Public Health Guidelines

OLDER PEOPLE: INDEPENDENCE AND MENTAL WELLBEING - Consultation on Draft Guideline
Stakeholder Comments Table

29 May – 10 July 2015

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Stakeholder Organisation	Section Number	Page Number	Comments Please insert each new comment in a new row.	Response Please respond to each comment
Action on Hearing Loss	General		Action on Hearing Loss is the charity formerly known as RNID. Our vision is of a world where deafness, hearing loss and tinnitus do not limit or label people and where people value and look after their hearing. We help people confronting deafness, tinnitus and hearing loss to live the life they choose. We enable them to take control of their lives and remove the barriers in their way. We give people support and care, develop technology and treatments and campaign for equality. Our response will focus on key issues that relate to people with hearing loss. Throughout this response we use the term 'people with hearing loss' to refer to people with all levels of hearing loss, including people who are profoundly deaf. We are happy for the details of this response to be made public. Action on Hearing Loss welcomes the NICE guidance on the Older people: Independence and mental wellbeing. We support the broad aims of guidance to help older people maintain their mental wellbeing, their independence, avoid future health problems and reduce health inequalities among older people. However, at present, we believe the guidance does not fully recognise the impact of hearing loss on older peoples' independence and mental wellbeing.	Thank you. The Committee recognises that hearing loss can have a major impact on the independence and mental wellbeing of older people. The guideline now specifies '*people with an age related disability'* (the definition of which includes hearing loss – please see the glossary) in recommendations 1.1 and 1.5.
Action on Hearing Loss			More than ten million people in the UK have hearing loss, about 1 in 6 of the population. The prevalence of hearing loss increases with age. Over 71.1% over 70 year olds have some form of hearing loss, and of these 40% have moderate or severe hearing loss[1].	Thank you. Some of this information has been included in the context section of the guideline.

[1] Action on Hearing Loss. (2011). Hearing Matters. www.actiononhearingloss.org.uk/hearingmatters

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			Without treatment, hearing loss can have older people with hearing loss may find it difficult to communicate with others and are at greater risk of developing other mental health problems. Being unable to hear properly can lead to a loss of confidence in social situations, reduced social activities and feelings of social isolation[2]. People with hearing loss are more likely to develop paranoia, anxiety and depression[3]. Hearing loss has also been associated with more frequent falls[4], diabetes[5], stroke[6] and sight loss[7]. There is also strong evidence of link between hearing loss and dementia. Research has shown that people with mild hearing loss are almost twice as likely to develop dementia compared to people with	

[2] Gopinath et al (2012). 'Hearing-impaired adults are at increased risk of experiencing emotional distress and social engagement restrictions five years later'. Age and Ageing 41(5): 618–623; Monzani et al (2008) 'Psychological profile and social behaviour of working adults with mild or moderate hearing loss'. Acta Otorhinolaryngologica Italica. 28(2): 61-6; Arlinger (2003). 'Negative consequences of uncorrected hearing loss – a review'. InternationalJournal of Audiology 42(2): 17-20

[3] Cooper (1976) 'Deafness and psychiatric illness'. British Journal of Psychiatry 129: 216-226; Saito et al (2010) Hearing handicap predicts the development of depressive symptoms after three years in older community-dwelling Japanese. Journal of the American Geriatrics Society 58(1): 93-7; Monzani et al (2008) Psychological profile and social behaviour of working adults with mild or moderate hearing loss. Acta Otorhinolaryngologica Italica 28(2): 61–66; Eastwood et al (1985) Acquired hearing loss and psychiatric illness: an estimate of prevalence and co-morbidity in a geriatric setting. British Journal of Psychiatry 147: 552–556

[4] Lin and Ferrucci (2012) Hearing loss and falls among older adults in the United States. Archives of internal medicine 172.4 (2012): 369-371

[5] Kakarlapudi et al (2003) The effect of diabetes on sensorineural hearing loss. Otology and Neurotology 24(3): 382-386; Mitchell et al (2009) Relationship of Type 2 diabetes to the prevalence, incidence and progression of age-related hearing loss. Diabetic Medicine 26(5): 483-8; Chasens et al (2010) Reducing a barrier to diabetes education: identifying hearing loss in patients with diabetes. Diabetes Education 36(6): 956-64

[6] Formby et al (1987) Hearing loss among stroke patients. Ear and Hearing 8(6): 326-32; Gopinath et al (2009) Association between age-related hearing loss and stroke in an older population. Stroke 40(4): 1496–1498

[7] Chia et al (2006) Association between vision and hearing impairments and their combined effects on quality of life. Archives of Ophthalmology 124(10): 1465-70

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			normal hearing. The risk increases three fold for people with moderate hearing loss and fivefold for people with severe hearing loss[8].	
Action on Hearing Loss			Hearing loss should be diagnosed and treated at the earliest opportunity to ensure older people maintain their independence and mental wellbeing. Evidence suggests there is a ten year delay in people seeking help and when people finally do contact their GP, referral rates for hearing assessments are low. Hearing aids are most effective when provided at an early stage of hearing loss. People with mild loss find it easier to adapt to hearing aids and derive more benefit from them over the longer term[9]. Timely access to hearing aids improve communication and enable people with hearing loss to communicate with friends, family and health professionals. Hearing aids have also been shown by numerous studies to improve quality of life[10]. Hearing aids reduce the risk of social isolation and depression[11], and new evidence suggests they may even reduce the risk of dementia[12].	Thank you – these points are noted. While access to hearing aids is not specified in the guideline, the implementation: getting started section includes *"Providing help and advocacy for people with specific needs. For example, if they are carers, or if they have mental health problems, difficulties with seeing or hearing or with their flexibility,*

[8] Lin FR et al. (2011) 'Hearing loss and incident dementia'. Archives of Neurology 68 (2): 214-220
[9] 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 11: 1–294
[10] Mulrow et al (1990) Quality-of-life changes and hearing impairment, a randomized trial. Annals of Internal Medicine 113(3): 188-94;
[11] Mulrow et al (1990) Quality-of-life changes and hearing impairment. A randomized trial. Annals of Internal Medicine. 113(3): 188-94; National Council on the Aging. (2000) The consequences of untreated hearing loss in older persons. Head and Neck Nursing 18(1): 12-6; Acar et al (2011) Effects of hearing aids on cognitive functions and depressive signs in elderly people, Archives of Gerontology and Geriatrics, 52(3): 250-2; Mulrow et al (1992) Sustained benefits of hearing aids. Journal of Speech & Hearing Research 35(6): 1402-5; Goorabi et al (2008) Hearing aid effect on elderly depression in nursing home patients. Asia Pacific Journal of Speech, Language and Hearing 11(2): 119-123; Cacciatore et al (1999) Quality of life determinants and hearing function in an elderly population: Osservatorio Geriatrico Campano Study Group. Gerontology 45: 323-323
[12] Dawes et al (2015) Hearing Loss and Cognition: The Role of Hearing Aids, Social Isolation and Depression. PLoS ONE 10(3): e0119616; Gurgel et al (2014) Relationship of hearing loss and dementia: A prospective, population-based study. Otology and Neurotology 35(5): 775-81; Lin et al (2011) Hearing loss and incident dementia. Archives of Neurology 68(2): 214-220; Lin

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			As a general point, the recommendations should include ensuring that regular hearing tests are available and accessible for older people. In line with NICE's quality standard for the mental wellbeing of older people in care homes[13], 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.	*balance or mobility".* Access to hearing aids is covered by these points.
Action on Hearing Loss			This should also be a strategic objective for joint strategic needs assessments and the health and wellbeing strategies.	Thank you. The implementation: getting started section on local assets and needs assessment has been updated to include the collection of data on the number of people with an age related disability (the definition of which includes hearing loss).
Action on Hearing Loss	1. Draft recommendations	5	We welcome the Recommendation 2 that local authorities should improve provision of education and learning activities where provision is inadequate. We suggest that lipreading classes should be included as an example of an education and learning activity which promotes independence and mental wellbeing in older people.	Thank you. The Committee have not given specific examples of education and learning activities as the only evidence they considered was on face to face university

et al (2013) Hearing loss and cognitive decline in older adults. Internal Medicine 173(4): 293-299; Uhlmann et al (1989) Relationship of hearing impairment to dementia and cognitive dysfunction in older adults. Journal of the American Medical Association 261: 1916-1919

[13] NICE (2013) Mental wellbeing of older people in care homes. QS50

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			Lip reading classes are vital source of rehabilitation and support for older people with hearing loss. Lip reading is a communication skill that enables people to recognise different shapes and lip patterns and to use context to fill gaps in conversation. Lip reading classes provide lip reading training and information on ways of improving communication (ensuring there is good lighting, facing the other person and asking them to speaking clearly and concisely) and other services and benefits for people with hearing loss. In addition, classes provide an important source of peer support, as people meet others with hearing loss and have an opportunity to share experiences and coping strategies. Our 2013 report 'Not Just Lip Service'[14] shows that lipreading can improve confidence and increase the independence of people with hearing loss. The report identified that lipreading classes are particularly beneficial for people who have recently been diagnosed with hearing loss. Our 2010 report 'Paying Lip Service'[15] found that there were approximately 450 lipreading classes in England and Wales, enough for only 5000 people, despite there being over 10 million people with hearing loss in the UK who could potentially benefit.	classes aimed at older people and education opportunities via the internet. Any list would not give a full picture of all the education and learning opportunities available, however, providing access to lipreading classes could be offered when implementing the recommendation.
Action on Hearing Loss	1. Draft recommendations	6	The role of the local co-ordinator in Recommendation 5 should be revised to include co-ordinating "communication equipment and support". This would bring the roles of the local co-ordinator in line with duties under the Equality Act 2010.	Thank you. implementation: getting started section on local coordination) includes "*Provide information for those in contact*

[14] Ringham, L. (2013). Not just lip service. Available at: www.actiononhearingloss.org.uk/notjustlipservice
[15] RNID. (2010). Paying lip service. Available at: http://www.actiononhearingloss.org.uk/get-involved/campaign/read-my-lips/what-we-are-doing.aspx

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			Under the Equality 2010, Local Authorities 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 interpreter provides translation for a video call).	*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, if necessary). This would cover helping people with hearing loss to access communication equipment and support. We are unable to be more detailed than this.
Action on Hearing Loss	1. Draft recommendations	8	Recommendation 7 should be revised to make it clear that local authorities have a duty to consider hearing loss when carrying out local needs assessments. The government's recently published Action Plan and Hearing Loss[16] states that local authorities should ensure hearing loss is included in Joint Strategic Needs Assessments and Joint Health and Wellbeing Strategies, either as part of a wider sensory impairment strategy or separately. An older people's mental health and wellbeing strategy should consider : • The links between hearing loss and other long term conditions • The importance of early diagnosis of hearing loss and prompt referral to treatment.	Thank you. The Implementation: getting started section on needs assessments has been updated to include the collection of information on the number of people with an age related disability (the definition of which includes people with hearing loss).

[16] Department of Health and NHS England. (2015). The action plan on hearing loss. Available at: http://www.england.nhs.uk/2015/03/23/hearing-loss/

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			• Improving staff knowledge of awareness of hearing loss • Barriers preventing people from hearing loss from accessing local services	
Action on Hearing Loss	1. Draft recommendations	9.	Recommendation 9 should be revised to incorporate raising awareness of the impact of hearing loss on older peoples' independence and mental wellbeing, and the effect this may have on physical and mental health and social interactions. Our research A World of Silence[17]suggested that large number of care home residents have undiagnosed hearing loss. Many residents did not want to address their hearing loss and care home staff found it difficult to encourage them to seek help. Although the care staff we interviewed displayed good awareness about ways of improving communication and the importance of reducing background noise, they also admitted that hearing loss was sometimes overlooked compared with other issues such sight loss, pain or safeguarding. Some care staff did not know about hearing loops and other assistive equipment such as amplified telephones and TV listeners. Others lacked the training to carry out basic hearing aid maintenance. For the avoidance of doubt, we suggest rewording the recommendation to add "older people with sensory loss" as group at risk of a decline in independence and wellbeing.	Thank you. This is now recommendation 1.5 and states "*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."* There is a list of groups who are most at risk of decline and this specifies older people with an age related disability. The definition of age related disability includes sensory loss.
Action on Hearing Loss	1. Draft recommendations	11	In Recommendation 10 "ensuring adjustments are made so that people with sensory loss can access and benefit from services" should be added as an example of providing help for people with specific needs.	Thank you. Implementation: getting started section on Getting people involved in

[17] Echalier, M (2012). A world of silence. Available at: www.actiononhearingloss.org.uk/aworldofsilence

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			We also recommend including a list of examples of communication formats relevant for people with hearing loss, including: - Textphones - Text relay - SMS text - Instant messaging - Video relay - Written information in plain English - Videos with subtitles and BSL interpretation - BSL translation of key written information - Communicating through a live or remote communication support professional, for example a BSL interpreter, lipspeaker, notetaker or speech to text reporter - Communicating with the support of equipment such as a personal listener or a hearing loop system Services are often inaccessible for people with hearing loss. Our 2012 research Access All Areas[18] shows that GP surgeries and pharmacies are falling short in terms of making their services accessible. The majority of respondents (72%) to our survey said they were forced to contact their GP by phone to book an appointment, yet services should offer alternatives such as email, SMS or online booking.	activities includes "*Providing help and advocacy for people with specific needs. For example, carers; people with mental health problems; people who have difficulties seeing or hearing; and people who have problems with their flexibility, balance or mobility*". It also recommends using existing services. This would cover helping people with sensory loss to access and benefit from activities, for example, through the communication formats suggested.

[18] Ringham, L.(2012) Access all Areas. Available at: www.actiononhearingloss.org.uk/accessallareas

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			When visiting the GP surgery, just under half (44%) said there a visual display screen in the waiting room and one in seven (14%) had missed an appointment because they hadn't heard their name being called. Worryingly, more than a quarter (28%) of respondents had been left unclear about their condition because of communication problems with their GP or nurse.	
Action on Hearing Loss			Recommendation 10 should also make reference to NHS England's recently published Accessible Information Standard[19] which sets out what adjustments people with hearing loss should expect when accessing health and social care. The standard, which is mandatory for NHS and adult social care services, provides clear guidance on what these services must do to ensure people with hearing loss understand the information they are given and can participate fully in treatment decisions.	Thank you. This standard is already mandatory for the NHS and adult social services.
Action on Hearing Loss	1. Draft recommendations	12	"is accessible to people with sensory loss" should be added Recommendation 13 to ensure information on services and activities is accessible to people with hearing loss. For example people who are deaf may require BSL translation of written information, either through a qualified BSL interpreter or BSL translated video.	Thank you. This is now described in the Implementation: getting started sections 1 and 6. . The Committee agreed that the needs of people with sensory loss have been covered in several recommendations including 1.5. It also describes using existing services (please see Implementation: getting started). The guideline is unable to provide an exhaustive

[19] NHS England. (2015). Accessible Information Standard. Availabe at: http://www.england.nhs.uk/ourwork/patients/accessibleinfo-2/

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				list of everyone affected in a variety of different circumstances Recommendations state (for example 1.1.1, 1.1.4) and the implementation section highlights that services should be needs led and those needs will be identified if the needs assessment are used.
Action on Hearing Loss	1. Draft recommendations	13	In Recommendation 15, "Find out are services accessible for people with sensory loss?" should be added as consideration when asking people what they think about a service or activity. To enable people with hearing loss who lip read to understand what is being said, the location of a service or activity should be well lit and free of shadows or glare. Poor acoustics in rooms such as echoes from hard surfaces can cause high levels of background noise. Soft furnishings can help minimise this problem. Communication equipment such as hearing loops can also improve understanding and transmit sound more clearly. Hearing loops transmit sound from a microphone in the form of magnetic field which can be picked up directly by hearing aids set to the hearing loop setting.	Thank you. The contents of this recommendation have moved into the Implementation: getting started section. It describes that service providers could "*Ask older people what they think about the service or activity*" and to also *"find out what motivates older people to come along and what stops them"* and to *"think about the timing, location and access to venues (for example, how physically accessible is it?)*" This would cover finding out if services are accessible for people with sensory loss. We are unable to be exhaustive in

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				the examples we provide in the guideline and have to represent many issues of importance to older people.
Action on Hearing Loss	1. Draft recommendations	14	In Recommendation 16, “sensory loss” should be added as a consideration for training providers when providing training. In ‘a World of Silence’ we found that NVQ qualifications in social care neglected the viewpoints and needs of people with hearing loss. Training programmes should be revised to incorporate good practice from elsewhere, notably in dementia training, so they can give staff an appreciation of what hearing loss feels like.[20]	Thank you. The contents of this recommendation have moved into the implementation section. It describes that training course content could include: – *factors that threaten older people’s independence and mental wellbeing* – *how to identify older people most at risk of decline* – *how to support and encourage older people to participate in community activities.* Sensory loss would be covered within this.

[20] Echalier, M (2012). A world of silence. Available at: www.actiononhearingloss.org.uk/aworldofsilence

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Action on Hearing Loss	6.1 Recommendations for research	25	We recommend that further longitudinal research is carried out to prove that hearing aids can make people with hearing loss more independent and improve their mental wellbeing.	Thank you. This point is noted but has not been prioritised by the committee as a research recommendation in the guideline.
Age UK	General		Age UK welcomes this guideline as a positive contribution to supporting older people's independence and wellbeing, as well as clarifying recommendations for service commissioners and providers around what works in this area. We welcome the reference to some of our services within the guideline which make a huge difference to the lives of older people.	Thank you for this comment.
Age UK	Introduction		We would recommend adding loneliness to the aims stated upfront as follows: *'-Help older people maintain their mental wellbeing, including their ability to remain independent to avoid health conditions linked to loneliness, social isolation, depression […]'*. This is notably important as the guideline does not make a clear distinction between loneliness and social isolation, and even appears to be referring to both concepts interchangeably in some sections. 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 on 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 (Age UK and Campaign to End Loneliness, 2015). 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	Thank you. The context section of guideline has been updated to reflect this point. Loneliness is also defined in the glossary.

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			isolation and living alone in later life, 2003).	
Age UK	General		Overall, the problem of loneliness and its wider impacts on older people's health and wellbeing are not emphasised enough within the guideline. Our surveys have found that over 1 million older people say they are always or often feel lonely – with around 10 per cent of those over the age of 65 experiencing chronic loneliness at any given time (TNS survey for Age UK, April 2014). Unless action is taken, the number of older people feeling lonely is likely to increase as more of us live longer. Loneliness can have negative implications for both our mental and physical health. It can be as harmful for our health as smoking 15 cigarettes a day (Holt-Lunstad J, Smith TB, Layton JB. *PLoS Med* 2010;7(7)), and more damaging than obesity (Age UK Oxfordshire, *The State We're In*, 2012). People with a high degree of loneliness are twice as likely to develop Alzheimer's disease as people with a low degree of loneliness (Wilson RS, Krueger KR, Arnold SE, Schneider JA, Kelly JF, Barnes LL, et al. *Arch Gen Psychiatry* 2007 Feb; 64(2)). Loneliness also heightens feelings of depression, anxiety, and increases vulnerability in older people (Hawkley, LC, Cacioppo, *Annals of Behavioral Medicine*, 2010, 40 (2)). As well as impacting on people's health and wellbeing, loneliness can lead to increased demand for NHS resources. Three quarters of family doctors (76 per cent) report that between one and five patients a day attend their surgery primarily because they are lonely (Campaign to End Loneliness/ComRes, November 2013). Due to the far-reaching impact of loneliness, it should be a key measure of success for this guideline that loneliness is mainstreamed within public health strategies at the local and national level as a preventable and manageable state.	Thank you. Some of this information has been included in the context section of the guideline.
Age UK	General		We recommend amending the order of the recommendations so as to follow a clearer pathway, e.g.:	Thank you. The Committee considered this point. Details

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			- Fundamental principles (recommendations 1 and 6) - Identifying the level of need and reaching out to people (7,5) - Specific interventions (2,3,4) - Removing barriers/ supporting people to participate (10,11) - Raising awareness of relevant issues and activities (9,8) - Improving training (16) - Supporting community organisations (12,13) - Supporting evaluation of services (14,15)	relating to training and evaluation have been moved to the implementation section of the guideline.. The committee discussed the order of the recommendations and agreed that the principles of good practice and key interventions were best placed in the recommendations of the guideline.
Age UK	General	2,7,8,20	We do not support the use of the phrase 'prematurely old'. We believe that linking people's needs to relative age as a predictor of poor health carries a risk of reinforcing current stereotypes and discrimination towards older people, particularly around people's expectation of good health in later life. Entrenched stigma towards ageing has meant that older people have often faced inequalities in accessing treatment. Public and private services, including the NHS, have a long way to go in establishing age equal practices and part of this process should be to overturn deeply entrenched cultural attitudes towards the 'value' of treating and supporting older people, and assumptions around what older people can or cannot do. The reference to 'premature old' risks further entrenching these attitudes and we would therefore recommend that this phrase is removed from the guideline.	Thank you. The Committee agreed with this point and the phrase 'prematurely old' has been removed from the guideline.
Age UK	1.1	4	Principles of good practice should take account of diversity and accessibility issues in light of duties under the Equality Act 2010. We know, for example, that loneliness can be particularly acute among older lesbian and gay people,	Thank you. The Committee agree that older people from BME and LGBT

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			and some evidence suggests that they experience problems in accessing mainstream services (Age UK and Campaign to End Loneliness, January 2015). Efforts must therefore be made to better understand and meet the needs of BME and LGBT communities. The guideline should also reference the importance of services becoming dementia-friendly to reflect the needs of the estimated 850,000 people living with dementia in the UK, as well as the many more that experience cognitive decline. Without such an approach, many services will remain inaccessible to the people that could most benefit from them.	groups may experience problems accessing mainstream services. The guideline aims to promote activities that are accessible to all. The lack of evidence in these groups is included in the gaps in the evidence and in the recommendations for future research. Dementia is out of scope for this guideline.
Age UK	1.4	6	We would like to see a greater recognition of the role of psychological approaches in supporting older people's independence and mental wellbeing, and would therefore recommend changing the line *'a programme to help people develop and maintain friendships'* to *'a programme to help people develop and maintain friendships, and support them in changing their thinking about their social connections'*. Our recent joint report with the Campaign to End Loneliness, *Promising approaches to reducing loneliness and isolation in later life,* recommended offering psychological approaches such as counselling, cognitive and behavioural therapy (CBT) and Mindfulness, in addition to other activities already highlighted within this guideline. Although these approaches have mostly been available to those with diagnosed mental health conditions, experts involved in our report believe psychological interventions show great promise in helping people to change their thinking	Thank you. Psychological interventions such as cognitive behavioural therapy are out of scope for this guideline.

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			about their social connections, thereby addressing what Masi et al have called 'maladaptive social cognition' (Masi et al, Pers Soc Psychol Rev, 2011;15(3)). Age UK Warwickshire, for example, has been offering psychological support services, which involve counselling services for people who are over 55 or their carers in their own homes as well as a 'Support, Time and Recovery' scheme for people over 55 who have a diagnosis of depression, stress or anxiety. Initial evaluation of the services provided has shown significant improvements in the wellbeing of service-users using the Warwick Edinburgh Mental Wellbeing Scale (WEMWBS), thereby highlighting the broader benefits of such approaches.	
Age UK	1.4	6	We suggest changing sentence from '*offer one-to-one activities'* to *'support, promote and, if there is not enough provision, commission activities'*, in line with the wording of previous recommendations, especially as such services are currently often provided by the voluntary sector (as noted in the examples provided by the guideline in the same section). For example, many local Age UKs provide befriending services, some by telephone and some where a volunteer visits the older person at their home. At the national level, Age UK also provides a telephone befriending service called 'Call in Time' (see comment below).Such vital services provide a link to the community and act as gateway to other forms of valuable support. It is therefore important to recognise the contribution of the voluntary sector in providing one-to-one services and adopt a consistent terminology, in line with previous recommendations.	Thank you. The recommended wording has been applied to recommendation 1.1.1 which now states "*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."*
Age UK	1.4	6	We would recommend amending *'brief visits providing befriending opportunities'* to *'regular, brief visits or telephone calls providing befriending opportunities (for example, Age UK's Call in Time service or local Age UK befriending services)'*. As well as home visits, the guideline should recognise	Thank you. The wording in recommendation 1.3 has been updated to *Offer one-to-one activities, such*

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			the role of telephone befriending services, which are particularly important to older people living in areas where home visits may not always be possible such as remote rural areas or areas where service provision is limited. For example, Age UK's Call in Time, our a national telephone befriending service, tends to serve older people in areas where no face-to-face services are available, sometimes due to a lack of funding, or difficulties recruiting volunteers. As part of the scheme, volunteers call someone for half-an-hour a week. An independent evaluation of the project has found that self-reported wellbeing and mood as well as activity levels had improved among service users, including those that had reported being affected by chronic loneliness or depression. It is also worth noting that one of the key features of all befriending programmes is their regularity, hence the addition of 'regular' to the line mentioned above. (Age UK, Campaign to End Loneliness, *Promising approaches* […], January 2015).	*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.'* This would cover Age UK's Call in Time service or local Age UK befriending services.
Age UK	1.6	8	We would suggest adding a point below the fourth line, as follows: *'- Recognising the potential referral pathways through primary care, for example GPs' social prescribing or integrated care pathways, which help older people to access non-medical services that support their independence and mental wellbeing'*. This is particularly important as GPs, for example, regularly come into contact with older people at risk of losing their independence or	Thank you. The Committee did not feel there was enough evidence to make specific recommendations about funding, however, social

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			experiencing a decline in their mental wellbeing (see point about loneliness above). This could be through an integrated care pathway across health, social care and the voluntary sector, or through social prescribing whereby GPs refer people to non-medical services often run by the voluntary sector. In one example of social prescribing, users showed statistically significant improvements in depression; anxiety; isolation; wellbeing; perceived economic wellbeing; and physical activity after three months (Kimberlee RH, University of the West of England, 2014). Overall, and in response to question 5 specifically, we would like to see a greater recognition of the role and responsibilities of health services, particularly primary care services and GPs, in supporting older people's independence and mental wellbeing.	prescribing is specified as a potential way to fund activities from existing resources in the Committee discussion section of the guideline.
Age UK	1.7	8	We would recommend adding '*regularly*', as follows: '*Regularly carrying out a needs assessment to'* (see line 8). It is indeed important to ensure such needs assessments are undertaken on a regular basis.	Thank you. The Committee did not think it was appropriate to specific how regularly a needs and assets assessment should be carried out as no evidence was available on this. That
Age UK	1.8	9	In line with our previous comments regarding the important role of primary care in supporting older people's access to support, we would recommend amending the last point in the section as follows: '*Publicising the service to other agencies and organisations working with older people, for example, local older people's forums and groups or local GP practices'*	Thank you. Publicising services and activities that could be covered in the role of the local coordinator(s) is described in the implementation: getting started (local coordination) section of the guideline: *"Provide information for those in*

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				contact with older people about the range of local activities and services available". A list of people or agencies in contact with older people is not provided, however, GPs and older people's forums would be covered.
Age UK	1.10	11	We would suggest adding the following line, after line 8: *'- Supporting initiatives that address social barriers to participation such as prejudice against ageing and older people (for example supporting the development of age-friendly cities, positive ageing activities as well as intergenerational projects)'*. We would indeed like to see a more explicit recognition in this section of the need to tackle both environmental and social barriers to older people's participation in society and community activities. Solutions to this not only include ensuring that older people have access to transport and technology to remain socially connected (which were both identified as 'gateway services' in our *Promising Approaches* report), but also involve creating the right environment for wellbeing interventions to work and thrive. As such, our joint report emphasised the importance of 'structural enablers' such as positive ageing (age-friendly cities/communities), neighbourhood approaches and asset-based (intergenerational) community development, which not only help to tackle stigma against ageing (an important social barrier to participation),	Thank you. Whilst the committee heard from Age friendly Manchester for context around this topic (including key partnerships, component activities to promote mental wellbeing as well as barriers and facilitators to engagement of partners and potential users of services). The specific issue of age friendly

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			but also enable the development of community and voluntary interventions that support older people's independence and mental wellbeing.	cities was out of scope for this guideline. The role of agencies such a , *teams that advise on public facilities in the built and outdoor environment, such as seats and toilets, pedestrian and cycle routes and street lighting* is described in the Implementation: getting started section
Age UK	4	17	We welcome this public health guideline as an opportunity to shine a light on the importance of access to mental health support for older people as well as challenging the on-going perception that issues such as loneliness and depression are inevitable parts of ageing. As such, we would recommend that the 'Context' section, which has more details on current practice, sets out more clearly the current challenges that older people face when it comes to mental wellbeing: public attitudes must change in this regard, so that more people feel empowered to seek help and are treated with dignity and compassion. Older people with mental health issues are currently confronted with dual prejudice against older age and mental health. Their experience of NHS funded services is worsened by the increasing cuts to specialist old age mental health services which make access to appropriate support even more difficult. Enabling them to prevent their mental wellbeing from deteriorating and supporting access to person-centred interventions, for example through	Thank you. Unfortunately, the context section is only intended to give a brief introduction within 1 page/screen and so it is not possible to include an exhaustive list of issues. The Committee acknowledges the difficulties that older people with mental health problems face. This guideline aims to maintain and improve the

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			implementation of this guideline, is all the more important in this context.	independence and mental wellbeing of all older people.
Age UK	6	25	In response to the research gaps identified in the guideline, it is worth noting that Age UK's own Research Team has developed a 'Loneliness Risk Index'. This research, applying the English Longitudinal Study of Ageing (ELSA) findings to the Census (2011), gives us a deeper understanding of possible causes of loneliness – e.g. poor health, household composition, age and marital status – and therefore its types. It was conducted in partnership the Office for National Statistics (ONS), and the findings are now available on the ONS website. Thanks to this research, Age UK can now identify 'hotspots' where older people have the highest risk of being lonely, not only at local authority level but now at neighbourhood level, and we will be working with our local partners in using this index to help target our services more effectively. We also expect to publish a methodology paper for the ELSA research and also one, jointly with ONS, on the local statistics shortly. While we appreciate this evidence was not available at the time of the development of the guideline, we would like to highlight this new resource as a means to target services and interventions more effectively in the future, and as a response to some of the research gaps around loneliness.	Thank you. This information is noted. Implementation: getting started section includes a description of using data from ONS within the needs and assets assessment.
Age UK	10	29	Local Age UKs are independent charities, which form part of the Age UK network. As such, 'local Age UK branches' should be replaced with 'local Age UK partners'.	Thank you. There is no longer any reference to local Age UK branches within the guideline.
Association of Directors of Adult Social Services		General comment	The intentions of the guideline for councils to identify and then commission for "non-statutory" services and support to enhance independence and mental wellbeing is commendable and is aligned with the general policy direction set out in the Care Act regarding universal health and wellbeing. However, councils are responding to significant and ongoing funding reductions and	Thank you. This point is acknowledged in the Committee's discussion section of the guideline.

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			rising demand, and therefore are having to make difficult choices to prioritise finite resources to meet assessed eligible need. The degree of discretion is extremely limited and it is important that the guidelines do not raise expectations that are unrealistic.	
Association of Directors of Adult Social Services			However councils very much recognise the tensions in making these difficult decisions and there has been a series of reports highlighting the impacts of unmet need upon individual's health and wellbeing, and likely additional costs upon the public sector and society further upstream. AgeUK have recently published a report reflecting upon the consequences of loneliness amongst older people (Promising_approaches-loneliness_and_isolation-Jan_2015)) and the NHS Information Centre published activity data for adult social care shows a fall of 400,000 people no longer receiving adult social care services between 209/10 and 2013/14. The guidelines are therefore an important prompt for commissioners to seek where possible early interventions to improve independence and health wellbeing.	Thank you for this comment.
Association of Directors of Adult Social Services			At the same time, it is noted that NICE has recognised the restrictions of funding for voluntary sector services (point 5.16) and we welcome further exploration to be undertaken by the NICE to consider recommendations on funding these vital services and support	Thank you. The Committee did not feel there was enough evidence to make specific recommendations on funding. This is included in the Committee's discussion section of the guideline. NICE are unable to make recommendations on how services should be funded.

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Association of Directors of Adult Social Services			W We welcome the NICE proposals to conduct further research relating to understanding the needs of different populations as they age, how interventions can be maximised, what factors or processes influence mental wellbeing at different stages of life and different socio-economic backgrounds, and what mid-life interventions are most effective. These are important areas critical to helping inform commissioning intentions to maximise independence and mental wellbeing outcomes for older people.	Thank you for this comment.
Association of Directors of Adult Social Services			We note that the guidelines makes no clear reference to personalisation within adult social care. Individuals are increasingly commissioning their own services and support through personal budgets instead of council commissioners and whilst the general theme of the guideline is consistent with the sustainable market duty upon councils (ensuring that there is a viable, variable and sustainable market to meet needs), much of this commissioning will be taken by individuals rather than councils	Thank you. The Committee did not think there was enough evidence to make specific recommendations about funding, however, the use of self-managed budgets is included in the Committee's discussion section of the guideline (Please see sub heading 'Supporting community organisations'.).
Association of Directors of Adult Social Services			The coordinating role of Health and Wellbeing Boards is welcomed and is consistent with ADASS's vision for Adult Social Care (Distinctive Valued Personal- March 2015). Empowered Health and Wellbeing Boards are central to ensuring services are joined up, designed and commissioned to meet local needs and improved outcomes	Thank you for this comment.
Association of Directors of Adult Social Services			The guideline proposals to evaluate services is welcomed (5.15), and it is noted that council commissioners already work closely with providers and the regulators to ensure high quality services that meet local need and improved outcomes. However, the guidelines need to be calibrated carefully to minimise	Thank you. Options for evaluation are now outlined in the Implementation: getting started section and is intended

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			unnecessary burden upon both providers and commissioners	to help service providers and commissioners to improve outcomes.
Association of Directors of Adult Social Services			Finally ADASS welcomes the opportunity to work with NICE in the next phrase of developing these guidelines to seek and sustain improved outcomes for individual's independence and health wellbeing	Thank you for this comment.
Evidence submitted for British Association for Music Therapy	General		As a stakeholder we are commenting upon the guidelines consultation and first make general points, but secondly list some research and RCT published trials evidence that is not included in your documentation so far. We welcome the new guidelines and dementia is a priority area for music therapy and BAMT, and we have recently had an MP sponsered event in Portcullis House, and put evidence to this Round Table and to the Parliamentary House of Lords debate chaired by Lord Berkley. This included music therapy and music and the brain evidence. However here we will confine our comments to the unique specific role music therapy can play for older people and the evidence for well- being and particularly for those with dementia, rather than commenting upon all sections of the document.	Thank you for this comment. Dementia is out of scope for this guideline.
Evidence submitted for British Association for Music Therapy	General Introduction to Music Therapy		Music therapists are professional musicians with a high level of skill as therapists and musicians. They are registered with the HCPC. Music therapy, as defined by the World Federation of Music Therapy is an intervention where a trained music therapist uses music and elements of it, to enhance quality of life, bring about change, and to improve social, 'emotional, intellectual communicative, intellectual and spiritual wellbeing'. Work is carried out in medical, community educational and social settings. Music therapy can involve interactive musical processes or receptive listening techniques, according to the needs of the participant. In groups it leads to social connectedness and higher levels of engagement (Odell-Miller, H.	Thank you for this information.

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			(1995)'Approaches to music therapy in psychiatry with specialist emphasis upon a research project with the elderly mentally ill' In T..Wigram., B. Saperston and R. West. (Eds). *The art and science of music therapy: a handbook Switzerland:* Harwood Academic. Also Aldrige, D. (2000). *Music therapy in dementia care* London: Jessica Kingsley. Music therapy became an established profession during the middle to latter part of the 20th century. In some countries music therapy is a legally registered profession, for example in the UK, similar to medicine nursing and other allied health fields. Although smaller in size, and more specialised than, for example sister professions, physiotherapy and psychotherapy, the music therapy profession has established rigorous training standards, a developing research and evidence base in some key areas. The practice varies across countries, and cultures, but leading music therapy associations, institutes and governments collaborate so that there is increasing parity and knowledge exchange. **How does music therapy work?** Music therapy is the use of music, whether live improvised and interactive, or receptive listening, in order to help towards desired change psychologically, socially, physically, or for larger communities, culturally engaging in change on a larger scale. Most commonly it is helpful on a non-verbal level for people who have communication problems, such as older people with cognitive decline following dementia or acquired brain injury, children and adults with autism, and children and adults with delayed or no spoken language with learning difficulties. Music therapy is also increasingly practised in community settings where processes and outcomes focus upon well- being, such as through singing, instrumental playing and recovery work.	

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			The UK Music therapists in the UK are registered with the Health and Care Professions Council HCPC. There are over 800 in the UK working in the public and private sector fully qualified and a further 80 in training at any one time, on MA courses approved by the HCPC. Universities are at the cutting edge of research in this area and have thriving PhD programmes. Dementia is a priority, so several studies are planned or have been completed in this area. There are several opportunities in universities and these are linked with the international field and research is carried out across countries in multi-centred studies.	
Evidence submitted for British Association for Music Therapy	ES R 1.5	P. 5	Regarding Singing and the Brain the RCT study (Coulton et al.,2015) included in the evidence statements shows good evidence. The programme is NIHR funded with 258 participants. The paper will be published in British Journal of Psychiatry. However whilst community singing demonstrates cost and health effectiveness, there seems to be no clear considerations in Coulton's study of barriers such as how to reach out to older adults, particularly ones who experience health, social or financial difficulties. Qualified professional music therapists receive referrals and work with anyone, and specifically target those in the final stages of dementia and those who cannot access such singing programmes. No prior musical experience or skill is needed and there are some research studies not included in the consultation	Thank you. Coulton 2015 demonstrates clear benefit and is an important part of the evidence base used by the Committee to form recommendation 1.2.1. Recommendation 1.5 and the extensive Implementation: getting started section are intended to help older people overcome barriers to access. As pointed out, singing may not be appropriate for everyone and

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			which show significant evidence from RCT trials. The programme in the Coulton study did not seem to extend to individuals who are not able to sing or independently access the programme due to age related/physical/mental health conditions. Community singing might not be one size fits all. However, music therapy offered on a 1:1 or group basis should be considered in order to cater for individuals with reduced faculties and those who find engaging in group activities difficult. Music therapists are trained to adapt and tailor make interventions when cognitive decline and words are not available. Evidence in the following study which is summarised shows singing and other live interventions are used, and a music therapist can draw upon any musical intervention that someone needs including but not only singing. Ridder, H. M. O., Stige, B., Qvale, L. G., & Gold, C. (2013). Individual music therapy for agitation in dementia: an exploratory randomized controlled trial. *Aging & Mental Health, 17*(6), 667-678. doi: 10.1080/13607863.2013.790926 **Summary of Ridder et al. (2013)** Objectives: Agitation in nursing home residents with dementia leads to increase in psychotropic medication, decrease in quality of life, and to patient distress and caregiver burden. Music therapy has previously been found effective in treatment of agitation in dementia care but studies have been methodologically insufficient. The aim of this study was to examine the effect of individual music therapy on agitation in persons with moderate/severe dementia living in nursing homes, and to explore its effect on psychotropic	other creative activities (which would cover other musical activities) are recommended in 1.2.1. Ridder 2013 relates to outcomes in nursing home residents with dementia. Dementia and people living in care homes are both out of scope for this guideline; therefore the Committee did not consider this evidence.

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			medication and quality of life. **Method:** In a crossover trial, 42 participants with dementia were randomized to a sequence of six weeks of individual music therapy and six weeks of standard care. Outcome measures included agitation, quality of life and medication. **Results:** Agitation disruptiveness increased during standard care and decreased during music therapy. The difference at !6.77 (95% CI (confidence interval): !12.71, !0.83) was significant (p ¼ 0.027), with a medium effect size (0.50). The prescription of psychotropic medication increased significantly more often during standard care than during music therapy (p ¼ 0.02). **Conclusion**: This study shows that six weeks of music therapy reduces agitation disruptiveness and prevents medication increases in people with dementia. The positive trends in relation to agitation frequency and quality of life call for further research with a larger sample.	
Evidence submitted for British Association for Music Therapy	ES R2.3	22	- Participation in arts-based interventions: The consultation document on P. 22 states: *"Barriers identified in 3 UK based studies to participation included lack of awareness of and interest in the arts, a perception that art, and some venues where events held, are elitist, challenges in understanding art, physical/technological obstacles to use of music player devices and difficulties in engaging BME populations. Practical barriers included out of pocket costs, transportation and attending events in the evening" (NICE guidelines consultation document P.22)*	Thank you. The research studies included in the comment all relate to dementia. Dementia is out of scope for this guideline.

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			There is evidence to suggest in research studies I have included here, that outreach music therapy services or community music therapy groups should be considered as a possible solution to the barriers. There is no requirement for musical training/literacy for participants to participate in music therapy sessions, but music therapists will be fully qualified. This overcomes the barriers listed above about elitism of the arts. Although there are no current music therapy RCT studies in comparison with studies of community singing, music therapy group and individual sessions have been run in residential care homes, day centres and individuals' homes. (Hsu et al 2015 described below). Singing can be one facet of a music therapy session, others include free music making, listening or moving to music and verbal discussion. There may be a need to investigate the advantages of providing this intervention that involves interactive and flexible components to suit individuals' varied abilities.	
Evidence submitted for British Association for Music Therapy	ESR 1 1.7	P. 6	In addition to evidence mentioned here a most recent study points to the benefits of music therapy as demonstrated in MHA, which is a group of over 70 residential care homes which increased posts for fully qualified music therapists from 1 post in 2006 to 13 music therapists in 2015 in the organisation. A testimony of the impact and efficacy which can be seen on its website. In addition the study accepted for publication summarised below is a small RCT trial showing significant results in areas of reduction of behavioural problems. **Summary of Hsu et al (2015)**	Thank you. The evidence presented is out of scope for this guideline.

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			Hsu, M., Flowerdew R., Parker M., Fachner J., Odell-Miller H. (2015) (expected date July 2015) Individual music therapy for managing neuropsychiatric symptoms for people with dementia and their carers: a randomised controlled feasibility study. *BMC Geriatrics* This study reports initial feasibility and outcomes from a five month music therapy programme including weekly individual active music therapy for people with dementia and weekly post-therapy video presentations for their carers in care homes. **Methods** 17 care home residents and 10 care staff were randomised to the music therapy intervention group or standard care control group. The cluster randomised, controlled trial included baseline, 3-month, 5-month and post-intervention 7-month measures of residents' symptoms and well-being. Carer-resident interactions were also assessed. Feasibility was based on carers' feedback through semi-structured interviews, programme evaluations and track records of the study. **Results** The music therapy programme appeared to be a practicable and acceptable intervention for care home residents and staff in managing dementia symptoms. Recruitment and retention data indicated feasibility but also challenges. Preliminary outcomes indicated differences in symptoms (13.42, 95%CI: [4.78 to 22.07; p=0.006]) and in levels of wellbeing (-0.74, 95%CI: [-1.15 to -0.33; p=0.003]) between the two groups, indicating that residents receiving music therapy improved. Staff in the intervention group reported enhanced caregiving techniques as a result of the programme.	

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			Conclusion The data supports the value of developing a music 52 therapy programme involving weekly active individual music therapy sessions and music therapist-carer communication. The intervention is feasible with modifications in a more rigorous evaluation of a larger population in a multi centred trial in the planning stages with partners including Anglia Ruskin University, Nottingham University and others.	
Evidence submitted for British Association for Music Therapy	General (and relating to all music interventions): ES R1 1.5; ESR2.3	General and P.5 and 22 and	**Music and brain research**. To support all the music therapy therapeutic and clinical evidence, the most recent relevant music and brain research is summarised here which points to the importance of music therapy which includes all aspects of music engagement for older people and not only singing. Regarding older people with depression and anxiety, recent RCT findings (Evidence level 1b) from Guetin et al. (2009) and Sarkamo et al. (2013) offers promising evidence for the relief of these common symptoms of dementia. Recent research (Evidence level 1b) indicates that music therapy is able to reduce symptoms of depression and anxiety (Erkkila et al., 2011; Fachner et al., 2013), with the findings of the abovementioned trials showing consistency with dementia clients. A common observation with dementia clients is that certain songs seem to reactivate memory and cognitive function, especially those songs with strong emotional connections (Cuddy, 2005). Research on music and emotion shows involvement of the nucleus accumbens and amygdala as well as orbito-frontal activation, which triggers dopamine release supporting attention and memory (Levitin, 2006; Salimpoor et al., 2011; Koelsch, 2012). Regarding the use of	Thank you. All the evidence presented is out of scope for this guideline as it is focussed on dementia.

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			singing, and in particular, familiar songs, MRI evidence from semantic dementia indicates that the right temporal pole is correlated with remembrance of songs and the grade of deterioration. This indicates a definite neuroanatomical correlate between deterioration and the degree of musical knowledge (Hailstone et al., 2009; Hsieh et al., 2011/2). Another RCT on singing with Clients with frontotemporal dementia benefit from group singing (Johnson, 2011) and choir singing induces neurotransmitter-balance and a good ratio of release and re-uptake, possibly indicating symptom prevention (Kreutz 2013). Making music trains audio-motor coupling and assists channel agitation with clients with dementia (indicated in a level 2b RCT, see Ridder et al., 2013) and helps to maintain healthy levels of motor function (Altenmueller, 2014). Raglio et al. (2015) investigated music therapy interaction by contrasting two independently rated excerpts of session material recorded in a therapy session prior to fMRI scanning. Participants listened to the two contrasts representing high and low interaction patterns from the sessions and differences in frontal, temporal and occipital areas of the brain were described. **References** Altenmüller, E. (2014). Wie lernen Senioren? Mechanismen der Hirnplastizität beim Musikunterricht im Alter. *Musikphysiologie und Musikermedizin*, 21(3), 154-163 Cuddy, L. L., & Duffin, J. (2005). Music, memory, and Alzheimer's disease: is music recognition spared in dementia, and how can it be assessed? *Medical Hypotheses, 64*(2), 229-235. doi: http://dx.doi.org/10.1016/j.mehy.2004.09.005 Erkkilä , J., Punkanen, M., Fachner, J., Ala-Ruona, E., Pöntiö, I., Tervaniemi, M., . . . Gold, C. (2011). Individual music therapy for depression -	

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			Randomised Controlled Trial. *Br J Psychiatry, 199*(2), 132–139. doi: 10.1192/bjp.bp.110.085431 Fachner, J., Gold, C., & Erkkilä, J. (2013). Music therapy modulates fronto-temporal activity in the rest-EEG in depressed clients. *Brain Topography, 26*(2), 338-354. doi: 10.1007/s10548-012-0254-x Guétin, S., Portet, F., Picot, M., Pommié, C., Messaoudi, M., Djabelkir, L., . . . Touchon, J. (2009). Effect of music therapy on anxiety and depression in patients with Alzheimer’s type dementia: randomised, controlled study. *Dementia and geriatric cognitive disorders, 28*(1), 36-46 Hailstone, J. C., Omar, R., & Warren, J. D. (2009). Relatively preserved knowledge of music in semantic dementia. *Journal of Neurology, Neurosurgery & Psychiatry, 80*(7), 808-809. doi: 10.1136/jnnp.2008.153130 Hsieh, S., Hornberger, M., Piguet, O., & Hodges, J. R. (2011). Neural basis of music knowledge: evidence from the dementias. *Brain, 134*(9), 2523-2534. doi: 10.1093/brain/awr190 Hsieh, S., Hornberger, M., Piguet, O., & Hodges, J. R. (2012). Brain correlates of musical and facial emotion recognition: Evidence from the dementias. *Neuropsychologia, 50*(8), 1814-1822. doi: http://dx.doi.org/10.1016/j.neuropsychologia.2012.04.006 Johnson JK, Chang CC, Brambati SM, Migliaccio R, Gorno-Tempini ML, Miller BL, Janata P. Music recognition in frontotemporal lobar degeneration and Alzheimer disease. Cogn Behav Neurol. 2011 Jun; 24(2):74-84. Koelsch, S. (2012). *Brain and music*. Oxford Wiley-Blackwell. Levitin, D. J. (2006). *This is your brain on music : the science of a human obsession*. New York, N.Y.: Dutton Raglio, A., Galandra, C., Sibilla, L., Esposito, F., Gaeta, F., Di Salle, F., . . . Imbriani, M. (2015). Effects of active music therapy on the normal brain: fMRI based evidence. *Brain Imaging and Behavior*, 1-5. doi:	

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			10.1007/s11682-015-9380-x Ridder, H. M. O., Stige, B., Qvale, L. G., & Gold, C. (2013). Individual music therapy for agitation in dementia: an exploratory randomized controlled trial. *Aging & Mental Health, 17*(6), 667-678. doi: 10.1080/13607863.2013.790926 Särkämö, T., Tervaniemi, M., Laitinen, S., Numminen, A., Kurki, M., Johnson, J. K., & Rantanen, P. (2014). Cognitive, Emotional, and Social Benefits of Regular Musical Activities in Early Dementia: Randomized Controlled Study. *The Gerontologist, 54*(4), 634-650. doi: 10.1093/geront/gnt100 Salimpoor, V. N., Benovoy, M., Larcher, K., Dagher, A., & Zatorre, R. J. (2011). Anatomically distinct dopamine release during anticipation and experience of peak emotion to music. *Nat Neurosci, 14*, 257-262. doi: 10.1038/nn.2726 **Acknowledgements** Ming Hsu, (MHA and ARU), Prof Jorg Fachner and Sarah Faber from Anglia Ruskin University have all contributed to this document.	
British Specialist Nutrition Association	General		As part of an individual's health and well-being, nutrition needs to be incorporated into care. Therefore, we consider NICE Clinical Guideline (CG) 32 (2006) Nutrition Support in Adults: Oral Nutrition Support, Enteral Tube Feeding and Parenteral Nutrition and the associated NICE Quality Standard (QS) 24, Nutrition Support in Adults, to be relevant to this guideline and should be referenced where appropriate.	Thank you for this comment. The Committee did not think that NICE CG32 and QS24 required specific reference although they acknowledge that both are relevant to older people.
Campaign to End Loneliness	General	1	The Campaign to End Loneliness warmly welcomes this Guidance and believes it has potential to drive improvements in efforts to improve older	Thank you. The context section of guideline has been updated to

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			people's independence and mental wellbeing. We are delighted to see that the document makes explicit reference to the issue of loneliness, and proposes a number of approaches which have shown to be effective in reducing loneliness and isolation. However, in a number of places (e.g. 1 line 13) the term "social isolation" is used without reference to "loneliness". We believe it is important that both are referred to throughout the document. One of the most common mistakes among those seeking to address loneliness and social isolation is to fail to grasp the distinction between the two, and therefore to imagine that the solution to loneliness is always increased social contact. While social isolation is an objective concept, loneliness is subjective and is related to a gap between the *quality* and quantity of relationships we desire and those we have (see Perlman, D, Peplau L. (1981) *Toward a Social Psychology of Loneliness*. Personal Relationships 3: Personal Relationships in Disorder, Pp. 31-43) While in some cases the two are linked, it is possible to be lonely, but not socially isolated, and to be socially isolated but not lonely (see for example, Victor, C, Scambler, S, Bond, J. (2009). *The social world of older people: Understanding Loneliness and Social Isolation in Later Life.* OUP table 5.5 pp. 199) It is also important to note that current research does not support the thesis that it is only those who are *both* lonely *and* socially isolated whose health is negatively impacted. For example Holwerda et al demonstrated that loneliness, but not social isolation, was associated with a 64% increase in the risk of developing dementia (see Holwerda, T. J.et al (2012). Research paper: Feelings of loneliness, but not social isolation, predict dementia onset: results from the Amsterdam Study of the Elderly (AMSTEL) *Journal of Neurology, Neurosurgery and Psychiatry)* It is important that this guidance does not perpetuate the problem of	reflect this point. Loneliness is also defined in the glossary.

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			authorities focussing efforts exclusively on the number of social contacts, without considering their quality, by failing to refer to both loneliness and social isolation throughout.	
Campaign to End Loneliness	General		The Campaign recommends its recent publication *Promising Approaches to reducing loneliness and isolation in later life*, and the associated guidance for Commissioners which is now available on our website. We believe this document and associated online guidance sets out a very practical framework for Local Authorities for understanding how best to put in place a workable range of interventions to promote older people's independence and mental wellbeing. While the guidance is focussed on loneliness and social isolation, we believe the model proposed has wider application across the piece envisaged here.	Thank you. This point is noted.
Campaign to End Loneliness	General		In our experience one of the biggest challenges facing authorities in addressing issues around mental health and wellbeing is ensuring their efforts reach those most in need, given the fact that often these individuals are isolated or otherwise "hard to reach". The Campaign to End Loneliness has recently undertaken research regarding the challenges of reaching individuals experiencing loneliness and these findings have been written up in our publication *Hidden Citizens: How can we identify the most lonely adults?* Which offers a range of practical ways in which authorities can start to address these challenges. We believe it may be helpful to acknowledge these challenges explicitly within the guidance and to refer to sources of support such as our guide.	Thank you. This point is noted. Recommendation 1.5 is all about identifying those most at risk of decline in their independence and mental wellbeing. This recommendation was not prioritised for implementation advice by the committee.
Campaign to End Loneliness	General		Measuring impact on issues relating to mental health and wellbeing remains a considerable challenge for many organisations delivering services in this field. However effective impact measurement is clearly vital if we are to continue to develop our understanding of what works. To that end, we recommend that	Thank you. A number of evaluation tools including the Campaign to End Loneliness's 'Measuring your impact on

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			NICE highlights the existence of a range of tools which authorities and service delivery organisations might use to measure their impact not just on overall wellbeing but on particular aspects of it, such as loneliness. We recommend that this includes reference to our new practical guidance on measuring loneliness *Measuring your Impact on Loneliness in Later Life*	loneliness in later life' have been highlighted in Implementation: getting started section of the guideline.
Campaign to End Loneliness	General	2	The Campaign welcomes the emphasis placed on relationships as a key determinant of mental wellbeing (at line 7). For too long policy has placed insufficient emphasis on individuals' need for connection, leading to health and social care provision which perpetuates isolation. We believe this guidance helpfully complements the new emphasis on relationships embodied in the Care Act and will be helpful to authorities in exercising their duties under that Act.	Thank you for this comment.
Campaign to End Loneliness	General	2	We welcome the recognition (in lines 23 and 24) of the importance of providing a variety of activities to older people within communities. Our recent publication - *Promising Approaches to reducing loneliness and isolation in later life* – argues that it is vital that communities are able to offer older people a "menu" of attractive options – to meet diverse needs to tap into diverse interests.	Thank you for this comment.
Campaign to End Loneliness	1.1	4	We would urge NICE to consider the findings set out in the Campaign's recent publication *Promising Approaches to reducing loneliness and isolation in later life* with regard to the efficacy of co-production approaches, and schemes based on the principles of asset-based community development, not only in supporting the development of services to promote wellbeing that are appropriate, attractive and sustainable, but also in bringing additional wellbeing benefits in themselves through the generation of additional sense of ownership and shared purpose among those involved in producing them. We would urge NICE to amend the wording used at lines 18-19 to make clearer	Thank you. The Committee did not feel there was enough evidence to make specific recommendations about funding; however, social prescribing is specified as a potential way to fund activities from existing resources in the Committee discussion section of the

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			that local authorities commissioning role should encompass a range of approaches including acting as a catalyst (perhaps with seed funding) to local co-production of solutions.	guideline.
Campaign to End Loneliness	1.1.	4	We would urge NICE to add an additional point to the list of characteristics activities should have, to make clear that activities should be developed with older people's active involvement. Involving older people in the development and delivery of activities aimed at them is a matter of good practice in any case, but in the particular context of improving mental wellbeing there is evidence to suggest that services based on older people's involvement are more likely to deliver good outcomes (see, in particular, Cattan et al (2005). *Preventing social isolation and loneliness among older people: a systematic review of health promotion interventions.* Ageing and Society, 25). In many cases adopting a co-production approach will be the most effective way of ensuring that services are appropriate to older people's needs.	Thank you. Recommendation 1.1.2 states *"Involve older people in the design and delivery of activities*" and To support this recommendation, the Implementation: getting started section includes *[asking] older people what they think about the service or activity" along with specific questions a service provider could consider. ".* Older people are also included as key members in the list of partnership members in the implementation section.
Campaign to End Loneliness	1.2	5	In line with our comments above, the document should be amended at lines 3 and 4 to make clear the potential for local authorities to act as catalysts to the development of such activities: e.g. using Asset Based Community Development or other co -production approaches with local older people.	Thank you. Please see the previous response.
Campaign to End Loneliness	1.2	5	NICE requested views on whether the current emphasis on singing interventions (at lines 8-9) was appropriate. In our opinion the current	Thank you for this comment. The evidence for singing

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			emphasis is disproportionate. The Campaign strongly endorses the decision to list arts-based approaches, in the broadest sense, among the potential activities to be provided. Furthermore we would support the inclusion of singing programmes as an example of this. However we feel that the relative strength of the current evidence base related to singing as compared to other arts-based approaches is more likely to be a quirk of the limited evidence base rather than linked to any intrinsic characteristic of singing. We believe it is more important that authorities seek to stimulate the development of arts-based programmes that accord with the expressed needs and wishes of local older people, than emphasise singing in particular. Our understanding of the evidence is that it is the opportunity to engage in an activity which one enjoys and finds stimulating that is paramount, rather than its precise form	activities demonstrated clear benefit and this activity remains in recommendation 1.2.1. Other creative activities are also included in this recommendation. This would cover other arts based programmes. The evidence base for recommendation 1.2 is described in the Committee's discussion section of the guideline.
Campaign to End Loneliness	1.3	5 and 6	It is disappointing that the section on volunteering activities does not more clearly emphasise the need to develop volunteering opportunities which give older people the chance to utilise the full range of their skills. While it is right to emphasise the potential of volunteering to develop new skills, many older people enter later life with significant skills and experience to offer already and too often these are not well-utilised. We also feel this section should more clearly emphasise the potential for older people to be involved in mutual and co-operative type arrangements as a means of giving their time – for example becoming involved in co-production exercises, working as expert advisers, offering their skills as Experts by Experience etc.	Thank you. Recommendation 1.4 states *"1.4.1 - Make older people aware of the value and benefits of volunteering. For example, it provides the opportunity to socialise, have an enjoyable experience and help others to benefit from their experience, knowledge and skills.". It* no longer focuses only on the development of new skills. It is not possible to give an exhaustive list of volunteering opportunities but all the

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				examples listed in the comment would be covered by the recommendation.
Campaign to End Loneliness	1.4	6	We would urge NICE to extend its list of one-to-one interventions to include outcomes-focussed mentoring schemed designed to offer support for individuals ultimately to access wider provision. These schemes are different from long-term one-to-one arrangements like befriending, as they are short-term and goal-oriented, but they are an important part of the package of one-to-one interventions. These distinctions are further discussed in the Campaign's recent publication *Promising Approaches to reducing loneliness and isolation in later life* where we emphasise the vital role that these mentoring services can play in supporting individuals to access the full range of community provision. We see these services as one of the vital "foundation services" to effective provision within a community.	Thank you. The Committee have not seen evidence on mentoring schemes; however, the implementation section on Getting people involved in activities describes ways of getting people involved in activities. The example mentoring scheme would be covered here.
Campaign to End Loneliness	1.		We believe this section should also include reference to the need to consider providing services based on psychological approaches – such as mindfulness and cognitive behavioural therapies – given the evidence demonstrating their promise in addressing loneliness and isolation and promoting wellbeing. See for example Masi et al and Masi,C, Chen, H, Hawkley L, and Cacioppo T. (2011) *A Meta-Analysis of Interventions to Reduce Loneliness* Pers Soc Psychol Rev. 2011 August ; 15(3): Dickens et al (2011) *Interventions targeting social isolation in older people: a systematic review*. BMC Public Health 2011, 11:647 and Creswell, JD, Irwin, M, Burklund L, Lieberman, M, Arevalo, Ma, J, Breen, E, Cole, S. (2012) ; and *Mindfulness-Based Stress Reduction training reduces loneliness and pro-inflammatory gene expression*	Thank you. Psychological interventions are out of scope for this guideline.

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			in older adults: A small randomized controlled trial Brain, Behavior, and Immunity 26, pp1095–1101	
Campaign to End Loneliness	1.5	6	We welcome the decision to recommend the development of a “local coordinator” for wellbeing at line 15. We believe that given the complexity of current provision, and the challenges of reaching the most isolated, such roles are vital. However we are concerned that the current generic description of the role could lead to confusion as to what is being proposed. The explanatory bullet points outlining this role encompass a wide range of potential areas of work – ranging from contacting older people (at line 18); to letting organisations know about particular geographical areas where at risk older people live (at lines 21-24). In section 5.7 (on “Context”) the reference to “wellbeing coordinators” appears more clearly to refer to services of the kind the Campaign to End Loneliness has described as “foundation services” in its report *Promising Approaches to reducing loneliness and isolation in later life*; and which are described in the SCIE paper (Windle, K, Francis, J, Coomber, C (2011) *Preventing loneliness and social isolation: interventions and outcomes* – Social Care Institute for Excellence) as Community Navigators; and which in practice are known as “Village Agents” / “Community Wayfinders” / “Community Wellbeing Practitioners” etc. However this is lost the guideline formulation. We recommend that NICE clarifies the guidance to recommend (1) community outreach work with vulnerable older people, to support them to connect with local provision, and to act in a community development role to recognise and fill gaps; (2) a strategic lead for wellbeing at an authority-wide level – to support identification of areas of need etc.	Thank you. The Implementation: getting started describes a range of components, at different levels, that could support activities for older people. These include: Local coordination; planning and partnerships and local needs assessment” These include inclusion of older people’s independence and mental wellbeing in local strategies and how to identify local need.
Campaign to End Loneliness	1.6	7	The Campaign welcomes the emphasis on building older people’s wellbeing into Health and Wellbeing board strategies and JSNAs. This aligns with our	Thank you for this comment.

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			own work to encourage Health and Wellbeing Boards to prioritise addressing loneliness. However we would urge NICE to ensure that the guidance makes clear that there should be an assessment of the most pressing threats to wellbeing and specific work to address these. We welcome the recognition in lines 26-31 of the wide range of agencies whose work affects older people's wellbeing. We know that NICE have heard from Age Friendly Manchester as part of their deliberations, and we feel that the approach outlined here is strongly aligned to that way of working – we are therefore puzzled as to why the guidance does not explicitly refer to these approaches as an "age friendly" or "age positive" approach	The Committee recommend taking a needs led approach and recommend specific issues to consider when undertaking needs assessment, however NICE are unable to give further advice as the recommendations need to remain flexible enough to allow implementation locally across many areas that have varying needs. Whilst the committee heard from Age friendly Manchester for context around this topic the specific issue of age friendly cities was out of scope for this guideline.
Campaign to End Loneliness	1.7	8	We would strongly endorse the recommendation to carry out a needs assessment in relation to older people's independence and wellbeing, however we feel this section needs to more explicitly state the need for older people to be involved in this process. We strongly endorse the recommendation to use existing data to identify the number of older people at risk, and would recommend this is extended to urge consideration of the possibility of mapping need within particular areas – as discussed in the Campaign's publication *Hidden Citizens: How can we identify the most lonely adults?*	Thank you for this comment. Please see previous response about involving older people.
Campaign to End Loneliness	1.8	9	The Campaign endorses the need for service providers to promote their services to local older people. We believe it would be helpful to recommend	Thank you. Please see previous response about involving older

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			consultation with local older people to determine the most appropriate way to promote services aimed at enhancing wellbeing and independence, as the evidence suggests that opinions about how best to communicate such issues vary from one community to the next. For example in the Joseph Rowntree Foundation Neighbourhood Approaches to Loneliness programme some communities found explicit reference to the issue of loneliness liberating, while others found it off-putting	people.
Campaign to End Loneliness	1.9	10	We welcome the emphasis placed on empowering individuals with information about the need to maintain their mental health and wellbeing, however at present the guideline does not really give much of a sense of how this might be done. In their consultation with people with experience of loneliness New Economics Foundation found that many individuals found the “Five ways to wellbeing” a positive and empowering tool and felt more could be made of this in public campaigning (see Nef *Talking wellbeing: A public dialogue approach to effective policy making*).	Thank you. Training for people in contact with older people most at risk of decline in their independence and mental wellbeing is covered in the Implementation: getting started section.
Campaign to End Loneliness	1.10	11	We welcome the recognition of the need to provide infrastructure and support to enable people to access activities and services which promote their independence and wellbeing – in the Campaign’s report *Promising Approaches to reducing loneliness and isolation in later life* we term these services – in particular transport and technology - “gateway services” in recognition of their pivotal role in enabling access to loneliness prevention, but we also recognise that these services can also act as a catalyst to social engagement in themselves.	Thank you for this comment.
Campaign to End Loneliness	1.12	11	We welcome the inclusion, in the guidance, of a request for local authorities to consider providing support and finance to organisations to run programmes. We would urge NICE to emphasis the potential for the impact of funding to be maximised by channelling funds into programmes which are based on Asset-	Thank you. Please see previous comments on funding.

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			Based Community Development principles, and which emphasise coproduction and promote volunteering. In our publication *Promising Approaches to reducing loneliness and isolation in later life* we termed these approaches "structural enablers" because our research showed that these not only enable the development of sustainable and appropriate services to promote older people's wellbeing within a community; but they also bring benefits in themselves because they create opportunities for older people to engage in activities which use their skills, are reciprocal and give them a sense of purpose.	
Campaign to End Loneliness	1.14	12 and 13	We welcome the emphasis on the role funders can play in encouraging good evaluation; however we feel it would be beneficial if this explicitly stated that funders could support evaluation through the provision of ring-fenced funds for this work. Funders can also play an important role in encouraging organisations to use tried and tested tools to measure their outcomes (such as are highlighted in the recent Campaign to End Loneliness guide *Measuring your Impact on Loneliness in Later Life)* as a means of improving the quality and comparability of evidence.	Thank you. The Committee did not feel there was enough evidence to specify how evaluations should be funded however, the implementation section described that local authorities "*could:* *Make collecting data for evaluation a requirement for statutory funding".* The Campaign to End loneliness guide is also specified in this section as a useful evaluation resource.
Campaign to End Loneliness	1.15	13	We welcome the emphasis on breaking down evaluation to make it as simple as possible. We would urge NICE to highlight the existence of a wide range of tools to support organisations in evaluating their work, including not just those	Thank you. This has been addressed in the implementation section of the

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			which measure mental wellbeing, but also some (including measures identified by the Campaign to End Loneliness in its recent guidance *Measuring your Impact on Loneliness in Later Life*) which measure specific aspects of / contributing factors to wellbeing	guideline.
Campaign to End Loneliness	2	14	While the Campaign would broadly agree with the list of organisations and individuals given in the Introduction to section 2, there remains a risk that some key actors may fail to recognise that they are covered under the description of “providing services for older people”. While in reality this designation should encompass almost all policy makers and providers, we know that too often authorities “park” older people’s issues in the area of health and social care. It may be more helpful therefore to provide an additional set of examples – e.g. to state explicitly that this includes transport providers, planners etc – or at least to state that the scope is “not limited to health and social care providers”.	Thank you. This section is no longer in the guideline.
Campaign to End Loneliness	3	16	The Campaign’s previous work to assess health and wellbeing boards’ work to tackle loneliness has demonstrated the very wide range of current understanding of the importance of taking action on older people’s independence and mental wellbeing among boards (see the Campaign’s publication - *Still Ignoring the Health Risks?)*. It is therefore very difficult to set out a single set of “next steps” that will be appropriate to all areas. Some areas have well-established partnerships of the nature outlined in the guidance, and have considerable data already – others will just be starting out. The Campaign to End Loneliness has developed online guidance which is intended to support health and wellbeing boards, local authority public health and adult social care teams and CCGs to develop plans for addressing loneliness and to consider practical action. This new guidance has just been launched and is available on our website. While this resource is obviously	Thank you for this comment.

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			focussed primarily on loneliness, we believe much of the content will be applicable to mental wellbeing more broadly.	
Campaign to End Loneliness	4	17	As per our previous comments, noted above, we believe it is important that the reference to isolation in line 22 is amended to refer to "loneliness and social isolation" as there is evidence that both can be harmful to mental and physical health.	Thank you. This section of the guideline has been updated and includes the impact of both social isolation and loneliness.
Campaign to End Loneliness	5.4	19	We welcome the recognition of the centrality of reciprocity to the development of quality relationships. It is important to note that formal volunteering is not the only way in which older people participate and contribute. As we have noted elsewhere, it is important to note the huge value for individual older people of participating in service design and development.	Thank you for this comment.
Campaign to End Loneliness	5.7	20	As noted above we very much welcome the recognition of the role that "wellbeing coordinators" in their various guises can play in ensuring that older people are able to access services and support, however we feel that the current explanation of this role is not sufficiently clear to lead to action in all cases. We feel it would be beneficial to provide some examples of how this role has been realised in practice – e.g. village agents / community wayfinders / local area coordinators – to offer greater clarity about what is meant here. Specific examples of these kinds of services are available in the Campaign to End Loneliness's publication *Promising Approaches to reducing loneliness and isolation in later life (*see in particular case studies 3, 5, and 6)	Thank you. This has been addressed Implementation: getting started section of the guideline (please see latter part of the heading titled 'local coordination').
Campaign to End Loneliness	5.8	20	As noted above we welcome the emphasis on raising awareness among older people of the need to promote independence and mental wellbeing, but feel that authorities will struggle to implement this without further guidance as to how this might be done.	Thank you. Please see the previous response to this point.
Campaign to End Loneliness	5.17	23	We would urge NICE to make clearer the importance of older people's	Thank you. Please see the

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			involvement in the design and delivery of services as a key contributor to their success, as evidenced in the systematic review by Cattan et al (see Cattan, C, White, M, Bond, J, Learmouth, A (2005). *Preventing social isolation and loneliness among older people: a systematic review of health promotion interventions.* Ageing and Society, 25, pp 41-67). There are emerging examples of local authorities taking an area-wide approach to such engagement. For example in Manchester where the Valuing Older People (VOP) team, based in Manchester City Council's Public Health Unit, is overseen by a board made up entirely of older people and is guided by the Manchester Ageing Strategy, launched in 2009, which sets out a 10 year plan to make Manchester, 'A Great Place to Grow Older.' This scheme is profiled in the Campaign's new guidance for local authorities (see http://campaigntoendloneliness.org/guidance/case-study/manchester-city-councils-valuing-older-people-team/)	previous response to this point.
Campaign to End Loneliness	5.18	23	We would endorse the importance of providing excluded groups with specific support to access services. An effective way of doing this is through the provision of short-term goal-oriented mentoring services, as discussed in the Campaign's publication *Promising Approaches to reducing loneliness and isolation in later life.* We believe these should be noted as a key service intervention within the guidance.	Thank you. Please see the previous response to this point.
Campaign to End Loneliness	5.20-25	23 and 24	We would echo NICE's findings regarding the lack of economic data and analysis available in this field. A small number of relevant studies are available via the Campaign to End Loneliness' website (see http://campaigntoendloneliness.org/guidance/evaluation/#tab_tab3.)	Thank you for this comment. The Committee does not feel this has led to a disproportionate emphasis being placed on any particular service.

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			However, more broadly, we would urge NICE to ensure that the relatively small amount of data available does not lead to disproportionate emphasis being placed on those services which have been able to demonstrate cost savings to date, as we believe this would not create a true reflection of the greatest impact, but would simply reflect that patchy state of the evidence base.	
Care and Repair England	General	Page 4 – 7 (Section I – 5)	We suggest that the guideline as drafted feels too narrow in focus in relation to the ‘What the guidance is about?’ The guideline, with regard to interventions and strategy, focuses specifically on activities and linked services. There is no consideration of environmental factors that impact on independence and mental wellbeing. This would include guidance on the infrastructure that supports independence and mental wellbeing which would include a broader focus on the development of ‘age friendly communities’ across all factors that impact on older people. (It should be noted that on page 7 there is a mention of public seating and toilets in line 29 whereas one would have expected the guidance to look much more broadly at the issues for creating age friendly communities focusing on this broader range of factors). Examples of this infrastructure would include good, decent housing that is suitable for people in later life, access to health and care at home, getting out and about, including transport, neighbourhood safety, accessibility etc... If this is the focus (and we believe it should be) then the guidance would need to be framed to include measures that support these infrastructure issues. We	Thank you. Whilst the committee heard from Age friendly Manchester for context around this topic the specific issue of age friendly cities was out of scope for this guideline.

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			have not done this in details in our comments since we feel clarity is needed on the purpose of the guidance first which we set out below.	
Care and Repair England	General - What is the guideline about	Page 1 line 8 - 10	If the guidance is purely aimed at the development of activities then this should be stated at the outset so that 'What the Guideline is about' states that it 'makes recommendations on maintaining and improving independence and mental wellbeing ***by the provision of activities and linked services'.***	Thank you. The guideline covers more than just provision of activities and linked services (includes needs assessment, identifying those most at risk for example). The requested change has not been made.
Care and Repair England	General	Page 7 -9 (Rec 6 and 7)	If the focus is only on activities and linked services the guidance on strategy, including needs assessment and working in partnership, misses the opportunity to be much bolder in considering environmental and neighbourhood factors that support independence and mental wellbeing. There needs to be more clarity at the outset of the parameters of the guidance.	Thank you for this comment. The guideline addresses the activities set out in the final scope. This does not include environmental or other neighbourhood factors.
Care and Repair England	Section 1 Draft recommendation s	Page 4 line 10 - 14	Throughout the report there should be a distinction between 'should' and 'should consider' which is what should be said here. At the moment line 12 just says 'consider' yet the report uses 'should consider'. This would help clarify expectations for those who need to take action.	Thank you. The guideline has been updated. Only recommendations that have a good evidence base are worded strongly (such as, 'should' be done or 'ensure') and other recommendations are 'could' or 'consider'. The rationale for the wording of each rec is described in the Committee's discussion section

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				of the guideline and Making decisions using NICE guidelines explains how we use words to show the strength (or certainty) of NICE recommendations,
Care and Repair England	Section 1.1 Interventions - principles	Page 4 after line 27	Add after line 27 – **ensure older people can access community activities in the locality (that were not developed exclusively for them but for which they might wish to partake in).** Currently this recommendation could imply age exclusive activities whereas older people should be able to access activities that interests them locally regardless of their age and there is benefit to encouraging greater intergenerational links for independence and well being	Thank you. This recommendation does not specify that the activities and services should only be age exclusive. The guideline supports older people taking part in all activities that would help to maintain and improve independence and mental wellbeing.
Care and Repair England	Section 1. 2 Interventions – group activities	Page 5 after line16	Add **access to work activities** (as relevant for older people as any other age)	Thank you. The Committee did not hear evidence on paid work activities and therefore this is not included in the recommendation.
Care and Repair England	Section 1.6 Strategy	Page 7 line 17	Add **housing authorities**	Thank you. The guideline has been updated the Implementation: getting started section now describes statutory and non-statutory housing providers and home improvement agencies in the list of organisations that

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				should be included in the partnership.
Care and Repair England	Section 1.6 Strategy	Page 7 line 18	Why only non- statutory housing providers?	Thank you. The guideline has been amended to also include statutory housing providers.
Care and Repair England	Section1. 6 Strategy	Page 7 line 28 - 29	This should be reworded to focus on age friendly neighbourhoods more broadly – not just toilets and seats. There is now very good evidence of councils developing age friendly cities to draw on – see http://www.who.int/ageing/publications/Age_friendly_cities_checklist.pdf for a checklist	Thank you. Whilst the committee heard from age friendly Manchester for context around this topic the specific issue of age friendly cities was out of scope for this guideline.
Care and Repair England	Section 1.6 Strategy	Page 7 line 30	This is not right. Fire services don't advise on whether home adaptations are needed. If talking about environmental factors like home adaptations there should be a reference to social services departments, the availability of Disabled Facilities Grants and other help and a reference to the role of Home Improvement Agencies	Thank you. This line no longer appears in the guideline. *"The Implementation: getting started section describes Many local authority departments and their partners could play a role in helping older people maintain and improve their independence and*

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				mental wellbeing. This could include the fire service or home improvement agencies and others who visit older people at home. (For example, such agencies could use their visits as an opportunity to identify older people at risk of a decline in mental wellbeing.)"
Care and Repair England	Section 1.7 Strategy local needs assessment	Page 8 line 17	Add **housing data**	Thank you. The guideline has been updated Needs assessment is now part of Implementation: getting started section and includes other sources. Housing data may be considered within the other sources *"Other sources may include market research, general practice profiles, the Projecting Older People Population Information System and the Office for National Statistics. ."*
Care and Repair England	Section 1.7	Page 8 line 31	Add such as their income, ethnicity **and housing circumstances**	Thank you. This list provided

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	Strategy local needs assessment			here is not intended to be exhaustive. This is now in the Implementation: getting started section and states "•*Local authorities could carry out a local assets and needs assessment that: 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..*"
Care and Repair England	Section 1.7 Strategy local needs assessment	Page 9 line 7	Add **link to local older people's groups and networks to consult and engage with local older people**	Thank you. This addition has not been made, however, recommendation 1.1.2 states *"Involve older people in the design and delivery of activities*" Older people are also key to partnership membership (see Implementation: getting started) .
Care and Repair England	Section 1.8 publicise services and	Page 9 line 10	Should not local authorities and Health and Wellbeing Boards also have the responsibility, too, to publicise not just service providers?	This section has now moved to the Implementation section and includes local authorities "*To*

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	activities			*help overcome these difficulties [to take part], local authorities, service providers and community organisations could::."*
Care and Repair England	Section 1. 8 publicise services and activities	Page 9 line 12-13	This seems very simplistic? What about use of social media, local libraries, GP surgeries, use of supermarkets/pubs/clubs etc...	Thank you. Please see the previous response.
Care and Repair England	Section 1.9 raise awareness	Page10 line 1	Add **housing practitioners**	Thank you. This list no longer appears in the guideline. This point is included in recommendation 1.5.2 and states *"Ensure staff in contact with older people are aware of the importance of maintaining and improving their independence and mental wellbeing."* Housing practitioners are covered within the term 'staff in contact with older people.
Care and Repair England	Section 1. 9 raise awareness	Page 10 after line 15	Add **diagnosed with dementia and other long term health condition**	Thank you. Dementia is out of scope for this guideline. This is now recommendation 1.5.3 and the wording remains the same: *"have recently experienced or*

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				developed a health problem (whether or not it lead to admission to hospital)". The list of life events or circumstance included here is based on evidence received from expert testimony.
Care and Repair England	Section 1.10 overcoming barriers	Page 11 line 3	Add **or mental health**	Thank you. The list of life events or circumstance included here is based on evidence received from expert testimony and this did not include mental health. However, the term "*have recently experienced or developed a health problem (whether or not it lead to admission to hospital)"* could cover people who have developed mental health difficulties.
Care and Repair England	Section 1.10 overcoming barriers	Page 11 line 7	It is not just about toilets but links to the earlier point about developing age friendly neighbourhoods so would include security and safety issues as well as general access issues	Thank you. Whilst the committee heard from Age friendly Manchester for context around this topic the specific issue of age friendly cities was out of scope for this

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				guideline.
Care and Repair England	Section 1.13 Support community orgs	Page 12 line 14	Add **and housing practitioners**	Thank you. This section has now moved to the Implementation: getting started section. The list now includes local authorities, service providers and community organisations.
Care and Repair England	Section 1.15 evaluate	Page 13 line 14	'...come along' seems very patronising. Could say **'engage'**	Thank you. This section has now moved to the Implementation chapter. 'Engage' could be considered to be jargon and that asking people why they come to activities to more straightforward. NICE aims to write in plain English.
Care and Repair England	Section 1.15 evaluate	Page 13 line 20	Isn't this process outputs not outcomes? It is suggested that evaluations should assess **outcomes and outputs**	Thank you. Both process and effectiveness outcomes are relevant and both are covered in the evaluation section which has moved to the Implementation: getting started section.
Care and Repair England	Section 1.15 evaluate	Page 13 after line 30	Add **benefits for older people and their carers**	Thank you. This has moved to the Implementation section and states "• *Form partnerships with academic and practice organisations (such as*

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				QaResearch and Ecorys) with the skills to help evaluate the activity or service.”. Implementation section – area 6, outlines support for “for more formal (‘summative’) evaluations” which could include assessment of benefits for older people and their carers
Care and Repair England	Section 1.16 design training	Page 14 line 1	Add **and housing practitioners**	Thank you. Training has moved to the Implementation section. The list of organisations to consider training includes local authorities, service providers and community organisations.
Care and Repair England	Section 2 Recommendations 6,7,10 and 11	Page 16 line 1	Add commissioners of health**, housing** and care services	Thank you. This section is no longer included in the guideline.
Care and Repair England	Section 3 - Implementation - Biggest impact on practice and challenging to implement (Question 1 in the consultation)	Page 16 line 22	It will be important to develop a local strategy which engages the key providers so that all those working with older people at any level think about the impact of their work and services on people’s independence and wellbeing. This will be a challenge for all especially in tough economic times. It is suggested NICE might consider supporting the development of practice in this area by supporting a learning and sharing network. SCIE has recently developed a library of practice on prevention which might be drawn upon as an example. See http://www.scie.org.uk/prevention-library this is an example of identifying evidence in this context and might work well for this guidance	Thank you for this comment.

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			once the parameters are established. This might also help with raising awareness (Question 4 in the consultation)	
Care and Repair England	Section 3 Implementation - Help to overcome challenges for users and others (Question 2 in the consultation)	Page 16 line 24	A network would help too with implementation - for users a key challenge will be gaining the knowledge about and accessing bespoke or general services and facilities that enhance wellbeing. Age UK London is developing a project where older people are assessing information provision by local councils. Again this might be drawn upon for this guidance – see http://www.ageuk.org.uk/london/news--campaigns/tell-me/ We also suggest that the guidance should add a section on the importance of advice and information for older people and would draw your attention to the First Stop. First Stop Advice is an independent, impartial and free service for older people, their families and carers to help them get the help or care they need to live as independently and comfortably as possible. It operates a national advice line and works in partnership with local services and as well as offering advice and information provides a directory of services for older people across housing, care and support. http://www.firststopcareadvice.org.uk/	Thank you for this comment. • The Implementation section includes details on how to help older people take part in activities and covers use of community networks. It describes what local authorities, service providers and community organisations could consider in order to overcome these difficulties,": For example: training in use information and communication technologies; help to access existing concessions and facilities. Recommendation 1.3 includes *"Information on national or local services offering support and advice by telephone and other media."* This could include

Public Health Guidelines

OLDER PEOPLE: INDEPENDENCE AND MENTAL WELLBEING - Consultation on Draft Guideline
Stakeholder Comments Table

29 May – 10 July 2015

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				services such as First Stop Advice.
Care and Repair England	Section 4 Context	Page 18 line 16	Add health, **housing** and economic situation. There should be a section here on where people live including tenure and house condition and whether in ordinary housing, specialist housing or residential care. This can have an impact on independence and mental wellbeing as well as on access to activities and services	Thank you. This paragraph is no longer included in the guideline.
Care and Repair England	Section 5 Considerations (5.9)	Page 20 line 29	This should also include older people with dementia	Thank you. Dementia is out of scope for this guideline.
Care and Repair England	Section 5 Considerations (5.14)	Page 22 line 8	This should include a consideration of **housing practitioners** as well as those in health and care	Thank you. This paragraph is no longer included in the guideline.
Central and North West London NHS Foundation Trust	**Question 1 (Impact and Implementation Challenges)** - Sections 5,6,7,8		The biggest impact will be having a local co-ordinator (*5. Identify or appoint a local co-ordinator)* - Currently expressed as a "consider" in the guidance. We feel that it should be an action that *should* be taken (See 1. *Recommendation Wording*) - We think that this role will help map and track local current local services, promote the utilisation and resourcing of appropriate existing services, and identify gaps in service provision and any unmet needs of older people - For this role to fulfil its potential there needs to be adequate resources to promote recruitment and retention at an appropriate level of skill, with adequate supervision.	Thank you for this comment. Implementation: getting started (area 3) describes options for local coordination.

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			- The role needs to be embedded into local systems with appropriate governance and management structures.	
Central and North West London NHS Foundation Trust	**Question 2 (Overcoming Challenges, Good Practice)** - Sections 9, 10, 12,13		- There may be a lack of community resources to enable older people to access resources/services and make use of activities/recommended options - This may include transportation, sitting services to allow carers to attend activities, provision for staff/carers at activity venues to assist service users, language/cultural differences. - There is a need to identify areas of need regarding access and then target resources to enable access to activities. - Access to personalised budgets may facilitate this. - This guidance could be viewed as social/health wellbeing promotion, which will avoid having to access social care/secondary care services, thus potentially saving on costs in the long run	Thank you for this comment. Helping older people to access services and activities is covered within the guideline. The use of personalised budgets is covered in the Committee's discussion section.
Central and North West London NHS Foundation Trust	**Question 3n(Strength of Singing Recommendati on)** - Section 2		- We agree with the prominence given to the singing interventions given the strength of the current evidence. - However, the evidence base for social activities with a different focus, such as an art group, baking group, or gardening group appears to be limited. - The evidence may reflect the benefits of social/collaborative activity rather than of the specific activity itself. - We see the possibility of expanding the evidence base through further research of community groups with a different focus. - Example: 'Contact The Elderly' Sunday tea group http://www.contact-the-elderly.org.uk/	Thank you for this comment. Singing is still strongly recommended within recommendation 1.2.1. A range of other group activities are also included in recommendation 1.2.1 and 1.2.2.
Central and North West London NHS Foundation Trust	**Question 4 (Intervention to**		- Raising awareness of services through engaging with service users to develop methods by which direct feedback about experiences and	Thank you for this comment.

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	Raise Awareness) - Sections 14 & 15		outcomes can be compiled. Work has been undertaken in community mental health services to develop user defined Patient Reported Outcome Measures (PROMs) and Patient Reported Experience Measures (PREMs) E.g. Whelan, P., Andrews, T., Patel, S., & Lewis, A.(2010) *Taking the Cinderella speciality to the PROM: developing a patientrelated outcome measure for an older adult mental health service*, Quality in Ageing and Older Adults, 11: 4, 51 - 55 - Information from such PROM and PREM measures, developed in collaboration with service users to be specific to the activities/services being evaluated, could be used by commissioners and providers to help them understand which services people might be more or less helpful.	Raising awareness of services and engaging with older people to develop services and activities is described within the Implementation: getting started section of the guideline.
Central and North West London NHS Foundation Trust	**Question 5 (Audience for Recommendati ons)**		The focus of the guidance has a 'community feel' to it. We would see the guidance as being pertinent to those older people who are living with greater disability (be it cognitive, physical, or mental) or those who are more challenging to reach or that may be overlooked in the recommendations. We would keenly encourage the holding in mind and inclusion of: people from BME backgrounds; those for whom English is not their first language; those with advanced levels of cognitive change; and the carers of these groups when making recommendations. This may include those people who live in sheltered, residential, or nursing accommodation, for whom independence and well-being are equally as important and may, in some circumstances, be more challenging to maintain.	Thank you for this comment. The guideline is intended to be of relevance to all older people who live outside of care homes (people living in care homes are out of scope for this guideline). The lack of evidence for older people from BME backgrounds is included in the gaps in the evidence section.
Department of Health	General		Thank you for the opportunity to comment on the draft for the above Public Health guideline. **I wish to confirm that the Department of Health has no substantive comments to make, regarding this consultation.**	Thank you.

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HQT Diagnostics (www.hqt-diagnostics.com)	General	General	Poor mental wellbeing may have underlying physical & chemical reasons Before talking therapies and pharmaceutical drugs are used, physical tests should be done by GPs. It is better to make improvements in diet & lifestyle before offering prescription drugs. These should include tests for Fatty Acids Major improvements in mental health have been seen within 3 months of supplementing levels of Omega-3 Fatty Acids to achieve: • **Omega-3 Index >8%** • **Omega-6/3 Ratio <3:1** The Omega-3 Index is designed to provide a more reliable indicator of the level of specific Fatty Acids than any other method. This can be achieved by eating more oily fish or taking Fish Oil supplements The Omega-6/3 Ratio shows the level of Omega-6 compared to Omega-3 and is a good indicator of Inflammation. This can be improved by eating less Sunflower oil (64% of the oil is Omega-6), less Corn oil (52%) and less Soybean oil (51%) The HQT Diagnostics Fatty Acid Test shows an average of all Fatty Acids eaten over the previous 60-90 days	Thank you for this information.

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			Sources: www.expertomega3.com/omega-3-study.asp?id=38 www.hqt-diagnostics.com (See Demo Report) www.ncbi.nlm.nih.gov/pubmed/17194275?dopt=AbstractPlus http://omega3care.com/wp-content/uploads/2013/11/Omega-3LiteratureListJuly2013.pdf (59 references on Depression) http://omegametrix.eu/wasistomega3index.html?lang=EN	
HQT Diagnostics (www.hqt-diagnostics.com)	General	General	Poor mental wellbeing may have underlying physical & chemical reasons Before talking therapies and pharmaceutical drugs are used, physical tests should be done by GPs. It is better to make improvements in diet & lifestyle before prescribing prescription drugs. These should include tests for Vitamin D Major improvements in mental health have been seen within 3 months of supplementing levels of Vitamin D so that 25(OH)D is between 100-150 nmol/L **Sources:** www.vitamindwiki.com/Depression	Thank you for this information.

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HQT Diagnostics (www.hqt-diagnostics.com)	General	General	Many older people suffer falls and fractures that affects their independence and might be preventable Higher levels of Vitamin D help to build stronger bones and improve muscle strength, which both help to reduce falls and fractures. Suggest that GP tests and adjusts levels of Vitamin D so that 25(OH)D is between 100-150 nmol/L **Sources:** www.vitamindwiki.com/Overview+Fractures+and+Falls+and+Vitamin+D	Thank you for this information
Institute of Public Health – University of Cambridge (IPH), Public Health, Ageing and the Brain research group, including comments arising from discussion with members of our 'Public Involvement in Research into Ageing and Dementia	General		I'm aware older people have been mentioned to be part of partnership group but would emphasise point that all interventions and services should be designed together with older people from outset. Local populations/environments differ and communities may require different things to become more independent. Key to ensure effective and locally responsive implementation is strong engagement with older people as core members.	Thank you. Recommendation 1.1.2 states "*Involve older people in the design and delivery of activities.*"
Institute of Public Health – University of Cambridge (IPH), Public Health, Ageing and the Brain research group, including comments arising from discussion with members of our	General		This guidance needs to reach those at strategic level and responsible for major decision making, across age-bands. Reversing stigma, promoting age-friendly communities requires awareness at all levels and sectors involved across age-bands.	Thank you. The committee heard from Age friendly Manchester for context around this topic. Age friendly cities was out of scope for this guideline.

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'Public Involvement in Research into Ageing and Dementia				
Institute of Public Health – University of Cambridge (IPH), Public Health, Ageing and the Brain research group, including comments arising from discussion with members of our 'Public Involvement in Research into Ageing and Dementia	General		There is no mention in the guidance of the potential for pets/animals to maintain health and wellbeing in older people. While much of the evidence has been conducted in people with e.g. existing dementia there is some work in this area in people without cognitive decline. Much of this work is referenced in the report 'Companion animals and the health of older people' by the International Federation on Ageing,	Thank you. The lack of evidence regarding pets is included in the Committee's discussion section about recommendation 1.2. Dementia is out of scope for the guideline.
Institute of Public Health – University of Cambridge (IPH), Public Health, Ageing and the Brain research group, including comments arising from discussion with members of our 'Public Involvement in Research into Ageing and Dementia	General		The draft guidelines offer a welcome and much needed policy for local authorities to move forward in setting strategies designed to enhance the lives and to go some way to alleviate the isolation and related problems experienced by many older people often living alone, perhaps recently bereaved, and/or caring for someone with disabilities and/or dementia. The draft makes many suggestions all relevant in their own right, however achieving these aims even partially could involve a significant level of resources, time and finance. The concept of using a variety of agencies would be essential, however managing and co-ordinating those ideas and efforts could prove to be an interesting exercise especially given the current economic situation. The draft states that 'Local authorities should ***Consider*** appointing a local co-ordinator', the potential scale of the work involved strongly indicates that it	Thank you for this comment. Implementation: getting started (area 3) describes options for local coordination. The description includes advocacy for older people; examples from practice and consideration of commissioners to *" 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"*

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			would be very difficult to carry out those tasks effectively without one and perhaps the guidelines should reflect this fact a little more strongly and that it should be regarded as being advisable for a full time post maybe at County Council level. A small central committee made up of interested volunteers and representatives from local agencies, both voluntary and statutory, led by the co-ordinator could then provide the main focal point and central driving force perhaps in turn assisted by local town and village sub committees who would feed in the information, ideas and suggestions and receive advice and guidance necessary to take this plan forward effectively. Many of the activities and involvement of some local organisations such as schools for example would suggest the need for formal information in the areas of Insurance, risk assessment and even CRB checks to name but a few. The central co-ordinating committee would have a central role in this area. It is to be hoped that the Policy and Guidelines are put into practice as soon as possible.	*Use of a local coordinators knowledge is also outlined in* Area 2: local assets and needs assessment of the Implementation section.
Institute of Public Health – University of Cambridge (IPH), Public Health, Ageing and the Brain research group, including comments arising from discussion with members of our 'Public Involvement in Research into Ageing and Dementia	General		As I stated at the meeting there are a lot of really good suggestions but my major worry is that there is not enough money within Local Authorities or Health Commissioning Groups to be able to fund them. I think it would be a shame to raise expectations in the older population that they would be able to access a myriad of interesting services/projects when in reality there is no funding to deliver it.	Thank you for this comment. The limitations in funding are acknowledged the Committee's discussion section.

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Institute of Public Health – University of Cambridge (IPH), Public Health, Ageing and the Brain research group, including comments arising from discussion with members of our 'Public Involvement in Research into Ageing and Dementia	'Questions to consider in the consultation – Question 4'	Consultation webpage	Question: 'Can stakeholders identify evidence for approaches or interventions that are effective in raising awareness of the importance of maintaining and improving older people's independence and mental wellbeing among commissioners, service managers, health and social care practitioners, community workers and the voluntary sector?' Relating to this query: Joseph Rowntree Foundation Report 'Information, advice and advocacy for older people: Defining and developing services, 2005. Author: Andrew Dunning' - includes some consideration of this with some examples of projects.	Thank you for this information.
Institute of Public Health – University of Cambridge (IPH), Public Health, Ageing and the Brain research group, including comments arising from discussion with members of our 'Public Involvement in Research into Ageing and Dementia	'Questions to consider in the consultation – Question 4'	Consultation webpage	Also relating to the same query above, the James Lind Alliance (JLA) Dementia Priority Setting Partnership aimed to involve people with dementia, carers, service users , clinicians and other health and social care professionals in an extensive process to identify research questions and prioritise and disseminate the questions to commissioners, service managers, health and social care practitioners and other stakeholders relating to dementia. The top prioritised question related to maintaining independence in people with dementia. The questions were checked against existing high quality systematic review literature. The JLA is now part of NIHR so this approach has contributed to highlighting the importance of maintaining independence. More information is available at: http://www.alzheimers.org.uk/site/scripts/download_info.php?fileID=2226	Thank you for this comment. Dementia is out of scope for this guideline.
Institute of Public Health – University of Cambridge (IPH),	2	14	The guideline is predominantly for people who are/come into contact with older people. Clearly this should be the focus however, marginalisation and	Thank you. This section is no longer included in the guideline.

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Public Health, Ageing and the Brain research group, including comments arising from discussion with members of our 'Public Involvement in Research into Ageing and Dementia			stigmatisation have major impacts on the wellbeing of older people. By starting off the "who should take action section" with older people, carers etc and finishing off with "may be of interest to other members of the public" the guidance in a sense follows suit and removes older people and the concerns of older people from the rest of society. If older people are to remain core members of their communities, independent and well, then this guidance should be for all and across communities – particularly if transgenerational interventions and increased engagement with communities is advocated for. This point should be emphasised if we are to really promote independence for older people within societies and communities.	
Institute of Public Health – University of Cambridge (IPH), Public Health, Ageing and the Brain research group, including comments arising from discussion with members of our 'Public Involvement in Research into Ageing and Dementia	2	15	Who should do what – consider including schools as optimum setting to encourage awareness, reduce stigma, promote transgenerational activities/volunteering and promote key messages e.g. dementia friends training sessions in schools	Thank you. This section is no longer included in the guideline.
Institute of Public Health – University of Cambridge (IPH), Public Health, Ageing and the Brain research group, including comments arising from discussion with members of our 'Public Involvement in Research into Ageing and Dementia	2	15	Local authorities – include district and parish councils who provide specific services relevant to independence of older people e.g. safe at home services (lifeline), community development and are locally responsive and aware of local needs.	Thank you. This section is no longer included in the guideline.

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Institute of Public Health – University of Cambridge (IPH), Public Health, Ageing and the Brain research group, including comments arising from discussion with members of our 'Public Involvement in Research into Ageing and Dementia	3	16	Which areas will have the biggest impact on practice and be challenging to implement? Please say for whom and why. 1) Identification of those at higher risk – numbers, resources, lack of awareness of who may be at higher risk, limitations of data and criteria to identify those. Must then also ensure services are available to meet these needs. 2) Engaging with harder to reach communities 3) Advocating for needs of older people in sectors where this is not the immediate priority (lack of awareness) and resources are already strained. 4) Implementing focus (and directing more resources) on preventive approaches, eg promotion of independence, while emphasis across many health and care organisations still on reducing hospital admissions/admissions to care and complex treatment of frail patients. Preventive culture and therefore change in current culture of medicalisation and treatment needs to be achieved and embedded across sectors and organisations.	Thank you for this information.
Institute of Public Health – University of Cambridge (IPH), Public Health, Ageing and the Brain research group, including comments arising from discussion with members of our 'Public Involvement in Research into Ageing and Dementia	3	16	What would help users overcome any challenges? (For example, existing practical resources or national initiatives, or examples of good practice.) 1) Evidence of effectiveness and cost-savings. I am aware evidence is lacking regarding health economics but an argument for the benefits/financial case/implications of promoting these interventions and approaches is necessary to galvanise action in cash-strapped and strained authorities. 2) Joined-up working and partnership working including budgets across health and social care as well as other sectors eg fire, transport and housing. Evaluation of partnership would incentivise this. 3) Innovation around service provision. Services need to be designed more widely (and move away from silo practice) across organisations and	Thank you for this information.

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			conventions broken to respond to needs of older people (greater optimisation of existing assets) eg fire service checking homes for falls hazards may be preferable to social worker entering home. Fire service skilled at assessing need and perform fire hazard checks – why not take on health and care function (and less stigmatised)?	
Institute of Public Health – University of Cambridge (IPH), Public Health, Ageing and the Brain research group, including comments arising from discussion with members of our 'Public Involvement in Research into Ageing and Dementia	4	17	Context - The UK population is ageing. This is correct however: 1) Ageing is actually a celebration & success that people are actually living longer – thanks to better health, diet, education & access to care etc 2) By branding ageing & older people as a "crisis" we are modifying (negatively) the way the people perceive & respond to older people, increasing the stigma that is already linked to this group & working against the changes we are trying to encourage through establishing dementia and age friendly communities. Would advise careful introduction to avoid labelling older people and ageing negatively thus advocate promoting what ageing really is and the key role older people have in communities with wisdom and skills they bring.	Thank you. This section of the guideline has been updated. This section is intended to only provide a brief background summary on the number of older people in the UK and the possible impact of age related conditions, loneliness and social isolation. It is not intended to provide a discussion on ageing in general.
Institute of Public Health – University of Cambridge (IPH), Public Health, Ageing and the Brain research group, including comments arising from discussion with members of our 'Public Involvement in Research into Ageing and Dementia	4	17	Health inequalities is not mentioned. Age has begun to function as an inequality (stigma and isolation) as well as poorer ease of access and use of technology. In addition, socio-economic factors compound this in older people. Would suggest this is emphasised more strongly as commissioners need to be aware when targeting services.	Thank you. Implementation: getting started (Area 2: local assets and needs assessment) describes local assets and needs assessment that "*notes any health inequalities*" within the needs and assets assessment. Concerns about widening health inequalities is discussed in the Committee's discussion section.

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Institute of Public Health – University of Cambridge (IPH), Public Health, Ageing and the Brain research group, including comments arising from discussion with members of our 'Public Involvement in Research into Ageing and Dementia	5.10	21	Suggestion that online repository of information available cannot be sole solution – evidence indicates only a third of older people access and attempt to use internet. For time being online plus other modes needed.	Thank you. The party of the Committee's discussion explains why an online repository has not been recommended (due to lack of evidence specifically on an online repository).
Mental Health Foundation	General		Which areas will be challenging to implement and why? Given the financial difficulties that Local Authorities are facing, we have serious concerns about their ability to implement recommendations 2, 3, 4 and 12 if there is insufficient provision in their areas and they have to commission services or if they have to support community organisations to develop or maintain programmes. Financial constraints faced by Local Authorities in England on the delivery of social care are very well documented. For instance, the Local Government Association annual report on Adult Social Care Funding (2014)i noted that "health and social care services are under extreme pressure and facing financial crisis". According to the report: Local government has faced unprecedented cuts over the last four years that have impacted dramatically on adult social care and its capacity to deliver.	Thank you for this information. Funding limitations are acknowledged in the Committee's discussion section.
Mental Health Foundation	General		Social prescribing.	Thank you.

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			We believe that primary care providers, such as GPs and nurses, could play a more active role in helping older people to maintain good mental health through "Social prescribing". Social prescribing provides an opportunity to respond effectively, and at an early stage, to symptoms of mental distress in older people, as well as to initiate a more proactive approach to mental health promotion.ii We encourage NICE to include a recommendation for the NHS to consider equipping GPs, nurses and other primary health practitioners across England to offer 'social prescribing' –linking people to activities in their local area.	The possibility of using social prescribing is covered in the Committee's discussion section and an example is presented in the Implementation: getting started section of the guideline.
Mental Health Foundation	General		Mental Health Inequalities We note that the guidelines are failing to recognise the importance of mental health determinants –social and economic conditions that put people at greater risk of developing a mental health problem. Central to prevention focused interventions for older people must be the understanding of the wider determinants of mental health. Mental health impacts negatively on health status overall and those with health conditions and disabilities are not only concentrated in higher numbers within areas of deprivation but are also disproportionately affected by mental health problems.iii The bi-lineal relationship between a person's internal world – their emotions and cognitions and the context in which they live their lives means that having a mental health problem can be both a consequence and a cause of socio-economic inequalities. Mental health problems aren't evenly distributed across society. Poverty, poor housing, lower levels of education, poor nutrition and/ or experiencing discrimination places older people at heightened risk of developing a mental health problem.iv	Thank you for this comment. The guideline includes a recommendation on identifying those most of risk of a decline in their independence and mental wellbeing (recommendation 1.5) and the list of life events or circumstances to be used to help identify people is evidence based and covers people who "*have recently experienced or developed a health problem".* This includes mental health problems.

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			We also note that people's gender, ethnicity, sexual orientation and disability are also determinants of mental health and should be taken into consideration by wellbeing boards, community services, service commissioners and providers.	
Mental Health Foundation	General		Integration of physical and mental health We note that the guidelines are failing to recognise that mental health is often a mediating factor in health outcomes. Indeed, poor mental health can make self-management, compliance with treatment, or adopting a healthy behaviour more challenging. The guidelines are also failing to recognise the link between mental and physical health. Consequently, the physical needs of older people, as well as the importance of physical activity to maintain good mental health, are not being addressed. In order to achieve parity of esteem between physical and mental health the guidelines need to encourage its target audience -, Clinical Commissioning Groups, primary care practitioners, managers, - to strengthen the links between physical and mental health, with the aim of benefitting older people by providing more integrated services that can address the twin impacts of mental and physical health issues.	Thank you. Please see the previous comment which would cover people who have recently developed a mental of physical health problem.
Mental Health Foundation	General		**Care homes** It is with great concern that we note the failure of the guidance to mention mental health services in care homes. Care home residents are often very old, with little or no social support networks and many have multiple physical and mental health needs, meaning that their care poses particular challenges. They are also a distinctly and profoundly marginalised group who are often	Thank you. Older people living in care homes are out of scope for this guideline.

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			invisible in the wider debates on quality of care including those about care homes.	
Mental Health Foundation	Section 0.27	2	**Definitions. Age.** We welcome the application of the guidelines to people age 55 and 64. But we would like to encourage NICE to expand the definition of older age. The Royal College of Psychiatrists has suggested the use of a needs based criteria to identify which people the interventions provided for older people's mental health services would be most relevant.v According to a needs-based criteria, and following good practice, the guidelines should also cover people of any age: with a diagnosis of primary dementia with psychological or social difficulties related to the ageing process, or end of life issues, or who feel their needs may be best met by a service for older people	Thank you. Dementia is out of scope for the guideline. The term 'prematurely older people' has been removed from the guideline.
Mental Health Foundation	Section 1.17	4	Promote and maximise opportunities for co-production. The Care and Support Statutory Guidance Issued under the Care Act 2014vi notes that "Local authorities should, where possible, actively promote participation in providing interventions that are co-produced with people, families, friends, carers and the community." Moreover, we know that co-production contributes to developing individual resilience and help promote self-reliance and independence, as well as ensuring that interventions reflect what the people who use them want. To support older people to maintain their mental wellbeing, we recommend that in accordance with the statutory guidance, NICE encourages Local Authorities to maximise opportunities for co-production in all interventions.	Thank you. . Recommendation 1.1.2 states *"Involve older people in the design and delivery of activities"* The Implementation: getting started section describes service providers could *"Ask older people what they think about the service or activity".* The implementation section - Area 4: getting older people involved in activities provides an

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			We have concerns regarding this point, because at the moment the NICE's guidance only references co- production in the evaluation of the programmes (Section 15.28 page 13), and it only mentions older people –and fails to ensure that families, friends, carers and the community are involved. We therefore suggest including co-production as one of the principles of good practice.	overview ways that older people can be involved in activities. Older people are also included in the list of partnership members.
Mental Health Foundation	Section 1. 17	4	**Interventions: principles of good practice** We note that the wellbeing principle as stablished in the Care Act 2014 has not been mentioned as a principle of good practice. Clause 1(1) of the Care Act establishes the promotion of the individual's wellbeing as the touchstone for the local authority in exercising any of its functions under Part 1 of the Act. The functions covered include: prevention of needs for care and support provision of information and advice services assessment of people's care and support needs, and the support needs of carers duties and powers to meet needs of individuals and carers care and support plans, personal budgets and direct payments ensuring continuity of care and support when people move safeguarding adults from abuse or neglect arrangement of independent advocacy to support user participation Moreover, the Law Commission Review of adult social care law identified a set of key principles on which all practice and service provision should be based. It proposed "The well-being of the individual" to be the over-arching principle and listed, in what is now the third section of Clause 1, the remainder of the key principles to be embodied in practice.	Thank you. The Care Act 2014 is specified in the implementation section. The activities outlined in Area 3: local coordination represents an example of how local authorities can meet their responsibilities under the Act. Recommendation 1.1.1 states *"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*

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			We therefore suggest including the wellbeing principle as one of the principles of good practice	*of a decline in their independence and mental wellbeing (see section 1.5)..”* The wellbeing of the individual is implicit within this recommendation.
Mental Health Foundation	Section 2.2	5	**Promote and maximise opportunities for co-production.** **See above** **We therefore recommend that co-production is encouraged in the development/implementation/evaluation of group-based activities.**	Thank you. Please see the previous response on this point.
Mental Health Foundation	Section 2.8	5	**Interventions: Provide a range of group-based activities.** **Peer support groups.** As the guidance recognises, loneliness and isolation are found to be linked to poor physical and mental health in older age including cognitive decline and the onset of dementia.x Creating emotional and social connections later in life is a key to maintaining good mental health. In practical terms, this means making and maintaining meaningful relationships with family, the community and the people who are providing care and support services. A review of evidence undertaken by the Mental Health Foundation on peer support for older people found that it enhances empathy and showed that it provides a safe and understanding environment for people who are going through difficult times. Moreover, peer support is a cost-effective tool that addresses social isolation.xi	Thank you. The Committee did not hear any specific evidence on peer support groups and there is no specific reference given in this comment. All services and activities included in recommendation 1.2 have a supporting evidence base.

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			We therefore recommend that peer support groups are included as one of a range of group-based activities that Local Authorities should promote and/or commission.	
Mental Health Foundation	Section 8	9	Publicise services and activities. Has the right audience being identified? We believe that primary health providers could also be asked to consider publicising services and activities for older people offered in their area. Promoting a service in the local surgery is a common and effective tactic for raising public awareness.	Thank you. Recommendation 1.5.4 Ensure staff in contact with older people give those most at risk information on activities that might help them (see sections 1.2–1.4).
Mental Health Foundation	Section 9.6	10	**Raising awareness of life events or circumstances that increase the risk of a decline in older people independence and mental wellbeing.** We recommend that factors found to increase older people's risk of experiencing loneliness and isolation be included in the list. Creating emotional and social connections later in life is a key to maintain a good mental health. Indeed, loneliness and isolation are found to be linked to poor physical and mental health in old age including cognitive decline and dementia. xii Factors that have been found to increase older people's risk of experiencing loneliness and isolation include: Being childless Having moved to a residential home Poor physical health –including long-term conditions- Have a mental health problem	Thank you. The expert testimony indicated uncertainty about the impact of childlessness and therefore it is not included in the list for recommendation 1.5. Further research is required in this area. People living in residential care homes are out of scope for this guideline. People in poor physical health and those with a mental health problem would be covered by

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			Becoming dependent on care or houseboundxiii	the item in the list *"have recently experienced or developed a health problem (whether or not it led to admission to hospital)."* The Committee did not hear evidence on becoming dependent on care or housebound. However, people who "*have recently experienced or developed a health problem"* or *"people with an age related disability"* would include these group.
Mental Health Foundation	Section 13.19	12	**Has the right audience being identified?** Primary health practitioners could also consider providing information about services and activities (see social prescribing comment above)	Thank you. Please see the previous response to this point.
Mental Health Foundation	Section 15. 28	13	**Promote and maximise opportunities for co-production.** **See above.** **We therefore recommend that co-production is encouraged at all stages of the intervention –from the development to the evaluation.** **We recommend that other people who might have an interest –such as family members, friends and carers- are also involved in the evaluation**	Thank you. Please see the previous response to this point.

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			of the programmes, and not just older people.	
Mental Health Foundation			i Local Government Association. (2015). Adult social care funding: 2014 state of the nation report. Available at: http://www.local.gov.uk/documents/10180/5854661/Adult+social+care+funding+2014+state+of+the+nation+report/e32866fa-d512-4e77-9961-8861d2d93238 ii Care Services Parnership. (2011). Social prescribing for mental health – a guide to commissioning and delivery http://www.centreforwelfarereform.org/uploads/attachment/339/social-prescribing-for-mental-health.pdf iii *The Spirit Level: Why Equality is Better for Everyone* Wilkinson and Pickett iv Friedli, L (2009) *Resilience and Inequalities* [Online]. WHO, Europe. Available at http://www.euro.who.int/__data/assets/pdf_file/0012/100821/E92227.pdf v Royal College of Psychiatrists. (forthcoming) Needs-based criteria for older people's mental health services. http://www.jcpmh.info/wp-content/uploads/jcpmh-olderpeople-guide.pdf vi Care and Support Statutory Guidance Issued under the Care Act 2014. https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/315993/Care-Act-Guidance.pdf vii Mental Health Foundation (2011) An Evidence Review of the Impact of Participatory Arts on Older People. http://www.mentalhealth.org.uk/content/assets/PDF/publications/evidence-review-participatory-arts.pdf?view=Standard viii Pinquart, M, Forstmeier, S, (2012) Effects of reminiscence interventions on psychosocial outcomes: A meta-analysis, Ageing and Mental Health, Volume 16, Issue 5, 2012 ix Mental Health Foundation, (forthcoming), Policy Briefing older people.	Thank you for this information.

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			x Mental Health Foundation (2010) The Lonely Society xi Mental Health Foundation (2012). Exploring Peer Support as an Approach to Supporting Self Management. http://www.mentalhealth.org.uk/content/assets/PDF/publications/exploring_peer_support.pdf?view=Standard xii Mental Health Foundation (2010) The Lonely Society xiii Age UK (2011) Loneliness and Isolation Evidence Review. http://www.ageuk.org.uk/documents/en-gb/for-professionals/evidence_review_loneliness_and_isolation.pdf?dtrk=true	
National Community Hearing Association	General		The *Five Year Forward View* makes clear that the NHS must take preventative and public health more seriously. We feel this NICE guideline will help the NHS achieve these goals. In our response below we make recommendations that, in our view, will improve the guideline and make it more consistent with the Health and Social Care Act 2012, Equality Act 2010, other NICE guidelines and advice from the World Health Organisation and NHS England.	Thank you for this comment.
National Community Hearing Association	General - Response to the questions *"are there any reasons why any of the recommendations in the guideline may*		**Summary** Yes, some recommendations – e.g. singing programmes – might increase inequality in opportunity for people with unsupported hearing loss. Older peoples' hearing needs are intrinsically linked to the guideline's aims and recommendations. The guideline can be improved by making the hearing needs of this population more explicit; this is likely to promote equality of opportunity relating to age and disability.	Thank you. The Committee recognises that hearing loss can have a major impact on the independence and mental wellbeing of older people. The guideline now specifies '*people with an age related disability'* (the definition of which includes hearing loss – please

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	result in an increase in inequality of opportunity relating to age, disability?" and *"Do you think this guideline could be improved to better promote equality of opportunity relating to age, disability?*		**Detail and Evidence** This guideline is for people aged 65 and over. In this cohort • age-related hearing loss is a major public health challenge[i] • 60-80% of people have a hearing impairment[ii] • hearing loss is the 6th leading cause of years lived with disability in England[iii]. Good hearing and support for hearing loss are intrinsically linked to the guideline's aims and recommendations: 1. the guideline aims to help older people ➢ maintain their mental wellbeing (p.1) ➢ remain independent (p.1) ➢ avoid health conditions linked to social isolation, depression and other conditions linked to poor mental wellbeing (p.1) ➢ build strong and positive relationships with others (p.2) 2. the guideline recommendations include ➢ provide opportunities to socialise (p.4) ➢ support and promote singing programmes (p.5) ➢ listening, support and advice from a telephone 'helpline' (p.6) ➢ fire safety checks on adaptations (p.7) ➢ identify anything that stops older people participating in local activities (such as… low self-confidence) (p.9). 3. Unsupported age-related hearing loss can have a significant impact on	see the glossary) in recommendations 1.1 and 1.5. Information on hearing loss in older people is also included in the context section of the guideline. Please note that people living in care homes are outside the scope of this guideline.

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			independence and mental wellbeing ➢ unsupported adult hearing loss increases the risk of depression[iv], social isolation[v], loneliness[vi], cognitive decline[vii], early retirement[viii] and reduced quality of life[ix] (the very issues this guideline aims to tackle) ➢ people with unsupported hearing loss and dementia or mental health problems are more likely to go straight to expensive care packages[x]. It is important that NICE guidelines support improvements in opportunity for people with age-related hearing loss. For too long this public health challenge has been ignored on the ground (e.g. in NICE guidelines and recommendations to commissioners), despite clear support at a national level – e.g. ➢ the World Health Organisation – in its active ageing strategy - highlights the importance of hearing care[xi] ➢ NHS England has recognised unsupported hearing loss as 1 of 11 risk factors associated with functional decline in older people[xii] and recommended older people to have their hearing tested without delay[xiii] ➢ a systematic review (and other evidence) has shown that hearing intervention and ongoing support can improve quality of life by reducing the psychological and social effects associated with age-related hearing loss[xiv] ➢ Monitor, the sector regulator, has noted that early intervention might also reduce pressure on health and social services[xv] ➢ yet an estimated 3.8 million older people in England have unmet hearing needs[xvi].	

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			In our view unless the hearing needs of this population are met, the aims and many of the recommendations specified in this guideline will be difficult to achieve. Inaction might also increase inequality in opportunity for those with unsupported hearing loss.– e.g. people with unsupported hearing loss might not feel confident enough to engage in singing programmes (p.5) but with intervention and support for their hearing loss they too might benefit from the same opportunities as their peers. We think, given the high prevalence and impact of age-related hearing loss, that this guideline should repeat the importance of hearing tests specified in the NICE guideline on mental wellbeing in people living in care homes[xvii] and encourage readers to support older people with their hearing needs.	
National Community Hearing Association	5	6	We agree that it is important to *"[i]dentify older people who are at greater risk of decline in their independence and mental wellbeing"* (line 16). Given the prevalence of hearing (and sight) loss in this population, we feel it is important that stakeholders in charge of implementing this guideline are aware of the healthy ageing guide (for people aged 70 and over) published by NHS England in 2015[xviii]. The guidance highlights 11 risk factors associated with functional decline in older age, unsupported hearing and sight loss are both noted[xix].	Thank you. This is now recommendation 1.5 and includes people who have an age related disability in the list of people at risk.
National Community Hearing Association	6	7	We support the call for Health and Wellbeing Boards (HWBs) to *"make older people's independence and mental wellbeing a core component of both the*	Thank you.

Public Health Guidelines

OLDER PEOPLE: INDEPENDENCE AND MENTAL WELLBEING - Consultation on Draft Guideline
Stakeholder Comments Table

29 May – 10 July 2015

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			join strategic needs assessment and health and wellbeing strategy". NHS England and the Department of Health, in their Action Plan on Hearing Loss (March 2015), also noted: • *"that by 2032, there will be around 620,000 older people living in care homes in England and of these, **almost 500,000 will have a hearing loss and will need support to maximise their independence and wellbeing**. …Overall, the personal, societal and economic costs of hearing loss will continue to rise as the incidence and prevalence of hearing loss increases with an ageing population"*[xx] and that • HWBs *"should ensure that hearing is included as part of the process to develop local health needs assessments, Joint Strategic Needs Assessments (JSNAs) and Joint Health and Wellbeing Strategies (JHWSs) either as part of sensory impairment or separately"*[xxi]. Unfortunately, hearing loss – a long-term rather than an acute condition - remains a low priority for the NHS and is not always included in local JSNAs or JHWSs, despite its impact on our ageing population (as noted above). We feel this and other NICE guidelines can help raise awareness of age-related hearing loss and support people to age well and maintain their independence.	The Implementation: getting started section suggest that 'A good understanding of local facilities and skills ('assets') and local needs will ensure services and activities are well targeted and any gaps in provision are addressed.' The section suggests local assets and needs assessment uses data on the number of older people with an age related disability.
National Community Hearing Association	7	9	We are pleased to see this guideline advise local authorities to consider *"identify[ing] anything that stops older people participating in local activities (such as… low self-confidence)".* The evidence provided above makes clear that unsupported hearing loss can	Thank you. The Implementation: getting started section (area 4: getting people involved in activities) describes local authorities,

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			act as a barrier to participating in activities. We feel, given its high prevalence and burden of disease, age-related hearing loss should specifically be mentioned in this section. E.g. *"identify[ing] anything that stops older people participating in local activities (such as…unsupported age-related hearing loss and low self-confidence)"*.	service providers and community organisations considering "developing a plan to overcome the barriers to getting involved. This could include: Providing help and advocacy for people with specific needs. For example: carers; people with mental health problems; people who have difficulties seeing or hearing; and people who have problems with their flexibility, balance or mobility.""
National Community Hearing Association	8	9	We welcome the guideline recommending that *"Services providers that help to maintain and improve older people's independence and mental wellbeing should consider: Publicising the services and activities on offer*" (p.9). It is however important to note that this requires support from leaders in the NHS (including NICE) and a significant change in culture. For example • the UK National Screening Committee accepts that age-related hearing loss is a major public health issue and that people can delay accessing support because of a lack of awareness[xxii] • the Department of Health encouraged providers of adult hearing services to publicise their service in 2012[xxiii] • in 2015 NHS England, as part of its healthy ageing campaign,	Thank you for this information. This guideline supports older people with an age related disability to access services and activities to maintain and improve their independence and mental wellbeing.

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			recommended people access free NHS hearing tests without delay[xxiv]. However when providers have followed this advice local commissioners and GPs have complained[xxv]. In our view this is because many NHS commissioners and GPs do not take prevention or public health as seriously as NHS England wishes and, as the Department of Health noted in 2007, still consider age-related hearing loss to be a low priority[xxvi]. The challenge is for all commissioners and GPs to understand (and then support the fact) that age-related hearing loss is a public health challenge and that tackling it is key to supporting active ageing – i.e. ensuring independence and mental wellbeing. Commissioners and GPs that block awareness campaigns solely to manage demand – e.g. without regard to cost-effectiveness – are at risk of exacerbating health inequalities as those that can afford to pay and/or have support from friends and family, are more likely to access care than people living alone and/or on lower incomes. The NHS and local authorities need to improve equality in access and empower older people with good information so that they can make informed choices, not withhold information to supress demand. Today, older people with sight care needs can access sight care on demand, however they cannot access NHS hearing service in the same way, despite hearing care being lower risk than sight care. These implicit rationing strategies inhibit supporting people to age well, act as	

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			a barrier to implementing this guideline and are likely to lead to perverse outcomes – e.g. NHS England advising people aged 70 and over to get a NHS hearing test without delay[xxvii] and local commissioners, who are accountable to NHS England, cutting hearing services in the same year despite the ageing population.	
National Community Hearing Association	8	9	We agree that it is important to ensure messaging does not act as a barrier to access. For example people might delay accessing NHS hearing care because hearing loss is associated with ageing[xxviii]. Using images of older and/or frail people might reinforce this message. This is why providers should be acknowledged for positive campaigns that encourage people to access cost-effective services, not punished by local commissioners – e.g. Monitor found that increasing choice of provider had improved access, standards, value for money and met unmet need, but because advertising had helped address unmet need commissioners had complained about growth in total costs and advertising services[xxix]. As noted above, to support older people age well the NHS needs to change. More can be done to support older people access the services that they will benefit from, but implicit barriers to innovation (e.g. threats of losing contracts because of successful messaging campaigns overcome the stigma associated with hearing tests) must be challenged. Commissioners should focus on measuring cost and quality of services and securing the best value and outcomes for their population, not focusing all their effort on rationing services at all costs as many are currently doing for	Thank you for this comment. The Implementation: getting started section describes local authorities, service providers and community organisations could *“Think about the images used to publicise services and activities. Check whether they are representative of the people the service is trying to reach, or whether they reinforce stereotypes or risk excluding some older people.”* It highlights examples from LinkAge Plus. Evaluation of services and activities is covered in the Area 6: evaluating effectiveness of the Implementation section.

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			age-related hearing services. Unless NICE and NHS England support promoting preventive and public health services this guideline is unlikely to be implemented successfully.	
National Community Hearing Association	9	10	Given the evidence above, we feel that hearing loss should be included in the risk factors listed after line 8. This would also be consistent with • page 17 line 15 • the economic paper that supports the guideline that notes *"People who are lonely report higher dissatisfaction with life compared with the not lonely group (15% vs. 3% respectively). People who are lonely also report increased needs of personal care and lower self-reported health. People considered lonely also say that poor hearing, poor sight and poor mobility affects things they would like to do compared with the not lonely group"*[xxx] and • NHS England noting hearing loss is 1 of 11 risk factors associated with functional decline in older people[xxxi] and recommended older people to have their hearing tested without delay[xxxii].	Thank you. This is now recommendation 1.5 and the list of risk factors includes people with an age related disability.
National Community Hearing Association	15	13	We agree that commissioners and providers should use validated measures to evaluate services. It would however be useful for experts at NICE to list tools that are already validated and recommend that commissioners and providers use the same tool(s) to allow services to be benchmarked.	Thanks you. Evaluation is now described in Area 6: evaluating effectiveness of the Implementation section and describes a list of approaches to aid evaluation. This has included Careful consideration by Committee of practicalities of

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				implementing evaluation by smaller services.
National Community Hearing Association	15	13	We agree that it is important to ask older people what encourages them to access available help (lines 10-19). Commissioners should be reminded that they must then listen to feedback and act upon it, in accordance with their public duties under the Health and Social Care Act 2012. For example we have known since the 1980s that people with age-related hearing loss want services closer to home and that the hospital environment can create mental barriers to accessing non-medical hearing care[xxxiii] (which is what 90% of people with hearing loss need[xxxiv]). Yet non-medical NHS adult hearing services remain predominately hospital based[xxxv] - e.g. hospitals reported over 1.1 million hearing aid repairs in 2014/15 meaning that patients with an average age of 70 and over have to travel to hospitals to have hearing aid repairs. Status quo bias means that change is slow and despite evidence that community based hearing services can improve standards, transparency and value for money – 20-25% cheaper per patient[xxxvi] - and that these services have a 98% patient satisfaction rate[xxxvii], many commissioners overlook cost-effective services and accessibility for older people in favour of reducing their own workload[xxxviii]. Currently this goes unchallenged and new NICE guidelines alone, unless supported by NHS England, are unlikely to achieve positive outcomes for our ageing population.	Thank you for this comment.
National Community Hearing Association	Avoiding Adverse Effects	23	We agree with the Committee that without enough choice - and if people are not given the opportunity to say what they would like to do – people could be at greater risk of reduced mental wellbeing. This is especially true in long-term	Thank you for this comment. NICE is unable to make a

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			conditions where co-management is shown to improve outcomes. People aged 65 and over, other things being equal, should have the same rights to choices as people aged 64 and under. Unfortunately, it is too easy to ignore this right – e.g. recent research has shown people aged 80 and over are less likely to be offered a choice of NHS hearing care provider based on assumptions about their preferences[xxxix]. We feel this guideline could go further in supporting older people by informing readers that age is a protected characteristic in the Equality Act 2010 and older people have the same rights to choices, other things being equal, as people aged 64 and under.	recommendation on adhering to the Equalities Act as this is mandatory for all public and private services or organisations and outside the remit of NICE.
Digital Assessment Service, NHS Choices	General		We welcome the guidance and have no comments as part of the consultation	Thank you.
NHS England	General		Thank you for the opportunity to comment on the above Clinical Guideline. I wish to confirm that NHS England has no substantive comments to make regarding this consultation.	Thank you.
Older People's Advocacy Alliance	Lines 29 – 30	6	It is really positive that the guideline makes reference to offering older people advocacy support so they can say what services they need to support their independence and mental wellbeing and the definition of advocacy is one OPAAL supports. However, by making this the responsibility of the care co-ordinator there is a risk that other professionals may think it is not their job to refer to Independent Advocacy. This is one role the care co-ordinator could take responsibility for but OPAAL recommends that independent advocacy be listed as one of the one-to-one interventions the local authority should offer (under recommendation 4).	Thank you. Advocacy is included in across the Implementation: getting started section, including Area 3: local coordination and Area 4: getting older people involved in activities.

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Older People's Advocacy Alliance	10		Advocacy support should also be referenced under section 10 as a support mechanism to support older people to be involved in their local communities, and to support their participation	Thank you. Please see the previous comment.
Older People's Advocacy Alliance	General		The role of independent advocacy should take a much greater precedence in this guideline – this guideline is about maintaining and improving the independence and mental wellbeing of older people and Independent Advocacy is of vital importance in this, indeed independent advocacy could be referenced as having a supporting role in all of the guideline recommendations. Advocacy is a free service that provides a voice for the voiceless, for those people who, for whatever reason are unable to speak up for themselves. Older people are often rendered vulnerable through circumstances beyond their control, bereavement and loss, illness, onset of chronic conditions, hospitalisation, or simply the frailty of old age. Independent Advocacy supports older people to get their voice heard regardless of the concerns and influence of others. These others could be service providers, family members or professionals. Older people tell us this independence is highly valued in planning for their future care and support, and in maintaining their personal independence. Our report Every Step Of the Way references the emotional and social support advocacy can offer (http://www.opaal.org.uk/Libraries/Local/1013/Docs/Resources/Advocacy%20Stories.pdf)	Thank you. Advocacy is included in across the Implementation: getting started section, including Area 3: local coordination and Area 4: getting older people involved in activities. Committee also agreed the principles of good practice (1.1) that give the necessary prominence to involving older people in the design of services and that services are inclusive. Advocacy could be a means of supporting good practice.

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OPENspace research centre	General		It is disappointing that interventions involving enabling access to outdoor environments, especially gardens, parks, woodland walks, etc., whether for passive enjoyment or active engagement (e.g. tending plants), are not included in this guidance. There is considerable evidence that access to 'nature', and the outdoors, is beneficial in many ways for mental wellbeing, including that of older people. It is a missed opportunity.	Thank you. Recommendation 1.2.1 includes *and refers to "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)."* This could cover the types of activities listed in this comment.
Optical Confederation and College of Optometrists	5 - Identify or appoint a local coordinator	6, 15-30	Although we fully support the actions recommended in this section of the guideline, we are concerned that tasking a well-situated individual to proactively engage with those most at risk is only a recommendation to be 'considered'. Without this dedicated support, it is very likely that disabled and other seldom heard groups may not be reached.	Thank you. The Implementation: getting started section (Area 3: local coordination) provides an overview of the aims of local level coordination. It also suggests "Local authorities could consider incorporating this work into existing posts" Committee's discussion is described within the guideline.
Optical Confederation and	7 - Carry out a		We propose expanding this list to include other primary care providers, such	Thank you. The Implementation:

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College of Optometrists	local needs assessment	8, 17-29	as those in the community optical sector, who are likely to have relevant knowledge of those older people at increased risk of social exclusion in the local community	getting started section outlines local assets and needs assessment. Other primary care services such as the community optical sector would be covered by the term 'other sources' in this section of the guideline.
Optical Confederation and College of Optometrists	7 - Carry out a local needs assessment	9, 2	We suggest that 'disability' – including sensory disability – be included in the list of barriers to older people participating in local activities.	Thank you. The Implementation section (Area 4: getting older people involved in activities) describes "*Providing help and advocacy for people with specific needs. For example, if they are carers, or if they have mental health problems, difficulties with seeing or hearing or with their flexibility or balance."*
Optical Confederation and College of Optometrists	7 - Carry out a local needs assessment	9, 5-7	Such enquiry must take account of factors such as disability, ethnicity and seldom heard status to ensure activities meet the needs of these populations.	Thank you for this comment. NICE agree that all issues of equality and protected characteristics should form part of needs assessment and would anticipate that this is what happens when they are carried out. It is not in NICE's remit to

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				specify how the equality act is implemented.
Optical Confederation and College of Optometrists	8 - Publicise services and activities	9, 12-14	Planned publicity for activities must take into consideration the formats (e.g. large print and other formats) and locations of information materials. Older people with visual or other disabilities may have lower than average digital literacy and may be more house-bound than similarly aged people without physical or sensory impairment.	Thank you for this comment. The Implementation section (Area 4: getting older people involved in activities) describes "*Providing help and advocacy for people with specific needs. For example, if they are carers, or if they have mental health problems, difficulties with seeing or hearing or with their flexibility or balance*". It also recommends using existing services. This would cover helping people with sensory loss to access and benefit from activities, for example, through the communication formats suggested.
Optical Confederation and College of Optometrists	10 - Overcome barriers to participation	10-11	We are pleased to see the inclusion of support for people with visual or other impairments that may affect their mobility or confidence to travel outside the home. However, we are again concerned that this guidance is only listed a something which 'should be considered'. Given the significant number of older people who are at risk of visual impairment - 1 in 5 of those aged 75 and older and 1 in 2 of those over 90 - and Britain's ageing population, strong support	Thank you. Where there is a limited evidence base, the Committee were only able to use the word 'consider' for recommendations. The rationale for the strength of each

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			for those most at risk of social isolation and loss of independence is essential.	recommendation is included in the Committee's discussion section of the guideline.
Optical Confederation and College of Optometrists	13 - Publicise local communities and services	12, 19-27	Again, we urge careful consideration of the formats to be used. Format and location of publicity materials should follow accessible information standards, bearing in mind that older people with visual or other disabilities may have lower than average digital literacy and may be more house-bound than similarly aged people without physical and sensory impairment.	Thank you for this comment. The Implementation section (Area 4: getting older people involved in activities) describes "*Providing help and advocacy for people with specific needs. For example, if they are carers, or if they have mental health problems, difficulties with seeing or hearing or with their flexibility or balance*". It also recommends using existing services. This would cover helping people with sensory loss to access and benefit from activities for example through the communication formats suggested.
Public Health England	Impact and	Throughout	It's unlikely that any one, two or three areas will have the 'biggest impact' in	Thank you for this comment.

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	implementation challenges		isolation. The suite of 16 recommendations are all important in their own right, however need to be implemented systematically and as a collective package to have the biggest impact across a system.	
Public Health England		Page 23	Enabling choice and avoiding adverse impacts by creating conflicts in people's selections is important in making sure that that inequality is not widened.	Thank you for this comment.
Public Health England	Overcoming challenges, good practice	Throughout	The cost-consequence and cost-utility case for these interventions is strong, so consider giving greater prominence to this aspect to raise understanding of the value of these measures as part of 'return on investment'	Thank you for this comment. The rational and evidence base for each intervention are covered in the Committee's discussion section in the guideline.
Public Health England		Throughout	The interventions appear to have a good level of replicability as well as adaptability to local circumstance. This should be highlighted to increase the speed of locally tailored implementations	Thank you for this comment. The rational and evidence base for each intervention are covered in the Committee's discussion section in the guideline.
Public Health England	Strength of singing recommendation		High and also worthy of greater prominence.	Thank you for this comment.
Public Health England	Strength of singing recommendation		The recommendation about singing in particular is strong, and striking. However, having reviewed your evidence assessment, including the economic modelling, the effect on falls is striking. Given the evidence from this trial, it is appropriate to make a specific mention of singing interventions (framed within arts interventions), as one of the interventions that should be included.	Thank you for this comment.
Public Health England	Audience for		Correct audience although note that the biggest impact on practice will be	Thank you for this comment.

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	recommendation s		achieved by also targeting other statutory commissioners (and provider bodies), as they should be leading and co-ordinating across the system	
Public Health England	General		An equality impact assessment should be undertaken on these guidelines.	Thank you. This has been completed as part of the guideline development process.
Public Health England	General		A caution that this scale of work may not be realistic in an environment where budgets are under immense strain. Way to overcome this are to recommend that an agreed clear vision, strategy and action plan (resourced) across a Local area, signed up by all partners would be the starting point for biggest impact – and overcoming conflicting partner priorities and austerity measures.	Thank you for this comment. Forming a partnership and inclusion of this topic in the local health and wellbeing strategy is outlined in the Implementation: getting started section (Area 1: planning and partnerships).
Public Health England	Programme level recommendation s		9-11 and 14-16 potentially could be covered elsewhere and consideration should be given to working with other organisations to promote.	Thank you. Evaluation and training are now included in the Implementation: getting started section.
Public Health England	General	5	Interventions : group based – should this also be for providers to do (i.e. not just LAs)	Thank you. The part about who each recommendation is for has been removed from the guideline.
Public Health England	General	6	Suggest re-ordering this section. These 1:1 options would follow on well from section 2. Group activities rather than follow on from volunteering. Volunteering could follow on from 1:1.	Thank you. The order of these recommendations is unchanged.
Public Health England	General	6	A local co-ordinator could be commissioned from the voluntary sector and need not be provided by the LA – this may vary from place to place.	Thank you for this comment.

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Public Health England	General	7	Strategy ; partnership. Note proposed new role for Fire Service nationally where they would take on a wider remit, rather than fire checks in homes. However, as this new role is currently under development, it may be too soon to include in these guidelines	Thank you for this comment. Within the Implementation section, the fire service has been included as an agency that comes into contact regularly with older people and they may have a role to play in identifying those most at risk.
Public Health England	General	8	Entirely appropriate for LAs to carry out needs assessments, but this should also include **future projected needs** including inequalities, and not solely focus on current demands. This will enable providers to gear up their services. Also, under second bullet of people at risk, this could include those recently bereaved, those over 80 and female (evidence to suggest that older women may be at risk of isolation)	Thank you for this comment. The list of those most at risk is based on expert testimony.
Public Health England	General	9	Language could be stronger and service providers **should** do the things listed, not just ‘consider;	Thank you. The rationale for the strength of each recommendation is covered in the Committee’s discussion section of the guideline.
Public Health England	General	9	Should also be relevant for Voluntary Sector providers, not just LAs	Thank you. Who should perform each recommendation has been removed from the guideline.
Public Health England	General	10	Barriers to participation : not clear who the ‘local partnership’ is – this could be specified for clarity	Thank you. Local partnership is specified in Area 1: planning and

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				partnerships of the Implementation section.
Public Health England	General	11.	This could also be a role for voluntary sector providers here, not just commissioners of health and social care.	Thank you. Who should perform each recommendation has been removed from the guideline. This is no longer a standard part of NICE guidelines.
Public Health England	General		Agree with the organisations identified here.	Thank you for this comment.
Public Health England	General	45	'Who should do what section' : this mentions older people and businesses, but the previous recommendations do not explicitly refer to what older people and businesses could do – there appears to be a disjoint between the table 'who should do what' and the actually recommendations.	Thank you. This section has been removed from the guideline.
RNIB	General	N/A	**About the RNIB:** Royal National Institute of Blind People (RNIB) is the UK's leading charity providing information, advice and support to almost two million people with sight loss. We are a membership organization with over 13,000 members throughout the UK and 80 percent of our Trustees and Assembly members are blind or partially sighted. We encourage members to get involved in our work and regularly consult them on matters relating to Government policy and ideas for change. As a campaigning organization we act or speak for the rights of people with	Thank you for this information.

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			sight loss in each of the four nations of the UK. We also disseminate expertise to the public sector and business through consultancy on products, technology, services and improving the accessibility of the built environment. RNIB is pleased to have the opportunity to respond to this consultation	
RNIB	General	N/A	**Equalities Act 2010:** We believe that all NICE work should reflect the duties of public bodies under the Equalities Act 2010, not just in relation to communication and accessible information, but in relation to non-discriminatory treatment. We would expect NICE to take steps to meet their legal obligations. This not only requires public bodies to have due regard for the need to promote disability equality in everything they do - including the provision of information to the public - but also requires such bodies to make reasonable adjustments for individual disabled people where existing arrangements place them at a substantial disadvantage.	Thank you for this comment. The guideline now specifies '*people with an age related disability'* (the definition of which includes hearing loss – please see the glossary) in recommendations 1.1, and 1.5.
RNIB	General	N/A	**Accessible information:** We believe this guideline should be culturally appropriate. It should also be accessible to people with additional needs such as physical, sensory or learning disabilities, and to people who do not speak or read English." The Equality Act expressly includes a duty to provide accessible information as part of the reasonable adjustment duty. Online information on websites should conform to the W3C's Web	Thank you. Recommendation 1.9 includes "*Providing help and advocacy for people with specific needs. For example, if they are carers, or if they have mental health problems, difficulties with seeing or hearing or with their flexibility or balance*". It also

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			Accessibility Initiative Web Content Accessibility Guidelines (WCAG) 1.0, level AA, as required by the NHS Brand Guidelines and the Central Office of Information. With regard to the accessibility of print materials, including downloadable content such as PDF files, we would request that wherever possible they comply with our "See it Right" guidelines	recommends using existing services. This would cover helping people with sensory loss to access and benefit from activities e.g. through the communication formats suggested.
RNIB	Stake holder questions		1. Which areas will have the biggest impact on practice and be challenging to implement? Please say for whom and why. We welcome the guidelines recognise that aging people may have difficulties seeing or hearing. However, for many older people the issues with ‘seeing,’ are more profound, as they may have a visual impairment in one eye or both, and may even be blind in one eye. In 2011 the number of people living with sight loss was approximately 1,564,340 and by 2020 this figure is estimated to increase to 1,903,330 (RNIB data tool www.rnib.org.uk/datatool, 2015). We would like to see the NICE guidelines address accessibility when planning for any services i.e. if a building has lots of steps or poor lighting. In addition, NICE recommendations should take into consideration the wider disability impact on older people, not just health inequalities. There is a clear link between visual impairment and reduced psychological wellbeing, particularly amongst older people (Hodge et al., 2010) and older blind and partially sighted people often experience depression than those with good vision (Evans et al., 2007). Moreover, older people with sight loss experience more difficulty getting out and about (McManus et al., 2012) and	Thank you for this comment. Implementation: getting started (Area 4: getting older people involved in activities_ describes “*Providing help and advocacy for people with specific needs. For example, if they are carers, or if they have mental health problems, difficulties with seeing or hearing or with their flexibility or balance*”. It also suggests that using existing services could support implementation. This would cover helping people with sensory loss to access and benefit from activities for example. ensuring appropriate

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			may experience negative outcomes in relation to health, economic wellbeing and social and civic participation (Nazroo et al., 2010; Gjonca and Nazroo, 2005).	spaces are used.
RNIB	Stake holder questions		2. What would help users overcome any challenges? (For example, existing practical resources or national initiatives, or examples of good practice. 'Seeing it from their side' (RNIB and Age UK, 2011) sets out what services can do to ensure that they are accessible to people with a visual impairment. It includes practical examples such as colour contrast for grab rails and lighting. It sets out the need to train staff so that they can guide people and how to consider how a person may get to and from an activity session. The document also sets out more practical examples for luncheon clubs which include: how to promote the service, printing menus in large print, using crockery and cutlery that is colour contrasted. The report also highlights examples of activity sessions which are set up by older people with a visual impairment with their needs in mind i.e. a visual impaired bowls group. There is also the challenge in ensuring that websites are not relied on as the primary way of disseminating information about wellbeing and local activities. Many older people with sight loss do not regard the use of the internet as an activity that is accessible to them (Edwards et al., 2012).	Thank you for this comment. Implementation: getting started (Area 4: getting older people involved in activities)_ describes "*Providing help and advocacy for people with specific needs. For example, if they are carers, or if they have mental health problems, difficulties with seeing or hearing or with their flexibility or balance* It also suggests that using existing services could support implementation. This would cover helping people with sensory loss to access and benefit from activities.
RNIB			References	Thank you for this information.

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			• RNIB datatool www.rnib.org.uk/datatool • McManus S and Lord C, 2012. Circumstances of people with sight loss: Secondary analysis of Understanding Society the Life Opportunities Survey. Natcen and RNIB. • Nazroo J and Zimdars A, 2010. Social inclusion, social circumstances and the quality of life of visually impaired older people. Thomas Pocklington Trust. • Hodge S, Barr W and Knox P, 2010. Evaluation of emotional support and counselling within an integrated low vision service. Liverpool University. • Evans JR, Fletcher AE, Wormald RP, 2007. Depression and anxiety in visually impaired older people. Ophthalmology. 2007 Feb; 114(2): 283–8. • Gjonca E and Nazroo J, 2005. An investigation of the circumstances of older people with sight loss: An analysis of the English Longitudinal Study of Ageing. Thomas Pocklington Trust. • RNIB, 2012 https://www.rnib.org.uk/sites/default/files/Seeing_it_from_their_side_adapting_services_0.pdf • Edwards A, 2012 (RNIB) Tackling digital exclusion – Older blind and	

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			partially sighted people and the internet.	
Royal College of Nursing	General	General	The Royal College of Nursing welcomes proposals to develop this guideline. It is timely. The RCN invited members of the Older Peoples Forum and those with interest in the topic to comment on the draft guideline.	Thank you for this comment.
Royal College of Nursing	General	General	Our members consider that the key issue which the guideline seemed not to have addressed is how to support people in their own homes, especially as some local authorities' social care sections do not seem to be versed with the implications for domically care and partners of people with issues. Our members consider that older people are generally under supported and the Care Act assessments are not being completed with these issues in mind.	Thank you for this comment. No evidence was identified or considered by the committee NICE are therefore unable to make recommendations on this area, it is not within NICE's remit to specify how the Care Act is implemented although we do make reference to the care act in the implementation section as suggested below.
Sense	General	1	The focus this guidance has on promoting older peoples independence and mental wellbeing is welcome, in particular the focus on providers planing and commissioning for services that promote this. Since the guideline refers to well-being it would be good to make a link with clause 1 of the Care Act on well-being.	Thank you. The Care Act 2014 is referred to in the Implementation and Committee's discussion sections of the guideline.
Sense	6.11	7	We welcome the recommendation that the Health and Wellbeing boards	Thank you. Implementation :

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			create a partnership that represents the whole community. However it is important that the needs of hard to reach groups, such as those with dual sensory loss are recognised and represented on these partnerships. People with dual sensory loss tell us that they often find it difficult to access group sessions or meetings, because there communication and access needs haven't been recognised or taken into account. It is important that any needs are recognised recorded and support is provided as necessary to support their inclusion e.g. large print information, loop systems and communication support.	getting started (Area 1: planning and partnerships) describes "*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"* in the list of agencies to be included in the partnership. Area 2: local assets and needs assessment of the implementation section describes collecting information on older people with age related disabilities.
Sense	7.20-26	8	We would like to see people with sensory loss included in the list of those who may be at risk of decline. People with sensory loss and especially those with dual sensory loss are at risk of isolation and exclusion from traditional well-being activities, and may need additional support to be able to access community activities.	Thank you. People with an age related disability are now specified in the guideline.
Sense	9.6-17	10	As previously stated the list of those groups of older people at risk of a decline in independence and mental wellbeing should include dual sensory loss.	Thank you. Please see the previous comment.

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			Brennan & Bally (2007) reported that people with dual sensory loss had a reduced quality of life, and smaller social networks. Furthermore, Schubotz (2004) found that people with dual sensory loss aged over 50 reported very limited interaction with others: 79% said they stayed at home every day, and 5% said they were housebound.	
Sense	10.3	11	We welcome the recommendation that people who have problems with seeing or hearing may need help to overcome factors that may prevent them from accessing activities and services.	Thank you for this comment.
Sense	13.19-27	12	People with dual sensory loss can have difficulty in accessing information; as such we would welcome the inclusion of providing information about activities in a variety of formats to ensure accessibility to this recommendation on information. The importance of this has been recognised in the NHS Accessible Information Standard.	Thank you. Implementation: getting started (Area 4: getting older people involved in activities) describes "*Providing help and advocacy for people with specific needs. For example, if they are carers, or if they have mental health problems, difficulties with seeing or hearing or with their flexibility or balance* It also suggests that using existing services could support implementation. This would cover helping people with sensory loss to access and benefit from activities for example through the

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				communication formats suggested.
Sense	16.1 - 12	14	Training provided should include meeting the needs of people with specific conditions, such as dual sensory loss. People with dual sensory loss are often unable to access group activities and volunteering opportunities due to difficulties with communication and inclusion. Banks *et al* (2006) found that sensory impairment can reduce access to services, independence and social interaction and also exacerbate other social excluded factors of old age. It is therefore crucial that providers are providing services that meet the needs of this group and are inclusive.	Thank you. Training has the Implementation: getting started section. Area 5: training suggests training should include knowledge about the factors that threaten older people's independence and mental wellbeing; how to identify older people most at risk of decline and how to support and encourage older people to participate in community *activities.* Please also see the previous responses about meeting the needs of people with sensory impairment.
WE Care & Repair	1.6	7	Lines 14 – 25. The list of partnerships should include HIAs – Home Improvement Agencies. T	Thank you. Home Improvement Agencies are described in the Implementation section. Please see Area 1: planning and partnerships
WE Care & Repair	1.6	7	Lines 20-22. It should also specifically include those for whom English is not their first language and those who are unable to speak English.	Thank you for this comment. The Implementation section (Area 1:

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				planning and partnerships) describes *"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".* This would cover people for whom English is not their first language.
WE Care & Repair	1.6	7	Lines 20 -22 Include people who predominately speak other languages including sign-language and people who are hard of hearing, deaf or deaf-blind.	Thank you for this comment. Please see response immediately above.
WE Care & Repair	1.6	7	Lines 20-22 Include people who are illiterate or who have extremely low levels of literacy.	Thank you for this comment. No evidence was identified for this population and therefore this is not covered within the guideline.
WE Care & Repair	1.6	7	Lines 20-22 Include people who have learning difficulties or disabilities.	Thank you for this comment. The Implementation section (Area 1: planning and partnerships) describes *"community groups, for*

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				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".
WE Care & Repair	1.6	7	Lines 20-22 Include people who are addicted to prescribed medication or to un-prescribed medication.	Thank you. People who are addicted to prescribed/ non-prescribed drugs would be covered by in the list under 'health condition'.
WE Care & Repair	1.6	7	Lines 20 -22 Include people who are addicted to alcohol or other drugs.	Thank you. People who are addicted to alcohol and drugs would be covered by in the list under 'health condition'.
WE Care & Repair	1.6	7	Lines 20-22 Include people who are long-term users of psychiatric drugs/medication.	Than people who take psychiatric medication because they have a mental health condition are covered in the list under 'health condition'.
WE Care & Repair	1.6	7	Line 30 – Fire services in partnership with Home Improvement Agencies – HIAs are better placed to advise on home adaptations. HIAs also do home safety checks and fit smoke alarms and other fire-prevention measures.	Thank you. The Implementation section The Implementation section (Area 1: planning and

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				partnerships) describes "Planning is more effective when it is developed in a partnership which reflects the diversity of the local community and its local services and facilities, and makes use of local people's skills". The implementation section suggests that home improvement agencies could support effective planning and partnership.
WE Care & Repair	1.9	10	Those most at risk also includes: people for whom English is not their first language or who are deaf or hard of hearing.	Thank you. This list is based on evidence received during expert testimony. This did not include people for whom English is not their first language. Age related disability is included in the list of factors that may identity those most at risk. Please see recommendation 1.5
WE Care & Repair	1.9	10	Those most at risk also includes: people who are addicted to prescribe or non-prescribed medication (e.g. those who are addicted to benzodiazepines or who buy such drugs illegally).	Thank you. People addicted to prescribed / non-prescribed drugs would be covered by "*have recently experienced or developed a health problem*

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				(whether or not it led to admission to hospital)" in the list. Please see recommendation 1.5
WE Care & Repair	1.9	10	Those most at risk also includes people addicted to alcohol or other drugs	Thank you. People addicted to alcohol or drugs would be covered by "*have recently experienced or developed a health problem (whether or not it led to admission to hospital)"* in the list. Please see recommendation 1.5
WE Care & Repair	1.9	10	Those most at risk also includes people who have ever been in the mental health system – partly due to stigma of the condition and especially those who have also had no or very little paid employment or voluntary work during their lifetime.	Thank you. No evidence was identified for this group, therefore this is not covered in the guideline.
WE Care & Repair	1.9	10	Those most at risk also includes people who hoard and have a compulsion to hoard or live in squalor as a result as they often cannot have anyone visiting them in their own homes for a variety of reasons (embarrassment and health and safety concerns).	Thank you. No evidence was identified for this group, therefore this is not covered in the guideline.
WE Care & Repair	1.10	11	Line 3 – add in "or mobility	Thank you. Implementation: getting started (Area 4: getting older people involved in activities)_ describes "*Providing help and advocacy for people with specific needs. For*

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				example, if they are carers, or if they have mental health problems, difficulties with seeing or hearing or with their flexibility or balance". This would cover people with mobility needs.
WE Care & Repair	1.10	11	Line 3 – add in "social phobia"	Thank you for this comment. Social phobia would be covered by 'mental health problems'.
WE Care & Repair	1.10	11	Lines 6&7 – Re word to say "ensuring accessible-toilet facilities.	Thank you. The wording used (in the Implementation: getting started section) is "This also includes ensuring access to suitable toilet facilities" NICE use plain English.
WE Care & Repair	General		Financial help needs to be provided to some older people to encourage or enable them to buy computer equipment and to pay for internet access as well as help people to learn how to use the internet and social media.	Thank you. The implementation section Area 4: getting older people involved in activities describes "*Help older people get financial support to participate in activities, such as help to get concessions and benefits.".*
WE Care & Repair	1.16	14	Course content for health and social care providers should include awareness of how Home Improvement Agencies can enable people to live in homes that are safe, secure and warm.	Thank you. Training is now described in Area 5: training in Implementation: getting started

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				section. This includes "*Provide training in how to maintain and improve older people's independence and mental wellbeing.*" This could include awareness of how Home Improvement Agencies can enable people to live in homes that are safe, secure and warm. Please also see NICE guideline on Excess winter deaths and illness and the health risks associated with cold homes
WE Care & Repair	1.16	14	Home Improvement Agencies can provide training for health and social care providers to enable them to identify issues in someone's properties/homes that are posing a risk to someone's physical or mental health.	Thank you. Training providers are not specified but could include Home Improvement agencies.
WE Care & Repair	6	25	Research should be done on the negative effects of mental health medication especially for those who have had a lifetime on such medication.	Thank you for this comment.
WE Care & Repair	6	25	Research should be done on the effects of hoarding on independence and mental well being.	Thank you for this comment.
WE Care & Repair	6.2	25	Line 17 include factors of sexual orientation and transgender	Thank you. Sexual orientation and transgender is covered in the gaps in the evidence section in the guideline.
WE Care & Repair	General		Work has been done on "Dementia-Friendly cities" and training around this to	Thank you. Dementia is out of

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			shop staff, businesses, health and social care workers and voluntary organisations may help.	scope for this guideline.
WE Care & Repair	General		Older volunteers are often extremely put-off by all the paperwork and monitoring required by the organisations that they volunteer for – because funders ask for some much of it.	Thank you for this comment.
WE Care & Repair	12.3	37	Gaps in evidence about the effects on independence and wellbeing of having the stigma of being diagnosed as “mentally ill” and treated with psychiatric medication at any point in their lives (including prior to becoming old).	Thank you for this comment.
WE Care & Repair	General		‘Homeshare’ schemes – where a younger person moves in with an older person who has a room to spare – could improve and older person’s independence and wellbeing. The schemes are not mentioned anywhere in the document.	Thank you for this comment. The Committee did not hear evidence on Homeshare schemes and therefore it is not included in the guideline.
WE Care & Repair	General		Services that help people to reduce or stabilise or withdraw completely from benzodiazepines are not mentioned in the document. People who are addicted to such substances whether prescribed or bought illicitly are hugely affected this and it adversely affects their health and wellbeing.	Thank you. Please see previous comments on where people addicted to prescription and non-prescription drugs are covered in the guideline.
WE Care & Repair	General		We have not noticed any references to older people or “prematurely old” people living with a diagnosis and the stigma of being HIV positive.	Thank you. The Committee did not hear any specific evidence on this group however; they would be covered where other health problems or long standing conditions are included in the guideline. The phrase ‘prematurely old’

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				has been removed from the guideline.
WE Care & Repair	Question 1 – impact and implementation challenges Which areas will have the biggest impact on practice and be challenging to implement? Please say for whom and why		Financial resources to pay for transport for service users and for volunteers are a big challenge because it costs a lot to provide transport where public transport is not appropriate for a variety of reasons. Financial resources to pay for enough publicity and advertising for existing services, events, resources, groups, etc. are also hard to find despite the huge importance of using a wide variety of means of publicity to reach isolated older people. Financial resources to provide even short periods of time for respite for carers whilst the carer takes part in any sort of activity to improve his or her wellbeing is almost impossible to come by. Financial resources are hard to come by to pay for interpreters or translators to include and reach out to people who have low-literacy or no-literacy, or who have learning difficulties. It costs more to communicate what services are available to people who are not computer literate.	Thank you for this comment. The limitations of available finding are acknowledged in the Committee's discussion section of the guideline. The implementation section Area 4: getting older people involved in activities describes "*Help older people get financial support to participate in activities, such as help to get concessions and benefits*
WE Care & Repair	Question 2 – overcoming challenges, good practice What would help		Home Improvement Agencies have a track record in training for health and social care and voluntary organisations in the following areas: (and could be more widely used by or do partnership working with other organisations) - Healthy Homes – awareness of health issues and safety issues in older people's own homes.	Thank you for this comment. Home Improvement Agencies are now included in implementation section of the guideline.

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	users overcome any challenges? (For example, existing practical resources or national initiatives, or examples of good practice.)		- Adaptations for older people's own homes - Housing options in later life sessions - Homeshare schemes	
WE Care & Repair	Question 3 – strength of singing recommendation Do stakeholders agree with prominence given to the singing interventions in recommendation 2 in relation to the strength of the evidence of effectiveness and cost effectiveness		We feel unable to comment on this.	Thank you for considering question 3.

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	and Committee considerations? Should singing programmes be identified as a key activity that should be offered or be placed as only one of a range of activities that could be offered in a locality to help maintain and improve the independence and mental wellbeing of older people			
WE Care & Repair	Question 4 – interventions to raise awareness Can stakeholders identify evidence for approaches		We can supply evidence about the effectiveness of offering “Thinking Ahead” workshops for people of pre-retirement age and above, or to the friends, carers, relatives or professionals working with older people. These sessions enable people to become aware of their housing options in later life – about whether to stay put and have necessary repairs or adaptations or whether to move home. We can supply evidence of the effectiveness of offering training to health and	Thank you for this comment.

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	or interventions that are effective in rising awareness of the importance of maintaining and improving older people's independence and mental wellbeing among commissioners, service managers, health and social care practitioners, community workers and the voluntary sector?		social care staff "Healthy Homes" sessions. Here they learn what to look out for and how to refer people to the services of Home Improvement Agencies. The national campaign of Mind and other national organisations called "Time to Change" is very effective at reducing the stigma of mental ill-health.	
WE Care & Repair	Question 5 – audience for recommendation s		Home Improvement Agencies ought to be specifically mentioned as appropriate throughout the document – especially in recommendations: 1-16. Home Improvement Agencies (HIAs) are often in a unique position in terms of reaching older people, especially those who are not already in touch with other	Thank you for this comment. Home Improvement Agencies are now included in the implementation section of guideline.

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	Are the appropriate audiences identified for each recommendation in the draft guideline (detailed in 'Who should take action?')? Are recommendations relevant for different audiences sufficiently clear and easy to find? See recommendations 1–16 and section 2.		services. So, with additional funding and more funded partnership working, HIAs could potentially widen their remit to provide more services and increase the number of older volunteers working with other older people. HIAs also work with disabled people of any age and therefore also reach those who are "prematurely old". HIAs work closely with or directly employ Occupational Therapists, so again, with more funding and partnership working, could offer a wider range of services and activities for older people.	Please note, the phrase 'prematurely old' has been removed from the guideline.
WE Care & Repair	Question 6 – programme level recommendations		We do not feel able to answer this question.	Thank you for considering question 6.

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	Can stakeholders identify any more general, ‘programme level’ recommendations (potentially, the undertaking needs assessment recommendation, as an example) that may not be core to this specific topic and could be better covered elsewhere, either by NICE or another agency?			

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