NATIONAL INSTITUTE FOR HEALTH AND CARE EXCELLENCE

Health and social care directorate

Quality standards and indicators

Briefing paper

Quality standard topic: Mental wellbeing and independence for older people

Output: Prioritised quality improvement areas for development

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Contents

1 Introduction

This briefing paper presents a structured overview of potential quality improvement areas for mental wellbeing and independence for older people. It provides the committee with a basis for discussing and prioritising quality improvement areas for development into draft quality statements and measures for public consultation.

1.1 Structure

This briefing paper includes a brief description of the topic, a summary of each of the suggested quality improvement areas and supporting information.

If relevant, recommendations selected from the key development source below are included to help the committee in considering potential statements and measures.

1.2 Development source

The key development sources referenced in this briefing paper are:

- Older people: independence and mental wellbeing (2015). NICE guideline NG32
- Mental wellbeing in over 65s: occupational therapy and physical activity interventions (2008). NICE guideline PH16

2 Overview

2.1 Focus of quality standard

This quality standard will cover interventions to maintain and improve the mental wellbeing and independence of people aged 65 or older, and how to identify those at risk of a decline. It will not cover the mental wellbeing and independence of people aged 65 or older who live in a care home or attend one on a day-only basis.

2.2 Definition

Mental wellbeing covers both emotional and psychological wellbeing. This includes self‑esteem and the ability to socialise and cope in the face of adversity. It also includes being able to develop potential, work productively and creatively, build strong and positive relationships with others and contribute to the community. Independence is the ability to make choices and to exercise control over your life.

Other terms used in this paper include loneliness and age-related disability. Loneliness is divided into emotional and social loneliness. Emotional loneliness is felt when people miss the companionship of one particular person – often a spouse,

sibling or best friend. Social loneliness is experienced when people perceive that they lack a wider social network or group of friends. An age-related disability is any physical or mental impairment associated with ageing, such as a reduction in, or loss of vision, hearing, mobility or cognitive ability.

2.3 Incidence and prevalence

In 2014, 17.6% of the population were aged 65 or older (Ageing of the UK population: part of the population estimates for UK, England and Wales, Scotland and Northern Ireland, mid-2014 Release Office for National Statistics). By 2035 this is estimated to rise to almost 1 in 4 (23%) (Health expectancies at birth and at age 65 in the United Kingdom, 2008–2010 Office for National Statistics).

2.4 Management

Improving the mental wellbeing of older people and helping them to retain their independence can benefit families, communities and society as a whole. Helping those at risk of poor mental wellbeing or losing their independence may also reduce, delay or avoid their use of health and social care services.

This can be done by ensuring that older people play an active role in society. For example, 65% of volunteers in the UK are aged 50 or older (Ageing well: an asset based approach Local Government Association).

2.5 National Outcome Frameworks

Tables 1–3 show the outcomes, overarching indicators and improvement areas from the frameworks that the quality standard could contribute to achieving.

Table 1 The Adult Social Care Outcomes Framework 2015–16

Domain	Overarching and outcome measures
1 Enhancing quality of life for people with care and support needs	***Overarching measure*** 1A Social care-related quality of life** ***Outcome measures*** **People manage their own support as much as they wish, so they are in control of what, how and when support is delivered to match their needs** 1B Proportion of people who use services who have control over their daily life **Carers can balance their caring roles and maintain their desired quality of life** 1D Carer-reported quality of life** **People are able to find employment when they want, maintain a family and social life and contribute to community life, and avoid loneliness or isolation** 1I Proportion of people who use services and their carers, who reported that they had as much social contact as they would like
2 Delaying and reducing the need for care and support	***Overarching measure*** 2A Permanent admissions to residential and nursing care homes, per 100,000 population ***Outcome measures*** **Everybody has the opportunity to have the best health and wellbeing throughout their life, and can access support and information to help them manage their care needs** **Earlier diagnosis, intervention and reablement means that people and their carers are less dependent on intensive services** 2B Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement/rehabilitation services* *Placeholder 2E The effectiveness of reablement services* **When people develop care needs, the support they receive takes place in the most appropriate setting and enables them to regain their independence** 2C Delayed transfers of care from hospital, and those which are attributable to adult social care

3 Ensuring that people have a positive experience of care and support	***Overarching measure*** **People who use social care and their carers are satisfied with their experience of care and support services** 3A Overall satisfaction of people who use services with their care and support 3B Overall satisfaction of carers with social services *Placeholder 3E The effectiveness of integrated care* ***Outcome measures*** **Carers feel that they are respected as equal partners throughout the care process** 3C The proportion of carers who report that they have been included or consulted in discussions about the person they care for **People know what choices are available to them locally, what they are entitled to, and who to contact when they need help** 3D The proportion of people who use services and carers who find it easy to find information about support **People, including those involved in making decisions on social care, respect the dignity of the individual and ensure support is sensitive to the circumstances of each individual** This information can be taken from the Adult Social Care Survey and used for analysis at the local level.
Alignment with NHS Outcomes Framework and/or Public Health Outcomes Framework * Indicator is shared ** Indicator is complementary Indicators in italics in development	

Table 2 Public health outcomes framework for England, 2013–2016

Domain	Objectives and indicators
1 Improving the wider determinants of health	***Objective*** Improvements against wider factors that affect health and wellbeing and health inequalities ***Indicators*** 1.18 Social isolation* 1.19 Older people's perception of community safety
2 Health improvement	***Objective*** People are helped to live healthy lifestyles, make healthy choices and reduce health inequalities ***Indicators*** 2.23 Self-reported well-being 2.24 Injuries due to falls in people aged 65 and over
4 Healthcare public health and preventing premature mortality	***Objective*** Reduced numbers of people living with preventable ill health and people dying prematurely, whilst reducing the gap between communities ***Indicators*** 4.11 Emergency readmissions within 30 days of discharge from hospital* 4.12 Preventable sight loss 4.13 Health-related quality of life for older people 4.14 Hip fractures in people aged 65 and over 4.15 Excess winter deaths
Alignment with Adult Social Care Outcomes Framework and/or NHS Outcomes Framework * Indicator is shared ** Indicator is complementary Indicators in italics in development	

Table 3 NHS Outcomes Framework 2015–16

Domain	Overarching indicators and improvement areas
2 Enhancing quality of life for people with long-term conditions	***Overarching indicator*** 2 Health-related quality of life for people with long-term conditions** ***Improvement areas*** **Ensuring people feel supported to manage their condition** 2.1 Proportion of people feeling supported to manage their condition **Enhancing quality of life for carers** 2.4 Health-related quality of life for carers**
3 Helping people to recover from episodes of ill health or following injury	***Overarching indicators*** 3b Emergency readmissions within 30 days of discharge from hospital* ***Improvement areas*** **Helping older people to recover their independence after illness or injury** 3.6 i Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement/rehabilitation service* ii Proportion offered rehabilitation following discharge from acute or community hospital*
4 Ensuring that people have a positive experience of care	***Overarching indicators*** 4a Patient experience of primary care i GP services 4b Patient experience of hospital care *4d Patient experience characterised as poor or worse* *I Primary care* *ii Hospital care* ***Improvement areas*** **Improving hospitals' responsiveness to personal needs** 4.2 Responsiveness to inpatients' personal needs **Improving access to primary care services** 4.4 Access to i GP services **Improving people's experience of integrated care** *4.9 People's experience of integrated care***
Alignment with Adult Social Care Outcomes Framework and/or Public Health Outcomes Framework * Indicator is shared ** Indicator is complementary Indicators in italics in development	

3 Summary of suggestions

3.1 Responses

In total 10 stakeholders responded to the 2-week engagement exercise 10/02/16 – 24/02/16.

Stakeholders were asked to suggest up to 5 areas for quality improvement. Specialist committee members were also invited to provide suggestions. The responses have been merged and summarised in table 4 for further consideration by the Committee.

Full details of all the suggestions provided are given in appendix 2 for information.

Table 4 Summary of suggested quality improvement areas

Suggested area for improvement	Stakeholders
Identifying those most at risk of a decline in their independence and mental wellbeing	AHL, NCHA, NHSE, OC, PHE, PUK, SCM
Getting older people involved in activities • One-to-one activities • Group based activities	AUK, PHE, PUK, SCM, THG
Physical activity	AUK, SCM
Principles of good practice • Planning and partnerships • Local assets and needs assessment • Local coordination • Evaluating effectiveness	AHL, ARCO, AUK, NHSE, PHE, SCM
Additional areas • Training • Older people with multi-morbidities • Fall prevention • Managing hearing loss • Midlife approaches to reducing risk	AHL, AUK, NHSE, PHE, SCM
AHL, Action on Hearing Loss ARCO, Associated Retirement Communities Operated AUK, Age UK NCHA, National Community Hearing Association NHSE, NHS England OC, Optical Confederation PHE, Public Health England PUK, Parkinson's UK SCM, Specialist Committee Member(s) THG, Tunstall Healthcare Group	

3.2 Identification of current practice evidence

Bibliographic databases were searched to identify examples of current practice in UK health and social care settings; 6419 papers were identified for mental wellbeing and independence for older people. In addition, 57 papers were suggested by stakeholders at topic and 10 papers internally at project scoping.

Of these papers, 4 have been included in this report and are included in the current practice sections where relevant. Appendix 1 outlines the search process.

4 Suggested improvement areas

4.1 Identifying those most at risk of a decline in their independence and mental wellbeing

4.1.1 Summary of suggestions

Stakeholders highlighted the need to prevent a decline in mental wellbeing and independence for older people. This can be achieved by identifying those most at risk of decline. This includes older people with degenerative conditions, older who live alone, older people who are carers, older people with a coexisting mental health problem and older people with hearing loss or visual impairments.

4.1.2 Selected recommendations from development source

Table 5 below highlights recommendations that have been provisionally selected from the development source that may support potential statement development. These are presented in full after table 5 to help inform the Committee's discussion.

Table 5 Specific areas for quality improvement

Suggested quality improvement area	Suggested source guidance recommendations
Identifying those most at risk of a decline in their independence and mental wellbeing	**Identifying those most at risk of a decline in their independence and mental wellbeing** NICE NG32 Recommendation 1.5.3

Identifying those most at risk of a decline in their independence and mental wellbeing

NICE NG32 – Recommendation 1.5.3

Ensure staff in contact with older people can identify those most at risk of a decline in their independence and mental wellbeing (see implementation section). This includes being aware that certain life events or circumstances are more likely to increase the risk of decline. For example, older people whose partner has died in the past 2 years are at risk. Others at risk includes those who:

- are carers
- live alone and have little opportunity to socialise
- have recently separated or divorced
- have recently retired (particularly if involuntary)
- were unemployed in later life
- have a low income

- have recently experienced or developed a health problem (whether or not it led to admission to hospital)
- have had to give up driving
- have an age‑related disability
- are aged 80 or older.

4.1.3 Current UK practice

Identifying those most at risk of a decline in their independence and mental wellbeing

While no published studies on current practice were highlighted for identifying this overall group studies did identify current practice for specific areas. For example carers of people with Parkinson's are an at-risk group, and they are a population that are less likely to ask for or receive the additional help they may require[1]. For older people with a coexisting mental health illness there is evidence that there are low referral rates to IAPT services, with just 5.66% of all IAPT referrals being people who are over 65, despite a 12.77% target (expected prevalence) being set[2]. Finally there is evidence that on average people will wait 10 years to seek help for their hearing loss and in primary care only 55% of people are referred when reporting hearing loss[3].

4.1.4 Resource impact assessment

This area was not included in the resource impact report for NICE guideline NG32. It was not identified as an area that would have a significant resource impact.

[1] Drutyte, G et al (2014) 'What impacts on the stress symptoms of Parkinson's carers? Results from the Parkinson's UK members' survey' in Disability and Rehabilitation 6(3):199-204 available at: http://www.ncbi.nlm.nih.gov/pubmed/23586667
[2] Improving Access to Psychological Therapies (2016). Older people.
[3] Davis et al (2007) Acceptability, benefit and costs of early screening for hearing disability: a study of potential screening tests and models. Health Technology Assessment, 2

4.2 Getting older people involved in activities

4.2.1 Summary of suggestions

In general stakeholders highlighted that older people needed to participate in activities that can improve their mental wellbeing and independence. Best practice includes being given a choice and participating in activities that are meaningful to the person. These are broken down into one-to-one activities and group based activities.

One-to-one activities

Stakeholders suggested that older people should be offered one-to one activities including befriending interventions as well as providing assistance to maintain their existing relationships, such as through the use of different technologies.

Group based activities

Stakeholders highlighted that it was essential that older people have the opportunity to take part in group based activities. This may include being enabled to use technology or other group activities if they are unable to use this technology.

4.2.2 Selected recommendations from development source

Table 6 below highlights recommendations that have been provisionally selected from the development source that may support potential statement development. These are presented in full after table 6 to help inform the Committee's discussion.

Table 6 Specific areas for quality improvement

Suggested quality improvement area	Selected source guidance recommendations
One-to-one activities	**One-to-one activities** NICE NG32 Recommendation 1.3.1
Group based activities	**Group based activities** NICE NG32 Recommendations 1.2.1 and 1.2.2

One-to-one activities

NICE NG32 Recommendations 1.3.1

Offer one‑to‑one activities, such as:

- Programmes to help people develop and maintain friendships. For example, peer volunteer home visiting programmes, programmes to learn about how to make and sustain friendships or befriending programmes based in places of worship.
- Befriending opportunities that involve brief visits, telephone calls or the use of other media.
- Information on national or local services offering support and advice by telephone and other media.

Group based activities

NICE NG32 Recommendations 1.2.1

Provide a range of group activities, including multicomponent activities, combining 1 or more of the following:

- Singing programmes, in particular, those involving a professionally-led community choir.
- Arts and crafts and other creative activities.
- Tailored, community-based physical activity programmes including walking schemes (see recommendations 2 and 3 in NICE's guideline on occupational therapy and physical activity interventions to promote the mental wellbeing of older people).
- Intergenerational activities involving; for example, older people helping with reading in schools or young people providing older people with support to use new technologies.

NICE NG32 Recommendations 1.2.2

Consider offering:

- Activities, training and ongoing technical support that encourages older people to use information and communication technologies such as mobile telephones, internet-enabled TVs and computers.
- Activities related to hobbies and interests, education and other learning opportunities.

4.2.3 Current UK practice

While no published studies on current practice were highlighted for these specific activities a review conducted as part of the NICE guideline development concluded that there is a number of barriers to the use of services and activities that can promote mental wellbeing and independence for older people. Examples included low levels of internet use by older people and differing levels of volunteers amongst older people, depending on the personal preferences of the volunteers.

4.2.4 Resource impact assessment

The resource impact report for NICE guideline NG32 states that providing activities for older people should be funded from existing resources where possible. Some additional costs related to organisation and delivery may be incurred locally. However, any additional costs may be offset by savings from a reduction in:

- the number of GP appointments needed
- the number of falls
- diabetes, stroke and coronary heart disease
- depression and dementia.

4.3 Physical activity

4.3.1 Summary of suggestions

Stakeholders highlighted that as well as improving physical health, physical activity can also improve an older person's mental wellbeing and independence. This includes being able to manage any pain, reducing the impact of mental health problems and improving cardiovascular fitness. It will also improve the likelihood that an older person can leave their own home, which makes them less likely to experience loneliness and social isolation.

4.3.2 Selected recommendations from development source

Table 7 below highlights recommendations that have been provisionally selected from the development sources that may support potential statement development. These are presented in full after table 7 to help inform the Committee's discussion.

Table 7 Specific areas for quality improvement

Suggested quality improvement area	Suggested source guidance recommendations
Physical activity	**Group based activities** NICE NG32 Recommendation 1.2.1 **Physical activity** NICE PH16 Recommendation 2

Physical activity

NICE NG32 Recommendations 1.2.1

Provide a range of group activities, including multicomponent activities, combining 1 or more of the following:

- Singing programmes, in particular, those involving a professionally-led community choir.
- Arts and crafts and other creative activities.
- Tailored, community-based physical activity programmes including walking schemes (see recommendations 2 and 3 in NICE's guideline on occupational therapy and physical activity interventions to promote the mental wellbeing of older people).
- Intergenerational activities involving; for example, older people helping with reading in schools or young people providing older people with support to use new technologies.

NICE PH16 Recommendation 2

Who is the target population?

Older people and their carers.

Who should take action?

Physiotherapists, registered exercise professionals and fitness instructors and other health, social care, leisure services and voluntary sector staff who have the qualifications, skills and experience to deliver exercise programmes appropriate for older people.

What action should they take?

- In collaboration with older people and their carers, offer tailored exercise and physical activity programmes in the community, focusing on:
    - a range of mixed exercise programmes of moderate intensity (for example, dancing, walking, swimming)
    - strength and resistance exercise, especially for frail older people
    - toning and stretching exercise.
- Ensure that exercise programmes reflect the preferences of older people.
- Encourage older people to attend sessions at least once or twice a week by explaining the benefits of regular physical activity
- Advise older people and their carers how to exercise safely for 30 minutes a day (which can be broken down into 10-minute bursts) on 5 days each week or more. Provide useful examples of activities in daily life that would help achieve this (for example, shopping, housework, gardening, cycling).
- Invite regular feedback from participants and use it to inform the content of the service and to gauge levels of motivation.

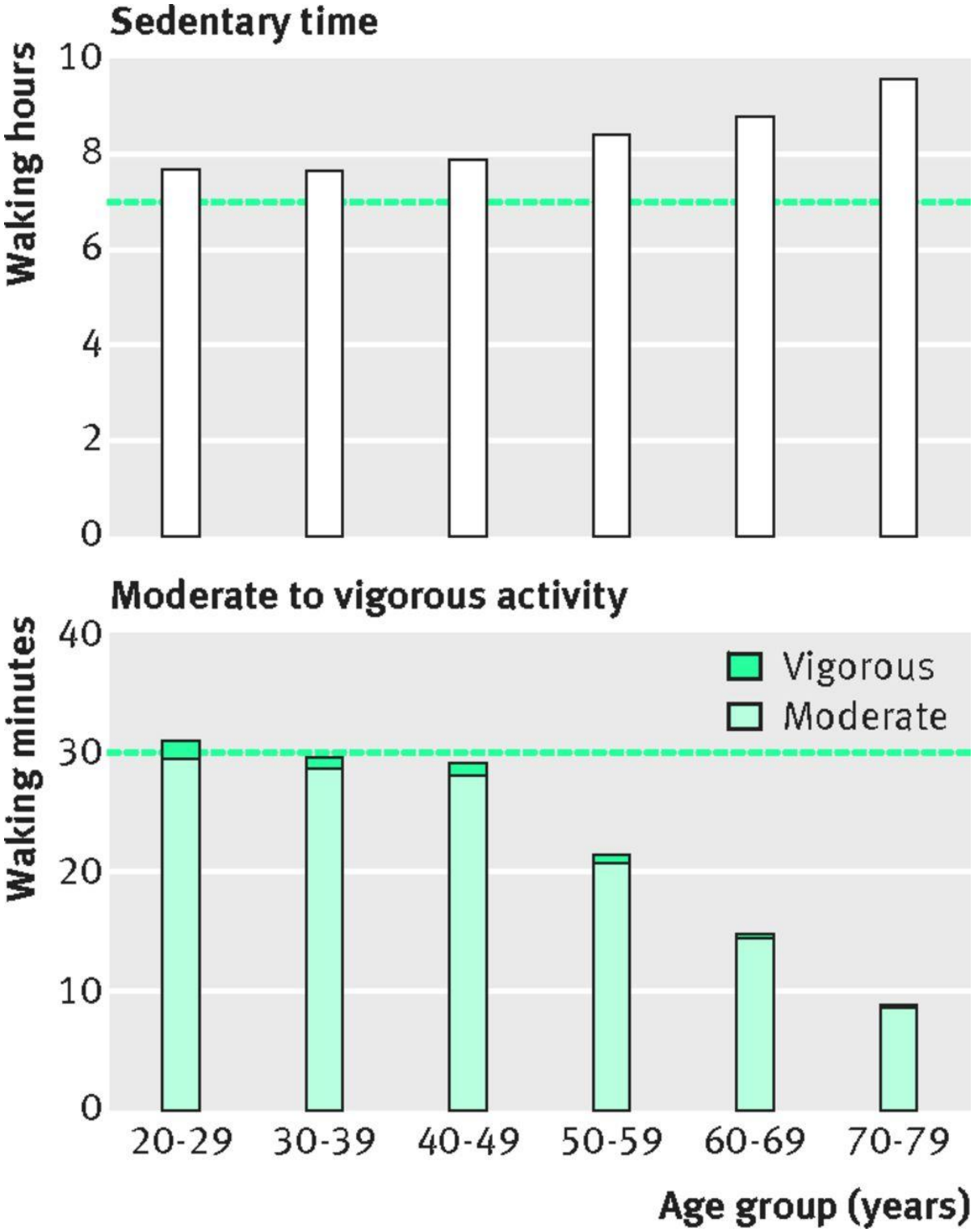
4.3.3 Current UK practice

Physical activity

A paper by Sparling et al (2015) highlights physical activity and sedentary behaviour by age. In found that the proportion of time spent sedentary rises with age: from 55% at ages 20 to 29 to a peak of 67% in those 70 to 79. Additionally the paper found that even when exercise is adjusted for age related decline in physical capacity, only 10-15% of older adults meet the minimum standard for “sufficient activity” (greater than 150 minutes per week of moderate intensity activity). Trends for sedentary time and activity levels are presented in figure 1, taken from the Sparling et al paper. The

dotted lines show the recommended amount of daily exercise (30 minutes) and the level at which sedentary behaviour is estimated to be harmful (7 hours)[4].

Figure 1: Sedentary time and moderate to vigorous activity time by waking hours/minutes.



[4] Sparling PB, Howard J, Dunstan DW, Owen N, Recommendations for physical activity in older adults, BMJ, 2015

4.4 Resource impact assessment

This area was included in the resource impact report for NICE guideline PH16 (recommendation 2). However due to the variable nature of service provision within each locality, the national cost impact could not be estimated.

Additional costs may be incurred through offering tailored exercise plans for individuals. The cost per hour of a community physiotherapist time is £36.

The cost of providing the intervention may be lower if it is delivered by health trainers and physical training instructors. The use of volunteer leaders will also reduce costs, but may require resources to provide appropriate training and expenses. This may be delivered using existing resources.

It is anticipated that a large number of older people will have access to physical activity schemes within their local area through free access to swimming or exercise and walking schemes. Where free access to physical activity schemes for older people is not already available, additional investment in these services will be necessary.

4.5 Principles of good practice

4.5.1 Summary of suggestions

Planning and partnerships

Stakeholders identified the need for mental wellbeing and independence for older people to be included as part of health and wellbeing strategies. This includes collecting data on their local population (including their age profile) and addressing housing needs of older people which includes enabling older people to stay in their own homes and existing communities.

Local assets and needs assessment

A stakeholder highlighted the need for local authorities to carry out local assets and needs assessment. This would take account of the number and location of older people, details of services available and gaps in provision of these services.

Local coordination

A stakeholder highlighted the need for a local coordinator role within communities. These would then be able to play an important preventative role within the community, including the prevention of admissions to hospitals.

Evaluating effectiveness

A stakeholder identified that services should evaluate the effectiveness of the interventions they are offering. As well as ensuring that all services that are offered to older people are effective, it would also ensure that they are cost effective and therefore enable funding to be invested appropriately.

4.5.2 Selected recommendations from development source

Table 8 below highlights recommendations that have been provisionally selected from the development sources that may support potential statement development. These are presented in full after table 8 to help inform the Committee's discussion.

Table 8 Specific areas for quality improvement

Suggested quality improvement area	Suggested source guidance recommendations and implementation sections
Planning and partnerships	**Principles of good practice** NICE NG32 recommendation 1.1.1 **Planning and partnerships** NICE NG32 Implementation area 1

Local assets and needs assessment	**Principles of good practice** NICE NG32 recommendation 1.1.1 **Local assets and needs assessments** NICE NG32 Implementation area 2
Local coordination	**Principles of good practice** NICE NG32 recommendation 1.1.1 **Local coordination** NICE NG32 Implementation area 3
Evaluating effectiveness	**Principles of good practice** NICE NG32 recommendation 1.1.1 **Evaluating effectiveness** NICE NG32 Implementation area 6

Principles of good practice

NICE NG32 Recommendation 1.1.1

Support, publicise and, if there is not enough provision, consider providing a range of group, one-to-one and volunteering activities that meet the needs and interests of local older people (see sections 1.2, 1.3 and 1.4 and implementation). In particular, target older people who are identified as being most at risk of a decline in their independence and mental wellbeing (see section 1.5).

Planning and partnerships

NICE NG32 Implementation area 1

Local authorities and the NHS could:

- Ensure their planning partnerships include older people and their representatives and representatives from:
    - other statutory providers such as the police and fire services
    - statutory and non‑statutory housing providers
    - home improvement agencies
    - voluntary sector organisations and charities
    - community groups, for example, groups with a general neighbourhood remit, those for people with shared interests or a shared ethnic, social or religious background, or with a health condition or disability in common, such as a sensory impairment
    - local high street businesses that older people visit
    - managers of neighbourhood facilities
    - maintenance and security workers, such as estate wardens.
- Include older people's independence and mental wellbeing as a core component of the joint strategic needs assessment and consider whether this should be included in the health and wellbeing strategy, based on local need.

- Identify a lead person to review and update this component of the joint strategic needs assessment and, if needed, the health and wellbeing strategy.
- Recognise the role of planning teams in helping older people maintain and improve their independence and mental wellbeing. Specifically, teams that advise on public facilities in the built and outdoor environment, such as seats and toilets, pedestrian and cycle routes and street lighting.
- Use a local coordinator (see area 3) to share data on older people at risk with other members of the partnership, in line with information governance arrangements (see the Health and Social Care Information Centre's material on information governance).
- Help community organisations to develop and sustain programmes of activities that maintain and improve older people's independence and mental wellbeing. This may include help with planning or providing transport to help people get involved. Or providing funding or spaces and facilities to host activities.

Local assets and needs assessment

NICE NG32 Implementation area 2

Local authorities could carry out a local assets and needs assessment that:

- Takes account of:
    - the number and location of older people in the local area
    - details of services and activities that may help to maintain or improve their independence and mental wellbeing
    - any gaps in provision or groups of older people who are not getting involved
    - details of 'local assets' such as the skills and knowledge of older people and others in the local community
    - community venues (halls, places of worship, sports clubs and public houses) that could be used.
- Uses data from sources such as health and social care services to estimate the number of older people who may be at risk of a decline in their independence and mental wellbeing. (Other sources may include market research, general practice profiles, the Projecting Older People Population Information System and the Office for National Statistics). Information could be collected on, for example, the number of older people:
    - aged 80 and older
    - who are carers
    - with long-term health conditions or an age-related disability
    - who live alone
    - who accept help, for example, with household tasks
    - who live in areas identified as deprived by national measures such as the indices of multiple deprivation (see English indices of deprivation 2010

Department for Communities and Local Government) and underprivileged area score.

- Uses an identified 'local coordinator' (see area 3) to develop knowledge 'on the ground' of local needs, skills and other relevant assets.
- Considers any differences in the groups at risk between and within local populations of older people (for example, in terms of their gender, sexuality, disability, income or ethnicity).
- Notes any health inequalities and finds out why these exist.
- Identifies anything that stops older people participating in local activities (such as limited access to transport or a low income) and addresses these barriers (see area 3).
- Uses interviews, focus groups or surveys to find out what type of local activities older people like to participate in and the types of community support they need to help them to enjoy life.
- Feeds the results into the joint strategic needs assessment and informs the local coordinator.

Local coordination

NICE NG32 Implementation area 3

Local authorities could consider incorporating this work into existing posts. The aim would be to:

- Identify older people who are at greater risk of a decline in their independence and mental wellbeing and tell organisations and others who can help.
- Contact older people at greater risk to find out more about their interests, capabilities and needs and develop a relationship with them.
- Provide information for those in contact with older people about the range of local activities and services available.
- Coordinate support to help older people use local services. This includes help to use digital services and information technology, if necessary.
- Offer older people advocacy support so they can say what services they need to remain independent and to maintain their mental wellbeing.

Commissioners could:

- Look at examples of local authorities that have created local coordinator positions. For example, Poynton town council has an adult health and wellbeing coordinator (see expert testimony paper 3). Other examples include village and community agents in Gloucestershire and the Dorset PoPP Wayfinder Programme (see evidence review 3).
- Consider using the coordinator's knowledge of local needs, the skills and other relevant 'assets' available in the local community and local services when commissioning services and activities.

- Highlight the local authority's statutory responsibility under the Care Act 2014. The Social Care Institute for Excellence provides advice and guidance, resources including videos, training, and consultancy to help understand and implement the Care Act.

Evaluating effectiveness

NICE NG32 Implementation area 6

To ensure organisations evaluate their activities and services and use the findings to improve them, local authorities could:

- Make collecting data for evaluation a requirement for statutory funding.
- Identify sources to help organisations carry out ongoing ('formative') evaluations along with sources of support for more formal ('summative') evaluations. (For example, the latter might be used annually to support funding applications.)

Service providers could:

- Get older people involved in designing and presenting evaluations, using examples such as those found in the Campaign to End Loneliness.
- Ask older people what they think about the service or activity. For example, how it is presented in publicity (web pages and posters), the activities on offer (whether there too much or not enough for specific groups, for example). Also:
    - find out what motivates older people to come along and what stops them
    - think about the timing, location and access to venues (for example, how physically accessible is it?)
    - identify other ways of getting older people involved, for example, through friends or family.
- Collect details on the following 'process outcomes' as a basis for evaluation:
    - number of sessions offered
    - numbers attending each session
    - new attendances at each session
    - demographic data.
- Form partnerships with academic and practice organisations (such as QaResearch and Ecorys) with the skills to help evaluate the activity or service.
- Use validated measures of mental wellbeing to gather evidence of effectiveness. Examples of evaluation tools incorporating these measures include:
    - Joseph Rowntree Foundation's Evaluating community projects practical guide. This provides step-by-step advice on how to evaluate a community project.
    - Warwick-Edinburgh Mental Wellbeing Scale.
    - Campaign to End Loneliness's Measuring your impact on loneliness in later life and The Charities Evaluation Services' general tool and resources. Both are for voluntary sector providers.

- Consider pooling resources across localities to fund joint evaluations of similar services.

4.5.3 Current UK practice

No published studies on current practice were highlighted for these suggested areas for quality improvement; these areas are based on stakeholder's knowledge and experience.

4.5.4 Resource impact assessment

These areas were not included in the resource impact report for NICE guideline NG32. They were not identified areas that would have a significant resource impact.

4.6 Additional areas

Summary of suggestions

The improvement areas below were suggested as part of the stakeholder engagement exercise. However they were felt to be either unsuitable for development as quality statements, outside the remit of this particular quality standard referral or require further discussion by the Committee to establish potential for statement development.

There will be an opportunity for the QSAC to discuss these areas at the end of the session on 7 April 2016.

Training

A stakeholder highlighted the need to provide training in how to maintain and improve mental wellbeing and independence for older people. Training is not usually included in quality standards as all health and social care practitioners should have the appropriate training and competencies to carry out any interventions in the quality standard.

Older people with multi-morbidities

Stakeholders suggested that older people are more likely to have multi-morbidity, with increased risk of polypharmacy. The quality standard in development Older people with social care needs and multiple long-term conditions will cover this group.

Fall prevention

Stakeholders identified that early interventions can prevent falls in older people, and preventing frailty in this population is important to maintain older people's mental wellbeing and independence. The quality standard in development Falls:prevention will cover these interventions.

Managing hearing loss

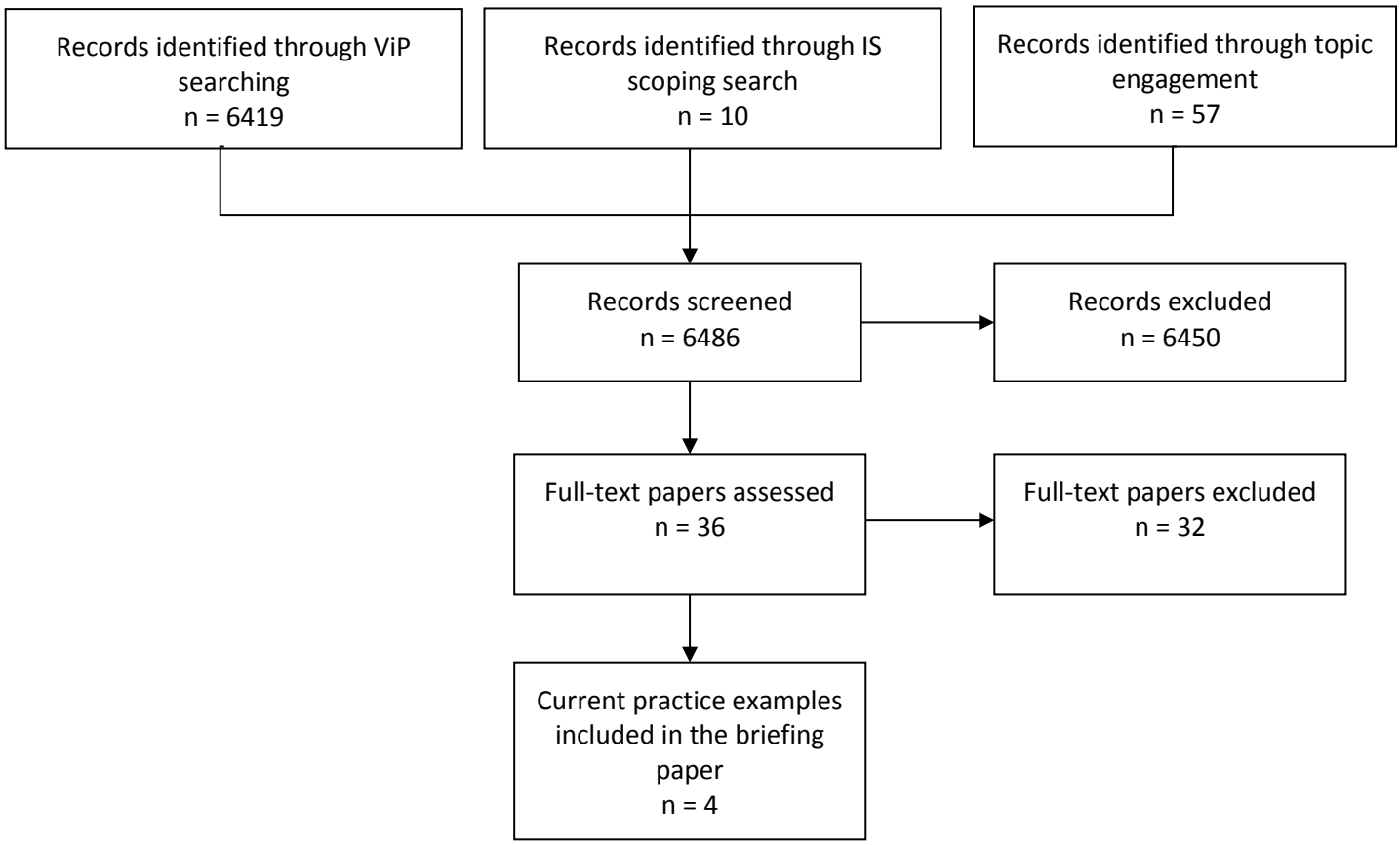
A stakeholder felt that support to manage hearing loss is required in order to allow older people to maintain their mental wellbeing and independence. This quality standard will not cover specific medical interventions, and Hearing loss (adults onset) is a topic that has been referred to the quality standards library.

Midlife approaches to reducing risk

A stakeholder highlighted an opportunity to prevent problems with mental wellbeing and independence at an earlier age, through midlife approaches to reducing risk. This population of this quality standard is people over 65 or people aged 55 and over

who are ageing prematurely, and therefore this population is not covered. The guideline on Dementia, disability and frailty in later life – mid-life approaches to delay or prevent onset is also aiming to cover this population in reference to those specific conditions.

Appendix 1: Review flowchart



Appendix 2: Suggestions from stakeholder engagement exercise – registered stakeholders

ID	Stakeholder	Suggested key area for quality improvement	Why is this important?	Why is this a key area for quality improvement?	Supporting information
4.1 Identifying those most at risk of a decline in their independence and mental wellbeing					
001	Parkinson's UK	An anticipatory and proactive approach to maintaining mental wellbeing and independence, particularly for people with degenerative conditions	Parkinson's is a complex neurological condition, which is both fluctuating and progressive. Research conducted by Sheffield Hallam University on behalf of Parkinson's UK found that people with the condition were often unaware of social care and the associated psychological and mental health support services that it can offer, and in many cases only accessed care at 'crisis point' – when their independence was at significant risk. The research therefore recommended an 'anticipatory' approach to social care planning, with support that escalates in-step with a person's growing care needs. An anticipatory approach to social care planning which recognises that people with degenerative neurological conditions are likely to have increasing needs for psychological support as their	Mental health problems are common for people with Parkinson's. However, the significant psychological impact of the condition is often overlooked, or misunderstood. A friend of a person with Parkinson's explains: "I think it's having that kind of perspective about him as a person in that very sort of holistic way, and recognising if you like all the different layers that Parkinson's presents, not just the kind of physical stuff that most people know about, like tremors and rigidity, but the psychological stuff, sort of the anxiety and depression, the kind of cognitive stuff" At any given time up to 40% of people with Parkinson's will have depression. Up to 40% of people with Parkinson's will experience anxiety and up to 50% will experience mild psychotic symptoms*. These symptoms may be caused by the side-effects of treatment, changes to the chemicals in the brain that are part of Parkinson's or associated with the challenges of living with Parkinson's, such	Tod, Angela Mary et al. "Good-Quality Social Care For People With Parkinson's Disease: A Qualitative Study". BMJ Open 6.2 (2016) available at: http://bmjopen.bmj.com/content/6/2/e006813.full?keytype=ref&ijkey=CuaBWbzDxtyfN3z NICE guidelines for Parkinson's Disease (2006) Parkinson's UK. Psychological services for people with Parkinson's disease (2009) NICE Older people: independence and mental wellbeing Clinical Guideline

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			condition progresses can therefore reduce hospital and GP visits and better support individuals to manage their own mental health and maintain their independence for longer. The recognition of an anticipatory approach in the quality standard could help identify 'those most at risk of a decline in their independence and mental wellbeing' as recommended in the NICE Clinical Guideline for this topic, and ensure their needs are met.	as freezing. Despite this, research conducted by Parkinson's UK has found that as few as 20% of depressed people with Parkinson's receive treatment[1]. This is thought to be caused either by under-diagnosis, or the fact that some treatments for mental health conditions can have side-effects which could exacerbate Parkinson's symptoms. Furthermore, one in three people with Parkinson's have some form of dementia and up to 80% of people with Parkinson's may develop dementia[2]. * Parkinson's UK. Psychological services for people with Parkinson's disease (2009)	
002	Parkinson's UK	Focussed support for carers to help them maintain their independence and mental wellbeing	Parkinson's UK strongly supports the inclusion of carers as groups who have been identified in the Clinical Guideline as being 'at risk of a decline in their independence and wellbeing'. We also support proposals to encourage befriending and individual activities to help maintain an individual's independence and wellbeing. However, it is not clear how well	In many cases, friends and family members will reduce or give-up work altogether to look after a person with Parkinson's. This can have a significant, psychological impact on the person undertaking this essential role. Research has found that increases in stress-related symptoms in those caring for a person with Parkinson's were associated with the number of tasks required of a carer. Caring impacted on their own health conditions and their financial status*.	Drutyte, G et al (2014) 'What impacts on the stress symptoms of Parkinson's carers? Results from the Parkinson's UK members' survey' in Disability and Rehabilitation 6(3):199-204 available at: http://www.ncbi.nlm.nih.gov/pubmed/23586667 Department of Health,

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			carers of people with Parkinson's are being supported by local authorities to maintain their independence, improve their mental wellbeing, or even continue their essential caring role. Care Act guidance to local authorities already requires councils to undertake assessments for 'any adult with an appearance of need for care and support, regardless of whether or not the local authority thinks the individual has eligible needs or of their financial situation' as set out in section 6.13. However, it is unclear to what extent local authorities are fulfilling this requirement, particularly in regards to unpaid carers. An explicit focus on carers' wellbeing in the Quality Standard would help to ensure that the needs of friends and family members, who provide care on an unpaid basis, are acknowledged and addressed. It could also	A carer of a person with Parkinson's explains: 'When someone is living with advanced Parkinson's your focus is on them and not yourself. In hindsight I now know my own health suffered, and I needed more support but didn't want to admit it. I'd really encourage people to get the support they need.' * Drutyte, G et al (2014) 'What impacts on the stress symptoms of Parkinson's carers? Results from the Parkinson's UK members' survey' in Disability and Rehabilitation 6(3):199-204 available at: http://www.ncbi.nlm.nih.gov/pubmed/23586667	Care and Support Statutory Guidance (2014) available at: https://www.gov.uk/government/publications/care-act-2014-statutory-guidance-for-implementation

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			ensure that local authorities are fulfilling their requirement to offer needs assessments to carers.		
003	SCM3	Key area for quality improvement 1 Identification and effective management of anxiety and depression in older people.	Anxiety and Depression are common in older people, particularly those with co-morbid long-term physical conditions (LTCs) or multimorbidity, and under-recognised and under-treated. Anxiety and Depression worsen outcomes for LTCs and increase health and social care utilisation.	Older people tend not to be referred to IAPT services by GPs, and if referred, may not engage, because they may not find interventions offered acceptable.	Chew-Graham CA, Burns A, Baldwin RC. Treating depression in later life: We need to implement the evidence that exists. [Invited Editorial] BMJ 2004; 329: 181-2. Chew-Graham C, Kovandžić M, Gask L, Burroughs H, Clarke P, Sanderson H, Dowrick C. Why may older people with depression not present to primary care? Messages from secondary analysis of qualitative data. Health and Social Care in the Community. 2011. 20(1), 52–60.
004	NHS England	Key area for quality improvement 3 Depression	The changes that often come in later life—retirement, the death of loved ones, increased isolation, medical problems—can lead to depression. Depression prevents people from enjoying life like they used to. But its effects go far	IAPT is available for older people but has low referral rates (< 60%) than for other adults even though recovery rates are higher (57% for OP compared to 45% for all other adults)	Depression can affect 1 in 5 older people living in the community (Royal College of Psychiatrists)

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			beyond mood. It also impacts people's energy, sleep, appetite, and physical health. However, depression is not an inevitable part of aging, and there are many steps people can take to overcome the symptoms.		
005	NHS England	Key area for quality improvement 8	Identify older people at risk of decline using a frailty toolkit	Frailty is a long term condition that will benefit from intervention	Frailty toolkit. http://www.nhsiq.nhs.uk/improvement-programmes/long-term-conditions-and-integrated-care/long-term-conditions-improvement-programme/house-of-care-toolkit/national/commissioning/tools-and-levers/enhanced-services-resources.aspx
006	National Community Hearing Association	Inclusion of the prevalence and impact of hearing loss in older people	Communication is important to the mental wellbeing and independence of people aged 65 or older. Age-related hearing loss in this cohort is very common and hearing should be included in the quality standard because 71% of people aged over 70 have a hearing loss age-related hearing loss is the	NICE recognise hearing loss as an age-related disability in its 'Older people: independence and mental wellbeing' guideline.[viii] NICE has previously accepted that unsupported hearing loss is a challenge. In its quality standard for mental wellbeing of older people in care homes (QS50) NICE note that	Department of Health and NHS England (2015) Action Plan on Hearing Loss NHS England and Age UK (2015) A practical guide to healthy ageing NICE (2015) Older people:

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			main cause of hearing loss age-related hearing loss is a long-term and progressive condition, so both the prevalence and severity of hearing impairment increase with age[i] adult hearing loss is the 6th leading cause of years lived with disability in England[ii], and the most common sensory impairment in older people unsupported adult hearing loss increases the risk of depression[iii], social isolation[iv], loneliness[v], cognitive decline[vi], and reduced quality of life[vii].	"hearing losses are a common feature of ageing and may go unnoticed for some time, but can have a serious effect on a person's communication, confidence and independence". Hearing loss is a major public health challenge. NHS England and the Department of Health, in their Action Plan on Hearing Loss note that "in older age, hearing loss becomes a major challenge and people with hearing loss can find it difficult to follow speech without hearing aids and are at greater risk of social isolation and reduced mental well-being. Social isolation has an effect on health and in older people there is a strong correlation between hearing loss and cognitive decline, mental illness and dementia."[ix] NHS England has also recognised unsupported hearing loss as 1 of 11 risk factors associated with functional decline in older people[x] and recommended older people to have their hearing tested without delay[xi]. Additionally, the World Health Organisation – in its active ageing strategy - highlights the importance of hearing care[xii].	independence and mental wellbeing NICE (2013) Quality Standard on Mental Wellbeing of Older People in Care Homes Public Health England and NHS Right Care (2013) Atlas of Variation World Health Organisation (2002) Active Ageing: A Policy Framework

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				The Atlas of Variation and the NHS England and Department of Health Action Plan on Hearing Loss acknowledge there is still unjustified variation in NHS adult hearing services across England.	
007	Optical Confederation	Visual impairment: community optical services	Older people are at significant risk of visual impairment with 1 in 5 of those aged 75 and older and 1 in 2 of those over 90 experiencing sight loss [1]. Communication and social inclusion are key aspects of valuing and supporting older people's independency and quality of life; both depend greatly on sensory functioning – at a minimum through either vision or hearing, though ideally through both [2]. There is evidence that unaddressed sight loss contributes to isolation, loneliness and depression in older adults and significantly increases the risk of falls and hip fractures [3]. Given the high prevalence of sight loss amongst older people and the multiple ways in which good vision supported by regular eye care can help to maintain physical, mental and social	We welcome NICE's recognition of visual impairment as an age-related disability in its 'Older people: independence and mental wellbeing' guideline [4]. Community optical practices offer effective and cost effective interventions nationally via GOS. All adults over 60 are entitled to free eye tests. Programmes such as diabetic retinopathy screening are also in place nationally on the NHS. In addition, optical practices provide locally commissioned community services including Minor Eye Condition Service (MECS). Where commissioned by CCGs, these services are free at the point of use. However, commissioning is currently piecemeal; for example, only one third of CCGs have commissioned MECS locally. This results in duplication of cost and effort and leads to postcode lotteries as well as confusion amongst the public. These services would enable provision of quality, accessible care in the community	Access Economics. 2009. Future Sight Loss (1): The economic impact of partial sight and blindness in the UK adult population, 1.1 Definitions of Partial Sight and Blindness, p.3 Older people with social care needs and multiple long-term conditions. Nice Guideline - Publication expected September 2016 Hodge, Barr and Knox. 2010. Evaluation of emotional support Older people: independence and mental wellbeing. NICE Guideline Douglas et al. 2006. Network 1000

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			wellbeing, community optical services have an important role to play in supporting older people to retain the maximum amount of independence, choice and control over daily life.	and provide a cost benefit to the NHS. In order to maximise these benefits they should be agreed through a national pathway with common standards, outcomes and experience measures that all areas could implement to avoid 'reinventing the wheel' – ideally at one fixed fee to save on commissioning costs. This would greatly reduce the cost and time burden on hospital ophthalmology and emergency departments as the majority of acute eye conditions are urgent rather than emergency, and most screening, monitoring and follow up can be done more cheaply but to the same standard by properly qualified community optometrists. However despite being one of the four primary care professions, Optometry is sometimes overlooked by health and social care professionals. If primary care services are to be fully utilised, we believe that the value of healthy vision and the role of community optical services in supporting this will need to be highlighted. Sight loss and other vision problems are often overlooked in part because their importance is not always well understood by front line staff. Regular sight tests and correction of any refractive error support communication and social interaction, and offer the opportunity to prevent and treat	Workplace policy and management practices to improve the health and wellbeing of employees. Nice Guideline - Publication expected March 2016 Nazroo, Whillans and Matthews. 2015. Changes in vision in older people: causes and impact. Thomas Pocklington Trust.

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				eye health conditions before they become sight threatening. Regular sight tests also support overall health and management of conditions such as diabetes and high blood pressure, and help to prevent falls and hip fractures, all of which are more prevalent among older people [5]. Where older people choose to remain in work, as is particularly true amongst lower earners [6], community optical services play an important role in reducing rates of avoidable age related sight loss. Rates of unemployment and unemployment-related psychological stress are high amongst people in the UK with visual impairment, and recent evidence shows that older people in the poorest fifth of the population have an almost 80% higher risk of developing severe visual impairment than those from the wealthiest fifth [7]. The rapidity of deterioration in vision is related to decreases in income, quality of life and social activity. Given the key importance of eye health for enabling independence and wellbeing in this population, and the potential for sight loss to exacerbate other social determinants of health, preventing visual impairment amongst older employees should be given greater attention.	

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				In cases where older people have multiple conditions or complex needs, visual impairment is often confused with other aspects of their diagnosis ('diagnostic overshadowing'). For example, it is particularly important that elderly people at greater risk of dementia attend regular eye examinations as symptoms of dementia can mask symptoms of sight loss. There is a need for training for those who care for older people around recognising changes in vision, particularly amongst those with sight loss and co-morbidities such as dementia, in order to ensure that vision problems are correctly and swiftly identified. Moreover, the variety of community optical services offers an opportunity for people to exercise real choice and control in their care and treatment, selecting the practice with the approach and accommodations that best suit their needs. It is important that this choice and continuity of care be preserved, for example through care home staff supporting arrangements for older people to continue to see their regular eye health practitioner if they wish. Older people who are unable to visit an optical practice in the community are entitled to an NHS-funded domiciliary eye care in their own home or in the care home where they reside; staff must	

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				support them in making the necessary arrangements with a provider of their choice.	
008	Action on Hearing Loss	Key area for quality improvement 1 Recognition of the impact of hearing loss on mental health and independence amongst health and social care professionals and from those with addressed and unaddressed hearing loss	Hearing loss is a long term condition which affects more than eleven million people in the UK. The prevalence of hearing loss increases with age, so with the ageing population the number of people with hearing loss is set to grow – by 2035 there will be approximately 15.6 million people with hearing loss in the UK, a fifth of the population. Over 71.1% of over 70 year olds have some form of hearing loss, so recognising the significant impact of unaddressed hearing loss on the mental health and independence of older adults is very important[3]. There is good evidence that hearing loss has an impact on mental health and independence. Research shows that all levels of hearing loss can cause communication difficulties, which often results in withdrawal and social isolation[4] and impacts on psychological and emotional wellbeing, in particular increasing	Although 71% of over 70 year olds have some form of hearing loss, there is still stigma attached to admitting having difficulties with hearing. Research by Action on Hearing Loss revealed that people wait on average 10 years to seek help for their hearing loss, and research also suggests that GPs currently aren't referring 45% of those reporting hearing loss to hearing services[13]. In order for mental wellbeing and independence not to be affected, awareness needs to be raised amongst professionals and older adults about the negative impact hearing loss can have and the importance of addressing it as soon as possible, through training and information delivered in professional settings and, for people with potential hearing loss, via health and social care and other services regularly accessed.	

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			the risk of depression. Older people with hearing loss are more than twice as likely to develop depression as their peers without hearing loss, the risk increasing to threefold with moderate hearing loss[5]. There is also growing body of evidence that has identified a strong association between all levels of hearing loss and decreased cognitive functioning and dementia[6]. Studies have also found that hearing loss can affect someone's ability to prevent and manage other conditions, which, considering that the likelihood of comorbidities increases with age, means that the damaging impacts of hearing loss could affect a significant proportion of older adults if it is not recognised or addressed. Hearing loss has been independently associated with increased health care use and burden of disease among older adults[7], and to cause an increased risk of cardiovascular disease[8], diabetes[9], stroke[10], sight loss[11], reduced		

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			mobility and more frequent falls[12].		
009	Action on Hearing Loss	Key area for quality improvement 2 Early intervention and adoption of hearing screening	There is evidence to show that identifying hearing loss early can reduce its potentially damaging effects on mental and physical health. This is particularly through the provision of hearing aids, which have been shown to enable people with hearing loss to stay socially active, reduce the risk of depression and possibly also reduce the risk of dementia[14]. There is evidence demonstrating that hearing aids fitted earlier give better results for the wearer. A systematic review has confirmed that hearing aids are the only viable treatment option for mild to moderate hearing loss[15], which will be affecting 63.5% of over 70 year olds[16], and a major Health Technology Assessment found that fitting hearing aids earlier was more cost effective, stating that "those identified early had greater benefit than those of the same age and hearing impairment who were fitted with hearing aids later"[17].	Given that people are waiting on average 10 years to seek help for their hearing loss[20] there is a need for early intervention to be prioritised, with health and social care professionals understanding the importance of addressing hearing loss, and more proactively seeking to identify and manage it amongst people in their care. We know there is considerable scope from improvement in this area. Action on Hearing Loss report, 'A World of Silence' [21], demonstrated that care home staff were reluctant to advise care home residents that they might be experiencing hearing loss. Procedures for recording incidences of hearing loss were not always followed. Some care home staff relied on memory or residents informing them who wears hearing aids and they also admitted that hearing loss was sometimes overlooked compared with other conditions like sight loss, pain and safeguarding. In order for the mental wellbeing and independence of older adults not to be affected, there needs to be greater awareness of the signs of hearing loss and treatment available, and health and social care professionals should be trained in how to undertake basic hearing checks and	Action on Hearing Loss has produced a nursing practice toolkit[23] for healthcare professionals that includes information on recognising hearing loss and outlines simple steps that can be taken to ensure it is addressed, such as training staff in how to recognise hearing loss and providing basic hearing screening equipment. Action on Hearing Loss and other organisations also offer hearing checks online and over the phone, to encourage early intervention[24].

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			There is also evidence to show that hearing screening for people aged over 65 would ensure that people with hearing loss receive effective treatment and support before the negative effects of hearing loss take effect, and would save the government £2 billion over ten years at an estimated cost of £255 million[18]. Other research has estimated that at least £28 million could be saved in England by properly managing hearing loss in people with dementia and thus delaying admission to residential care[19].	make timely referrals to support. In GP surgeries, pharmacies, care settings, community locations and at points of transition in care, hearing checks or hearing screening should be introduced to refer individuals for a full hearing test when staff recognise signs of hearing loss. NICE's quality standard for the mental wellbeing of older people in care homes[22] also states that commissioners, managers and practitioners with older people as part of their remit should be alert to the early signs of hearing loss, record instances of hearing loss and also be aware of the GP referral pathway for assessment and treatment.	
010	Public Health England	Support for carers	There are over 1m carers aged 65 and over. The mental health and wellbeing of carers is often neglected.	Older carers often find it difficult to look after themselves. As a result, their mental health may decline.	DH are working on a Carer's Strategy due 2016.
011	Age UK	Availability of old age psychiatry	Access to appropriate mental health services is a crucial part of maintaining mental wellbeing and independence in older people. This includes fair access to all services, including psychological therapies, and to old-age psychiatry services where appropriate. A recent paper in the	The quality standard must reference housing and communities. Housing is currently inconsistently thought of as a component of effective integrated care, with research by Leonard Cheshire finding that: "one third (37 per cent) of councils … are not planning to spend any of their [Better Care Fund] allocation on housing" (Leonard Cheshire Disability, 2015); another report	Beard JR, Cerdá M, Blaney S, Ahern J, Vlahov D, Galea S., Neighborhood characteristics and change in depressive symptoms among older residents of New York City. Am J Public Health, 2009

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			British Journal of Psychiatry identified old-age services as providing specific benefit for older people when compared to adult services (BJPsych, 2015), showing significantly lower rates of unmet needs. The independent Mental Health Taskforce Report (The five year forward view for mental health) recommended access to old-age psychiatry liaison services as an important part of caring for older people in acute settings. It also recommended that “bespoke older adult services should be the preferred model until general adult mental health services can be shown to provide age appropriate care”.	found “of local authorities identified as pioneers on integration … nearly three quarters (73 per cent) did not consider housing to be a key component in the integration of health and social care” (MHP Health, 2014). In meeting this challenge, health and social care commissioners should be encouraging an integrated approach to home support by involving home improvement agencies and occupational therapists in the strategic planning, delivery and investment in services, especially where there are gaps in provision. This has particular implications for discharge planning, for example. The process, including the effectiveness of a discharge coordinator, is highly dependent on the availability of local home support services with funding arrangements in place. Guidance on both the legal requirements and best practice in this regard can be found here: https://homeadaptationsconsortium.files.wordpress.com/2013/09/dfg-good-practice-guide-30th-sept-13.pdf. Achieving age-friendly communities must be a priority for all levels of local planning, and	World report on Ageing and Health, WHO, 2015 The long wait for a home, Leonard Cheshire Disability, 2015 Health and housing: From consensus to practice, MHP Health, 2014

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				health and care services can play an important role. The WHO describes age-friendly communities as “enabling greater functional ability … by filling the gap between what people can do given their level of capacity and what they could do in an enabling environment (for example, by providing appropriate assistive technologies, providing accessible public transport or developing safer neighbourhoods)”. This quality standard recognises mental health morbidity as a significant challenge for older people. 22% of men and 28% of women over 65 are living with depression. The broader role of wider services and society working better to preserve mental wellbeing in older people, as described in this QS, renders no less important the role of specialist services. Extensive evidence has demonstrated that access for older people is poor (Centre for Policy on Ageing, 2009; RCPsych, 2009, NDTi, 2011; Mind, 2013; Age UK, 2015). Furthermore, the NHS programme Improving Access to Psychological Therapies (IAPT) has stated that “older people are underrepresented in referrals to IAPT services and people completing IAPT treatment”. This quality standard must account for these inequalities, which can significantly	

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				undermine older people's long-term mental wellbeing and independence when needs arise. This should include scoping appropriate referral mechanisms for people both at risk of and already experiencing changes in their mental health, including where they may already be accessing existing services, for example physical health services.	
4.2 Getting older people involved in activities					
012	Parkinson's UK	Group based activity	Group based activities can be really positive for people living with Parkinson's. They can provide opportunities to meet others with similar experiences, maintain physical activity, and combat social isolation. It is therefore essential that everyone with Parkinson's has the opportunity to benefit from group based activity. Parkinson's UK believe that the Quality Standard must stipulate that telephone and face to face communication are also offered when organising group activities.	The recommendations in the guideline state in 1.2.2 that people should be offered technical support and information to use digital technology such as telephone, internet enables TVs and computers. This is certainly something that can be encouraged. However many people with Parkinson's are in later life, and some do not use digital technology, and may not wish to. There could be issues around their dexterity and whether they can effectively use a computer, or economic implications preventing them from purchasing equipment.	Katey Matthews and James Nazroo, University of Manchester, Understanding digital engagement in later life (May 2015). "For the English population aged 50 and over, large differences exist in the frequency of internet use by each of gender, age, wealth and region of England." "The percentage of people using the internet frequently (at least once a week) shows a strong decrease with age. Over 90 per cent of men aged 50 to 54 use the internet

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					frequently, but by age 80 only just over a third of men are frequent internet users. The proportion of women using the internet is lower. At age 50-54 81 per cent use the internet frequently and by age 80 this is the case for fewer than 14 per cent of women." "The prevalence of frequent internet use drops to below half by age 75 for men and by age 70 for women." Nancy M. Gell, PhD, MPH, Dori E. Rosenberg, PhD, MPH, George Demiris PhD, Andrea Z. LaCroix, PhD,and Kushang V. Patel, PhD, MPH The Gerontologist Advance Access published: Patterns of Technology Use Among Older Adults With and Without Disabilities (Dec 30, 2013)

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					"Those with more severe disability such as requiring help to perform ADLs or mobility outside the home used technology at significantly lower rates. Similarly, e-mail and internet use decreased with increased physical capacity impairment. Technology use also varied by activity-limiting symptoms and impairments. In particular, older adults with vision and memory impairment were less likely to use technology compared with those without these impairments."
013	SCM3	Key area for quality improvement 2 Role of befriending for older people with anxiety and depression.	Befriending interventions offered by third sector services are available but vary across services.	It is important to establish what the key components of an intervention are, and define the skills needed by third sector practitioners to deliver such interventions.	Mead N, Lester H, Chew-Graham C, Gask L & Bower P. Effects of befriending on depressive symptoms and distress: systematic review and meta-analysis. BJP. 2010 v. 196, p.96-101. Lester H, Mead N, Reilly S, Chew-Graham C, Gask L. An exploration of the

ID	Stakeholder	Suggested key area for quality improvement	Why is this important?	Why is this a key area for quality improvement?	Supporting information
					value and mechanisms of befriending for older adults in England. Ageing and Society. doi: 10:1017/S01044686X11000353
014	SCM4	Offer a range of activities and interventions for older people to promote or maintain independence and mental wellbeing	The NICE Guidelines highlight evidence for various types of group activities and one-to-one interventions that can promote or maintain wellbeing and independence in later life. This can be provided by a range of different people and bodies – including local authorities, NHS, charities, faith groups etc.	Making sure that older people – who are clearly not a homogenous group – have choice is an important element to any service trying to promote and maintain wellbeing or independence. Encouraging the development of 'multi-component' services that offer a range of different activities, groups or clubs can be one way to both meet different people's interests but also needs. One-to-one interventions, such as face-to-face befriending, are often oversubscribed but offer a vital service to people who are limited by mobility, sensory loss or lack of confidence.	Evidence Review 1 https://www.nice.org.uk/guidance/ng32/evidence/evidence-review-1-review-of-effects-2242568557 Promising approaches http://www.campaigntoendloneliness.org/wp-content/uploads/Promising-approaches-to-reducing-loneliness-and-isolation-in-later-life.pdf
015	Tunstall Healthcare Group	Key area for quality improvement 1 - Use of technology-enabled care for loneliness, independence and wellbeing	Loneliness affects millions of people in the UK, and as well as being a social issue it can have a detrimental effect on health. • 3.5 million people aged 65 and over 2 million (49%) of people aged 75 and over live alone • Over 1 million older people say they are always or often feel lonely	The Birmingham Telecare Service (BTS) was established in 2012 (Tunstall and Birmingham City Council) with the aim of supporting residents of the city to remain living independently in their own homes. The service combines a response service with a range of telecare solutions to support older people and those with long-term needs. Should the telecare sensors detect a problem, such as a fire or flood, they will	George's story George is in his 90s. He's been married for over 70 years but lives alone as his wife has advanced dementia and now lives in a care home where George visits her each day. He reports his wellbeing as generally

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			• 2.9 million older people in the UK feel they have no one to turn to for help and support • Loneliness can be as harmful for our health as smoking 15 cigarettes a day • People with a high degree of loneliness are twice as likely to develop Alzheimer's than people with a low degree of loneliness Statistics from Later Life in the UK, Age UK, August 2015	automatically notify the Tunstall Response monitoring centre, where trained operators can talk to the service user and send appropriate help. Service users can also use a personal pendant to contact the monitoring centre for assistance from anywhere in their home 24 hours a day. There are currently around 15,000 people benefitting from the service. Whilst this supports people's independence 24/7, BTS has recently begun working with The Silver Line to evaluate whether offering a Reassurance Calls Service to BTS service users could help to meet some of the additional challenges presented by loneliness and depression. The Reassurance Calls Service gives BTS service users who feel isolated or vulnerable emotional support, in addition to the reassurance gained from the telecare service. The Service was offered initially to 100 people, who were regular users of BTS, had recently been discharged from hospital, new users and those who had previously expressed an interest in helping to develop BTS. People receiving the Reassurance Calls service are contacted by a member of The Silver Line Friendship Team once a	good but he often becomes upset when talking about his wife's condition. On one Reassurance Call, George was extremely distressed, having just had bad news regarding his wife's health, and said he found it a relief to talk to someone about it. George has family but does not wish to be a burden to them, which leaves him feeling more isolated as he tries to cope with the emotional distress that the ongoing deterioration of his wife's condition is causing him. George was matched with a Silver Line Friend, who has been bereaved after a long marriage. When asked how his first call with his Silver Line Friend had gone, George commented on what a lovely lady she was and that he was really looking forward to their next call

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				week for a ten minute chat at a time convenient to them. Following this, service users may then be directed to The Silver Line's existing befriending service.	
016	SCM- Paul Cooper	Participation in meaningful occupation	Participation in activities meaningful to the individual during the day is important to a person wellbeing physically and mentally. This might include a person ability to complete their own personal care, social interactions with family and friends, exercise/activities in and/or out of the home.	As mentioned above an older person ability to participate in previously important occupations may be inhibited due to ill health or reduced social networks.	NICE Quality Standard on Mental wellbeing of older people in care homes. Talks about importance of participation in meaningful activity. Living well through activity in care homes: the toolkit (College of Occupational Therapists) https://www.cot.co.uk/living-well-through-activity-care-homes-toolkit-0
017	SCM- Paul Cooper	Choice and control for older people.	Giving people choice and control over areas of their life supports participation in activities that are important to them and their independence.	In order to ingrain in professional practice that throughout your life you are entitled to choice and control over your health and social care needs. To support aims within the Care Act 2014 and personalisation care approach. Acts central focus on Wellbeing and empowering individuals with choice and control.	Care Act 2014 http://www.scie.org.uk/care-act-2014/ NHS Five Year Forward https://www.england.nhs.uk/ourwork/futurenhs/ Dignity factors - Choice

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				Also the aim set out within the NHS five year forward view on people have greater control on their own care.	and control http://www.scie.org.uk/publications/guides/guide15/factors/choice/index.asp
018	SCM1	Key areas for quality improvement 1 Increased Internet access and skills on using the resources of the internet	Loneliness and Isolation are a key factor determining older people confidence , wellbeing and self-determination, This has been referred to in the guideline Older people independence and mental wellbeing.	Older people want to feel connected to the world and especially the new world. Information, is now often only available/ accessible in this format.	Research that was completed in Jewish Care with our users discussed the importance of having access to family, communication with friends and information on local events etc. The lack of internet access and the skills to do this made them feel disconnected. Happy to share the research and insights it gave us on older, disabled people and their carers and the impact technology could have on their lives.
019	Public Health England	Reducing social isolation and loneliness	Big impact on mental wellbeing caused by loneliness, opportunities to intervene should be maximised. Consider helping older people MAINTAIN their contacts rather than setting up opportunities for new interactions	SI&L are two separate,but interconnected issues. There is much promising practice, and guidance would help signpost commissioners to the best available evidence. SI&L is harmful to health and costs NHS ££	https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/461120/3a_Social_isolation-Full-revised.pdf is a very useful publication commissioned by PHE.

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020	Age UK	Loneliness and isolation	In our report Promising approaches to reducing loneliness and isolation in later life (2015), co-authored with the Campaign to End Loneliness, we outline a number of programmes that are shown to improve mental wellbeing in older people by addressing loneliness. For example, an Age Friendly Manchester scheme supports older people to become "culture champions", linking up with their local community to encourage their peers to engage with art and cultural events. An evaluation of the project showed people were more confident and connected as a result of their involvement. Many other projects combine activities to address isolation with physical wellbeing approaches, achieving a dual benefit. Halton Community Wellbeing Practices, for example, undertake structured "wellbeing reviews" to identify social causes of poor physical and mental wellbeing. These lead to support programmes that span everything from physical activities	In developing the quality standard, NICE must be clear in its distinction between loneliness and social isolation. Although these concepts are related, they have distinct causes and manifestations, and do not necessarily require the same solutions. While social isolation is an objective state in terms of the quantity of social contacts an person has, loneliness is a subjective experience. Loneliness is a negative emotion associated with a perceived gap between the quality and quantity of relationships that we have and those that we want. It can be a temporary, recurrent, or persistent (chronic) state. It is therefore possible to be lonely but not to be socially isolated – likewise, it is possible to be socially isolated but not lonely (Age UK, Loneliness Evidence Review, 2015). However, tackling social isolation does matter as it can be a risk factor for loneliness (Victor C et al, Loneliness, social isolation and living alone in later life, 2003). Over 1 million older people say they are always or often feel lonely, while nearly half of older people (49% of 65+ in the UK) say that television or pets are their main form of company. Persistent loneliness can have profound impacts on physical and mental health, and quality of life. For example,	Promising approaches to reducing loneliness and isolation in later life, Campaign to End Loneliness/Age UK, 2015 Evidence Review: Loneliness in Later Life, Age UK, 2014 Holt-Lunstad J, Smith TB, Layton JB (2010) 'Social relationships and mortality risk: a meta-analytic review' Wilson RS, Krueger KR, Arnold SE, Schneider JA, Kelly JF, Barnes LL, et al. (2007) 'Loneliness and risk of Alzheimer disease', Arch Gen Psychiatry

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			to interest groups and self-help classes. 64% of participants report improvements in mental wellbeing while 55% reported a reduction in depressive symptoms.	loneliness can be as harmful for our health as smoking 15 cigarettes a day (Holt-Lunstad J, Smith TB, Layton JB, 2010), and people with a high degree of loneliness are twice as likely to develop Alzheimer's than people with a low degree of loneliness (Wilson RS, et al. 2007). Promising approaches to reducing loneliness and isolation in later life, Campaign to End Loneliness/Age UK, 2015 Evidence Review: Loneliness in Later Life, Age UK, 2014 Holt-Lunstad J, Smith TB, Layton JB (2010) 'Social relationships and mortality risk: a meta-analytic review' Wilson RS, Krueger KR, Arnold SE, Schneider JA, Kelly JF, Barnes LL, et al. (2007) 'Loneliness and risk of Alzheimer disease', Arch Gen Psychiatry	
4.3 Physical activity					
021	SCM2	Improve awareness of older adults and service providers of importance of physical activity to help maintain mental wellbeing.	Strong evidence that maintaining physical function in older age has many benefits for health and wellbeing, outcomes include higher levels of cardio-respiratory fitness and physical function, improved disease risk factor	The ageing population in the UK will continue to place greater demands on health and social care systems. Older people can be effectively supported to maintain their physical and mental wellbeing and their quality of life in later life. There are many examples and evidence of the	Please see Start Active, Stay Active – report on physical activity for health from the Chief Medical Officers (2011), this contains guidelines specifically looking at

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			profiles and lower incidence of numerous chronic non-communicable diseases than those who are inactive. Randomised controlled trials have demonstrated that increasing physical activity improves cardiovascular fitness, strength and physical function; reduces aspects of cognitive decline and susceptibility to falls; and can improve aspects of mental well-being such as self-esteem and mood.	importance of physical activity, including maintaining muscle strength and reduction of muscle and bone loss associated with ageing, this enables people to remain more engaged with their communities, reduces the risk of falling, assists with maintenance of daily living tasks and can help reduce social isolation.	needs of older adults aged 65 and over https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/216370/dh_128210.pdf
022	SCM3	Key area for quality improvement 5 Increasing physical activity in older people.	Physical activity can help older people manage pain, and may reduce depression (and may impact on loneliness and social isolation).	More evidence needed on how to increase physical activity in older people.	Craig, R., Mindell, J., Hirani, V. (eds) (2009). Health Survey for England 2008, London: The Information Centre. Harris T, Kerry SM, Victor CR, Ekelund, Woodcock A, Iliffe S, Whincup PH, Beighton C, Ussher M, Limb ES, David L, Brewin D, Adams F, Rogers A, Cook DG. (2015). A Primary Care Nurse-Delivered Walking Intervention in Older Adults: PACE (Pedometer Accelerometer

ID	Stakeholder	Suggested key area for quality improvement	Why is this important?	Why is this a key area for quality improvement?	Supporting information
					Consultation Evaluation)-Lift Cluster Randomised Controlled Trial. PLoS Med 12(2): e1001783. doi:10.1371/journal.pmed.1001783.
023	SCM- Paul Cooper	Link between mental health wellbeing, independence, social Isolation and loneliness in older people.	In older people physical ill health may inhibit a person's ability to leave the home and networks of family friends might be reduced or difficult to maintain. As such this may affect mental wellbeing.	Research as highlighted in SCIE's publication across details links between depression with social isolation in older adults.	Loneliness and Isolation Evidence review by Age Uk. http://www.ageuk.org.uk/documents/en-gb/for-professionals/evidence_review_loneliness_and_isolation.pdf?dtrk=true At a glance 60: Preventing loneliness and social isolation among older people http://www.scie.org.uk/publications/ataglance/ataglance60.pdf NICE Guideline on Older people with social care needs and multiple long-term conditions. Section 1.6. http://www.ageuk.org.uk/Documents/EN-

ID	Stakeholder	Suggested key area for quality improvement	Why is this important?	Why is this a key area for quality improvement?	Supporting information
					GB/Factsheets/Later_Life_UK_factsheet.pdf?dtrk=true From P.23
024	SCM- Paul Cooper	Recognition of impact that physical disability and pain have on mental health and independence.	The effects of pain and physical pain are different for everyone and the impact that this has on mental health wellbeing and independence can also be variable. Recognition of this is important.	Pain affects everyone and although not an inevitable part of getting older life is can still be a major factor in a lot of older people's lives.	Assessment of pain in Older people. http://www.bgs.org.uk/index.php?option=com_content&view=article&id=313:painassessment&catid=42:catclinguidelines&Itemid=107 The management of long-term conditions http://www.kingsfund.org.uk/projects/gp-inquiry/management-long-term-conditions
025	Age UK	Exercise and activity	Age UK's fit as a fiddle programme supported a range of activities across the country to encourage physical exercise. These included support to get to centres offering physical activity classes; managed programmes aimed at tackling obesity which provided exercise classes and Nordic walking; and information aimed at improving health literacy. Across a range of these programmes there was significant	It is well-recognised that physical activity creates huge physical and mental health benefits for older people. As the WHO points out, doing the recommended amount can "improve cardiorespiratory and muscular fitness, bone and functional health, reduce the risk of [non-communicable diseases], depression and cognitive decline". The general benefits are important in their own right, but reducing the risk and/or impact of long-term conditions creates additional benefit with mental health problems being a common co-morbidity with	Fit as a fiddle, Final evaluation report Ecorys UK with Centre for Social Gerontology, University of Keele, 2013 Age UK's fit for the future: Project Evaluation Report, University of Leeds, 2015 Sparling PB, Howard J, Dunstan DW, Owen N, Recommendations for

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			improvement in mental wellbeing using the Warwick Edinburgh Mental Wellbeing Scale. Some of this work continued under the banner of fit for the future. Similar improvements were noted with almost 40% of respondents reporting a statistically significant positive outcome in rating their overall satisfaction with life by 3 months (that appears to remain at 9 months). A 2015 BMJ paper pointed out the specific risk to older people of long periods of sedentary behaviour, pointing to NICE guidelines not featured in the topic outline for this consultation (Physical activity: brief advice for adults in primary care). It also pointed to the benefits of helping older people achieve small increases in physical activity which may come under the recommended levels but still provide benefit.	physical health conditions. Guidance suggests that older adults should aim for the same levels of recommended activity (at least 150 minutes of moderate-intensity aerobic) as younger adults. However, as little as 10-15% of people over 65 meet this level (BMJ, 2015) with a particular drop off for people over 75 (Age UK, 2015). Physical activity can also reduce people's risk of falling (HSCIC, 2012), a key risk factor for older people losing confidence and becoming socially isolated.	physical activity in older adults, BMJ, 2015 Agenda for Later Life 2015: A great place to grow older, Age UK, 2015 Health Survey for England – 2012, HSCIC, 2012
4.4 Principles of good practice					

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026	NHS England	Key area for quality improvement 5	Include older people's independence and mental wellbeing as a core component of the joint strategic needs assessment and consider whether this should be included in the health and wellbeing strategy, based on local need.	If this is not routinely assessed we do not know we have made a difference. A multi - organisational and professional approach is needed.	
027	NHS England	Key area for quality improvement 6	Local authorities could carry out a local assets and needs assessment that: Takes account of: the number and location of older people in the local area details of services and activities that may help to maintain or improve their independence and mental wellbeing any gaps in provision or groups of older people who are not getting involved details of 'local assets' such as the skills and knowledge of older people and others in the local community	This links with identifying needs and will provide a resource to signpost individuals to.	

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			Community venues (halls, places of worship, sports clubs and public houses) that could be used.		
028	SCM4	Collecting data through Joint Strategic Needs Assessment on older adults at risk of poor mental wellbeing or losing independence	Area 1 of the NICE Guidelines Older people: independence and mental wellbeing implementation section recommends that data on older people's independence and mental wellbeing should be collected through the local authority's joint strategic needs assessment. This could help councils and the NHS to better identify local need and plan what services and support is required by their older population.	The JSNA can inform a range of services and strategies, including the Joint Health and Wellbeing Strategy. Better data on people who may be at risk of poor mental wellbeing and/or loss of independence could also help local councils to design services that prevent such a decline. This is also in line with the local authority's duties under the Care Act 2014 to prevent care and support needs and promote wellbeing across their whole population.	Area 1 in NICE Guideliness Older people: independence and mental wellbeing https://www.nice.org.uk/guidance/ng32
029	SCM4	Evaluating effectiveness of interventions that promote or maintain independence and mental wellbeing in older age	As stated in the NICE Guidelines "collecting routine monitoring and outcome data for evaluation means providers can demonstrate the impact of their activities or services". This data is important for ensuring the continuation of funding for effective services, and can help a service adapt and improve its work to better meet the needs and interests of its users.	A review conducted for the NICE Guidelines committee found that very few local or small services conduct regular and/or formal evaluations. Those that do evaluate their services tended to focus more on "qualitative experiences" than quantitative data about effectiveness. Even fewer looked at the cost effectiveness of their services. Research for the 2015 report from Age UK and CTEL Promising approaches to tackling loneliness and isolation in later life concluded that there was a lack of both academic and practice-based evidence for loneliness interventions. If we are to offer	Area 6 in NICE Guidelines Older people: independence and mental wellbeing https://www.nice.org.uk/guidance/ng32 Evidence review 3 – mapping services https://www.nice.org.uk/guidance/ng32/evidence/evidence-review-3-review-of-practice-2242568559 Promising approaches http://www.campaigntoend

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				effective and cost-effective interventions to older people at risk of poor mental wellbeing and loss of independent we need to improve the evidence base.	loneliness.org/wp-content/uploads/Promising-approaches-to-reducing-loneliness-and-isolation-in-later-life.pdf Measuring your impact on loneliness in later life http://www.campaigntoendloneliness.org/wp-content/uploads/Lonelines s-Measurement-Guidance1-1.pdf
030	SCM4	Establish local coordination to identify, contact and support older people at risk of decline in mental wellbeing and/or independence	There is a growing practical evidence base (such as local evaluations) that show a local coordinator role in a community, district or town can help statutory and third sector organisations better identify and support older people who may be in need of services to promote mental wellbeing and independence. This coordinator can play an important preventative role – helping reach and inform or support older people before they reach a point of crisis or need more intensive care/support from a local authority or NHS.	Local coordination schemes – sometimes called Village or Community Agents or Wayfinders – are only implemented by a small number of local authorities. There is also a need for better data on their effectiveness and the economic benefits of such schemes, so statutory bodies could consider both trialling a coordinator scheme and evaluating its impact.	NICE Guidelines Older people: independence and mental wellbeing https://www.nice.org.uk/guidance/ng32 Evaluation of Dorset Partnership for Older People Programme – Wayfinder service https://www.dorsetforyou.com/article/376802/Evaluation-of-Dorset-POPP
031	ARCO	Key area for quality	Housing and health are closely	Research by Aston University comparing	Please see the research

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	(Associated Retirement Communities Operated)	improvement 1 Local authority/NHS Trust development or assistance to Extra Care/Retirement Community housing developments in order to increase older people's independence	related, and there is good evidence to show that living in an extra care supported living setting dramatically increases and maintains older people's independence and wellbeing. Health and care staff need to consider housing interventions as part of their toolbox for helping maintain/improve older people's wellbeing, and commissioners need to build links with housing and care stakeholders in order to advance this model. Rather than just a dichotomy between home-care in general needs housing, and care homes, there is a need to foster intermediate options which allow people to 'age in place' and which foster independence. Amongst other things, local authorities and/or health trusts can improve the supply of housing-with-care for older people by: 1) Making sure older people's housing needs are emphasised and noted in local planning documents such as local plans 2)	residents moving in retirement communities with a control group, found that residents in extra care saw a reduction in depressive symptoms over 18 months. This was accompanied by a 64.3% reduction in people with significant 'clinical level' depression over the same period. The research also showed that 19% of residents who were 'pre-frail' at baseline returned to a 'resilient' state after 18 months, and that autobiographical memory improved for many residents after 18 months. NHS costs were reduced by 38% for those moving into extra care housing, as unplanned hospital stays and delayed discharge were reduced for residents who moved into supported living settings. Unplanned hospital stays reduced from an average of between 8-14 days to 1-2 days. In another report from the ILC, the emphasis on the ability of retirement villages to increase older people's wellbeing and independence was also noted. It found that the average person in a retirement village experiences half the amount of loneliness (12.17%) than those in the community (22.83%). Nearly two thirds of respondents living in retirement villages (64.2%) could be classified as not at all lonely, and over four	by Aston University emphasising the benefits of this sort of housing option: http://www.aston.ac.uk/lhs/research/centres-facilities/archa/extracare-project/ Please also see this research by the ILC into older people's independence and the improvements that retirement villages bring to social isolation and feelings of control: http://www.ilcuk.org.uk/index.php/publications/publication_details/village_life_independence_loneliness_and_quality_of_life_in_retirement_vill

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			Supporting development of new housing-with-care through partnerships e.g. allowing use of NHS/LA land specifically for building this sort of housing provision. 3) Making sure that state funded and private paying individuals with social care needs are aware of older people's retirement communities as well as care homes.	out of five (81.7%) said they hardly ever or never felt isolated. People living in this type of accommodation also reported a strong sense of control over their daily lives, nearly 10% higher than those living in the community. Control is a crucial component of quality of life measurement. They also felt secure in their homes, with 97% of respondents agreeing that they felt safe where they lived. Both of these findings were assessed using recognised quality of life measures. However currently only around 0.5% of older people live in retirement communities in the UK, compared to around 5% in other countries such as New Zealand and USA, and there is a need to increase supply of this vital housing option.	
032	SCM- Paul Cooper	Impact of environment on mental wellbeing and independence for older adults.	Often the homes that people have been living in for years are not suited to meet their needs as they grow older. People may need support in order to adapt their property or it might be that they need to move out in order to be safe and/or be independent. A statement within the commissioning home care for older people speaks about the	It is acknowledged that home adaptation is an important area with the commitment by government to increase the DFG monies via the Better Care Fund. Ensuring that properties are suited to people's needs and professionals are aware of the impact environment have is in my view important.	genHome project https://www.cot.co.uk/genhome What older people want: Commissioning home care for older people http://www.scie.org.uk/publications/guides/guide54/what-older-people-want.asp

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			preference that older people have for remaining in their own homes for longer. If the home is not suited for their needs this may impact on their wellbeing and independence.		DFG resources: Better Care Fund and DFG allocations 2016/17 http://www.foundations.uk.com/resources/home-adaptations/dfg-resources/
033	Action on Hearing Loss	Key area for quality improvement 3 Ensuring healthcare and wider services are accessible	Enabling older adults with a hearing loss or deafness to access services themselves is key to ensuring both that people receive treatment and support they need, and to enable people to retain independence. Under the Equality Act 2010, all service providers are required to make reasonable adjustments for people with physical or mental impairments who have substantial difficulties when accessing services. For people with hearing loss, this would mean ensuring alternative contact methods are made available such as textphone, text relay, email or SMS. For some people who are deaf may use British Sign Language (BSL) as their main language and may require a qualified BSL interpreter or video relay services (where a BSL	We know that people with hearing loss frequently have difficulties accessing services and communicating with professionals they come into contact with who are not deaf aware. For example, Action on Hearing Loss research found that nearly three quarters (72%) of people with a hearing loss contacted their by GP by telephone to book an appointment, but just under half (44%) wanted to book in this way, and just under half (46%) of people visited their GP surgery in person to make an appointment but a much smaller proportion (9%) wanted to. In appointments, more than a quarter of people (28%) have said they haven't understood a diagnosis, and one in five (19%) have been unsure about their medication after an appointment[26]. For British Sign Language users this is worse. Research shows that even when people ask for a BSL interpreter at appointments, around two-thirds (68%) don't get one; and almost half of those who do find the quality	Professionals and volunteers running services must be aware of how to communicate well with people with hearing and other sensory losses before and after any diagnosis, and also how to make services accessible. Our nursing practice toolkit and information about communication give more detail on what care staff should do to ensure services are accessible, and it would be useful to reference these in the Quality Standards[30].

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			interpreter provides translation for a video call). The Accessible Information Standard, produced by NHS England, becomes mandatory for all NHS and adult social care providers from 31s July 2016 and states that providers must have robust processes in place for identifying, recording, sharing and meeting the communication needs of people with hearing loss, and create environment that facilitates good communication[25]. The standard will ensure people with hearing and other sensory losses understand the information they are given, and will contribute to older people remaining active and independent for as long as possible. It is important that this Standard is supported by other high profile national guidance documents, such as appropriate NICE Quality Standards.	of interpretation isn't good enough[27]. Our Open to All? Research found that 79% of respondents said they believed that being deaf or hard of hearing makes it harder for them to take part in art, entertainment and leisure activities. The main causes were the poor deaf awareness of staff (46%), the lack of subtitles/captioning (37%), and the lack of induction loops /loops switched off (45%)[28]. Reducing "the variation in access and quality of services experienced by people with hearing loss" has been prioritised as an important area for quality improvement in the government's Action Plan on Hearing Loss. The Plan also calls on the 'hearing sector' to "work with Age UK, the Alzheimer's Society, University of the Third Age and others to promote awareness of and opportunities for personal development and fulfilment for older people with hearing loss and to ensure appropriate providers of such services are hearing aware and do all they can to remove barriers" [29], which demonstrates the importance of accessing services and social interaction for physical and mental wellbeing and independence.	

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034	Public Health England	Integration of services	Older people are not put at the centre of services and as a result of the consequent disjoint, mental wellbeing and independence are not optimised when they could be	Because there is a pitiful lack of join up across services, primary to secondary care and with the voluntary sector.	CQC are publishing a report on integration (which will highlight the lack of it) during 2016 (I'm on the advisory group)
035	Age UK	Age friendly communities/housing	Research has shown that older people are likely to spend more time in their local neighbourhood and in many cases to have lived in the same community for a considerable amount of time. The homes and neighbourhoods in which people live are an important part of meaning and self-identity for older people. Researchers have warned that "Most older people want to remain living at home, but if their neighbourhoods are inaccessible they are effectively trapped inside" (ILC, 2011). Fair Society Healthy Lives (the Marmot Review) recognised there are social determinants of health at a neighbourhood level, such as barriers associated with community participation, being able to access green spaces, public transport and active travel. Older people encounter	Research has shown that older people are likely to spend more time in their local neighbourhood and in many cases to have lived in the same community for a considerable amount of time. The homes and neighbourhoods in which people live are an important part of meaning and self-identity for older people. Researchers have warned that "Most older people want to remain living at home, but if their neighbourhoods are inaccessible they are effectively trapped inside" (ILC, 2011). Fair Society Healthy Lives (the Marmot Review) recognised there are social determinants of health at a neighbourhood level, such as barriers associated with community participation, being able to access green spaces, public transport and active travel. Older people encounter challenges across all of these areas. Research suggests "that the neighbourhood in which an older person lives has a significant impact on his or her mental health, even after accounting for individual-	Beard JR, Cerdá M, Blaney S, Ahern J, Vlahov D, Galea S., Neighborhood characteristics and change in depressive symptoms among older residents of New York City. Am J Public Health, 2009 World report on Ageing and Health, WHO, 2015 The long wait for a home, Leonard Cheshire Disability, 2015 Health and housing: From consensus to practice, MHP Health, 2014

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			challenges across all of these areas. Research suggests “that the neighbourhood in which an older person lives has a significant impact on his or her mental health, even after accounting for individual-level determinants” (Beard JR, et al, 2009). Furthermore, a review reported on by the WHO found “a range of environmental interventions have been shown to be helpful in reducing risks for older people living at home, particularly risk of falling which can significantly impact long-term wellbeing and independence”.	level determinants” (Beard JR, et al, 2009). Furthermore, a review reported on by the WHO found “a range of environmental interventions have been shown to be helpful in reducing risks for older people living at home, particularly risk of falling which can significantly impact long-term wellbeing and independence”.	
4.5 Additional areas					
036	NHS England	Key area for quality improvement 7	Provide training in how to maintain and improve older people's independence and mental wellbeing.	The Five Year Forward view describes a new way of working which relies on changing the way services are provided. Practitioners need to be supported with education to enable this to happen.	
037	Action on Hearing Loss	Key area for quality improvement 4 Awareness and take-up	Good support that’s convenient and easily accessible can help people maintain independence and not need to rely on health and	We know at the moment there are not enough referrals from audiology and other care settings to support that could have a positive impact on older adults’ mental	Our World of Silence report[37], nursing practice toolkit[38] and information about assistive listening

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		of follow-up and support to help manage hearing loss, which allows older people to retain independence	social care institutions, and this is of benefit to older adults as well as to commissioners and health and social care institutions. In the case of hearing loss, evidence strongly shows that given good support, follow up and rehabilitation, high levels of hearing aid use and satisfaction can be achieved at low costs[31]. Evidence also demonstrates the risk of social isolation and the adverse impact on people who spend time and care for older people with hearing loss[32]. Action on Hearing Loss runs a volunteer-led community-based aftercare service, Hear to Help, across many areas of the country. These services reduce the burden on audiology departments and support evidence suggesting that good follow-up and aftercare support for people with hearing aids increases use and satisfaction, and helps people retain independence. In 2013-14, 46% Hear to Help service users found their hearing aid/s very	wellbeing and ability to be independence. Our 2008 survey of 8,000 people with hearing loss found that four out of five people, when fitted with a hearing aid, received no information about other services, equipment or assistive technology, which can help to maximise independence and wellbeing[34]. Our World of Silence report also demonstrated that in care homes there were significant variations in the take up and understanding of hearing loop systems, TV listeners and amplified telephones. Awareness of supportive equipment and services amongst health and social care professionals and relevant community organisations is key to ensuring that older people can remain independent for as long as possible[35]. Key forms of support are also not readily available. Research undertaken in 2010, for example, revealed that only 450 lipreading classes were available in England and Wales, enough for just 5,000 people. Some are not free, few are put on outside working hours, and lipreading-teacher-training opportunities are limited[36]. It is crucial that support is available to ensure that conditions such as hearing loss don't hinder	equipment[39] give more detail on what care health and social care staff should provide to make sure people are supported as well as possible to manage their hearing loss, and much of this information is transferable to other professional or voluntary groups that are involved in supporting the mental wellbeing and independence of older people. These resources include information about: training on understanding hearing loss, hearing aid maintenance and communication; the use of assistive listening equipment; and promoting other equipment such as hearing aid storage boxes. Action on Hearing Loss particularly promotes the value of hearing aid support services, hearing

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			useful before accessing the service, compared with 86% afterwards. 80% reported that they were able to communicate better with people and 77% felt less isolated because their hearing aid is maintained to help them hear better. The survey also revealed that 5% people would 'do nothing' if they had a problem with their hearing aid/s and aftercare outside a clinical setting wasn't available[33]. People with hearing loss are entitled to support from their social services that will help them to be able to live independently for longer, including community equipment such as amplified telephones and television loop systems, and other aspects of local authority sensory services. It is important that health and social care professionals are aware of this support and older people are referred onto these services.	older adults' ability to remain independent.	therapy, good communication support, befriending services and lipreading classes for the management of hearing loss.
038	Public Health	Midlife approaches to	Opportunity to take positive steps to improve wellbeing during	Potential to improve this during other interactions with older people, e.g. during	NICE guidance on midlife approaches to reducing

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	England	reducing risk	midlife	screening programmes (breast, bowel, AAA), NHS Health Check, MECC	disability, dementia , frailty (2015)
039	SCM3	Key area for quality improvement 4 Impact of treatment burden and polypharmacy on mental well-being.	Older people are more likely to have multimorbidity, with the consequent treatment burden including polypharmacy (with risk of side-effects such as falls, and prescribing errors/drug interactions, and hospital admissions).	Interventions to reduce treatment burden and polypharmacy may improve mental well-being and independence.	We will need to refer to the forthcoming NICE CG Multimorbidity.
040	NHS England	Key area for quality improvement 1 Proactive case finding opportunities for people at risk of falling but not yet fallen.	There is good evidence in NICE CG 161 that early evidence-based intervention can prevent a fall. 1.1.1.2 Older people reporting a fall or considered at risk of falling should be observed for balance and gait deficits and considered for their ability to benefit from interventions to improve strength and balance. (Tests of balance and gait commonly used in the UK are detailed in section 3.3 of the full guideline.) [2004]	The topic overview references NICE QS 86 which is good however this only applies to older people who have already fallen. Reference to CG 161 would improve the proposed standard in terms of pro-active case finding and identification of people at risk for whom the fear and worry of a potential fall may be adversely affecting them and causing negative lifestyle modifications leading to increased falls risks. An example of this would be a person becoming unsteady and then fearful of leaving the house. This increase in sedentary behaviour can commonly lead to decreased strength and balance, decreased bone density with concomitant increased fracture risk, social isolation and increased potential depressive illness.	NICE 161 Falls in older people: assessing risk and prevention – reviewed 2016 https://www.nice.org.uk/guidance/QS86/chapter/introduction

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041	NHS England	Key area for quality improvement 4 Care plans	Every person with a LTC should have a care plan in place which clearly sets out the care and treatment they should expect, how they interact with clinicians, and their care needs.	Care plans are not always in pace, either at all or in a timely manner. A care plan means that both patients and health professionals know what to expect.	
042	Age UK	Frailty (including prevention)	Preventing frailty is recommended in NICE guideline NG16, Dementia, disability and frailty in later life – mid-life approaches to delay or prevent onset. We believe preventative approaches to all health conditions remain relevant into later old age and British Geriatrics Society/Age UK/RCGP guidance, Fit for frailty, recommends approaches that can be utilised in managing frailty regardless of stage or severity. Approaches such as comprehensive geriatric assessment is known to improve outcomes and longer-term quality of life for people living with frailty, positively influencing mental wellbeing and the chance to remain independent. For people with mild or “pre” frailty, often simple support such	Frailty can affect people of all ages but is most prevalent in people over 85 and the total numbers are likely to grow substantially in the coming years. Work carried out by Age UK has identified frailty as an important risk factor for low mood and depression and feelings of “losing control”. Older people included in qualitative research frequently talked about “turning points” in their ability to do every-day tasks and the impact this had on both their feelings of self-reliance and their mental wellbeing. There was often no response from local services when these turning points occurred and important chances to remain active and independent were missed (see supporting information). There was both a perceived and actual risk of rapid deterioration following such moments, substantially impacting mental wellbeing. Frailty and/or comorbidity can often be seen as a reason not to offer certain kinds of support or treatment to people rather than as a “diagnosis” to respond to. Recognising	Fit for frailty (parts 1 and 2), BGS/Age UK/RCGP, 2014/2015) Practical Guide to Healthy Ageing, Age UK/NHS, 2015 Understanding the lives of people living with frailty, Age UK/Ipsos MORI, 2014 Frailty: Language and Perceptions, Age UK/BGS/Britain Think, 2015 I’m Still Me, UCLPartners/Age UK/National Voices, 2015

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			as providing information to people can help to delay onset into later life and help to engage people with local services and community support. See for example Age UK/NHS booklet, a Practical Guide to Healthy Ageing (updated October 2015). The “electronic frailty index” (eFI) is available for use throughout England within existing general practice software and is shown to be highly predictive of presence and severity of frailty. Using the eFI in conjunction with interventions relevant to a person’s stage of frailty is increasingly effective in managing the condition.	frailty using many available, validated, methods and proactively planning care would make a huge difference to a person’s long-term outcomes and overall mental wellbeing.	
General					
043	SCM3	Key area for quality improvement 3 The impact of loneliness on mood – does loneliness cause depression?	It is assumed that loneliness and social isolation causes depression and that loneliness should be tackled in it’s own right (Campaign to end loneliness) – evidence is limited.	Interventions to tackle loneliness might have the potential to prevent depression.	Materials on Campaign to end Loneliness website.
044	NHS England	Key area for quality improvement 2	Older people are especially vulnerable to loneliness and	Whatever the cause, it's shockingly easy to be left feeling alone and vulnerable, which	According to Age UK, more than 2 million people

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		Loneliness	social isolation – and it can have a serious effect on health.	can lead to depression and a serious decline in physical health and wellbeing. This then has an avoidable knock on effect to other parts of the health and social care system.	in England over the age of 75 live alone, and more than a million older people say they go for over a month without speaking to a friend, neighbour or family member. http://www.ageuk.org.uk/documents/en-gb/for-professionals/evidence_review_loneliness_and_isolation.pdf?dtrk=true