NATIONAL INSTITUTE FOR HEALTH AND CARE EXCELLENCE

DRAFT GUIDELINE

Older people: independence and mental wellbeing

[Issue date: month/year]

What is this guideline about?

This guideline makes recommendations on maintaining and improving the independence and mental wellbeing (including social and emotional wellbeing) of older people.

The aim is to:

- Help older people maintain their mental wellbeing, including their ability to remain independent to avoid health conditions linked to social isolation, depression, and other conditions linked to poor mental wellbeing.
- Help service commissioners and providers to plan, deliver and evaluate services that help older people maintain their independence and mental wellbeing.
- Reduce health inequalities among older people.

It includes recommendations on strategy, needs assessment, awareness raising, interventions, support for community organisations, service evaluation and training for health and social care practitioners.

Following consultation, the final recommendations from this guideline will also appear in NICE's pathway on mental wellbeing and older people. This pathway already includes recommendations from related NICE guidance, including occupational therapy and physical activity interventions to promote the mental wellbeing of older people.

Definitions

'Older people' in this guideline means people aged 65 or older and those aged 55 to 64 who are prematurely old and are particularly at risk of the same physical and mental conditions as those over 65.

'Mental wellbeing' refers to emotional and psychological wellbeing, including self-esteem and the ability to 'function' socially and to be able to cope in the face of adversity. It also includes being able to develop potential, work productively and creatively, build strong and positive relationships with others and contribute to the community (Mental capital and wellbeing: making the most of ourselves in the 21st century Government Office for Science).

'Independence' is defined as having the capacity to make choices and to exercise control over your life. This includes the ability to live independently, with or without support.

Who is this guideline for?

The guideline is for commissioners, managers and practitioners with older people as part of their remit. They could be working in the NHS, local authorities or the wider public, private, voluntary and community sectors. It will also be of interest to older people, their carers, family and friends and other members of the public. (For further details, see Who should take action?)

See About this guideline for details of how the guideline was developed and its current status.

The type of activities and programmes recommended in this guideline are based on the identified evidence. This may be stronger for some interventions than others, but the recommendations make it clear that it is important to offer a varied programme of activities.

Contents

1 Draft recommendations

Recommendation wording

The Guideline Committee makes recommendations based on an evaluation of the evidence, taking into account the quality of the evidence and cost effectiveness.

In general, recommendations that an action 'must' or 'must not' be taken are included only if there is a legal duty (for example, to comply with health and safety regulations), or if the consequences of not following it could be extremely serious or life threatening.

Recommendations for actions that should (or should not) be taken use directive language such as 'agree', ‘offer’ 'assess', 'record’ and ‘ensure'.

Recommendations use 'consider' if the quality of the evidence is poorer, there is a closer balance between benefits and risks or there may be other options that are similarly cost effective.

1 Interventions: principles of good practice

Local authorities should:

- Support, promote and, if there is not enough provision (see recommendation 7), commission a range of activities that meet the needs and interests of local older people. Each activity should:
  - have a clear aim
  - take place on a regular basis in a regular location where there is space to socialise
  - provide the opportunity to socialise
  - take account of how different activities may support different aspects of older people’s independence and mental wellbeing, such as involvement with others (‘social connectedness’), physical health and sense of purpose.

2 Interventions: provide a range of group-based activities

Local authorities should:

- Support, promote and, if there is not enough provision (see recommendation 7), commission group activities, including multicomponent activities. These should include:
  - Education and learning activities for example, covering current affairs, languages, history or science.
  - Singing programmes and other hobbies and creative activities, for example arts and crafts.
  - 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).
  - Training in (and ongoing technical support and encouragement for) the use of information and communication technologies, such as mobile phones, Internet-enabled TVs and computers.
  - Intergenerational activities. For example, voluntary work in schools helping younger people with their reading or other activities.

3 Interventions: encourage volunteering activities

Local authorities should:

- Support, promote and, if there is not enough provision (see recommendation 7), commission opportunities for older people to volunteer. This could include:
  - highlighting the value and benefits (for example, volunteering provides the opportunity to socialise, have fun and help others to benefit from their experience, knowledge and skills)
  - varying the length and times of volunteering sessions to suit individual ability or preference
  - providing help to gain new skills (including good quality training)
  - providing effective supervision

- using a variety approaches to recruit volunteers, including articles and advertisements in local print and broadcast media, posters in community and care settings, direct mailing techniques and word-of-mouth.

4 Interventions: offer one-to-one options

Local authorities should:

- Offer one-to-one activities. This could include:
  - brief visits providing befriending opportunities
  - a programme to help people develop and maintain friendships
  - listening, support and advice from a telephone 'helpline' with a local or national remit (for example, The Silver Line or services provided by other older people's and carers' organisations such as Age UK and the Carers Trust).

5 Identify or appoint a local coordinator

Local authorities should consider:

- Identifying or appointing a local coordinator to:
  - identify older people who are at greater risk of a decline in their independence and mental wellbeing (see recommendations 7, 9 and 11)
  - contact older people at greater risk to find out more about them, for example their interests, capabilities and needs, and to help build up a relationship with them
  - let organisations and others responsible for older people know if there are specific geographical areas where older people live that make them more at risk of losing their independence or experiencing a decline in their mental wellbeing
  - provide information for those in contact with older people about the range of activities and services available for older people locally
  - coordinate support to help older people use local services (this includes help to use digital services, where necessary)
  - offer older people advocacy support so they can say what services they need to support their independence and mental wellbeing.

- Helping the local coordinator share with commissioners their knowledge of local needs, the skills and other relevant 'assets' available in the local community and local services (see recommendation 6 and 7).

6 Strategy: focus on older people and work in partnership

Health and wellbeing boards should consider:

- Making older people's independence and mental wellbeing a core component of both the joint strategic needs assessment and the health and wellbeing strategy.
- Identifying a lead person to review and update this component of these strategies.
- Creating a partnership that represents the diversity of the local community, the skills people have to offer and representatives of local services and facilities. It should include:
  - older people (including those who are prematurely old or carers) and their representatives
  - local authorities, NHS and other statutory providers such as the police and fire services
  - non-statutory housing providers
  - voluntary sector organisations
  - community groups, for example, groups with a general neighbourhood remit and those for people with shared interests or a shared ethnic, social or religious background
  - local high street businesses that older people visit
  - managers of neighbourhood facilities and maintenance and security workers, such as estate wardens.
- Recognising the role that many local authority departments and their partner organisations can play in helping older people maintain and improve their independence and mental wellbeing. For example, planning teams can give advice on public seating and toilets for older people to use. Or fire services conducting safety checks can advise whether home adaptions are needed to help a person to live independently.

- Working with the partnership to assess the services and support older people need to maintain or improve their independence and mental wellbeing, develop a strategy and develop and implement services (see NICE's guideline on community engagement).

7 Strategy: carry out a local needs assessment

Local authorities working in partnership (see recommendation 6) should consider:

- Carrying out a needs assessment to:
  - determine the number and location of older people (including those who are prematurely old) in the local area
  - gather details of services and activities that help to maintain and improve their independence and mental wellbeing
  - identify 'local assets' such as the skills and knowledge of older people and others in the local community, and community venues (halls, places of worship, sports clubs and public houses) that could be used
  - identify any gaps in provision or groups that are not getting involved.
- Using routine data held by health and social care services and other data (for example, from market research) to determine the number of older people who may be at risk of a decline in their independence and mental wellbeing. This could include the number of older people:
  - registered with general practices
  - who are carers
  - with long-term health conditions
  - who are sole occupants of properties
  - who accept help with, for example, managing household tasks
  - who live in areas identified as deprived by national measures such as the indices of multiple deprivation (see English indices of deprivation 2010 Department for Communities and Local Government) and underprivileged area score.
- Identifying any differences between and within local populations of older people (such as their income or ethnicity) so that any health inequalities can be noted.

- Identify anything that stops older people participating in local activities (such as limited access to transport, low income or low self-confidence). Think about how to address these barriers (see recommendations 1, 10 and 11).
- Finding out what types of activities and community support older people would like to improve their independence or mental wellbeing. Consider using interviews, focus groups or surveys.
- Feeding the results into the joint strategic needs assessment.

8 Publicise services and activities

Service providers that help to maintain and improve older people's independence and mental wellbeing should consider:

- Publicising the services and activities on offer using, for example, posters or the service website. Clearly state the objectives, location and times and who they are for.
- Thinking about the images used to publicise the service. Are they representative of the people the service is trying to reach? Do they reinforce stereotypes or risk excluding some older people?
- Publicising the service to other agencies and organisations working with older people, for example, local older people's forums and groups.

9 Raise awareness of the importance of older people's independence and mental wellbeing and those who are most at risk of a decline

Local authorities (see recommendation 6) should consider:

- Raising awareness of the importance of maintaining and improving older people's independence and mental wellbeing. This includes making service providers and others aware of the effect that poor mental wellbeing and lack of independence can have on their mental and physical health and their social interactions. Focus on:
  - commissioners
  - service managers

  - health and social care practitioners
  - community workers
  - voluntary sector organisations and others in contact with older people, including faith groups and groups focused on people with specific health conditions.
- Raising awareness of life events or circumstances that increase the risk of a decline in older people's independence and mental wellbeing. Those most at risk include older people who:
  - are carers
  - live alone and have little opportunity to socialise
  - have recently been bereaved
  - have recently retired (particularly if involuntary)
  - were unemployed in later life
  - have a low income
  - have recently experienced or developed a health problem (whether or not it led to admission to hospital)
  - have had to give up driving.
- Sharing data on older people at risk with other members of the partnership, within information governance arrangements (see the Health & Social Care Information Centre's material on information governance).
- Raising awareness among those commissioning services for, and in contact with, older people of local activities that may maintain and improve their independence and mental wellbeing.
- Noting that some older people may not recognise that they are a 'carer' and that they could, as a result, become socially isolated and put their mental wellbeing at risk.

10 Overcome barriers to participation

The local partnership (see recommendations 6 and 7) should consider:

- Developing a plan to overcome factors that prevent older people from participating in activities and services that could help maintain or improve their independence and mental wellbeing. This includes:

  - Providing help for people with specific needs. For example, if they are carers, or if they have difficulties with seeing or hearing, or with their flexibility or balance.
  - Using existing services. For example, using concessionary fares and encouraging transport services to coordinate their timetables and stops to help people get to the activities. This also includes ensuring access to suitable toilet facilities.
  - Providing a choice of activities.
- Providing training to help older people who are interested to use information and communication technologies effectively. Use training providers such as UK online centres, libraries and older peoples' organisations.
- Helping older people use and maintain access to the Internet via good quality connections by identifying providers who can provide support.
- Providing help to get concessions, such as a free TV licence, for those who are eligible.

11 Help older people who are carers to get involved

Commissioners of health and care services should consider:

- Ensuring referral pathways are in place for health and social care practitioners to offer carers activities that may help to maintain or improve their independence and mental wellbeing.
- Ensuring older people who are carers can use services aiming to maintain and improve their independence and mental wellbeing. This may include arrangements for respite care.

12 Support community organisations: provide funding or facilities to run programmes

Local authorities should consider:

- Helping local community organisations develop and sustain programmes of activities that maintain and improve older people's independence and mental wellbeing. This may include organisations that plan or provide

transport to help people get involved. For example, provide funding or spaces and facilities to host activities.

- Helping local community organisations evaluate (see recommendations 14 and 15) and present evidence to commissioners on the impact these activities are having on older peoples' independence and mental wellbeing.

13 Support community organisations: publicise local activities and services

Local authorities should consider:

- Publicising services and activities offered by community organisations for older people to help them maintain or protect their independence and mental wellbeing. Focus on:
  - commissioners
  - service managers
  - health and social care practitioners
  - community workers
  - voluntary sector organisations and others in contact with older people, including faith groups and groups focused on people with specific health conditions.
- Providing information about services and activities that:
  - is presented as a catalogue of services and activities
  - is available in printed format and via a website (people should be able to access it from the government's Local councils and services page)
  - includes the name of the service or activity, location and accessibility options, email or telephone details, how to make contact, timings and costs and the date the information was updated
  - includes services or activities for older people who want to become volunteers.

14 Encourage service providers to evaluate their services

Funders of activities that maintain and improve the independence and mental wellbeing of older people should consider:

- Encouraging service providers to evaluate the activities offered and use the findings to improve them.
- Identifying sources of help for service providers to complete ongoing (formative) evaluations. Also identify sources of support for more formal (summative) evaluations, for example annually, to support funding or major changes.

15 Evaluate services

Those providing services to maintain and improve older people's independence and mental wellbeing should consider:

- Asking older people what they think about the service or activity. For example, how it is presented in publicity (web pages and posters), the activities on offer (is there too much or not enough for specific groups, for example?). Also:
  - Find out what motivates older people to come along.
  - Find out what may deter or stop older people from coming along.
  - Think about the timing, location and access to venues (for example, how physically accessible is it?).
  - Identify other ways of getting older people involved, for example, through friends or family.
- Collecting details on the following 'process outcomes' as a basis for evaluation:
  - number of sessions offered
  - number attending each session
  - new attendances at each session
  - demographic data.
- Using validated measures of mental wellbeing to gather evidence of the effectiveness of services.
- Involving older people in designing and presenting evaluations.
- Thinking about forming partnerships with academic and practice organisations with the skills to help evaluate the service.

16 Design training for health and social care practitioners

Training providers for health and social care practitioners should consider:

- Providing training in how to maintain and improve older people's independence and mental wellbeing.
- Ensuring course content is based on current knowledge of:
  - how independence and mental wellbeing affect the health of older people and their use of health and social care services
  - activities that improve and maintain older people's independence and mental wellbeing
  - factors that threaten older people's independence and mental wellbeing
  - how to support and encourage older people to participate in community activities.

2 Who should take action?

Introduction

The guideline is for: older people (including carers); commissioners, managers and practitioners providing services for older people; and others who come into contact with older people as part of their duties. They could be working in local authorities, the NHS and other organisations in the public, private, voluntary and community sectors. In addition, it will be of interest to other members of the public.

Who should do what at a glance

Who should take action	Recommendation
Health and wellbeing boards	6
Local authorities	1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15
NHS commissioners	6, 7, 10, 11
Primary healthcare and social services	11
Service providers for older people	8, 15
Funders of services and activities for older people	14
Training providers	16
Older people	6, 7, 10
Housing providers	6, 7, 10
Voluntary sector	6, 7, 10
Community groups	6, 7, 10
Local businesses	6, 7, 10
Police	6, 7, 10
Managers of neighbourhood facilities	6, 7, 10
Transport services	6, 7, 8, 10
Fire service	6, 7, 10

Who should take action in detail

Recommendations 1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15

Local authorities

Recommendations 6

Health and wellbeing boards

Recommendations 6, 7, 10

Older people; local authorities, for example, directors of public health, directors of adult social services and housing and local authority customer enquiry services; NHS commissioners; voluntary sector organisations; community groups, including groups with a general neighbourhood remit and those for people with shared interests or a shared ethnic, social or religious background; housing providers, including housing associations or managers of private housing for older people; local businesses; police; managers of neighbourhood facilities; the fire service

Recommendations 6, 7, 10, 11

Commissioners of health and care services

Recommendations 8, 15

Service providers may include: voluntary sector organisations for example, Age UK and University of the Third Age; community and faith organisations; local authority-run services such as home meals and community transport services; community groups; health and social care services

Recommendation 14

Funders of services may include: local authorities; the NHS (for example, clinical commissioning groups); voluntary sector organisations, for example, Age UK and the Big Lottery Fund; local community groups

Recommendation 16

Training providers may include: Health Education England; Public Health England; Skills for Care; voluntary, community and faith organisations; academic health science networks; local authorities; clinical commissioning groups

3 Implementation: getting started

This section will be completed in the final guideline using information provided by stakeholders during consultation.

To help us complete this section, please use the comments form (see link below) to give us your views on these questions:

1. Which areas will have the biggest impact on practice and be challenging to implement? Please say for whom and why.

2. What would help users overcome any challenges? (For example, existing practical resources or national initiatives, or examples of good practice.)

Please use the stakeholder comments form to send us your comments and suggestions.

Challenges for implementation

The Context section has more details on current practice.

4 Context

The UK population is ageing. In 2012, 1 in 6 people (17%) were 65 or older. By 2035 this is estimated to rise to almost 1 in 4 (23%) (Health expectancies at birth and at age 65 in the United Kingdom, 2008–2010 Office for National Statistics).

The number of people aged 85 and older has risen the fastest. In 1985 nearly 0.7 million people (1% of the population) was 85 or older. By 2010 this had increased to more than 1.4 million (2%). By 2035 the number is expected to more than double again, reaching 3.5 million and accounting for 5% of the population (Population ageing in the United Kingdom, its constituent countries and the European Union Office for National Statistics 2012).

Older people may experience age-related physical changes, such as a decline in their sight or hearing. They are at higher risk of developing 1 or more chronic health conditions, such as diabetes or osteoarthritis (painful and stiff joints). They may also experience poor mental health. These factors all contribute to the risk of a decline in their independence and mental wellbeing.

Depression affects 1 in 5 adults over 65 living in the community and 2 in 5 of those living in care homes (Mental health statistics: older people Mental Health Foundation).

In addition, older people can experience social isolation due, for example, to not being employed (because of retirement, redundancy or carer responsibilities). This can affect both physical and mental health (Holt-Lunstead et al. 2010). Between 5 and 16% of people over 65 report they are often or always lonely (Safeguarding the convoy Campaign to End Loneliness).

People who are lonely or isolated are more likely to be admitted to residential or nursing care (SCIE Research briefing 39: Preventing loneliness and social isolation: interventions and outcomes Social Care Institute for Excellence).

Older people often have to care for someone else (25% of carers are 60 or older). This may lead to a reduced income, pressures on household expenditure and less opportunity to take part in community and leisure activities. Again, this can lead to social isolation and loneliness, for both carers and those they care for.

Contrary to popular belief, only a minority (about 15%) of older people are in contact with care services (Older people – independence and well-being: the challenge for public services Audit Commission). Many play an active role in society. For example, 65% of volunteers in the UK are 50 or older (Ageing well: an asset based approach Local Government Association).

How independent someone is can have a big impact on their quality of life and their general mental wellbeing, regardless of their personal circumstances (such as health and economic situation). Equally, poor mental wellbeing affects people's quality of life and their general physical health.

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

5 Considerations

This section describes the factors and issues the Public Health Advisory Committee (the Committee) considered when developing the recommendations. Please note: this section does **not** contain recommendations. (See Recommendations.)

Background

5.1 The Committee agreed that many older people are already involved in activities that keep them independent and maintain and improve their mental wellbeing. Members also agreed that many such activities are not always seen as contributing to mental wellbeing or keeping someone independent.

5.2 The Committee agreed that ageing is an individual experience and that not all approaches may be right for everyone – or certainly not at the same point in their lives. Members discussed how risk factors build up and then result in a decline in independence and mental wellbeing. But they also acknowledged that people have different levels of resilience.

5.3 The Committee took an 'assets-based' approach (Ageing well: an asset based approach Local Government Association) when developing this guideline. This involves taking a broad view of factors or resources that help people, communities and populations to maintain and sustain health and wellbeing.

5.4 The Committee discussed evidence that 'reciprocity' (the practice of exchanging things with others for mutual benefit) and 'payback' (benefit gained as the result of a previous action) benefit the mental wellbeing of people involved in community or voluntary work. Members also discussed the fact that many older people want to continue to contribute to their community. They agreed that volunteering is a way they could do this and, at the same time, improve their mental wellbeing.

5.5 For the purposes of this guideline, 'vulnerable' older people are those at greater risk of a decline in their independence or mental wellbeing than others of the same chronological age. Everyone may experience a particular event (or events) that can cause worry and stress, limits mobility or restricts their life choices. Examples of such events include the loss of a partner or developing a health

condition. Vulnerable people lack resilience to such challenges. This may be because they lack resources (such as money, housing, or support from family and community). Or it may be that their life has always been difficult, for example because of limited income. However, individual circumstances will differ and the Committee was aware that not everyone who could be assessed as being at 'higher risk' will experience poor mental wellbeing.

Interventions

5.6 The Committee discussed different approaches to identifying vulnerable older people. Members noted that risk assessments of individual circumstances and needs are useful. However, they agreed that this guideline should focus on a general assessment of local need using: routine data, such as information available from the census or Public Health England; or drawing on the knowledge of people working in the local community. It could also involve taking account of 'key life events', such as bereavement or divorce.

5.7 The Committee heard from experts about 'wellbeing coordinators'. These community-based coordinators are employed by local authorities to identify older people who need support. They coordinate local services and activities for them.

5.8 The Committee discussed the need to raise awareness of the importance of older people's independence and mental wellbeing among older people themselves (including those who are carers), local policy makers, commissioners and practitioners. The Committee also discussed the need to raise awareness of how to identify vulnerable older people and the services that may support their independence and mental wellbeing. Members agreed that local policy could prioritise this.

5.9 The Committee identified a number of groups that may need specific approaches and activities. This included: men, people older than 85, those who are prematurely old and carers. But there is a

lack of evidence on activities for subgroups. Members also noted that people's needs and interests vary within any group (as noted in 5.1).

5.10 Noting evidence from reviews and expert testimony on current UK practice, the Committee agreed that people would only be able to choose which services or activities to get involved with if they were given enough information about what was on offer. Members discussed the idea of a local 'repository' of information (based on set criteria) using the Internet. They also acknowledged the difficulties involved in maintaining such a resource – and that using online information is a significant challenge for some people.

5.11 The Committee carefully considered evidence reviews, economic evaluation and expert testimony on the effects of specific interventions. Members were aware that these did not represent all relevant activity. In addition, it was not possible to identify specific interventions or features (such as the ideal length of an intervention) to prioritise. However, the Committee agreed that broad types of intervention do appear to be effective in the current UK context (see 5.13).

5.12 The Committee drew on the foundations of mental wellbeing model (see expert paper 1). According to the model, 4 key 'pillars' contribute to positive mental health and wellbeing: functional ability, psychological attributes, power and resources and 'social connectedness'. These change throughout life. The types of effective intervention identified by Committee link to the foundation of mental wellbeing model and include the following:

- Interventions based in a single location such as a community venue and offering a range of activities.
- Activities that support social connections, either in groups or via one-to-one 'befriending' activities or telephone support (befriending involves regular support and companionship).

- Intergenerational activities. This could include, for example, inviting older people to work with younger people in schools.

5.13 The Committee recognised that carers may value emotional support from other carers, so activities for groups of carers may be beneficial. Members also noted that the Care and Support Act 2014 specifies that the support carers need should be assessed by care practitioners. This includes emotional support.

5.14 The Committee noted the need for health and social care practitioners to understand the importance of independence and mental wellbeing for older people. In particular, how it affects their use of health and social services. So the Committee made a recommendation on training.

5.15 The Committee discussed the need for good quality evaluation. Members noted that providers may not be able to carry out a complex evaluation and that funders may have a role in this. Members agreed that it would be possible for providers to collect 'process outcomes', such as numbers of people involved, proportion completing a programme or activity, or demographic data. Members also noted that promising innovative practice may lack evaluation or evidence of impact. They wanted to encourage evaluation without blocking support for new practice.

5.16 The Committee noted that many services and activities for older people are provided by the voluntary sector and that funding arrangements may be short term. In some cases, local authorities provide funding. Often people using the service or who get involved in the activity have to pay a fee. Members agreed that there was insufficient evidence to develop recommendations on funding. However, they agreed that it would be useful to find out more about funding arrangements as part of any evaluation.

Avoiding adverse effects

5.17 The Committee was concerned that if there was not enough choice in terms of activities – and if people were not given the opportunity to say what they would like to do – this could be detrimental to their mental wellbeing. For example, it may lead to some people being excluded, or it may lead to conflict over the choice of activities.

5.18 The Committee was aware of the risk of widening inequalities if activities only reach people who already use services. The Committee agreed that inequalities could be avoided by recommending a variety of interventions (see 5.19) and providing help to access services.

5.19 The Committee recognised that promoting social activities outside the home and involving a range of people working in the community in those activities could make older people more vulnerable to crime. For example, theft from an unoccupied home or fraud through 'bogus callers'. The same is true of training to help older people use information and communication technologies – they could then be susceptible to Internet-based scams. The Committee agreed that this could be overcome using governance arrangements and by providing advice, training and support.

Economics

5.20 The Committee considered that the cost effectiveness evidence identified in the literature review was limited, and with limited applicability to England. Therefore a new economic evaluation was developed using a cost–consequence analysis and a cost–utility analysis.

5.21 The Committee felt that a cost–consequence analysis was the most suitable type of economic analysis, given the wide range of outcomes that are relevant to interventions to maintain and improve older people's independence and mental wellbeing. Where data permitted, the Committee agreed a cost–utility analysis would be

useful (albeit limited in scope,) for comparing the cost effectiveness of different types of interventions using a common outcome.

5.22 The Committee highlighted the complex nature of the evidence, in particular the inter-relationship between independence, mental wellbeing and other health and non-health outcomes. The fact that independence and mental wellbeing are also reported as outcomes in their own right was noted as a further complication. In addition, there is a lack of published studies demonstrating a causal relationship or direction of any causality between the range of measures and outcomes. Members agreed that this meant the economic analysis would be an oversimplification of the scope of activities and outcomes.

5.23 The evidence reviews and expert testimony identified a vast array of different activities and interventions. The interventions selected for economic analysis represented the different types of interventions identified in the effectiveness reviews.

5.24 As with any economic analysis undertaken during guideline development, the results are subject to uncertainty and numerous assumptions. Nevertheless, based on the examples used in the present analysis, the Committee considered that the types of interventions tested can be cost effective or even cost saving, and thus represent a good use of public money.

5.25 The Committee noted that there may be a difference between the sector or organisation that pays for some of the proposed interventions and the sector or organisation that apparently benefits. For example, if a social care budget is used to fund activities that primarily achieve a health benefit. Members acknowledged the difficulty for commissioners in such cases.

This section will be completed in the final document.

6 Recommendations for research

The Public Health Advisory Committee recommends that the following research questions should be addressed. It notes that 'effectiveness' in this context relates not only to the size of the effect, but also to cost effectiveness and duration of effect. It also takes into account any harmful or negative side effects.

All the research should aim to identify differences in effectiveness among groups, based on characteristics such as socioeconomic status, age, gender and ethnicity.

6.1 What are the needs of different populations (including people who are prematurely old) as they age? How can interventions be tailored to maximise independence and mental wellbeing at different stages of someone's life?

6.2 Which factors or processes influence mental wellbeing? Does the importance of these factors differ by different population characteristics, for example, ethnicity, social class, gender or geography?

6.3 Which mid-life interventions are most effective in preparing people for later life by helping them maintain their independence and mental wellbeing?

More detail identified during development of this guideline is provided in Gaps in the evidence.

7 Related NICE guidance

Published

- Falls (2013) NICE guideline CG161
- Alcohol dependence and harmful alcohol use (2011) NICE guideline CG115
- Depression in adults (2009) NICE guideline CG90

- Occupational therapy and physical activity interventions to promote the mental wellbeing of older people in primary care and residential care (2008) NICE guideline PH16
- Community engagement (2008) NICE guideline PH9
- Behaviour change: the principles for effective interventions (2007) NICE guideline PH6
- Dementia (2006) NICE guideline CG42

Under development

- Excess winter deaths and illnesses NICE guideline (publication expected March 2015)
- Disability, dementia and frailty in later life – mid-life approaches to prevention NICE guideline (publication expected March 2015)
- Home care NICE guideline (publication expected July 2015)
- Social care of older people with multiple long-term conditions NICE guideline (publication expected September 2015)
- Transition between inpatient hospital settings and community or care home settings for adults with social care needs NICE guideline (publication expected November 2015)
- Workplace health – older employees NICE guideline (publication expected February 2016)
- Oral health – nursing and residential care NICE guideline (publication expected June 2016)

8 Glossary

Prematurely old

People aged 55 to 64 who are particularly at risk of the same physical and mental conditions as those over 65.

Multicomponent activities

Programmes involving a range of topics, settings, media and activities. A programme could include, for example, lunch and the opportunity to socialise and to learn a new craft or skill in a community venue. Or it could involve a

physical activity, such as a dance class or walking group, plus printed information on the benefits of physical activity.

9 References

Holt-Lunstead, Smith TB, Bradley Layton J (2010) Social Relationships and Mortality Risk: A Meta-analytic Review. PLoS Medicine 7 (7): e1000316

10 Summary of the methods used to develop this guideline

Introduction

The reviews and economic modelling report include full details of the methods used to select the evidence (including search strategies), assess its quality and summarise it.

The minutes of the Public Health Advisory Committee meetings provide further detail about the Committee's interpretation of the evidence and development of the recommendations.

Guideline development

The stages involved in developing public health guidelines are outlined in the box below.

1. Draft scope released for consultation

2. Stakeholder comments used to revise the scope

3. Final scope and responses to comments published on website

4. Evidence reviews and economic modelling undertaken and submitted to the Committee

5. The Committee produces draft recommendations

6. Draft guideline (and evidence) released for consultation (and for fieldwork)

7. The Committee amends recommendations

8. Final guideline published on website

9. Responses to comments published on website

Key questions

The key questions were established as part of the scope. They formed the starting point for the reviews of evidence and were used by the Committee to help develop the recommendations. The overarching questions were:

Question 1: What are the most effective and cost effective ways that local authorities, other services and communities can raise awareness of the importance of older peoples' mental wellbeing and independence?

Question 2: What are the most effective and cost effective ways that local government, other services and communities can identify older people who are at high risk of a decline in their mental wellbeing or independence?

Question 3: What are the most effective and cost effective ways to improve or protect the mental wellbeing and/or independence of older people?

Question 4: What links are there between the mental wellbeing and independence of older people and their: mental and physical health, capability, quality of life, isolation and participation in community, civil and family activities?

These questions were made more specific for each review.

Reviewing the evidence

Effectiveness reviews

One review of effectiveness was conducted:

- Review 1: What are the most effective ways to improve or protect the mental wellbeing and/or independence of older people?

Identifying the evidence

Several databases were searched in March 2014 for intervention studies from January 2003 to December 2013. See review 1.

In addition, biographies and citation of included records were used to identify further intervention studies.

Selection criteria

Inclusion and exclusion criteria for each review component varied. Details can be found in review 1.

Other reviews

One barriers and facilitators review was conducted. See review 2: Barriers and facilitators to interventions and services to improve or protect the mental wellbeing and/or independence of older people.

Two practice reviews were conducted. See review 3: 'Mapping services for mental wellbeing and independence for older people' and review 4, 'Older people: independence and mental wellbeing a practice case study: Wigan'.

Identifying the evidence

Review 2: several databases were searched in March 2014 for intervention studies published from January 2003 to December 2013. See review 2.

Review 3: 6 areas of England were selected as case studies. In each area, directors of public health and local Age UK branches were contacted to get information for a structured questionnaire. Websites for local authority and other local services in the selected areas were also searched.

Review 4: A focused case study was conducted for 1 of the areas selected for review 3: Directors of public health and local Age UK branches were contacted initially to obtain an overview of services, then services were contacted to get information for a structured questionnaire. Websites for local authority and other local services in the selected area were searched and health and wellbeing strategies reviewed.

Selection criteria

Review 2: inclusion and exclusion criteria for each review component varied. Details can be found in review 2.

Review 3: inclusion and exclusion criteria for each review component varied. Details can be found in review 3.

Review 4: Wigan was selected as a focused case study from review 3.

Quality appraisal

Included papers were assessed for methodological rigour and quality using the NICE methodology checklist, as set out in Methods for the development of NICE public health guidance. Each study was graded (++, +, −) to reflect the risk of potential bias arising from its design and execution.

Study quality

++ All or most of the checklist criteria have been fulfilled. If they have not been fulfilled, the conclusions are very unlikely to alter.

\+ Some of the checklist criteria have been fulfilled. Those criteria that have not been fulfilled or not adequately described are unlikely to alter the conclusions.

− Few or no checklist criteria have been fulfilled. The conclusions of the study are likely or very likely to alter.

The evidence was also assessed for its applicability to the areas (populations, settings, interventions) covered by the scope of the guideline. Each evidence statement concludes with a statement of applicability (directly applicable, partially applicable, not applicable).

Summarising the evidence and making evidence statements

The review data were summarised in evidence tables (see the reviews in Supporting evidence).

The findings from the reviews were synthesised and used as the basis for a number of evidence statements relating to each key question. The evidence

statements were prepared by the external contractors (see 'Supporting evidence'). The statements reflect their judgement of the strength (quality, quantity and consistency) of evidence and its applicability to the populations and settings in the scope.

Cost effectiveness

There was a review of economic evaluations and an economic modelling exercise. See the review of economic evaluations (review 5): 'Older people: independence and wellbeing – evidence review of cost effectiveness. Also see the economic modelling report 'Independence and mental wellbeing (including social and emotional wellbeing) for older people: economic analysis'.

Review of economic evaluations

Eight databases were searched in March 2014 for intervention studies published from February 2007 to February 2013. The search was designed to retrieve the highest proportion of potentially relevant material, so it was an optimised, rather than an exhaustive search.

Studies were included if they:

- Met the inclusion criteria for the population, interventions and outcomes in the scope.
- Reported on full economic evaluations or analyses presenting costs and consequences. For example, cost-benefit analysis, cost-effectiveness analysis, cost-minimisation analysis and cost-utility analysis.

Included studies were then quality assessed.

See the review of economic evaluations (review 5).

Economic modelling and analysis

Due to the lack of data from the review of economic evaluations, a bespoke economic analysis was undertaken using both cost–consequence and cost–utility analyses.

The cost–consequence analysis was considered the most suitable type of economic analysis for this topic and, more specifically, for the range of likely outcomes. This included wellbeing, quality of life and health outcomes.

An economic model was constructed to incorporate data from the reviews of effectiveness and cost effectiveness. The model was used to run 2 cost–utility analyses for interventions that reported outcomes linked to loneliness. This is because data on the relationship between loneliness and health outcomes, such as depression, has been more rigorously established.

The cost–utility analysis complemented the cost–consequence analysis.

The results are reported in the economic modelling report.

How the Committee formulated the recommendations

At its meetings in July, October, November, December 2014 and January 2015 the Public Health Advisory Committee considered the evidence, and cost effectiveness to determine:

- whether there was sufficient evidence (in terms of strength and applicability) to form a judgement
- if relevant, whether (on balance) the evidence demonstrates that the intervention, programme or activity can be effective or is inconclusive
- if relevant, the typical size of effect
- whether the evidence is applicable to the target groups and context covered by the guideline.

The Committee developed recommendations through informal consensus, based on the following criteria:

- Strength (type, quality, quantity and consistency) of the evidence.
- The applicability of the evidence to the populations/settings referred to in the scope.
- Effect size and potential impact on the target population's health.
- Impact on inequalities in health between different groups of the population.
- Equality and diversity legislation.

- Ethical issues and social value judgements.
- Cost effectiveness (for the NHS and other public sector organisations).
- Balance of harms and benefits.
- Ease of implementation and any anticipated changes in practice.

If evidence was lacking, the Committee also considered whether a recommendation should only be implemented as part of a research programme.

If possible, recommendations were linked to evidence statements (see The evidence for details). If a recommendation was inferred from the evidence, this was indicated by the reference 'IDE' (inference derived from the evidence).

11 The evidence

Introduction

The evidence statements from 3 reviews are provided by external contractors. and an internal NICE review team.

This section lists how the evidence statements and expert papers link to the recommendations and sets out a brief summary of findings from the economic analysis.

How the evidence and expert papers link to the recommendations

The evidence statements are short summaries of evidence, in a review, report or paper (provided by an expert in the topic area). Each statement has a short code indicating which document the evidence has come from.

Evidence statement number 1.1.1 indicates that the linked statement is numbered 1.1 in review 1. **Evidence statement number 2.1** indicates that the linked statement is numbered 1 in review 2. **Evidence statement EP1** indicates that expert paper 1 is linked to a recommendation.

If a recommendation is not directly taken from the evidence statements, but is inferred from the evidence, this is indicated by IDE (inference derived from the evidence).

If the Public Health Advisory Committee has considered other evidence, it is linked to the appropriate recommendation below. It is also listed in the additional evidence section below.

Recommendation 1: evidence statements 1.1.1, 1.1.2, 1.1.5; review 3; EP1, EP3, EP4; IDE

Recommendation 2: evidence statements 1.1.1, 1.1.2, 1.1.5, 1.1.7, 1.2.1, 1.2.2, 1.2.3, 1.4.1, 1.4.2, 1.6.1, 1.6.2, 1.6.3; 2.1; review 3; EP1, EP3, EP4; economic modelling report; IDE

Recommendation 3: evidence statements 1.2.1, 1.2.2, 1.2.3; 2.3; review 3; EP4; IDE

Recommendation 4: evidence statement 1.3.1; review 3; IDE

Recommendation 5: review 3; EP3, EP4, EP6; IDE

Recommendation 6: review 3; EP3, EP4; IDE

Recommendation 7: evidence statement 2.3; review 3; EP3; IDE

Recommendation 8: evidence statement 2.6; review 3; IDE

Recommendation 9: evidence statement 1.2.6; review 3; EP1, EP4, EP5; IDE

Recommendation 10: evidence statement 1.2.1; 2.1, 2.3, 2.6; EP3; IDE

Recommendation 11: evidence statement 1.1.8; EP2, EP6

Recommendation 12: evidence statement 1.2.2; EP3, EP6; IDE

Recommendation 13: evidence statements 1.1.1, 1.1.2, 1.1.5, 1.1.7, 1.2.1, 1.2.2, 1.2.3, 1.4.1, 1.4.2, 1.6.1, 1.6.2, 1.6.3; review 3; EP3, EP4; economic modelling report; IDE

Recommendation 14: review 3; IDE

Recommendation 15: review 3; IDE

Recommendation 16: IDE

Expert papers

Expert papers 1–6.

Economic analysis

Review of economic studies

The published evidence on the cost-effectiveness of interventions to maintain and improve older people's mental wellbeing was very limited. In total, 719 titles and abstracts were screened by 2 reviewers. Of these, 34 were identified as potentially relevant. After applying the eligibility criteria, 3 studies were included:

- A one-to-one visiting service for older people who had been widowed in the Netherlands. It was cost effective but judged to have potentially serious limitations (+).
- A psychosocial group rehabilitation intervention for lonely older people in Finland. It was cost saving but judged to have very serious limitations (−).
- A community singing intervention for people aged 60 and over in England. It was cost effective but judged to have potentially serious limitations (+).

Cost–consequence analyses

Cost–consequence analyses were carried out for 4 interventions:

- singing (arts-based intervention)
- Internet and computer training (education and training)
- school-based intergenerational activities and volunteering

- friendship programmes.

For a relatively small cost (£86 per person) the singing intervention would be cost saving and improve health outcomes, compared with the comparator (no programme).

The Internet and computer training cost £564 per person and is associated with a range of positive outcomes that could, in turn, help reduce depression and death rates.

School-based intergenerational activities cost £10 per participant and showed improvements in 9 areas, such as connecting with children who are not part of the family, self-rated health and social support. This is likely to improve mortality outcomes. However, there was significant decline in the support received from friends and this could have an adverse effect on health.

The friendship intervention cost an estimated £77 per participant. This increased to £120 for follow-up interviews and tokens given out for participating in them. This led to more friendships and more contact with friends, improved self-esteem and general satisfaction with life. It is also likely to improve health and reduce death rates.

Cost–utility analyses

A cost–utility analysis was carried out for the Internet and computer training and friendship interventions. This focused only on the impact the interventions had on loneliness – and any health outcomes linked to loneliness.

The cost per quality-adjusted life-year (QALY) gained for the Internet and computer training intervention was £17,828. Given that this left out all the other benefits discussed in the cost–consequence analysis, apart from its effect on loneliness (and other potential benefits not captured) the intervention was cost-effective.

The friendship intervention was cost saving and improved health more than the comparator (no programme) and again, even though it only looked at the

effect on loneliness and its potential health consequences, the intervention was cost-effective.

The specific scenarios considered and the full results can be found in:

- Economic modelling: 'Independence and mental wellbeing (including social and emotional wellbeing) for older people: economic analysis'
- Review of economic evaluations (review 5): 'Older people: independence and wellbeing – review of cost effectiveness evidence'.

12 Gaps in the evidence

The Public Health Advisory Committee identified a number of gaps in the evidence related to the programmes under examination based on an assessment of the evidence and expert comment. These gaps are set out below.

1. How to identify and assess older people at risk of a decline in their independence and mental wellbeing.

(Source: review 1; modelling report 1; expert comment)

2. UK-based evidence of the effectiveness of a range of interventions to help older people maintain their independence and mental wellbeing.

(Source: review 1)

3. The effectiveness of a range of interventions to help older people in specific groups maintain their independence and mental wellbeing. This includes people:

- from black and minority ethnic groups
- from lesbian, gay, bisexual and transgender groups
- with long-term disabilities
- living in rural or urban areas
- living with high levels of social deprivation.

(Source: review 1)

4. Characteristics of interventions that effectively help older people maintain their independence and mental wellbeing. This includes:

- optimal duration or intensity of the intervention
- duration of benefits following the intervention
- the relative effectiveness of interventions provided remotely (via telephone or Internet) compared with face-to-face.

(Source: review 1; review 2; modelling report 1; expert comment).

13 Membership of the Public Health Advisory Committee and the NICE project team

Public Health Advisory Committee B

NICE has set up several Public Health Advisory Committees. These standing committees consider the evidence and develop guidelines. Membership is multidisciplinary, comprising academics, public health practitioners, topic experts and members of the public. They may come from the NHS, education, social care, environmental health, local government or the voluntary sector. The following are members of Public Health Advisory Committee B:

Chair

Alan Maryon-Davis

Honorary Professor of Public Health, Kings College London

Core members

Brendan Collins

Research Fellow in Health Economics, University of Liverpool

Jo Cooke

Programme Manager and Capacity Lead, National Institute of Health Research Collaboration for Leadership in Applied Health Research and Care for South Yorkshire

Jackie Cowley

Community member

Daniela DeAngelis

Programme Leader, Medical Research Council

Rachel Johns

Deputy Director, Public Health England North, Public Health England

Richard Watt

Professor in Dental Public Health, University College London

Topic members

Carolyn Arscott

Health Promotion Manager, Public Health, Somerset County Council

Mima Cattan

Professor of Public Health, Northumbria University

Anna Goodman

Topic Community Member; Learning and Research Manager, Campaign to End Loneliness

Martin Landers

Topic community member

Gail Mountain

Professor of Health Services Research, University of Sheffield

Christina Victor

Professor of Gerontology and Public Health, Brunel University, Uxbridge

Lynne Wealleans

Programme Lead, Beth Johnson Foundation

Expert testimony to the Committee

Scott Bennet

Chair Volunteer, Age UK Cornwall and the Isles of Scilly

Ruth Hannan

Senior Policy Manager (interim), Carers Trust

Trish Hill

Adult Health and Wellbeing Coordinator, Poynton Town Council

Paul McGarry

Senior Strategy Manager, Public Health Manchester, Manchester City Council

James Nazroo

Professor of Sociology, University of Manchester

Tracey Roose

Chief Executive, Age UK, Cornwall and the Isles of Scilly

NICE project team

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Kay Nolan

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Ruaraidh Hill

Lead Analyst

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Project Manager (from June 2014)

Denise Jarrett

Coordinator

Sue Jelley

Senior Editor

Susie Burlace

Editor

Declarations of interests

The members of the Public Health Advisory Committee declared any relevant interests.

About this guideline

What does this guideline cover?

The Department of Health (DH) asked the National Institute for Health and Care Excellence (NICE) to produce this guideline on maintaining the independence and mental wellbeing of older people (see the scope).

This guideline does not provide detail on mid-life interventions, or cover care for older people with substantial health or social care needs, for example, due to dementia or another pre-existing cognitive impairment. (See Related NICE guidance for other recommendations that may be relevant to the independence and mental wellbeing of older people.).

The absence of any recommendations on interventions that fall within the scope of this guideline is a result of lack of evidence. It should not be taken as a judgement on whether they are cost effective.

How was this guideline developed?

The recommendations are based on the best available evidence. They were developed by the Public Health Advisory Committee.

Members of the Committee are listed in Membership of the Public Health Advisory Committee and the NICE project team.

For information on how NICE guidelines are developed, see the NICE website.

What evidence is the guideline based on?

The evidence that the Committee considered included:

- Evidence reviews:
  - Review 1 'What are the most effective ways to improve or protect the mental wellbeing and/or independence of older people?' was carried out by London School of Economics. The principal authors were: David McDaid, Anna Forsman, Tihana Matosevic, A-La Park and Kristian Wahlbeck.
  - Review 2 'Barriers and facilitators to interventions and services to improve or protect the mental wellbeing and/or independence of older people' was carried out by London School of Economics. The principal authors were: David McDaid, Tihana Matosevic, A-La Park and Anna Forsman.
  - Review 3 'Mapping services for mental wellbeing and independence for older people' was carried out by London School of Economics. The principal authors were: David McDaid, A-La Park, Tihana Matosevic and Anna Forsman.
  - Review 4 'Older People: independence and mental wellbeing – a practice case study: Wigan' was carried out by an internal NICE review team. The principal author was Jennifer Connolly.
- Review of economic evaluations (review 5): 'Older people: independence and wellbeing – evidence review of cost effectiveness' was carried out by an internal NICE review team. The principal authors were: Charlotte Simpson, Tracey Shield and Thomas Hudson.
- Economic modelling: 'Independence and mental wellbeing (including social and emotional wellbeing) for older people: economic analysis' was carried

out by Optimity Matrix. The principal authors were: Jacque Mallender, Clive Pritchard, Rory Tierney and Ketevan Rtveladze.

- Expert papers:
  - Expert paper 1 ‘The development of a multi-dimensional, theoretical model of the foundations of mental wellbeing’ by Mima Cattan, Northumbria University
  - Expert paper 2 ‘Interventions to support older carers’ by Ruth Hannan, Carers Trust
  - Expert paper 3 ‘Independence and wellbeing: engaging with older people in Poynton’ by Trish Hill, Poynton Town Council
  - Expert paper 4 ‘Age friendly cities’ by Paul McGarry, Manchester City Council
  - Expert paper 5 ‘Emotional wellbeing in later life: patterning, correlates, inequalities and resilience’ by James Nazroo, University of Manchester
  - Expert paper 6 ‘People, place and purpose: living well’ by Tracey Roose and Scott Bennet, Age UK Cornwall and the Isles of Scilly

Note: the views expressed in the expert papers above are the views of the authors and not those of NICE.

In some cases the evidence was insufficient and the Committee has made recommendations for future research. For the research recommendations and gaps in research, see Recommendations for research and Gaps in the evidence.

Status of this guideline

This is a draft guideline. The recommendations made in section 1 are provisional and may change after consultation with stakeholders.

This document does not include all sections that will appear in the final guideline. The stages NICE will follow after consultation are summarised below.

- The Committee will meet again to consider the comments, reports and any additional evidence that has been submitted.

- After that meeting, the Committee will produce a second draft of the guideline.
- The draft guideline will be signed off by the NICE Guidance Executive.

The key dates are:

- Closing date for comments: 10 July 2015.
- Next Committee meeting: 29 and 30 July 2015.

All healthcare professionals should ensure people have a high quality experience of the NHS by following NICE's recommendations in Patient experience in adult NHS services.

All health and social care providers working with people using adult NHS mental health services should follow NICE's recommendations in Service user experience in adult mental health.

The recommendations should be read in conjunction with existing NICE guidance unless explicitly stated otherwise. They should be implemented in light of duties set out in the Equality Act 2010.

NICE produces guidance, standards and information on commissioning and providing high-quality healthcare, social care, and public health services. We have agreements to provide certain NICE services to Wales, Scotland and Northern Ireland. Decisions on how NICE guidance and other products apply in those countries are made by ministers in the Welsh government, Scottish government, and Northern Ireland Executive. NICE guidance or other products may include references to organisations or people responsible for commissioning or providing care that may be relevant only to England.

Implementation

NICE guidelines can help:

- Commissioners and providers of NHS services to meet the requirements of the NHS outcomes framework 2013–14. This includes helping them to deliver against domain 1: preventing people from dying prematurely.

- Local health and wellbeing boards to meet the requirements of the Health and Social Care Act (2012) and the Public health outcomes framework for England 2013–16.
- Local authorities, NHS services and local organisations determine how to improve health outcomes and reduce health inequalities during the joint strategic needs assessment process.

NICE will develop tools to help organisations put this guideline into practice. Details will be available on our website after the guideline has been issued.

Updating the recommendations

This section will be completed in the final document