can video calls prevent loneliness?

PAGE 20

opening the spiritual gate

PAGE 9

cochrane review

PAGE 18

MENTAL HEALTH
loneliness & depression

Those that provide care, must care

Tracey Robbins talks about the work of The Big Lunch; an Eden Project aiming to bring together communities. Some helpful suggestions of what people can do to combat loneliness are also provided.

Junior doctors’ perspective on loneliness

Dr. Poppy Mackay and Dr. Grace Baxter from the Older Adult Liaison Psychiatry Team at Chelsea and Westminster Hospitals discuss the important role that Junior Doctors’ can play in helping to tackle loneliness.

contributors:

Kellie Payne
Learning and Research Manager
Campaign to End Loneliness

Matthew Prina
Lecturer in Ageing and Mental Health
King’s College London

Nicole Valtorta
Research Fellow in Public Health
University of York
This is our 15th issue and we thank you for all of the excellent feedback we have received from you to date. We are aiming to continually develop the publication and would welcome your thoughts in helping shape further issues. If you have time, please fill in the attached questionnaire, or complete the online version (see page 12). In the meantime, we welcome you to this issue focussing on mental health – loneliness and depression.

As we get older, circumstances such as retirement, bereavement, lack of companionship and poor health can increase feelings of loneliness. Chronic loneliness can cause real distress and have a serious impact on both physical and mental health. It has been found to significantly increase the risk of having a stroke, developing coronary artery disease, Alzheimer’s and premature death. It is also a major cause of depression. Evidently, social contact is crucial for our wellbeing.

Leading this issue, Tracey Robbins highlights the work of the Eden Project, trying to bring communities together and therefore increase people’s social networks. Kellie Payne from the Campaign to End Loneliness discusses their new report that aims to help commissioners identify people at risk of suffering from loneliness, in order to implement services to alleviate this.

We also learn of the role that Junior Doctors can play in helping reduce loneliness and current research into whether video-calls can improve the overall quality and quantity of peoples’ contact. Matthew Prina introduces an EU-funded project called ATHLOS and its findings relating to depression and healthy-ageing. Kate Bennett emphasises the beneficial effects of exercise on mental wellbeing and suggests ways to get active, whilst researchers at the University of York discuss the implications of what we know about loneliness in older age for prevention strategies.

We also hear of the importance of addressing people’s spiritual needs, an award winning innovation that is tackling malnutrition and the work of Johnnie Johnson Housing Trust to help older people live independently for longer.

Finally, our resident contributor Tracey Howe provides an overview of the literature surrounding depression in older people as well as an introduction to the newly established Cochrane Global Ageing.

I hope you feel inspired after reading this issue to get in touch with family, friends or neighbours. For me, the thought that many older people regard television as their main form of company is heart-breaking. Everyone should deserve to feel like they have somebody to turn to – even just a good chat and cup of tea can break the monotony of the day.

Jackie Oldham
Honorary Director, Edward Centre for Healthcare Management Research
Contents

4 Insight – Those that provide care, must care
6 Finding the loneliest in our communities
8 Junior Doctors’ perspective on loneliness
9 Opening the spiritual gate
10 Get up and go for it!
12 News…
14 Living longer, living better
16 Loneliness in later life: opportunities and challenges for intervention
18 Cochrane Corner – Review
20 Can video-calls help prevent loneliness for care home residents?
21 Depression and healthy ageing: current state of the evidence
22 PaperWeight Armband
23 Spotlight on…
Those that provide care, must care

Tracey Robbins has recently been appointed as the Big Lunch Community Delivery Manager. She previously worked as Policy and Research Manager on the Neighbourhood Approaches to Loneliness programme at the Joseph Rowntree Foundation. Tracey’s career has focussed on asset based community development approaches, health, wellbeing and social care within the voluntary and community sector for 20 years. Tracey uses action research and participatory techniques to work directly with individuals and groups to bring about change, develop opportunities and redress imbalances.

Loneliness is the mismatch between the relationships people have and those that they want. It is their internal trigger telling them to seek company, just as thirst tells them to drink and hunger tells them to eat (Robbins, 2014).

In combatting this, Dr Keming Yang (2015), Senior Lecturer in Sociology at Durham University, argues that loneliness is a social problem and therefore needs a social solution.

One could go a step further, and say that; Loneliness is a human condition and needs a human response.

Loneliness affects everyone, but many older and younger people experience overwhelming feelings of loneliness.

So what is loneliness?

Loneliness describes the pain of being alone (whereas solitude describes the joy of being alone). Somebody can be surrounded by lots of people and still feel lonely.

Through her work with the Joseph Rowntree Foundation (JRF), Tracey learnt that loneliness can affect anyone, regardless of age. In fact, it affects 15–25 year olds the same as those over the age of 65. It affects people’s health and their communities. This makes place-based approaches to reducing loneliness crucial, connecting people to each other in the areas where they live.

Through the community led approaches to poverty programme (JRF), Tracey gained a greater understanding of, and insight into, the importance of intergroup work in creating empathy for others (Fell and Hewstone, 2015).

In her current role for the Eden Project (delivering its UK wide community outreach programme and The Big Lunch), Tracey and her colleagues aim to connect people with each other and the living world, exploring how they can work towards a better future. They bring together people of all ages and backgrounds wherever they live.

Over the past six years while Tracey has been working on loneliness, disconnection and loss, she has lost her mother, had her grandchildren move away, colleagues leave and job roles change. But often there is very little room in life to consider the impact of loneliness personally, let alone for those as professionals.

Those in work find the environment pressured, limited, and functional. They lack time to build new relationships and friendships, often having long distances to travel, working long hours or juggling numerous jobs – meaning there is often no time to socialise or engage with their neighbours or their communities.

For those who no longer work, no longer have a ‘job’ to do, including volunteering, caring for others, raising a family etc. there is a sense of worthlessness that accompanies loneliness. This increases the longing for a return to the world or life that they once had, for their connections, structure, purpose and for their sense of identity. Often the people being cared for are longing for their families, friends and communities of times past. Many people will have come across those whose sense of loss and loneliness has left them unable to engage in, or forgotten by, previous networks.

To add to this sense of loneliness and lack of worth, older people often find themselves grouped together: in residential care, groups, activities and clubs for peer support and solace. However, this common remedy for social support may not be as soothing as is hoped and may even have a negative impact. This is because their peers are also likely to be experiencing the same sense of loss, lack of identity, low self-esteem and loneliness which can reinforce an individual’s sense of worthlessness.

A potential way to reduce loneliness is to think about ‘intergroup’ contact. All too often like with like are put together, but it ought to be the lonely and not lonely, socially connected and socially isolated, employed and unemployed that are brought together. This will not only disrupt the negative and judgemental stereotypes that prevail about getting older or being younger, but will improve understanding and attitudes. It will promote positive emotions such as empathy and it will help people to reconnect as humans.
The long term ramifications of the devaluing of so many lives is sobering and heart breaking for both the young and the old and those in between.

Lonely people are often excluded from the opportunities many people take for granted – especially those in care. They don’t have access to new opportunities, to meeting new and different people in ordinary everyday situations, and yet it is from these that people develop new relationships, experiences, insights, interests, hobbies and hopefully new friendships. For Tracey, it can be as simple as chatting to people on the train, trying yoga because workmates have inspired her to give it a go, or the happenstance of recently meeting her old colleague in a village hall, in a village where neither of them lived. She hadn’t seen her for six years – they are meeting up for coffee next week.

These are simple, ordinary, everyday things that matter to everyone.

Marie Greenhalgh, Big Lunch Extras participant, recognised the lack of opportunity for older people and is now running a project to address loneliness and isolation for older people living in her community near Manchester.

Marie’s inspiration came from working in a similar paid position near to where she lives.

‘I was getting referrals to my project for lonely people from Wythenshawe, my home town, but I was unable to accept them because the funding didn’t allow it.’

Feeling increasingly uncomfortable about this, Marie took the brave decision to leave her job and set up a project in her neighbourhood.

Initially she coordinated and trained volunteers to visit older people in their homes, befriending them and supporting them with everyday tasks. Marie was keen to do more though, and says, ‘I was at a bit of a crossroads, feeling overwhelmed by what I had taken on. However, after joining the Big Lunch Extras programme and attending the camp at the Eden Project, I went back with renewed vigour and got a community coffee morning off the ground in my local pub.’

Marie says the pub ‘was a place for younger people to gather and did not engage and attract volunteers and elderly people’. However, now they hold weekly coffee mornings for isolated elderly people and their families. This is first and foremost a chance to come together and socialise, but Marie also arranges easy access to local services in an informal setting. A hair stylist, optician, solicitor and a pharmacist are regularly available. As people’s confidence grows, more people are arranging to meet independently and plan outings.

**What can people do about loneliness?**

- Make every contact and conversation count
- Know how to ask the next question—and ask it
- Be pre-emptive and proactive
- Look out for loneliness
- Look after the health and wellbeing of themself, their colleagues, and their neighbourhood
- Ensure groups and activities have welcoming and are open to all
- Look out for opportunities to meet people, and cultivate new friendships and social interactions
- Smile and say hello, even when it’s hard
- Create and safeguard their personal convoy of friendships and social networks
- Talk about loneliness
- Don’t give up, get out
- Give the gift of time, give someone a little extra time

Also be aware that:

- Practical, flexible, low-level informal support is often most effective
- Lonely people often expect rejection, so focus on the positive. Expect the best.

**Those that provide care, must care:**

‘The business of business is relationships. The business of life is human connection.’

Robin S. Sharma

For more information on current research and best practice, the Campaign to End Loneliness (campaigntoendloneliness.org) is recommended.

**References:**


Finding the Loneliest in our Communities

Dr Kellie Payne graduated in 2015 with a PhD in Cultural Geography from the Open University. She looks after the Campaign’s Learning Network which is made up of over 1000 member organisations who work with older people on the issue of loneliness. Kellie also manages the Research Hub which comprises 100 academics working in the area of loneliness research. Prior to her PhD, Kellie worked in Research Communications at HGCA (Agriculture & Horticulture Development Board, Cereals and Oilseeds). Kellie is originally from Chicago, Illinois and has been in London since doing her MSc at the London School of Economics and Political Science (LSE) in 2004.

Everyone has experienced the hurt and pain of loneliness at one point in their lives. It can be an awful, debilitating feeling that makes us feel trapped and unable to cope with life. For most this is a temporary feeling caused by a change in one’s circumstances in life. For others though, this is a long-term and chronic condition.

On average 10% of the population of people aged 65 and over say that they are lonely often or always. This equates to over one million older people in the UK who suffer from chronic loneliness. Because of this, the public and political attention on loneliness has sharpened significantly as the social, economic and moral case for tackling this issue grows in awareness, evidence and support.

However, while it is known that there are some million older people experiencing chronic loneliness, finding them, in order to help them, can be difficult. When the Campaign to End Loneliness team surveyed a collection of over 1000 service providers, they were consistently told it would be difficult to help identify lonely older people.

To address this problem, the Campaign team has published two reports. The first, a research report examining methods of identification, is called ‘Hidden Citizens: How Can We Identify the Most Lonely Adults?’, and was published in 2015. In June of this year, the Campaign also published new guidance entitled ‘Missing Million: In Search of the Loneliest in Our Communities’.

The Missing Million report (hereafter referred to as ‘the report’) aims to help commissioners and service providers develop methods to help them identify older people that are experiencing, or are at risk of experiencing loneliness. The report also includes case studies which illustrate the methods identified.

The first section of the report, entitled ‘Identifying Loneliness’, explains different methods of identifying the lonely. It focuses on two types of approaches. The first is a top-down approach which seeks to discover what data is available to help locate lonely individuals and to find geographical areas that are more likely to house older people at risk of becoming lonely. The second is a bottom-up approach that looks at ways that local, hidden intelligence might be used.

Loneliness Heat Maps

Crucial to this first approach is the use of data to help identify those at risk of being lonely. The report features three different means of using different data sets to do so. One of the most promising of these approaches is using a tool developed by Age UK. They developed ‘loneliness heat maps’ working with the Office of National Statistics (ONS) to show the levels of risk of loneliness in a given area. By analysing English Longitudinal Study on Ageing (ELSA) data, they isolated the six risk factors associated with feeling lonely.

Of these factors, three were measured in the Census (marital status, self-reported health status, and age and household size) and could be found in the ONS
Dr Kellie Payne  
Learning and Research Manager  
Campaign to End Loneliness

A model was run on the 2011 Census data which enabled the team to produce maps of the data for individual localities. Risk of loneliness could be mapped at the neighbourhood, ward and street level using the tool that was developed.

These maps can help commissioners and service providers determine which parts of an area have a higher risk of loneliness among the older population. It will show which areas have a higher concentration of loneliness and allow service providers to determine where to best target their resources. It should be noted that the maps do not take account of variations within individual and community resilience, which will affect how an individual person and their surrounding community might react to the risk of loneliness. It is, however, a great indicative tool to show where the risk lies, enabling people to target resources.

Age UK have developed a series of pilot projects which are using the heat maps to help them identify which parts of their local areas they should target. For example, Age UK Wirral has a project entitled ‘Friends in Action’ and when they mapped their local area, they noticed that there appeared to be a high percentage of possible loneliness in a specific area. The team identified that there was a lack of social activities being programmed in this area and in discovering the high risk levels, they decided to develop more provision in that area. They set up a new monthly coffee morning which is going to be extended to a lunch club. The participants in the programme have said that this provision of service allowed them to build their social networks and in turn helped reduce their loneliness.

Exeter Data System

Another data set that can be applied to loneliness is the Exeter System which is a database of all patients registered with an NHS GP in England and Wales and is hosted by National Health Applications and Infrastructure Services (NHAIS). In order to protect patient confidentiality, access to the data is restricted. However, pioneering data sharing agreements have been developed which enable the data to be used.

The best example is a project entitled Springboard Cheshire in which an agreement was made between the NHS and a coalition between Cheshire Fire and Rescue Service (CFRS) and Age UK Cheshire. Using their access to the Exeter System, Springboard Cheshire supplemented information with other data from open sources (for example; assisted bin delivery, home oxygen therapy, and fuel poverty) which enabled households to be ranked and prioritised according to certain risks. This combined data is often referred to as ‘Open Exeter’. There is an overlap between these risk factors and the risk of having a domestic fire. Using the list created, the CFRS carried out home visits to vulnerable people and because they were partnered with Age UK Cheshire, they were able to signpost these people to further support. The success of the Cheshire scheme has led to a wider collaboration between the NHS and the Fire and Rescue Service.

Co-production and conversations

In addition to these examples of using data sets and mapping, the report also includes methods which are community driven and a project entitled ‘Connected Communities’. Another aspect explored is the possibility of creating partnerships. Also, the idea of creating programmes using the method of co-production which ensures that users work together with service providers to create service provision.

The final section of the report introduces ways to talk to someone who might be lonely and engage them in a meaningful and helpful conversation. It stresses that when engaging a possibly lonely individual, you should ensure you use the skills and qualities of empathy, openness, warmth and respect to facilitate a conversation about loneliness and the psychological distress it causes. A conversation should be problem solving and should enable signposting to available resources in order to help the person.

Combined, the new report sets out interesting and useful ways people can go about using data to find those at risk of loneliness, gives examples of the methods used and ways to start a conversation once they are found.

The report can be found here:

See also:
Junior Doctors’ Perspective on Loneliness in the Older Population

Poppy Mackay, Foundation Year 1 Doctor graduated from King’s College London with MBBS and a BSc (Hons) in Gerontology.

Grace Baxter, Foundation Year 1 Doctor graduated from Cardiff University with MBBSCh and a BSc in Psychology in Medicine.

With an ageing population comes a greater risk of social isolation and loneliness. It has been estimated by Jopling (2015) that around 10% of older people are ‘chronically lonely’ and Age UK have found that over one million older individuals identify themselves as being lonely (Age UK, 2016). Although loneliness can be objectively defined, the real impact of its definition is how the word is interpreted by the individual. To be lonely in older age does not merely imply being physically alone.

Kileen (1998) stated that loneliness is under reported “in today’s self-obsessed climate, where it is seen as a negative embarrassing condition.” However, junior doctors have a unique opportunity to care for people at their most vulnerable. Being acutely aware of an individual’s social circumstance allows them to offer simple interventions to tackle loneliness.

Loneliness is not purely a social problem; it has been reported that it is a predictive indicator for a number of negative health outcomes such as depression, dementia and hypertension (Age UK, 2016; Prina et al, 2013). Gerst-Emerson and Jayawardhana (2015) believe that a “targeting of interventions for lonely elders may significantly decrease physician visits and health care costs”.

Loneliness is a growing problem in the United Kingdom as life expectancies rise, transport links improve and there is globalisation of the labour market. A combination of these factors has resulted in the breakdown of traditional social networks. A recent review by Hagen et al (2014) discussed the effectiveness of new technology as a positive intervention for loneliness. However, without the ability to utilize such services, a proportion of the older population is becoming increasingly secluded in an ever more connected world.

The Role of the Junior Doctor

There are many simple interventions that can have a huge impact on how an individual perceives their situation. During hospital admissions, patients often report experiencing boredom and isolation. In particular, those undergoing long term admissions who have had intense initial support whilst acutely unwell often find that this is not sustained. However, junior doctors are uniquely placed to be able to raise issues of loneliness and its impact and create an environment where they can be discussed openly. Encouraging family members and friends to visit can help alleviate feelings of loneliness. Whilst ward rounds can be overwhelmingly busy, a few minutes focused on the mental well-being of a patient and their current emotional state can have a huge impact in how they view their care.

As a first step, patients can be referred to Liaison Psychiatric services for assessment of their mood. In particular, if Older Adult Liaison Psychiatry services are present in a hospital, they are better equipped to understand the specific needs of older individuals.

Additionally, as an inpatient, individuals can be referred to the Royal Voluntary Services who visit patients for a social chat in order to reduce social isolation. In busy situations where doctors may not be able to give their patients the time needed, these services are an invaluable support to curb loneliness and depression.

Age UK is an essential resource to many individuals. Not only do they provide a vast amount of information and research on the ageing population but they have practical groups addressing loneliness. Their befriending programme allows people to access social situations they may have been previously isolated from and to strengthen their friendship network. Another tool to tackle loneliness in hospital is ‘The Silver Line’, a helpline for older people that offers twenty four hour support. It is a free telephone number that provides someone at the end of a phone to interact with.

Spiritual support can also provide a vital resource to some individuals but is often not addressed unless in the presence of terminal illness. Most hospitals have access to spiritual leaders of all faith denominations, who can be contacted at the request of patients.

In conclusion, there are many interventions available to the older population in order to tackle the growing problem of loneliness. It is the role of junior doctors to further their understanding of services available and to take the time to address this issue whilst patients are under their care.

References


Enhancing the recognition of spiritual needs and care for patients: the value of the Opening the Spiritual Gate Programme

Dr Karen Groves MBE is Medical and Education Director for Queenscourt Hospice in Southport and Consultant in Palliative Medicine for Southport & Ormskirk Hospital NHS Trust. She is also Chair of the Cheshire & Merseyside Network Spiritual Care Group. This group was developed to ensure implementation of the NICE Supportive & Palliative Care Improving Outcomes Guidance, Spiritual Support Services, 2004.

Having a chronic debilitating condition, ageing, and approaching the end of life, have been shown to raise questions that may rekindle or intensify spiritual concerns. Some, mainly western world, evidence suggests positive benefits between spiritual awareness and emotional/mental health. Spiritual, and/or religious belief potentially helps a person to cope, find meaning, purpose and peace of mind at their impending death (Candy et al., 2012; O’Brien & Clark, 2015). Patients state that they expect clinical staff to be interested in them as individuals and address spiritual issues. They report less satisfaction with care when spiritual needs are not met (Astrow et al., 2007; Yardley et al., 2009).

Policy Background
Recent policies stress the responsibility of healthcare workers in addressing the holistic and spiritual needs of patients and families. Chapter 7 of The National Institute for Clinical Excellence: Supportive and Palliative Care Improving Outcomes Guidance (2004) is dedicated to spiritual care. More recently, the Leadership Alliance for the Care of Dying People (2014) report stressed the need to address individual needs and concerns of each patient and family. Furthermore, the Department of Health commissioned a systematic literature review of spiritual care at the end of life (2011) and the European Association for Palliative Care (EAPC) Task Force on Spiritual Care in Palliative Care recommended that palliative care professionals, and volunteers, need training to identify spiritual needs and provide spiritual care (Paal et al., 2015).

Despite this policy background, clinical staff describe feeling ill prepared, undereducated, uncomfortable and lacking in both confidence and skills for the task of addressing spiritual issues and are unsure whether it is part of their role (Best et al., 2015; Candy et al., 2012; Holloway et al., 2011). With the predicted rise in the elderly population, there is an even greater need to ensure staff are adequately prepared to provide this support.

Opening the Spiritual Gate Programme
Cheshire & Merseyside Network, Spiritual Care Group adapted an existing Queenscourt Hospice education programme, developed it further and rolled it out over the last decade. In its 2015 survey, the EAPC Spiritual Care Task Force identified reference to this programme in a small number of spiritual care training courses (Paal et al., 2015). Furthermore, it was recently described as a ‘significant training programme’ by the Care Quality Commission inspection of the Royal Devon and Exeter NHS Hospital Foundation Trust (February 2016).

The programme aims to raise awareness of spiritual and religious issues and needs as well as to encourage staff to:
• foster understanding that spiritual care is everyone’s business
• discern what gives meaning to life and may be important to those who are ill
• demonstrate the diversity and individuality of spiritual and religious needs
• consider the importance of rituals and rites of passage
• consider how to open, maintain and close a conversation about spiritual issues
• concisely and confidentially record and handover spiritual and religious needs
• devise a management plan for spiritual and religious care
• be aware of resources available for meeting spiritual and religious needs
• plan the transfer of learning, and confidence gained, into the workplace and to develop an action plan for individual development

The course is intended for frontline healthcare staff and is delivered both face to face and online as an introduction to spiritual assessment and support for staff. For more information see: www.openingthespiritualgate.net

Course evaluations to date have demonstrated the value to the participants’ confidence and willingness to undertake spiritual conversation and assessments. Currently, an independent evaluation of the impact on the course participant’s clinical practice is being conducted by Edge Hill University.

References:
Best, M., Buttow, P. and Olver, L. (2015). Doctors discussing religion and spirituality: A systematic literature review Palliative Medicine (online)
Leadership Alliance for the Care of Dying People (2014). One Chance to get it Right. London.
These days people can’t turn around without being told to do more exercise and with the Olympics just behind us, it has been dominating the news. People are constantly encouraged to hit the gym, jump on a bike or fit activity into their daily routine in other ways, such as taking the stairs instead of the lift or getting off the bus a stop earlier. While most people are aware of the benefits of physical activity on their bodies, less is known about the beneficial effects on their mental wellbeing.

Exercise is known to have positive physical, mental and emotional benefits. As the ability to undertake physical activity decreases in the elderly, incidence rates of anxiety and depression increase, as does impairment of memory, cognition and intelligence. These factors combined lead to a lower quality of life in the elderly population. A study in 2014 has shown that increasing prevalence of depression in the elderly correlates with increasing suicide rates in this population (Lee et al., 2014).

Depression is a general health problem affecting the public and is associated with many physical diseases, including cardiovascular disease and diabetes (Carney et al., 2002). Symptoms can include a continuous low mood, anxiety, a decline in enthusiasm and motivation and sleep disorders; it can also induce a decline in cognitive and mental function. This can lead to difficulties in performing normal daily tasks, both for personal care and around the house (van Milligen et al., 2011).

Regular exercise or physical activity has been shown to exert a positive influence on both the physical and mental health of older people. It leads to improvements in strength, balance, flexibility and agility, cardiopulmonary endurance and also creates psychological stability and happiness (Park and Kim, 2011). Physical activity has also been shown to reduce symptoms of mild and severe depression. A Korean study (Lee, 2015) showed that high levels of physical performance were associated with low levels of depression in elderly women. The findings also indicated that strength, strength endurance, cardiorespiratory endurance level and improvements in agility could have positive outcomes on the symptoms of depression.

A study initiated by the Ministry of Health, Labor (sic) and Welfare in Japan led to a revision of the long-term care insurance act in 2008 and greater emphasis on preventative long-term care and associated activities (Maki et al., 2012). Three areas were selected as models to evaluate how effective community-based programmes were against preventing mental decline. Takisaki was selected as an area for an intervention-based walking programme; the intervention was designed to test whether a walking programme was effective in preventing mental decline in elderly individuals with no diagnosis of dementia. The resulting randomised controlled study showed that the group that undertook the walking programme benefited from improvements in word fluency, quality of life, social interaction and the ability to complete physical tasks. The benefits of undertaking the programme in a small group included enhanced motivation, positive emotion and social interaction.

Exercise classes have also been shown to reduce loneliness and feelings of isolation. Social isolation has been shown to be associated with a greater risk of mental...
decline (Bassuk et al., 1999; Wilson et al., 2007). In 2014, a study was published showing that older people who undertook a 12 week community exercise programme felt that the programme reduced social isolation (Wallace et al., 2014). This finding has two aspects; firstly participants felt the programme provided structure and allowed them to meet new people, gain social support and feel cared for. Secondly, the programme provided them with physical benefits that increased their ability/motivation to socialise within existing networks and groups.

So what does exercise or physical activity actually entail? For many people the thought of donning brightly coloured lycra and pumping iron at the gym is not appealing. Fear not! Physical activity comes in many shapes or forms and people can choose what suits their level of fitness or what fits into their lifestyle.

**Ways to increase activity levels can include the following:**

- Gardening
- Housework/chores
- Walking to the shops rather than driving/getting the bus
- Joining the local gym

Before choosing to join a local gym, people should have a chat with their GP to discuss any activities/machines they should avoid or be careful of. It could be an idea to book an initial session with a personal trainer who can help devise a suitable and effective programme.

There is also the option to take up specific activities such as strength and balance classes, yoga or Tai Chi. Yoga in particular has been shown to have a number of health benefits such as improvements in walking and balance, muscle strength and cardiovascular fitness, as well as improvements to quality of life and psychosocial benefits through the prevention and control of common health and emotional problems linked with ageing. A review of the literature around yoga by Patel et al., 2012 showed that taking part in yoga led to substantial improvements in individuals’ abilities to undertake daily household chores, and the symptoms of depression were reduced at both 3 and 6 months after the intervention took place (Krishnamurthy and Telles, 2007).

Two further studies have shown that older people who undertake regular Nordic walking sessions have reported improved mood and a reduction in depressive symptoms (Suija et al., 2009). These findings also support the theory that outdoor exercise has a greater effect on stabilising people psychologically then exercising indoors. Outdoor exercise programmes involving group activities have been shown to be more effective at improving depression than indoor exercise groups (Lee and Park, 2015).

The effect of nature on mental wellbeing should also not be underestimated. A multi-study analysis carried out by Barton and Pretty (2010) showed that exercising in the presence of nature leads to both short and long term health benefits. The presence of water appeared to enhance these effects.

There is no doubt from the evidence above that taking part in physical activity or exercise of some kind enhances people’s mood and alleviates depression in all age groups including older adults. There are many misconceptions around what constitutes exercise and this can often put people off increasing their physical activity. The important thing to remember is that people need to do something enjoyable and suitable to their current level of fitness. If they love the outdoors, they should consider increasing the time they spend gardening or maybe look for a local walking group in their area. If they love to socialise, they should look for local exercise classes where they can meet new people. Exercise remains an important aspect of maintaining not just physical but mental wellbeing, especially into later life, and the more people can be encouraged to be active, the better they will feel.

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Lee et al. (2014). Association between depression and physical fitness, body fatness and serum vitamin D in elderly population. Korean J Obes. 23, pp.125-130.


**An active lifestyle = better brain health**

The Global Council on Brain Health is a new independent collaboration of scientists, doctors, scholars and policy experts from around the world, created by AARP – the leading US not-for-profit organisation for people aged 50 and above – in collaboration with Age UK. Their first report, released in July 2016, looks at physical activity and brain health.

The report provides five evidence-based statements agreed by the expert group on the relationship between exercise and brain health as we age:

1. Physical activity has a positive impact on brain health.
2. People can change their behaviour to become more physically active at any age.
3. Based on randomized controlled trials, people who participate in purposeful exercise show beneficial changes in brain structure and function.
4. Based on epidemiological evidence, people who lead a physically active lifestyle have lower risk of cognitive decline.
5. In spite of the link between physical activity and brain health, there is not yet sufficient scientific evidence that physical activity can reduce risk of brain diseases that cause dementia (e.g. Alzheimer’s disease).

People therefore have the power to protect their brains against ageing by taking part in regular exercise. What’s more it is never too late to start and people can change their behaviour to become more active at any age, reaping the beneficial changes to brain structure and function.

Practical advice and recommendations on ways to increase activity and the amount we should be aiming for per week are also included.

Volunteering in later life may enhance mental health and wellbeing

A study from researchers at the University of Southampton and University of Birmingham who reviewed data from the British Household Survey has found a potential link between volunteering and improved mental wellbeing over the age of 40.

Previous research has suggested that freely giving time to help others can boost self-wellbeing but has mainly focussed on older adults. This study aimed to examine the affects across the whole life course. They found that the association between mental wellbeing and volunteering varied according to age and did not emerge until later in life. During early-mid adulthood taking part in volunteering activities did not appear to have any significant positive benefit on mental wellbeing. However, once over the age of 40-45, mental health scores improved for those who took part in volunteering activity whilst getting worse for those who didn’t.

However, as pointed out in NHS Choices (2016) it’s important to bear in mind that it’s not necessarily the case that the volunteering has caused the good state of health. It could be that the association works both ways – better wellbeing probably makes you more inclined to help others, and helping others probably boosts your sense of wellbeing.

For more information please see:
http://bmjopen.bmj.com/content/6/8/e011327

Upcoming Events…

The Future of Ageing Conference
9th November 2016
The International Longevity Centre – UK hosts this conference in London to bring together Government, industry, academia and civil society in order to discuss the implications of our ageing society.
http://www.futureofageing.org.uk

Transforming Mental Health and Dementia Provision with the Natural Environment
10th November 2016
This one day conference organised by The Centre for Sustainable Healthcare takes place in London. It looks to discuss practical ways to allow the adoption of nature-based interventions into mainstream health and social care provision in order to help tackle mental health issues and dementia.

For Later Life Conference
8th February 2017
This one day conference hosted by AGE UK takes place in London to discuss the latest developments in age-related policy and practice.
http://www.ageuk.org.uk/professional-resources-home/conferences/forlaterlife/

The Mental Capacity Act in Dementia Care – 1 day Masterclass
8th December 2016
This one day master class hosted by the Association for Dementia Studies takes place at the University of Worcester. It will explore how the Mental Capacity Act relates to the everyday practice and dilemmas that occur in dementia care. Open to all health and social care staff who work with people living with dementia.
https://www.eventbrite.co.uk/e/dementia-one-day-masterclass-mental-capacity-act-8-december-2016-registration-25788474020?aff=es2
Living Longer, Living Better

Tricia Grierson was appointed to the role as Head of Independent Living in 2015 but has worked for Johnnie Johnson Housing Trust (JJHT) for 14 years. It is a strategic role, leading the development of a new offer for residents over the age of 50. The aim is to position JJHT as a market leader for Independent Living in social housing, delivering outstanding services for current residents and being the most attractive option for future customers.

Tricia has worked in the field of Social Housing since 1985. She is a Fellow of the Chartered Institute of Housing, a Board member of Women in Social Housing (North West) and a Trustee of Age UK Cheshire East.

Johnnie Johnson Housing Trust (JJHT), founded by the fighter pilot Air Vice Marshall James Edgar ‘Johnnie’ Johnson in 1969, is rapidly approaching its 50th Anniversary. It now has 5000 homes across the country, mainly in the North of England. Over 3000 properties are designated for people aged 50+ with support also provided for many other older people living in their family homes. In 2000, JJHT established their Social Alarm centre called Astraline which provides telecare support for over 60 housing associations and other agencies across the UK. Astraline has recently been accredited to Platinum status with the TSA (Telecare Services Authority), one of only 29 Telecare Alarm Receiving Centres in the UK to achieve this status. Staff from the Trust and Astraline work jointly to deliver a unique service to the residents.

Until 2015, JJHT delivered a traditional service to their sheltered housing schemes with a full-time scheme manager based at just one scheme. They have, however, recently reviewed their services as a result of regulatory requirements, and commissioned an independent consultation with their residents. The residents demonstrated a very strong brand loyalty to the Trust and were very happy with their homes but wanted increased choice and better value for money, especially with service charges.

This review led to the creation of their new vision “Living Longer Living Better” – helping the residents to age well, live independently and maintain their quality of life for as long as possible. JJHT are focussing on ‘Independent Living’ for residents of over the age of 50, many of whom may not need support at the moment but are preparing for their futures.

As a consequence of the new vision, the Trust have transformed their organisation and restructured the whole Independent Living service to offer a flexible approach to deliver targeted services. The aim is to offer a menu of choice to residents so that they can select the level and type of service they need, with the option to extend or vary this as their needs change. Striving to deliver value for money, the restructure has enabled a reduction in service charges for 2016/17 and with carefully negotiated procurement they will continue to reduce costs.

JJHT Connections is vital to their Independent Living offer bringing together residents, staff and partners, both in person and virtually. The diagram below shows the different elements of the offer which can be delivered. They fulfil the needs of current residents whilst being attractive and financially viable for future younger customers. A core service is delivered to all tenants, additional services are available in their Independent Living schemes and they are now preparing an offer of services including assistive technology. Residents can select from a range of services to enable them to enjoy staying independent for longer. Such offerings may be provided by the Trust or partner organisations that JJHT help tenants to connect with.

Investment
Maximising the use of new technology, JJHT now have agile working Independent Living Coordinators (ILCs) who deliver services and information to people in their own homes. The focus of their role is now more outward looking, working with the wider community to facilitate health and well-being activities for residents and their local neighbours. They are
creating supportive communities (rather than supported) that engender independence to create a preventative service, rather than a reactive or one-size-fits-all approach.

Services are being re-focused based on individual residents’ data that they have shared about their medical and support needs, and the levels of outgoing calls to Astraline, etc. Moving from a blanket service of morning calls for all tenants, JJHT can now offer more tailored solutions such as alternative methods of contact. This allows the ILCs more time to deliver a face to face service to those who really need it.

This aim to tailor services to customers’ needs and create a flexible service approach, meant JJHT needed to understand more about their customers. From knowledge and data about their residents, they are creating a number of key customer profiles or ‘personas’ such as:

• Pete – the 58 year old single man in the Independent Living scheme with limited family contacts and decreasing social life other than going alone to the pub.
• Betty – the 85 year old lady in the Independent Living scheme with no obvious health issues, out and about every day volunteering to help others with no check calls.
• James & Irene – a couple in their mid-70s living in a bungalow with a social alarm where one partner is the carer for the other and feels very isolated.
• Jon & Jane – future residents – a couple in the late 40s with no children who are considering their future options

The aim is to promote these key personas across the business, using them to understand customers’ needs, habits and worries and shape what JJHT or their partners could do with the services they offer. Personas help the staff to identify with residents, avoiding generalisations and assumptions that could lead them to believe that one offer would suit all. For example where they have a number of ‘Petes’ in their schemes, JJHT are putting on some male specific activities – art classes is one idea they are currently trialling. Where they have elderly and independent ‘Bettys’ they are testing some new Astraline Telecare technology which is not intrusive, but there as a “comfort” for the customer, or their family, knowing that if ‘Betty’ fell, Astraline would be alerted and they could respond immediately.

The approach to developing the service offer has been to pilot new ideas in a range of different schemes. The pilots cover:

• Alternative options to the morning check call
• Greater use of assistive technology
• Targeted personal visits
• Safe and secure packages (individual home safety checks, security measures, adaptions)
• Social activities to combat loneliness and isolation, particularly in men

Planning for our future
The future is looking positive for JJHT and its residents. They are starting to plan the development of new properties, creating modern practical homes with innovative flexible designs. They will maximise the opportunities available from innovative development in assistive technology, allowing the residents to live independently for longer in their own homes.

Astraline is the first alarm receiving centre in the UK to implement the SCAIP protocol (Social Care Alarm Internet Protocol). JJHT have reviewed their IT infrastructure making considerable investment so that as technology develops they will have ample capacity to receive calls over the internet. This will entail no call charges to any of their customers, making the service much better value for money. In the future they will be able to have face to face communication with their customers and provide them with the ability to do this with each other as well as with their families, friends and even GPs.

JJHT have properties located in very rural areas where even analogue lines are not always reliable. Astraline has been working with B4RN (Broadband for the Rural North) who provide fibre optic cable, supplied with a battery back-up, to enable such properties to access extremely high speed broadband connections 100% of the time.

Finally, looking into the more distant future, JJHT is keen to ensure that the properties and services that they have been developing for the past fifty years will still be relevant and valuable for the next 50 years. To that end, they are working with Newcastle University’s Institute for Ageing to test out in practice their views about future needs and requirements of older people for services and homes in 2030+. JJHT is striving to ‘future proof’ its service so that it fulfils the aspirations of younger generations to come.
Loneliness in later life: opportunities and challenges for intervention

Nicole Valtorta is a Research Fellow in Public Health at the University of York, currently funded by the National Institute for Health Research to study for a PhD on loneliness, social isolation and the risk of cardiovascular disease.

Professor Simon Gilbody founded and directs the Mental Health and Addictions Research Group at the University of York’s Department of Health Sciences.

In the UK, persistent loneliness in later life affects 14.5% of adults aged 65 to 79, and close to 30% of those aged 80 and over (Office for National Statistics, 2015). Commonly defined as the perception that one’s relationships are quantitatively and/or qualitatively deficient (de Jong Gierveld & al., 2006), this negative feeling, when it becomes chronic, is associated with a range of poor health and wellbeing outcomes. Lonely individuals are, on average, 26% more likely to die prematurely - an effect size exceeding the increased risk of mortality associated with physical inactivity or high Body Mass Index (Holt-Lunstad & al., 2015). Recent systematic reviews of the evidence have identified loneliness as a risk factor for some of the greatest causes of morbidity worldwide, including cardiovascular disease and dementia (Kuiper & al., 2015; Valtorta & al., 2016). Three main health-damaging pathways have been evidenced: psychological distress, behaviours such as smoking and poor diet, and physiological mechanisms (Berkman & Krishna, 2014).

Policy makers in UK and other countries have begun to recognise the public health challenge associated with persistent loneliness, and with the more objective situation of social isolation. In 2012, the White Paper Caring For Our Future explicitly identified loneliness as a key societal concern: ‘Loneliness and social isolation remains a huge problem that society has failed to tackle… Social isolation and persistent loneliness, particularly in later life, have a huge impact on people’s health and wellbeing… We must work together to tackle social isolation’ (Department of Health, 2012).

Recognising poor social relationships as a societal challenge concern is a first step in tackling the problem – the next stage is to identify the best strategies for addressing such a multifaceted issue. In this article, drawing on evidence from observational and evaluative studies, we discuss opportunities for prevention, and associated challenges.

1. Targeting at-risk groups
Chronic loneliness in older age is not inevitable. Certain circumstances, which people in later life are more likely to face, can act as triggers: the loss of a spouse, retirement, becoming a carer, declining health and entry into care have all been associated with a decrease in the quality and/or quantity of a person’s social relationships (Dykstra & al., 2005). In recognition of these risk factors, much of the intervention effort to date has focused on people with a long-term condition or limited mobility, bereaved individuals, nursing home residents, retirement community residents, and caregivers (Dickens & al., 2011).

Comparatively less attention has been given to factors which, earlier in life, can lead to persistent loneliness into later age. These include some of the most important determinants of social inequality, such as lower socioeconomic status, unemployment and migration (Public Health England, 2015). Lower education level, lower income and chronic work and/or social stress have also been associated with heightened levels of loneliness (Hawkley & al., 2008). From the perspective of opportunities for intervention, this suggests that initiatives aimed at improving people’s social and economic circumstances have the potential to tackle loneliness. It also highlights the pertinence of action earlier in the life-course to tackle loneliness in older age (see Figure 1. for a summary of opportunities for interventions across key stages of the life course).

2. Designing and implementing tailored interventions
A wide range of interventions have been developed to combat loneliness. These include group activities (e.g. choir practices, writing clubs, exercise sessions), one-to-one interaction (e.g. home visits, befriending), and
technology-based solutions (e.g., computer and internet training). To date, because few of these interventions have been robustly evaluated, their effectiveness in tackling persistent loneliness is unclear. Systematic literature reviews have identified that, in general, initiatives underpinned by a theoretical framework, and actions whose design and delivery actively involve participants, are more successful; but no single type of intervention has been shown to be effective across target groups (Dickens & al., 2011).

Given the range of experiences that can lead to chronic loneliness, it is likely that different circumstances will require different interventional approaches. Loneliness stemming from the perceived absence of a confidant (emotional loneliness) differs from loneliness deriving from the perceived absence of a wider social network (social loneliness) (van Baarsen & al., 2001). Befriending would seem more suited to the former while group activities may be more appropriate for the latter. The challenge for interventions is to take into account this plurality of experiences, and tailor actions accordingly. A promising example of how this might be done is the ‘Reconnections’ service set up by Age UK Herefordshire and Worcestershire in 2015, whereby individuals identified as being lonely or isolated through local social care, healthcare and community networks co-produce an action plan with the charity to strengthen their social relationships (http://www.reconnectionsservice.org.uk). Ongoing evaluation of this service includes monitoring effects on loneliness but also health outcomes; information that will help to further our understanding of whether initiatives tackling loneliness can help improve health and wellbeing.

3. Implications for patient care

The evidence linking loneliness to health and wellbeing suggests that social relationships should be taken into account when caring for patients and service users. Social relationships can be used as a lever to promote and support improvements in behaviours relating to health such as physical exercise, diet and smoking cessation. Effects on physiological functioning could reduce the effectiveness of treatments, while interventions relying on the involvement of close relationships in medical care have the potential to positively effect adherence to advice and medication (Holt-Lunstad & Smith, 2016).

Figure 1. Opportunities for strengthening social relationships across the life-course.

...continued on next page
In elderly care and family practice, if lonely and isolated patients are being treated more often than others, then health practitioners are well placed to play a key role in identifying those at highest risk. One of the challenges this raises is developing a means of assessment that captures the multifaceted nature of loneliness whilst being easily incorporated into day-to-day practice. Because individuals may not wish to publicly admit to frequent loneliness feelings due to stigmatization, using a direct single question is unlikely to be sufficient. A variety of tools exist to measure various social relationship dimensions (Valtorta & al., 2016) – familiarity with these is likely to require that social relationships and associated social circumstances be covered in medical, nursing and social care education (Holt-Lunstad & Smith, 2016).

As responses to the challenge of persistent loneliness in later life develop, it will be important to monitor and evaluate their effects. Effective cooperation between policy-makers, the third sector, practitioners, service users and researchers will be key to furthering our understanding of how best to tackle this public health and societal challenge.

References


Introducing Cochrane Global Ageing

A new initiative - Cochrane Global Ageing - has been launched on 1 October 2016 to coincide with the United Nations International Day of Older Persons. Its mission is to connect people and facilitate sharing of knowledge and experiences related to global ageing and health that are relevant and accessible to the public, scientists, health professionals, policy makers, educators, commissioners, journalists and funders.

Why is Cochrane Global Ageing required? The number of older people (over 65) is currently at its highest level in human history. Indeed, the World Health Organisation (WHO) has responded to global population ageing through several important publications. One of these is the WHO Global Network of Age-friendly Cities and Communities which was established in 2010 to connect cities, communities and organizations worldwide with the common vision of making their community a great place to grow old in.

The United Nations member states recently signed up to Global Sustainable Development Goals. One of these is devoted to “ensure healthy lives and promote well-being for all at all ages”.

Cochrane Global Ageing’s call to action is to challenge negative stereotypes and misconceptions about older people by highlighting the need for and producing age appropriate research and evidence. The team wants to ensure older people are meaningfully and statistically represented in research studies and are included in the process of clinical trial development, dissemination and implementation of results.

For more than 20 years, Cochrane has produced systematic reviews of research in health care and health policy. Systematic reviews are a type of literature review that collect and summarize the best evidence from research to help in making informed choices about treatment.

Cochrane reviews are internationally recognized as the highest standard in evidence-based health care resources. The reviews investigate the effects of interventions for prevention, treatment, and rehabilitation. They also assess the accuracy of a diagnostic test for a given condition in a specific patient group and setting. They are published online in the Cochrane Library: http://www.cochranelibrary.com

Cochrane works collaboratively with contributors around the world, including 37,000 people from more than 130 countries. Cochrane reviews have helped to transform the way health decisions are made across the globe.

One of the first projects for Cochrane Global Ageing is to compile a list of topics relevant to global ageing and generate and publish appropriate high quality information as entries on Wikipedia. The call to action for readers is to please send your suggestions for Wikipedia entries on global ageing.

Cochrane Global Ageing will be writing Cochrane Corners, similar to the ones published in Innov-age, which summarize the evidence from Cochrane reviews on particular topics.

The team will work with their network to identify priorities for new Cochrane reviews on topics related to Global Ageing. Another call to action for readers is to please send any questions requiring an answer about the effectiveness of a treatment related to global ageing.

Questions usually take the form of – how effective is [treatment A] compared to [treatment B] or [no treatment] on the [goal of the treatment] in a [certain group of people]. Examples of this structure:

• What are the effects of [exercise] compared with [no exercise] on [balance] in [older people, aged 60 and over, living in the community or in institutional care].

• How effective are [different types of psychotherapy treatments] in the treatment of [depression] in [older people].

Visit the website, www.globalageing.cochrane.org, to see links to resources relevant to global ageing including research groups and organizations, conferences and funding.

Cochrane Global Ageing will be using social media such as twitter to help start and spread conversations about global ageing. They will create Twitter lists and hashtags. Follow them @CochraneAgeing

For further information sign up to their newsletters or email globalageing@cochrane.org
Social isolation is the lack of ‘structural’ and ‘functional’ social support. Structural social support is normally assessed through the size of networks and frequency of contacts. Functional social support is a subjective judgment of the quality or perceived value of emotional, instrumental and informational support provided by others. Loneliness is a subjective concept resulting from a perceived absence or loss of companionship. The need for companionship and to feel related to others is a core human need (Deci & Ryan 2008).

Loneliness and social isolation among older adults has the potential to increase the risk of cognitive decline and even the risk of death (Dickens et al., 2011). Older residents in care homes and in community hospitals can be socially isolated and feel lonely with insufficient family contact. Family support may prevent depression (Masi et al., 2011) but families may live far away and find it difficult to make frequent visits. Seeing the talking faces of family members may aid older people’s memory whilst reducing loneliness and increasing quality of life and well-being. Technological interventions, such as video-calls, help to keep people connected who may find it difficult to see one another face-to-face.

Socialisation interventions incorporating face to face communication through Skype have been developed, and tested among older adults living alone with cognitive decline. This type of socialisation intervention has been demonstrated to be beneficial and enjoyable amongst older people, and has proved positive in increasing their social networks over a long-term period (Jimison et al., 2012). Post intervention follow-up of using Skype amongst older adults to reduce depression and loneliness has proven to be valuable in the treatment of depression (Choi et al., 2014).

Even so, older people and their family may be concerned that video calls may replace face-to-face visits (Tiberto et al., 2013). Improving the quality and quantity of social contacts may help in maintaining quality of life both of people with dementia and their families (Golden et al., 2009; Bamford & Bruce, 2000). However, it is not clear if the capability for video calls improves overall quantity and quality of contact and there is a need to explore this further. In 2013, the development of a ‘Skype on Wheels’ (SoW) device was undertaken as part of a proof of concept study by Professor Ray Jones. The focus of this study was to design a ‘chassis’ suitable to allow a carer or staff member in a care setting to take a video-call and wheel it around to a resident or patient. The older person, perhaps with cognitive decline or dementia, may see it as a telephone call but where you can see the other person on a screen (an iPad or tablet). This SoW device was first introduced into a care home in Devon UK in 2014, where two residents successfully began to use Skype to communicate with family. However, for those with more advanced dementia it was felt, as a minimum, residents needed to be able to engage with and understand television in order to successfully use Skype. This early proof of concept study suggests that video-calls are likely feasible with older adults with no noticeable or mild cognitive impairment and perhaps early onset or moderate dementia rather than severe.

Collaboration with care home staff, family and residents is key to ensuring that an intervention such as video-calls could be feasible in aiding older people to stay in touch with relatives within a care setting. Therefore, the team at Plymouth University have begun to collaborate with older people, with or without cognitive decline, living in care homes across Devon, along with their families and staff members, to assess feasibility and acceptability through a pilot trial. In addition, outcome measures of loneliness, social networks and well-being will be assessed through qualitative and quantitative measures. This pilot trial will enforce a future definitive trial that can be implemented across all care homes in the UK.

References
Depression and healthy ageing: current state of the evidence

Matthew Prina is an Epidemiologist and Lecturer in Ageing and Mental Health at the Institute of Psychiatry, Psychology and Neuroscience, King’s College London (KCL). His research interests include ageing, mental health, frailty and the co-morbidity between mental disorders and other non-communicable diseases. He is author of several articles on mental health in older age and co-author of the Dementia UK report and of a number of recent World Alzheimer Reports. He currently leads, together with Professor Martin Prince, the KCL team of the ATHLOS project (Ageing Trajectories of Health: Longitudinal Opportunities and Synergies).

A better understanding of how we age will provide insight into interventions that can alter pathways to old age, promoting healthy ageing, and subsequently having a positive impact in our ageing societies. Although there is some evidence on the beneficial effect of altering ageing trajectories upon population health (Depp et al.), we still do not fully understand what drives pathways to healthy ageing. ATHLOS (Ageing Trajectories of Health: Longitudinal Opportunities and Synergies) is an EU-funded project bringing together 14 partners from 11 European Countries which aims to achieve a better understanding of ageing through the identification of healthy ageing trajectories, determinants of these patterns, critical points in time when changes in trajectories occur, and timely clinical and public health interventions to optimise healthy ageing (more information is available at: http://athlosproject.eu/).

As part of this project, Dr Carolina Kralj (ATHLOS team, KCL), has systematically assessed the evidence surrounding biological, behavioural, psychological and socio-demographic determinants of healthy ageing across the life span. One of the most consistent factors predicting healthy ageing was found to be depression.

Nine studies were identified which explored the longitudinal association between depression and healthy ageing, comprising a total of almost 50,000 participants. The findings across the studies, which were of relatively good quality and primarily carried out among people living in the USA, were consistent. Seven out of nine studies reported that having depression at baseline was associated with reduced healthy ageing at follow-up.

It is already known that depression is a primary cause of disability (Ferrari et al.), reduced quality of life (Sivertsen et al.), hospitalisation (Prina et al.), and mortality (Cuijpers et al.) across the life-course, but it seems likely that depression also has a role in whether we age successfully. Given that psychological and pharmaceutical treatments for depression are readily available and have demonstrated reasonable effectiveness, our finding leaves the door open to future intervention studies which could potentially evaluate whether targeting depressive symptomatology could shape healthy ageing.

It is important to highlight however, that depression is likely to be a smaller piece of a larger puzzle, where many factors (biological, behavioural, psychological, environmental and socio-demographic) interact to produce the overall observed effect. Using a large harmonised data set, including over 20 international longitudinal studies comprising more than 340,000 individuals, the ATHLOS project will explore how these complex interactions shape healthy ageing trajectories over time. This deeper understanding of ageing will also result in the creation of a more realistic definition of “old age”, beyond the standard chronological approach.

What is healthy ageing?
Although many different terms have been used to describe healthy ageing (e.g. successful, productive, active, positive, etc.), a consensus on its conceptual and operational definition has not yet been reached (Cosco et al., 2014). It is, however, accepted that healthy ageing cannot only represent the lack of disease, but also a longer life with less disability, as well as high levels of physical and mental functioning with active engagement.

Acknowledgement
This project has received funding from the European Union’s Horizon 2020 research and innovation programme under grant agreement No 635316.

References
Kirstine Farrer, Consultant Dietitian at Salford Royal NHS Foundation Trust, is leading the team that is pioneering the PaperWeight Armband – a non-medical, non-intrusive tool that is helping health and social care professionals identify older people at risk of malnutrition and signpost them to information and advice. Now, thanks to a partnership with Age UK Salford, the PaperWeight Armband is available across the country to help save lives and cut costs associated with treating malnutrition – all with a simple strip of paper.

There has never been a more urgent need for health care providers and commissioners to act and address the problem of malnutrition in older people. Needless suffering, neglect and inconsistent standards of dignity are unacceptable. Malnutrition is a major cause and consequence of poor health and older people are particularly vulnerable. Not only is this intolerable from a health perspective for the quality of life in older people, malnutrition can lead to more hospital admissions and re-admissions, longer hospital stays and greater healthcare needs. Consequently, the cost of malnutrition has spiralled out of control with BAPEN (the British Association for Parenteral and Enteral Nutrition) suggesting this may be around £19.6 billion each year (Elia, 2015). One in 10 older people, equating to around one million older people in the UK, are suffering from or are at risk of malnutrition. Furthermore, more than one in four are malnourished or at risk of malnourishment on admission to hospital.

Mid-arm muscle circumference is a well-established surrogate measure for body mass index. The PaperWeight Armband is, as its name implies, a paper armband that can be used to measure arm circumference. If the PaperWeight Armband can be stuck together at the red line and slide freely up and down the upper arm, clearly the arm circumference is less than 23.5cm. This may suggest that the person has a body mass index of less than 20kg/m², an indication of being underweight and at risk of malnutrition. By having a QR code on the armband, the carer can immediately get access to a high energy protein diet sheet written by community of dietitians and older adult residents in Salford. This leaflet includes further information, advice and support available locally, such as food banks and Age UK Salford services. The guidance outlined in the leaflet should be followed for a maximum of 12 weeks, following which time if there is no improvement, the advice is to ask to see a health care professional. Data from the Salford Public Health team has shown a decrease in hospital related admissions for malnutrition in the last year. Case studies also demonstrate an increase in the proportion of older people who feel supported to manage their own conditions, thus improving the quality of life for service users and carers.

The Salford Age UK volunteers and community asset group found the PaperWeight Armband easy to use. One volunteer said, ‘it has allowed us an opportunity to broach the subject of malnutrition; It saves us time as we don’t need to refer to GP to then refer on to the dietitians, but we have the safety net of working closely with the community and hospital dietetic teams when we really need their advice. I don’t see any reason why we can’t incorporate this into our Age UK Salford hospital discharge work programme’.

Due to the positive feedback from colleagues around the UK, Age UK Salford have now partnered with Salford Royal NHS Foundation Trust to upscale and spread the PaperWeight Armband. Mr Dave Haynes, Chief Executive from Age UK Salford, accepted a public health excellence award at the House of Commons in June on behalf of the team from Salford.

The PaperWeight Armbands can be purchased by health care providers. For more information on the PaperWeight Armband, please visit the following link: http://www.ageuk.org.uk/salford or follow us on Twitter -@PARmband.

References
Kate Bennett
Project Manager on the Physiotherapy Works programme for the Chartered Society of Physiotherapy

What is your current position and what was your career path that took you there?
I am a physiotherapist specialising in falls and balance issues in the elderly, working in the community of Southampton. I fell into this area of work (pardon the pun) after attending a course with a friend on dizziness and balance in the elderly several years ago. I have worked with the elderly population for a number of years in a variety of settings including hospitals, in the community and in clinics. I have also worked as a project manager both in the NHS and for the Chartered Society of Physiotherapy (CSP) where I worked on their ‘Physiotherapy Works’ programme.

What challenges do you face in your current position and which has been the greatest one?
The greatest challenge is the lack of integration between health and social care. For example, when people come out of hospital we need to ensure all their needs are met in the community. This lack of integration leads to immense problems with the setting up of appropriate care packages. This leads to longer stays in hospital and also a higher risk of people being readmitted because they cannot cope at home.

In your opinion, what are the top three issues affecting the care of older people?
• Increase in an ageing population – we are not prepared for this
• Lack of co-ordination of health and social care nationally
• Lack of options for elderly patients who don’t need to be in acute hospital beds – we need more step up/step down facilities to enable people to recover their independence in appropriate environments

What changes in elderly care do you anticipate in the next few years?
I anticipate that more and more services will be community based and that primary care will have a greater role in the care of our elderly population. I hope that in five or ten years’ time A&E will not be the default setting for the unwell elderly but they will have access to more intermediate care facilities or community-based services. I also think that society as a whole will become more dementia friendly with the growing prevalence of this disease.

If you hadn’t become a physiotherapist, what might you have done?
My passion outside of work is horses (I currently have 5) so I like to think I would have been on the Olympic three day event team!

What experience has influenced your career the most?
It was the day I was inspired to set up my pathway for elderly patients to access rehabilitation services directly from A&E. A patient from a residential home had come in via A&E with a broken pelvis and had ended up on the acute wards. She had severe dementia and kept refusing her painkillers; subsequently she was refusing to walk because of the pain. When she came down to the rehab ward where we worked, we found ways of encouraging her to take her medicine and she gradually was able to use an aid to stand and move around with. Sadly she never regained enough mobility to return to her residential home and had to move to a nursing home. The saddest thing was she lived in the residential home with her best friend; they had been to school together. We felt that if she had had access to specialist elderly rehabilitation earlier, we may have been able to get her back to her friend. At this point I started thinking there must be a better way… The pathway I set up won awards and was presented internationally. It also prompted my move into project management which enabled me to take on a more strategic role with the CSP.

What advice would you give to someone contemplating following in your footsteps?
Be brave, think outside the box and don’t be afraid to bend the rules (within reason) and argue your case. Also work out who your allies are and talk to them. I knew I needed to get A&E onside and consider how they worked before I could set up the pathway so I went and worked with them in my own time and at all hours of the day.

Where do you go for advice and information?
I have a number of mentors for various things so I usually consult them… or Google!

Who would you most like to work with?
Simon Stevens (Chief Executive of NHS England)… I have a few ideas to share!

What do you enjoy doing when you are not working?
The aforementioned five horses tend to take up most of my time. Other than that I love sewing, reading and watching any sport except football. Occasionally I get to see my husband too!

What do you do in a typical working day?
There is no such thing but it generally involves treating patients and driving around Southampton plus the odd meeting.

If you were stranded on a desert island what would be your one luxury?
My mobile phone because I can literally do anything on it. I would just hope they have Wi-Fi…
In our next quarterly issue of Innov-age we will be looking at Older People and Cancer.

Half of all cancer cases in the UK each year are diagnosed in people aged 70 and over (Cancer Research, 2011-2013). With 1 in 2 people now diagnosed with some form of cancer during their lifetime, it is an extremely topical and important healthcare issue to discuss.

Join us for the next issue of Innov-age where our contributors share their knowledge and experiences of cancer care and other important eldercare issues...