodation is unsuitable owing to disability would cost c. £975 million, with the average cost of a home adaptation being c.£6,600.[80] However, the net benefits could be substantial: according to a report by the Welsh Assembly, every £1 spent on home adaptation can generate £4 in savings by reducing demand on other public services.[81] A literature review by the London School of Economics provides a lower, but still significant, assessment of the benefit in home adaptation: in a model population of 45,000, £270 million outlay would yield net gains of £156 million.[82]

Potential theory of change and outcomes sought

A robust theory of change in this area will require more detailed scoping work. It will also require the cooperation of well-funded, committed partners who can work with us to implement change. At this stage, our early view is that:

- Given the scale of the problem and the fiscal limitations that they face, funders need to be able to identify the most at-risk groups, to target interventions most effectively. More evidence is needed on how housing conditions vary among disadvantaged groups, and on the most effective ways to identify those that most need help.

- There is inadequate evidence of the benefit of physical improvements, and other interventions necessary to support independence in the home. The business case for such interventions needs developing and sharing with funders.

- Local councils are not the only channel through which change can be effected. Private and third-sector alternatives should be encouraged with best practice nationally and internationally, and there is a need to seed innovative models of service delivery, with new tools and technologies that can be scalable.

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75   *The Personal Social Services Survey of Adult Carers in England, 2010*
76   *London School of Economics, Building a business case for investing in adaptive technologies in England, 2012*
77   *HousingLIN, From Home Adaptations to Accessible Homes, 2012.*
78   *NHF, Adaptations Briefing, 2012. See also House of Commons Library, Disabled Facilities Grants, 2013.*
79   *See foundations.uk.com*
80   *Office for Disability Issues, HM Government, Better outcomes, lower costs, 2007.*
81   *Welsh Assembly, Evaluation of the Independent Living Grant, 2012.*
82   *London School of Economics, Building a business case for investing in adaptive technologies in England, 2012.*

- The needs of individuals can only be fully understood through dialogue. Home is an expression of individuality, and older people will want to feel empowered in maintaining their independence at home. Localities need to understand best practice in building an on-going dialogue with people in their community.

Our goal would be to see the number of older people with unsuitable housing reduced, especially for populations more at risk. People who require support to adapt their homes would receive it quickly and effectively by integrated local service providers. Those most at risk of injury, accident or declining ill health due to their home conditions would be identified and supported early. Outcomes we might measure could include reductions in the number of people who:

- report living in homes that do not meet their needs;

- feel they are unable to get around the home safely;

- live in housing that is 'non-decent'; and

- live in fuel poverty.

Example early interventions the Centre might consider

- Work with research funding bodies to enhance evidence around the outcomes and the costs/benefits for health and social care of home adaptation.
- Fund research on the effectiveness of advice services to at-risk groups.
- Identify several localities who have recently changed approach, for example Bristol. We could disseminate key lessons learned and help develop robust business cases for the most promising interventions.[83]
- Map the landscape of service delivery in the UK, identifying different models of provision and where there is inconsistency, overlap, or substantial gaps in provision. We might focus in particular on helping to establish levels of need for services and the best way to target limited resources at those most at risk.

- Build on work by groups such as Care & Repair England and Foundations to evaluate the body of knowledge (both national and international) about best practice in delivery of home adaptations, disseminating findings to key national and local agencies.

- CfAB was interested that this issue was mentioned as needing action in the March 2015 Budget. We should look to CLG/DH working with the LGA to review and change the system for aids and adaption and advice, as evidence of what works will not be useful without this. Similarly we might review what works to help individual's to plan and prepare their own home better to support their independence and how the private sector can better contribute to this.

OUR KEY QUESTIONS

We welcome your reactions to the brief discussion above, and in particular your thoughts on the following questions:

1. Prioritisation. Does this topic matter for better later lives? Should it be one of the three or four priority topics for inclusion in the Centre's initial portfolio of work?

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83   *Following a review in 2011, the city reorganised housing adaptation services, which involved new end-to-end processes and the integration of several services under a single Accessible Homes service. (HousingLIN, From Home Adaptations to Accessible Homes, 2012.)*

2. Landscape. Which initiatives, pieces of evidence or research are you aware of that are particularly relevant to this topic?

3. Focus. On which aspects of this topic should the Centre focus? What most needs action by the Centre on this topic – to synthesise evidence, to share it, to seed innovation, to scale proven practice, or to secure change?

4. Theory of change. The Centre aims to help promote change with evidence and other actions. What are your views on the high-level theory of change outlined in the paper?

5. Working together. If we decide to proceed with this topic, how might we work with your organisation? Which other organisations should we seek to work with?

TOPIC 5: READY FOR AGEING LOCALLY: WHAT WORKS?

SUMMARY

Our prospects for a better later life are significantly affected by where we live. Localities differ greatly in the diversity of their populations and their readiness for the opportunities and challenges of an ageing population. Local leaders and communities can have a great impact on our well-being, by planning effectively both for optimisation and prevention.

TOPIC OVERVIEW

WHY THIS MATTERS

Localities are at the frontline of better ageing. The well-being of older people is influenced by their local physical environment, local opportunities to keep active and contribute, and local services.[84]

Some localities are more age-friendly or better prepared for ageing than others. It is not immediately clear which these are: "age-friendliness" cannot be measured purely based on quantitative outcomes, nor solely on short term improvements (best practice will value prevention at least as much as remediation).[85] But leading commentators agree that we are far from best practice. Local communities should deliver "much more than the basics," argue Age UK and the ILC: they should be places for all ages, and places of fun, but "we are still a long way from the kind of substantial changes we need to see to get our communities fit for ageing."[86] 20% of people over 65 feel they do not belong to their neighbourhood; 23% (over 60) live in non-decent homes; 12% describe public transport as poor.[87]

An age-friendly city, says the WHO, "emphasises enablement rather than disablement; [and is] friendly for all ages and not just 'elder-friendly'."[88] (Whether an older person is in a rural or urban environment may also make a difference; 77% of over-65 year olds in England live in urban areas.[89])
Age friendly localities are not purely about delivering better health and social care, but empowering people in their society. An age friendly locality would:

- Think about older people in all its physical plans and regeneration schemes, including transportation and housing.;

- Empower older people best to use their skills, both as volunteers and paid employees;

- Engage with older people's voices about specific needs; and

- Take into account the many different groups who fit within the population of older people, particularly disadvantaged groups.

- As noted by the DCLG, an age friendly neighbourhood will aim to be: accessible and inclusive; aesthetically pleasing and safe; a community that offers plenty of services, facilities and open space; and fostering a strong social and civic fabric, with a strong local identity of place.[90]

Localities are the sum of all their parts, and many sectors play a role in determining their age-friendliness:

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84   *For a synthesis of why localities matter see for example Department for Communities and Local Government, Lifetime Neighbourhoods, 2011.*

85   *See e.g. UK Urban Ageing Consortium, A Research & Evaluation Framework for Age-friendly Cities, 2014.*

86   *ILC & Age UK, Making our communities ready for ageing, May 2014.*

87   *Age UK, Agenda for later life, 2014.*

88   *UK Urban Ageing Consortium, A Research & Evaluation Framework for Age-friendly Cities, 2014.*

89   *Department for Environment, Food & Rural Affairs, Rural population and migration, Nov 2013.*

90   *Department for Communities and Local Government, Lifetime Neighbourhoods, 2008.*

Local government impacts on the lives of people as they age across a range of areas: in planning housing, transport and the built environment; delivering education and leisure services; providing adult social care; and in ensuring coordination across all sectors.[91] With income falling and expenditure rising, local councils must prioritise and plan effectively.[92] The most at-risk localities are under greatest pressure from spending cuts.[93] These economic challenges are accompanied by increasing powers and responsibility. Willingness to engage is generally high, but the challenge is in establishing priorities: "Officers and members have to give their time…and they are already trying to deliver more with less."[94]

Where local leaders have fully grasped the opportunities and issues of their ageing population, it can still be a struggle to bring others along, to work in concert, and to plan for the long term.[95] The 2008 corporate assessment of local councils by the Audit Commission concluded that only a third of councils across the UK were well prepared for ageing.[96] Councils have responded, but in self-evaluations in 2012, only 40% of local authorities surveyed had a standalone ageing strategy.[97] Best practice favours prevention over remediation, but it is not straightforward for leaders (including health agencies) to plan for the long term especially when faced with immediate challenges.

Public health agencies such as CCGs and health & well-being boards are key local actors. There is an ongoing opportunity and challenge for such agencies to work effectively with other local actors.[98] While this topic would not concentrate on delivery of health and social care, effective local planning requires coordination with key local services.

The voluntary and private sectors play a significant part. Austerity has increased the importance of voluntary and private sectors in contributing to quality of life in a locality, whether through community activities, communal spaces, or age-friendly services, and coordination with the public sector.[99]

Above all, the people who live in a locality are central to its age-friendliness. Populations are composed of different ages and different backgrounds. In an age-friendly locality, older people will be empowered to act independently and in society, and will feel supported by neighbours' attitudes and actions. However, "those giving their time voluntarily need to understand the impact of their involvement and see the results of their efforts."[100]

Age-friendliness is not a "one-size-fits all" criterion: local leaders must assess and understand differing demographics, and in particular the needs of their most vulnerable populations. A key challenge for localities going forward will be to tackle rising inequalities across different groups in the population. Some localities have greater needs than others, some have more limited resources: a key question for the Centre will be how best to engage with the wide range of localities across the UK.

91   ILC & Age UK, Making our communities ready for ageing, May 2014.

92   Local Government Association, Future funding outlook 2014, July 2014.

93   The Guardian, "Local government cuts hitting poorest areas hardest", 30 Jan 14.

94   ILC & Age UK, Making our communities ready for ageing, May 2014.

95   Ibid.

96   Audit Commission, Don't stop me now, 2008.

97   Department for Work and Pension, Preparing for an Ageing Society: Evaluating the Ageing Well programme, 2012.

98   See e.g. The Kings Fund, Health and wellbeing boards: One year on, Oct 2013.

99   ILC, Population Ageing & the Voluntary Sector, April 2014 and ILC & Age UK, Making our communities ready for ageing, May 2014.

100   Ageing Well case study: Hounslow, 2012.

POTENTIAL THEORY OF CHANGE AND OUTCOMES SOUGHT

A robust theory of change in this area will require more detailed scoping work. It will also require the cooperation of well-funded, committed partners who can work with us to implement change. At this stage, our early view is that:

- Localities will benefit from clear methods for assessing their locality's readiness for ageing. There is a need to evaluate existing methods or fund design new ones for sharing across localities.

- Effective strategic planning is needed to meet the long-term opportunities and challenges of an ageing population. Localities will benefit from knowing what best practice looks like, and receiving support in implementing it.

- This would include better consultation with and involvement of local people in decision making: "If you ask older people what they want from their communities, the priorities are strikingly different from what is currently being delivered."[101] What works in such consultation needs to be better understood and shared more broadly across localities.

- Ultimately, better planning will lead to a better environment for ageing. This will also require better delivery of services for older people, with better coordination. There are local models of accountability for ensuring coordination, some of which may offer examples to other localities.[102]

Our goal would be to see all local leaders and agencies across the UK planning and delivering effective, coordinated responses to ageing, based on evidence of what works. Older people would be empowered, with their skills and abilities fully realised in localities. There would be a greater emphasis on prevention over remediation, and on tackling inequalities in ageing outcomes, helping empower the most vulnerable populations in localities. We would measure progress of localities' preparedness for ageing through new or existing evaluation methods.

EXAMPLE EARLY INTERVENTIONS THE CENTRE MIGHT CONSIDER

We have held early conversations with potential stakeholders such as the LGA and specific localities such as Greater Manchester to understand better where the Centre might contribute best. Example interventions we might consider include:

- Develop regional evaluation benchmarks to give regions better insight into their own readiness for ageing. This could be a checklist, dashboard or traffic light system for good practice which LAs and other public sector agencies could use to review themselves. This could build on work done for example by the UK Urban Ageing Consortium in its Evaluation Framework.[103]
- Support a specific locality to become a UK champion of ageing better in urban or rural localities. For example, Greater Manchester aspires to be a national champion of better ageing in the manner of New York in the US and Dundalk in Ireland. One determinant of their success would be sharing of best practice and lessons learned that can be used by other cities.[104] We have had initial discussions with Greater Manchester on how we might work together.
- Disseminate existing research on best practice in planning and support its implementation in select localities. "We do not need revolutionary ideas... There are piecemeal solutions or guidance in place, but often these are not being followed or do not go far enough."[105]

101   ILC & Age UK, Making our communities ready for ageing, May 2014.

102   See for example Bradford's Older Person Programme Manager. ("Older People's Development Manager, KIVCA – Bradford MDC", local.gov.uk.)

103   UK Urban Ageing Consortium, A Research & Evaluation Framework for Age-friendly Cities, 2014.

104   See Greater Manchester Agreement, 2014; UK Urban Ageing Consortium, A Research & Evaluation Frame work for Age-friendly Cities, 2014.

105   ILC & Age UK, Making our communities ready for ageing, May 2014.

OUR KEY QUESTIONS

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1. Prioritisation. Does this topic matter for better later lives? Should it be one of the three or four priority topics for inclusion in the Centre's initial portfolio of work?

2. Landscape. Which initiatives, pieces of evidence or research are you aware of that are particularly relevant to this topic?

3. Focus. On which aspects of this topic should the Centre focus? What most needs action by the Centre on this topic – to synthesise evidence, to share it, to seed innovation, to scale proven practice, or to secure change?

4. Theory of change. The Centre aims to help promote change with evidence and other actions. What are your views on the high-level theory of change outlined in the paper?

5. Working together. If we decide to proceed with this topic, how might we work with your organisation? Which other organisations should we seek to work with?

TOPIC 6: AGEISM: UNDERSTANDING ITS PERCEPTION AND IMPACT

SUMMARY

Ageism exists today in society, in employment, and in the provision of goods and services; over a third of older people report that they experience age discrimination.[106] Despite the widespread impact of ageism, there is only partial evidence and understanding of its perception, impact and causes, and how these are changing over time. This topic review is a brief preface to a detailed evidence review which the Centre might undertake, to better inform the debate about how to end ageism.

TOPIC OVERVIEW

DEFINITIONS

Ageism is the stereotyping of, or discrimination against, a person or group because of their age.[107] In the UK, ageism is commonly understood as "an attitude of mind that leads to discrimination" against older people.[108] Ageism can have a positive framing;[109] and it can apply to any age.[110]

Individuals can experience negative ageism either as a subjective lack of respect or as overt mistreatment. There is speculation that older people tend to be more aware of lack of respect, and may either be unaware of mistreatment or view it as "inevitable".[111]

Ageism can also be directed inwards, as a state of mind that affects our self-confidence and self-perception, and limits our potential.

By its definition, negative ageism can lead to age discrimination, which can be:

- Direct or indirect. Direct means treating someone less favourably because of their real or perceived age. Indirect arises when a neutral rule or practice that applies to everyone puts one age group at a disadvantage.

- Harassment and/or victimisation. Harassment is violating an individual's dignity due to their age. Victimisation is unfair treatment (e.g. of an employee) who has made a complaint of discrimination.[112]

- Overt i.e. explicit, or covert, referring to hidden conventions and subconscious attitudes.

- Institutional (e.g. arising from policies) or individual (i.e. arising from personal ageist attitudes).[113]

Ageism can appear in:[114]

- Social relations and attitudes. It is "perhaps even more corrosive [than sexism/racism], since it is more likely to be accepted as 'normal' or 'inevitable'."

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106   Rippon, I. et al., "Perceived age discrimination in older adults" in Age and Ageing, 2013.

107   Butler, R., "Ageism" in The Encyclopaedia of Aging, 1995.

108   CPA, Achieving Equality in Health and Social Care for Older People, 2013.

109   Palmore, Ageism Negative and Positive, 1999.

110   ESS, Experiences and Expressions of Ageism, 2012.

111   Ibid.

112   acas.org.uk (at 15 March 2015).

113   Department of Health, Implementing a ban on age discrimination in the NHS, 2012.

114   ILC, Ageism and Age Discrimination, 2010.

- Employment, where it might be defined as use of age as a rationale for making decisions about employees (e.g. hiring, firing).

- Goods and services, through discriminatory provision of e.g. insurance, healthcare, etc.

WHY THIS MATTERS

Ageism damages "intergenerational solidarity" and alters expectations of ageing.[115] The experience of ageism is linked with negative well-being outcomes, though the causal relationship is not clear. In one survey, over-70s who had experienced ageism reported 16% lower life satisfaction and 14% lower happiness compared with people who had not experienced ageism. They were also more likely to think their age peer group has a lower status in society.[116]

The perception of ageism is hard to document, as it necessarily relies on subjective impressions. In one survey, 37% of people aged >65 felt they had experienced discrimination which they perceived as caused by their age; the poorest older people were 20% more likely than the richest to perceive age discrimination.[117] 60% of older people in the UK agree that age discrimination exists in the daily lives of older people; 68% agree that politicians see older people as a low priority; 76% believe the country fails to make good use of the skills and talents of older people.[118] The UK appears to be worse off than other European countries: ~65% of those surveyed in the UK see ageism as "a very serious/quite serious problem", the second highest in Europe after France; in Denmark the figure is 22%.[119]

The overt consequence of ageism is age discrimination, which is documented in the UK across a range of areas, such as:

- Healthcare (which appears to be the most studied): for example, there are ~14,000 avoidable cancer deaths a year in over-75s;[120] no routine breast screening invitations for women over 73;[121] and there is evidence that GPs are reluctant to discuss weight reduction with older patients.[122]

- Mental healthcare: (in 2009) there were ~50% more psychiatrists per 1,000 cases for adults under 65 than for older people, and nearly 300% with psychologists.[123]

- Social care: As of 2008, Disability Living Allowance (DLA) 'mobility' components were not available to older people with disability.[124]

- Pharmaceuticals: Older people have historically been under-represented in clinical trials, though this has been improving.[125]

- Other services: In 2008, 97% of annual travel insurance policies imposed an upper age limit for new customers.[126] Though this may have shifted since the 2010 Equality Act, financial services are still granted an exception to continue use of age.[127]

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115   ESS, Experiences and Expressions of Ageism, 2012.

116   Ibid.

117   Rippon, I. et al., "Perceived age discrimination in older adults" in Age and Ageing, 2013.

118   Age Concern and Help the Aged, One Voice: Shaping our ageing society, 2009.

119   Age UK / EURAGE (Kent), Grey Matters – A Survey of Ageism across Europe, 2011.

120   Macmillan Cancer Support, The age old excuse, 2012.

121   APPG on Breast Cancer, Age is just a number, 2013.

122   CPA, Achieving Equality in Health and Social Care for Older People, 2013.

123   Ibid.

124   Ibid.

125   Ibid.

126   Age UK, Later Life factsheet, Nov 2014.

127   "Age discrimination in services" on equalityhumanrights.com (at 23 March 2015).

- Other forms of discrimination can disproportionately affect older people; for example, against those with mobility and sensory impairment.

Potential theory of change and outcomes sought

A robust theory of change in this area will require more detailed scoping work. It will also require the cooperation of well-funded, committed partners who can work with us to implement change.

As a first step, the Centre will carry out an evidence review on ageism. We will consider both the national and international evidence base. In the latter case, we will seek to understand how attitudes differ across nations, and what interventions have been taken to impact these.

Our long-term goal with partners would be to contribute to the reduction of ageism in the UK.

OUR KEY QUESTIONS

We welcome your reactions to the brief discussion above, and in particular your thoughts on the following questions:

1. Prioritisation. Does this topic matter for better later lives? Should it be one of the three or four priority topics for inclusion in the Centre's initial portfolio of work?

2. Landscape. Which initiatives, pieces of evidence or research are you aware of that are particularly relevant to this topic?

3. Focus. As discussed above, our first exercise on ageism will be a landscape review. Which aspects of ageism should the review focus on? Beyond this review, where should the Centre focus its efforts on this topic – to synthesise evidence, to share it, to seed innovation, to scale proven practice, or to secure change? Should the Centre focus on a specific area of age discrimination, such as healthcare or social care?

4. Theory of change. The Centre aims to help promote change with evidence and other actions. What are your views on the high-level theory of change outlined in the paper?

5. Working together. If we decide to proceed with this topic, how might we work with your organisation? Which other organisations should we seek to work with?

TOPIC 7: INEQUALITY IN AGEING OUTCOMES

SUMMARY

The gaps in well-being between different groups of the population are growing wider as we age.[128] Inequalities in health, psychosocial, financial and place increase for those of us who are most vulnerable in society. The causes of such inequalities are complex, inter-related, and challenging to eliminate.

This topic review is a brief preface to a much more in-depth piece of work – either an evidence summary or a systematic review – that the Centre will undertake. This more in-depth project will be a key foundation for our work on other topics; the Centre is minded to undertake this project early in its life, as we need to understand what the evidence tells us about the diverse range of inequalities in later life and their causes to ensure we understand diversity and focus on those most in need.

TOPIC OVERVIEW

WHY THIS MATTERS

This brief topic overview cannot reflect all inequalities, and so will focus on select examples. There is evidence of unequal ageing outcomes across each of the four domains of well-being in ageing: health, psychosocial, finance and place. The below distinctions are drawn to give examples within each area and not to argue that they are unrelated; outcomes will frequently overlap, for example health and finance, as will groups of the population, such as race and sex.

Health

- Race: Pakistani and Bangladeshi men and women are estimated to have an average life expectancy of ~1 year less than White British.[129] Analysis of the 2001 census suggested black African and Caribbean men over 65 had the lowest disability free life expectancy of any ethnic group.[130]

- Sex: Older women have higher levels of disability, functional impairment and musculoskeletal problems than men.[131]

- Social class: "The gap in life expectancy at age 65 between people from the highest and lowest social classes is widening."[132]

- Region: There is strong evidence of regional variations in health, with a seven-year difference in life expectancy between richest and poorest regions.[133]

Psychosocial

- Disability: "Some disabilities impact upon people's ability to manage their social networks independently and are associated with increased loneliness."[134]
- Race: Studies have found that reported loneliness was 24-50% for over-65s from China, Africa, the

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128   Lords Committee on Public Service and Demographic Change, Ready for Ageing?, 2013.

129   CPA/Runnymede, The future ageing of the ethnic minority population of England and Wales, 2010.

130   Inhale, Inequalities in disability free life expectancy…, (2001 census). See also NDA Programme Handbook, 2014.

131   Ready for Ageing? On the other hand, see for example NEP, An Anatomy of Economic Inequality in the UK, 2010, showing evidence that the gap in life expectancy between men and women has closed since 1987.

132   JRF, A Better Life: Valuing Our Later Years, 2013. For more on health inequalities in class, see for example ONS, Trends in Life Expectancy by social class, 2008; and EHRC/Age UK, Just Ageing?, 2009.

133   Lords Committee on Public Service and Demographic Change, Ready for Ageing?, 2013. See also ONS, Life Expectancy… at Age 65…, 2014.

134   Kings College London / Age UK, Diversity in older people and access to services – an evidence review, 2012.

Caribbean, Pakistan and Bangladesh; those from India were similar to the norms reported of 8-10% for White.[135]

- Sex: Nearly half of women over 65 live alone, with nearly half widowed.[136]
- Sexual orientation: There is some evidence that LGB people "experienced social exclusion due to their sexual orientation and health problems, so they did not feel confident accessing mainstream services."[137]

Financial

- "Poverty in old age is consistently associated with gender, ethnicity, marital status and lower educational levels."[138]
- Marital status: Being newly widowed over 55 years old was associated with higher poverty risks.[139]
- Race: 31% of pensioners living in a household headed by someone of Asian/Asian British background were in relative low income after housing costs compared to 13% of pensioners living with a white head of household.[140]

- Sexual orientation: "Lesbian, gay and bisexual people are more likely [than heterosexual people] to be reliant on personal or employer pensions and to be worried about their future housing arrangements."[141]

Place

- Disability: There is some indication – though not substantial evidence – that older owner occupiers with learning disabilities may not have adequate "contact with [home] helping agencies, indeed they might be largely unknown to local services."[142]
- Gender reassignment: A quarter of trans people responding to a survey lived in private rented accommodation, twice the proportion for the UK general population. "The researchers noted that private sector housing is often of poorer quality and has less security of tenure", though this was based on evidence from the survey itself.[143]
- Race: Black and certain other minority ethnic groups are over-represented in non-decent housing.[144] "People from BME communities are less likely to be homeowners and more likely to be living on a low income in social rented accommodation."[145]

135   Victor, Burholt, Martin, "Loneliness and ethnic minority elders in Great Britain" in Journal of Cross Cultural Gerontology , 2012. There are various discussions on levels of support within ethnic minority communities: see for example Joseph Rowntree Foundation, Poverty and Ethnicity, 2014; and Age UK, Life course influences and well-being in later life: a review, 2009.

136   Lords Committee on Public Service and Demographic Change, Ready for Ageing?, 2013.

137   Kings College London / Age UK, Diversity in older people and access to services – an evidence review, 2012.

138   Age UK, Life course influences and well-being in later life: a review, 2009.

139   EHRC/Age UK, Just Ageing?, 2009. For discussion of inequalities based on sex, see for example NEP, An Anatomy of Economic Inequality in the UK, 2010.

140   Department of Work and Pensions, Households Below Average Income, 2014. Relative low income is defined as below 60% of the UK median household income; median for total population in 2012/13 was £440pw be fore housing costs and £374pw after housing costs. This paper also covers regional inequalities.

141   Stonewall, Lesbian, Gay and Bisexual people in later life, 2011.

142   Kings College London / Age UK, Diversity in older people and access to services – an evidence review, 2012.

143   Ibid.

144   Ibid.

145   Shelter, Older people and housing, 2007.

OUR THEORY OF CHANGE AND OUTCOMES SOUGHT

A single theory of change across such a diverse spectrum of issues would not make sense. However, our early findings in this topic suggest that there is more to do in both assessing and communicating existing evidence, and helping determine new research priorities. Many efforts are running concurrently in this space, but there may be inadequate convening of groups, integration of findings, and communication to policy makers. The Centre may choose to continue with a broad scope across inequalities, or focus on a specific area, and we will welcome views from a wide range of respondents.

Over the long term, the Centre would seek to narrow inequality gaps in the key domains of well-being – health, psychosocial, financial and place – across a range of vulnerable groups.

OUR KEY QUESTIONS

We welcome your reactions to the brief discussion above, and in particular your thoughts on the following questions:

1. Prioritisation. Does this topic matter for better later lives? Should it be one of the three or four priority topics for inclusion in the Centre's initial portfolio of work?

2. Landscape. Which initiatives, pieces of evidence or research are you aware of that are particularly relevant to this topic?

3. Focus. As discussed above, our first exercise on inequality will be a landscape review. Which aspects of inequality should the review focus on? Beyond this review, what most needs action by the Centre on this topic – to synthesise evidence, to share it, to seed innovation, to scale proven practice, or to secure change? Should the Centre focus on inequalities linked to a particular strand, for example ethnicity, or even a specific group within that strand, for example Black Caribbean and Black African people?

4. Theory of change. The Centre aims to help promote change with evidence and other actions. What are your views on the high-level theory of change outlined in the paper?

5. Working together. If we decide to proceed with this topic, how might we work with your organisation? Which other organisations should we seek to work with?

TOPIC 8: THE CONTRIBUTION OF OLDER PEOPLE TO A BETTER LATER LIFE

SUMMARY

Older people – serving as carers and volunteers, in other forms of community activity, and also in paid employment around the provision of social care - make an extensive contribution to meeting other older people's needs. This contribution is not only effective for the recipients; it also offers a sense of purpose and connectedness to the providers that can, in turn, help them to age better. The Centre would seek to understand and promote this contribution, and also to understand what works in securing more of it.

TOPIC OVERVIEW

WHY THIS MATTERS

David Robinson[146] has described a spectrum of community activity – starting with engagement by family and friends, and ending with the voluntary and community-based delivery of public services commissioned and funded by statutory bodies – that can contribute towards better ageing. In broad terms, movement along this spectrum involves three types of shift: from preventative to reactive activity; from activity that arises out of free association to activity that is specified and directed by government; and from activity that takes place at little or no cost to the taxpayer to more activity that requires considerable expense of public funds.

Provision across the earlier parts of this spectrum is not only effective; it can also be highly economical, thereby easing pressure on the public finances. Neighbourliness, voluntary association, informal social care and light-touch support can all be undertaken at low or no cost to the state – and these types of service can also help delay (or even avoid) the need for more expensive hospital and residential care. In a period where the number of people over 65 receiving publicly funded care is falling (from 1.2m in 2004-05 to 898,000 in 2012-13[147]), non-statutory provision is likely to be an important means of plugging the gap between needs and public funds.

Much of this provision will come from older people themselves – as volunteers and carers, and through other forms of community activity. The importance of this activity is likely to rise over the coming decades, as the rate of growth in the needs of older people (By 2030 there will be 2 million people aged over 65 without adult children to look after them - and about 230,000 of these older people will be in need of more than 20 hours' care a week, with no informal support[148]) outstrips both the capacity of public finances to fund statutory provision and the capacity of immediate family members to respond to those needs.

Meeting the challenge of this rising demand will require an extensive coalition of efforts - with significant contributions from civil society, charitable foundations, and the state at both national and local level. Within this coalition, it will be particularly important to understand how the national and local state can enable and support caring, voluntary and activity by older people without crowding out the capacity of those older people for enterprise and self-managed activity.

This is a wide-ranging issue. But, across its broad canvas, several issues are of particular interest to CfAB:

- Understanding and publicising the contribution that older people make to meeting the needs of other older people;

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146   David Robinson, Maximising community engagement, paper for CfAB 2014

147   HSCIC, Community Care Statistics, 2005 and 2013.

148   IPPR, Getting Older and Staying Connected, 2013.

- Understanding the benefits to the older people engaged in making this contribution. Some of these benefits will be psycho-social, and measurable in terms of older people's wellbeing. But some types of care activity can also offer economic benefits to the older people performing them: in particular, opportunities may open up for older people to establish community enterprises which may yield an income stream as part of a new economic model for social care (in which less use is made of bulk contracts with corporates and large businesses, and more made of more procurement from small and micro- enterprises), thereby strengthening the financial position of some of these older entrepreneurs in their later lives.

- Understanding how this contribution might be focused on particular challenges – for example, problems around loneliness and social isolation, and the generation of social care and support to be deployed in the context of efforts by statutory authorities to meet the care needs of older people;

- The role of the state in relation to the contribution of older people as volunteers and carers within any locality – as described above, in terms of the general enabling and support role, and in terms of stimulating activity and aligning it with need.

OUR THEORY OF CHANGE AND OUTCOMES SOUGHT

Our first thoughts on the theory of change for this topic are that the Centre should seek to influence the 'supply side' of voluntary and community activity: the organisations and initiatives that encourage and support older people to serve as volunteers and carers and then focus those older people's resources on the meeting of needs, and also the local public-sector organisations that enable these efforts through commissioning and other forms of financial and non-financial support.

EXAMPLE EARLY INTERVENTIONS THE CENTRE MIGHT CONSIDER

CfAB would seek to bring evidence to bear on a range of issues facing these institutions and initiatives, through:

- enriching the existing evidence base, by challenging and supporting existing providers to evaluate what they do

- seeding innovative ventures that demonstrate potential to plug gaps in the current landscape of community activity

- scaling existing provision that has shown itself to be highly effective – and, in the process, seeking to understand the challenges that successful community organisations and initiatives face when attempting to expand their footprint

- securing improvement across localities by working with local public-sector organisations to understand what role the local state can best play in supporting and enabling community activity – ensuring that any work by the Centre on these issues aligns with any work that we undertake in relation to the topic of local leadership for an ageing society. As part of such work: the Centre might select a number of localities to form a 'pathfinder' programme, testing a series of systemic interventions over time and evaluating their impact on a series of key outcomes.

OUR KEY QUESTIONS

We welcome your reactions to the brief discussion above, and in particular your thoughts on the following questions:

1. Prioritisation. Does this topic matter for better later lives? Should it be one of the three or four priority topics for inclusion in the Centre's initial portfolio of work?

2. Landscape. Which initiatives, pieces of evidence or research are you aware of that are particularly relevant to this topic?

3. Focus. On which aspects of this topic should the Centre focus? What most needs action by the Centre on this topic - to synthesise evidence, to share it, to seed innovation, to scale proven practice, or to secure change?

4. Theory of change. The Centre aims to help promote change with evidence and other actions. What are your views on the high-level theory of change outlined in the paper?

5. Working together. If we decide to proceed with this topic, how might we work with your organisation? Which other organisations should we seek to work with?

APPENDIX 2

SUMMARY OF CONSULTATION QUESTIONS

A. CfAB's Vision, Aims and Objectives	Any high-level comments?
B. How We Will Work	Any reactions to how we will: • involve older people; • identify the issues that matter most to people and where our capabilities allow us to bring about change; • manage and deliver programmes, working in partnership with other bodies; • evaluate and adjust our portfolio of activities; • and build an organisation that is fit for purpose?
C. 8 Potential Topics	Any comments on the eight potential topics in and, in particular, the key questions listed at the end of each topic paper?:
Topic 1: Healthy Living for All	1. **Prioritisation.** Does this topic matter for better later lives? Should it be one of the three or four priority topics for inclusion in the Centre's initial portfolio of work? 2. **Landscape.** Which initiatives, pieces of evidence or research are you aware of that are particularly relevant to this topic? 3. **Focus.** On which aspects of this topic should the Centre focus? What most needs action by the Centre on this topic – to synthesise evidence, to share it, to seed innovation, to scale proven practice, or to secure change? 4. **Theory of change.** The Centre aims to help promote change with evidence and other actions. What are your views on the high-level theory of change outlined in the paper? 5. **Working together.** If we decide to proceed with this topic, how might we work with your organisation? Which other organisations should we seek to work with?

Topic 2: Extending Working Lives	1. **Prioritisation.** Does this topic matter for better later lives? Should it be one of the three or four priority topics for inclusion in the Centre's initial portfolio of work? 2. **Landscape.** Which initiatives, pieces of evidence or research are you aware of that are particularly relevant to this topic? 3. **Focus.** On which aspects of this topic should the Centre focus? What most needs action by the Centre on this topic – to synthesise evidence, to share it, to seed innovation, to scale proven practice, or to secure change? • In particular, should we focus on certain sizes of organisations? (There are 6,000 large employers in the UK who employ roughly half of the workforce, and are arguably more straightforward to "go to market".) Or on particular sectors (e.g. public, manual)? 4. **Theory of change.** The Centre aims to help promote change with evidence and other actions. What are your views on the high-level theory of change outlined in the paper? 5. **Working together.** If we decide to proceed with this topic, how might we work with your organisation? Which other organisations should we seek to work with?
Topic 3: Social Connectedness	1. **Prioritisation.** Does this topic matter for better later lives? Should it be one of the three or four priority topics for inclusion in the Centre's initial portfolio of work? 2. **Landscape.** Which initiatives, pieces of evidence or research are you aware of that are particularly relevant to this topic? 3. **Focus.** On which aspects of this topic should the Centre focus? What most needs action by the Centre on this topic – to synthesise evidence, to share it, to seed innovation, to scale proven practice, or to secure change? 4. **Theory of change.** The Centre aims to help promote change with evidence and other actions. What are your views on the high-level theory of change outlined in the paper?

5. **Working together.** If we decide to proceed with this topic, how might we work with your organisation? Which other organisations should we seek to work with?

Topic 4: Sustaining Independence in the Home

1. **Prioritisation.** Does this topic matter for better later lives? Should it be one of the three or four priority topics for inclusion in the Centre's initial portfolio of work?

2. **Landscape.** Which initiatives, pieces of evidence or research are you aware of that are particularly relevant to this topic?

3. **Focus.** On which aspects of this topic should the Centre focus? What most needs action by the Centre on this topic – to synthesise evidence, to share it, to seed innovation, to scale proven practice, or to secure change?

4. **Theory of change.** The Centre aims to help promote change with evidence and other actions. What are your views on the high-level theory of change outlined in the paper?

5. **Working together.** If we decide to proceed with this topic, how might we work with your organisation? Which other organisations should we seek to work with?

Topic 5: Ready for Ageing Locally: What Works?

1. **Prioritisation.** Does this topic matter for better later lives? Should it be one of the three or four priority topics for inclusion in the Centre's initial portfolio of work?

2. **Landscape.** Which initiatives, pieces of evidence or research are you aware of that are particularly relevant to this topic?

3. **Focus.** On which aspects of this topic should the Centre focus? What most needs action by the Centre on this topic – to synthesise evidence, to share it, to seed innovation, to scale proven practice, or to secure change?

4. **Theory of change.** The Centre aims to help promote change with evidence and other actions. What are your

views on the high-level theory of change outlined in the paper?

5. **Working together.** If we decide to proceed with this topic, how might we work with your organisation? Which other organisations should we seek to work with?

Topic 6: Ageism: Understanding its Perception and Impact	1. **Prioritisation.** Does this topic matter for better later lives? Should it be one of the three or four priority topics for inclusion in the Centre's initial portfolio of work? 2. **Landscape.** Which initiatives, pieces of evidence or research are you aware of that are particularly relevant to this topic? 3. **Focus.** As discussed above, our first exercise on ageism will be a landscape review. Which aspects of ageism should the review focus on? Beyond this review, where should the Centre focus its efforts on this topic – to synthesise evidence, to share it, to seed innovation, to scale proven practice, or to secure change? Should the Centre focus on a specific area of age discrimination, such as healthcare or social care? 4. **Theory of change.** The Centre aims to help promote change with evidence and other actions. What are your views on the high-level theory of change outlined in the paper? 5. **Working together.** If we decide to proceed with this topic, how might we work with your organisation? Which other organisations should we seek to work with?
Topic 7: Inequality in Ageing Outcomes	1. **Prioritisation.** Does this topic matter for better later lives? Should it be one of the three or four priority topics for inclusion in the Centre's initial portfolio of work? 2. **Landscape.** Which initiatives, pieces of evidence or research are you aware of that are particularly relevant to this topic?

3. **Focus.** As discussed above, our first exercise on inequality will be a landscape review. Which aspects of inequality should the review focus on? Beyond this review, what most needs action by the Centre on this topic – to synthesise evidence, to share it, to seed innovation, to scale proven practice, or to secure change? Should the Centre focus on inequalities linked to a particular strand, for example ethnicity, or even a specific group within that strand, for example Black Caribbean and Black African people?

4. **Theory of change.** The Centre aims to help promote change with evidence and other actions. What are your views on the high-level theory of change outlined in the paper?

5. **Working together.** If we decide to proceed with this topic, how might we work with your organisation? Which other organisations should we seek to work with?

Topic 8: The Contribution of Older People to a Better Later Life

1. **Prioritisation.** Does this topic matter for better later lives? Should it be one of the three or four priority topics for inclusion in the Centre's initial portfolio of work?

2. **Landscape.** Which initiatives, pieces of evidence or research are you aware of that are particularly relevant to this topic?

3. **Focus.** On which aspects of this topic should the Centre focus? What most needs action by the Centre on this topic - to synthesise evidence, to share it, to seed innovation, to scale proven practice, or to secure change?

4. **Theory of change.** The Centre aims to help promote change with evidence and other actions. What are your views on the high-level theory of change outlined in the paper?

5. **Working together.** If we decide to proceed with this topic, how might we work with your organisation? Which other organisations should we seek to work with?

THANK YOU