National Institute for Health and Care Excellence

Stakeholder comments proforma – engagement exercise for quality standard on mental wellbeing and independence for older people

Please enter the name of your registered stakeholder organisation below.	
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Please note: comments submitted are published on the NICE website.	
Would you like to express an interest in formally supporting this quality standard? ☐ Yes ☐ No	

Key area for quality improvement	Why is this important?	Why is this a key area for quality improvement?	Supporting information
Separately list each key area for quality improvement that you would want to see covered by this quality standard. **EXAMPLE: Pulmonary rehabilitation for chronic obstructive**	EXAMPLE: There is good evidence that appropriate and effective pulmonary rehabilitation can drive significant improvements in the quality of life and health status of people with COPD. Pulmonary rehabilitation is recommended within NICE guidance. Rehabilitation should	EXAMPLE: The National Audit for COPD found that the number of areas offering pulmonary rehabilitation has increased in the last three years and although many people are offered referral, the quality of pulmonary rehabilitation and its availability is still limited in the UK. Individual programmes differ in the precise exercises used, are of different duration, involve variable amounts of home exercise and have different referral criteria.	EXAMPLE: Please see the Royal College of Physicians national COPD audit which highlights findings of data collection for quality indicators relating to pulmonary rehabilitation. http://www.rcplondon.ac.uk/resources/chronic-obstructive-pulmonary-disease-audit

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pulmonary disease (COPD)	be considered at all stages of disease progression when symptoms and disability are present. The threshold for referral would usually be breathlessness equivalent to MRC dyspnoea grade 3, based on the NICE guideline.		
Key area for quality improvement 1 **Frailty (including prevention)**	Preventing frailty is recommended in NICE guideline NG16, *Dementia, disability and frailty in later life – mid-life approaches to delay or prevent onset*. We believe preventative approaches to all health conditions remain relevant into later old age and British Geriatrics Society/Age UK/RCGP guidance, *Fit for frailty*, recommends approaches that can be utilised in managing frailty regardless of stage or severity. Approaches such as comprehensive geriatric assessment is known to improve outcomes and longer-term quality of life for people living with frailty, positively influencing mental wellbeing and the chance to remain independent. For people with mild or “pre”	Frailty can affect people of all ages but is most prevalent in people over 85 and the total numbers are likely to grow substantially in the coming years. Work carried out by Age UK has identified frailty as an important risk factor for low mood and depression and feelings of “losing control”. Older people included in qualitative research frequently talked about “turning points” in their ability to do every-day tasks and the impact this had on both their feelings of self-reliance and their mental wellbeing. There was often no response from local services when these turning points occurred and important chances to remain active and independent were missed (see supporting information). There was both a perceived and actual risk of rapid deterioration following such moments, substantially impacting mental wellbeing. Frailty and/or comorbidity can often be seen as a reason not to offer certain kinds of support or treatment to people rather than as a “diagnosis” to respond to. Recognising frailty using many available, validated, methods and proactively	Fit for frailty (parts 1 and 2), BGS/Age UK/RCGP, 2014/2015) Practical Guide to Healthy Ageing, Age UK/NHS, 2015 Understanding the lives of people living with frailty, Age UK/Ipsos MORI, 2014 Frailty: Language and Perceptions, Age UK/BGS/Britain Think, 2015 I’m Still Me, UCLPartners/Age UK/National Voices, 2015

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	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). The "electronic frailty index" (eFI) is available for use throughout England within existing general practice software and is shown to be highly predictive of presence and severity of frailty. Using the eFI in conjunction with interventions relevant to a person's stage of frailty is increasingly effective in managing the condition.	planning care would make a huge difference to a person's long-term outcomes and overall mental wellbeing.	
Key area for quality improvement 2 **Loneliness and isolation**	In our report *Promising approaches to reducing loneliness and isolation in later life (2015)*, co-authored with the Campaign to End Loneliness, we outline a number of programmes that are shown to improve mental wellbeing in older people by addressing loneliness. For example, an Age Friendly Manchester scheme supports	In developing the quality standard, NICE must be clear in its distinction between loneliness and social isolation. Although these concepts are related, they have distinct causes and manifestations, and do not necessarily require the same solutions. While social isolation is an objective state in terms of the quantity of social contacts an person has, loneliness is a subjective experience. Loneliness is a negative emotion associated with a perceived gap between the quality and quantity of relationships that we have	Promising approaches to reducing loneliness and isolation in later life, Campaign to End Loneliness/Age UK, 2015 Evidence Review: Loneliness in Later Life, Age UK, 2014 Holt-Lunstad J, Smith TB, Layton JB (2010) 'Social relationships and mortality risk: a meta-analytic review'

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	older people to become "culture champions", linking up with their local community to encourage their peers to engage with art and cultural events. An evaluation of the project showed people were more confident and connected as a result of their involvement. Many other projects combine activities to address isolation with physical wellbeing approaches, achieving a dual benefit. Halton Community Wellbeing Practices, for example, undertake structured "wellbeing reviews" to identify social causes of poor physical and mental wellbeing. These lead to support programmes that span everything from physical activities to interest groups and self-help classes. 64% of participants report improvements in mental wellbeing while 55% reported a reduction in depressive symptoms.	and those that we want. It can be a temporary, recurrent, or persistent (chronic) state. It is therefore possible to be lonely but not to be socially isolated – likewise, it is possible to be socially isolated but not lonely (Age UK, Loneliness Evidence Review, 2015). However, tackling social isolation does matter as it can be a risk factor for loneliness (Victor C et al, Loneliness, social isolation and living alone in later life, 2003). Over 1 million older people say they are always or often feel lonely, while nearly half of older people (49% of 65+ in the UK) say that television or pets are their main form of company. Persistent loneliness can have profound impacts on physical and mental health, and quality of life. For example, loneliness can be as harmful for our health as smoking 15 cigarettes a day (Holt-Lunstad J, Smith TB, Layton JB, 2010), and people with a high degree of loneliness are twice as likely to develop Alzheimer's than people with a low degree of loneliness (Wilson RS, et al. 2007).	Wilson RS, Krueger KR, Arnold SE, Schneider JA, Kelly JF, Barnes LL, et al. (2007) 'Loneliness and risk of Alzheimer disease', Arch Gen Psychiatry
Key area for quality improvement 3 **Exercise and activity**	Age UK's *fit as a fiddle* programme supported a range of activities across the country to encourage physical exercise. These included support to get to centres offering physical activity	It is well-recognised that physical activity creates huge physical and mental health benefits for older people. As the WHO points out, doing the recommended amount can "improve cardiorespiratory and muscular fitness, bone and functional health, reduce the risk of [non-	Fit as a fiddle, Final evaluation report Ecorys UK with Centre for Social Gerontology, University of Keele, 2013 Age UK's fit for the future: Project Evaluation Report, University of Leeds,

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	classes; managed programmes aimed at tackling obesity which provided exercise classes and Nordic walking; and information aimed at improving health literacy. Across a range of these programmes there was significant improvement in mental wellbeing using the Warwick Edinburgh Mental Wellbeing Scale. Some of this work continued under the banner of *fit for the future.* Similar improvements were noted with almost 40% of respondents reporting a statistically significant positive outcome in rating their overall satisfaction with life by 3 months (that appears to remain at 9 months). A 2015 BMJ paper pointed out the specific risk to older people of long periods of sedentary behaviour, pointing to NICE guidelines not featured in the topic outline for this consultation (*Physical activity: brief advice for adults in primary care*). It also pointed to the benefits of helping older people achieve small	communicable diseases], depression and cognitive decline". The general benefits are important in their own right, but reducing the risk and/or impact of long-term conditions creates additional benefit with mental health problems being a common co-morbidity with physical health conditions. Guidance suggests that older adults should aim for the same levels of recommended activity (at least 150 minutes of moderate-intensity aerobic) as younger adults. However, as little as 10-15% of people over 65 meet this level (BMJ, 2015) with a particular drop off for people over 75 (Age UK, 2015). Physical activity can also reduce people's risk of falling (HSCIC, 2012), a key risk factor for older people losing confidence and becoming socially isolated.	2015 Sparling PB, Howard J, Dunstan DW, Owen N, Recommendations for physical activity in older adults, BMJ, 2015 Agenda for Later Life 2015: A great place to grow older, Age UK, 2015 Health Survey for England – 2012, HSCIC, 2012

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	increases in physical activity which may come under the recommended levels but still provide benefit.		
Key area for quality improvement 4 **Age friendly communities/housing**	Research has shown that older people are likely to spend more time in their local neighbourhood and in many cases to have lived in the same community for a considerable amount of time. The homes and neighbourhoods in which people live are an important part of meaning and self-identity for older people. Researchers have warned that "Most older people want to remain living at home, but if their neighbourhoods are inaccessible they are effectively trapped inside" (ILC, 2011). Fair Society Healthy Lives (the Marmot Review) recognised there are social determinants of health at a neighbourhood level, such as barriers associated with community participation, being able to access green spaces, public transport and active travel. Older people encounter challenges across all of these areas.	The quality standard must reference housing and communities. Housing is currently inconsistently thought of as a component of effective integrated care, with research by Leonard Cheshire finding that: "one third (37 per cent) of councils … are not planning to spend any of their [Better Care Fund] allocation on housing" (Leonard Cheshire Disability, 2015); another report found "of local authorities identified as pioneers on integration … nearly three quarters (73 per cent) did not consider housing to be a key component in the integration of health and social care" (MHP Health, 2014). In meeting this challenge, health and social care commissioners should be encouraging an integrated approach to home support by involving home improvement agencies and occupational therapists in the strategic planning, delivery and investment in services, especially where there are gaps in provision. This has particular implications for discharge planning, for example. The process, including the effectiveness of a discharge coordinator, is highly dependent on the availability of local home support services with funding arrangements in place. Guidance on both the legal requirements and best practice in this regard can be found here:	Beard JR, Cerdá M, Blaney S, Ahern J, Vlahov D, Galea S., Neighborhood characteristics and change in depressive symptoms among older residents of New York City. Am J Public Health, 2009 World report on Ageing and Health, WHO, 2015 The long wait for a home, Leonard Cheshire Disability, 2015 Health and housing: From consensus to practice, MHP Health, 2014

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	Research suggests "that the neighbourhood in which an older person lives has a significant impact on his or her mental health, even after accounting for individual-level determinants" (Beard JR, et al, 2009). Furthermore, a review reported on by the WHO found "a range of environmental interventions have been shown to be helpful in reducing risks for older people living at home, particularly risk of falling which can significantly impact long-term wellbeing and independence".	https://homeadaptationsconsortium.files.wordpress.com/2013/09/dfg-good-practice-guide-30th-sept-13.pdf. Achieving age-friendly communities must be a priority for all levels of local planning, and health and care services can play an important role. The WHO describes age-friendly communities as "enabling greater functional ability … by filling the gap between what people can do given their level of capacity and what they could do in an enabling environment (for example, by providing appropriate assistive technologies, providing accessible public transport or developing safer neighbourhoods)".	
Key area for quality improvement 5 **Availability of old age psychiatry**	Access to appropriate mental health services is a crucial part of maintaining mental wellbeing and independence in older people. This includes fair access to all services, including psychological therapies, and to old-age psychiatry services where appropriate. A recent paper in the British Journal of Psychiatry identified old-age services as providing specific benefit for older people when compared to adult services (BJPsych, 2015),	This quality standard recognises mental health morbidity as a significant challenge for older people. 22% of men and 28% of women over 65 are living with depression. The broader role of wider services and society working better to preserve mental wellbeing in older people, as described in this QS, renders no less important the role of specialist services. Extensive evidence has demonstrated that access for older people is poor (Centre for Policy on Ageing, 2009; RCPsych, 2009, NDTi, 2011; Mind, 2013; Age UK, 2015). Furthermore, the NHS programme *Improving Access to Psychological Therapies* (IAPT) has stated that "older people are	Abdul-Hamid WK, Lewis-Cole K, Holloway F, Silverman AM, Comparison of how old age psychiatry and general adult psychiatry services meet the needs of elderly people with functional mental illness: cross-sectional survey. British Journal of Psychiatry, 2015 The five year forward view for mental health: A report from the independent Mental Health Taskforce to the NHS in England, 2016 Ageism and age discrimination in mental

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	showing significantly lower rates of unmet needs. The independent Mental Health Taskforce Report (The five year forward view for mental health) recommended access to old-age psychiatry liaison services as an important part of caring for older people in acute settings. It also recommended that "bespoke older adult services should be the preferred model until general adult mental health services can be shown to provide age appropriate care".	underrepresented in referrals to IAPT services and people completing IAPT treatment". This quality standard must account for these inequalities, which can significantly undermine older people's long-term mental wellbeing and independence when needs arise. This should include scoping appropriate referral mechanisms for people both at risk of and already experiencing changes in their mental health, including where they may already be accessing existing services, for example physical health services.	health care in the United Kingdom, Centre for Policy on Ageing, 2009 The need to tackle age discrimination in mental health: A compendium of evidence, RCPsych, 2009 A Long Time Coming: Part 2 - Achieving age equality in local mental health services, NDTi, 2011 We still need to talk: A report on access to talking therapies, Mind, 2013 Agenda for Later Life 2015: A great place to grow older, Age UK, 2015 http://www.iapt.nhs.uk/equalities/older-people/
Additional developmental areas of emergent practice			
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