

Older people: independence and mental wellbeing

NICE guideline

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Your responsibility

The recommendations in this guideline represent the view of NICE, arrived at after careful consideration of the evidence available. When exercising their judgement, professionals and practitioners are expected to take this guideline fully into account, alongside the individual needs, preferences and values of their patients or the people using their service. It is not mandatory to apply the recommendations, and the guideline does not override the responsibility to make decisions appropriate to the circumstances of the individual, in consultation with them and their families and carers or guardian.

Local commissioners and providers of healthcare have a responsibility to enable the guideline to be applied when individual professionals and people using services wish to use it. They should do so in the context of local and national priorities for funding and developing services, and in light of their duties to have due regard to the need to eliminate unlawful discrimination, to advance equality of opportunity and to reduce health inequalities. Nothing in this guideline should be interpreted in a way that would be inconsistent with complying with those duties.

Commissioners and providers have a responsibility to promote an environmentally sustainable health and care system and should assess and reduce the environmental impact of implementing NICE recommendations wherever possible.

Contents

Overview	5
Who is it for?	5
Recommendations	6
1.1 Principles of good practice.....	6
1.2 Group-based activities	7
1.3 One-to-one activities	7
1.4 Volunteering.....	8
1.5 Identifying those most at risk of a decline in their independence and mental wellbeing.....	8
Terms used in this guideline.....	9
Implementation: getting started.....	11
Area 1: planning and partnerships	11
Area 2: local assets and needs assessment.....	13
Area 3: local coordination.....	14
Area 4: getting older people involved in activities.....	15
Area 5: training.....	17
Area 6: evaluating effectiveness.....	18
Need more help?.....	19
Context.....	20
The committee's discussion	22
Background	22
People in mid-life at risk.....	22
Avoiding adverse effects	22
Interventions	23
Implementation	31
Economics	35
Evidence reviews.....	36
Gaps in the evidence.....	36

Recommendations for research	37
1 Interventions.....	37
2 Identifying older people at high risk	37
3 Local coordination.....	38
4 Involving older people in developing interventions	38
5 Factors that influence older people's mental wellbeing	38
6 Mid-life interventions.....	39
Glossary	40
Age-related disability	40
Independence	40
Loneliness.....	40
Mental wellbeing.....	40

This guideline is the basis of QS137.

Overview

This guideline covers interventions to maintain and improve the mental wellbeing and independence of people aged 65 or older and how to identify those most at risk of a decline.

Who is it for?

- Local authorities
- Organisations in the public, private, voluntary and community sectors that come into contact with older people
- NHS and other service providers with a remit for older people
- Older people, their families and carers

Commissioners of services for older people should ensure any service specifications take into account the recommendations in this guideline.

Recommendations

People using services have the right to be involved in discussions and make informed decisions about their care, as described in [your care](#).

[Making decisions using NICE guidelines](#) explains how we use words to show the strength (or certainty) of our recommendations, and has information about prescribing medicines (including off-label use), professional guidelines, standards and laws (including on consent and mental capacity), and safeguarding.

1.1 Principles of good practice

- 1.1.1 Support, publicise and, if there is not enough provision, consider providing a range of group, one-to-one and volunteering activities that meet the needs and interests of local older people (see sections 1.2, 1.3 and 1.4 and implementation). In particular, target older people who are identified as being most at risk of a decline in their independence and mental wellbeing (see section 1.5).
- 1.1.2 Involve older people in the design and delivery of activities.
- 1.1.3 Ensure each activity:
- includes a clear description of what is on offer
 - takes place at regular times and in a regular location
 - provides the opportunity to socialise
 - complements other activities that may support different aspects of older people's independence and mental wellbeing, such as their physical health, their sense of belonging to a community ('social connectedness') and their sense of purpose.
- 1.1.4 Ensure activities are inclusive and take account of a range of different needs (for example, think about the needs of older people with an age-related disability).

1.2 Group-based activities

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

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

1.2.2 Consider offering:

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

1.3 One-to-one activities

1.3.1 Offer one-to-one activities, such as:

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

1.4 Volunteering

- 1.4.1 Make older people aware of the value and benefits of volunteering. For example, it provides the opportunity to socialise, have an enjoyable experience and help others to benefit from their experience, knowledge and skills.
- 1.4.2 Provide opportunities for older people to volunteer.
- 1.4.3 Encourage older people to volunteer by:
- varying the length and times of volunteering sessions to suit individual ability or preference
 - helping them to gain new skills (including good quality training)
 - providing supervision and ongoing support.
- 1.4.4 Use a variety of approaches to recruit older volunteers. This includes: articles and advertisements in local print and broadcast media, posters in community and care settings, direct mail, digital (including social media) and word of mouth.

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

- 1.5.1 Make service providers and others aware of the effect that poor mental wellbeing and lack of independence can have on an older person's mental and physical health and their social interactions.
- 1.5.2 Ensure staff in contact with older people are aware of the importance of maintaining and improving their independence and mental wellbeing.
- 1.5.3 Ensure staff in contact with older people can identify those most at risk of a decline in their independence and mental wellbeing (see implementation section). This includes being aware that certain life events or circumstances are more likely to increase the risk of decline. For example, older people whose partner has died in the past 2 years are at risk. Others at risk includes those who:
- are carers

- live alone and have little opportunity to socialise
- have recently separated or divorced
- have recently retired (particularly if involuntary)
- were unemployed in later life
- have a low income
- have recently experienced or developed a health problem (whether or not it led to admission to hospital)
- have had to give up driving
- have an age-related disability
- are aged 80 or older.

1.5.4 Ensure staff in contact with older people give those most at risk information on activities that might help them (see sections 1.2–1.4).

Terms used in this guideline

Mid-life

People aged 40 to 64.

Multicomponent activities

Programmes for older people involving a range of topics, settings, media and activities. A programme could include, for example, lunch with the opportunity to socialise and learn a new craft or skill in a community venue. Or it could involve a physical activity, such as a dance class, gardening or walking group, plus printed information on the benefits of physical activity.

Older people

People aged 65 or older.

Vulnerable older people

People at greater risk of a decline in their independence or mental wellbeing than others of the

same chronological age. Vulnerable people may not be able to cope with stressful events or may have limited physical mobility or restricted life choices, possibly due to lack of finances or support.

For other public health and social care terms see the Think Local, Act Personal [Care and Support Jargon Buster](#).

Implementation: getting started

This section highlights 6 areas of the guideline that were identified as a focus for implementation and outlines activities that will support this. This section also gives information on resources and examples from practice.

Area 1: planning and partnerships

Planning is more effective when it is developed in a partnership which reflects the diversity of the local community and its local services and facilities, and makes use of local people's skills (see NICE's guideline on [community engagement](#) – recommendations 3, 4 and 6). If the aim is to improve older people's mental wellbeing and independence, it should include older people (including carers) and their representatives.

Many local authority departments and their partners could play a role in helping older people maintain and improve their independence and mental wellbeing. This could include the fire service or home improvement agencies and others who visit older people at home. (For example, such agencies could use their visits as an opportunity to identify older people at risk of a decline in mental wellbeing.)

Local authorities and the NHS could:

- Ensure their planning partnerships include older people and their representatives and representatives from:
 - other statutory providers such as the police and fire services
 - statutory and non-statutory housing providers
 - home improvement agencies
 - voluntary sector organisations and charities
 - community groups, for example, groups with a general neighbourhood remit, those for people with shared interests or a shared ethnic, social or religious background, or with a health condition or disability in common, such as a sensory impairment
 - local high street businesses that older people visit
 - managers of neighbourhood facilities
 - maintenance and security workers, such as estate wardens.
- Include older people's independence and mental wellbeing as a core component of the joint strategic needs assessment and consider whether this should be included in the health and wellbeing strategy, based on local need.
- Identify a lead person to review and update this component of the joint strategic needs assessment and, if needed, the health and wellbeing strategy.
- Recognise the role of planning teams in helping older people maintain and improve their independence and mental wellbeing. Specifically, teams that advise on public facilities in the built and outdoor environment, such as seats and toilets, pedestrian and cycle routes and street lighting.
- Use a local coordinator (see area 3) to share data on older people at risk with other members of the partnership, in line with information governance arrangements (see the Health and Social Care Information Centre's material on [information governance](#)).
- Help community organisations to develop and sustain programmes of activities that maintain and improve older people's independence and mental wellbeing. This may include help with planning or providing transport to help people get involved. Or providing funding or spaces and facilities to host activities.

Area 2: local assets and needs assessment

A good understanding of local facilities and skills ('assets') and local needs will ensure services and activities are well targeted and any gaps in provision are addressed.

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

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

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

Area 3: local coordination

See [section 1.5](#).

Local coordinators (sometimes called village or town agents or community navigators) know an area well. They help make it easier for older people to access community activities, social support and other non-medical services.

Using a local coordinator can help local authorities meet their general responsibilities as set out in the [Care Act 2014](#). By ensuring that more people have access to services that may help prevent problems needing more costly health and social care services, a local coordinator can also help local authorities make long-term savings.

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

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

- Offer older people advocacy support so they can say what services they need to remain independent and to maintain their mental wellbeing.

Commissioners could:

- Look at examples of local authorities that have created local coordinator positions. For example, Poynton town council has an adult health and wellbeing coordinator (see [expert testimony paper 3](#)). Other examples include village and community agents in Gloucestershire and the Dorset PoPP Wayfinder Programme (see [evidence review 3](#)).
- Consider using the coordinator's knowledge of local needs, the skills and other relevant 'assets' available in the local community and local services when commissioning services and activities.
- Highlight the local authority's statutory responsibility under the Care Act 2014. The Social Care Institute for Excellence provides [advice and guidance, resources](#) including videos, training, and consultancy to help understand and implement the Care Act.

Area 4: getting older people involved in activities

Research shows that people are more likely to take part if services and activities are easy to access, and making people feel welcome encourages them to keep on taking part.

A review carried out for this guideline showed that many older people find it difficult to take part in services or activities that could help maintain their independence and mental wellbeing. This is particularly true if it involves using information and communications technologies (see [evidence review 2](#)).

To help overcome these difficulties, local authorities, service providers and community organisations could:

- Train older people who are interested to use information and communication technologies effectively. See [Promising approaches](#) (Age UK) for case studies. This shows how technology can be used to get people socialising and to provide cost effective social support.
- Help older people get good quality connections to the internet by identifying providers who can support them. For example, [Age Action Alliance](#) provides a range of free digital resources.
- Help older people get financial support to participate in activities, such as help to get concessions and benefits.

- Clearly state the objectives, location and times for each local activity or service and who they are for. Ensure this information is current, easy to access and gives a contact for each activity or service. Use outreach, community networks and social media to disseminate it (see NICE's guideline on [community engagement](#)). For an example of how a community network operates in practice see [Somerset Active Living](#). This is a network of over 110 community, voluntary groups, clubs and statutory organisations across Somerset.
- Think about the images used to publicise services and activities. Check whether they are representative of the people the service is trying to reach, or whether they reinforce stereotypes or risk excluding some older people. See [LinkAge Plus](#) for ideas. It ran pilots across the UK from 2006 to 2008 to explore new approaches to improving local services for older people. A DVD about the project brings together information, resources, tools, good practice and real-life case studies.
- Provide opportunities for older people to mix with people of all ages, for example, by providing community activities during the day.
- Recognise the benefits of volunteering programmes for older people's mental and physical wellbeing. For example, Age UK's short guides [Older people as volunteers: evidence review](#) and [Ideas for volunteering roles in health and social care](#) provide information for commissioners, service developers and fundraisers.
- Consider developing a plan to overcome the barriers to getting involved. This could include:
 - Providing help and advocacy for people with specific needs. For example: carers; people with mental health problems; people who have difficulties seeing or hearing; and people who have problems with their flexibility, balance or mobility.
 - Use of existing services. For example, using concessionary fares and encouraging transport services to coordinate their timetables and stops to help people get to the activities. This also includes ensuring access to suitable toilet facilities.
 - Providing a choice of activities (see sections [1.2-1.4](#)).
- Put pathways in place so that health and social care practitioners offer older carers activities that may help to maintain or improve their independence and mental wellbeing.
- Provide older carers with support so they can use services. This may include arrangements for respite care. Note that some older people may not recognise that they are a 'carer' and, as such, they could become socially isolated and put their mental wellbeing at risk.

Area 5: training

See [section 1.5](#).

Training is essential to help staff in contact with older people identify those most at risk of a decline in their independence and mental wellbeing. This includes health and social care practitioners (including those working in primary care), housing practitioners and some workers in the voluntary sector and other services.

Managers of practitioners most likely to come into contact with older people could:

- Provide training in how to maintain and improve older people's independence and mental wellbeing.
- Provide training on how to establish systems to identify and refer older people at risk of being lonely to services and support. Examples of the type of support that could help include initiatives like the [Rotherham Social Prescribing Scheme](#).
- Involve older people in developing and delivering training. Case studies from [The Campaign to End Loneliness](#) demonstrate ways in which the views and experiences of older people can be incorporated into training and strategy development.
- Ensure course content is based on current knowledge of:
 - how independence and mental wellbeing affects the health of older people and their use of health and social care services
 - activities that may improve and maintain older people's independence and mental wellbeing
 - factors that threaten older people's independence and mental wellbeing
 - how to identify older people most at risk of decline
 - how to support and encourage older people to participate in community activities.

Area 6: evaluating effectiveness

Commissioners need evidence that public funds are being used in the most effective way. Collecting routine monitoring and outcome data for evaluation means providers can demonstrate the impact of their activities or services.

A practice mapping review carried out for this guideline showed that few local activities or services for older people have been (or are currently) the subject of a formal qualitative or quantitative evaluation. Where evaluation or monitoring has been conducted, the emphasis has been on process measures and qualitative experiences, rather than quantitative information about effectiveness and cost effectiveness (see [evidence review 3](#)).

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

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

Service providers could:

- Get older people involved in designing and presenting evaluations, using examples such as those found in the [Campaign to End Loneliness](#).
- Ask older people what they think about the service or activity. For example, how it is presented in publicity (web pages and posters), the activities on offer (whether there too much or not enough for specific groups, for example). Also:
 - find out what motivates older people to come along and what stops them
 - think about the timing, location and access to venues (for example, how physically accessible is it?)
 - identify other ways of getting older people involved, for example, through friends or family.

- Collect details on the following 'process outcomes' as a basis for evaluation:
 - number of sessions offered
 - numbers attending each session
 - new attendances at each session
 - demographic data.
- Form partnerships with academic and practice organisations (such as [QaResearch](#) and [Ecorys](#)) with the skills to help evaluate the activity or service.
- Use validated measures of mental wellbeing to gather evidence of effectiveness. Examples of evaluation tools incorporating these measures include:
 - Joseph Rowntree Foundation's [Evaluating community projects practical guide](#). This provides step-by-step advice on how to evaluate a community project.
 - [Warwick-Edinburgh Mental Wellbeing Scale](#).
 - Campaign to End Loneliness's [Measuring your impact on loneliness in later life](#) and The Charities Evaluation Services' [general tool and resources](#). Both are for voluntary sector providers.
- Consider pooling resources across localities to fund joint evaluations of similar services.

Need more help?

[Further resources](#) are available from NICE that may help to support implementation:

- Annual indicators for use in the Quality and Outcomes Framework (QOF) for the UK. See the [process and the NICE menu](#).
- [Uptake data](#) about guideline recommendations and quality standard measures.

Context

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

The number of people aged 85 and older has risen the fastest. In 1985 nearly 1.2% of the population was 85 or older. By 2014 this had increased to 2.3% ('Ageing of the UK population: part of the population estimates for UK, England and Wales, Scotland and Northern Ireland, Mid-2014 Release'). By 2035 the number is expected to reach 3.5 million and account for 5% of the population ([Population ageing in the United Kingdom, its constituent countries and the European Union](#) Office for National Statistics).

Older people may experience an age-related disability. For example, 71% of people aged 70 and over have hearing loss ([Hearing matters](#) Action on Hearing Loss). One in 5 people aged 75 and older and 1 in 2 aged 90 and older have sight loss ([Sight loss statistics postcard](#) RNIB).

Older people are at higher risk of developing chronic health conditions such as diabetes or osteoarthritis (painful and stiff joints). In addition, depression affects 1 in 5 adults aged over 65 living in the community ([Mental health statistics: older people](#) Mental Health Foundation).

Loneliness affects 1 million older people ([Safeguarding the convoy](#) Campaign to End Loneliness). 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).

Many older people play an active role in society. For example, 65% of volunteers in the UK are aged 50 or older ([Ageing well: an asset based approach](#) Local Government Association).

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.

You can also see this guideline in the NICE pathway on [mental wellbeing and independence in older people](#).

To find out what NICE has said on topics related to this guideline see our web pages on topics relevant for older people: for example, [care homes](#), [community engagement](#), [depression](#), [homes and older people](#).

The committee's discussion

See [evidence reviews](#) for details of the evidence.

Background

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

The committee agreed that ageing is an individual experience and that not all approaches may be right for everyone – or certainly not at the same point in their lives. Members discussed how risk factors build up and then result in a decline in independence and mental wellbeing. But they also acknowledged that people have different levels of resilience. The committee was aware that not everyone who could be assessed as being at 'high risk' will experience poor mental wellbeing.

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

The committee noted that many older people who are at risk of a decline in their independence and mental wellbeing may not identify themselves as such.

People in mid-life at risk

No evidence was identified on people aged 55 and over who are at risk of the same health conditions as people aged 65 or older. The committee agreed to make a research recommendation for mid-life interventions.

Avoiding adverse effects

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

The committee was aware of the risk of widening inequalities if activities only reach people who already use services. The committee agreed that inequalities could be avoided by recommending a variety of interventions and providing help to access services, including reducing the barriers to access, as described elsewhere.

The committee recognised that promoting social activities outside the home and involving a range of people working in the community in those activities could make older people more vulnerable to crime. For example, theft from an unoccupied home or fraud through 'bogus callers'. The same is true of training to help older people use information and communication technologies – they could then be susceptible to internet-based scams.

The committee agreed that this potential problem could be overcome by using governance arrangements and by providing advice, training and support.

Interventions

The types of effective intervention identified by the committee link to the Foundations of Mental Wellbeing model (see [expert paper 1](#)). According to the model, 4 key 'pillars' contribute to positive mental health and wellbeing: functional ability, psychological attributes, power and resources and 'social connectedness'. These change throughout life.

The committee noted that other similar models are available (for example, [Lay perspectives of successful ageing: a systematic review and meta-ethnography](#) Cosco et al.).

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

The committee identified groups that may need specific approaches and activities. These included: men, people older than 85, carers and people with a sensory impairment. But there is a lack of evidence on effective activities for these subgroups. Members also noted that people's needs and interests vary within any group.

The committee was aware that the evidence reviews, economic evaluation and expert testimony on the effects of specific interventions did not represent all relevant activities. In addition, it was not

possible to identify specific interventions or features (such as the ideal length of an intervention) to allow 1 activity to be prioritised over another. However, the committee agreed that broad types of intervention do appear to be effective in the current UK context.

The committee agreed that people would only be able to choose which services or activities to get involved with if they were given enough information about what was on offer. Members discussed the idea of a local 'repository' of information (based on set criteria) using the internet. They also acknowledged the difficulties involved in maintaining such a resource – and that using online information is a significant challenge for some people. So there is not a specific recommendation on this.

The committee noted that there was a lack of evidence on the differences between activities provided in urban and rural settings. Members acknowledged that it may be harder to provide some activities in a rural setting where populations are more dispersed.

When developing recommendations, the committee considered relevance to the scope of this guideline, strength of evidence, applicability, evidence on cost effectiveness, expert knowledge of practice and broader social value judgements.

It agreed which activities described in the review evidence should be developed into recommendations. Members also agreed which activities should not be included in this guideline. For example, mentoring of older people, health education, a national arts programme, attitudes of health and care professionals toward older people, and self-management ability (evidence statements 1.1.3, 1.1.4, 1.1.6, 1.2.4 and 1.5.1 respectively). The committee agreed there is considerable uncertainty as to how effective these interventions would be across different settings.

The committee used the evidence to prioritise areas for implementation (see [implementation: getting started](#)).

Section 1.1 principles of good practice

Recommendations in this section are linked to evidence statements: 1.1.1, 1.1.2; review 3; review 4; EP1, EP3, EP4, EP6; IDE.

The committee agreed that the following are important principles:

- Improving the types and variety of provision of interventions, based on the population's needs and interests.
- Targeting interventions at those at greatest risk of decline.
- Involving older people in the design and delivery of interventions. This is crucial to ensure interventions are acceptable to the target population (expert paper 1).

Based on their own experiences, committee members agreed this was likely to increase the number of people who use and benefit from the interventions. They also thought this approach would most effectively reduce risk and rates of decline and subsequent morbidity in the target populations.

The committee drew on expert papers 3, 4 and 6 and reviews 3 and 4 when formulating this recommendation, in addition to evidence from review 1. The evidence from review 1 included evidence statements:

- 1.1.1 on multi-location activities, which was inconsistent
- 1.1.2 on single location activities, which was of poor quality but positive and consistent.

Overall, the committee thought that activities should have a regular location and be held at regular times to be most effective.

The committee recognised it did not have cost effectiveness evidence to support these recommendations. However, because they are general principles on which all interventions should be based, they were not considered to have a measurable cost impact or additional resource implications beyond the interventions themselves.

The committee was confident that using these principles would increase the likelihood that interventions would both benefit the target population and be cost effective.

Section 1.2 group-based activities

Recommendations in this section are linked to: evidence statements 1.1.1, 1.1.2, 1.1.5, 1.1.7, 1.2.1, 1.2.2, 1.2.3, 1.4.1, 1.4.2, 1.6.1, 1.6.2, 1.6.3, 1.6.4; review 3; review 4; EP3, economic modelling report; IDE.

Recommendation 1.2.1 The evidence on multicomponent programmes included evidence statements:

- 1.1.1 on multi-location activities, which was inconsistent
- 1.1.2 on single location activities, which was of poor quality but positive and consistent.

The committee was confident that, for most older people, the activities specified (see below) will prevent a decline in independence and support their mental wellbeing. There was strong, consistent evidence of effectiveness, including good to moderate quality studies with a low likelihood of bias.

Strong cost effectiveness evidence was also reported for singing, intergenerational, and information and communication technology activities. This included the economic modelling and an economic evaluation identified in review 5.

All the evidence was considered applicable and transferable to UK practice.

Singing

The committee discussed the evidence on singing and noted that it is unclear whether it is the singing itself that produces the benefit, the group-based nature of the activity or something else. But members agreed that the evidence (evidence statement 1.1.5) demonstrated a clear benefit. This was further supported by the consistent direction of effect in the evidence. In addition the best quality evidence, from a randomised controlled trial (RCT), counterbalanced uncertainty from the poor quality before-and-after study.

The committee also noted that the evidence on singing was based on professionally-led programmes but there was no strong evidence that singing programmes are only effective if there is a paid lead. The singing recommendation acknowledges the value of leadership and professional qualities of the lead.

Creative activities

The committee agreed that the evidence (evidence statement 1.1.7) demonstrated clear support for a range of art- and music-based interventions. This was further supported by the consistent direction of effect in the evidence.

Some studies may have some inherent uncertainty because of their type or quality. But the committee was confident that the evidence base indicated a benefit and implied such activities would be a good use of limited resources. This was supported by members' own experiences of delivering such interventions.

Physical activity

The committee agreed that the group-based activities in recommendations 2 and 3 in NICE's guideline on [occupational therapy and physical activity interventions to promote the mental wellbeing of older people](#) were relevant and should be referred to in this guideline.

Intergenerational activities

The committee agreed that the evidence demonstrated a clear benefit: evidence statements 1.2.1, 1.2.2 and 1.2.3.

Only the RCT was of good quality, with a design to control bias. But the direction of effect of the evidence was consistent and the committee was confident that, on balance, these interventions are beneficial. The committee also noted that if the principles laid out in recommendation 1.1 are followed, then the likely benefits would outweigh any uncertainty regarding the evidence base.

In addition, committee members reflected on their own involvement in interventions of this type. They agreed that these interventions were a good use of resources and would provide benefits beyond those captured in the data for both the target population and for the younger people involved. They also agreed that this would mean the positive outcomes would be underestimated.

Recommendation 1.2.2 The committee noted that there was a substantial evidence base on activities relating to information and communication technologies, and some evidence on education and learning.

Information and communication technologies

The evidence comprised evidence statements:

- 1.4.2 on the benefit of education via the internet and other electronic media, with weak but consistent evidence
- 1.6.1 on the benefit of training to use personal computers and the internet, with inconsistent evidence
- 1.6.2 on the positive effects of telephone- and internet-based communication, with weak but consistent evidence
- 1.6.3 on the positive effects of information and communication technologies on older people who are carers, with weak but consistent evidence

- 1.6.4 on the improvement in mental health and positive mood among older people from using computer or console games, with weak but consistent evidence.

The committee also noted the results of an economic evaluation of a computer skills training course that led to increased internet usage by older people and cost approximately £564 per person. Members agreed this could be linked to a number of improvements in older people's wellbeing.

There is some uncertainty because of the mixed quality of the studies. But the committee agreed that, on balance, and from their expert opinion and experience, the interventions are likely to be of benefit. As a result, it recommended that providers consider them.

Education and learning

The committee noted that there was some evidence on education and learning opportunities for older adults (both face-to-face at university and in community settings and via the internet). The evidence comes from expert paper 3 and evidence statements:

- 1.4.1 on an improvement in psychological measures and wellbeing, with weak but consistent evidence
- 1.4.2 on an improvement in wellbeing from education provided via the internet and other electronic media, with weak but consistent evidence.

The direction of effect in the evidence statements was consistent. But the overall quality of the studies leads to some uncertainty, because the weak methods used could produce a different result if they were re-run. Based on the committee's expertise members agreed that, on balance, these interventions are likely to be of benefit and recommended that providers consider them.

No evidence was identified in the effectiveness review on hobbies (such as gardening) or interests (such as current affairs) but the committee noted that this does not necessarily mean they would not be effective. Members noted from review 3 that varied programmes involving hobbies, interests, physical activity and learning were being used in practice in the UK to improve older people's independence and mental wellbeing.

The committee thought it likely that all the interventions cited will benefit some people and may be cost effective. But the interventions listed in recommendation 1.2.1 are more likely to be cost effective. That is because they are based on more consistent evidence of effect from higher quality studies and are supported by evidence of cost effectiveness.

The choice of intervention, and whether or not to get involved, is likely to depend more on the

person's values and preferences than whether an intervention has been shown to be effective. The committee therefore believes providers should spend time considering wider options to ensure the interests of all older people can be covered. That is because it is likely that involvement in any kind of group activity aimed at maintaining their independence and mental wellbeing will have some measurable benefit.

Section 1.3 one-to-one activities

The recommendation in this section is linked to: evidence statements 1.3.1, 2.6; review 3; IDE.

The effectiveness evidence was of mixed quality but consistent, and the committee was confident about the overall benefit of this type of intervention. The effectiveness evidence on interventions to build friendships demonstrated a clear benefit (evidence statement 1.3.1). The following also support a strong recommendation:

- economic modelling data on friendship programmes
- evidence statement 2.6 on the barriers to, and facilitators of, 'social connectedness'
- examples in review 3.

Section 1.4 volunteering

Recommendations in this section are linked to: evidence statements 1.2.1, 1.2.3, 2.2; review 3; review 4; EP4; IDE.

The committee discussed evidence that 'reciprocity' (exchanging things with others for mutual benefit) and 'payback' (benefit resulting from a previous action) both have a positive impact on the mental wellbeing of people involved in voluntary work. Members also discussed the fact that many older people want to contribute to their community.

The effectiveness evidence on volunteering demonstrated a clear benefit. It comprised evidence statements:

- 1.2.1 on school-based intergenerational activities (including older people reading to children or offering life-skills training) improving older people's mental wellbeing, with moderate, consistent evidence

- 1.2.3 on intergenerational activities involving volunteering having a positive effect on older people (this included older people providing mentoring and other support and activities) with weak but consistent, positive evidence.

The studies have potential for bias. But, the positive direction of the evidence was consistent and, in their expert opinion, the committee was confident that volunteering would have a positive impact. The additional qualitative study supported this view by providing an understanding of the mental wellbeing benefits as perceived by older people involved in volunteering.

The favourable economic modelling evidence (using 1 RCT from Japan) also supported a strong recommendation. The committee acknowledged that volunteering programmes do have an associated cost and should not be 'done on the cheap'. But members also agreed that they provide benefits to the local economy in terms of the time, skills and support that volunteers offer.

The committee noted evidence (evidence statement 2.2) on barriers to, and facilitators of, older people volunteering. It discussed the factors presented in review 2 (based on 8 studies that used survey and interview methods) and members' expert knowledge of practice. It was agreed that awareness-raising and a range of recruitment methods were key.

Section 1.5 identifying those most at risk of decline

Recommendations in this section are linked to: review 3; EP1, EP2, EP3, EP5, EP6; IDE.

The committee considered it important to take a preventive approach to all those at risk. But members agreed to focus on those at greatest risk due to limited local authority funds and because this would be a way of addressing health inequalities.

The committee noted that some of the data needed to identify people most at risk may need to be collected locally because it is unlikely to be available via routine national data collection sources. (National data sources, for example, are unlikely to include people who have recently experienced or developed a health problem.) The committee also recognised that the type of data collected, and how complete it is, may be inconsistent across areas.

Members noted that although extra data might need to be collected locally, the fact that it could lead to earlier identification of, and support for, people at greatest risk would outweigh any extra resource implications.

The recommendation includes only groups at high risk cited in the expert testimony (expert paper 5). The impact of factors such as not having children, or factors linked to gender and sexual

orientation, is not clear. But it was clear, for example, that the death of a partner in the previous 2 years could have a significant impact on someone's mental wellbeing.

The committee also drew on evidence from expert papers 1, 2, 3 and 6 and review 3 for this recommendation because the data either support the identification of people at most risk or give examples of how this has been done locally.

This is a strong recommendation because the evidence was clearly demonstrated in the expert testimony. In addition, the committee thought this recommendation would have limited opportunity or other cost implications, because staff in contact with older people are already visiting those most at risk. It recognised that some training may be needed. But it believed that any cost impact would be outweighed by the early identification of, and support for, those at most risk.

Implementation

Based on the evidence presented and members' expertise, the committee discussed how the recommended interventions could be implemented. These discussions, and the evidence on which they are based, are outlined below. The actions proposed are not formal recommendations. (For details of these actions see [implementation: getting started](#).)

Planning and partnerships

The committee noted evidence from: review 3 (the practice mapping review) and expert papers 3, 4 and 6 (plus IDE). It agreed plans developed by a local partnership could lead to a number of benefits, including:

- more widespread knowledge of what is available
- reduced duplication or better economies of scale by sharing resources
- more effective identification of those in greatest need.

The only resource implications for operating the partnership may be the opportunity costs for attendance at meetings. But the committee noted that the added benefit from a more joined up approach should outweigh any resource implications.

The committee agreed that effective partnerships may only contain some of the representatives suggested for implementation. But the list provides a basis for establishing such groups. It also agreed that effective partnerships would always include older people and their representatives.

The committee noted the importance of including home improvement agencies in the partnership because they are likely to come into contact with people at risk on a regular basis.

The committee discussed the need to raise awareness of the importance of older people's independence and mental wellbeing among:

- older people themselves (including those who are carers)
- local policy makers
- commissioners
- practitioners.

Committee members noted from their own experience that identifying a lead person to review and update the joint strategic needs assessment and health and wellbeing strategy would help to ensure the task is completed.

Local assets and needs assessment

The committee noted evidence from: review 3; review 4; EP3; IDE.

The committee discussed the importance of conducting a local needs assessment so that local authorities can consider their population needs and plan to meet those needs.

Evidence on the use of needs assessments was found in reviews 3 and 4. But no evidence on the benefits and harms was considered by the committee because it is a requirement of health and wellbeing boards under the Health and Social Care Act.

The committee agreed that, on balance, needs assessment offers many benefits, not least because it gives local areas the detail they need for effective decision making. In addition, the data and information generated can be used as a baseline for service evaluation and drive an outcome-focused approach.

The committee agreed that it was important to collect data from appropriate sources to inform the needs assessment. Without this, the needs assessment will not be fit for purpose.

The committee noted there was limited evidence on the best way to identify needs and address barriers to older peoples' participation (from expert testimony and review 3). For example, there was a lack of evidence in terms of gender, sexuality, disability, income or ethnicity.

In the committee's expert opinion, needs assessment can most effectively be used to support service design if people are asked to express their own needs as part of the planning process.

The committee agreed that feeding the results into the joint strategic needs assessment can help influence plans for the wider determinants of health, such as housing. It may also bring economies of scale compared with individual needs analysis in separate commissioning streams. It can highlight areas of unmet need and aid decisions about allocation of resources.

Local coordination

The committee noted evidence from: review 3, review 4 (practice mapping reviews); EP3, EP4, EP6; IDE.

The committee heard from experts about several 'wellbeing coordinator' models. These community-based coordinators identify older people who need support and then coordinate local services and activities for them, as well as acting as a local source of information. The committee noted there were no economic effectiveness data on this.

The committee agreed that local authorities may consider appointing someone if there is a high level of local need. Members recognised the resource implications of appointing a coordinator. But they also felt that this could be important in areas with a higher than average ageing population at particular risk (for example, in rural communities). In such cases, any resources used to coordinate local activities could be offset by the cost of providing other services, as older people lose their independence or mental wellbeing.

The committee acknowledged that some geographical areas may be too large for 1 coordinator. It also agreed that information sharing within the partnership would help to avoid duplication of effort and connect older people at risk with appropriate services and agencies.

Getting older people involved in activities

The committee noted evidence from: review 3, review 4; EP2, EP3, EP4, EP5; IDE.

The committee felt this was an important action and would have limited resource implications, because local authorities have to consult with communities regularly and can use forums already established to support this.

The committee noted that the cost of participation can be a barrier for some people, as demonstrated in expert paper 5. It agreed that helping maximise older people's income so they can

get involved would be a positive move. This could include help with the cost of a bus or taxi fare or benefits advice, all of which local government can provide.

Helping older carers to get involved

The committee noted evidence from: evidence statement 1.1.8; review 3; EP2; IDE.

The effectiveness evidence (evidence statement 1.1.8) was of mixed quality because of the varied study types and the potential for bias. But it did show consistent positive effects in terms of support for older carers.

The committee also drew on evidence from expert paper 2 and review 3 (highlighting the decline in mental wellbeing of older carers and examples of how they can be supported locally).

In addition, members recognised that carers may value emotional support from other carers, so activities for groups of carers may be beneficial. Members also noted that the Care and Support Act 2014 specifies that care practitioners should assess and provide the support carers need. This includes emotional support.

As a result, the committee believes these activities should be offered to older carers to reduce their risk of decline and to provide a broad range of support to help them participate in local activities to reduce their risk of isolation. Because local authorities are already required to support carers, the committee noted that it might be a matter of reallocating – rather than finding new – resources to implement these activities.

Supporting community organisations

The committee noted evidence from: review 3, review 4: EP3, EP4, EP6; IDE.

The committee wanted to make a recommendation because of the importance of evaluation in sustaining and improving services and activities. But the evidence base was very limited (unpublished examples of evaluation in reviews 3 and 4 and support for, and further examples of, evaluation in expert papers 3, 4 and 6).

The committee noted that providing community organisations with support for evaluation may have some resource implications, but that any short-term set-up costs would be more than offset by improved outcomes in the community. This includes developing sustainable community assets and support.

Members noted that local solutions, based on expressed community needs, are preferable to continuing with an approach simply because it is the way projects have always been run. They also noted that there may be new ways to use existing resources; for example, by using social prescribing by GPs or self-managed budgets. Members agreed that it would be useful to find out more about funding arrangements as part of any evaluation.

Economics

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

The committee felt that a cost–consequence analysis was the most suitable type of economic analysis, given the wide range of outcomes that are relevant to interventions to maintain and improve older people's independence and mental wellbeing. Where data permitted, the committee agreed a cost–utility analysis would be useful (albeit limited in scope) for comparing the cost effectiveness of different types of interventions using a common outcome.

The committee highlighted the complex nature of the evidence, in particular the inter-relationship between independence, mental wellbeing and other health and non-health outcomes. The fact that independence and mental wellbeing are also reported as outcomes in their own right was noted as a further complication.

In addition, there is a lack of published studies demonstrating a causal relationship or direction of any causality between the range of measures and outcomes. Members agreed that this meant the economic analysis would be an oversimplification of the scope of activities and outcomes.

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

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

The committee noted that there may be a difference between the sector or organisation that pays for some of the proposed interventions and the sector or organisation that apparently benefits. For

example, if a social care or other local authority budget is used to fund activities that primarily achieve a health benefit. Members acknowledged the difficulty for commissioners in such cases.

Evidence reviews

Details of the evidence discussed are in [evidence reviews, reports and papers](#) from experts in the area.

The evidence statements are short summaries of evidence. Each statement has a short code indicating which document the evidence has come from.

Evidence statement number 1.1 indicates that the linked statement is numbered 1 in review 1. Evidence statement number 2.1 indicates that the linked statement is numbered 1 in review 2. Evidence statement EP1 indicates that expert paper 1 'Theoretical model relating to independence and mental wellbeing of older people' is linked to a recommendation. EP2 that expert paper 2 'Carers' is linked. EP3 that expert paper 3 'Practice in England – local town council approach' is linked. EP4 that expert paper 4 'Age friendly cities' is linked. EP5 that expert paper 5 'Emotional wellbeing in later life: patterning, correlates, inequalities and resilience' is linked. EP6 that expert paper 6 'Living well in Cornwall and the Isles of Scilly' is linked.

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

Gaps in the evidence

The Committee's assessment of the evidence, stakeholder and expert comment on older people and mental wellbeing identified a number of gaps. One of these gaps is set out below. The others are the subject of research recommendations

1. The needs of different populations as they age. In particular how interventions can be tailored for different stages of someone's life.

(source: review 1; review 2; IDE)

Recommendations for research

The guideline committee has made the following recommendations for research.

1 Interventions

In the UK, which activity-based interventions are most effective and cost effective at protecting older people who are at risk of a decline in their independence and mental wellbeing?

Why this is important

The evidence of effectiveness and cost effectiveness on interventions to help older people at risk is limited. At-risk groups include those:

- whose partner has recently died
- who have recently separated or divorced
- who have recently been made redundant or involuntarily retired
- who are carers.

The only high quality cost effectiveness evidence available was on the benefits of singing, and this was not specific to any particular groups. A wide range of other activities could be explored.

It is also unclear which utility measures should be used in cost effectiveness studies of these interventions. Evidence of the most effective ways to measure the impact of interventions would inform future updates of the guideline.

2 Identifying older people at high risk

In the UK, what are the most effective ways to identify older people who at risk of a decline in their independence and mental wellbeing?

Why this is important

Evidence in this area was very limited and mainly comprised expert testimony. More and better quality evidence is important to improve the recommendations on identifying people at high risk.

3 Local coordination

In the UK, what are the key components of a local coordination role to ensure best value for money in promoting older people's independence and mental wellbeing?

Why this is important

The evidence base for recommendation 5.1.1 (to appoint a local coordinator) came mainly from expert testimony and a service mapping review (review 3). Pinpointing the elements of a local coordinator's role that make it a success and good value for money are needed to improve this recommendation. Studies would need to include relevant cost effectiveness data and measures of success.

4 Involving older people in developing interventions

In the UK, what are the most effective ways of involving older people in developing interventions to promote their independence and mental wellbeing?

Why this is important

There is no evidence on this. Studies would help providers to improve participation in interventions and that, in turn, would help more older people to maintain their independence and mental wellbeing. Evidence on effectiveness would also allow providers to better judge the levels of services needed and ensure enough places are available locally for these activities.

5 Factors that influence older people's mental wellbeing

In the UK, which factors or processes in an intervention influence older people's mental wellbeing? How do these factors interact with one another and does the importance differ for different groups?

Why this is important

The evidence base is unclear. By understanding the factors or processes that influence mental wellbeing it will be possible to design more effective interventions. For example, it would be useful to determine whether the importance of these factors and processes varies according to ethnicity, long-term disability, level of social deprivation, gender, sexuality or geography (urban or rural). Evidence is also needed on:

- optimal duration or intensity of the intervention
- duration of benefits following the intervention
- relative effectiveness of interventions provided remotely (via telephone or internet) compared with face-to-face
- impact of the interactions between factors (such as between gender and social deprivation) and the size of impact?

6 Mid-life interventions

In the UK, which mid-life groups are currently at most risk of losing their independence or experiencing poor mental wellbeing in later life? And which interventions are most effective and cost effective in preparing these people for later life?

Why this is important

Interventions that prevent or slow down a decline in independence and mental wellbeing in mid-life may be more cost effective than later interventions. But there is a lack of UK-based evidence on the effectiveness and cost effectiveness of a range of interventions for this age group.

Evidence on the most effective ways of measuring the impact of these interventions could also help commissioners and providers to evaluate their services, and inform guideline updates.

Glossary

Age-related disability

Any physical or mental impairment associated with ageing, such as a reduction in, or loss of vision, hearing, mobility or cognitive ability.

Independence

The ability to make choices and to exercise control over your life. This includes being able to live independently with or without support.

Loneliness

Emotional loneliness is felt when people miss the companionship of one particular person – often a spouse, sibling or best friend. Social loneliness is experienced when people perceive that they lack a wider social network or group of friends.

Mental wellbeing

Emotional and psychological wellbeing. This includes self-esteem and the ability to socialise and cope in the face of adversity. It also includes being able to develop potential, work productively and creatively, build strong and positive relationships with others and contribute to the community.

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Accreditation

