NATIONAL INSTITUTE FOR HEALTH AND CARE EXCELLENCE

HEALTH AND SOCIAL CARE DIRECTORATE

QUALITY STANDARD CONSULTATION

SUMMARY REPORT

1 Quality standard title

Mental wellbeing and independence for older people

Date of Quality Standards Advisory Committee post-consultation meeting:
01 September 2016

2 Introduction

The draft quality standard for mental wellbeing and independence for older people was made available on the NICE website for a 4-week public consultation period between 16 June and 14 July 2016. Registered stakeholders were notified by email and invited to submit consultation comments on the draft quality standard. General feedback on the quality standard and comments on individual quality statements were accepted.

Comments were received from 20 organisations, which included service providers, national organisations, professional bodies and others.

This report provides the Quality Standards Advisory Committee with a high-level summary of the consultation comments, prepared by the NICE quality standards team. It provides a basis for discussion by the Committee as part of the final meeting where the Committee will consider consultation comments. Where appropriate the quality standard will be refined with input from the Committee.

Consultation comments that may result in changes to the quality standard have been highlighted within this report. Comments suggesting changes that are outside of the

process have not been included in this summary. The types of comments typically not included are those relating to source guidance recommendations and suggestions for non-accredited source guidance, requests to broaden statements out of scope, requests to include thresholds, targets, large volumes of supporting information, general comments on the role and purpose of quality standards and requests to change NICE templates. However, the Committee should read this summary alongside the full set of consultation comments, which are provided in appendix 1.

3 Questions for consultation

Stakeholders were invited to respond to the following general questions:

1. Does this draft quality standard accurately reflect the key areas for quality improvement?

2. Are local systems and structures in place to collect data for the proposed quality measures? If not, how feasible would it be to be for these to be put in place?

3. Do you have an example from practice of implementing the NICE guideline(s) that underpins this quality standard? If so, please submit your example to the NICE local practice collection on the NICE website. Examples of using NICE quality standards can also be submitted.

4. Do you think each of the statements in this draft quality standard would be achievable by local services given the net resources needed to deliver them? Please describe any resource requirements that you think would be necessary for any statement. Please describe any potential cost savings or opportunities for disinvestment.

Stakeholders were also invited to respond to the following statement specific questions:

5. For draft quality statements 1, 2 and 3: Can we be more specific about which service would be expected to carry out the action?

6. For draft quality statements 2 and 3: Given that it is unrealistic to expect every person over 65 to be offered these services, which groups do you believe should be a priority, for example a subpopulation from the definitions in statement 1?

4 General comments

The following is a summary of general (non-statement-specific) comments on the quality standard.

- In general stakeholders supported the quality standard and felt that the key areas for quality improvement had been identified.
- Stakeholders suggested that in order for these statements to be achieved it will be necessary to work across multiple sectors. This includes the public and private sector as well as voluntary and community services.
- Stakeholders highlighted that the quality standard should consider the needs of older people from different equality groups. In particular focus should be given to lesbian, gay, bisexual and transgender (LGBT) groups as well as black, Asian and minority ethnic groups.
- A stakeholder felt that terms such as “prematurely old” or “prematurely ageing” could increase stigma amongst older people.

Consultation comments on data collection

- Stakeholders suggested that data would be best collected within primary care. Additional resource may be required to do this.
- Stakeholders highlighted that these statements may rely upon people self-reporting in order for data to be collected. A single care plan owned by the service user may aid this.

Consultation comments on resource impact

- Stakeholders felt that local services are already under financial pressure and are struggling to provide basic care. Further resource investment would be required to deliver this quality standard.

- A potential solution to significant resource impact would be to ensure that services are provided across the public and private sector as well as voluntary and community services.

5 Summary of consultation feedback by draft statement

5.1 Draft statement 1

Local authorities have coordinators to help identify and support older people who are most at risk of a decline in their independence and mental wellbeing.

Consultation comments

Stakeholders made the following comments in relation to draft statement 1:

- In general stakeholders supported the intent of this statement and highlighted examples of best practice such as Nottingham City who have an Older Persons Champion.
- Stakeholders felt that many of those most in need of support may be missed, and suggested that to overcome this local authority coordinators would need to have a good understanding of local facilities and skills ('assets') against local needs.
- Stakeholders suggested that local authorities may need to “ensure the availability of” rather than “have” coordinators, as coordinators are often provided by other organisations such as voluntary services.
- A stakeholder felt that outcome measures should focus on improvement in wellbeing. This can be assessed by tools such as the Warwick-Edinburgh Mental Well-being Scale.
- A stakeholder suggested that the statement should focus on how and when information should be accessed and shared across sectors to identify those most at risk.
- Stakeholders were conflicted about the list of those at risk. Some felt that this may be too long and require additional resources, while others felt additions should be made, such as those with specific long-term conditions, or older people in poorly maintained or inappropriate housing.

Consultation question 5

Stakeholders made the following comments in relation to consultation question 5:

- Some stakeholder felt that it was not beneficial to specify which services carried out the action within the statement, given that it should be as part of local health and social care partnerships.
- Other stakeholders highlighted services that could carry out this role. Suggesting primary care, local health and wellbeing boards and social care services.

5.2 Draft statement 2

Local authorities support and publicise tailored, community-based physical activity programmes for older people.

Consultation comments

Stakeholders made the following comments in relation to draft statement 2:

- Stakeholders suggested that the definitions of physical activity should also include opportune exercise, such as walking to local shops.
- Stakeholders felt that this statement needed to be more explicit in taking into account older people's disabilities or difficulties.
- A stakeholder suggested that this statement should also include health promotion, such as regular eye checks.
- Stakeholders suggested that a simple count of people attending these programmes is inadequate as a measure and stated an acceptable alternative would be proportions of the vulnerable population.
- A stakeholder suggested that physiotherapists and nurses should be added to the list within the healthcare professional audience descriptors.
- A stakeholder highlighted that it may be difficult to maintain an up-to-date registry of physical activity programmes in individual areas.

Consultation question 5

Stakeholders made the following comments in relation to consultation question 5:

- Some stakeholders felt that it was not beneficial to specify which services carried out the action within the statement, given that it should be as part of local health and social care partnerships.
- Stakeholders suggested that local authorities should take a lead but they would need input from specialists.

Consultation question 6

Stakeholders made the following comments in relation to consultation question 6:

- Stakeholders largely agreed offering these services to everyone over 65 would overwhelm services. They suggested the following subgroups:
  - people aged over 80
  - older people at risk of becoming isolated due to physical impairments
  - older people with multiple risk factors, e.g. over 80 and who are carers
  - older people who are LGBT
  - older people of black, Asian and minority ethnic groups
  - older people who are frail
  - older people who are obese
  - older people with mental health problems
  - older people who live alone
  - older people in poorly maintained or inappropriate housing

5.3 Draft statement 3

Local authorities support and publicise a range of activities for older people to build or maintain social participation.

Consultation comments

Stakeholders made the following comments in relation to draft statement 3:

- Stakeholders agreed with the purpose of this statement, that procedures should be in place to ensure that a range of activities are promoted by local authorities.
- A stakeholder highlighted that this statement would require local facilities and skills sets to be mapped in order to assess what local activities are currently available.

- Stakeholders felt that this statement needed to be more explicit in taking into account older people's disabilities or difficulties.
- Stakeholders highlighted that a simple count of people attending these programmes as a measure is inadequate and proportions of the vulnerable population should be included as an alternative.
- A stakeholder highlighted that this statement could be expanded to focus on sustaining health as well as increasing social participation.

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  - older people who are obese
  - older people with mental health problems
  - older people who live alone
  - older people in poorly maintained or inappropriate housing

6 Suggestions for additional statements

The following is a summary of stakeholder suggestions for additional statements.

- Stakeholders highlighted that older people's participation in activity programmes is largely dependent on the nature of their local communities. They suggested a statement on promoting age friendly communities.
- A stakeholder suggested that there should be a quality statement on eye health, given that sensory impairment can play a substantial role in an older person's mental wellbeing and independence.
- A stakeholder highlighted that the quality standard could focus on specific activities rather than programmes in general. Social linking, singing and apprentice schemes were suggested.
- Stakeholders felt that a statement on recording older people's preferences would be beneficial. Carrying this out can ensure that older people have the opportunity to take control over their own care, maintaining their independence.

Appendix 1: Quality standard consultation comments table – registered stakeholders

ID	Stakeholder	Statement number	Comments[1]
001	Age UK	General	Age UK welcomes this quality standard as a step towards supporting continuous improvement in older people's independence and wellbeing, as well as clarifying expectations of service commissioners and providers around what needs to happen.
002	Age UK	General	As we highlighted in reference to the use of "prematurely old" or "premature ageing" as part of the consultation on the NICE Guideline NG32, we believe this type of phrase risks of reinforcing current stigma towards older people and the ageing process, 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. Despite the passage of the Equality Act 2010, 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 deep-rooted cultural attitudes towards the 'value' of treating and supporting older people, and assumptions around what older people can or cannot do. In addition, we believe this could further impact negatively on older people's self-esteem or willingness to engage in activities that might help them due to negative perceptions around ageing. The phrase also begs the question of what "premature ageing" actually means, given that ageing is a life-long process. As such, we would suggest removing the mention of "premature ageing" and keeping the second half of the sentence, which is about health risks associated with older age.
003	Care and Repair England	General	Care and Repair England has decided not to comment on this draft quality standard given its focus specifically on activities to support mental wellbeing and independence. In our comments on the guideline for this area we had suggested there should also be a consideration of environmental and neighbourhood factors (including decent and suitable housing) but this was rejected as out of scope. We still believe that independence and mental wellbeing are maintained and enhanced by more than just activities and specific services but accept that this has been rejected for this standard. As a result we do not feel it worth making further suggestions about housing and neighbourhood interventions.
004	Department of Health	General	I wish to confirm that the Department of Health has no substantive comments to make, regarding this consultation.

[1]PLEASE NOTE: Comments received in the course of consultations carried out by NICE are published in the interests of openness and transparency, and to promote understanding of how quality standards are developed. The comments are published as a record of the submissions that NICE has received, and are not endorsed by NICE, its staff or its advisory committees.

ID	Stakeholder	Statement number	Comments[1]
005	Foundations: The National Body for Home Improvement Agencies	General	Foundations really welcomes the drafting of this quality standard on the independence and well being of older people. Particularly as it focuses exclusively on older people living in the community in their own home. We should therefore like to see a much more explicit link being made between the independence and wellbeing of older people and the conditions in the place in which they live; their home. With that in mind we should like to make the following suggestions:
006	National Community Hearing Association	General	We appreciate the quality standard does not cover the mental wellbeing and independence of people who live in a care home or attend one on a day-only basis. This however is unhelpful in that the Standard also aims to support people not move into care etc and it is of course not only possible but also highly likely that individuals might lose their independence and quality of life and slip further down the dependency scale, also adding to NHS and social care costs. The population in question (and covered by this Standard) is also likely to be at risk of similar co-morbidities as people who do end up in care homes and/or otherwise losing their independence. The following NICE guidelines/standards would be useful to review in the context of the current consultation: Delirium in adults Mental wellbeing of older people in care homes Older people: independence and mental Wellbeing Medicines adherence: involving patients in decisions about prescribed medicines and supporting adherence Mental wellbeing in over 65s: occupational therapy and physical activity interventions Older people with social care needs and multiple long-term conditions Patient experience in adult NHS services: improving the experience of care for people using adult NHS services Rehabilitation after critical illness in Adults Stroke rehabilitation in adults Dementia: independence and wellbeing

ID	Stakeholder	Statement number	Comments[1]
			Excess winter deaths and illness and the health risks associated with cold homes Service user experience in adult mental health: improving the experience of care for people using adult NHS mental health services Social anxiety disorder: recognition, assessment and treatment This is because these all highlight the importance of ensuring individuals' hearing (and sight) care needs are met in order to help people make informed choices, stay independent, stay engaged in social activities, and age well etc. Other NICE guidance therefore already makes clear that hearing and sight needs are directly linked to mental wellbeing and independence for older people, but the current NICE Standard by the same name does not. We appreciate NICE follows protocols when developing guidance and standards, but it is unclear why there is limited cross referencing and prioritisation across guidelines for populations with similar needs – for example ensuring sensory needs are assessed and met in all guidelines for groups which are at much higher risk of both hearing and sight loss, when both hearing and sight are fundamental to achieving all the other stated objectives in the 'mental wellbeing and independence for older people quality standard'. One example of how information is lost between guidelines published by NICE is on page 12 of the current Standard. There is a list of people at most risk, and one bullet point is "who have age-related disability". When reviewing the primary source (Older people: independence and mental wellbeing, page 38) it is clear in the annex that hearing and sight loss are classified as age-related disabilities. Yet no agency reading this NICE Standard would know – Hearing loss is the 6th leading cause of years lived with disability in adults in England, with 9 million people affected, 97% of who are aged 40 and older, 90% 50 and older, and the average NHS hearing care patient is 74 years of age Hearing loss is the most prevalent sensory impairment in this group Unsupported hearing loss is a major risk factor for: social isolation, loss of independence, can limit an individual's ability to achieve their potential, work productively, seriously limit building relationships with others and contributing to their community – i.e. hearing loss in the group covered by the mental wellbeing and independence for older people quality standard, if left unsupported, will act as a barrier to achieving all the goals in the quality standard That unsupported hearing loss has a negative impact on the quality of life of the individual affected and on their family, friends and carers.

ID	Stakeholder	Statement number	Comments[1]
			On this basis, we would ask the committee to consider the following changes Clearly identify the importance of ensuring the group covered by this Standard is supported to make informed choices about their sensory (hearing and sight) needs and that they are encouraged to have regular hearing and sight tests at recommended intervals as part of an active ageing strategy That the impact of unsupported hearing loss on carers quality of life is acknowledged That those organising activities to build or maintain participation (page 17-18) ensure hearing and sight needs have been met, this is in addition to the equality considerations (page 18) The NCHA would be happy to provide references, but due to time constraints these have not been included in this submission.
007	NHS England	General	I wish to confirm that NHS England has no substantive comments to make regarding this consultation.
008	RCGP	General	Carers can balance their caring roles and maintain their desired quality of life. The RCGP feels that most carers may disagree with this statement. The aim should be attainable so carers can cope and be supported as far as able to maintain important aspects of their quality of life – can it be more accurate to reflect possible outcomes. Living with a demented partner does not vet, however much help society gives, change the facts of caring. This sort of rhetoric needs to go – it disengages GPs who offer sensible support and empathise with the losses which come as a carer, sometimes for decades. (JW)
009	RCGP	General	People who use social care and their carers are satisfied with their experience of care and support services. People know what choices are available to them locally, what they are entitled to, and who to contact when they need help. The RCGP welcomes these statements.

ID	Stakeholder	Statement number	Comments[1]
			(JW)
010	RCGP	General	Injuries due to falls in people aged 65 and over. The RCGP recommends further clarification. The statement will mean that people who would rather be at home with a fall risk are nudged into care homes to reduce this indicator. Success with elderly and infirm people leads to a next illness ultimately, which will again lead to more frailty. This is not being recognised in this document. (JW)
011	RCGP	General	The RCGP welcomes the indicators 11, 12 and 13. Indicators 14 and 15 would need to be reviewed. Suppose we decide to get the elderly on bicycles to improve muscle strength and getting out? We will have more fractures and RTAs. It is a global statement and requires tighter definition re hip fractures which we can prevent and same for winter deaths. (JW)
012	RCGP	General	The RCGP welcomes all the domains in Table 3 about enhancing quality of life for people with long-term conditions, helping people to recover from episodes of ill health or following injury and ensuring that people have a positive experience of care. (JW)
013	RCN	General	This is to inform you that the Royal College of Nursing have no comments to submit to inform on the draft mental wellbeing and independence for older people quality standard at this time.
014	Royal College of Psychiatrists	General	Local services are already under a lot of financial pressure and would need further resource investment to deliver this quality standard especially setting up or supporting programmes for physical and occupational therapeutic activities. Many of these programs used to be delivered via day care and care home programmes which could be explored again with private care home providers for the larger community.
015	Tees Esk and Wear Valleys NHS Foundation Trust	General	Still a tendency to allow poor choice rather than ensure appropriate care is being provided in the best interests of individuals lacking capacity. Need to be mindful that the target could potentially lead to poor decision making.
016	Tees Esk and Wear Valleys NHS Foundation Trust	General	This has been focused on acute general hospitals. There are also patients on mental health wards whose discharge is delayed for long periods because they are awaiting placements (with multi-factorial delay such as identifying placement, agreeing funding).

ID	Stakeholder	Statement number	Comments[1]
017	Tees Esk and Wear Valleys NHS Foundation Trust	General	There are many socially isolated individuals who fall under the radar and would probably not be counted.
018	Tees Esk and Wear Valleys NHS Foundation Trust	General	Patients may be admitted to an acute hospital under one code and re-admitted under a different code but essentially for the same issue. E.g. a patient with heart failure who then falls post discharge (which relates to a period of poor mobility when their heart failure was worse) would not be counted as being readmitted for the same problem (despite the cause of the emergency readmission being the same). This compromises the reliability of the data.
019	Tees Esk and Wear Valleys NHS Foundation Trust	General	Indicators in section 4 do not take into account that the most vulnerable/isolated people, often with very poor physical and mental health and quality of life, are not presenting to their GPs. These indicators will miss this group of patients who may present later with complex problems requiring long and costly hospital stays.
020	The National LGB&T Partnership	General	Stakeholders using this guidance would not recognise older lesbian, gay, bisexual and trans (LGBT) people's health needs as the Quality Standard embeds Outcomes Frameworks that do not capture LGBT health inequalities. The National LGB&T Partnership has LGBT companion documents to the mainstream Adult Social Care Outcomes Framework (ASCOF), Public Health Outcomes Framework for England (PHOF), and NHS Outcomes Framework (NHSOF; in development, to be published 2017). There is a substantial body of evidence demonstrating that LGBT people experience significant health inequalities which impacts upon both health outcomes and experiences of healthcare. Neither mainstream ASCOF, PHOF nor NHSOF have data relating to LGBT communities and so the health needs of LGBT people are not captured within these documents. This discrepancy is addressed by the Partnership's companion documents. For example, to complete the ASCOF LGB&T Companion we carried out the largest survey of LGB&T people and their carers about social care. The evidence gathered through the survey on Adult Social Care shows that only 4% of LGBT people surveyed felt they were able to balance their caring responsibilities with their own quality of life. The majority of respondents (64%) felt they couldn't balance these two together, with many describing it as very difficult to achieve. The evidence base shows a clear requirement for the Standard to be inclusive of the specific needs of older LGBT people in relation to mental wellbeing and independence. A research study comparing the needs of just over 1000 heterosexual people and an equal number of LGB people all aged over 55, found that older LGB people are more likely to be single, more likely to live alone, less likely to have children and less likely to see biological family members than their heterosexual peers (Stonewall, Lesbian, gay and bisexual people in later life, 2011). Half of the respondents felt their sexual orientation would have a negative impact on getting older. Many were also much more anxious than heterosexual people about their future care needs, independence, mobility and future ill health. Older LGB people expect to be twice as likely as their heterosexual peers to rely on GPs, health and social care

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			services and paid help, and yet 3 in 5 are not confident that those same public services would be able to understand or meet their needs. (Stonewall, LGB People in Later Life, 2011). Evidence of diminished support networks leaves many older LGB people feeling vulnerable and anxious about the future. Whilst there isn't corresponding evidence in relation to older trans people, we would expect the situation to be equally poor for older trans men and women. In light of this evidence base it is extremely important that mainstream providers working with older LGBT people are aware of the additional barriers facing older LGBT people to having good mental wellbeing and levels of independence. One way of doing this would be to publish links to the LGBT Companion Documents to ensure LGBT needs are included. The LGBT Public Health Outcomes Framework Companion Document can be found here: http://lgbt.foundation/policy-research/the-lgbt-public-health-outcomes-framework-companion-document/ The LGBT Adult Social Care Outcomes Framework Companion Document can be found here: http://lgbt.foundation/policy-research/ASCOF/
021	The National LGB&T Partnership	General	Equality and diversity training should be recommended alongside the listed training in assessing, caring for and treating older people, and training to deliver actions in the quality standards. Equality and diversity training, or topic specific training such as LGBT, Black & Minority Ethnic (BME) and disability awareness training, can ensure staff are made aware of the barriers facing marginalised groups in accessing services and how they can address them. Training can ensure services are genuinely inclusive and that staff feel confident in meeting the needs of LGBT people, subsequently improving the experiences of those that use the service.
022	EPA UK/EU	Question 1	Whilst this draft quality standard reflects some key areas for improvement it does not go far enough to embrace what is required for long term change. The House of Lords Select Committee's report 'Ready for Ageing' (http://www.parliament.uk/business/committees/committees-a-z/lords-select/public-services-committee/report-ready-for-ageing/) informs that: 'The House of Lords Committee on Public Service and Demographic Change warns that the Government and our society are woefully underprepared for ageing. The report identifies how England will see a 51% rise in those aged 65+ and a 101% increase in those aged 85+ from 2010 to 2030. Living longer represents progress, but as well as opportunities for the elderly to have extended lives, the changes involved create major challenges for individuals, for employers, for our welfare services, and for the Government and all political parties. Radical changes to the way that health and social care is delivered are needed to provide appropriate care for the population overall and particularly for older people, and to address future demand."

ID	Stakeholder	Statement number	Comments[1]
			"The Committee has concluded that the quality of healthcare for older people is already inadequate, and that England has an inappropriate model of health and social care to cope with a changing pattern of ill health from an ageing population, with many more older people living for more years, often with one or more chronic long-term health conditions. Without radical changes in the way that health and social care serve the population, needs will remain unmet and cost pressures will rise inexorably."
023	EPA UK/EU	Question 1	The report calls for 'Suitable health and social care for an ageing society'. Given that what we have already is not held to be sufficient, we need to look in more depth at what has worked and what could work, and taking this into account we could design a new model going forward that would support the ageing society Consideration of the work done with the Intentional whole health system redesign by Southcentral Foundation's 'Nuka' system, is a well documented success story we can learn from. (http://www.kingsfund.org.uk/publications/commissioned/intentional-whole-health-system-redesign-nuka-southcentral) where over 3 decades they have transformed health care from being amongst the worst to now being a global quality standard. The SLIC model is a further example of a redesigned integrated care system put in place in Southwark and Lambeth (http://www.slicare.org/system/documents/files/000/000/070/original/FINAL_Full_End_of_SLIC_Report.pdf?1465917483&utm_source=The%20King%27s%20Fund%20newsletters&utm_medium=email&utm_campaign=7258216_HMP%202016-06-28&dm_i=21A8,4BKH4,FM9TW3,FUM0V,1
024	EPA UK/EU	Question 1	The House of Lords Select Committee's report 'Ready for Ageing' states: 'Are the Government ready for ageing? The Cabinet has not assessed the implications of an ageing society holistically, and has left it to Departments who have looked, in parts and in varying degrees, at the implications for their own policies and costs. The Government have not looked at ageing from the point of view of the public nor considered how policies may need to change to equip people better to address living longer. 'The ageing of the population is inevitable, and affects us all.' What The House of Lords Committee on Public Service and Demographic Change is showing us is that we are not equipped to deal with what we have in front of us. It is apparent that we need to broaden our vision in order to support the future for the elderly. To do this we need to

ID	Stakeholder	Statement number	Comments[1]
			see that to truly support with the ageing demographic we need to focus on impacting health care to a much younger age group because good health and well being in the elderly starts from an early age. The outcomes we are seeing in elderly care are due to the lack of responsibility for our own health in our younger and mid-adult years. This is when our behaviours and patterns determine our future health. We need whole health system reform calling for change from a much young age and asks for responsibility from the onset. For example, The NUKA Intentional Health System Re-design (above) has built in 'patient owner' responsibility into its strategic plan. Taking responsibility for our own health is part of the contract ' patient owners' agree to when receiving services. Awareness and behaviour change is more likely to occur when people are supported to change as young and middle aged adult not at old age. We need to be looking at supporting health of a much younger cohort in order to see a shift by 2030 and beyond, when the demographics are set to present us with such alarming pictures of the elderly. In some countries morning exercise is compulsory in schools and businesses. Responsibility for our health and well being needs to be embedded firmly in our mid- years, not left to trying to battle with 65 years of self neglect and self abuse, causing bodies to be obese and needing hoisting to go to the toilet.
025	EPA UK/EU	Question 1	We can look after ourselves in lots of different ways that supports our mental, emotional and physical health. We know that regular gentle exercise, well balanced nutrition and a regular sleep pattern all support the body to maintain a balanced homeostasis. Taking responsible care of ourselves with regular health checks and avoiding harmful substances, such as smoking and alcohol consumption, and over eating is foundational to maintaining health and vitality. Transforming the nation's health means actively participating and taking steps to remain vital and well into our elder This way of life is not something that can be developed overnight, it is a long tern investment that brings huge rewards to all those who participate in such a health and well being way of life. There are many examples of individuals who live in such a way and have proven its benefits. 1. http://www.unimedliving.com/before-and-after

ID	Stakeholder	Statement number	Comments[1]
			2. http://www.unimedliving.com/before-and-after/everyday-people-in-livingness/before-and-after-ariana-ray-s-weight-loss-transformation.html 3. http://www.unimedliving.com/before-and-after/everyday-people-in-livingness/before-and-after-sandra-schneider.html 4. http://www.unimedliving.com/before-and-after/everyday-people-in-livingness/before-and-after-angela-perin.html 5. http://www.unimedliving.com/before-and-after/the-before-and-after-photo-diary/the-before-after-project.html The NHS in conjunction with a specific group (Universal Medicine) have the capacity to initiate and support such a way of living that brings about such transformations. In Australia this is known as the integrated care model. The integrated care model has to, by definition, include community groups such as Universal Medicine and Unimedliving as they are leading the way in how to take responsibility for our health and wellbeing. “Loneliness affects 1 million older people ..and… Loneliness is linked to the onset of dementia (Feelings of loneliness, but not social isolation, predict dementia onset: results from the Amsterdam Study of the Elderly Holwerda et al.) and is associated with depression. It increases as people become less able to undertake routine activities. 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).” It is noted that: “many older people who are at risk of a decline in their independence and mental wellbeing may not identify themselves as such.” (https://www.nice.org.uk/guidance/ng32/chapter/The-committees-discussion), We need to be asking ourselves how to access and connect with adults and older people who do not identify themselves as being at risk of decline
026	NIHR Maudsley	Question 1	The quality standard should include access to activities that promote cognitive health and mental activity, as well as

ID	Stakeholder	Statement number	Comments[1]
	Biomedical Research Unit for Dementia		physical activity. The rationale is that, as well as potentially delaying cognitive decline, there is RCT evidence that cognitive training activities improve older people's ability to perform activities of daily living (Corbett et al 2015) - essential to maintaining independence. The inclusion of evidence based interventions to promote cognitive health, alongside those which promote physical activity, will better enable the quality standard to drive improvements in the independence and mental wellbeing of older people. A range of smaller studies suggested improvements in memory following a programme of cognitive training (Derwinger et al, 2005, O'Hara et al, 2007). Building on these, a large randomized controlled trial of in-person cognitive training (CT) in a cognitively health group found significant improvements in key aspects of cognition such as reasoning (effect size 0.26) and memory (effect size 0.28), which were sustained for up to 10 years (Willis 2006, Rebok 2014). The study also showed benefit to activities of daily living. But importantly in terms of access and cost-effectiveness, on-line cognitive training has also been shown to improve activities of daily living and specific cognitive abilities in people aged over 60 without cognitive impairment. Corbett et al (2015) performed a double blind 6-month on-line RCT in adults older than 50, randomized to general cognitive training (CT), reasoning CT, or control. The primary outcome was activities of daily living (IADL) in adults aged over 60. The data demonstrate a significant benefit to activities of daily living in a group of adults older than 60 receiving the on-line training interventions compared with control, over a the period of 6 months. The standardized effect sizes of 0.16 and 0.15, respectively, are comparable to previously published studies of in-person CT packages in older adults, indicating the efficacy and feasibility of an on-line approach to CT in this group, and are also comparable to the effect size of cholinesterase inhibitors in mild dementia and cognitive stimulation therapy in studies with a control intervention. These findings are extremely valuable since it is known to be difficult to elicit change in IADLs, particularly in a cognitively healthy group. This impact on IADLs therefore indicates the potential for on-line cognitive training as an effective public health intervention that could improve this key measure of independence and quality of life in older adults in a cost effective way. The NICE Guideline 'Older people: independence and wellbeing' clearly describes how a range of activities must be made available to older people to support them to maintain independence and that individuals will of course have a preference regarding the type of programme they engage with and which they would most benefit from. Evidence of the impact of cognitive training on activities of daily living, with its implications for independence, supports its inclusion in the Quality Standard. We would therefore like to see Statement 2 amended to "Local authorities support and publicise tailored programmes which promote physical and mental activity."

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			References: Corbett A, Owen A, Hampshire A, Grahn J, Stenton R, Dajani S, Burns A, Howard R, Williams N, Williams G, Ballard C. The effect of an online cognitive training package in healthy older adults: an online randomized controlled trial. JAMDA 2015;16:990-997 Derwinger A, Stigsdotter Neely A, MacDonald S, Backman L. Forgetting numbers in old age: Strategy and learning speed matter. Gerontology 2005;51:277e284. O'Hara R, Brooks JO 3rd, Friedman L, et al. Long-term effects of mnemonic training in community-dwelling older adults. J Psychiatr Res 2007;41:585e590. Willis SL, Tennstedt SL, Marsiske M, et al. Long-term effects of cognitive training on everyday functional outcomes in older adults. JAMA 2006;296: 2805e2814. Rebok GW, Ball K, Guey LT, et al. Ten-year effects of the advanced cognitive training for independent and vital elderly cognitive training trial on cognition and everyday functioning in older adults. J Am Geriatr Soc 2014;62: 16e24.
027	Royal College of Psychiatrists	Question 1	Yes, the draft quality standard accurately reflects the areas for key improvement.
028	The Chartered Society of Physiotherapy,	Question 1	Yes – we are especially pleased to see the focus on physical activity.
029	The National LGB&T Partnership	Question 1	Question 1 Does this draft quality standard accurately reflect the key areas for quality improvement? On the whole the Quality Standard identifies the key areas for improvement. An additional crucial aspect of improving mental wellbeing and independence for all older people would involve increasing access of services, to ensure that services reach out to people who currently don't access support. There are demographic (i.e living in a rural community), cultural (i.e. having another language as your first language), attitudinal (i.e. belief that a service won't understand your needs) and lifestyle (i.e. being a carer) characteristics that determine the likelihood of accessing services/support and services for older people should be encouraged to be as accessible, inclusive and diverse. In addition, the survey for the ASCOF LGB&T Companion showed that a major hurdle for older LGBT people was poor information and access to information about services. Only 14% of respondents found it easy to find information

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			about support, whereas three quarters said they had not found it easy.
030	EPA UK/EU	Question 2	Current local systems and structures are adept at reporting and collecting data on health and social well being. Both health and social services have good methods of gathering such data and staff are well versed in its application. In order to address the reality of the fact that ageing starts young, and looking at adults at 40 years of age or younger, presents a different problem of data collection as this age group present as fairly invisible unless they visit their GP regularly. No doubt it could be easily redesigned to collect the data, however we would need to identify markers where links with this age group are established. This could be achieved in a similar way to an immunization health-screening programme, where adults are required to visit their GP or health screening professional at a designated appointment. It is not at all insurmountable to establish such a programme for all adults where they are taken through various lifestyle screening and assessment tools. Once first contact had been made, appointments for groups of people at one time could be initiated. A true whole health system could involve employers and occupational health teams to identify people. Job Centre Plus could do the same with the unemployed.
031	Royal College of Psychiatrists	Question 2	The data for the proposed measure would best be collected from primary care and through GP practices. A system to highlight and pass these on to the local authority can easily be devised although there's the issue of additional time and resource needed for GP practices to implement this.
032	Tees Esk and Wear Valleys NHS Foundation Trust	Question 2	Mental Health Trusts are not currently reporting all indicators. Therefore if not included within indicator this needs to be specified e.g. 3.6.ii refers to discharged from acute or community hospital but 3.6.i doesn't specify where the patient was discharged from. Anticipate that Mental Health Trusts don't routinely report this data.
033	The Chartered Society of Physiotherapy,	Question 2	Locally, the systems and structures in place are based on people self-reporting their needs and problems either via GP, social services or via 'community connecters' an off shoot team linked with social services. Therefore it is unclear how people over 65, particularly those focused on in the document, would and could be identified. Those over 65's that access services such as physiotherapy, or GP could be sign-posted into supportive services but there is a risk that at this stage valuable months/ years of preventative input will be missed. Another route to the over 65's could be via guidance or information given at yearly flu-jab clinics, where it may be possible for the health and council services to combine efforts to identify those in need and initiate help. Collecting these measurements would also be made far easier if there was a single care plan, owned by the older person which is contributed to by all involved with their care/ wellbeing.
034	The National LGB&T	Question 3	Question 3 Do you have an example from practice of implementing the NICE guidelines that underpin this quality

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	Partnership		standard? N/A
035	Tees Esk and Wear Valleys NHS Foundation Trust	Question 4	Yes, but there is a need to recognise that services are struggling to provide basic care to a large population and there is a need to concentrate on delivering the fundamental aspects first.
036	Tees Esk and Wear Valleys NHS Foundation Trust	Question 4	No, as services currently struggle to provide basic care. There has been a failure to recognise the importance of things such as social day care particularly for those who are frail and who have mental health issues (especially depression and dementia) who benefit greatly from these provisions. These services also give carers much needed respite.
037	The Chartered Society of Physiotherapy,	Question 4	Working across private/ voluntary/ leisure sectors will be necessary to achieve these standards. The challenge will be for people to be aware of the different services available locally, and having easy access to a database of resources.
038	The National LGB&T Partnership	Question 4	Question 4 Do you think each of the statements in this draft quality standard would be achievable by local services given the net resources needed to deliver them? Please describe any resource requirements that you think would be necessary for any treatment. Please describe any potential cost savings or opportunities for disinvestment Voluntary & Community Sector (VCS) organisations are a key part of community-based engagement activities. Where the statements indicate an expansion, improvement or change to existing funded services, local authorities should ensure additional resource is available to meet the need. For example, both Statements 2 (Physical activity) and 3 (Social participation) suggest that VCS organisations will be service providers. If a service a VCS organisation currently offers, for instance a weekly social group for older LGBT people, needs to change its opening times or promote itself to wider demographic of service users, it is likely to require additional resource to become compliant. Similarly, additional resource might be required to ensure services are promoted by VCS organisations to all local health, public health and social care practitioners.
039	Age UK	Question 5 (statement 1)	In response to the question on page 12 (i.e. whether we would need to be “specific about which service would be expected to carry out the action”) we would argue that it would be unhelpful to be overly specific about the nature of the coordinator/navigator role. Our view is that that we should be less prescriptive about a specific model but clearer about the design principles associated with roles of this type and how these translate into better outcomes. For example, Age UK’s Personalised Integrated Care Programme has shown how adopting truly person-centred design principles can improve wellbeing and resilience while also helping to build local community capacity. Through this programme, we support people to express what is most important to them and the challenges they may be having. These “guided conversations” result in a collaborative care planning process based on shared-decision making principles between the older person and our Age UK staff that is then fed back into the care team, to help better target subsequent interventions. This further allows individuals to better identify the services that are right for them,

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			whether NHS services or the many voluntary sector services in their area. Our model also promotes a new way of working, shifting away from siloed medical interventions towards a model featuring non-medical support delivered by multi-disciplinary teams that include the voluntary sector, wrapping support around the person. Our model shows that simply being linked into services does not guarantee a good outcome and is therefore only a minor part of the process.
040	EPA UK/EU	Question 5 (statement 2)	The Local Authority working in partnership with the CCG (NHS), local Day Centers, GP Surgeries and Leisure Centers and local community groups can support and publicise tailored community-based physical activity. This activity should include free swimming for older people, as the cost of a regular swim is prohibitive for pensioners, and the freedom and encouragement to go outside the home that the free bus pass gives should be protected. Some Local Authorities have installed exercise machines in playgrounds and this could be extended to all areas
041	EPA UK/EU	Question 5	The Local Authority can work as in Quality statement 3, but should begin to foster activity in the community for all ages so that it becomes second nature to people, and thereby encourage life skills in keeping active and enjoying good health.
042	Foundations: The National Body for Home Improvement Agencies	Question 5 (statement 1)	Can we be more specific about which service would be expected to carry out the action? In relation to the commissioning of Village and Town agents or navigators the QS can be more specific by suggesting that the function sits with local Health and Wellbeing Boards that bring together a coordinated response to local needs. Foundations should therefore like to see explicit reference to the Health and Wellbeing Board's function in maintaining a Joint Strategic Needs Assessment where the risks to the independence and wellbeing of local older people are identified and quantified. That would entail commissioning agents able to carry out that function.
043	Royal College of Psychiatrists	Question 5	A specific service needs to be named and empowered to deliver in this service with responsibilities for primary care also highlighted.
044	South West Yorkshire Partnership NHS Foundation Trust	Question 5 (statement 1)	Can we be more specific about which service would be expected to carry out the action? Clarification is required with regards to who should be expected to carry out the action. The quality statement does clearly states that "local authorities" should provide coordinators to help and support older people. However following on from this statement under the heading of Service Providers the document becomes vague in defining who the responsibility lies with, suggesting multiple services including local NHS providers, housing organisations and voluntary organisations. There are also concerns around the accurate identification of older people who are at risk. Are the suggested service provider's best equipped to identify hard to reach and isolated individuals who are at risk of poor mental wellbeing and loss of independence? It is perhaps felt that primary care services (specifically GP's) would be better equipped to identify those who are most at risk of decline than local authorities or voluntary organisations.

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045	South West Yorkshire Partnership NHS Foundation Trust	Question 5 (statement 2)	Can we be more specific about which service would be expected to carry out the action? In our service area we currently have Community Development Workers who are funded by the local authority and who meet Quality Statement 2. Our concern is around how services, specifically local authorities maintain an up-to-date register of current activity programmes in individual wards/areas and how this information is effectively disseminated to socially isolated and hard to reach older people. This concern in compounded further considering that local authorities are under ever increasing financial pressure and service cuts.
046	South West Yorkshire Partnership NHS Foundation Trust	Question 5 (statement 3)	Can we be more specific about which service would be expected to carry out the action? The same concerns apply as stated above in Statement 2.
047	Tees Esk and Wear Valleys NHS Foundation Trust	Question 5	Each Quality Statement should clearly define which services have lead responsibility for delivery/ who is expected to carry out the action. This is necessary to inform local commissioning etc. and to prevent potential implementation barriers. Some suggestions for individual statements follow: Statement 1: Social Services predominantly but identifying need will likely also involve other professionals (primary care, secondary physical and mental health care, OT etc.) and these groups may need to work in partnership with care coordinators to identify level support needed. Statement 2: Local Authority, however, older people are likely to need signposting or even referral via other services such as primary and secondary care and also will likely need input of specialists to tailor the exercise (such as physiotherapists) so that programmes are suitable. Might be able to use some voluntary sector in delivery (such as use of public space, activity facilitators, transport to activity etc.). Statement 3: Local authority predominantly but in partnership with other groups such as voluntary sector (e.g. Alzheimer's Society, churches and so on) to actually deliver. Transport is key, especially for older people living in less populated/ rural areas. Some may be unable to use public transport and those who are able to may not have regular services in their area. This can be a barrier to activity and means people become stranded in their own homes.
048	The Chartered Society of Physiotherapy,	Question 5	Unsure – this needs an integrated approach across health and social care, therefore is difficult to specify particular services carrying out particular actions. For statement 2, we would advocate that physiotherapists are well placed to safely deliver tailored physical activity for older people with comorbidities.
049	The National LGB&T	Question 5	Question 5 For draft quality statement 1, 2 and 3: Can we be more specific about which service would be expected to carry out the action?

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	Partnership		N/A
050	Age UK	Question 6	In response to question 6 on page 9 (and the same question on pages 15 and 18) around the potential groups/issues to prioritise to target services, we would argue that the impact of frailty should be explicitly recognised. Although we anticipate that many of the subgroups identified within statement 1 may include older people living with, or at risk of, developing frailty, we believe it would be helpful to explicitly target people living with the condition. Frailty can affect people of all ages but is most prevalent in people over 85 and the total numbers are likely to grow substantially in the coming years. Work carried out by Age UK has identified frailty as an important risk factor for low mood and depression and feelings of "losing control". Older people included in our research often talked about "turning points" in their ability to do every-day tasks and the impact this had on both their feelings of self-reliance and their mental wellbeing. There was often no response from local services when these turning points occurred and important chances to remain active and independent were missed, which increased risks of rapid deterioration in people's wellbeing following such moments. Recognising frailty using many available, validated, tools and proactively planning care would make a huge difference to a person's long-term outcomes and overall mental wellbeing. For people with mild or "pre" frailty, often simple support such as providing information to people can help to delay onset into later life and help to engage people with local services and community support. See for example Age UK/NHS booklet, A practical Guide to Healthy Ageing (updated October 2015). We would therefore like to suggest adding a point to the definitions on page 12 to include people: "who are living with frailty, i.e. who struggle to do everyday tasks themselves and are becoming increasingly vulnerable to physical and emotional setbacks".
051	Compassion in Dying	Question 6	Through our work with older people as part of our My Life, My Decision (MLMD) programme, we have highlighted numerous groups that would benefit from further information and support to access information about their choices regarding their medical treatment and care. In particular, we have been working with numerous BAME and LGBT groups and individuals to learn the barriers that they face in accessing quality information and support to make decisions about their health and how these can be addressed. For example, older people from the LGBT community are much more likely to be single, not have children and live alone. They may also be concerned about discrimination when accessing information and services around their health due to historical prejudice. These factors all contribute to a detrimental impact on wellbeing and independence amongst older LGBT people. Within BAME groups there are also barriers around language and illiteracy which can hinder their ability to maximise their independence. This is because their access to appropriate information is limited, as well as their ability to communicate what they want. MLMD has run projects with people from the South Asian community and women from the Somali community. In one

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			of these projects a participant commented, “we are already at the stage where we cannot communicate our wishes” when discussing how they could be supported to plan ahead for the end of life or a loss of capacity. This inability to communicate or express what they want has a huge impact on their ability to feel confident enough to take control over their care. MLMD has also frequently worked with older individuals that are isolated, either living alone or living far from their social networks. Providing these people with the opportunity to socialise and engage in decisions about their health and care would contribute to improving their independence, especially if they feel they do not have supportive structures around them. An opportunity to discuss their care preferences in a collaborative way can also lead to more positive relationships with various healthcare professionals and people around them. We will be publishing reports on specific work with BAME groups and wider learning from the MLMD programme in Summer and Autumn 2016.
052	EPA UK/EU	Question 6	As we have discussed above, it is recognized that to have any long term impact to turn the tide of poor health and well being that is forecast to establish itself as a firm and expensive disaster for the UK health service by 2030, (http://www.parliament.uk/business/committees/committees-a-z/lords-select/public-services-committee/report-ready-for-ageing/), then there is an urgent need to target the pre-elderly adult cohort with the 40+ age group with health promotion, awareness and tools to support healthy and positive choices. The promotion of self and community responsibility is central to this approach. Those who are most vulnerable within this group are those who are overweight. This is not to act in any discriminatory way, but it is a fact that an obese person today is likely to increase that weight, and come 2030 and beyond will see the immobility of such people with very poor life choices. Obesity (http://www.nhs.uk/Livewell/loseweight/Pages/statistics-and-causes-of-the-obesity-epidemic-in-the-UK.aspx) Obesity levels in the UK are at 24.9% and have more than trebled in the last 30 years, and, on current estimates, more than half the population could be obese by 2050. The other group to target would be those who perceive they are lonely, given the link between perceived loneliness and dementia. Social isolation and loneliness is pretty well established as a risk factor for poor health and a shorter life. Isolation is also linked to obesity, both as a complication of obesity and a potential trigger for obesity. In fact, health, social isolation, and obesity are so tightly bound together that separating cause and effect is a daunting challenge.(http://conscienhealth.org/2013/08/social-isolation-obesity-health/)

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			Obesity and feelings of loneliness will impact not only on people's willingness and capacity to engage Evidence is apparent and visible on the high street of the harm being done by obesity and loneliness. What will it be like on the streets and in the communities in 2030?
053	London Fire Brigade	Question 6	We note that the quality standard covers interventions to maintain and improve the mental wellbeing and independence of people aged 65 or older, and how to identify those at risk of decline. LFB have a particular interest in this area as our evidence(1) shows that the majority of people who are injured in, or die from accidental fires share a number of characteristics including - Aged 60 or older Lack of mobility Often living alone Experienced a physical or mental health problem It is apparent that those most at risk of accidental fire also share common characteristics with older people most at risk of a decline in their independence and mental wellbeing as set out in Quality Statement 1 – Identifying And Supporting Those Most At Risk Of A Decline, so would recommend that services are prioritised toward older people who - Live alone and have little opportunity to socialise Have low income Have recently experienced or developed a health problem Have an age related disability We would also recommend that health and social care providers, practitioners and commissioners seek to form partnerships with their local fire and rescue service as 'an integrated approach to targeting through better co-ordination, prevention and early intervention has been demonstrated to increase the reach and impact of all services'

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			ensuring 'people with complex needs get the personalised, integrated care and support they need to live full lives and sustain their independence for longer(2'). For example, fire and rescue services will be able to identify those at risk of a decline in their mental wellbeing and independence through contact at operational incidents and fire prevention interventions such as home fire safety visits and help them access local services by referring them to local coordinators for support. Similarly, health and social care support agencies working with older people will be able to identify those at risk of fire and refer them to their local fire service for fire prevention advice specific to their needs. [1]Review Of Accidental Dwelling Fires and Fatalities – FEP 2484 http://moderngov.london-fire.gov.uk/mgconvert2pdf.aspx?id=4384 2Consensus Statement on Improving Health and Wellbeing between NHS England, Public Health England, Local Government Association Chief Fire Officers Association and Age UK – 1st October 2015
054	Royal College of Psychiatrists	Question 6	The standard states supports and publicise local programs etc. There's no reason this cannot apply to the groups considered at risk as offering does not automatically mean uptake. Many people offered might decline but it's important no groups are excluded.
055	South West Yorkshire Partnership NHS Foundation Trust	Question 6 (statement 2)	Given that it is unrealistic to expect every person over 65 to be offered these service, which group do you believe should be a priority, for example a subpopulation from the definition in statement one? It is felt that the current list of individuals at risk is too broad and that services would be over whelmed if the acceptance criteria included standalone measures like "giving up driving". The acceptance criteria should possibly focus on the complexity of an individual's needs and not by reducing the number of subpopulations. For example, giving priority to those who have a multiple risk factors such as being unable to drive along with being a carer and being over the age of 80.
056	South West Yorkshire Partnership NHS Foundation Trust	Question 6 (statement 3)	Given that it is unrealistic to expect every person over 65 to be offered these service, which group do you believe should be a priority, for example a subpopulation from the definition in statement one? The same concerns apply as stated above in Statement 2.
057	Tees Esk and Wear Valleys NHS Foundation Trust	Question 6	Identify those most at need in terms physical health, mental health (exercise can help mood disorders and meaningful activity is helpful for those with dementia) and in terms of isolation.

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058	The Chartered Society of Physiotherapy,	Question 6	The groups that we feel should be given priority are: Those aged over 80 Those with a loss of capability who are at risk of becoming isolated e.g. deteriorating sight/ hearing, decreasing mobility
059	The National LGB&T Partnership	Question 6	Question 6 For draft quality statements 2 and 3: Given that it is unrealistic to expect every person over 65 to be offered these services, which groups do you believe should be a priority, for example a subpopulation from the definitions in statement 1? As discussed above, older lesbian, gay, bisexual and trans (LGBT) people are more likely to have poorer mental wellbeing and more likely to be socially isolated. We would therefore recommend that LGBT people are a priority subpopulation for both statements 2 and 3. Statement 2 - Local authorities support and publicise tailored, community-based physical activity programmes for older people. Provision remains problematic for LGBT people participating in physical activity, and across all ages LGBT people are less likely to be engaging in enough physical activity required for good health. The National LGB&T Partnership, with support from Public Health England, conducted a report in 2015 on physical activity levels of LGBT people, including a survey of 1,000 LGBT people in England who self-reported physical activity habits, sport participation and other physical activity. Fewer LGBT people meet the level of physical activity required for good health (at 42%) than in the general population (at 59%) (from PHE, Everybody Active, Every Day, 2014). Lesbian, bisexual and trans (LBT) women and gay, bisexual and trans (GBT) men were equally likely to not reach government recommendations in rates of physical activity compared to the general population, at between 55%-56% of respondents doing less activity than was recommended. Similarly, 64% of LGBT people who identified as neither male nor female (e.g. non-binary, genderfluid or genderqueer) were not active enough to maintain good health. The full report can be viewed here: https://nationallgbtpartnershipdotorg.files.wordpress.com/2016/02/lgbt-people-and-physical-activity-what-you-need-to-know.pdf Part of the issue is that there is limited evidence into what works best to engage LGBT people in sustainable physical activities for health. A report from the Brunel Centre for Sport, Health and Wellbeing into physical activity among LGBT communities in England (2014) highlighted that provision still remains problematic in terms of inclusiveness, discrimination and access to appropriate environments to encourage participation. LGBT specific groups have been

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			delivering physical activities for LGBT people for decades and there is a need to share this expertise across mainstream provision and tailor support for specifically older LGBT people.
060	Age UK	Statement 1	Age UK welcomes the recognition of the need for a specific coordinator/navigator role to identify and support older people in the local area to maintain their independence and mental wellbeing. We have supported the development of similar roles throughout our network for a number of years, including through pilot programmes. Evaluations have shown that they not only support older people's overall wellbeing and independence, they can also help achieve cost savings to the local health economy. For example, our local Wellbeing Coordinator schemes have shown that people who access the service have reported using fewer NHS services, including fewer admissions to hospital and fewer GP appointments. However, given that such roles are often provided by non-statutory organisations, including in the voluntary sector, we would recommend making explicit that local authorities' responsibility may not be to "have" coordinators, but to "support" other organisations that do so, and promote the availability of such coordinator/navigator roles in the local area. We therefore recommend amending the statement so that it reads as: "Local authorities ensure the availability of coordinators in their area to help identify and support people who are most at risk of a decline in their independence and mental wellbeing".
061	Age UK	Statement 1	In addition to measuring the number of older people who are identified as being at risk of a decline in their independence and wellbeing, and among these, the number who access local services, local areas should also measure and report progress in improving older people's wellbeing and independence. The measures chosen for this quality statement so far seem to focus on process, rather than actual person-centred outcomes. We would argue that in supporting the availability of local coordinators/navigators, local authorities should promote and sustain consistent and robust evaluation mechanisms to capture outcomes in terms of older people's wellbeing and quality of life. This could involve using the Warwick-Edinburgh Mental Well-being Scale (WEMWBS) to record any improvements in the mental wellbeing of service users. We would therefore recommend adding the following outcome measure: "c) Proportion of older people and their carers who use services who reported improvements in their wellbeing. Data source: local data collection."
062	EPA UK/EU	Statement 1	Local examples The Local Authority has an Older Persons Champion who works in partnership with Commissioning Officers and whose job it is to identify and support older people who are most at risk of a decline in their independence and wellbeing. This is the case in Nottingham City, where the person is a local Councillor, has been in post for some years and knows the community and its groups, and the functioning of the Local Authority well. This person should link with Community Nurses and social workers because they visit people at home and get to know their patients, family and carers over a period of time, and can pick up changes in life circumstances, behaviour and health before decline happens.

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063	Foundations: The National Body for Home Improvement Agencies	Statement 1	The list of Older people who are most at risk of a decline in their independence and mental wellbeing must include older people in poorly maintained or inappropriate housing.
064	Optical Confederation	Statement 1	The Optical Confederation welcomes the ambition behind this statement and advocates a joined-up approach with clear channels of communication between all professionals supporting an individual's care. However, this statement poses several practical difficulties for optometrists and opticians working in the community not least because of the lack of IT connectivity investment in England for the optical sector. We would welcome further discussion and clarity on these matters to ensure that we can play our part in making the quality standard a success without placing a new unfunded burden on optical practices and other primary care professionals. Regrettably the standard is unclear about how health professionals delivering key elements of holistic primary care in the community (such as optometrists and opticians) are to be enabled and supported in playing their role in identifying those at increased risk of a decline in independence/mental wellbeing. We would also welcome clarification about how local authority co-ordinators will pro-actively engage with practices in seeking out information to help them meet the standard without creating or increasing existing burdens on already hard-pressed optical practices. Standards cannot be delivered by wish fulfilment, they need practical implementation underpinning and support. Having a clear pathway for information sharing is crucial to this standard being realised. The mechanism by which such information sharing and notification would occur is also important. In terms of investment in new software, technology, patient record management and training to facilitate any new system, community optical practices should be supported by necessary investment in the same way that other areas of the NHS have been. Most community optical practices do not have the resources to invest in new systems in the same way that local authorities do. For large multiples with practices throughout the country, there is also the added risk of having to take account of a lack of uniformity in arrangements or systems across local authorities, making it even more burdensome and costly. If appropriate investment is not forthcoming, we propose instead that, in order to remove the risk for fragmented data collection and inconsistencies, primary health care providers such as optometrists and opticians feedback any concerns and flag up any adverse incident affecting a patient with the patient's general practitioner as the NHS coordinators of health care services as they do now. Local authority co-ordinators would then be able to collect this information via GPs in the normal way including contact information for the patient's eye health advisor if they need further information. Shared and standardised training in, and implementation of, such arrangements by NHS England, the Welsh Government and local authorities would also instil confidence across the professions that a notification system of this

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			sort works. This will need to include reassurances about how the security of patient data will be safeguarded in meeting the standard across multiple agencies and health and social care practitioners. It might also be helpful to set out thresholds in terms of risk of impact on a patient's independence or mental wellbeing and what warrants sharing information with social care services. As drafted, the standard is open to wide interpretation, making its application either overly cumbersome (i.e. anything, no matter how trivial, that increases the risk of a decline in independence is reported), or ineffectively restrictive (the impact has to be of such a magnitude as to significantly increase the risk to their independence/mental wellbeing, therefore those who would have benefited from an intervention earlier would miss out). Without defining this clearly, it will be much more difficult for local co-ordinators to deliver the standard uniformly across the country. Given the importance of visual health to the independence and mental wellbeing of older people, we feel that there should be further investigation and discussion as to how the community eye health sector (outpatients ophthalmology clinics, community optical practices etc.) can contribute to local authorities adhering to the standard without any undue burden being created or adopted by them in order to do so. The Optical Confederation would be very willing to be engaged in further discussions about this.
065	Parkinson's UK	Statement 1	We agree that identifying and supporting those most at risk of a decline is an important ambition. People with Parkinson's, and other long term conditions, will often be at high risk of decline due to the progressive nature of their condition. We welcome the principle of 'local coordinators', we view this as a positive suggestion to support older people and their carers to access services. However, we are concerned that this important responsibility could be provided on a voluntary basis, rather than through qualified health and social care professionals. For example, if this important role is undertaken on a voluntary basis, there are fewer opportunities to benchmark the quality of local coordination, or hold coordinators to account if they fail in their duties, or do not perform to expected standards. Parkinson's UK recommends: NICE provides further information about the role of local coordinators and identifies models of good practice to demonstrate how they could operate and further suggestions for how they should be quality assured.
066	Parkinson's UK	Statement 1	On page 12 it states how people can be identified for support. Though it includes those who have recently experienced or developed a health problem and those with an age related disability, people with Parkinson's could fall through the gap. Many people with Parkinson's have had the condition for a long time, and may not have recently been in hospital. It should state that anyone with a long term condition or disability should be prioritised for this

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			support. This is of particular importance for people with Parkinson's, given the degenerative nature of the condition. A person with Parkinson's explains: 'The unfortunate thing is at the time they diagnose it most people don't really need anything, you know, and if you're very lucky it'll be many years before you do. But there ought to be flag in there, there ought to be something to tell those organisations there's a potential problem here. It may not be today, it may not be tomorrow, but it will be there.' Research conducted by Sheffield Hallam University (Tod, Angela Mary et al. "Good-Quality Social Care For People With Parkinson's Disease: A Qualitative Study". BMJ Open 6.2 (2016) available at: http://bmjopen.bmj.com/content/6/2/e006813.full?keytype=ref&ijkey=CuaBWbzDxtyfN3z) on behalf of Parkinson's UK found that people with the condition were often unaware of social care and the associated psychological and mental health support services that it can offer, and in many cases only accessed care at 'crisis point' – when their independence was at significant risk. he research therefore recommended an 'anticipatory' approach to social care planning, with support that escalates in-step with a person's growing care needs. An anticipatory approach to care planning which recognises that people with degenerative neurological conditions are likely to have increasing needs for psychological support as their condition progresses can therefore reduce hospital and GP visits and better support individuals to manage their own mental health and maintain their independence for longer. Parkinson's UK recommends: That the NICE quality standard specify that people with long term conditions are identified for support.
067	RCGP	Statement 1	The RCGP welcomes the intentions behind this quality standard and agrees that there are considerable benefits from keeping older patients both independent and mentally well. However there are a few comments we would like to make in regards to the recommendations suggested. Has the time that would need to be set aside to implement the first recommendations been estimated? Do we know the effectiveness of the measures suggested? For instance, how good is anyone at assessing with any accuracy those older patients who are at risk of cognitive & physical fitness? The assessment result may not be accurate. I note the list of those potentially at risk on p12 is long and very inclusive; targeting at everyone in the groups listed is likely to be a major task. Second, if there are cadres of nurses charged with this job, how effective will they be at improving patients' health? Again my reading of the literature is that advice given by doctors is usually

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			ineffective. Finally, are we sure that the money spent in this way is not going to take the health workers away from more important tasks? (DJ)
068	RCGP	Statement 1	The list of those potentially at risk is long and very inclusive; targeting at everyone in the groups listed is likely to be a major task. If there are cadres of nurses charged with this job, how effective will they be at improving patients' health? Are we sure that the money spent in this way is not going to take the health workers away from more important tasks? (DJ)
069	Royal College of Psychiatrists	Statement 1	How do you identify the people who have access to local services? What does that actually mean?
070	The National LGB&T Partnership	Statement 1	Question 2 Are local systems and structures in place to collect data for the proposed quality measures? If not, how feasible would it be for these to be put in place? Statement 1 - Local authorities have coordinators to help identify and support older people who are most at risk of a decline in their independence and mental wellbeing By nature, many of the individuals most in need of support would be 'off the radar' and therefore methods need to put in place to ensure coordinators are engaging with the most at risk older individuals. Local authority coordinators would need to be fully engaged with local assets who might be best place to identify many of the older people who are at risk of decline in independence and mental wellbeing. The ASCOFLGB&T Companion surveyed service providers and commissioners as well as LGBT people and carers. It found that nearly three quarters (73%) of respondents said that the service they provide or commission does not collect data for LGB&T service users with dementia in relation to the effectiveness of post-diagnosis care in sustaining independence and improving quality of life. We hope that all three statements are measured across a range of monitoring indicators, including sexual orientation, trans status, ethnicity etc. Without monitoring the effectiveness of services/interventions across equalities groups local authorities cannot be sure they are meeting their obligations under the Equality Act 2010 to ensure equality of service and access for the whole population.
071	College of Occupational	Statement 2	Health visitors are cited as a key profession. Health Visitors are specialist community public health nurses but

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	Therapists		primarily work with children to deliver the Healthy Child Programme. We query why they are put before professions that routinely work with older people. In the NICE guidelines [PH16] the full text: Encourages physical activity through a variety of common daily activities this is not reflected in the quality standard. This physical activity can then be advised on from a variety of MDT members, Occupational therapists, Physiotherapists, Nurses and assistants in a variety of services.
072	Parkinson's UK	Statement 2	Quality statement 2 revolves around physical activity for older people. This is a good ambition and oftenexercise can support people with Parkinson's. However with Parkinson's people may well face varying mobility issues when trying to exercise, so it is important that people with the condition are not compelled to undertake such activity. Parkinson's UK recommends: People's long term conditions, and physical abilities must be taken into account when encouraging people to exercise. And that personalised activities are developed where appropriate.
073	The Chartered Society of Physiotherapy,	Statement 2	Whilst we welcome the inclusion of physical activity as a quality statement, the descriptor of physical activity programmes could include a reference to opportune/adhoc exercise. Links could be made across the statements, for example brief visits mentioned in statement 3 could include a walk to the local shop. This would also help place greater emphasis on the integration of exercise and the use of outdoor environments.
074	The National LGB&T Partnership	Statement 2	Question 2 Are local systems and structures in place to collect data for the proposed quality measures? If not, how feasible would it be for these to be put in place? Statement 2 - Local authorities support and publicise tailored, community-based physical activity programmes for older people. It would be relatively simple to count the number of older people to attend tailored, community-based physical activity programmes. As above, it would be essential that monitoring of attendees is comprehensive to ensure that services are inclusive. Services should reach a diverse group of people who are more likely to face barriers to accessing existing services, and therefore more likely to be experiencing poorer mental wellbeing, lower levels of physical activity and higher levels of isolation. It would be a simple task to ensure that demographic monitoring covered factors which may or may not already be asked as standard, such as sexual orientation, trans status, ethnicity, carer duties and disability.
075	Optical Confederation	Statements 2 and 3	The Optical Confederation warmly welcomes these standards and supports community initiatives to keep older people physically active and socially engaged. We would welcome a further clarification about the statements to make explicit that all programmes delivered under

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			these standards are inclusive and take account of a person's sensory abilities or difficulties and will aim to meet the needs of those who are sensorially impaired with communications, reassurance and support. We would also welcome a commitment within the standards that social engagement and physical activity programmes would also be used as a channel of communication for health promotion, including the need for regular eye checks to prevent visual impairments and loss of sight as far as possible.
076	Royal College of Psychiatrists	Statements 2 and 3	A count of people attending is inadequate and should be reflected as a proportion of the identified vulnerable population.
077	Age UK	Statement 3	In line with the overarching quality statement, we would recommend including a measure of whether local authorities have arrangements in place to promote a range of activities to build or maintain social participation. Older people as well as health and care professionals often report they cannot find accessible and reliable information on the range of non-medical and support services available in their area. As such, we would recommend amending the quality measure as follows: "Evidence of local arrangements that ensure a range of activities are in place and promoted for older people to build or maintain social participation."
078	College of Occupational Therapists	Statement 3	Participation in activities improves health and wellbeing as well as support social participation. PH16 states; "Offer regular group and/or individual sessions to encourage older people to identify, construct, rehearse and carry out daily routines and activities that help to maintain or improve their health and wellbeing…." The recommendation could expand to: Quality statement 3: Activities to sustain health and social participation.
079	Parkinson's UK	Statement 3	As mentioned above, Parkinson's UK strongly supports the principle of the third statement, which requires 'Local authorities support and publicise a range of activities for older people to build or maintain social participation' we remain concerned that local authorities will not provide this information in a clearly accessible way, or proactively to local Citizens Advice Bureaux and Parkinson's Local Groups. Recommendation: Information about social care and support provided to individuals by local authorities is clearly promoted and accessible to older people.
080	The National LGB&T Partnership	Statement 3	Question 2 Are local systems and structures in place to collect data for the proposed quality measures? If not, how feasible would it be for these to be put in place? Statement 3 - Local authorities support and publicise a range of activities for older people to build or maintain social participation.

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			This statement would involve a level of asset mapping of communities to measure local arrangements of activities that encourage social participation. Many groups that are integral to communities are not commissioned by local authorities and therefore wouldn't necessarily be counted. It would need to be made clear whose role it is to do this. As above, it would be essential that monitoring of attendees is comprehensive to ensure that services are inclusive. Services should reach a diverse group of people who are more likely to face barriers to accessing existing services, and therefore more likely to be experiencing poorer mental wellbeing, lower levels of physical activity and higher levels of isolation. It would be a simple task to ensure that demographic monitoring covered factors which may or may not already be asked as standard, such as sexual orientation, trans status, ethnicity, carer duties and disability.
081	The National LGB&T Partnership	Statement 3	Statement 3 - Local authorities support and publicise a range of activities for older people to build or maintain social participation. Equally, LGBT people are more likely to be socially isolated than the general population and less likely to have existing support networks around them. As a community of identity rather than place many LGBT people feel at distance to their local community and not be aware of available support that will understand their needs. The ASCOF LGB&T Companion states that over half of respondents (53%) reported they were unable to maintain social contact, for example due to impairment and poor care. Older LGBT people have grown up in a world hostile to their identities; their health related quality of life needs to be understood within the social context of their lives. For example, prolonged exposure to stigma and discrimination is recognised as having a detrimental impact upon physical and mental health outcomes. Research conducted by Stonewall found that half of all lesbian, gay and bisexual people over 55 felt that their sexual orientation has – or will have – a negative impact on ageing. Moreover, older LGBT people are more likely than both their heterosexual peers and younger generations of LGBT people to be single and live alone, and are less likely to have children (International Longevity Centre, 2008), and 1 in 5 LGBT people have no one to contact in times of crisis (Age Concern, 2002). This increased isolation is more likely to mean that older LGBT people have a greater need of formal care and support, increasing reliance on public services and ultimately costing the state. Focus groups held at LGBT Foundation with older LGB people in 2014 in Manchester found that that many respondents were experiencing daily struggles with isolation and loneliness, and complex health problems. Some felt that as they grew older they became invisible on the 'gay scene' and subsequently less connected to the wider LGBT community. Older LGBT people living in large urban areas with strong gay scenes such as London, Manchester and Brighton can often feel disconnected from what is a traditionally youth-oriented scene, whilst older LGBT people living in more rural areas are likely to experience even greater levels of social isolation and lack of support. LGBT people of

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			all ages living in rural communities report feeling lonely and isolated, and face heightened harassment because of their sexuality or gender identity (Equality and Human Rights Commission, 2015).
082	Age UK	Additional area	We support the focus provided by the three areas shortlisted for the quality statements. However, we are concerned that the importance of promoting inclusive environments and infrastructure has been overlooked. Older people's ability to build or maintain social participation will depend on the inclusiveness of their local community and environment. This includes whether these are age-friendly and dementia-friendly. While many older people continue to play an active part in their community, problems with mobility, vision and memory can make neighbourhoods difficult to navigate. A lack of public transport, or somewhere to sit down, or access to clean public toilets limits how far people are able to get around and poor quality pavements, poor street lighting or fear of crime can stop people feeling confident enough to go out at all. Our joint report with the Campaign to End Loneliness, Promising approaches to reducing loneliness and isolation in later life, showed that age-friendly environments are an important 'structural enabler' of solutions to support older people participating in the community. As such, NICE's quality standard should recognise the importance of fostering age-friendly communities, considering for example the addition of a new quality statement along the lines of: "Local authorities take steps to become age-friendly to enable older people to build or maintain participation in their local community".
083	Compassion in Dying	Additional area	Compassion in Dying is a national charity working to inform and empower people to exercise their rights and choices around their future medical treatment and care, particularly at the end of life. We do this by providing information and support through our Information Line; supplying free Advance Decision to Refuse Treatment (ADRT) forms (on paper and online at www.MyDecisions.org.uk) and publications which inform people how they can plan ahead for the end of their life; delivering one-to-one support to older people through our outreach service, My Life, My Decision; running information sessions and training for professionals, community groups and volunteers on a range of end-of-life topics, including accredited Continuing Professional Development (CPD) modules and conducting and reviewing research into end-of-life issues to inform policy makers and promote patient-centred care. Given the focus of our organisation, our response to this consultation primarily focusses on how the Quality Statements support independence for older people - in accordance with the definition set out on page 1 – in the context of their future treatment and care. Supporting older people to discuss and record their preferences for care at an early stage can contribute to the outcomes listed on page 2, namely quality of life for older people and their carers[1] and hospital admission rates of older people. Respondents to monitoring we have carried out have stated that completing an advance care planning document (such as an ADRT or Lasting Power of Attorney for Health and Welfare) gives them peace of mind and confidence that they have taken steps to ensure their wishes will be respected in the future.[2] It also means that they

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			can control their care according to what they believe is a good quality of life.
084	Compassion in Dying	Additional area	A poll conducted by YouGov in 2015 of people who had known someone who had recently died, revealed that 34% of those whose end-of-life wishes were not formally recorded were thought to have spent time in hospital that could have been avoided, compared to 28% of those whose wishes were recorded. Even a small reduction in the number of unplanned end-of-life hospital admissions would allow a significant increase in the number of patients who die at home or in their usual place of residence.[3] As dying in hospital is associated with higher care costs, reducing the amount of people who die in hospital would have an impact on healthcare costs. We commissioned think-tank the International Longevity Centre-UK, to conduct a review of the literature and data analysis on the impact of advance care planning on care. The results showed that when people record their preferences in advance, it can reduce the need for avoidable hospital admissions. For example, studies demonstrated that for people with a diagnosis of dementia, advance care planning can reduce the need for hospital admission in the later stages of the disease. Reducing the number of hospital admissions (particularly towards the end of life) can have a significant impact on the costs associated with dying in hospital.[4] Therefore, providing older people with the opportunity to take control over their own care and treatment by recording their preferences in advance not only enhances older people's independence and wellbeing, but as explained can lead to cost savings for commissioners particularly for those nearing the end of life.
085	EPA UK/EU	Additional area	Lifestyle and way of living The NHS, Social Services and Universal Medicine have all have the capacity to work with this project to support people to have the choice to live another way, one that does not end up with intensive care or in any care setting. No one wants to have that kind of life for themselves. It is a process of education, awareness raising and presenting such skills that have been developed and proven to be effective again and again and can transform the lives of adults and the pre-elderly. Social Linking scheme It is possible to connect people who are affected by loneliness with buddies. This could be a mix of 6-8 people who then form a social support pod. Each pod would be connected to other pods for bigger social and learning events. A similar scheme could also be set up for carer's who are liable to feeling isolated with their caring responsibilities, or

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			they could be included as a part of the scheme. This could be linked to additional schemes that are currently working in the field of ageing. Singing The evidence demonstrated a clear benefit of singing (https://www.nice.org.uk/guidance/NG32/chapter/The-committees-discussion#people-in-midlife-at-risk), it and this can be a route to engage people at the outset. The health benefits are well recognized and promoted nationally. 60+ 'apprentice' programme's Organisations can establish scheme's of 60+ 'apprentices'/ consultants, where the company become the learners because of the wealth of experience and knowledge elders have to bring. The potential is for a strong positive impact the mature 'apprentice' can have on a whole business system. "Improving the mental wellbeing of older people and helping them to retain their independence can benefit families, communities and society as a whole. Helping those at risk of poor mental wellbeing or losing their independence may also reduce, delay or avoid their use of health and social care services." Time to retire the word 'retirement' Research evidence confirms the benefits of continuing to work whether paid or unpaid, full or part-time after 'retirement'. 'Full-time employment and low-level volunteering had independent protect effects against decline in psychological well-being' http://psychsocgerontology.oxfordjournals.org/content/63/2/S64. http://www.iea.org.uk/sites/default/files/publications/files/Work%20Longer,%20Live_Healthier.pdf It should be mandatory for all employers to begin preparing people for later life by providing employees with information well before they leave long held jobs. We now know later life could extend to 30 years or more. In line with what is said already, people need to be made aware of the reality of old age and importance of self managing themselves, and heath in their mid-years. Healthy living courses for people in later life (now called pre-retirement courses) are usually funded by employers for

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			offered free of charge by some training providers.
086	Optical Confederation	Additional area	The Optical Confederation welcomes this quality standard on mental wellbeing and independence for older people. These are both significant public health and interlinked challenges facing us in the 21st Century as a result of the advances made during the 20th. We believe it is the responsibility of all health and social care professionals to promote independent living and of health and social care systems to ensure that everybody has the opportunity to have the best health and wellbeing throughout their lives. NICE have rightly recognised that health and social care for older people should be focused on providing support, treatment and care in the most appropriate setting and in a way that contributes to older people's independence and overall wellbeing. We would have hoped that eye health, or wider sensory impairment, and the substantial roles they play in maintaining an individual's independence and ability to manage would have received explicit attention. The effects of sight loss and other vision problems on older people's independence and mental wellbeing – and the key role of community optical services in addressing these – are often overlooked by other health and social care professionals. This is partly because they are not always well understood by front line health and care staff. Loneliness and isolation are the scourges of our age for older people and are correlated with depression, other mental health issues and cognitive decline. Regular sight tests and correction of any refractive error support communication and social interaction and so can help tackle some of the root causes of isolation as well as offering the opportunity to prevent and treat eye health conditions before they become sight threatening and impairing. Regular sight testing in older people also contributes to overall health and management of conditions such as diabetes, high blood pressure, and helps to prevent falls and fractures, all of which are more prevalent in older people, and where resulting dependence or mortality is high. That said, we feel that the standard correctly identifies particular areas where improvements can be made such as standardised training and the co-ordination of services and agencies across health and social care to provide a more holistic and joined-up care pathway for older people.
087	RCGP	Additional area	This draft quality standard does not completely reflect the key areas for quality improvement. To have elderly people mobile, socialising, getting out safely requires targets on access to public toilets with good changing facilities for incontinence pads, level paths and pavements, frequent seating some with covered areas because of rain. These items are more likely to stop someone getting out.

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			Most people don't want a community activity that they have to get to - they want to get outside when it suits them or the weather and whenever they want because it is possible, they want to feel independent and capable to make their own decisions. Less programmes and more societal infrastructure. (JW)

Registered stakeholders who submitted comments at consultation

- Age UK
- Care and Repair England
- The Charted Society of Physiotherapy
- College of Occupational Therapists
- Compassion in Dying
- Department of Health
- Esoteric Practitioners Association UK/EU (EPA UKEU)
- Foundations: The National Body for Home Improvement Agencies
- London Fire Brigade
- NHS England
- NIHR Maudsley Biomedical Research Unit for Dementia
- National Community Hearing Association
- The National LGB&T Partnership

- Optical Confederation
- Parkinson’s UK
- Royal College of GPs (RCGP)
- Royal College of Nurses (RCN)
- Royal College of Psychiatrists (RCPysch)
- South West Yorkshire Partnership NHS Foundation Trust
- Tees Esk and Wear Valleys NHS Foundation Trust