Department of Health

Modern Standards and Service Models

Older People

national service framework

National Service Framework for Older People

National Service Framework for Older People

Contents

contents

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National Service Framework for Older People

Contents

National Service Framework for

Older People

FOREWORD

Just like the rest of us, older people want to enjoy good health and remain independent for as long as possible. As people get older remaining independent often depends on health and social care services being effective enough to support them.

Older people are the main users of health and social care services but sometimes services have not adequately addressed need. This National Service Framework is the first ever comprehensive strategy to ensure fair, high quality, integrated health and social care services for older people. It is a 10 year programme of action linking services to support independence and promote good health, specialised services for key conditions, and culture change so that all older people and their carers are always treated with respect, dignity and fairness.

The NHS and social care services in England lead the world in many aspects of care for older people. We have already taken action to:

- **Improve standards of care:** in care homes, through the new National Care Standards Commission, and through the *Better Care, Higher Standards* Charters.

- **Extend access to services:** Free NHS sight tests for those aged 60 or over, improved access to cataract services, extension of the breast screening programme to women aged up to 70. Carers' needs are particularly important: their access to services in their own right has been ensured through the *Carers and Disabled Children Act 2000*.

- **Ensure fairer funding of long term care:** Nursing care will be free this year for people in nursing homes.

- **Develop services which support independence:** New intermediate care services to help people avoid an unnecessary hospital admission and to speed recovery and rehabilitation are being put in place. The *Promoting Independence Grant* supports councils to help more people to retain their independence for longer. *Supporting People* is a new initiative to help vulnerable people live independently in the community by providing a wide range of housing support services.

- **Help older people to stay healthy:** Free influenza immunisation for everyone aged 65 and over. Action is being taken to improve oral health in older people and increase access to dentistry. *Keep Warm, Keep Well* campaigns are helping to prevent deaths from cold each winter.

It is true though that services sometimes fail to meet older peoples' needs - sometimes by discriminating against them, by failing to treat them with dignity and respect, by allowing organisational structures to become a barrier to proper assessment of need and access to care, and because best evidence-based practice is not in place across important clinical areas.

This National Service Framework sets out a programme of action and reform to address these problems and deliver higher quality services for older people. There will be more consultants, nurses and therapists working for older people and better access to high-tech surgery and community equipment. New national standards will be put in place to modernise NHS and social services and promote new ways of working.

This National Service Framework is the result of extensive consultation with older people, their carers and the leading professionals involved in the care of older people. Its implementation will be led by the National Director for Older People, Professor Ian Philp.

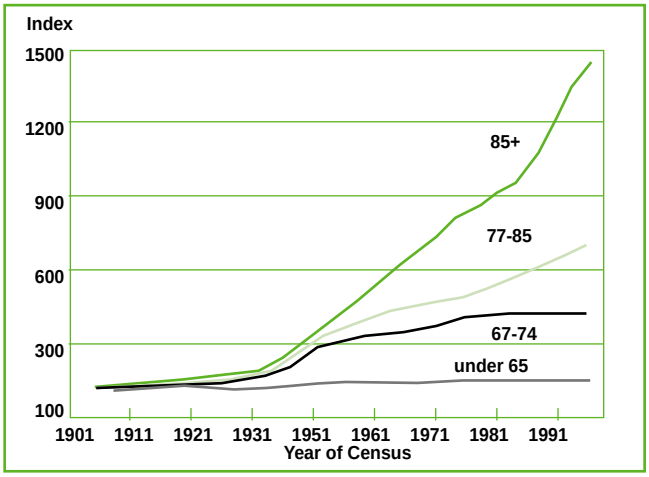
The Government is determined to deliver real improvements for older people and their families. Pensioners are sharing in the rising prosperity of our nation, and we're looking after the poorest first. Now, through this National Service Framework we will see improvements in health and social care services for older people across the country.

Alan Milburn
Secretary of State for Health

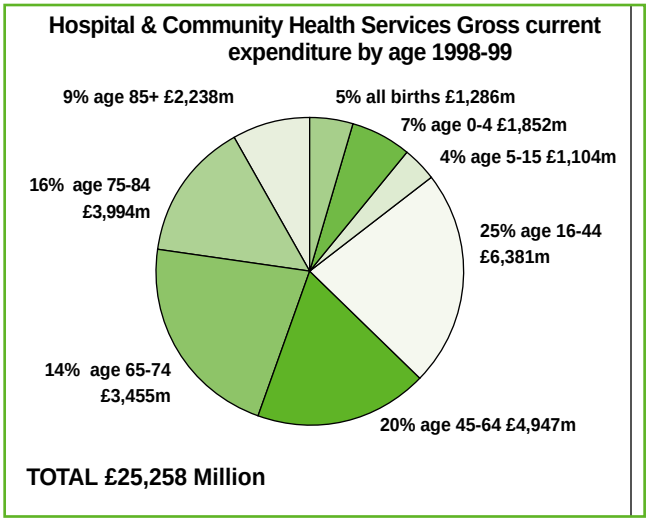
CHAPTER ONE: Setting the Scene

Introduction

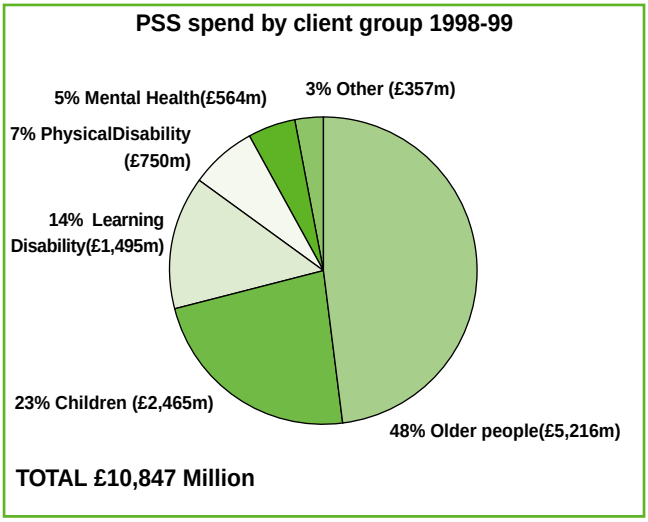
1. England is an ageing society. Since the early 1930s the number of people aged over 65 has more than doubled and today a fifth of the population is over 60. Between 1995 and 2025 the number of people over the age of 80 is set to increase by almost a half and the number of people over 90 will double.



2. The NHS spent around 40% of its budget - £10 billion - on people over the age of 65 in 1998/99. In the same year social services spent nearly 50% of their budget on the over 65s, some £5.2 billion. Older people tend to have a much greater need for health and social services than the young, so the bulk of health and social care resources are directed at their needs. For example, almost two thirds of general and acute hospital beds are used by people over 65.



3. In both social care and in health care there are many examples of excellent care for older people. The expertise and hard work of NHS and social care staff who have developed, and now sustain, these services have led the way in developing the standards in this document.



4. But too often the financial commitment to older people in these core public services has not been translated into a cultural and institutional focus on the needs of older people. In the NHS, the one-size fits all world of the post war years has survived for too long. For many decades both health and social care systems, and the dedicated staff on whom they depend, have been under constraints that have tended to frustrate the best efforts of staff to change them. Too often they have had to work against the systems, and across organisational boundaries, to try to get the best for the patients and service users to whom they are responsible.

5. In the intervening years, society has changed and attitudes have changed. Retirement is no longer seen as preparation for decline. All services, public and private, are attempting to catch up with a concept of old age that encompasses new ideas like the third age, the grey pound, grandparent power and increased volunteering particularly in services like the NHS. In recent decades an overdue and new found respect for older people has emerged, and the attitude that too often wrote people off as "elderly" has given way to one that demands that older people are seen as having individual needs. That people are living longer is something to celebrate, reflecting the achievements of organisations like the NHS, social services and the voluntary sector. Older people should no longer be seen as a burden on society. They are a vital resource of wisdom, experience and talent.

6. However, there have been reports of poor, unresponsive, insensitive, and in the worst cases, discriminatory, services. Instances of adverse discrimination have usually been inadvertent, a result of the survival of old systems and practices that have failed to keep pace with changing attitudes or advances in the capacity of professionals to intervene successfully. This has been shown in specific problems such as the lack of rehabilitation, inadequate dementia services and inconsistencies in stroke care. Health and social care staff have been at the forefront of efforts to secure a better deal for older people, but too often the structures and practices that they have had to work with have frustrated these efforts.

7. In the NHS context, the evidence suggests that, in spite of these problems, older people are more satisfied with services than are younger people. More than two thirds of people over the age of 65 say they are satisfied with the NHS, compared to just over half of 25-34 year olds. 91% of people over the age of 65 are satisfied with their GP, compared to 74% of 25-34 year olds. The same pattern is repeated for inpatient and outpatient care. For social care services, Social Services Inspectorate inspections of services for older people regularly show user satisfaction rates of around 80%.

8. This is probably partly because people who have more contact with the NHS and social services tend to be more satisfied, but also because older people are often more conscious of how difficult things could be before the advent of the NHS and the modern welfare state. In 2008 the women born in 1948 are due to retire. They are very different from the women who retired in 1948, with higher expectations, of public sector services.

Older people

9. Older people are not a uniform group and they have a wide range of needs. They may be broadly seen as three groups:

- **Entering old age** These are people who have completed their career in paid employment and/or child rearing. This is a socially-constructed definition of old age, which, according to different interpretations, includes people as young as 50, or from the official retirement ages of 60 for women and 65 for men. These people are active and independent and many remain so into late old age.

  The goals of health and social care policy are to promote and extend healthy active life, and to compress morbidity (the period of life before death spent in frailty and dependency).

- **Transitional phase** This group of older people are in transition between healthy, active life and frailty. This transition often occurs in the seventh or eighth decades but can occur at any stage of older age.

  The goals of health and social care policy are to identify emerging problems ahead of crisis, and ensure effective responses which will prevent crisis and reduce long-term dependency.

- **Frail Older People** These people are vulnerable as a result of health problems such as stroke or dementia, social care needs or a combination of both. Frailty is often experienced only in late old age, so services for older people should be designed with their needs in mind.

  The goals of health and social care policy are to anticipate and respond to problems, recognising the complex interaction of physical, mental and social care factors, which can compromise independence and quality of life.

Older people from black and minority ethnic communities

10. The proportion of older people from black and minority ethnic communities is small but growing. It was estimated that between 1981 and 1991, the percentage growth of people of pensionable age from black and minority ethnic groups increased by 168% (from 61,200 in 1981 to 164,306 in 1991). Figures from the 1991 Census estimated that the total black and minority ethnic population was just over 3 million (5.5% of the total population of Great Britain).

11. Local health and social care services should recognise the greater prevalence of some illnesses among specific groups of people, for example increased rates of hypertension and stroke among African-Caribbeans and of diabetes among South Asians. This will become increasingly significant as these populations continue to age.

12. At the same time, all services should be culturally appropriate, reflecting the diversity of the population that they serve, and ensuring that services are accessible for those who do not have English as their first language. The needs and wishes of each individual should be recognised and taken into account as far as possible in planning their health and social care.

Older people with disabilities

13. As well as chronic illness, older people are also more likely to have a disability. Nearly half of disabled people are aged 65 or older. The most common problems relate to movement and to vision and hearing.[1] (D) Sensory impairments become increasingly common as people age: around 80% of people over 60 have a visual impairment, 75% of people over 60 have a hearing impairment, and 22% have both a visual and hearing impairment.[2] (P) These disabilities can reduce the ability of older people to look after themselves, resulting in a need for personal care.

Older people with learning disabilities

14. Services need also to be able to respond to older people with learning disabilities, many of whom begin the ageing process at an earlier age than the general population. For some, their difficulties as older people overshadow any problems associated with their learning disability and their needs are practically identical to the older population as a whole. Others remain active and alert and would be misplaced alongside much older and more incapacitated people but nevertheless need occupational and recreational activity and residential support which takes account both of their learning disabilities and of the ageing process. About a third of people with Down's Syndrome may be expected to show clinical signs of dementia. Dementia may begin in the early thirties and health can deteriorate quite rapidly.

Older people in prison

15. The NHS and Prison Service are working in partnership to ensure that prisoners have access to the same range and level of health services as the general public. At any point in time 700 people in prison are aged over 60. They have a wide range of health and social care needs, both while in prison and on release. Over 1,000 people aged over 60 leave prison every year. It is important that there is good liaison between prison healthcare staff and their colleagues in health and social care organisations in the community to ensure that prisoners who are being released are assessed for and receive services which meet their continuing health and social care needs.

The NHS Plan and Modernising Social Services

16. The NHS Plan [3] (P) set out a programme of investment and reform for a twenty-first century health and welfare service. The principles which underpin the NHS Plan (see box) are vital to a modern care system for older people.

17. *Modernising Social Services* [4] (P) set out the Government's proposals to achieve social services that promote people's independence, improve protection for vulnerable people and raise standards across the board.

18. The National Service Framework for Older People is the key vehicle for ensuring that the needs of older people are at the heart of the reform programme for health and social services.

19. This reform programme will be taken forward through:

- assuring standards of care
- extending access to services
- ensuring fairer funding
- developing services which promote independence
- helping older people to stay healthy
- developing more effective links between health and social services and other services such as housing, and partners in the voluntary and private sectors.

The NHS Plan: Principles

- *The NHS will provide a universal service for all based on clinical need, not ability to pay.* Older people have supported the NHS all their lives. The NHS should be there to provide the services they need, based on their clinical need alone, and no other consideration [Standard 1].

- *The NHS will provide a comprehensive range of services.* Older people are more likely to have more complex health needs and require access to a full range of primary, community and acute hospital services. They will also benefit from intermediate care initiatives designed to bridge the gap between hospital and home either as part of rehabilitation after an acute event or where a problem can be more appropriately managed by measures other than hospital admission [Standard 3].

- *The NHS will shape its services around the needs and preferences of individual patients, their families and their carers.* This NSF is based on a person-centred approach to care. Older people and their carers will be given a voice to put their views forward through patient forum and patient councils, subject to legislation currently before Parliament [Standard 2].

- *The NHS will respond to different needs of different populations.* Different communities may have different needs; this should be recognised when delivering services to older people from any community. This is particularly important as there are now more older people from minority ethnic communities who have become established in the UK over the last 50 years [Standard 2].

- *The NHS will work continuously to improve quality services and to minimise errors.* All NSF standards are supported by performance measures designed to monitor progress against the standards and to provide health bodies with the information they need to assess whether and how their services need to be improved [Chapter 4].

- *The NHS will support and value its staff.* Providing a quality service for older people means having trained and motivated staff. Within the context of wider developments on workforce, action will be taken to ensure that staff working with older people are properly prepared and supported in their work [Chapter 5].

- *Public funds for healthcare will be devoted solely to NHS patients*

- *The NHS will work together with others to ensure a seamless service for patients.* As people age, they have an increasingly complex range of needs which may mean they need a range of services across health and social services. These should be provided in as seamless a way as possible, to avoid confusion for older people and their carers and to minimise duplication of effort [Standard 2].

- *The NHS will help keep people healthy and work to reduce health inequalities.* Older people benefit from health promotion initiatives and these should be tailored to be accessible and relevant. The overall aim is to ensure that people have additional years of healthy life, free from disability [Standard 8].

- *The NHS will respect the confidentiality of individual patients and provide open access to information about services, treatment and performance.* Older people should be treated as partners in their own care, and have their confidentiality respected as with other patients. Information should be provided to older people and their carers about the services which are available and the options they have [Standard 2].

20. Much progress on improving services for older people has already been made.

- **Assuring standards of care:** The Care Standards Act 2000 puts in place a strong, independent regulatory system for care principally outside the NHS through the creation of the National Care Standards Commission. For example, the Commission will ensure that all care homes for older people meet the relevant National Minimum Standards. Promoting consistency and improving the health, welfare and quality of life for older people. *No Secrets* provides guidance for all public services on the development of policies and protocols to protect vulnerable adults from abuse. *Better Care, Higher Standards* (BCHS) is a national charter which requires local BCHS charters to set out standards of services agreed locally across the NHS, social care, and housing. Local charters are now in place across the country.

- **Extending access to services:** People aged 60 or over now have free NHS eye examinations and best practice guidance (supported by a £20 million modernisation fund) has been introduced to improve access to cataract services. Carers' access to services in their own right has been ensured through the Carers and Disabled Children Act 2000. The Government is piloting *Care Direct*, a one-stop shop gateway to information about social care, health, housing and social security benefits, which will complement *NHS Direct*. The Department will issue *Fair Access to Care Services* guidance to councils in Spring 2001 setting out how they should develop fair and consistent eligibility criteria for adult social care services.

- **Ensuring fairer funding:** The Government is acting to end the anomaly that people in nursing homes may have to pay for their nursing care – it will be provided on the same basis as other NHS services, free at the point of use. It is also acting to relieve residents of some of the costs of entering residential accommodation through a 3-months property disregard and by raising the capital limits for when councils may step in with financial support. A deferred payment scheme, to be introduced from October 2001, will give people more choice in how they pay for residential accommodation. This scheme, together with the property disregard will give people a valuable breathing space between entering a care home and selling their home, if that is their wish.

- **Developing services which promote independence:** Intermediate care services are now being developed. The new Intermediate Care guidance gives [5] (P) new impetus to these developments and adds clarity about financial arrangements. Local councils are being supported in work to help more people to retain their independence at home through a special *Promoting Independence Grant*. Housing services that meet older people's needs are being developed under *Quality and Choice for Older People's Housing: A Strategic Framework*. *Supporting People* [6] (P) is a new initiative being developed to help vulnerable people live independently in the community by providing a wide range of housing related support services. The Supporting People Programme starts in April 2003.

- **Helping older people to stay healthy:** Free influenza immunisation is being offered to everyone aged 65 and over. Routine breast cancer screening is being extended to women up to and including the age of 70. Action on improving oral health in older people and improving access to dentistry is being taken forward through the oral health strategy *Modernising NHS Dentistry* [7](P). A Minimum Income Guarantee has been introduced to help those on the lowest incomes; this is helping 1.6 million pensioner families. In addition, the Winter Fuel Payment has been increased to £200.

- **Developing more effective links between health and social services:** The Health Act 1999 introduced new partnership flexibilities to enable Health Authorities and councils to improve services at the interface of health and social care. In addition, Local Strategic Partnerships (LSPs) will be established across the country from April 2001. These will be umbrella partnerships committed to improving the quality of life and governance in a particular locality through the refocusing of mainstream services and resources. LSPs will be expected to bring together the public, private, voluntary and community sectors and service users to provide a single overarching local framework within which more specific local partnerships such as the arrangements for implementing this NSF can operate.

The NSF for Older People

21. National Service Frameworks (NSFs) were established to improve services through setting national standards to drive up quality and tackle existing variations in care. This NSF is the third to be produced. NSFs have already been published for mental health and coronary heart disease. A National Cancer Plan was published last autumn, and a NSF for diabetes will be published later this year. The next phase of the NSF programme will address renal services, children's services and long-term neurological conditions.

The development of the NSF for Older People

22. The NSF has been developed from the advice of an External Reference Group (ERG) which was co-chaired by Professor Ian Philp, Professor of Health Care for Elderly People, University of Sheffield and Ms Denise Platt, Chief Inspector, Social Services Inspectorate. The Membership of the ERG and task groups reflected the wide range of practitioner and management groups involved in care for older people as well as organisations representing users' and carers' interests. The membership of all groups involved is shown in Annex II.

Terms of Reference of the External Reference Group

Background

The new NHS introduced a range of measures to raise quality and decrease variations in service including National Service Frameworks (NSFs). NSFs will set national standards and define service models for a defined service or care group; put in place strategies to support implementation; and establish performance measures against which progress within an agreed timescale will be measured. The NSF will be informed by advice from an External Reference Group (ERG). The ERG for Older People will be co-chaired by Professor Ian Philp and Ms Denise Platt.

Parameters

- The NSF will be set within the context of current policy.
- It must be set in the context of available resources, and ensuring value for money in the use of resources.
- The focus of the NSF will be the NHS, but the vital role of social care will be intrinsic to the work of the ERG.
- The NSF must be evidence based where possible, or if not to be based on the consensus of best clinical practice.

Tasks

Working within the parameters above and informed by the views of older people, their carers, and the range of professionals and other staff involved in their care, the task of the ERG is:

- To advise on the development of standards for the health care of older people, for consideration by the Department of Health which will be generically applicable, regardless of setting or condition.
- Through small task groups working to agreed terms of reference and including a range of stakeholders, chaired by a member of the ERG, to advise on the development of guidance on implementation of the standards in relation to older people experiencing:
  - stroke
  - injuries sustained as the result of accidents, especially falls
  - organic and functional mental illness
  - care in acute hospital, including palliative care
  - models of care in primary and community settings
  - transition to and from hospital
  - assessment and care management.
- To advise on the development of performance measures to monitor the standards.

The Work of the External Reference Group

The External Reference Group was supported by nine task groups, each chaired by a member of the ERG, to examine different aspects of the system of health care for older people. They addressed:

a. *locations of care:*
   i. acute hospital care (including palliative care)
   ii. models of primary and community care

b. *process issues:*
   i. models of assessment and care management
   ii. transitions to, from and within hospital

c. *conditions prevalent among older people:*
   i. stroke
   ii. falls
   iii. mental health (including dementia and depression)

In addition, a user and a carer group, both chaired by a member of the ERG, were established to provide pro-active input to the ERG and its task groups. The task groups also used their own contacts to seek the views of other users and carers. These task groups influenced the development of each standard area.

The ERG worked through 1999 and into the spring of 2000. Their report has been developed into this NSF, in the context of the NHS Plan and other relevant work.

The evidence base

23. The proposals in this NSF are based on expert advice, the values underpinning care services and research evidence. In order for some weight to be attached to the supportive evidence, a typology was developed to distinguish between evidence stemming from, for instance, systematic reviews of existing information, the experience of patients or carers, and case studies of individual interventions. The typology adopted is set out below.

Typology of Supporting Evidence

Evidence from research and other professional literature

A1	Systematic reviews which include at least one Randomised Control Trial (RCT) (eg Systematic Reviews from Cochrane or Centre for Reviews and Dissemination)
A2	Other systematic and high quality reviews which synthesise references
B1	Individual RCTs
B2	Individual non-randomised, experimental/intervention studies
B3	Individual well-designed non-experimental studies, controlled statistically if appropriate; includes studies using case control, longitudinal, cohort, matched pairs, or cross-sectional random sample methodologies, and well-designed qualitative studies; well-designed analytical studies including secondary analysis
C1	Descriptive and other research or evaluation not in B (eg convenience samples)
C2	Case studies and examples of good practice
D	Summary review articles and discussions of relevant literature and conference proceedings not otherwise classified

Evidence from expert opinion

P	Professional opinion based on clinical evidence, or reports of committees
U	User opinion from Older People's Reference Group or similar
C	Carer opinion from Carers' Focus Group or similar

The scope of the NSF

24. Many major diseases and conditions are more common in older people. This NSF sets standards for the care of older people in all settings across health and social services.

25. In addition it focuses on those conditions which are particularly significant for older people and which have not been addressed elsewhere – stroke, falls and mental health problems associated with older age. At the same time, conditions such as stroke and dementia are not limited to older people, and the standards and service models will apply for all who need these services, regardless of their chronological age.

26. Where NSFs or other strategies are being developed for particular diseases (such as cancer or coronary heart disease or diabetes), the needs of older people will be addressed within these. This NSF is, however, a living document and other conditions which are important to older people will be addressed. The next priority within the 10 year framework will be arthritis and, following that, respiratory diseases in older people.

27. Older people may be under the care of a range of health and social services. This NSF applies to both. Where standards are more relevant to the NHS than to social services, this is made clear. The standards of the NSF apply whether an older person is being cared for at home, in a residential care or nursing home, or in a hospital or intermediate care facility.

Carers

28. Some issues are integral to all standards and service models in this NSF. The Carers Group established by the External Reference Group emphasised that carers' needs should be considered as an integral part of the way in which services are provided for older people.

Medicines management

29. The management of medicines is a fundamental component of each of the NSF standards. As well as dealing with relevant medicines issues within the NSF itself, further detail is provided in the accompanying booklet, *Medicines and Older People*. The majority of older people are taking medicines: this important issue therefore forms part of the NSF for Older People. The principles are however also relevant to other patients with chronic conditions, including those covered by other NSFs.

30. The four themes in this NSF are:

- **Respecting the individual:** The need for an NSF for older people was triggered by concerns about widespread infringement of dignity and unfair discrimination in older people's access to care. This NSF therefore leads with plans to tackle age discrimination and to ensure that older people are treated with respect, according to their individual needs. Person centred care will be supported by newly integrated services. This will ensure a well co-ordinated, coherent and cohesive approach to assessing individual needs and circumstances, and to commissioning and providing services to meet them.

  Standard 1: Rooting out age discrimination
  NHS services will be provided, regardless of age, on the basis of clinical need alone. Social care services will not use age in their eligibility criteria or policies, to restrict access to available services.

  Standard 2: Person-centred care
  NHS and social care services treat older people as individuals and enable them to make choices about their own care. This is achieved through the single assessment process, integrated commissioning arrangements and integrated provision of services, including community equipment and continence services.

- **Intermediate care:** A new layer of care, between primary care and specialist services is being developed to help prevent unnecessary hospital admission, support early discharge and reduce or delay the need for long-term residential care. Older people will be the main but not exclusive beneficiaries of these services.

Standard 3: Intermediate care
Older people will have access to a new range of intermediate care services at home or in designated care settings, to promote their independence by providing enhanced services from the NHS and councils to prevent unnecessary hospital admission and effective rehabilitation services to enable early discharge from hospital and to prevent premature or unnecessary admission to long-term residential care.

- **Providing evidence-based specialist care:** The UK has some of the best specialist services for older people in the world with a solid evidence-base for their effectiveness. Timely intervention by evidence-based services reduces long-term needs. But these services are not uniformly available and access to them can be haphazard.

Standard 4 General hospital care
Older people's care in hospital is delivered through appropriate specialist care and by hospital staff who have the right set of skills to meet their needs.

Standard 5 Stroke
The NHS will take action to prevent strokes, working in partnership with other agencies where appropriate.

People who are thought to have had a stroke have access to diagnostic services, are treated appropriately by a specialist stroke service, and subsequently, with their carers, participate in a multidisciplinary programme of secondary prevention and rehabilitation.

Standard 6 Falls
The NHS, working in partnership with councils, takes action to prevent falls and reduce resultant fractures or other injuries in their populations of older people.

Older people who have fallen receive effective treatment and rehabilitation and, with their carers, receive advice on prevention, through a specialised falls service.

Standard 7 Mental health in older people
Older people who have mental health problems have access to integrated mental health services, provided by the NHS and councils to ensure effective diagnosis, treatment and support, for them and for their carers.

- **Promoting an active, healthy life:** Older age is not always associated with an emphasis on health promotion. It should be. Older people wish to remain healthy, active and independent of the need for support from services and from their families. This NSF concludes with a strong emphasis on promoting the health and independence of those in older age.

  Standard 8: The promotion of health and active life in older age
  The health and well-being of older people is promoted through a co-ordinated programme of action led by the NHS with support from councils.

Delivering the NSF

31. To help the NHS and councils to plan and implement this ambitious programme of change, each standard identifies milestones to help mark progress towards improved health and social care services. Further milestones will be set as change is rolled out. These will be more challenging for some areas than in others and some will meet the milestones earlier than others, but all should have met the national milestones by the date set. In some areas, partnership arrangements between the NHS and councils are particularly well developed and they will be expected to make faster progress than others where relationships are not so well formed. Chapter three describes how we expect the NSF to be delivered.

32. Chapter four describes how the performance management systems will help deliver the targets in the NHS plan and ensure the NSF standards are met. Performance indicators and the NHS and PSS Performance Assessment Frameworks will provide a national overview, and these will continue to be developed to give a complete and rounded picture of how the NSF is being delivered.

33. Chapter five sets out the underpinning programmes essential to the delivery of the NSF. These are:

- finance
- workforce development
- research and development
- clinical and practice decision support services
- information systems.

CHAPTER TWO: Standards

Overarching Action

This NSF has a broad scope. Some key changes will impact across all standards.

Every NHS organisation and council with social service responsibilities should:

- ensure that older people's views are properly represented [Standard 2] in decision making including on the local Modernisation Board
- designate champions for older people [Standard 1]
  - an elected council member or an NHS non-executive director to lead for older people across each organisation
  - a clinical or practice champion within each organisation to lead professional development
  - in NHS Trusts an older people's patient champion through the Patients' Forum to look after patient interests
- work with partners in the local health and social care system to establish an interagency group, including older people and their carers, to oversee the implementation of the NSF [Standard 2]
- recognise the very significant implications of this NSF for staff at all levels – and work with them to ensure that they understand the particular needs and wishes of older people and are able to help each service user and their carers receive the best possible experience of care
- ensure that, within the generic programmes relating to finance, workforce development and information systems, older people are recognised as a priority. These are discussed further in Chapter 5.

Standard One: Rooting out age discrimination

Aim

To ensure that older people are never unfairly discriminated against in accessing NHS or social care services as a result of their age.

Standard

NHS services will be provided, regardless of age, on the basis of clinical need alone. Social care services will not use age in their eligibility criteria or policies, to restrict access to available services.

Rationale

1.1 Fair access lies at the heart of good public services. This is particularly true of the provision of both health and social care to older people. However, in some health and social care services, older people and their carers have experienced age-based discrimination in access to and availability of services [8] (U/D) [9] (B3) [10] (U) [11] (C1/C).

1.2 Decisions about treatment and care should be made on the basis of each individual's needs not their age. Even very complex treatment, used appropriately, can benefit older people and should not be denied them solely on the basis of age. There are also some specific procedures and services which are particularly important for older people, for example, joint replacement, cataract surgery and community equipment. Local investment should ensure fair access to these services as well as to the full range of specialist services.

1.3 Some evidence suggests there has been age discrimination in certain areas of health care. In 1991, 20% of cardiac care units operated upper age limits and 40% had an explicit age-related policy for thrombolysis [12] (C1). In the decade since then practice has changed such that explicit age related policies in cardiac care units are now almost unknown. However more recently, a study of the management of older trauma victims in Scotland suggested that older patients were less likely than younger patients with similar injuries to receive appropriate treatment [13] (C1). Quality of care has also been affected by negative staff attitudes in a number of settings [14] (C2) [15] (B3) [16] (B3) [17] (P) [18] (P) [19] (P) [20] (P) [21] (D) [22] (C1). Many older people and their carers have also found that palliative care services have not been available to them [23] (A2). This may be related to the fact that palliative care services have been concentrated on those with cancer: only a fifth of Health Improvement Programmes (HImPs) explicitly include non-cancer palliative care needs.

1.4 For social care, there is some evidence that councils can discriminate against older people where they apply commissioning strategies that are not sufficiently flexible to take account of individual needs. [24] (P) [25] (P) [26] (P). In some localities the eligibility criteria for non-residential services mean older people have had to demonstrate higher needs to qualify for services compared with younger adults. [27] (P) [28] (C1).

1.5 There is also considerable variation across the country in the range of services available to older people and their families or carers [29] (C1). Older people from black and minority ethnic groups can be particularly disadvantaged [30] (C1) [31] (P) [32] (P) and are likely to suffer more discrimination in accessing services [33] (C1) [34] (B3) [35] (C1) [36] (D) [37] (C1) [38] (B3).

1.6 Specific concerns have been raised about resuscitation policies, and whether older people are more likely to be denied cardiopulmonary resuscitation on the grounds of age alone. Guidance issued last year [39] (P) made it clear that local resuscitation policies should be based on the guidelines issued by the BMA, RCN and Resuscitation Council [40] (P), and should be regularly audited to prevent age discrimination.

1.7 Denying access to services on the basis of age alone is not acceptable. Decisions about treatment and health care should be made on the basis of health needs and ability to benefit rather than a patient's age. In social care assessed need should be matched to fair eligibility criteria for access to help and support. This standard sets out the action needed to identify and tackle discrimination where it exists and to promote fair access. That is not to say that everyone needs the same health or social care, nor that these needs should be met the same way. As well as health needs, the overall health status of the individual, their assessed social care need and their own wishes and aspirations and those of their carers, should shape the package of health and social care.

Key Interventions

1.8 The NHS and local councils should work together to ensure an integrated approach to combating age discrimination.

Leadership

1.9 Tackling age discrimination demands strong clinical and managerial leadership. Each local organisation should establish arrangements which make it absolutely clear that older people are a local as well as a national priority. These arrangements should include:

- representation of older people across every organisation. In the NHS this will include Modernisation Boards, and Patients' Forums. In Social Services, older people will be included within consultation aspects of the Best Value programme. And across the system older people should be involved in setting and monitoring standards within the framework of local *Better Care, Higher Standards* charters

- an elected council member or an NHS non-executive director who will lead for older people across each organisation. They will be responsible for ensuring that older people become and remain a priority within their organisation and for supporting implementation of the NSF specifically. They will present a progress report to their Board (NHS) or the scrutiny committee responsible for social services every 6 months. They will be a key player in the local programme to modernise health and social services

- a clinical or practice champion within each organisation to lead professional development

- an older people's patient champion through each Patients' Forum, to be involved in decisions about NHS services and in scrutinising the quality of care provided. Patients' Forum membership will represent the patients who are using these services. Where older people are the main users of services, this will be properly reflected in Patients' Forum membership, which will be overseen by the NHS Appointments Commission. At local level, there will be an overarching body - a Patients' Council - which will draw its membership from local Patients' Forums. This will be subject to legislation currently before Parliament

- each chief officer taking personal responsibility for implementation within their organisation. By local agreement one will lead the local implementation process overall (Standard 2 and Chapter 3).

Policy review leading to a rolling programme of action

1.10 Policies which permit age to influence the access of older people to any specific service inevitably raise concerns that age is being used to deny access. All such policies should be identified and reviewed in liaison with patient and user groups.

1.11 In the NHS, the review should critically examine the justification for an age-based approach, explore alternative ways of managing access to the service and propose changes where necessary. Hospital services for older people may be provided separately from general acute services and in some places these are organised on the basis of age – an "age related service". The intention is to ensure an environment of care which recognises the complex needs of some older people, and the fact that it can take them longer to recover. But such arrangements can appear to discriminate or even to restrict access to other specialists [41] (D) and should be included in these reviews.

Policy review checklist for the NHS

- identify all relevant policies and scrutinise for references to age, prioritising those areas where concerns have been raised
- a scrutiny group set up to review each policy, involving at least one non-executive director, representatives of patients and carers, clinicians and practitioners, and managers
- the scrutiny group reviews the reasons for each policy, including clinical evidence and patient and carer views
- the scrutiny panel makes recommendations to the Board which agrees a rolling programme of action
- details of the policy reviews, programme of action and results published in Annual Report.

1.12 In some cases there may be good reasons for treatment rates to be lower in older age groups. Older people are more likely to suffer from co-morbidities which can complicate treatment, or compromise its effectiveness. And some older people may choose to decline the most complex treatments. But each decision should be made on the basis of the individual clinical need, overall health status, and the personal wishes of the older person (and, where appropriate, their carers).

1.13 Age discrimination locally may take two different forms:

- low overall rates of provision of those interventions which are relatively more important for older people – for example, hip and knee replacement, cataract surgery, occupational therapy, chiropody, or community equipment

- low relative rates of access of older people to specialist services compared with younger people – for example, revascularisation, or expensive drugs.

1.14 National guidance will be developed by May 2001 to assist with the audits of age-related policies to establish whether these discriminate on grounds of age. This will set out how to carry out the audits of age related services. Age discrimination may not always be explicit. We need therefore to establish a better understanding of variations in treatment rates to establish what part, if any, is due to age discrimination leading to denial in access and what part is best explained by other factors. Further work is needed to understand better what types and levels of intervention may be appropriate given the health needs of older people.

1.15 Once this benchmark has been developed, a core group of services will be monitored nationally. This monitoring will be on a rolling basis with priorities reflecting, in the first instance, national service priorities, such as cancer and coronary heart disease.

1.16 Action is already underway to expand older people's access to services:

- routine breast cancer screening is being extended to women up to and including age 70: the first local programmes will begin inviting older women in 2001/02, with all programmes starting by 2004

- over the next three years, people over the age of 65 will benefit from around 70,000 more cataract operations, 16,000 more hip and knee replacements and at least 3,000 more coronary revascularisations.

1.17 Using guidance on Fair Access to Care Services (FACS) councils should develop and review their eligibility criteria for adult social care, and their policies for funding care packages and placements, to ensure that these do not unjustly discriminate against older people. They should do this in consultation with key local interests, including service users and carers. FACS will be published for consultation in spring 2001 and should be implemented from April 2002. FACS will provide a national framework for councils to use when determining their eligibility criteria for supporting adults of any age. Councils will be guided to follow a consistent approach of defining priorities for meeting needs so as to promote people's independence and quality of life. FACS will emphasise the importance of people being fully involved in their assessment and fully informed of decisions about eligibility. The local charters produced under the 'Better Care, Higher Standards'

(BCHS) initiative should include details of councils' eligibility criteria and will be widely available to users and carers. Local councils' performance against BCHS standards should be published in an annual report.

Workforce development

1.18 Staff do not necessarily intend to behave in a discriminatory fashion, but lack of skills and lack of confidence in working with older people can lead to behaviour which is perceived as discriminatory.

1.19 Staff working in health and social care will be better able to provide responsive care to older people and their carers if they understand their requirements and the need to ensure equality in service access. [42] (P).

1.20 Staff should be fully involved in the development of services for older people – including in the policy reviews and in advising about local priorities for change. Within this, health and social care organisations should provide additional training and support for staff at all levels to build their knowledge base and foster more positive attitudes towards ageing and older people [43] (B2) [44] (B3) [45] (B1) [46] (B3) [47] (B3) [48] (P) [49] (A2/P) [50] (B3) [51] (C1) [52] (B2) [53] (C1) [54] (C1) [55] (C1).

Communications

1.21 All members of the local health and social care community should use their existing systems to communicate better with older people and their carers and with the wider community. The communication should be two way – seeking views about how services can be improved and providing information about the action under way.

1.22 Proactive communication will be essential to ensure that the totality of concerns about age discrimination is addressed, and that the confidence of older people in their local services is established.

Actions

Every NHS organisation and council with social services responsibilities should:

- establish local leadership for older people's services
- establish a review, with service users and carers, of all relevant policies to ascertain whether they enable older people to access services on the basis of need or whether there are also age criteria which determine access
- within the NHS, agree a rolling programme to tackle any areas of age discrimination which are identified including additional resources (both financial and human) where these are required
- implement for social services, guidance on *Fair Access to Care Services*
- involve staff in implementing this programme, providing additional training and support where necessary
- communicate this programme of work to patients and users to their carers, and to the local community.

Milestones

October 2001	Audits of all age-related policies to be completed, with the outcomes to be reported in annual reports.
April 2002	From this date SAFFs and JIPs to include initial action to address any age discrimination identified. Strategic direction to be reflected in HImPs. Councils to have reviewed their eligibility criteria for adult social care to ensure that they do not discriminate against older people.
October 2002	Analysis of the levels and patterns of services for older people, in order to facilitate comparisons across health authorities and establish best practice benchmarks based on health outcomes and needs. Once this work is complete, and we have appropriate benchmarks, local health systems should, from 2003/04, be able to demonstrate year on year improvements in moving towards these benchmarks

Standard Two: Person-centred care

Aim

To ensure that older people are treated as individuals and they receive appropriate and timely packages of care which meet their needs as individuals, regardless of health and social services boundaries.

Standard

NHS and social care services treat older people as individuals and enable them to make choices about their own care. This is achieved through the single assessment process, integrated commissioning arrangements and integrated provision of services, including community equipment and continence services.

Rationale

2.1 Older people and their carers should receive person-centred care and services which respect them as individuals and which are arranged around their needs. [56] (B3) Person-centred care requires managers and professionals to:

- listen to older people
- respect their dignity and privacy [57] (C1) [58] (U) [59] (D/C2)
- recognise individual differences and specific needs [60] (C1/D) including cultural and religious differences [61] (P)
- enable older people to make informed choices, involving them in all decisions about their needs and care [62] (P)
- provide co-ordinated and integrated service responses
- involve and support carers whenever necessary.

2.2 Older people and their carers have not, however, always been treated with respect or with dignity [63] (B3) nor have they always been enabled to make informed decisions through proper provision of information about care across care sectors [64] (C1).

2.3 Proper assessment of the range and complexity of older people's needs and prompt provision of care (including community equipment) can improve their ability to function independently; reduce the need for emergency hospital admission; and decrease the need for premature admission to a residential care setting [65] (A1). But despite the fact that older people are in frequent contact with health or social care services, physical, social and psychological problems can be missed or go unreported [66] (B3) [67] (D). Assessments are often duplicated with no coherent approach across health and social care services [68] (C1). This problem is exacerbated by the fragmentation of information systems, which may unnecessarily duplicate information held about individuals. Failure to share such information can result in failure to deliver the best package of care [69] (D). Care provided on the basis of assessment may not be well co-ordinated or follow the complex care pathway an older person might follow [70] (C1) [71] (A2). These service and system failings have undermined older people's confidence in other aspects of care and their ability to remain independent [72] (C1/C). Furthermore, the specific needs of people from diverse cultural groups are often not properly addressed in assessment processes [73] (C1) [74] (B3).

2.4 Community equipment services and continence services are particularly important for older people. Community equipment helps older people to remain independent. But the provision of community equipment is often delayed with unacceptable variation in access and availability across the country. Incontinence is distressing for the individual, and for their carers, and is the second most common reason for admission to residential care. Continence services have not been readily available to all those who need them [120] (P).

Key Interventions

2.5 The NHS and local councils should ensure that services meet the assessed needs of older people in ways that value and respect their individuality, their dignity and their privacy. This starts with:

- appropriate personal and professional behaviour by staff in all care settings, which can be particularly important at the end of life
- providing information so the service user and, where appropriate their carer, can be involved in decisions about their own care.

2.6 Person-centred care needs to be supported by services that are organised to meet needs. The NHS and councils should deploy the 1999 Health Act flexibilities to:

- establish joint commissioning arrangements for older people's services, including consideration of a lead commissioner and the use of pooled budgets

- ensure an integrated approach to service provision, such that they are person centred, regardless of professional or organisational boundaries.

2.7 Some specific service improvements should be achieved as a priority:

- a new single assessment process should be put in place
- integrated community equipment services should be established
- integrated continence services should be established.

Personal and professional behaviour

2.8 Service users and their carers should be able to expect that [75] (P) [76] (D/C2):

- staff are polite and courteous at all times, for example, using the older person's preferred form of address and relating to them as a competent adult
- procedures are in place to identify and, where possible, meet any particular needs and preferences relating to gender, personal appearance, communication, diet, race or culture, and religious and spiritual beliefs [77] (P) [78] (P)
- staff communicate in ways which meet the needs of all users and carers, including those with sensory impairment, physical or mental frailty, or learning disability or those whose first or preferred language is not English.. Interpreting and translation services should be made available [79] (B3) [80] (P)
- personal hygiene needs, including toiletting and bathing, are met sensitively, and other intimate interventions are also carried out in privacy
- in hospital, if patients choose to wear their own clothes, they are enabled to do so, and (safety and space allowing) they are also able to have personal effects at their bedside
- staff support those with a long-term illness or disability to develop expertise in their own care, and to become partners in managing their continuing needs for health care - using the learning from the Expert Patient Programme [81] (P).

2.9 These personal and professional behaviours are particularly important at the end of life [82] (D). Supportive and palliative care aims to promote both physical and psycho-social well-being. All those providing health and social care, who have contact with older people with chronic conditions or who are approaching the end of their lives may need to provide supportive and palliative care. This may include:

Dignity in end-of-life care

information and communication

to facilitate choice about treatments and care options for older people and their carers [83] (C1)

control of painful and other distressing symptoms

to anticipate, recognise and treat pain and distressing symptoms, and provide timely access to appropriate specialist teams, equipment or aids. There is evidence that older people are less likely to receive proper pain management [84] (A2).

rehabilitation and support as health declines

to ensure that quality of life and independence is maximised, and that an older person can remain at home (if that is their wish) until death or for as long as possible, through providing therapy and personal care and housing related support services

social care

to maintain access to safe and accessible living environments, practical help, income maintenance, social networks and information

spiritual care

to recognise and meet spiritual and emotional needs through the availability of pastoral or spiritual carers reflecting the faiths of the local population

complementary therapies

to provide evidence based complementary therapies that support emotional, psychological and spiritual well-being and help with symptom control

psychological care

to anticipate, recognise and treat any psychological distress experienced by the older person, carer or their family

bereavement support

to ensure the needs of family, friends and carers are provided for, relieving distress, meeting spiritual needs and offering bereavement counselling [85] (B3).

2.10 Arrangements for reviewing and auditing this fundamental aspect of care should be put in place in each care setting [86] (A2) [87] (B3) [88] (U) The *Essence of Care* [89] (C1/C2/D/P/U) developed by service users, patients and professionals, is one such continuous quality improvement tool. It provides good practice standards in eight fundamental aspects of care:- privacy and dignity, personal and oral hygiene, continence and bladder and bowel care, food and nutrition, pressure ulcers, principles of self care, record-keeping, and safety of patients with mental health needs. As well as providing benchmarks of good practice which are relevant for teams caring for older people, *The Essence of Care* tool kit allows teams to assess their own practice, supporting them in their work with colleagues and service users to identify and share good practice. Attainment of *The Essence of Care* standards is an integral part of local clinical governance activity, and they are important to consider in any monitoring of the quality of care or services for older people.

Information and involvement

2.11 Information should be provided at key points in care pathways, or stages of treatment [90] (P) [91] (B3). Many older people live with long-term illness, frailty or disability; if they have appropriate information, they will be better able to participate in managing their own condition and their lives [92] (C2/P). Carers' information needs should also be met [93] (C1/C).

2.12 Older people need information about:

- their own health - how they can improve their health through the promotion of health and well-being and the prevention of illness [94] (C1) [95] (B3)
- their assessment, investigation, diagnosis, treatment, rehabilitation and care
- any referral procedures or eligibility criteria
- the range of local health and social services and housing services available, for example from local *Better Care Higher Standards* charters; the range of services and equipment available to meet their needs; and, where needed, training on appropriate use of equipment. As more information about the performance of services locally is being made available, this too will help to inform older people's choices.

2.13 Older people should be involved in making their own decisions, where this is possible and is what they wish, about the options available to them. Last year, direct payments for social services were extended to older people giving them more choice and control over their care options. It is also for the older person to determine the level of personal risk they are prepared to take when making decisions about their own health and circumstances [96] (C2).

2.14 In order to make decisions about their care older people need:

- to understand their care - letters between clinicians about an individual patient's care will be copied to the patient if that is their wish [97] (P), and service users will be given a copy of their care plan
- the opportunity to ask questions including about their medicines, why they have been prescribed, and any possible side effects
- contact points for further information and support, such as local voluntary organisations and independent advocacy services
- a named contact in case of problems or emergencies
- to know how to complain [98] (P) [99] (U).

2.15 All information should be provided in appropriate formats. This may include providing information.

- in a range of languages, depending on local needs [100] (B3) [101] (P) [102] (P), or as visual or spoken information, as well as the written word
- for people with sensory impairment through languages such as the British Sign Language and the deafblind manual; and in accessible formats, for example via large print letters, telephone, e-mail, or textphone
- in formats accessible to those with literacy or learning difficulties for example easy-read versions of leaflets using simple language and pictures [103] (C1) [104] (B3) [105] (C1/C).

2.16 Good information is also essential for carers [106] (C1). Subject to the consent of the older person, carers need information and advice about the health or condition of the person they are caring for, what they can do, and the services available. Good information enables carers to become partners in the provision of care, and supports them in best helping the person they are caring for. Conversely, without information carers are more likely to suffer from stress and consequently be less able to continue to care.

2.17 Staff working with older people should also be provided with information so that they may be able to support older people by giving accurate and helpful information about additional sources of local help and advice. The sharing of information is of course subject to the obligations of confidentiality and the provisions of the Data Protection Act 1998.

Integrated commissioning and delivery of older people's services

2.18 Staff working in services for older people and their carers will be supported in their aim to deliver person-centred care across organisational boundaries by joined-up processes for commissioning and delivering older people's services. Successful delivery of older people's services at local level requires a common vision and a strategy supported by a wide local constituency. The 1999 Health Act placed a duty of partnership on health authorities and councils (social services, housing and other council services) and provided for new flexibilities through pooled budgets, joint/lead commissioning and integrated provision, as well as money transfer powers.

2.19 In some cases the NHS and councils have developed a more collaborative approach to commissioning and capacity building, based on shared information, open dialogue with independent providers, and informed by the views of users and carers. This good practice needs to become the norm.

2.20 To implement this NSF local councils and health authorities should build on existing arrangements for planning and commissioning services for older people, in particular the arrangements for developing the Joint Investment Plan (JIP).

2.21 Where there is a Local Strategic Partnership (LSP) or its equivalent, this should provide the overall framework for such planning. Where LSPs are not yet in place but are being developed, the need to implement the NSF should be built in from the start. Health authority chief executives and local council chief executives (under their new duties of partnership as defined by the Health Act 1999 and the Local Government Act 2000) will be required to ensure that such arrangements are in place, and that all relevant stakeholders, including older people, are represented.

2.22 Local council chief executives are also requested to ensure that the implementation of this NSF sits within their council's overall strategy for older people and is coherent with it.

2.23 For community equipment services, while appropriate use of the Health Act flexibilities will provide the vehicle for integration, agencies' underlying responsibilities will not change. The NHS and councils will continue to fund the equipment for which they are each responsible, typically by contributing an appropriate amount for that equipment to a pooled budget, and they will need to agree an appropriate method of apportioning financial contributions for equipment (such as lifting and handling devices) for which they have shared responsibility.

Care Trusts

2.24 Care Trusts will, subject to legislation currently before Parliament, offer a further opportunity to develop integrated care models, through both commissioning and the delivery of services. Care Trusts may be formed where a council enters into a

partnership arrangements with a Primary Care Trust or an NHS Trust. This will enable the Care Trust to exercise the council's health related functions specified in the arrangements. The Care Trust framework is intended to be flexible enough to allow for a range of models and service configurations, such as:

- focused strategic commissioning with primary care teams and partners developing a wide range of service delivery options
- integrated health and social care teams providing care management, assessment and service delivery
- joint multi-disciplinary teams with a single budget created from NHS and local government resources, joint priorities, a single management structure and a single information system
- integrated provision within supported housing, enabling the housing warden to be an integral part of the team.

2.25 Integrated information systems will be required to support these approaches (Chapter 5).

2.26 Care Trusts can be formed where Primary Care Groups, Primary Care Trusts or NHS Trusts make a joint application in partnership with local council(s). Care Trusts will create a stable organisational framework allowing long-term service and organisational continuity and will provide a useful mechanism to improve services for older people. Care Trusts will usually be established where there is a joint agreement at a local level that this model offers the best way to deliver better services. However where any of the functions provided by local NHS and social services are not being delivered adequately and this results in poor quality services for users, the Secretary of State will have the power, where he believes it will lead to an improvement in those inadequate services, to take directive action. One of the options available to him will be to require the parties to enter into partnership arrangements, such as a Care Trust.

The single assessment process

2.27 The NHS Plan proposed a single assessment process across health and social care for older people. Implementing this should ensure that:

- a more standardised assessment process is in place across all areas and agencies
- standards of assessment practice are raised
- older people's needs are assessed in the round.

2.28 Delivering the single assessment process will mean putting in place a framework to ensure good assessment practice by the professionals involved and to assist information sharing between professions. It will also involve working to agreed principles about best practice on assessment and care management.

2.29 All older people should receive good assessment which is matched to their individual circumstances. Some older people will benefit from a fuller assessment across a number of areas or domains (as described in the box below), and some may need more detailed assessment of one, or a few, specialist areas. The single assessment process should be designed to identify all of their needs. For the older person, it will also mean far less duplication and worry - the fuller assessment can be carried out by one front-line professional and where other professionals need to be involved to provide specialist assessment this will be arranged for the older person, to provide a seamless service.

2.30 Properly targetted assessment and active care management promotes older people's independence through preventing deterioration and managing crises. It may reduce demand for services through assessing need more accurately and by ensuring services remain appropriate to needs [107] (A1). Such systematic assessment is also valued by older people [108] (C1). However, assessment methods and practice vary [109] (A2) [110] (B3) [111] (B3). Proven assessment scales and tools should be used to carry out assessments. This will ensure that individual needs are assessed properly. The new single assessment process will ensure that good practice becomes the norm and is supported by a locally agreed framework.

2.31 Good assessment also requires that the needs and circumstances of older people from black and minority ethnic communities are assessed in ways that are not culturally biased and by staff who are able to make proper sense of how race, culture, religion and needs may impact on each other.

2.32 Whenever older people attend primary care, seek help from social services or attend hospital, either as an elective admission or in an emergency, health and social care professionals should be aware that they may have needs, beyond their immediate problem. Front-line professionals should explore whether these further problems exist through questions which may be asked at first contact. Further investigation of particular problems such as eyesight or mobility may be needed. Alternatively, the problems may appear to be of such complexity that a fuller assessment is needed. Older people who have complex needs may have multi-factorial problems, such as dementia, or incontinence, or exhibit challenging behaviour.

2.33 A fuller assessment will consist of the exploration of a set of standardised domains of need, as outlined in the box below. This can be carried out by front-line health and social care staff such as community nurses, social workers, occupational therapists or physiotherapists [112] (C1) [113] (B1) [114] (C1). Further investigation of

domains will need to be carried out by appropriately qualified professionals; for example, measuring blood pressure needs to be carried out by a nurse or doctor. What is important in the fuller assessment is that all of the domains are considered and that no presumptions are made about whether exploration of a particular area is important.

2.34 Older people should be invited to play as full a part in this overview, including elements of self-assessment.

User's perspective

- Problems and issues in the user's own words
- User's expectations and motivation

Clinical background

- History of medical problems
- History of falls
- Medication use

Disease prevention

- History of blood pressure monitoring
- Nutrition
- Vaccination history
- Drinking and smoking history
- Exercise pattern
- History of cervical and breast screening

Personal care and physical well-being

- Personal hygiene, including washing, bathing, toiletting and grooming
- Dressing
- Pain
- Oral health
- Foot-care
- Tissue viability
- Mobility
- Continence
- Sleeping patterns

Senses
- Sight
- Hearing
- Communication

Mental health
- Cognition including dementia
- Mental health including depression

Relationships
- Social contacts, relationships and involvement
- Caring arrangements

Safety
- Abuse or neglect
- Other aspects of personal safety
- Public safety

Immediate environment and resources
- Care of the home
- Accommodation
- Finances
- Access to local facilities and services

2.35 While undertaking an assessment it will be important for users and professionals to confirm and record current levels of help from carers, health services, social services, housing services, and other services. Assessment information will need to be updated or revised over time as needs change or as older people move through the care system.

2.36 Assessment may identify the need for more specialist assessments; for example, a specialist medical need such as cognitive impairment, for a mobility or dexterity problem, or a need for pensions or benefits advice. If admission to long-term care is a possibility, full multi-disciplinary assessment should take place to identify opportunities for rehabilitation and to reduce inappropriate admissions. This will involve assessment by the most appropriate team - such as the specialist stroke team, old age multi-disciplinary team, or the old age mental health team.

2.37 Finding out about the help that older people already receive should reveal whether family members or friends are acting as carers. Carers should be identified and offered either the opportunity to be involved in the older person's assessment, or where it appears appropriate, informed of their right as part of a holistic assessment to an assessment in their own right under the Carers and Disabled Children Act 2000. Guidance on carers' assessments is to be found in the practice guidance on the Carers and Disabled Children Act 2000, and the Practitioner's Guide to A Carer's Assessment.

2.38 Suitably trained registered nurses will be involved in any assessment process which has identified registered nursing needs, including the decision on the appropriate setting for the delivery of that nursing care. These determinations will be submitted to the manager in the PCG/T who is responsible for the implementation of 'free nursing care in nursing homes' and is the budget manager for this expenditure. This manager will be responsible for agreement that the free nursing care budget will pay for the determined level of registered nursing care.

2.39 Consideration of what help to provide and how care should be managed follows assessment. While the care of all older people should be managed appropriately and effectively, the most vulnerable older people will often require fuller assessment and more intensive forms of care management. For this reason dedicated care managers should work with the most vulnerable older people over time. [115] (A2/B3) [116] (B3) [117] (A2) [118] (B3) [119] (B3). The care managers should be the most appropriate professional, given the individual older person's needs.

2.40 Following assessment, older people will receive an individual care plan that clearly describes the objectives and outcomes of providing help as well the detail of that help and who to contact in emergencies or if needs change. Care plans should be agreed with the older person, who should hold their own copy of the care plan.

2.41 There will be national work to support the implementation of the single assessment process. An Assessment Working Group is being established by the Department of Health and will provide national guidance, based on the best current evidence, which will advise on:

- identifying the circumstances which would lead to an exploration of all the domains (as described in the box) or a more focused assessment
- a tool and, as part of that, scales to support assessment practice.

2.42 Guidance based on the work of the Assessment Working Group will be published in summer 2001. The aim is to move towards a more standardised approach on assessment, so that organisational boundaries become less important; for example, where PCG/Ts deal with more than one social services department, the similar arrangements in place will facilitate the sharing of information collected in a systematic way by all agencies.

A framework for assessment

2.43 Health and social care agencies will need to agree arrangements about professional responsibility for assessment, referral arrangements between professions or agencies, and information sharing. This will include jointly agreed arrangements for training, auditing and developing quality standards:

- those carrying out the assessment: staff will need to be skilled in assessment practice and in multi-disciplinary working as well as in caring for older people. This applies across the range of professionals who may be involved in carrying out assessments - GPs, nurses, social workers, therapists, or, where standardised assessment scales and tools are in use, appropriately skilled and supervised care assistants. Agencies should ensure that suitably competent staff are available to carry out assessments and that more qualified and specialist professionals can be readily accessed if more specialist assessment or investigation is needed

- working arrangements: some older people will require assessment from more than one health professional, from both health and social care professionals, or from a wider range of agencies. The early priority is to establish good working relationships between primary health care, community health and social services teams, but arrangements will also need to be put in place between the community and acute sectors and with other agencies such as benefits and housing. Health and social care agencies should ensure arrangements are in place to allow this to happen smoothly

- information sharing: information about older people will be built up over time, through the single assessment process and from other routine contact with health and social care professionals. This should be stored in a systematic way by health and social care agencies, and shared between them, to minimise the need for users and carers to provide similar information to different professionals and agencies subject to the obligations and confidentiality and the provisions of The Data Protection Act 1998.

2.44 There may also need to be a common process to provide a proactive approach to inviting people for assessment. The Assessment Working Group will advise on this as further evidence becomes available.

2.45 The single assessment process should fit with current approaches to the pro-active identification of potentially vulnerable older people, evolving as better systems emerge to reach the older people who would most benefit from a fuller assessment. For example, general practitioners are required under their existing terms of service to offer an annual health check to their patients who are over 75. Ways of delivering this requirement vary between practices, however, and the Department of Health will need to consider with the GP professional bodies the best way of assessing the health of older people proactively in primary care, in the light of the new single assessment process and the development of integrated service delivery through primary care groups and trusts, and in the context of discussions about how the GP contract should develop in future to incentivise the delivery of improved service quality, as well as quantity, in primary care.

Integrated community equipment services

2.46 The Audit Commission has estimated that nearly a million people need equipment to help them live independently in the community [120] (P). Demand for disability equipment is increasing as a result of the ageing population, user expectations, and advances in technology and medical science. Boundaries between health and social care services have resulted in an inefficient service and delays in providing equipment. The NHS Plan set out the Government's intention to achieve single, integrated community equipment services by 2004 and to increase by 50% the number of people able to benefit from these services. By 2004 NHS annual funding will have increased to £65m, providing, for example:

- an extra 35,000 items of hoist and lift equipment in older people's homes
- 250,000 more older people with walking aids.

2.47 Community equipment services provide the majority of disability equipment needed by older people, but should also provide a well-informed gateway to other equipment services such as those provided by the NHS, councils and voluntary organisations. Older people are major users of wheelchair and artificial limb services and many need to use low vision or hearing aids. Older people frequently need a range of assistive equipment but do not know where to get it. Or they may be provided with one device, such as a hearing aid, but are not informed about associated equipment such as visual door bells, which would be of value to them.

2.48 The following key principles should govern the provision of community equipment services:

- identifying the need for equipment provision should be an integral part of any assessment, treatment or care plan, whether in hospital or community settings
- accountability should be clear with relevant professionals having specified responsibilities for ensuring older people and their carers know what is available and that they have a choice in the selection of equipment provided for them
- services should take a preventive approach, recognising that effective equipment provision (including for people with moderate disabilities) is likely to:
  - help older people to maintain their independence and live at home
  - slow down deterioration in function and consequent loss of confidence and self-esteem

- prevent accidents
- prevent pressure sore damage
- support and better protect the health of carers

- services should be timely and resolve the frequently long delays which inhibit older people's discharge from hospital, or their safety and confidence in coping at home.

2.49 Agencies should work to deliver:

- an integrated service across health and social care
- a comprehensive service, wherever and however people access the system
- speedy and flexible supply of equipment
- facilities to get independent advice and try out equipment
- the wider application of 'new technologies' to support the safety and security of older and disabled people, such as fall alarms and sensors
- efficiency gains through improved purchasing and stores management.

2.50 Specific guidance on modernising community equipment services will be issued to the NHS and councils in March 2001.

Integrated continence services

2.51 Integrated continence services support older people and their carers. Good practice for the provision of continence services was issued in April 2000 [121] (P). This laid down evidence based policies, procedures, guidelines and targets for the establishment of integrated continence services The attainment of good practice is supported in *The Essence of Care* [122] (C1/C2/D/P/U) standards.

Integrated continence services

Integrated continence services should:

- be in line with published guidance on good practice
- link identification, assessment and treatment across primary, acute and specialist care

and should include:

- primary and community staff igiving general advice to older people and their carers about healthy living (in particular diet, and drinking appropriate fluids)
- primary and community staff involved in the identification, initial assessment and care of older people
- staff in nursing and residential care homes to identify, assess, treat and review the needs of residents within agreed protocols
- hospital nurses to identify people with incontinence, and to ensure that treatment is provided and that continence needs are assessed and a plan agreed before discharge from hospital
- specialist continence services to provide expert advice and be available to people whose condition does not respond to initial treatment and care
- links to designated medical specialities such as urology and geriatrics
- links to regional and national units for specialist surgery to form part of the care pathway for continence services
- availability and provision of continence aids / equipment
- access to bathing and laundry services
- patients and carers in developing local services.

Actions

The NHS and councils

- agree at Board (NHS) and Committee (Social Services) level their core values for the care of older people, and how in practice they intend to make sure that needs are best met
- communicate this to older people and their carers, and to the wider local community
- involve staff, users and carers in reviewing the information provided for older people across the organisation - and where appropriate across the whole health and social care system
- agree a rolling programme to develop local information systems so that information is provided in appropriate format and languages, for both older people themselves and their carers. This should be in line with the *Better Care Higher Standards* charters guidance published in March 2001.
- agree local arrangements for a single assessment process for older people. This process will cover both health and social care needs, including physical and mental health
- implement the single assessment process
- ensure that, where appropriate, the carers of older people are offered their own assessment of their caring and health needs
- establish a single integrated community equipment service which meets key national targets
- implement integrated incontinence services.

Milestones

June 2001	Local arrangements for implementing the NSF are established.
April 2002	The single assessment process is introduced for health and social care for older people. All health and social care services to have reviewed the information they provide on older people's services and the formats in which it is available, and to have developed an action plan to correct any shortcomings. This should be reflected in the local *Better Care, Higher Standards* charter.
April 2003	Systems to explore user and carer experience should be in place in hospitals in all NHS and PSS organisations. This will include regular use of the surveys to be developed within the national programme for NHS patients and carers.

	NHS organisations should have systems in place to ensure all complaints from older people, or their carers and relatives, are analysed and reported to each Board.
	HImPs and other relevant local plans should have included the development of an integrated continence service.
April 2004	Systems to explore user and carer experience in PCTs should be in place.
	Single integrated community equipment services are in place.
	All local health and social care systems should have established an integrated continence service.

Standard Three: Intermediate care

Aim

To provide integrated services to promote faster recovery from illness, prevent unnecessary acute hospital admissions, support timely discharge and maximise independent living.

Standard

Older people will have access to a new range of intermediate care services at home or in designated care settings, to promote their independence by providing enhanced services from the NHS and councils to prevent unnecessary hospital admission and effective rehabilitation services to enable early discharge from hospital and to prevent premature or unnecessary admission to long-term residential care.

Rationale

3.1 A new range of acute and rehabilitation services is needed to bridge the gap between acute hospital and primary and community care.

3.2 The Government is committed to ensuring that all older people who need hospital care receive it through an expansion of staff numbers, hospital beds and other facilities, and shorter waiting times. However, currently too many older people are admitted to hospital for want of community-based services that would better meet their needs. Consequently, they are running unnecessary risks of disruption to their social networks, disorientation and hospital acquired infections. Many older people want alternatives to hospital admission [123] (A2).

3.3 In a 1997 report [124] (P), the Audit Commission concluded that there was too little investment in preventative and rehabilitative services, leading to unplanned admissions of older people to hospital and, in turn, premature admission to long term residential care. They recommended breaking into the vicious circle through investment in prevention and rehabilitation.

3.4 Similarly, the National Beds Inquiry (NBI) [125] (P) found that significant numbers of older people stay in acute hospitals longer than is necessary or desirable. A literature review commissioned by the NBI from the University of York [126] (A2) concluded that for older people around 20% of bed days were probably inappropriate and would be unnecessary if alternative facilities were in place. The

NBI report also highlighted wide and unexplained geographic variations in the availability of such services – and in patterns of acute bed use for older people – after adjusting for health and social factors.

3.5 Consultation on the NBI report demonstrated overwhelming support for "care closer to home", and the NHS Plan signalled a significant new investment in intermediate care.

Key interventions

3.6 This NSF builds on the intermediate care guidance issued in January 2001 [127] (P) which describes the essential components of intermediate care services, and how intermediate care should be commissioned and delivered. Many successful local schemes have been developed over the past few years. The key to this next phase of intermediate care development is integrated and shared care, including primary and secondary healthcare, social care and involving the statutory and independent sectors. The NHS Plan set clear targets for expansion of intermediate care services.

3.7 By 2004, there will be:

- 5,000 extra intermediate care and 1,700 supported intermediate care places together benefiting around 150,000 more older people each year
- rapid response teams and other avoidable admission prevention schemes benefiting around 70,000 more people each year
- 50,000 more people enabled to live at home through additional home care and other support
- carers' respite care services extended to benefit a further 75,000 carers and those they care for.

3.8 The NHS Plan Implementation Programme set early milestones for 2001/02, including to:

- ensure that there are 1,500 more intermediate care beds in 2001/02, compared with 1999/2000
- ensure that 60,000 more people receive intermediate care services in 2001/02, compared with 1999/2000
- ensure that 25,000 more carers benefit from respite/breaks services in 2001/02, compared with 2000/01. Such services are of vital importance to people of all ages, including those with physical and learning disabilities

- ensure that the number of older people helped to live at home per 1,000 of the population aged 65 or over increases by at least 2% nationally in 2001/02, compared with 2000/01.

3.9 The achievement of these targets will result in tangible benefits for older people. Nationally, they will achieve in 2001/02:

- an average rate of delayed transfer of care for people aged 75 and over of 10%
- a reduction of an average of approximately 1,000 hospital beds occupied at any time by people aged 75 and over awaiting transfer of care, compared with 2000/01
- an increase in the per capita rate of emergency admissions for people aged 75 and over of less than 2 per cent compared with 2000/01
- no increase in the rate of emergency re-admissions within 28 days of discharge, compared with 2000/01.

3.10 Intermediate care services should:

- be targetted at people who would otherwise face unnecessarily prolonged hospital stays or avoidable admission to acute in-patient care, long-term residential care or continuing NHS inpatient care
- be provided on the basis of a comprehensive assessment, resulting in a structured individual care plan that involves active treatment and rehabilitation
- be designed to maximise independence and to enable patients/users to remain or resume living at home
- involve short-term interventions, typically lasting no longer than 6 weeks and frequently as little as 1-2 weeks or less
- involve cross-professional working, within the framework of the single assessment process, a single professional record and shared protocols.

3.11 An essential component of intermediate care services is that they should be integrated within a whole system of care including primary and secondary health care, health and social care, the statutory and independent sectors. This creates challenges for the commissioning, management and provision of care entailing complex multi-sectoral work. Intermediate care cannot be the responsibility of only one professional group or agency. However, clinical and managerial accountability should at all times be clear, especially when the service user moves from one setting to another.

3.12 In line with the principle of 'care closer to home,' intermediate care services should generally be provided in service users' own homes or in community based settings but may be provided in discrete facilities on acute hospital sites.

3.13 Intermediate care services should focus on three key points in the pathway of care:

- responding to or averting a crisis
- active rehabilitation following an acute hospital stay
- where long-term care is being considered.

Responding to or averting a crisis

3.14 Each local health and social care system needs to establish a method of responding to crises, or impending crises caused by sudden change in circumstances. This should involve rapid assessment, diagnosis and immediate treatment followed by referral to the most appropriate services. This will include, as well as emergency hospital admission, where that is appropriate, the following options which can be delivered close to - or in - people's own homes:

- counselling, information and advice to enable care to be provided at home
- intensive support at home for a short period, including community nursing, community therapy services and home care support (sometimes known as 'hospital at home')
- step-up care in a residential or other setting (e.g. community hospital, nursing home, residential care home or very sheltered housing) for a short period

in conjunction, where necessary, with:

- further, specialist assessment and diagnostic services
- other ambulatory services, e.g. diagnosis, treatment or rehabilitation at a day hospital
- community equipment services and housing improvement services
- support to carers – family and friends.

3.15 There need to be arrangements across the full range of community services, including out of hours primary care services, and emergency departments to trigger an emergency response and, where appropriate, comprehensive assessment.

3.16 Intermediate care can be particularly effective in breaking into the spiral of unnecessary hospital admission. This is especially so if the period of intermediate care is used as an opportunity to assess the older person's home situation, and take preventative measures such as short-term rehabilitation, provision of community equipment or adaptations, or simply linking an older person to social support networks. The needs of carers should also be revisited and additional support provided if necessary.

3.17 Evaluative evidence of intermediate care schemes in this context is scarce, but it suggests that they can deliver equally good outcomes as emergency hospital admission for some patient groups. A review of hospital at home schemes also suggested positive economic benefits [128] (A1). Local evaluations [129] (B3) [130] (B1) [131] (B3) [132] (B3) [133] (A1) suggest that some schemes are effective and that, based on comparisons with average hospital lengths of stay for comparable diagnostic groups, they are also cost-effective. There is also local evidence of strong support for such schemes from users and carers and from primary care professionals [134] (B3).

Active rehabilitation and supported discharge

3.18 Some patients will receive rehabilitation in the acute hospital. Others will be able to return directly home from hospital without the need for special short-term support. In between, there will be a number of people who are medically stable but either:

- need further rehabilitation or opportunity for recovery before they can return safely home. This group of patients should have access to residential intermediate care (e.g. in community hospitals, nursing homes, residential care homes or very sheltered housing, or step-down beds in acute hospitals)

  or

- can return home, but need nursing, therapeutic and/or home care support for a short period to help complete their rehabilitation and recovery. This group of service users should have access to domiciliary forms of intermediate care, often known as hospitals at home schemes, linked where appropriate to community equipment and housing support services.

3.19 In either case, intermediate care should be used as an opportunity to maximise people's physical functioning, build confidence, re-equip them with the skills they need to live safely and independently at home, and plan any on-going support needed. Rehabilitation reduces the risk of older people being readmitted to hospitals or being placed in long-stay residential care and improves survival rates and physical and cognitive functioning, provided there is timely access to services, comprehensive assessment leading to implementation of individual care plans, and effective co-ordination and continuity in service delivery [135] (A1) [136] (A2) [137] (A2) [138] (D). Effective rehabilitation can also ensure that, where people do need to enter

long-term residential care, they can enter the most appropriate type of care and do so in ways that maximise their independence.

3.20 Well-managed intermediate care can improve recovery rates, increase patient satisfaction, reduce impact on the primary care team of the otherwise unplanned approach that characterises some discharges from hospital, and avoid unnecessary admission to long-stay residential/nursing home care for the patient [139] (B1) [140] (P). The evidence is strongest for specialist units for stroke rehabilitation and geriatric orthopaedic rehabilitation, with evidence of more patients being discharged home (compared with conventional care) and some evidence of faster improvement in physical function and fewer hospital re-admissions with no greater costs [141] (A1) [142] (B1). The evidence on early discharge schemes appears to suggest lasting and significant benefits in enabling people to remain in their own homes and possibly cost savings for the NHS [143] (B1).

3.21 Local evaluations[144] (D) also suggest that there is strong support for such schemes from users and carers, possible cost savings for the NHS or increase in overall capacity (reducing acute lengths of stay) and possible cost savings for social services (reducing long term care costs).

Where long term residential care is being considered

3.22 Intermediate care may also be appropriate where a person is being considered for possible long-term residential or nursing home care. Many people enter care homes prematurely and stay there due to lack of suitable alternative provision. The available evidence suggests a high success rate for short-term rehabilitation schemes that have been set up with the aim of preventing admissions to long-stay residential care [145] (C1) [146] (D).

3.23 Around 63% of older people permanently entering nursing home care and around 43% of those entering residential care homes come direct from hospital [147] (P). While many people quickly adapt to and welcome the security of residential care, there can also be feelings of sadness and regret and a feeling that community-based options have not been fully explored [148] (D).

3.24 Health and social services should routinely identify the scope for rehabilitation and consider, along with housing authorities, possible alternatives to residential accommodation. Hospital discharge planning and provision of a range of services for post-acute rehabilitation are an essential part of any strategy aimed at reducing premature or inappropriate admission to long-stay residential accommodation.

Providing integrated services

3.25 A three-year implementation plan, forming an integral part of the Joint Investment Plan, needs to be agreed by January 2002. Year One of the implementation plan will have been noted in the Local Action Plans.

3.26 Overall planning of intermediate care services, should be based on health authority boundaries. Service delivery will, however, need to be organised on a locality basis, agreed by PCTs, health authorities and councils. Over time, these arrangements should become consistent with arrangements for overall NSF implementation, which are, where possible, being based within the LSP Framework (see paragraphs 2.18 ff). A jointly appointed manager should be responsible for service co-ordination and planning locally and may also hold a pooled budget. Service design should include evaluation and audit to help inform future investment decisions for 2002/03 and beyond.

3.27 Intermediate care services will be provided by a core team of professionals including general practitioners and hospital doctors, nurses, physiotherapists, occupational therapists, speech and language therapists and social workers, with support from care assistants and administrative staff. In addition, the team will need to draw on the expertise of a wide range of other health care professionals and will also require the support of other services in local government, especially housing, and of the independent sector. Key elements will be:

- for medical care the underlying principle is one of shared care between general practitioners and hospital based specialists. Locally agreed protocols and care pathways will determine the precise arrangements within a particular intermediate care service, and ensure that at any time the locus for medical responsibility is clear. In most cases, the hospital based consultant will be a specialist in old age medicine but other specialties such as rehabilitation medicine, diabetic medicine or chest medicine may be involved if this best meets the older person's needs. The arrangements should, wherever possible, build on existing relationships and good practice locally

- a named nurse will be responsible for co-ordinating nursing care and for ensuring the effective transition between hospital and community based services

- intermediate care services will always include a programme of active rehabilitation involving the contribution of one or more of the following: occupational therapy, physiotherapy, and speech and language therapy

- social work is an integral part of the intermediate care service and the team should include a nominated social worker to be fully involved in the development of the team's practice

- a clinical team leader will be accountable for professional development and clinical governance issues

- new or increased support from care assistants may be required while patients recover independence within a rehabilitation programme following an acute event or after hospital discharge.

3.28 An integrated multi-professional record should be used by all members of the team. It should set clear goals and timescales for the individual care plan, and a management plan following discharge from the service. The care plan should demonstrate user and carer involvement in decision-making and each user and carers should hold their own copies of the care plan.

The role of community equipment and housing improvement (Standard 2)

3.29 Intermediate care services, particularly supported discharge schemes and services designed to prevent avoidable admission, should specifically address any changes that are needed to the home environment to enable the older person to remain at home or to return home. This may include:

- home safety checks
- equipment provided by statutory and voluntary organisations' equipment services (Standard 2)
- housing and related support services, including home improvement, repairs and adaptations such as those funded through Disabled Facilities Grants and the Home Energy Efficiency Scheme (through Home Improvement Agencies which will be part funded by Supporting People grants from 2003/04).

3.30 Intermediate care services will need to work closely with housing authorities and housing agencies to assess needs for housing adaptations, repairs or improvements, including eligibility for grant aid (such as Disabled Facilities Grants), or for a move to different housing.

Commissioning

3.31 Commissioning should be undertaken jointly by the NHS and councils, using pooled budgets and other Health Act 1999 flexibilities. This is explained in more detail in the Intermediate Care Guidance [5] (P).

3.32 Partnership with independent sector providers of residential and domiciliary services should be sought actively in commissioning intermediate care services.

3.33 Whilst intermediate care services are likely to have a particular importance for older people, service planning and investment will need to take into account the needs of all potential service users.

Actions

The NHS and councils should, in line with the national guidance:

- agree a 3 year implementation plan for intermediate care, as part of the Local Action Plan and Joint Investment Plan, with arrangements for systematic monitoring and review focusing on:
  - responding to or averting a crisis – including, for every PCG/T area, a clear strategy for preventing avoidable acute hospital admissions
  - rehabilitation and recovery – to include discharge/rehabilitation planning at the earliest possible opportunity during an acute hospital admission. Every PCG/T area to develop an appropriate range of services to meet local needs
  - preventing unnecessary or premature admission to residential care – ensuring that early investment is targeted at service users at highest risk and that care plans clearly identify any potential for rehabilitation
- ensure that the plan addresses the service, organisational and personal development needs of the new intermediate care teams.

Milestones

July 2001	Local health and social care systems to have designated a jointly appointed intermediate care co-ordinator in at least each health authority area; to have agreed the framework for patient/user and carer involvement; and to have completed the baseline mapping exercise.
January 2002	Local health and social care systems to have agreed the joint investment plan for 2002/03.
March 2002	At least 1500 additional intermediate care beds compared with the 1999/2000 baseline. At least 40,000 additional people receiving intermediate care services which promote rehabilitation and supported discharge compared with the 1999/2000 baseline. At least 20,000 additional people receiving intermediate care which prevents unnecessary hospital admission compared with the 1999/2000 baseline.

March 2004	At least 5000 additional intermediate care beds and 1700 non-residential intermediate care places compared with the 1999/2000 baseline. At least 150,000 additional people receiving intermediate care services which promote rehabilitation and supported discharge compared with the 1999/2000 baseline. At least 70,000 additional people receiving intermediate care which prevents unnecessary hospital admission compared with the 1999/2000 baseline.

Standard Four: General hospital care

Aim

To ensure that older people receive the specialist help they need in hospital and that they receive the maximum benefit from having been in hospital.

Standard

Older people's care in hospital is delivered through appropriate specialist care and by hospital staff who have the right set of skills to meet their needs.

Rationale

4.1 Older people are cared for within a range of hospital settings including in specialist medical wards for older people: in specialist units (for example, critical care or coronary care), and in general medical and surgical wards. Older people may have a pre-existing illness or disabilities, and are particularly vulnerable to problems which can arise during a hospital stay [149] (P). Quality of care depends not only on good health care but on respect for the older person as an individual (Standard 2). Too often, the older person's experience of hospital care has been of outdated and unclean wards which have undermined their need for privacy and damaged their confidence in other aspects of care [150] (C1).

4.2 The care of older people in hospital is complex, and action is needed to improve the clinical care of older people in general hospitals:

- through ensuring early access to the care and advice of a specialist team for each older person admitted to a general acute hospital. This is particularly important for emergency admission, but frail older people are also vulnerable to complications with elective surgery
- through ensuring early involvement of a consultant in old age medicine or rehabilitation, so that appropriate treatment, and management decisions are made for older people with atypical disease presentation, or complex needs [151] (C1) [152] (C1)
- through ensuring appropriate attention to maintaining and improving the health status of the older person while in hospital, making use of the available range of professional groups and specialist advice

- through ensuring that hospital facilities and support services support privacy and overall quality of care [153] (C2)

- through ensuring all staff are properly trained and supported in caring for older people

4.3 Better care should be provided throughout the older person's stay in hospital, from early emergency care, and including very specialist care through to discharge [154] (P). The challenge is to ensure that hospitals are organised so that specialist care is readily accessible, and that all staff have the support they need to care for older people.

Key interventions

4.4 Hospitals need to consider the needs of older people throughout any stay in hospital. This involves action at the following key stages of their stay:

- emergency response

- early assessment

- ongoing care in medical and surgical wards

- old age specialist care

- discharge planning.

4.5 Delivering good care wherever the older person is being cared for in hospital depends on staff who have the skills and experience to work with older people. Given that older people are the predominant users in most hospital services, skills in their care should form a part of the core competencies of all staff. This includes sufficient knowledge about initial assessment, discharge planning, needs of carers and how to refer for specialist advice from the whole range of disciplines that older people need to access. It should be underpinned with fundamental principles for the promotion of dignity.

Emergency Response

4.6 The need for an emergency hospital attendance or admission can be triggered by an emergency ambulance call, a call to *NHS Direct*, the GP, other emergency services, or by presentation at A&E. It involves initial diagnosis and assessment and, if required, life-saving resuscitation at the first point of contact.

4.7 Older people should be transferred from A&E as soon as possible. The NHS Plan commitment is that, by 2004, no patient should stay longer than 4 hours in A&E before transfer or discharge. This commitment will bring particular benefit to older people who can become dehydrated or confused, may suffer skin damage, and can be very distressed by long delays. Multiple transfers through the hospital system can impede the care and discharge planning as well as increasing disorientation in older people. Wherever possible transfers should be kept to a minimum.

4.8 Work is under way to improve the way emergency admissions and other unscheduled care needs are dealt with. A review team will report later this year with a strategy for achieving improvements in the speed and quality of assessment and treatment, wherever people enter the system. Earlier, more accurate assessment of people's needs will lead to their being offered appropriate urgent services from both health and social care. These will be delivered in a variety of settings and might prevent avoidable hospital admission for some people.

4.9 In line with the commitment set out in the NHS Plan, the strategy will also include the development of protocols for emergency and unscheduled care that will take account of the needs of older people.

Early Assessment

4.10 Once stabilised, early assessment should identify the further care the older person requires. Early assessment will include investigation, observation and multidisciplinary assessment, and in hospital can take place in an admissions unit, observation ward, acute general ward or a specialist unit.

4.11 Early specialist input to assessment is required for older people with atypical or complex disease presentation or multiple medical problems. Specialist input may be required from geriatricians, specialists in stroke, falls and mental health or a wide range of other disciplines including specialist nurses, therapists, pharmacists and social workers.

Ongoing Care on General Medical and Surgical Wards

4.12 Older people may be cared for on general medical and surgical wards, or in specialist wards for, for example, gastroenterology or cardiac care. Wherever the older person is being cared for, good management will involve attention to:

- maintaining fluid balance [155] (D/P)
- pain management
- pressure sore risk management

- acute confusion
- falls and immobility
- nutritional status and risk management
- continence risk management
- cognitive impairment
- rehabilitation potential [156] (A1) [157] (A2)
- depression
- infection control
- medicines management
- social circumstances
- family and other carers' needs
- how and where to access other specialist services
- end of life care [158] (A2), [159] (P), [160] (C1), [161] (B3).

4.13 This will enable effective acute care, plus an assessment of the older person's functional capacity and the scope for rehabilitation, which together will inform their discharge planning.

4.14 Guidance issued last year [162] (P) made clear that every hospital should have clear and explicit policies relating to resuscitation. Decisions with regard to resuscitation should be made on the basis of clinical fact and not age alone. Staff will also need to be aware of these policies, which should be regularly audited to prevent age discrimination ever occurring. The British Medical Association, Royal College of Nursing and Resuscitation Council (UK) published updated guidance on taking resuscitation decisions in March 2001 [163] (P).

4.15 Nutrition is of particular importance and requires a co-ordinated multidisciplinary approach [164] (B3) [165] (A1) [166] (P/C2). Nursing, dietetic and catering services should be involved to ensure that good food is provided, that the nutritional needs of older people are properly assessed and met, and that this takes account of cultural factors and individual preferences. Nutritional risk screening should take place to identify those with characteristics of nutritional concern. For those at particular risk, a nutritional plan needs to be developed, appropriate food provided, food intake

monitored and action taken if nutritional needs are not being met [167] (P/C2). Both the timing and content of meals should take account of the older person's normal dietary pattern, their changing needs while in hospital and the management of any other health issues. Assistance should be given to those who cannot adequately feed themselves [168] (C1) [169] (P) [170] (P). Patient focused standards for good nutritional care can be found in *The Essence of Care* [171] (C1/C2/D/P/U).

4.16 Specialist attention is particularly relevant for older people undergoing surgery. With advancing age, there is an increased risk of post-operative complications. The oldest patients also have a high incidence of co-existing diseases which will further increase their post-operative risk. The 1999 National Confidential Enquiry into Perioperative Deaths (NCEPOD) report highlighted areas of poor practice which led to excess deaths in older age groups [172] (B3). Their recommendations should be followed [see box].

Extremes of Age: The 1999 Report of the National Confidential Enquiry into Perioperative Deaths

Recommendations

- Fluid management in older people is often poor; it should be accorded the same status as drug prescription. Multidisciplinary reviews to develop good local working practices are required.
- A team of senior surgeons, anaesthetists and physicians needs to be closely involved in the care of older patients who have poor physical status and high operative risk.
- The experience of the surgeon and anaesthetists need to be matched to the physical status of the older patient, as well as to the technical demands of the procedure.
- If a decision is made to operate on an older patient then that must include a decision to provide appropriate postoperative care, which may include high dependency or intensive care support.
- There should be sufficient, fully-staffed, daytime theatre and recovery facilities to ensure that no older patient requiring an urgent operation waits for more than 24 hours once fit for surgery. This includes weekends.
- Older patients need their pain management to be provided by those with appropriate specialised experience in order that they receive safe and effective pain relief.
- Surgeons need to be more aware that, in older people, clinically unsuspected gastrointestinal complications are commonly found at post-mortem to be the cause, or contribute to the cause, of death following surgery.

4.17 Older people who are admitted to hospital with physical problems may also be suffering from depression or dementia or both. The care of older people with mental health problems, especially those associated with behavioural disturbance in a general hospital setting often poses problems. Other patients may be distressed by behavioural disturbance in others. This can lead to inappropriate and unnecessary use of sedative drugs which reduce rehabilitation potential.

4.18 Clear guidelines for involving specialist mental health services in the care of older people in hospital should be developed, and staff on wards where there is a high level of mental health problems, should be trained to recognise and manage behavioural problems appropriately.

The Hospital Environment

4.19 The hospital environment and support services should support the quality of care for older people. Wards and other care environments should be clean, allow for privacy and assist in promoting independence [173] (P).

4.20 Hospital support services are an integral part of providing proper care and meeting personal needs. Sufficient supplies of bedding, clothing and personal linen are needed. Help with eating, dressing and bathing, should be provided in ways which ensure that people's dignity is always maintained, and culture is respected. Aids to mobility should be supplied to enable patients to be as independent as possible [174] (P).

4.21 National standards of cleanliness are being developed for all hospitals. The particular needs of older people have been considered in putting these together.

4.22 Wards where there is little opportunity for private discussion detract from the older person's right to privacy [175] (C1) [176] (P). A separate room should always be available for older people and their carers to discuss matters in private or with staff if they wish and to make personal telephone calls. When new or existing services for older people are being designed or redesigned, planning should take the need for privacy into account.

4.23 Older hospitals may care for older people on Nightingale wards – wards where staff can find it difficult to provide an appropriate environment for older people. £120 million will be spent over three years, making many of these wards into wards particularly for the use of older people. This will bring in more four-bedded bays, with more privacy and peace; rooms available for private conversations; and single rooms for those who are most vulnerable. Rehabilitation is an integral part of such new wards, with space provided for therapy equipment, or a small gym, comfortable day rooms and specially adapted kitchens.

4.24 Mixed-sex wards can be embarrassing and for some older people culturally insensitive. The Government is committed to eliminating mixed sex accommodation - 95% of NHS accommodation will be single sex by 2002. Converting Nightingale wards will also help to meet this objective as existing mixed-sex accommodation will be converted into single sex accommodation.

4.25 For older people with dementia, the physical environment may exacerbate problems, causing acute confusion. Ward design should take into account the needs of older people with mental health problems and ensure that patients can move safely in the ward but not wander out. Distress may be caused by:

- excessive noise
- harsh lighting
- unfamiliar activity
- pace and numbers of people in the ward
- strangers.

4.26 Effective nursing leadership is essential in providing patient-focused care and ensuring positive patient experience including promoting dignity and privacy. Clinical leaders (Modern Matrons), who will be easily identifiable to patients and responsible for groups of wards will provide the support and development for ward managers to improve the care of older people in hospitals. In addition development of clinical expertise through nurse specialist and nurse consultant roles will support improvements in care through research and development and education and training of staff working across all adult services.

Old age specialist care

4.27 All ward staff should be competent in the care of older people. But specialist attention from a range of disciplines, for example, audiology, ophthalmology, podiatry and orthotics services, or from the specialist old age multidisciplinary team may be necessary. Older people who have complex co-morbidities associated with older age are best treated by a dedicated specialised team. Care provided by specialist old age medicine teams can result in shorter lengths of stay and a reduction in the need for long-term care [177] (C1) [178] (C1).

Discharge planning

4.28 Planning for discharge should start prior to the hospital stay for planned admissions and as soon as possible during the hospital stay for other admissions [179] (C1) [180] (P) [181] (B3) [182] (C1) [183] (D) [184] (C1) [185] (P). This will mean building on or adding to any assessment undertaken prior to admission.

4.29 The NHS Plan includes a commitment to ensure by 2004 that every NHS patient has a discharge plan developed from the start of hospital admission.

430 The older person may be discharged to:

- home: the individual care plan will have identified what is needed to support the patient and their carers at home e.g social care, primary health care, community support, housing. Arrangements should have been made to ensure that support is in place before discharge home
- intermediate care (Standard 3): arrangements should exist for the timely transfer of older people who are medically stable but need short-term care to intermediate care facilities
- long-term care: access to long-term residential care should be through intermediate care, hospital rehabilitation or step-down care units to allow opportunities for prevention, treatment, rehabilitation and domiciliary support to be fully explored (before placement is decided upon) and to support patients in making the transition to long-term care. Decisions about admission to long-term care should follow from a multidisciplinary assessment and take account of the patient's (and carer's) wishes [186] (D).

Service Models

4.31 There should be a specialist old age multidisciplinary team with the following core members in all general hospitals:

- consultants in old age (geriatric) medicine
- specialist nurses / nurse consultants
- physiotherapists, occupational therapists and speech and language therapists (including at advanced practitioner and consultant level)
- dietitians
- social workers / care managers
- pharmacists.

4.32 This team should be based around a specialist unit which will serve as a centre of excellence for developing and disseminating best multidisciplinary practice throughout general and acute wards and A&E Departments. General staff and trainees from medicine, nursing and members of the allied health professions

should rotate through these units to develop skills in the care of older people with complex problems. Effective clinical leadership will be key in the delivery of this NSF in the hospital setting. Clinical leaders (Modern Matrons) will provide leadership and development for groups of wards, ensuring positive patient experience and promoting dignity and privacy across services. Specialists in caring for older people with complex problems should have key roles in setting standards, protocols and guidelines for the care of older people in the general hospital; in clinical governance; and in ongoing training programmes for other staff, in order to disseminate good practice.

4.33 These mechanisms are required to ensure that older people receive the care they need in hospital. But different models of care can deliver these benefits. The relationship between old age and general medical contributions to acute care in hospitals is organised according to three predominant models:

- **Age-defined models** where patients are admitted to specialist or general medical wards (with a degree of flexibility) around an agreed chronological age (usually 75). This is the predominant UK model. Age-defined wards were developed initially in response to concerns that the needs of older people were being overlooked in general wards where there were people of all ages. Dedicated resources and environments have an opportunity to provide older people with better, higher quality, more specific services. Success will depend on the wards being on the main acute site with full access to other specialities and not singled out for a lower level of resource provision

- **Integrated models** where all physicians receive patients irrespective of age. The acute care of patients of all ages is undertaken on acute wards where specialists in old age medicine work with physicians in specialties within an integrated team. The aim is for older people to be treated to the same standards and have access to specialist advice on the same basis as younger people – although they also have access to consultants in old age medicine as required. Success will depend on the acute general medical workload of these consultants being such that their skills are available to those older people who most need them and on the hospital having designated wards for specialist rehabilitation following acute care.

- **Needs-based models** where patients are allocated on admission either to specialist wards for older people or to general wards, based on locally agreed criteria. Decisions on the most appropriate ward are based on perceived clinical need (complexity, non-specific frailties of old age not chronological age). Admission to the specialist wards is usually arranged direct from the community or following the acute medical take. Success will depend on there being clear and agreed operational policies which are closely adhered to at all times, together with sufficient resources on the main acute site to ensure reliable access without delay for all those who need it.

4.34 There is no evidence that any one model is better than another, and each has its strong advocates. Any age-defined model in operation will need careful scrutiny as set out in Standard 1.

4.35 By 2002, hospitals should be able to demonstrate to Patient Forums that the service model adopted is responsive to individual need and has adequate systems for referral and transfer between specialist old age services and general acute care.

Actions

Every NHS Hospital Trust which provides services for older people, working with the rest of the health and social care system, should:

- agree protocols between their specialist old age team and other departments within the hospital to ensure that all older people can benefit from the expertise of the specialist team
- recognise the risks which hospital admission can pose for older people, assess the risks for each individual and ensure that the risks are anticipated and minimised. This will require particular attention to hydration, nutrition, skin care and continence, from arrival at hospital to discharge
- identify Clinical Leaders (Modern Matrons) for Older People to oversee care of older people in wards
- ensure that discharge is planned from the point of admission.

Milestones

April 2002	All general hospitals which care for older people to have identified an old age specialist multidisciplinary team with agreed interfaces throughout the hospital for the care of older people. All general hospitals will have developed a nursing structure which clearly identifies nursing leaders with responsibility for older people. Consideration will have been given to Nurse Specialist/ Nurse Consultant and Clinical Leaders (Modern Matrons).
April 2003	All general hospitals which care for older people to have completed a skills profile of their staff in relation to the care of older people and have in place education and training programmes to address any gaps identified.

Standard Five: Stroke

Aim

To reduce the incidence of stroke in the population and ensure that those who have had a stroke have prompt access to integrated stroke care services.

Standard

The NHS will take action to prevent strokes, working in partnership with other agencies where appropriate.

People who are thought to have had a stroke have access to diagnostic services, are treated appropriately by a specialist stroke service, and subsequently, with their carers, participate in a multidisciplinary programme of secondary prevention and rehabilitation.

Rationale

5.1 Stroke has a major impact on people's lives. It starts as an acute medical emergency, presents complex care needs, may result in long-term disability and can lead to admission to long-term care. Each year 110,000 people in England and Wales have their first stroke, and 30,000 people go on to have further strokes. It is the single biggest cause of severe disability and the third most common cause of death in the UK and other developed countries [187] (A1). A substantial proportion of health and social care resources are devoted to the immediate and continuing care of people who have had a stroke. At any one time there are 25-35 patients with stroke as their primary diagnosis in the average general hospital [188] (B3).

5.2 Stroke is caused by a disturbance of blood supply to the brain. There are two main types of stroke:

- *ischaemic stroke:* when a clot either narrows or blocks a blood vessel so that blood cannot reach the brain. This reduced blood flow causes brain cells in the area to die from lack of oxygen. This is the most common form of stroke.

- *haemorrhagic stroke:* when a blood vessel bursts, and blood leaks into the brain causing damage.

5.3 Transient ischaemic attacks (or TIAs) are often described as 'mini strokes'. The term TIA is used where the symptoms and signs resolve within 24 hours. A TIA increases the subsequent chance of a stroke.

5.4 Around 30% of patients die in the first month after a stroke, most in the first ten days. Although after a year, 65% of surviving stroke patients can live independently, 35% are significantly disabled and many need considerable help with daily tasks or visits from a district nurse. Around 5% are admitted to long-term residential care [189] (D).

5.5 The effects of a stroke depend on the part of the brain that has been damaged, how widespread the damage is and the patient's general health at the time. Effects can include difficulties in movement, balance, walking, swallowing, speaking, writing, understanding the spoken or written word, activities of daily living including dressing, maintenance of personal hygiene, feeding, controlling bladder or bowel movements, vision and mood. These conditions are treatable through careful and co-ordinated intervention. Recovery can continue for several years after a stroke.

5.6 Some population groups are at higher risk of stroke than others. The risk increases with age, although stroke can affect younger people too. Each year 10,000 people under 55 years and 1,000 people under 30 years have a stroke [190] (C1). Data from the Health Survey for England show that amongst African-Caribbean and South Asian men the prevalence of stroke was between about 40% and 70% higher than that of the general population after adjusting for age. People in socio-economic group V (unskilled manual workers) have a 60% higher chance of having a stroke than those in socio-economic group I (professionals), and the mortality rates from stroke are 50% higher in socio-economic group V than in socio-economic group I. [191] (C1) [192] (B3).

5.7 A number of conditions predispose to stroke - most importantly a previous stroke, a TIA, high blood pressure, atrial fibrillation (a form of irregular heart beat) or carotid stenosis (a narrowing of the carotid artery). There is good evidence that effective and systematic programmes of prevention can identify those at risk and reduce the future incidence of stroke. It is also important to modify lifestyles - especially to stop smoking, reduce alcohol consumption, improve diet and increase physical activity [193] (B3) [194] (B3).

5.8 There is strong evidence that people who have a stroke are more likely both to survive and to recover more function if admitted promptly to a hospital based stroke unit [195] (A1) with treatment and care provided by a specialist co-ordinated stroke team within an integrated stroke service [196] (B1) [197] (A1) [198] (A1) [199] (A1) [200] (A1). These benefits can be achieved at no overall additional cost to health and social care. Although the evidence is less clear, stroke units may also reduce the number of inpatient days spent in hospital.

5.9 Some NHS organisations have developed their services in line with this evidence, but in 1999 only 18 % [201] (C1) [202] (B3) of patients were being treated on a specialist stroke unit [203] (P) [204] (C1) [205] (B3). The latest stroke audit to be published shortly, will show that this has now increased to 26% of patients.

Key interventions

5.10 This standard sets out four main components for the development of integrated stroke services:

- prevention
- immediate care
- early and continuing rehabilitation
- long-term support.

5.11 Given the higher prevalence of stroke in some minority ethnic communities, integrated stroke services and stroke prevention advice should take into account the need for interpreting or advocacy support, especially for those patients and carers for whom English is not their first language.

Prevention

5.12 The prevention of stroke depends on reducing risk factors across the whole population as well as in those at relatively greater risk of stroke.

Population approaches to preventing stroke

5.13 Actions to reduce the risk factors for stroke in the population are addressed in Standard 8. They build on *Our Healthier Nation,* the National Service Framework for Coronary Heart Disease and the NHS Cancer Plan, together with the themes drawn together in the NHS Plan. At population level, the interventions to prevent stroke are broadly the same as those for coronary heart disease - increasing levels of physical activity, encouraging healthy eating (particularly reducing salt intake and increasing fruit and vegetable consumption), and supporting smoking cessation[206] (B3) [207] (B3) as well as identifying and managing high blood pressure.

Preventing strokes in individuals at greater risk

5.14 The main risk factors for stroke are:

Cardiovascular disease [208] (A2)

- previous stroke or TIA
- hypertension (high blood pressure) [209] (B3)
- atrial fibrillation (a form of irregular heart beat) [210] (B1)
- other cardiovascular disease such as coronary heart disease and peripheral vascular disease

- carotid stenosis (a narrowing of the carotid artery)

Metabolic

- diabetes
- hyperlipidaemia (high cholesterol level)
- obesity

Lifestyle

- alcohol misuse
- poor diet
- low level of physical activity
- smoking.

5.15 It is estimated that in the UK more than half of the 10 million people aged over 65 are hypertensive. Risk of stroke for people with hypertension can be reduced by 37% through appropriate treatment. Having atrial fibrillation increases the risk of having a stroke by 3 – 7 times. Of people who have a stroke, 13% are in atrial fibrillation.

5.16 In the younger population, there are additional risk factors for stroke which can be significant. These include sickle cell disease, congenital heart disease, abnormalities of blood clotting and arterio-venous malformations of the brain.

5.17 Individuals at particular risk of stroke should be identified and offered advice and support to make lifestyle changes. GP Practices should build on registers being developed for the prevention of coronary heart disease as described in the Coronary Heart Disease National Service Framework (Standards 3 and 4) and put in place models of care so that a systematic approach is used for:

- identifying those at high risk of stroke
- identifying and recording modifiable risk factors of people at high risk of stroke
- providing and documenting the delivery of appropriate advice, support and treatment

- offering a regular review to those at risk of stroke

5.18 Advice on constructing and populating stroke registers will follow with the Information Strategy for Older People to be published shortly (Chapter 5).

5.19 The risk factors for each patient who is at risk of a stroke or who is recovering from a stroke should be identified, and advice, support and treatment provided as appropriate. Both primary and secondary prevention measures should be in line with clinical guidelines [211] (A1) [212] (A1). Risk modification should include:

Previous stroke	In most cases, for stroke patients with hypertension [213] (D) [214] (A1) or atrial fibrillation, [215] (B1) [216] (B1) the interventions are the same as for those who have not had a stroke.
TIA	Urgent referral of patients with suspected TIA to a rapid response neurovascular clinic, managed by a clinician with expertise in stroke for investigation and treatment
Carotid stenosis	Referral for carotid endocardectomy (to restore normal blood flow) in patients with 70 – 99% carotid stenosis (narrowing of the carotid artery).
Atrial Fibrillation	Treatment with warfarin, or where warfarin is inappropriate, aspirin or other anti-platelet agent [217] (B1). Prescribing such drugs may not be appropriate where a patient won't benefit, but reasons for not prescribing should be clearly documented.
Hypertension	Anti-hypertensive drug treatment [218] (A1) to maintain blood pressure below 140/85. [219] (A1) [220] (P) [221] (P).

Immediate care

5.20 All patients who may have had a stroke will usually require urgent hospital admission. They should be treated by specialist stroke teams within designated stroke units. Better outcomes for patients with suspected stroke will depend on:

- making a diagnosis, including a brain scan to ensure patients have the best possible chance of recovery and to minimise disabilities later
- giving care and treatment to patients during the acute phase in line with the National Clinical Guidelines on Stroke [222] (A1) [223] (P).
- carrying out a wider assessment of other health, social and environmental factors under the single assessment process in order to begin to plan for discharge.

5.21 Immediate management to improve chances of survival and minimise the risk of complications should include:

- a brain scan [224] (A1) within 48 hours
- giving aspirin [225] (B1) [226] (B1) if a diagnosis of haemorrhage is unlikely
- appropriate control of blood pressure without jeopardising cerebral blood flow
- maintenance of hydration
- management of hyperglycaemia
- management of fever
- maintenance of oxygen level/saturation
- treatment of co-existing medical conditions.

5.22 Treatment and care should also include:

- vigilant observation for and early management of possible complications including: chest infection, deep vein thrombosis, incontinence, swallowing disorder [227] (B2), pressure ulcers, [228] (P) malnutrition [229] (A1)
- giving advice to patients and their carers [230] (U/C) to help manage the effects of the stroke on their lives and providing information and explanations about the treatment and care needed
- carrying out a multi-disciplinary assessment and starting rehabilitation early (within 24 hours). This process should include a formal swallowing assessment and a plan for safe hydration, feeding and medication. Early interventions are also required in the following areas: balance, mobility, pain, communication, cognition, mood and activities of daily living
- co-ordination of care by a member of the stroke team including:
  - clearly documenting plans for treatment and care
  - ensuring identified needs for treatment, care and early rehabilitation are met
  - ensuring all professionals involved share a common understanding of the goals agreed for each patient.

5.23 Where recovery is not possible, this should be recognised by staff. The care of the patient should be discussed with them as far as possible, and with their carers as appropriate. The principles of palliative care should inform the care plan, with priority being given to supporting the patient to die with dignity, without unnecessary suffering, and in the place of their choice wherever possible.

Early and continuing rehabilitation

5.24 The evidence indicates that early, expert and intensive rehabilitation in a hospital stroke unit improves the long-term outcome for patients [231] (B1). Rehabilitation will vary according to needs but might include:

- speech and language therapy for patients with communication or swallowing difficulties
- nutritional advice if texture modification or other nutritional support is required
- physiotherapy to improve mobility and independence at home
- occupational therapy to help adjustment back to the workplace
- occupational therapy to assess and manage problems with activities of daily living
- clinical psychology for patients with problems affecting intellectual function or mood
- specialist treatment for patients with bladder or bowel problems
- equipment to support independent living.

5.25 Patients and their carers should be involved in planning their care and safe discharge from hospital [232] (B1). This should identify an initial overview of needs likely on discharge, and pursue a fuller assessment of the issues that will impact on the patient's independence. The assessment will result in a statement of need and an individual care plan which identifies proposed services, the responsibilities of various professionals for providing those services and the aims and potential outcomes of rehabilitation (Standard 2) [233] (P). The stroke care co-ordinator will be responsible for:

- co-ordinating assessment and individual care plans and ensuring arrangements for support and secondary prevention measures are in place prior to discharge

- ensuring an efficient flow of relevant information to community-based professionals
- ensuring a smooth transfer between care settings
- ensuring that the need for home adaptations, repairs and improvements are identified, and work completed pre-discharge.

5.26 Secondary prevention measures are a key part of the individual care plan. Treatment should be initiated in hospital, with arrangements made with the primary care team for it to be continued after discharge. Patients and their families should be provided with information, advice and support to prevent further strokes, and GPs notified of the risk factors and steps that have been, or will be taken, to reduce risk.

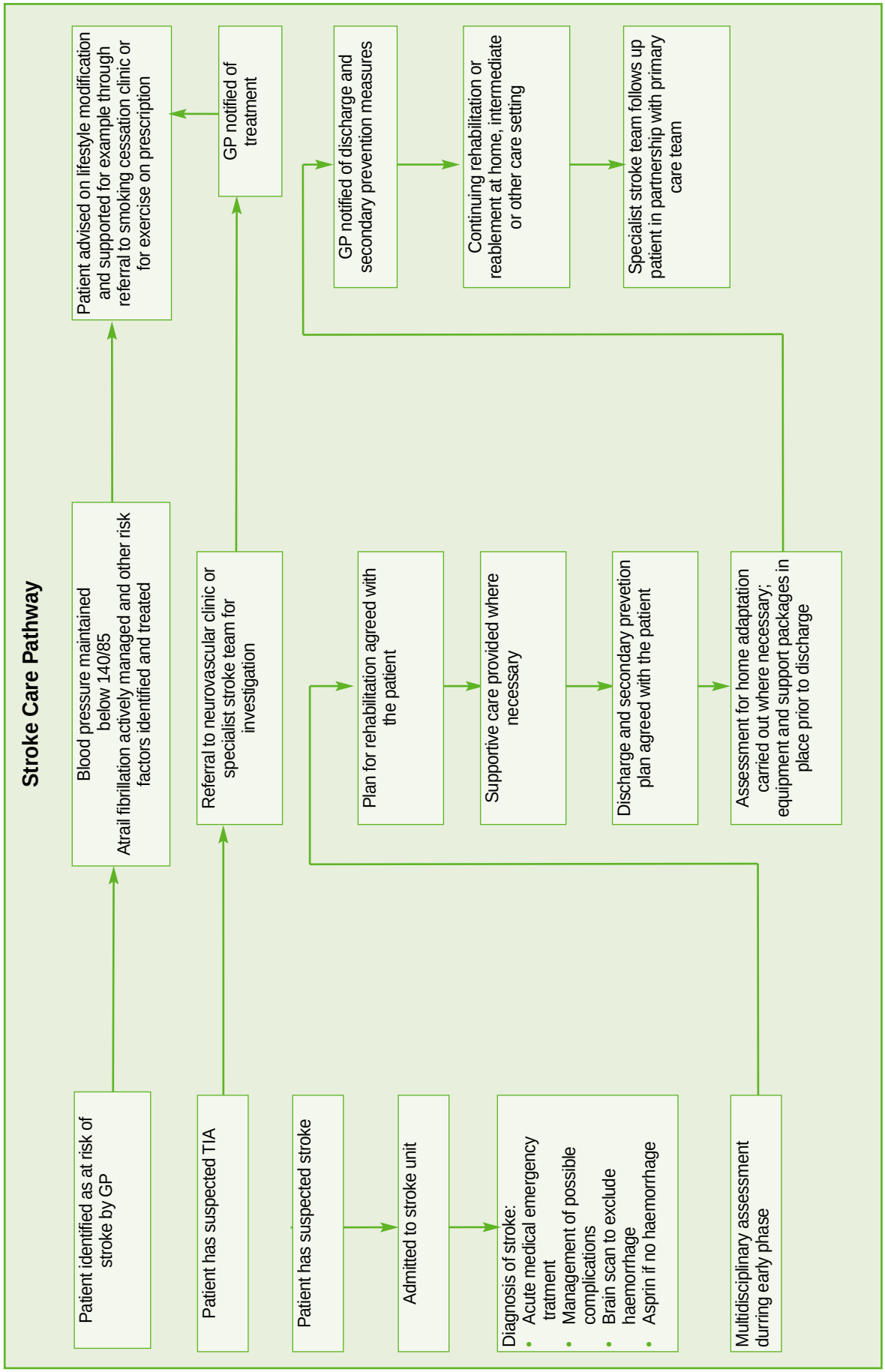
Long-term support

5.27 Recovery from stroke can continue over a long time, and rehabilitation should continue until it is clear that maximum recovery has been achieved. Some patients will need ongoing support, possibly for many years. These people and their carers should have access to a stroke care co-ordinator who can provide advice, arrange reassessment when needs or circumstances change, co-ordinate long-term support or arrange for specialist care. Following a stroke, any patient reporting a significant disability at six months should be re-assessed and offered further targetted rehabilitation if this can help them to recover further function [234] (B1).

5.28 Long-term support should be within the care management arrangements described in Standard 2 and include:

- providing patients and carers with the name of a stroke care co-ordinator they can contact for advice or to discuss changing needs or to facilitate access to rehabilitation services as appropriate
- making sure stroke patients are followed up to ensure expert team care, including medical care to prevent further strokes
- hospital outreach teams delivering care in people's own homes
- regular reviews of medication and nutritional well-being
- providing patients with advice, treatment and support to reduce risk of further stroke
- providing social and emotional support to minimise the loss of independence following the stroke, and help manage the consequences of stroke [235] (U/C)
- ensuring that accommodation after discharge - whether ordinary housing,

sheltered accommodation or a care home - is suitable to meet individual needs and that adaptations and community equipment services are provided where appropriate.


Stroke Care Pathway
Patient identified as at risk of stroke by GP
Blood pressure maintained below 140/85
Atrail fibrillation actively managed and other risk factors identified and treated
Patient advised on lifestyle modification and supported for example through referral to smoking cessation clinic or for exercise on prescription
Patient has suspected TIA
Referral to neurovascular clinic or specialist stroke team for investigation
GP notified of treatment
Patient has suspected stroke
Admitted to stroke unit
Diagnosis of stroke:
Acute medical emergency tratment
Management of possible complications
Brain scan to exclude haemorrhage
Asprin if no haemorrhage
Multidisciplinary assessment durring early phase
Plan for rehabilitation agreed with the patient
Supportive care provided where necessary
Discharge and secondary prevetion plan agreed with the patient
Assessment for home adaptation carried out where necessary; equipment and support packages in place prior to discharge
GP notified of discharge and secondary prevention measures
Continuing rehabilitation or reablement at home, intermediate or other care setting
Specialist stroke team follows up patient in partnership with primary care team

Service Models

5.29 An integrated stroke service will involve:

- stroke prevention for those at risk of a first or further stroke
- specialist stroke services providing acute care and rehabilitation
- long-term support for stroke patients and their carers.

5.30 Preventing stroke will involve:

- health promotion initiatives designed to reduce the risk factors for stroke in the general population (Standard 8)
- the development of systems systematically to identify and treat those at risk of a first or repeat stroke.

5.31 Managing stroke patients in hospital will mean establishing specialist stroke teams led by a clinician with expertise in stroke. Stroke teams should include:

- physician specialising in stroke medicine (normally a geriatrician, neurologist or consultant in stroke or disability medicine, or a named consultant with expertise in stroke) who should supervise care
- clinical specialist nurse with expertise in stroke
- speech and language therapist, physiotherapist, and occupational therapist
- dietitian
- clinical psychologist
- pharmacist
- social worker/family support
- trained bi- or multi–lingual co-worker to reflect language needs of local populations
- stroke care co-ordinator (this may be a specific post or a role that any team member could undertake)
- ready access to additional services.

5.32 Stroke teams will be involved in all aspects of stroke services and should contribute to the development of strategies to prevent strokes. Good working relationships and protocols with other hospital specialists and with primary and community based professionals, including housing will be needed to ensure effective and integrated stroke services and sharing the care of those recovering from stroke.

5.33 Stroke teams should meet at least weekly to discuss individual patients' progress and work to ensure there is a consistent approach to providing patient care, treatment and rehabilitation. They should make links to voluntary organisations and support groups such as the Stroke Association, Different Strokes or Speakability who will be able to complement the work of the service. Some older people from minority ethnic communities may be more comfortable being supported by their own community organisations. These organisations may require training and support on stroke care issues.

5.34 Prior to discharge, the needs of patients and their carers for care and support at home should be identified. Stroke teams will need to work with other professionals to ensure that these needs are met and support packages are in place before patients return home. This includes ensuring patients are advised about how they can reduce their risk of a further stroke and making whatever arrangements are required to provide long-term support.

5.35 Providing integrated stroke services will require staff to be trained and competent in caring for stroke patients and providing access to expert advice as necessary. Specialist stroke services should provide advice to and train other professionals and service providers in all aspects of stroke care consistent with the responsibilities of the individual members. Training should include:

- causes and effects of stroke
- acute care
- swallowing and nutritional needs
- oral health
- avoiding complications
- medication and other treatment
- physical rehabilitation
- overcoming communication problems

- patients' and carers' needs for information
- personal care needs
- social and employment needs
- emotional needs
- secondary prevention measures.

5.36 Staff should also understand the need for multidisciplinary working and the roles of other professionals within the team. Staff should also understand the role of the independent and voluntary sector and the help they can provide so that they can fully inform stroke patients and their carers about the support that is available.

Actions

Every health system should, in partnership with other agencies where appropriate:

- review current arrangements, in primary care and elsewhere to identify those at greatest risk of stroke, and to intervene actively to reduce these risks; and agree local priorities to improve the rates of identification and effective intervention in stroke
- review current arrangements, in primary care and elsewhere, for TIA and to agree and implement a local protocol for the rapid referral of patients with TIA who may be at risk of stroke
- review current hospital services for stroke using the clinical audit methodology developed by the Royal College of Physicians [236] (B3)
- on the basis of this, agree local priorities for action required to establish an integrated stroke service, which is regularly audited with a continuing cycle of improvement.

Milestones

April 2002 — Every general hospital which cares for people with stroke will have plans to introduce a specialised stroke service as described in the stroke service model from 2004.

April 2003 — Every hospital which cares for older people with stroke will have established clinical audit systems to ensure delivery of the Royal College of Physicians clinical guidelines for stroke care.

April 2004 — PCG/Ts will have ensured that:

- every general practice, using protocols agreed with local specialist services, can identify and treat patients identified as being at risk of a stroke because of high blood pressure, atrial fibrillation or other risk factors
- every general practice is using a protocol agreed with local specialist services for the rapid referral and management of those with transient ischaemic attack (TIA)

- every general practice can identify people who have had a stroke and are treating them according to protocols agreed with local specialist services

- every general practice has established clinical audit systems for stroke.

100% of all general hospitals which care for people with stroke to have a specialised stroke service as described in the stroke service model.

Standard Six: Falls

Aim

To reduce the number of falls which result in serious injury and ensure effective treatment and rehabilitation for those who have fallen.

Standard

The NHS, working in partnership with councils, takes action to prevent falls and reduce resultant fractures or other injuries in their populations of older people.

Older people who have fallen receive effective treatment and rehabilitation and, with their carers, receive advice on prevention through a specialised falls service.

Rationale

6.1 Falls are a major cause of disability and the leading cause of mortality due to injury in older people aged over 75 in the UK. [237] (C1) Over 400,000 [238] (C1) older people in England attend A&E Departments following an accident [239] (C1) and up to 14,000 people a year die in the UK as a result of an osteoporotic hip fracture [240] (P).

6.2 Osteoporosis, a condition characterised by a reduction in bone mass and density increases the risk of fracture when an older person falls. Fractures occur most commonly in the hip, spine and wrist. Vertebral fractures due to osteoporosis can cause loss of height, curvature of the spine and chronic back pain. One in three women and one in twelve men over 50 are affected by osteoporosis and almost half of all women experience an osteoporotic fracture by the time they reach the age of 70 [241] (P).

6.3 Most falls do not result in serious injury, but the consequences for an individual of falling or of not being able to get up after a fall can include:

- psychological problems, for example a fear of falling and loss of confidence in being able to move about safely
- loss of mobility leading to social isolation and depression
- increase in dependency and disability
- hypothermia

- pressure-related injury
- infection.

6.4 A fall can precipitate admission to long-term care. After an osteoporotic fracture, 50% can no longer live independently. Fear of falling can provide a significant limitation on daily activities. Falls in a later life are also a common symptom of previously unidentified health problems which need be identified and managed.

6.5 Hip fracture is the most common serious injury related to falls in older people, resulting in an annual cost to the NHS of around £1.7 billion for England [242] (C1) Of this, 45% of the cost is for acute care, 50% for social care and long term hospitalisation and 5% for drugs and follow up.

Key Interventions

6.6 This standard sets out changes needed to reduce the number of falls and their impact through:

- prevention including the prevention and treatment of osteoporosis
- improving the diagnosis, care and treatment of those who have fallen
- rehabilitation and long-term support.

Prevention

6.7 Preventing falls in frail older people will save lives and decrease disability. A community-wide strategy at population level, the provision of information, and advice and support to individuals are needed [243] (C1). Older people who have fallen are at risk of falling again. A specialist falls services [244] (B1) should be established within specialist multidisciplinary and multi-agency services for older people and work with older people who are at high risk of falling.

Population approach to falls prevention

6.8 Public health strategies should aim to reduce the incidence and the impact of falls, [245] (A1) [246] (C2) through actions to encourage appropriate weight-bearing and strength enhancing physical activity, [247] (A1) [248] (B3) promote healthy eating (including adequate intake of calcium) and reduce smoking in the general population. These are explored in more detail in Standard 8.

6.9 A community strategy to prevent falls should also include:

- ensuring that pavements are kept clear and in good repair and there is adequate street lighting
- providing information such as that produced by the Department of Trade and Industry in their leaflet *Avoiding Slips, Trips and Broken Hips*. Information is also available on the internet at http://www.preventinghomefalls.gov.uk
- making property safer. Property fitness standards are being developed by the Department of the Environment, Transport and the Regions (DETR) to ensure that health and safety measures, including falls prevention, are tackled.

Preventing falls in individuals

6.10 Preventing falls in older people depends on identifying those most at risk of falling and co-ordinating appropriate preventive action [249] (P/D) [250] (A1). Many older people who fall do not seek medical help. But they may be identified as being at risk through the presence of the following risk factors. Interventions which target both multiple risk factors for individuals (intrinsic risk factors) and environmental hazards are most successful [251] (A1) [252] (B1).

6.11 Intrinsic risk factors include:

- balance, gait or mobility problems including those due to degenerative joint disease and motor disorders such as stroke and Parkinson's disease
- taking four or more medications, in particular centrally sedating or blood pressure lowering medications
- visual impairment
- impaired cognition or depression
- postural hypotension [253] (D).

6.12 Risk factors in the home environment include:

- poor lighting, particularly on stairs
- steep stairs
- loose carpets or rugs
- slippery floors

- badly fitting footwear or clothing
- lack of safety equipment such as grab rails
- inaccessible lights or windows.

6.13 Older people who fall should, with their consent, be referred to a specialist falls service particularly those who:

- have had previous fragility fractures
- attend A&E having fallen
- called an emergency ambulance having fallen
- have two or more intrinsic risk factors in the context of any fall
- have frequent unexplained falls
- fall in hospital or in a nursing or residential care home [254] (D)
- live in unsafe housing conditions
- are very afraid of falling.

6.14 Specialist assessment [255] (A2/P) [256] (B3) should be carried out by the falls service in collaboration with primary and social care professionals. This should build on the single assessment process. It should identify risk factors associated with an older person's health and their environment and should:

- identify and diagnose any risk factors for falls associated with an older person's health (including any physical impairment) and environment, particularly those likely to respond to intervention.
- establish how the older person (and their carer) coped following any previous fall and if they have any strategies for coping with a fall in the future
- identify any psychological consequences of the fall that might lead to self-imposed restriction of activity
- lead to an investigation and treatment for osteoporotic risk.

Interventions

6.15 Interventions [257] (A1) [258] (B1) should be agreed with the older person. These may include:

- diagnosis and treatment of underlying medical problems such as eye examinations to identify visual impairment [259] (C1) correction of postural hypotension or cardiac rhythm abnormality, discontinuing inappropriate or excessive medication, changes in medication, specialist assessment for carotid sinus syndrome
- rehabilitation,[260] (P/D) including physiotherapy to improve confidence in mobility, occupational therapy to identify home and environmental hazards
- equipment to improve the safety of the older person at home
- repairs or improvements to the home and an assessment for home adaptations if warranted
- social care support.

6.16 Individually tailored exercise programmes administered by a qualified trained professional can reduce the incidence of subsequent falls in fit older people or as part of a multiple intervention approach in those at risk [261] (A1). Programmes which provide training in balance, along with individual tuition, may also help older people reduce their risk of falling. Falls prevention programmes for individuals should contain more than one intervention and focus on the individual's particular risk factors [262] (A1).

Preventing falls in service settings

6.17 Older people are at particular risk of falling in hospital and residential care or nursing care homes. Falls in these settings should be recorded on registers. (Advice on constructing a population falls register will be included in the Older People Information Strategy which will be developed shortly – Chapter 5). Critical incident analysis, following a fall will develop an awareness and learning culture amongst staff and will ensure that action taken will minimise future incidents.

Osteoporosis

Assessment of risk of osteoporosis

6.18 Strategies to prevent osteoporosis should focus on selective case finding, whereby people are identified for intervention because of fragility fracture or the presence of strong risk factors. Evidence on effectiveness [263] (C1) suggests that a prevention strategy of building up bone mass when young (particularly among females) may help prevent osteoporosis in later life. The evidence strongly suggests - as in other areas of care for older people – that intervention should be focused on people with multiple risk factors [264] (A1).

6.19 Prevention and management of osteoporosis can have a significant effect on the numbers and costs of fractures [265] (C1). Identifying those at high risk of developing osteoporosis and offering appropriate advice and treatment can reduce the number and severity of fractures in the long-term [266] (P) [267] (P). Risk factors for osteoporosis include:

- previous fragility fracture
- prolonged corticosteroid therapy
- hysterectomy, premature menopause or history of amenorrhoea (not treated to reduce risk of osteoporosis)
- risk factors e.g. liver or thyroid disease, malabsorption, alcoholism, rheumatoid arthritis and male hypogonadism
- family history of osteoporosis (including maternal hip fracture)
- low body mass < 19kg/m^2
- smoking.

6.20 Osteoporosis may also be identified through:

- DXA (Dual Energy X-ray Absorptiometer) bone mineral scan
- radiographic evidence of vertebral fracture and/or loss of height associated with vertebral fracture
- previous fragility fracture.

Treating osteoporosis

6.21 Where patients are identified as being at high risk of developing osteoporosis, investigations such as measurements of bone mineral density should be carried out in line with the Royal College of Physicians Clinical Guidelines [268] (A1/P) [269] (A1/P) on the prevention and treatment of osteoporosis. Results from the investigations will determine whether treatment such as hormone replacement therapy is appropriate. All patients should be offered lifestyle advice to reduce the risks of osteoporosis including advice on:

- adequate nutrition especially with calcium and vitamin D
- regular weight bearing exercise
- stopping smoking
- avoiding alcohol.

6.22 Drug interventions, for example, hormone replacement therapy, selective oestrogen receptor modulators (SERMS) and biophosphonates will be most cost-effective when prescribed in carefully defined, high risk, older people. Older people who are frail or housebound or who have had previous fragility fractures may benefit from supplements of calcium and vitamin D to help prevent hip fracture. Identifying these patients should be a priority in primary care [270] (A2).

Improving care and treatment following a fall

Primary care

6.23 Minor falls or injuries, and the subsequent loss of confidence, may seriously restrict an older person's ability to carry out their normal activities at home. Some older people will seek treatment from, or be referred to their GP. In addition GPs should take responsibility for assessing risk of osteoporosis and identifying those who need prevention or treatment, This is an important opportunity to identify those patients where osteoporosis drug treatment is most cost effective and most likely to achieve reductions in fracture. GPs should determine whether the older person should be referred:

- to the specialist falls service for assessment (if they meet the criteria at paragraph 6.13)
- to hospital for treatment for specific injuries
- to intermediate care services for assessment and rehabilitation.

In hospital

6.24 Older people who are taken to hospital following a fall should have their needs assessed as soon as possible after arrival in A&E to determine whether they are safe to return home, or should be admitted to intermediate care or to hospital for further assessment and management.

6.25 All older people taken to hospital with a fall should be reviewed by a member of the specialist falls service and the need (or otherwise) for a fuller assessment determined. For older people returning home from the A&E Department, this initial review can be undertaken either on-site in A&E or subsequently on an out-patient, day-patient or domiciliary basis. Comprehensive specialist assessment, if indicated, will need to take place in outpatient or day-hospital settings with access to full diagnostic and multidisciplinary facilities.

6.26 Older people exhibiting high risk for osteoporotic fracture but without any injury to their bones should be referred for assessment of Bone Mineral Density (BMD). Those with results consistent with osteoporosis should be offered appropriate therapeutic interventions [271] (A1/P).

6.27 If the older person does not need admission to hospital, or referral to intermediate care services, other options are available which offer more than discharge while awaiting review at home by a member of the specialist falls service. These include:

- discharge home accompanied by occupational therapist to assess risks in the home and provide immediate advice or plan equipment provision or home repair services
- discharge home accompanied by, and with low key support from, a voluntary agency or good neighbour scheme
- discharge home with care from statutory agencies
- discharge home with safety or mobility equipment.

6.28 Older people with suspected hip fracture [272] (A2) or other serious injury should be admitted to hospital as soon as possible after arrival in A&E. Potentially serious injuries may present in a complex fashion. For example, an older person may complain of a pain in the knee, which is in fact due to a hip fracture (referred pain). Examinations and investigations of apparently minor injuries should also determine whether a more serious injury has occurred.

6.29 Operations for fracture repair should be carried out within 24 hours of admission by experienced staff [273] (P). Following surgery, older people with hip fracture repairs should be mobilised within 48 hours where appropriate [274] (A2). They should also

be referred to the falls service for further assessment and decisions on appropriate management and back to their GP for on-going care. For those older people with complex problems, further management will require formal orthogeriatric collaboration. There are a variety of models, including hospital and intermediate care modes of delivery [275] (A1). The most appropriate models should be agreed locally between the falls service, the orthopaedics service, the hospital-based specialist service for older people and intermediate care services. At least one general ward in the acute hospital should be developed as a centre of excellence for orthogeriatric practice.

6.30 Discharge from hospital needs careful and early planning by multidisciplinary teams fully involving older people and their carers [276] (A2) [277] (B1) [278] (C1). The specialist falls service will be responsible for co-ordinating the assessment and individual care plan for discharge and for ensuring that arrangements for support are in place prior to discharge. This assessment should build on any assessment information already held on the older person.

Rehabilitation

6.31 Many older people will need rehabilitation after a fall whether they have been treated in hospital or remain at home. The aim is to maximise an older person's independence and enable them to carry out their normal activities of daily living and social participation. Effective rehabilitation will be responsive to the wishes of older people, involve a number of agencies and disciplines, be available when required and work towards identified outcomes. A combination of clinical, therapeutic and social interventions may be needed to address an older person's health and social care needs and to reduce the risk of further falls [279] (D).

6.32 Rehabilitation strategies [280] (C1) [281] (C1) should aim to:

- increase the older person's stability during standing, transferring, walking and other functional movement by:
  - balance training
  - strengthening the muscles around the hip, knee and ankle
  - increasing the flexibility of the trunk and lower limbs
  - providing appropriate mobility and safety equipment
- help older people regain their independence and confidence to relearn and practise their previous skills in every day living, and to cope successfully with increasing threats to their balance and increasingly demanding functional tasks

- improve the safety of the older person's environment by, with their consent, removing, replacing or modifying any hazards

- teach awareness of hazards and how to avoid them

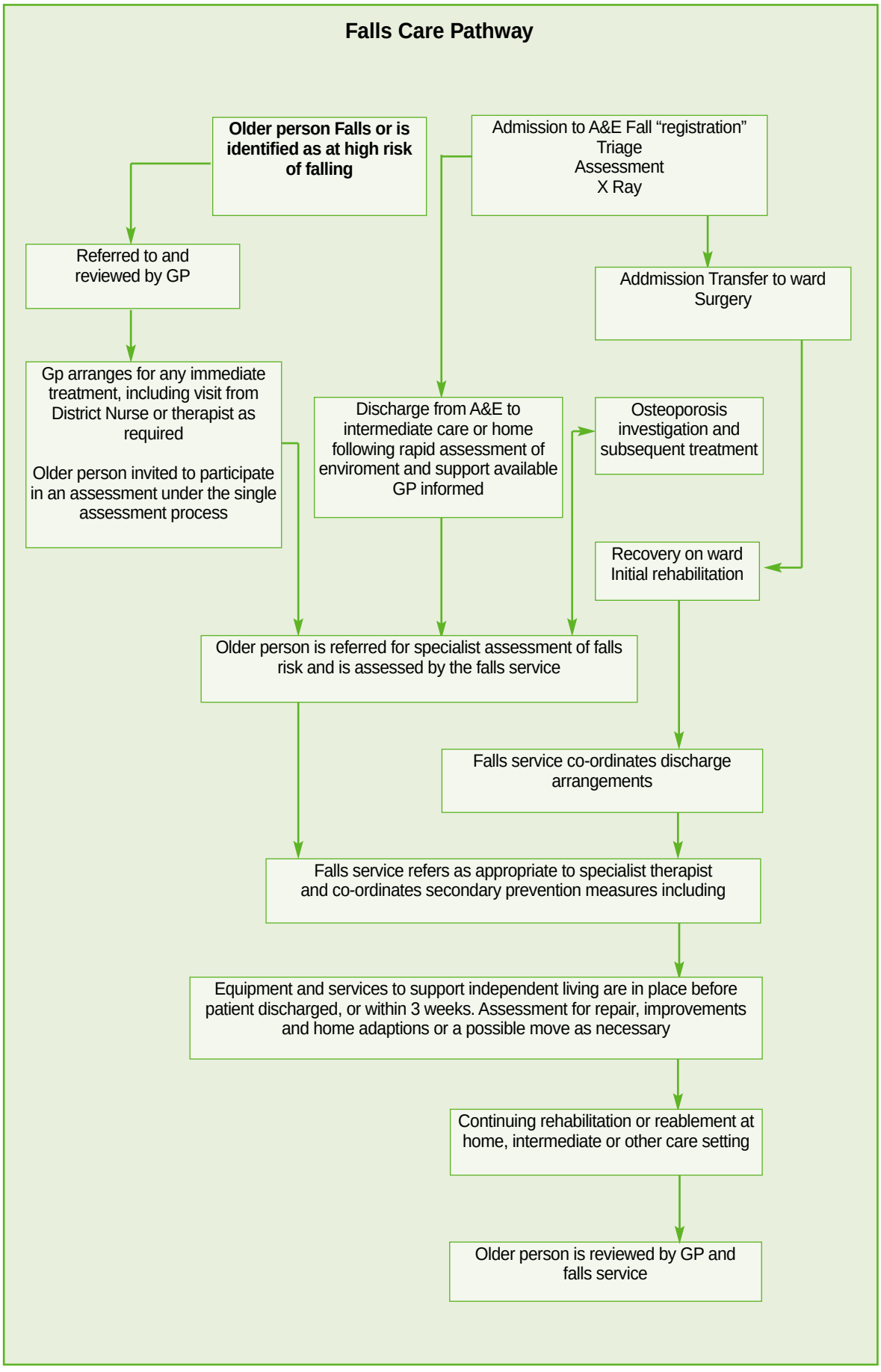
- teach the older person strategies to cope with any further fall and prevent a long lie. If possible the person should be trained how to get up from the floor. Otherwise methods for summoning help, including use of community alarms, should be rehearsed. Strategies for preventing hypothermia and pressure sores should also be discussed

- establish a network of community support and supervision if this is needed, including the voluntary sector and organisations such as the National Osteoporosis Society, many of whom have befriending services to relieve isolation and support rehabilitation of older people.

Long-term support

6.33 Longer-term support may be required. Care practices should not aim to restrict mobility, but explore how older people can manage safely in their own home, or in a residential or nursing home. The least invasive methods of intervention and management of care should be used. The use of community alarm systems (including pendants and phone-based systems) for people who have fallen to summon help can increase the security and confidence of an older person. But they are only valuable if the person is conscious or within reach of a pull cord. The community equipment services initiative (Standard 2) will include proposals to extend the use of 'tele-care' or environmental control technologies (including passive alarms) capable of providing added safety for those who are particularly vulnerable.

6.34 Older people who have fallen should be assessed and reviewed regularly to monitor their needs. Longer-term social and emotional support may be required to minimise any loss of independence caused by the effects of the fall. This may include provision of personal or domestic care services or introduction to social activities to prevent social isolation and depression.


Falls Care Pathway
Older person Falls or is identified as at high risk of falling
Admission to A&E Fall "registration"
Triage
Assessment
X Ray
Referred to and reviewed by GP
Addmission Transfer to ward
Surgery
Gp arranges for any immediate treatment, including visit from District Nurse or therapist as required
Older person invited to participate in an assessment under the single assessment process
Discharge from A&E to intermediate care or home following rapid assessment of enviroment and support available GP informed
Osteoporosis investigation and subsequent treatment
Recovery on ward
Initial rehabilitation
Older person is referred for specialist assessment of falls risk and is assessed by the falls service
Falls service co-ordinates discharge arrangements
Falls service refers as appropriate to specialist therapist and co-ordinates secondary prevention measures including
Equipment and services to support independent living are in place before patient discharged, or within 3 weeks. Assessment for repair, improvements and home adaptions or a possible move as necessary
Continuing rehabilitation or reablement at home, intermediate or other care setting
Older person is reviewed by GP and falls service

Service Model

6.35 The NHS and councils should ensure the delivery of services for older people who are at risk of falling or who have fallen. This will include:

- health promotion initiatives designed to reduce the risk factors for osteoporosis and falls in the general population (Standard 8)
- using the single assessment process and community equipment services to promote older people's safety and independence (Standard 2)
- developing a falls service
- providing support for older people who have fallen.

6.36 Staff in community health, primary and social care settings should be trained to recognise when older people are at risk of falling and be able to refer them to the falls service for assessment. Assessments should identify the risk factors for falls and osteoporosis and offer appropriate interventions.

6.37 A falls service should be set up. The local health and social care system should ensure that it is in place. This should be part of the overall specialist services for older people in both hospital and community settings. It may have its main operational base in an acute hospital, day hospital or intermediate care setting, but should include:

- consultant in old age medicine
- nurses
- physiotherapists
- occupational therapists
- social workers
- pharmacists
- chiropodists/podiatrists.

6.38 The team should have access to:

- dietitians
- optometrists

- orthotists
- opthalmologists
- audiologists
- trained bi or multi-lingual co-workers to reflect the needs of local populations
- assessment for bone mineral density.

6.39 These team members are likely to work part-time in the falls service and have other responsibilities.

6.40 The team should develop referral arrangements to all medical and surgical subspecialities, such as osteoporosis and cardiology and well as to facilities for specialist syncope assessment or to day hospitals as required. Protocols should be developed for the management of older people who have fallen through consultation and liaison with Primary Care Groups and Trusts, social services and housing agencies.

6.41 Staff in A & E, imaging and orthopaedics should work with the falls service to examine current practice and agree new procedures for the care and management of older people with osteoporotic hip fracture or other serious injuries on admission.

6.42 Prior to discharge, the needs of patients and their carers for care and support at home should be identified. Falls services should work with primary and social care professionals to ensure that these needs are met and support packages are in place before patients return home. This includes making sure patients are advised about how they can reduce their risk of a further fall and further fractures and making whatever arrangements are required to provide long-term support.

Actions

Every health system should, in partnership with councils:

- review the local system of services for falls, including the prevention of falls, identifying those at risk and minimising this risk, improving the care of those who have fallen, including rehabilitation and the continuing care for those whose falls have longer term consequences
- agree and implement local priorities to reduce the incidence of falls, and to reduce the impact which a fall can have on health, well-being and independence including appropriate interventions and advice to prevent osteoporotic fracture.

Milestones

April 2003	Local health care providers (health, social services and the independent sector) should have audited their procedures and put in place risk management procedures to reduce the risk of older people falling.
April 2004	The HImP, and other relevant local plans developed with local authority and independent sector partners, should include the development of an integrated falls service.
April 2005	All local health and social care systems should have established this service.

Standard Seven: Mental health in older people

Aim

To promote good mental health in older people and to treat and support those older people with dementia and depression**.**

Standard

Older people who have mental health problems have access to integrated mental health services, provided by the NHS and councils to ensure effective diagnosis, treatment and support, for them and for their carers.

Rationale

7.1 Mental health problems among older people exact a large social and economic toll on patients, their families and carers, and the statutory agencies [282] (P). The annual direct cost to the NHS in England of caring for people with Alzheimer's disease was estimated at over £1 billion in 1993 [283] (A2). Taking into account the costs of informal caring and the costs to all statutory agencies, the total cost of caring has been estimated to be £6 billion [284] (D) [285] (A2). There is considerable variation around the country in mental health services in both health and social care for older people [286] (C1/C2).

7.2 Under-detection of mental illness in older people is widespread, due to the nature of the symptoms and the fact that many older people live alone [287] (P). Depression in people aged 65 and over is especially under-diagnosed [288] (B3) [289] (P) and this is particularly true of residents in care homes [290] (B3). Mental and physical problems can also interact in older people making their overall assessment and management more difficult. And mental health problems may be perceived by older people and their families, as well as by professionals, as an inevitable consequence of ageing, and not as health problems which will respond to treatment.

7.3 Older people from black and minority ethnic communities need accessible and appropriate mental health services [291] (P). Unfortunately, for a number of reasons, services may be neither readily accessible nor fully appropriate. Assessments may be culturally biased making it difficult for needs to be properly identified or assumptions may be made about the capacity and willingness of families to act as primary carers for their older relatives. Information about services may not be effective if this relies on translated leaflets or posters rather than on more appropriate mechanisms. Where this has happened there may be distrust of agencies by some black and minority ethnic communities.

7.4 Older people with learning disabilities may also have difficulty obtaining appropriate mental health care. Some will be dependent on family or paid carers who may not be alert to their mental health needs. Others with less significant learning disabilities may not be in contact with services on a day to day basis, and may not recognise the need to seek help or know how to access it.

7.5 Although the focus tends to be on depression and dementia, which are particularly common in older people, illnesses such as schizophrenia also occur [292] (B3) [293] (A2). Where an older person has severe mental illness due to a psychotic illness such as schizophrenia, they will require the packages of care set out in the NSF for Mental Health [369] (P), and the same standards should apply as for working age adults. For these people care should be provided within the framework of the Care Programme Approach.

7.6 Recent policy guidance addresses the integration of the Care Programme Approach with Care Management for adults of working age in contact with secondary mental health services, and stresses that the same principles are relevant to the care of older people with mental health problems[294] (P).

Key interventions

7.7 Mental health services for older people should be able to respond effectively to individual needs, and take account of the social and cultural factors affecting recovery and support. Improving prevention, care and treatment of mental health problems in old age depends on [295] (D):

- promoting good mental health
- early recognition and management of mental health problems
- access to specialist care.

7.8 Improving care of older people with depression or dementia depends on providing high-quality evidence-based care, within this broader framework. Carers of older people with mental health problems may also need information, advice, and practical help to support them in caring for the older person.

7.9 Mental health services for older people should be community-orientated and provide seamless packages of care and support for older people and their carers. [296] (B1). The hallmark of good mental health services is that they are: comprehensive, multidisciplinary, accessible, responsive, individualised, accountable and systematic. [297] (P).

Promoting mental health

7.10 Promoting mental health is as important in older people as in younger people. Standard 8 sets out the interventions at population level to promote good mental health - educational activities, and creative and social pursuits. Specific additional interventions which will promote mental health include tackling social isolation, providing bereavement support and suicide prevention [298] (B3). Key elements of suicide prevention will include health maintenance and promotion, treatment of depression in primary care, and screening for suicidal thinking coupled with direct prevention efforts

7.11 Older people in residential care and nursing homes and those receiving day care should be able to participate in a range of stimulating group or one to one activities. These can include reminiscence, art-therapy, news-based discussions, aromatherapy, games and quizzes, adult education and drama. Older people should be offered a choice of activities matched to their needs and preferences. An appropriate environment can also aid orientation and help to avoid visual and sensory confusion. This will involve good quality design, lighting, colour contrast and accessible accommodation.

Early recognition and management of mental health problems

7.12 Early and accurate diagnosis of mental health problems enables older people and those caring for them to understand what is happening to them, to access appropriate help and to meet their care needs. Co-existing physical problems should also be diagnosed and treated [299] (A2), [300] (A1), [301] (A2). Whilst specialist services will continue to be available to support the care of those with the greatest problems, many people will be diagnosed and cared for within primary care, with the support of social services. The Department of Health will be commissioning exemplar protocols for local agreement to support the integrated care of mental health problems in older people.

7.13 Older people with mental health problems are a particularly vulnerable group who may come into contact with a number of health and social care services [302] (B3). These agencies should have systems in place to communicate with one another, share information, to understand how and when to refer older people on to appropriate services, and to review the older person's needs as changes in circumstances or conditions arise [303] (CI/P) [304] (P).

7.14 Carers of older people with mental health problems often need support. They may have physical and mental health needs of their own. They also need information, advice, and practical help to support them in caring for the older person.

7.15 Standard 2 describes a single assessment process for health and social care needs, including an individual care plan which should be used by all agencies for managing the care and treatment of older people including those with mental health problems.

7.16 Support should be available to help older people with mental health problems live safely in the familiarity of their own homes. Social care and other services should include provision covering, for example, personal care, care of the home, relationships, accommodation, finance, and support to carers.

Access to Specialist care

7.17 Specialist mental health services should be available to be consulted about and treat the most common mental health disorders in old age (depression, dementia, schizophrenia, mania and confusional states) and the other less common disorders including anxiety, delirium, and dependency problems. They should provide a range of services from diagnosing and treating more complex problems, to providing community and in-patient services for those with a clinical need. The emphasis should be on promoting the independence of older people with mental health problems and supporting them, and their carers, in the community wherever possible and practical.

7.18 In-patient admission may be indicated for severe mental illness, especially if there is a risk to the safety of the patient or others, or where particular problems require more intensive assessment and treatment. A full range of psychological and physical treatments should be available.

7.19 The NHS and local councils should work with care home providers in their areas to develop a range of services to meet the needs of older people with mental health problems, including specialist residential care places for older people with dementia.

Depression

7.20 At any one time, around 10-15% of the population aged 65 and over will have depression [305] (A2). More severe states of depression are less common, affecting about 3-5% of older people. Depression can severely affect the quality of life and may adversely affect physical health [306] (A2).

7.21 Depression is a disorder of mood and may be characterised by:

- low mood and feelings of sadness
- loss of enjoyment

- poor memory and concentration
- tiredness and fatigue
- unexplained pain
- feelings of guilt
- suicidal thoughts or impulses
- delusions.

7.22 Depression may be triggered by a variety of factors such as bereavement and loss, life changes such as unemployment, retirement and social isolation. Older people can also become depressed because of increasing illness or frailty, or following a stroke or a fall.

7.23 Early recognition [307] (P) and prompt treatment of depression can reduce distressing and sometimes apparently inexplicable symptoms and prevent more serious consequences such as physical illness, adverse effects upon social relationships, self-neglect or, in the more serious cases, self-harm or suicide.

7.24 The diagnosis of depression involves an assessment of psychiatric, psychological and social factors. This means:

- history taking and examination of mental state to assess severity of depression in particular any suicidal risk. Any possible causal factors e.g. bereavement, social isolation, alcohol abuse, prescribed medicines, should be identified
- using assessment scales to aid diagnosis [308] (D)
- carrying out a physical examination and investigations.

7.25 Some of this information may already have been collected where someone has been through the single assessment process (Standard 2). When applying tests for depression, assessors should take steps to counter any cultural biases in the questions and in how the responses are evaluated.

7.26 Treating any co-existing physical illnesses, and improving the general health of older people who present with symptoms of possible depression, will further improve their quality of life. Strategies for recovery should include enhancing social networks and sources of social support.

7.27 The treatment of depression involves:

- making the diagnosis and giving the person an explanation of their symptoms
- assessment of risk, especially suicidal intent, and looking for co-existing physical problems, especially possible dementia or physical illness
- giving information about the likely prognosis and options for packages of care
- making appropriate referrals to help with the fears and worries, distress, practical and financial issues that will affect the person and their carer
- prescribing antidepressant medicines [309] (D) taking into account the use of therapeutic dosages, anticipated side-effects, known contraindications of antidepressants and being sure that older people are able to take their medicines
- offering psychological therapies [310] (D/P) alongside antidepressant drug treatment. The evidence suggests that the most effective treatments for depression are cognitive behaviour therapy, interpersonal therapy or brief, focused analytic therapy, offered by a trained person. Counselling in primary care may also be effective for depression at the less severe end of the spectrum [311] (B1).

7.28 Clinicians should prescribe according to available published guidance for effective health care.

7.29 Treatment, involving adequate doses of antidepressants, should last a minimum of six weeks. In practice, longer may be required, and improvement can take place over several months. Usually treatment will probably need to be continued for six months and often for up to two years.

7.30 Referral to the specialist mental health service should be considered for those suspected with depression if:

- diagnosis is uncertain
- there are complex symptoms, for example, multiple physical problems
- there is a suicide risk. Risk factors include past attempt, painful medical condition, bereavement, severity of current depression, alcohol dependence, being male, and for some, transition from employment

- there has been an inadequate response to first line treatments
- the older person has psychotic symptoms such as delusions.

7.31 Specialist treatment can include:

- non-pharmacological treatments as first line management wherever possible, such as cognitive behaviour therapy and individual counselling and support
- further and possibly more intensive antidepressant treatment for example dual drug therapy
- supportive psychotherapy for bereavement or other forms of crisis
- ECT for very severe depression, for example, if characterised by delusions leading to extreme self-neglect or indicators of suicide.

Dementia

7.32 Dementia is a clinical syndrome characterised by a widespread loss of mental function, with the following features:

- memory loss
- language impairment (having difficulty finding words especially names and nouns)
- disorientation (not knowing the time or place)
- change in personality (becoming more irritable, anxious or withdrawn; loss of skills and impaired judgement)
- self neglect
- behaviour which is out of character (for example, sexual disinhibition or aggression).

7.33 Dementia has a number of causes, the most common of which are:

- Alzheimer's disease - this causes up to 60% of cases of dementia. It is characterised by memory loss and difficulties with language in its early stages, and gradually becomes more severe over several years

- vascular dementia - this is the consequence of strokes and/or insufficient blood flow to the brain and causes up to 20% of cases of dementia. It has a more varied clinical picture depending on which parts of brain are most affected. In any individual, Alzheimer's disease and vascular dementia can co-exist

- dementia with Lewy bodies - this causes up to 15% of dementia cases and is characterised by symptoms similar to Parkinson's Disease as well as hallucinations, and a tendency to fall.

7.34 The prevalence and incidence of dementia increase with age [312] (B3). Approximately 600,000 people in the UK have dementia. This represents 5% of the total population aged 65 and over, rising to 20% of the population aged 80 and over. Dementia can also occur before the age of 65; there are about 17,000 people with dementia in younger age groups in the UK. Of the people with dementia, 154,000 live alone [313] (D/P). It is estimated that by 2026 there will be 840,000 people with dementia in the UK, rising to 1.2 million by 2050.

7.35 For older people with suspected dementia, early diagnosis [314] (D), [315] (D), [316] (P) gives access to treatment, allows planning of future care, and helps individuals and their families come to terms with the prognosis. Diagnosis also aids better understanding of any changes in memory, behaviour and personality. If dementia is not diagnosed early, carers can become demoralised due to lack of support and having to cope with apparently unexplained behavioural changes. Early onset dementia may present major difficulties in diagnosis, where the first signs may be poor memory or failing performance at work. Providing support is also challenging, as the impact of the condition upon those affected and their families may be devastating.

7.36 Initial awareness of developing dementia may start with the older person, their family or carer, a neighbour or even the police. Many older people come into contact with health or social care providers either directly, through referral for assessment, or during health checks. People diagnosed with dementia should be assessed for their social care and other needs, under the single assessment process (Standard 2).

7.37 Initial diagnosis of dementia [312] (P) involves:

- taking a history. This should include speaking to someone who knows the person well

- using assessment scales to aid diagnosis to estimate the severity of cognitive impairment where there is sensitivity to asking direct questions about memory

- carrying out a physical examination and investigations such as blood and urine tests

- being able to distinguish between dementia, delirium, depression and the effects of drugs. While memory loss is a universal symptom, psychiatric symptoms and behavioural disturbances (such as depression, wandering, agitation, aggression, hallucinations and paranoid ideas) and problems with activities of daily living are also often associated with dementia.

7.38 As with depression, professionals should ensure that tests for dementia and the subsequent interpretation of results, are free of cultural bias.

7.39 Treatment of dementia [318] (A2) always involves:

- explaining the diagnosis to the older person and any carers and where possible giving relevant information about sources of help and support

- giving information about the likely prognosis and options for packages of care

- making appropriate referrals to help with fears and worries, distress, practical and financial issues that may affect the person and their carer

- at all stages emphasising the unique qualities of the individual with dementia and recognising their personal and social needs [319] (D)

- using non-pharmacological management strategies [320] (P) such as mental exercise, physical therapy, dietary treatment alongside drug therapy [321] (D/P). These may be beneficial in reducing the impact or slowing down the progression of the disease

- prescribing antipsychotic drugs for more serious problems, such as delusions and hallucinations, serious distress or danger from behaviour disturbance.

7.40 The National Institute for Clinical Excellence (NICE) has recently recommended that the drugs donepezil, rivastigmine and galantamine should be made available in the NHS as one component of the management of those people with mild and moderate Alzheimer's disease (AD) under the following conditions:

- mini mental state (MMSE) score over 12 points

- a diagnosis of Alzheimer's disease made in a specialist clinic

- treatment to follow specialist assessment, including tests of cognitive, global and behavioural functioning

- compliance with treatment is likely
- treatment to be initiated by relevant clinical specialists - GPs can take over prescribing under agreed shared care protocols
- review response to treatment after 2-4 months, and only continue if positive evidence of benefit
- patients continuing on the drug should be reviewed by MMSE score and by global, functional and behavioural assessment every six months.

7.41 There has been concern about the prescription of antipsychotic drugs to older people with dementia, especially those in residential and nursing home care [322] (B3). Such drugs may hasten cognitive decline and may cause increased deaths [323] (B3). In dementia with Lewy bodies, side effects may be extremely serious [324] (C1). However, there is evidence that antipsychotics are moderately effective for some behaviour problems associated with dementia [325] (P). There is emerging evidence that the newer antipsychotic neuroleptic drugs have fewer side effects than the older drugs. Older people with dementia should be considered for treatment with the newer drugs. Clinicians should prescribe according to available published guidance for effective health care [326] (P) [327] (P) [328] (P).

7.42 Referral to the specialist mental health service should be considered for those with suspected dementia:

- if diagnosis is uncertain
- if certain behavioural and psychological symptoms are present, for example, aggressive behaviour
- if there are safety concerns, for example, if an older person is wandering
- for risk assessment, for example, if the older person is thought to be at risk of abuse or self harm
- if there is a need for specialist assessment of dementia, for example, testamentary capacity or driving
- for consideration of treatment of antidementia drugs in accordance with local protocols
- if the older person has complex or multiple problems, for example, where an older person needs specialist methods of communication due to their sensory impairments

- where there is dual diagnosis, for example, possible dementia and learning disability or dementia and other severe mental disorders.

7.43 Specialist treatment includes:

- antidementia drug treatment [329] (P) based on guidance set out by NICE and locally agreed prescribing protocols

- specialist care for people suffering from behavioural and psychological symptoms of dementia, including:

  - advice on behavioural management for people in residential care and nursing homes [330] (B1) [331] (B1)

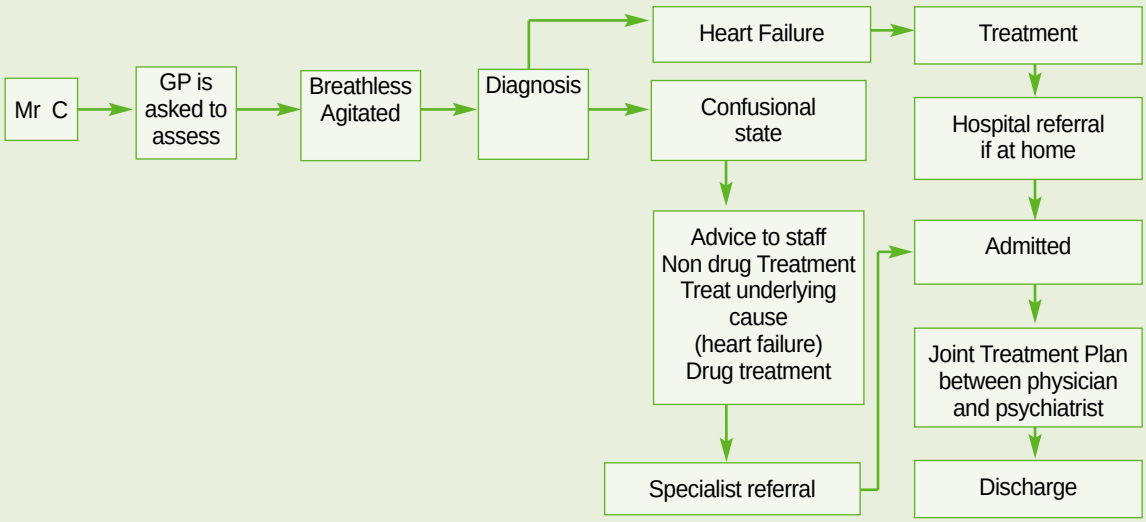
  - drug treatment with antipsychotic and other forms of medication, such as antidepressants, as indicated with the treatment being reviewed on a regular basis

  - individual and family counselling and support

- interventions for carers of people with dementia, for example counselling services or short breaks.

CARE PATHWAYS

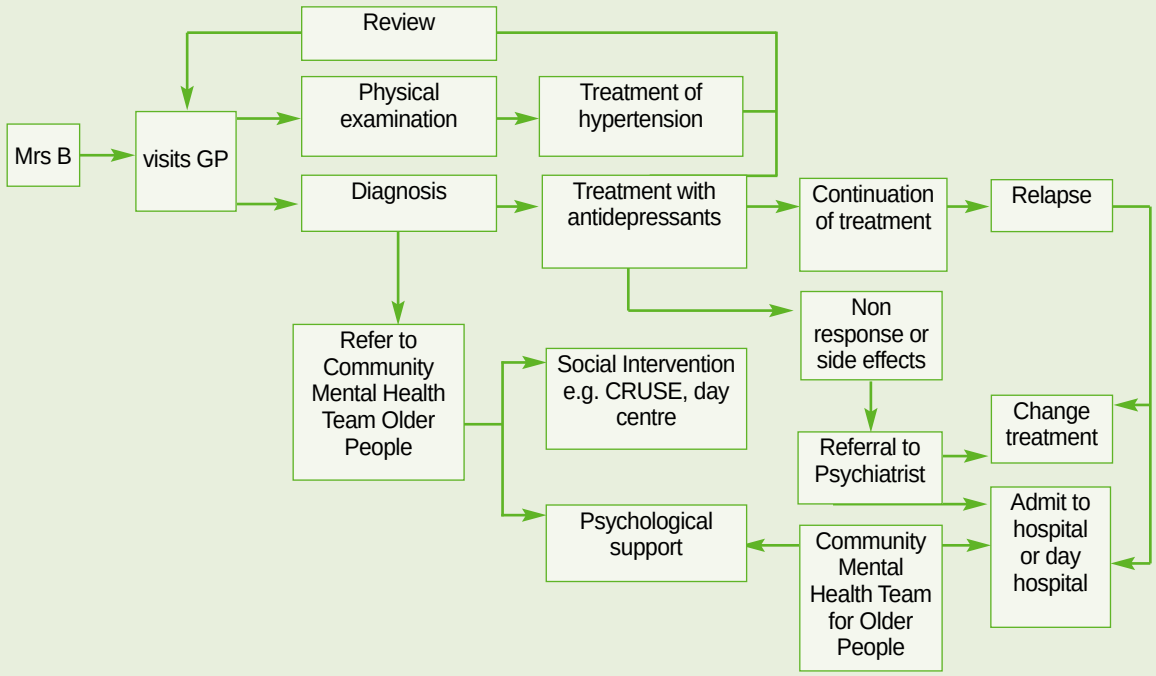
Confusional state



ENTRY **DIAGNOSIS** **TREATMENT**

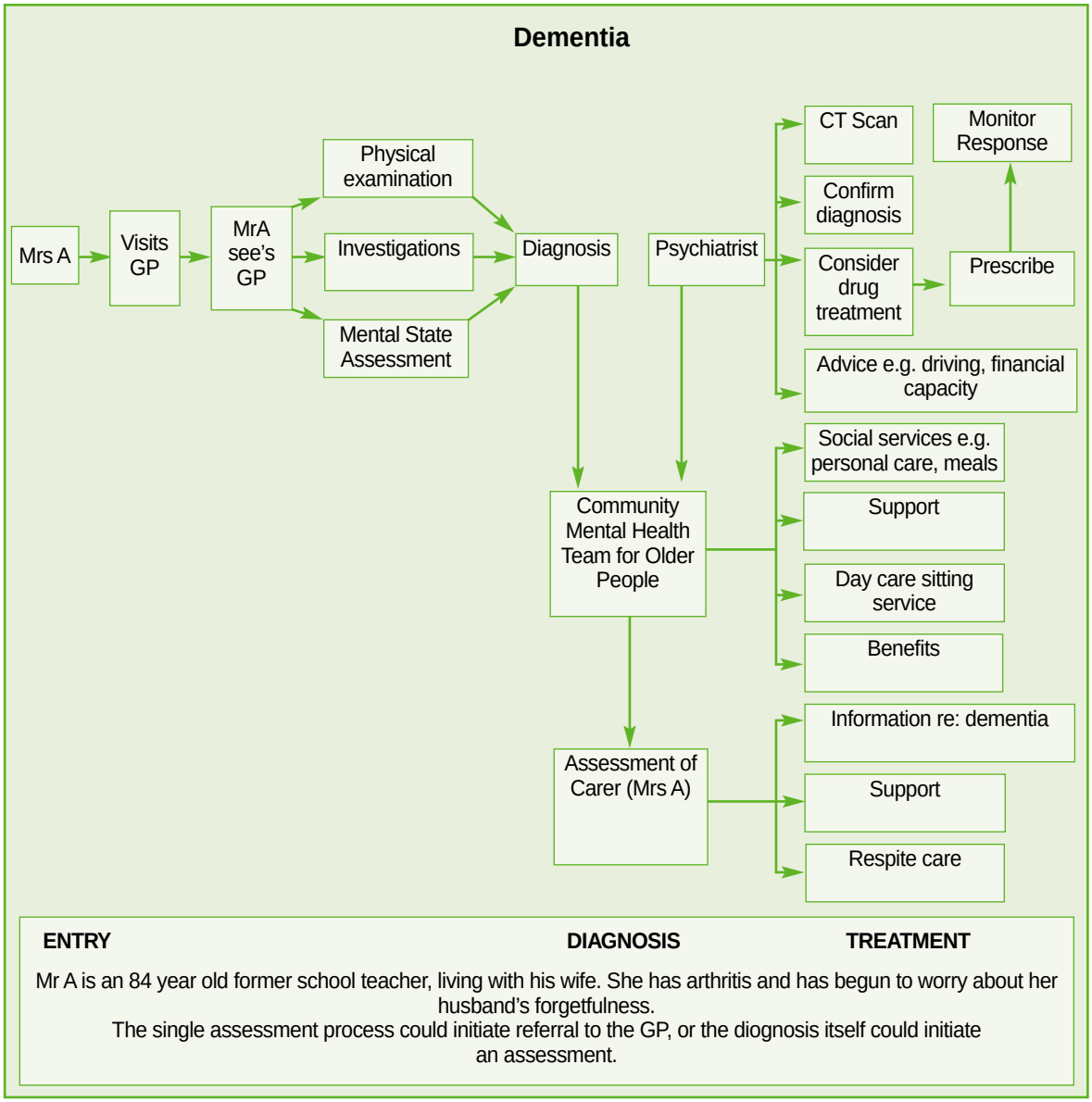
Mr C is a 79 year old man living in a reidential home. The single assessment process could initiate referral to the GP, or the diagnosis itself could initiate an assessment.

Depression



ENTRY **DIAGNOSIS** **TREATMENT**

Mrs B is 71. Her husband died a year ago and she still feels she 'hasn't got over it'. She cries a lot and can't sleep. She is losing weight and feels very tired. The single assessment process could initate referral to the GP, or the diagnosis itself could initate an assessment.


Dementia
Mrs A
Visits GP
MrA see's GP
Physical examination
Investigations
Mental State Assessment
Diagnosis
Psychiatrist
CT Scan
Monitor Response
Confirm diagnosis
Consider drug treatment
Prescribe
Advice e.g. driving, financial capacity
Social services e.g. personal care, meals
Support
Day care sitting service
Benefits
Community Mental Health Team for Older People
Assessment of Carer (Mrs A)
Information re: dementia
Support
Respite care
ENTRY
DIAGNOSIS
TREATMENT
Mr A is an 84 year old former school teacher, living with his wife. She has arthritis and has begun to worry about her husband's forgetfulness.
The single assessment process could initiate referral to the GP, or the diognosis itself could initiate an assessment.

Service model

7.44 A comprehensive mental health service for older people will involve:

- promoting good mental health in older people [332] (D/P)
- early detection and diagnosis
- an integrated approach to assessment, care planning and treatment planning [333] (P)
- support for carers and
- providing a specialist mental health service for older people.

7.45 Primary Care Groups and Trusts should ensure that there is integrated planning and delivery of local services to support the detection, diagnosis and treatment of mental health problems in primary care. PCG/Ts should be supported by specialist services, where appropriate. Local councils commissioning social care should require providers to ensure that staff can recognise signs of developing mental health problems, refer older people appropriately for assessment and provide appropriate care whether older people are living at home or in a residential care setting.

7.46 The specialist mental health service for older people will diagnose and treat more complex cases and work with the specialist mental health service for working age adults, learning disability services, primary and social and housing services, to deliver an integrated service.

7.47 Core team members of the specialist mental health service should include:

- consultant psychiatrists specialising in mental health problems in old age
- community mental health nurses
- clinical psychologists
- occupational therapists
- social workers.

7.48 The specialist mental heath service for older people should also have agreed working and referral arrangements with:

- speech and language therapists
- physiotherapists

- dietitians
- chiropodist/podiatrists
- community dental services
- pharmacists
- district nurses
- health visitors
- trained bi- or multi-lingual co-workers
- housing workers.

7.49 Hospital based services provided by the specialist mental health services should include:

- acute admission and rehabilitation beds. These may be separate facilities for patients with dementia and those with other mental health problems
- day hospitals to offer intensive assessment and treatment to people with functional disorders and dementia, including aftercare following in-patient admissions and rehabilitation and support for older people with long term mental illness such as schizophrenia
- memory clinics.

7.50 The £120 million programme to convert many Nightingale wards will include the conversion of some wards to accommodation particularly suitable for older people with dementia.

7.51 Patients with complex mental health needs can and should be treated and supported in the community and wherever practicable at home. Community based mental health services should include:

- domiciliary care
- out-patient facilities, including combined old age medicine/old age psychiatry clinics. Such facilities may be in health centres and community settings as well as in hospital outpatient departments. People can also be followed up at home when this is more appropriate

- outreach facilities, including telecare and environmental technologies
- day care, providing a range of stimulating group and one to one activities.

7.52 Short-term breaks and other support services should be available for carers of older people with mental health problems, and this should include out of hours and weekend provision.

7.53 A core team member should act as a care co-ordinator for each older person referred to the specialist mental health service throughout his or her contact with the service.

7.54 Specialist mental health services should provide training and advice for other professionals and staff whose responsibilities include providing care and treatment for older people with mental health problems. Specialist mental health teams should work with primary care trainers to develop training in:

- at least one screen for cognitive impairment
- one depression screen
- assessment of suicide risk.

7.55 Training to work with older people from different cultures and backgrounds should be available.

7.56 Specialist mental health services for older people should provide advice and outreach to those providing:

- primary care
- residential care and nursing homes, and sheltered housing
- domiciliary care
- day care
- hospital care, where there are known to be particularly high levels of mental health problems in older people.

7.57 Working arrangements and protocols should be developed for making and accepting referrals from other hospital and mental health specialists, primary and social care services and the adult mental health service. These arrangements should ensure:

- there is continuity of care when patients transfer between specialist mental health service for working age adults and the specialist service for older people
- patients with both physical illness and mental health problems can receive prompt and effective assessment and treatment
- there are treatment protocols for use of antidementia drugs.

7.58 Specialist teams providing mental health services should make links to voluntary organisations and support groups such as Dementia Voice and the Alzheimer's Society.

Action

The NHS, and councils, should:

- review the local system of mental health services for older people, including the arrangements for mental health promotion (Standard 8), early detection and diagnosis, assessment, care and treatment planning, and access to specialist services
- review current arrangements, in primary care and elsewhere, for the management of depression and dementia, and agree and implement local protocols across primary care and specialist services, including social care. In time, this should be extended to cover all mental health problems in older people
- review current arrangements, in primary care and elsewhere, for the management of dementia in younger people, and agree and implement a local protocol across primary care and specialist services, including social care.

Milestones

April 2004

HImPs and other relevant local plans developed with local authority and independent sector partners, should have included the development of an integrated mental health service for older people, including mental health promotion.

PCG/Ts will have ensured that every general practice is using a protocol agreed with local specialist services, health and social services, to diagnose, treat and care for patients with depression or dementia.

Health and social care systems should have agreed protocols in place for the care and management of older people with mental health problems.

Standard Eight: The promotion of health and active life in older age

Aim

To extend the healthy life expectancy of older people.

Standard

The health and well-being of older people is promoted through a co-ordinated programme of action led by the NHS with support from councils.

Rationale

8.1 Growing old has been seen to represent a period of increasing dependency, as physical strength, stamina and suppleness decline, and the individual has to cope with chronic or long term conditions. But chronic degenerative disease, disability and ill health are not an inevitable consequence of ageing. The NHS and local partners should re-focus on helping and supporting older people to continue to live healthy and fulfilling lives [334] (C2/P).

8.2 There is a growing body of evidence to suggest that the modification of risk factors for disease even late in life can have health benefits for the individual; longer life, increased or maintained levels of functional ability, disease prevention and an improved sense of well-being [335] (P) [336] (D/P). Integrated strategies for older people aimed at promoting good health and quality of life, and to prevent or delay frailty and disability can have significant benefits for the individual and society [337] (P) [338] (B3). Action can be taken by the NHS and councils to:

- prevent or delay the onset of ill health and disability
- reduce the impact of illness and disability on health and well-being,
- identify barriers to healthy living (for example cultural appropriateness of services)
- work in partnership with other agencies to develop healthy communities which support older people to live lives which are as fulfilling as possible. This will include working with council services such as leisure and lifelong learning.

8.3 Health promotion activity should take account of differences in lifestyle and the impact of cultural/religious beliefs. For instance, it would not be appropriate to advise a strict Muslim woman to take up a certain form of exercise which would mean that she would have to wear scant clothes for exercise or be in the same room as men. It is therefore important to consult with local black and minority ethnic communities and work across agencies to identify and develop appropriate and accessible forms of exercise/physical activity.

8.4 Activities which can promote healthy active life for older people include:

- access to mainstream health promotion and disease prevention programmes
- health promotion activities of specific benefit to older people, tailored where necessary to reflect cultural diversity [339] (A2)
- wider initiatives involving a multi-sectoral approach to promoting health, independence and well-being in old age [340] (B3), [341] (B3), [342] (B3).

Access to mainstream health promotion and disease prevention programmes

8.5 Older people should have access on the basis of need, not age, to health promotion activities announced in the Mental Health NSF, Coronary Heart Disease NSF and the NHS Cancer Plan. Breast cancer screening, smoking cessation and hypertension management have the best evidence for effectiveness in older people.[343] (A1), [344] (B1), [345] (A1), [346] (A1), [347] (A1), [348] (B1), [349] (A1).

MENTAL HEALTH National Service Framework

Standard One:
Health and social services should:

- promote mental health for all, working with individuals and communities
- combat discrimination against individuals and groups with mental health problems and promote social inclusion.

By April 2001 services should have an evidence-based mental health promotion strategy in place based on local needs assessment.

CORONARY HEART DISEASE National Service Framework

Standard One:
The NHS and partner agencies should develop, implement and monitor policies that reduce the prevalence of coronary risk factors in the population, and reduce inequalities in risks of developing heart disease.

Standard Two:
The NHS and partner agencies should contribute to a reduction in the population in the prevalence of smoking in the local population.

Standard Three:
General practitioners and primary care teams should identify all people with established cardiovascular disease and offer them comprehensive advice and appropriate treatment to reduce their risks.

Standard Four:
General practitioners and primary care teams should identify all people at significant risk of cardiovascular disease but who have not yet developed symptoms and offer them appropriate advice and treatment to reduce their risks.

THE NHS CANCER PLAN

The NHS Cancer Plan sets out new ambitions for cancer services, including:

- reducing the risk of cancer through reducing smoking and promoting a healthier diet
- raising public awareness with better, more accessible information
- extending cancer screening. Including breast screening to all women up to the age of 70 and making it available on request for women over 70
- improving cancer services in the community. Providing funding for a lead clinician for cancer in every primary care trust and investing in training and support in palliative care for district and community based nurses.

Health promotion activities which are of specific benefit to older people

8.6 Strong evidence [350] (A2) exists that older people benefit from:

- increasing physical activity
- improved diet and nutrition
- immunisation and management programmes for influenza.

8.7 Specific strategies for preventing falls and their consequences and for preventing stroke are described in Standards 6 and 7.

Increasing physical activity

8.8 Any form of social, physical or mental activity is good for health and well-being. The adoption of a more physically active lifestyle can add years to life for previously inactive older people, but perhaps more importantly, physical activity can significantly enhance mobility and independence and improve quality of life [351](B3). Analysis shows that a large proportion of people aged over 50 are sedentary (take less than half an hour moderate intensity physical activity a week) and that few take levels of activity recommended for improving health (30 minutes of moderate physical activity on at least five occasions a week – for example, brisk walking, household chores such as vacuuming or social activities like dancing). Adapted exercise, even for very frail older people can help strength, mobility and balance, and can reduce the risk of falling. Activity and exercise which improve physical health, increase the sense of well being and also tend to promote more positive social interaction and will in turn promote positive mental health. Activity can include educational, creative and social pursuits as well as physical exercise [352] (A2), [353] (B3), [354] (P), [355] (D), [356] (A1).

Improving diet and nutrition

8.9 Being either overweight or underweight can have a detrimental effect on an older person's health and well-being. Being overweight is related to a higher risk of developing diabetes, and a higher prevalence of osteoarthritis of the knees. Being underweight can predispose an individual to pressure sores, and these will take longer than average to heal. Amongst older women increased risk of hip fracture has also been associated with extreme thinness.

8.10 The most effective interventions to improve the diet and nutrition of older people ensure that minimum nutritional requirements for older people are adequately met, and that specific disease risks such as cardiovascular disease, stroke, diabetes and osteoporosis are addressed [357] (A1) [358] (P). Change to a diet containing whole grain cereals and more fruit and vegetables also has the potential to reduce constipation

which affects the quality of life of about 20% of older people [359] (D). Advice on diet should take into account the older person's culture and not refer solely to a diet that would be unsuitable for some communities.

8.11 Healthy eating is also likely to promote a sense of well-being and self esteem. This has a beneficial effect on depression and mental health. This is of particular relevance to the provision of food through 'meals on wheels', at day care and in residential care and hospitals.

8.12 Surveys have shown [360] (B3) the importance of providing older people with dental treatment and advice on oral health. This will enable them to eat a varied and healthy diet, and to retain their independence and dignity.

Immunisation and management of influenza

8.13 It is estimated that, if all older people were immunised against influenza, almost 5,000 additional lives might be saved each year in England. Studies show influenza immunisation among older people is cost-effective [361] (B3), [362] (D), [363] (A1), [364] (A1). Older people, as a vulnerable group, are eligible for NHS flu immunisation, and are included in groups that may be offered flu vaccine. The national target for influenza immunisation coverage in older people is 70%. Everyone aged 65 and over should be actively contacted and offered flu vaccine.

Wider initiatives

8.14 Local initiatives to reduce poverty and improve housing and local amenities, including transport, also promote good health and support independence. These may include plans and actions to:

- promote the material well-being of older people, for example through providing access to and advice on benefits
- improve the quality of homes in order to reduce fuel poverty, prevent ill health and accidents
- promote mobility and social contacts, in particular policies to reduce the fear of crime and violence
- develop high quality, accessible public transport which is affordable
- further develop road safety for older people
- develop policies which reduce disability and ameliorate its consequences in older people, particularly those living alone.

8.15 Access to wider community facilities, libraries, education, and leisure for example, will enable older people to participate in and contribute to society. This may be promoted by local council planning and transport departments.

8.16 A neighbourhood that is perceived to be safe will enable an older person to feel safe in their own home, and able to go out at will. The NHS and social care agencies should collaborate with local community safety partnerships and other community-based activities.

8.17 The Government has introduced a programme of measures aimed at ensuring older people know the importance of staying warm in winter. A grant-funded programme of energy efficiency schemes is part of the Government's strategy to end fuel poverty for vulnerable households. Health professionals are raising awareness and encouraging people to apply for the help available. Supporting material for such campaigns is made available by the Department of Health as part of the national *Keep Warm, Keep Well* campaign.

8.18 Specific multi-sectoral health promotion programmes should also be developed for:

- exercise services which take account of the health and material circumstances of older men and women, some of whom may be without access to private transport or may be house bound.

- better quality diet: multi-sectoral health promotion programmes should take into account the practical difficulties experience by older people in getting to the shops on a regular basis.

Further national work

8.19 Additionally, there is an identified need to provide guidance on how to operationalise, monitor and evaluate health promotion for older people in local settings. The Department of Health and the Health Development Agency will develop national guidance and make good, up-to-date information available through their websites.

8.20 Starting in 2001 the Health Development Agency will take the lead on pre-retirement pilots focused on those reaching retirement age, who do not receive a similar check within their occupational pension scheme. Support to help people to stay healthy will be provided. The pilots will explore, amongst other things, alternative ways of providing this service, such as NHS walk-in-centres and Healthy Living Centres, and ways to make it more accessible to those otherwise least likely to seek advice in other ways.

Actions

The NHS with councils, should:

- assess the local priorities to promote both physical and mental health and well being among the older population groups
- ensure that older people have fair access to programmes of disease prevention and health promotion, including cancer screening, blood pressure management, smoking cessation, advice about lifestyle including nutrition and physical activity, and falls prevention. These should take account of the impact of cultural and religious beliefs and lifestyles
- take stock of all existing services (including the newer programmes for regeneration and neighbourhood renewal, as well as more traditional programmes such as housing, leisure and transport) which are relevant to health and well being; identify the broader opportunities to promote health and well being for older people; implement a rolling programme.

Milestones

April 2003

HImPs, SaFFs and other relevant local plans should have included a programme to promote healthy ageing and to prevent disease in older people. They should reflect complementary programmes to prevent cancer and CHD and to promote mental health, as well as the continuation of flu immunisation.

Plans should also include action specific to older people, utilising the range of local resources, including those within regeneration programmes and reflecting wider partnership working.

April 2004

Local health systems should be able to demonstrate year on year improvements in measures of health and well being among older people:

- flu immunisation
- smoking cessation
- blood pressure management.

CHAPTER THREE: Local Delivery

1. Translating the national standards in this NSF into new and better services for older people will be achieved through local arrangements which:

   - listen to and act on the views of older people and their carers
   - develop a shared vision, and partnership working
   - build strong leadership
   - promote inclusive planning
   - develop and implement a communications strategy
   - ensure that local services are culturally appropriate, meeting the needs of increasingly diverse communities of older people.

Preparing for the NSF

2. The Department of Health, including the NHS and Social Care Regional Offices, have established a National Implementation Group for this NSF. The Regional Offices have, in turn, been working with and supporting health authorities, councils with social services responsibilities and primary care groups and Trusts as they prepare to implement the NSF.

Involving older people and their carers

3. The inclusive approach of the national External Reference Group should be reflected locally with older people and their carers playing their full part in local planning and implementation, advising on priorities, providing feedback on progress and acting as a reality check. The NHS Plan gives a commitment to ensure that patients' views are given greater prominence in shaping NHS services, and that should apply for older people as much as for any other group.

4. Older people and their carers should be represented across every organisation, the local Modernisation Board, the Patients' Forum which will be established in every NHS Trust and Primary Care Trust, within the Best Value Programme, in the local council scrutiny role, and in setting and monitoring standards within the framework of local *Better Care, Higher Standards* charters. These arrangements should be consistent with the leadership arrangements set out in Standard One including:

   - an elected council member or NHS non-executive director to lead for older people in each organisation

- a clinical or practice champion within each organisation to lead professional development
- a patient champion for older people's services on each Patients' Forum
- all chief officers to take personal responsibility for implementation.

5. The local arrangements should reflect the diversity of the community which is served – to ensure that local plans take full account of the specific needs and choices of black and minority ethnic groups. At the same time, they should identify and develop resources within the community, to support older people and their carers.

6. This engagement with older people and their carers as patients, service users and citizens should inform the whole system of care. The focus should be on both long-term sustainable change, towards meeting the standards in the NSF, and on delivering the early milestones to demonstrate tangible progress to local people.

Action

Local arrangements for involving older people and their carers in implementing the NSF should be in place by 30 June 2001

Sharing a common vision, working in partnership

7. The Health Act 1999 places a Duty of Partnership on health authorities and councils which is reflected in Health Improvement Programmes (HImPs). The Local Government Act 2000 provides additional powers for councils to work in partnership with other local agencies to improve economic, social and environmental well-being. Local Strategic Partnerships (LSPs) and community strategies offer further opportunities to strengthen partnerships for reducing deprivation and social isolation. Whatever local arrangements are made for implementing the NSF, links with the Local Strategic Partnership should be made clear in order to provide for a more effective and joined up working relationship.

8. Local NSF implementation arrangements will be based on existing arrangements for the Older People's JIP and within the framework of LSPs, where they exist. These arrangements should be inclusive and represent all relevant stakeholders (see Standard Two, paragraph 2.20). Planning boundaries should also be based on LSPs where they exist and, where they do not, be agreed locally.

9. A shared vision will require a thorough understanding of the joint resource base. One of the early priorities in pursuing the service development milestones and targets set out in this NSF will be for the NHS and social care services to ensure that they have an agreed, comprehensive and accurate map of all current local resources and services.

10. The Concordat between the NHS and the Independent Healthcare Association published last year provides for the development of a strategic relationship both nationally and locally between the NHS and private and voluntary health care providers. The initial focus is on intermediate care, elective surgery and critical care, and further services may be identified in future. The Concordat builds on established partnership working for the delivery of residential and nursing care. The Government is also helping to develop a new Concordat with local government and care providers. It will be a catalyst for developing a new approach for managing capacity in the care system.

11. Local elected members and NHS non-executive directors should play a key role in partnership building. Each organisation should identify an elected member or non-executive director who will lead for older people, and support a whole system approach.

Action

Local arrangements for implementing the NSF be established by 30 June 2001

The elected member or non-executive director who will lead for older people in each organisation should be identified by 30 June 2001.

Strong leadership

12. The agenda set out in this NSF will require local agencies to lead change across traditional organisational boundaries. Strong leadership within all relevant organisations will be essential – every chief officer will need to demonstrate their personal support.

13. In addition to this process of co-leadership, for every local health and social care system one chief officer should be identified with responsibility to lead the implementation process overall. Initially, this should usually be either the health authority chief executive or the director of social services. As Primary Care Trusts are established, and (subject to legislation currently before Parliament) Care Trusts, the focus for leadership should be kept under review.

14. Similarly, each organisation needs to identify a "champion" – a doctor, nurse, a member of the allied health professions or a social work practitioner to lead professional development. These champions will require the support of local chief officers, including opportunities for their own professional development. They should work closely with the elected member or non-executive director designated to lead for older people.

Action

A chief officer for each defined geographical area with responsibility for leading implementation should be identified by 30 June 2001

A clinical or practice champion in each organisation to lead professional development identified by 30 June 2001

Inclusive planning

15. The NSF implementation arrangements will bring together all the health, social services and housing agencies involved, as well as the independent sector and wider partners, including other elements of the local council. Older people, reflecting the diversity of communities, and their carers and their representatives should also be represented. The lead chief officer will need to agree ways of working which sustain involvement and enable participation by *all* stakeholders. Those implementing the NSF should balance the need for time to agree the best approaches to local implementation with the need to make early progress in identifying and tackling local priorities, and delivering tangible improvements for older people and their carers.

16. Planning for delivery should address all the national milestones in this NSF. Strategic planning should be included in HImPs and detailed planning in older people's Joint Investment Plans. NHS organisations, with local councils, will carry out a modernisation review in summer 2001 and prepare three to five year plans demonstrating the pathway to deliver the NHS Plan. Planning for service development, associated with this NSF and the NHS Plan, is being included in NHS Service and Financial Frameworks (SaFFs) and older people's Local Action Plans (LAPs). The Joint Investment Planning process also provides a mechanism for ensuring that decisions on the application of Councils' new Supporting People grant can be properly co-ordinated with the application of NHS and other council resources to deliver co-ordinated housing, care and support options for older people [365] (P).

17. Understanding available resources is crucial. Joint Investment Plans should include a comprehensive financial statement of all available and expected NHS and council funding for meeting the milestones in the NSF. Where appropriate, this should also

be reflected in the SaFF. Joint Investment Plans should also describe:

- local NSF implementation arrangements
- the lead responsibilities of each chief officer for implementing specific areas of the NSF
- the arrangements made for involving users and carers
- the arrangements for involving staff
- details of agreed local priorities and milestones.

18. For each milestone, the Joint Investment Plan will need to contain:

- the size and nature of the population to be served
- a map of all current service and finance activity
- an analysis of the gaps between current services against services required to meet the milestone
- local milestones towards meeting the national milestone
- a risk assessment relating to meeting the national milestone and contingency arrangements.

19. The gap analysis should set out:

- the means of meeting any additional costs from either planned additional investment or from reorganising local priorities
- workforce and training implications and development priorities including costs and availability of suitably qualified and experienced staff. This should include staff in the independent sector
- implications for the local NHS and Social Care information strategies
- capital funding requirements and proposed source of funding.

20. Implementation of the NSF should recognise the new role of Primary Care Groups and Trusts (PCG/Ts) in improving the delivery of primary care, shaping specialist services through commissioning, and health improvement working with the range of local partners. All PCG/Ts have a responsibility to work closely with their council partners to develop services that meet the needs of their registered population.

PCG/Ts need to look beyond social services and consider how other services (such as housing, transport and environmental services) can contribute to their health improvement role. PCG/Ts need to review their contribution to the local HImP, to ensure it contributes to setting the strategic framework for the priorities of the NSF.

21. The new Care Trusts will, subject to legislation currently before Parliament, offer further potential for integration of service commissioning and provision. They will build on the flexibilities in the Health Act 1999 which enable the integration of service provision and commissioning, including the use of pooled budgets.

Action

The NHS modernisation review should include older people as a priority, and reflect this within the 3-5 year plan

Joint Investment Plans should be updated to include milestones from 2002/03 to 2004/05 by 31 March 2002

HImPs set the strategic framework within which milestones from 2002/03 can be set by April 2002

Plans for clinical governance, Best Value and Information for Health for 2002/03 should reflect the milestones within this NSF, with services for older people as one of the priorities.

Developing a communications strategy

22. Local health and social care services need to establish two way communications to explain the proposals for service improvement and to hear the views of service users and carers.

23. At the same time the communications process needs to involve staff, building on local processes for staff involvement.

Action

Local communications strategy should be agreed with the NHS and Social Care Regional Offices by 31 May 2001.

Regional support for implementation

24. The NHS and Social Care Regional Offices will work closely with local health and social care partnerships to support implementation and to monitor progress.

25. Regional Offices will prepare a Regional Review to synthesise the work done at local level and to provide a focus for Regional action. This Review will be published and include a regional view of:

- **the gap analysis**

- **variation in service provision** across the localities. This will highlight where service improvements need to be prioritised to reduce variation. It may also highlight differences in service provisions between different urban areas and between rural and urban areas

- **excellence**: describing services at the leading edge of implementation will celebrate success and provide learning for other services

- **local leadership**: to identify the local leadership in management – an elected member or non-executive director, a clinical or practice champion in every organisation, and an older patients' champion on every Patient Forum, when established and subject to legislation currently before Parliament, plus a designated Chief Officer to lead the implementation process overall

- **agreed one year position**: this will emphasise progress to be expected in the short-term. It will be based on finalised SaFFs and relate to the JIP and Gap Analysis

- **agreed three year position**: this will be based on the NHS's modernisation review and local social care plans and will show progress to be expected over three to five years and identify any risks to achieving that

- **agreed strategic direction**: this will give a comprehensive picture of how the NSF standards will be achieved within the ten year planning period

- **regional support and development**: in the short-term, this will show areas where the Regional offices will support progress in individual localities , and how longer term support may be necessary on underpinning programmes such as workforce planning, research, and financial strategies.

26. The Regional role will include both performance monitoring and organisational and personal development, working with the Modernisation Agency. This will build on the early work of the intermediate care change agents.

27. In addition to the underpinning strategies set out in Chapter Five, the Learning Zone will contain a national dataset of examples of good practice in service delivery and practice (http://nww.learningzone.nhsweb.nhs.uk).

CHAPTER FOUR: Ensuring Progress

Introduction

1. Each standard in the NSF has milestones to assure that progress is being made within every local health and social care system.

2. Although the achievement of the standards across the country is likely to take ten years, it is essential that early and systematic progress is made. The milestones will enable both the local implementation groups to monitor locally, and the regional tier to intervene where there are problems in delivery.

3. The milestones and performance measures can be found at the end of this chapter. A summary of all the milestones is at Annex III.

Performance assessment

4. The aim of performance assessment is to ensure impetus for service improvement and to assure progress. For the NHS performance is assessed across the six domains of the NHS Performance Assessment Framework (PAF):

   - health improvement
   - fair access
   - effectiveness delivery of appropriate care
   - efficiency
   - patient/carer experience
   - health outcomes of NHS care.

5. The performance of social services is considered within the equivalent PSS Performance Assessment Framework (PAF) whose five domains are the same as those used by all other local government services under Best Value, and which map to the six domains above.

6. Where service delivery requires the joint participation of both health and social care services, information from the two frameworks is drawn together as interface information.

7. Each of the PAFs has a set of high level performance indicators which are used nationally. The frameworks also provide the umbrella for a broader range of indicators and other information, of local relevance. Within this, more detail can be developed, to highlight specific areas of interest or concern.

8. Performance measures can be broadly categorised as relating to inputs (such as staffing and investment), processes (such as the establishment of new services or better ways of working) and outcomes (improved health and well being).

9. Outcome measures are ideal as they reflect improvements in health and well being, and in the experience of health care. The index of Healthy Life Expectancy will for the first time provide a composite outcome measure for older people.

10. Meanwhile, the work programme of the National Centre for Health Outcomes Development (NCHOD) has explored some interim outcome measures for specific conditions and interventions, including stroke, fractures and joint replacement [366] (P) [367] (P).

11. It can take longer to demonstrate changes in outcome as a result of service improvement and, as long as input and process changes are known from the research literature to improve health and well being, and/or the experience of care, measures of these can provide interim surrogate indicators. Input and process indicators can assess early local progress. The focus should be on those where a clear relationship with outcome has been demonstrated.

Performance monitoring

12. The NHS and Social Care Regional Offices will assess local performance against the Joint Investment Plan (JIP), and the NHS Service and Financial Frameworks (SaFFs) using the NHS and PSS Performance Assessment Frameworks (PAFs).

13. Some of the indicators (primarily outcome indicators) that are contained in the PAFs will be included in the measures which will inform both the new performance arrangements for NHS organisations and the banding of local councils. Under the new arrangements, the overall assessment of both health and social care organisations will inform access to both Performance Funds.

14. The numerical data will be complemented by regular surveys of users' and carers' views. From 2001 every NHS Trust and PCT and, subject to legislation currently before Parliament, Care Trust will carry out annual surveys asking patients and carers about their experience of the services they have received.

15. The surveys will include a core of questions developed nationally to inform the NHS PAF, as well as additional questions developed by local NHS organisations and for local Trusts and councils to cover issues of local relevance.

16. Social services users are also being asked about their experiences of services, with the first data for every council being published in autumn 2001. It will also be possible to produce England estimates specifically for older people. The content and coverage of the surveys will expand, growing from councils' own experience of carrying out surveys. The National Minimum Standards for Care Homes for Older People (standard 33) includes a requirement to survey the experiences of those in long-term care.

17. There will also continue to be systematic programmes of reviews and inspections.

18. The Social Services Inspectorate (SSI), which is part of the Department of Health, has responsibilities which include the assessment of how well social services are organised to meet service users' and carers' needs. An SSI programme of inspections of older people's services is currently underway. The first programme of 21 inspections is complete and SSI will publish a national overview report later in 2001. The fieldwork for the second programme of inspections will start in August 2001 with inspection methodology tailored to the social care aspects of this NSF.

19. The programme of Social Services Inspectorate/Audit Commission Joint Reviews covers each council which provides social services once every five years, publishing reports which look across all social care provision.

20. The remit for the Commission for Health Improvement (CHI) which was established last year as a Non Departmental Public Body includes monitoring the implementation of the NSF programme. The reviews will involve all local health and social care organisations, with older people represented on every review team. The date for the first NSF review will be announced shortly.

21. In addition CHI is responsible for a rolling programme of reviews of clinical governance. These have now begun and will include services for older people. Each NHS organisation will be reviewed every 4 years.

22. Securing continuous improvements in performance is one of the aims of the Best Value process. The duty of Best Value – which came into force for all local government services on 1 April 2000 - is to deliver services to clear standards covering both cost and quality, by the most effective, economic and efficient means available. Best Value indicators are linked to the PSS Performance Assessment Framework.

23. From April 2002 the National Care Standards Commission (NCSC) will register and inspect all private and voluntary care homes, the private health care sector, and domiciliary care agencies. Services will have to comply with regulations and national minimum standards, which will in turn reflect the NSF standards.

24. In addition to the responsibilities of each individual organisation, the SSI, CHI, and Audit Commission have accepted a collective responsibility to work together to ensure that health and social services for older people are looked at in the round.

25. In order to keep the local burden of additional data collection and inspection to the minimum compatible with rigour, the review of each NSF will draw on all existing information sources. In future this will include not only the PAFs, but also local monitoring data, survey data, and, for the NHS, the analysis of critical adverse incidents which will be available through new national monitoring arrangements to be introduced following the publication of *An Organisation with a Memory* in 2000.

National oversight

26. This will be provided through the Modernisation Board and the Taskforce for Older People, both established in 2000.

27. The NHS Modernisation Board is responsible for the implementation of the NHS Plan. It is supported by ten national taskforces, including the Taskforce for Older People. This is chaired by Professor Ian Philp, National Director for Older People, and includes representatives of older people and carers, of the professional bodies, and staff from the NHS, local government and the Department of Health.

28. Key roles of the Taskforce are to:

- track delivery of the NSF for Older People
- further develop proposals where required
- support local planning implementation through advice and feedback
- communicate key messages throughout the NHS and Social Services.

29. The Taskforce will draw on information from Regional Offices and the Inspectorates, and on additional evidence from research or from local surveys, for example. Its role will be to ensure that blocks to progress are identified and tackled, supporting local implementation in whatever way is required.

Standard 1 – Age Discriminaton		
Date	**Milestone**	**Performance Measure**
October 2001	Audits of all age related policies to be completed with the outcomes to be reported in annual reports.	Completion monitored by RO (new measure).
April 2002	From this date SAFFs and JIPs to include initial action to address any age discrimination identified. Strategic direction to be reflected in HImPs. Councils to have reviewed their eligibility criteria for adult social care to ensure that they do not discriminate against older people.	Completion monitored by RO (new measure). Completion monitored through the biannual reporting of councils to Social Care Regional Offices
October 2002	Analysis of the levels and patterns of services for older people, in order to facilitate comparisons across health authorities and establish best practice benchmarks based on health outcomes and needs	For some key areas, intervention rates may be used to monitor access to services. The benchmarking exercise will be critical to develop a better understanding of appropriate intervention rates for a given population. Clearly what matters most is health outcomes and we are therefore undertaking further work to develop measures for older people based on health outcomes such as overall patient and carer well-being; the proportion of older people enabled to live at home; decreasing levels of disability, life expectancy, morbidity and mortality; greater patient, service user and carer satisfaction. In the meantime, monitoring access to services may include examining the rates of the following key procedures and interventions for people aged 65+, 75+ and 85+, those which cover these interventions key to providing quality of life for older people: • Elective cataract surgery • Elective hip replacement • Elective knee replacement • Community equipment And those which reflect national clinical priorities to ensure that older people are accessing surgical interventions and medical treatments for the major illnesses on the basis of clinical need: • Revascularisation (CABG and PTCA) • Treatment for end stage renal failure (new measure).
April 2003	Once this work is complete and we have appropriate benchmarks, local health systems should, from 2003/04 be able to demonstrate year on year improvement in moving towards those benchmarks.	Completion monitored by RO (new measure).

Standard 2 – Person-centred care		
Date	**Milestone**	**Performance Measure**
June 2001 April 2002	Local arrangements for implementing the NSF are established The single assessment process is introduced for health and social care for older people.	• Numbers/rates of people aged 75+ entering long-term institutional care (total in PAF) • Numbers/rates of people aged 75 +in nursing and residential care (total in PAF) • Proportion of total people aged 75 +receiving long term intensive support who are receiving this at home (total in PAF) • Numbers/rates of people aged 75 + admitted to hospital as an emergency (SaFFR and proposed PAF indicator). We will investigate continual collections on an age-standardised basis. [i] • Numbers/rates of people aged 75+ whose discharge from hospital is delayed (overall total collected by WEST and in SaFFR and proposed PAF indicator) • Numbers/rates of people aged 75+ readmitted to hospital as an emergency within 28 days of discharge (SaFFR and proposed PAF indicator). Collection to be continued by age standardisation will be explored. • Numbers/rates of people aged 75+ who receive an assessment under the new single assessment protocol (new measure). • Numbers/rates of people aged 75+ in receipt of an individual care plan (new measure). Information to be collected at year end on an age-standardised basis. Waiting time for social services packages: • For new older clients, the proportion where the time from first contact to first services is more than six weeks (version of PSS PAF PI specifically for older people), broken down by whether referral from primary/community health, secondary health or other • As above, except the proportion where the time from first contact to provision or commission of all services in the care plan is more than six weeks (new measure). • Numbers/rates of people aged 75+ receiving overnight respite care commissioned by SSD (RAP) • Numbers/rates of people aged 75+ of key staff: • District nurses • Health visitors • Physiotherapists • Occupational therapists • Chiropodists and podiatrists • Health care assistants • Support workers • Pharmacists These cannot be broken down into the proportion of staff grades assigned to older people, but can give a general measure of access by dividing by population adjusted for age and need.

i. Age standardisation is an alternative to employing an age cut off, by taking into account the differing age structures of the local population in the calculation of indicator values. Age standardised indicators apply to all age groups, while enabling variations to be explored in more detail to see if any particular age group is contributing most to the overall indicator.

Standard 2 – Person centred care		
Date	**Milestone**	**Performance Measure**
April 2002	All health and social care services to have reviewed the information they provide on older people's services and the formats in which it is available, and to have developed an action plan to correct any shortcomings. This should be reflected in the local *Better Care, Higher Standards* charter.	Completion monitored by RO/SCR (new measure).
April 2003	Systems to explore user and carer experience should be in place in hospitals in all NHS and PSS organisations. This will include regular use of the surveys to be developed within the national programme for NHS patients and carers.	This milestone ensures that the focus is on exploring user and carer experience. Performance measures will be developed to allow benchmarking and performance management.
	NHS organisations should have systems in place to ensure all complaints from older people, or their carers and relatives, are analysed and reported to each Board.	Completion monitored by RO/SCR (new measure).
	HImPs and other relevant local plans should have included the development of an integrated continence service	Inclusion monitored by RO (new measure)
April 2004	Systems to explore user and carer experience in PCTs should be in place.	The milestone ensures that the focus is on exploring user and carer experience. Outcome performance measures are needed to back this up. These will be based on local survey questions which will feed into PAF indicators.
April 2004	Single integrated community equipment services are in place	Community equipment (which is predominantly although not entirely provided for older people): • Numbers/rates of people receiving community equipment • Time from first contact to completed assessment • Time from completed assessment to provision • Percentage of items of equipment costing less than £1000 delivered in less than 3 weeks [PSS Indicator] • Percentage of items of equipment recycled by value
	All health and social care systems to have established an integrated continence service	• Achievement monitored by RO/SCR (new measure)

Standard 3 - Intermediate care		
Date	**Milestone**	**Performance Measure**
July 2001	Local health and social care systems to have designated a jointly appointed intermediate care co-ordinator in at least each health authority area; to have agreed the framework for patient/user and carer involvement; and to have completed the baseline mapping exercise.	Achievements monitored by RO/SCR (new measure)
January 2002	Local health and social care systems to have agreed the joint investment plan for 2002/03.	

Standard 3 - Intermediate care		
Date	**Milestone**	**Performance Measure**
March 2002	At least 1,500 additional intermediate care beds compared with the 1999/2000 baseline. At least 40,000 additional people receiving intermediate care services which promote rehabilitation and supported discharge compared with the 1999/2000 baseline. At least 20,000 additional people receiving intermediate care which prevents unnecessary hospital admission compared with the 1999/2000 baseline.	Number of people referred to non-residential intermediate care teams: 8103 To prevent inappropriate hospital admission 8104 To facilitate timely hospital discharge and/or effective rehabilitation Number of people referred to/receiving intermediate care in a residential setting ('Rapid Response'/Supported Discharge): 8101 To prevent inappropriate hospital admission 8102 To facilitate timely hospital discharge and/or effective rehabilitation Intermediate Care Beds: 8157 Numbers of intermediate care beds Expenditure on Intermediate Care: 8106 Total Expenditure on intermediate care (£1,000s) 'Places' in non-residential Intermediate Care schemes: 8105 Number of "places" in non-residential intermediate care schemes Social services' support for intermediate care is indicated by: • Households receiving intensive home care per 1000 population aged 65 or over • Older people helped to live at home per 1000 population aged 65 or over These are both Best Value/PSS PAF indicators. **In addition, the performance measures for Standard 2 will indicate progress on this standard.**
March 2004	At least 5,000 additional intermediate care beds and 1700 non-residential intermediate care places compared with the 1999/2000 baseline. At least 150,000 additional people receiving intermediate care services which promote rehabilitation and supported discharge compared with the 1999/2000 baseline. At least 70,000 additional people receiving intermediate care which prevents unnecessary hospital admission compared with the 1999/2000 baseline.	

Standard 4 – General hospital care		
Date	**Milestone**	**Performance Measure**
April 2002	All general hospitals which care for older people to have identified an old age specialist multidisciplinary team with agreed interfaces throughout the hospital for the care of older people. All general hospitals will have developed a nursing structure which clearly identifies nursing leaders with responsibility for Older People. Consideration will have been given to Nurse Specialist/ Nurse Consultant and Clinical Leaders (Modern Matrons).	Achievement monitored by RO (new measure).
April 2003	All general hospitals which care for older people to have completed a skills profile of their staff in relation to the care of older people and have in place education and training programmes to address any gaps identified.	Achievement monitored by RO (new measure). **In addition, the performance measures for Standard 2 will indicate progress on this standard**

Standard 5 – Stroke		
Date	**Milestone**	**Performance Measure**
April 2002	Every general hospital which cares for people with stroke will have plans to introduce a specialised stroke service as described in the Stroke Service Model from 2004.	Achievements monitored by RO (new measure). **Collective outcome measures** Collectively over time the milestones for stroke will reduce: • mortality from stroke (ONS) • incidence of stroke (new measure; HES data available but would need analysing) • prevalence of inadequately treated high blood pressure
April 2003	Every hospital which cares for people with stroke will have established clinical audit systems to ensure delivery of the Royal College of Physicians clinical guidelines for stroke care.	
April 2004	PCG/Ts will have ensured that: • every general practice, using protocols agreed with local specialist services, can identify and treat patients identified as being at risk of a stroke because of high blood pressure, atrial fibrillation or other risk factors • every general practice is using a protocol agreed with local specialist services for the rapid referral and management of those with transient ischaemic attack (TIA) • every general practice can identify people who have had a stroke and are treating them according to protocols agreed with local specialist services • every general practice has established clinical audit systems for stroke 100% of all general hospitals which care for people with stroke to have a specialised stroke service as descriibed in the Stroke Service Model.	

Standard 6 – Falls		
Date	**Milestone**	**Performance Measure**
April 2003	Local health care providers (health, social services and the independent sector) should have audited their procedures and put in place risk management procedures to reduce the risk of older people falling.	Achievements monitored by RO (new measure). **Collective outcome measures** Collectively over time the milestones for falls will reduce: • incidence of fractured femur (new measure; HES data available but would need analysing). • deaths following fractured femur (ONS). • avoidable harm through falls or hypothermia (PSS PAF).
April 2004	The HImP, and other relevant local plans developed with local authority and independent sector partners, should include the development of an integrated falls service.	
April 2005	All local health and social care systems should have established this service.	

Standard 7 Mental Health in older people		
Date	**Milestone**	**Performance Measure**
April 2004	HImPs and other relevant local plans developed with local authority and independent sector partners, should have included the development of an integrated mental health service for older people, including mental health promotion. PCG/Ts will have ensured that every general practice is using a protocol agreed with local specialist services, health and social services, to diagnose, treat and care for patients with depression or dementia. Health and social care systems should have agreed protocols in place for the care and management of older people with mental health problems.	Achievements monitored by RO/SCR (new measure) **In addition the performance measures for Standard 3 about reducing premature admission to long-term care will indicate progress in this area.**

Standard 8 – The promotion of health and active life in older age		
Date	**Milestone**	**Performance Measure**
April 2003	HImPs, SAFFs and other relevant local plans should have included a programme to promote healthy ageing and to prevent disease in older people. They should reflect complementary programmes to prevent cancer and CHD and to promote mental health, as well as the continuation of flu immunisation. Plans should also include action specific to older people, utilising the range of local resources, including those within regeneration programmes and reflecting wider partnership working. Local health systems should be able to demonstrate year on year improvements in measures of health and well being among older people: • flu immunisation • smoking cessation • blood pressure management	Inclusion monitored by RO (new measure). Flu immunisation rate in people aged 65+. Numbers of excess winter deaths (ONS). Smoking cessation rates in people aged 60+. Blood pressure • high blood pressure detected • high blood pressure effectively treated in people aged 65+ **Collective outcome measure** Healthy Life Expectancy index under development.

Medicines and older people		
Date	**Milestone**	**Performance Measure**
April 2002	All people over 75 years should normally have their medicines reviewed at least annually and those taking four or more medicines should have a review 6 monthly. All hospitals should have “one stop dispensing/dispensing for discharge schemes” and, where appropriate, self-administration schemes for medicines for older people.	Proposed new measure for development Achievement monitored by RO (new measure)
April 2004	Every PCG or PCT will have schemes in place so that older people get more help from pharmacists in using their medicines.	Achievement monitored by RO (new measure)

CHAPTER FIVE: National support to underpin local action

Introduction

1. Five underpinning programmes will support local and national implementation:

- finance
- workforce
- research and development
- clinical and practice decision support services
- information strategy for older people.

Finance

2. This NSF will be implemented by a mixture of targeted funds and the increases in general resources for health and social care. Around half of health and social care spending nationally is directed at the care of older people and they will therefore benefit significantly.

Targeted resources

3. Within these overall resources, the NHS Plan commits an extra £1.4 billion specifically for older people to be provided annually by 2004.

4. The NHS Plan announced that there would be £900 million made available by 2003/04 for intermediate care and related services to promote independence. A substantial component of that relates to resources being provided to local government, mostly through the Personal Social Services Standard Spending Assessments (SSA). These are for a range of services which link to intermediate care, for example through the provision of home care. Over the next three years the increases in SSA should allow councils to increase the range of service activity that helps users to live independently, in their own homes if that is their wish.

5. **Intermediate care** - The Department has put in place a substantial programme of investment in intermediate care through the NHS, £150 million in 2000/01 rising to £405 million in 2003/04. These resources are being allocated through health authorities, on condition that they be deployed through pooled budgeting arrangements agreed with councils. As part of these arrangements, health authorities

and councils will be required to have agreed joint plans and targets for outcomes for older people.

6. **Community equipment services** - Community equipment services are in urgent need of modernisation. Funding of £12m in 2001/2, £28m in 2002/03 and £65m in 2003/04 will be directed through the NHS to improve these services (Standard 2). The need for a co-ordinated approach with councils will, as for intermediate care, require joint investment plans and pooled budgeting.

7. To ensure that councils can play their part in these developments, extra investment is being made available in councils' Personal Social Services settlement for 2001/02 to 2003/04. The funding should enable:

- investment in intermediate care and community equipment services – complementing the additional resources being made available through the NHS
- expansion of integrated home care services and other support to enable more older people to live independently at home
- higher quality standards of residential and domiciliary care for older people and other adults.

8. Other funds directed at improving older people's health and social care include:

- £120 million to convert many Nightingale wards to accommodation specially designed for older people and to provide single sex accommodation.
- the doubling of the Carers Grant from £50m currently to £100m in 2003/04.
- the creation of the new Personal Social Services Performance Fund which will initially focus on intermediate care; £50m in 2002/03 and increasing to £100m in 2003/04. The NHS Performance Fund will also be able to reward joint working.
- funding for the development of Care Direct which aims to improve information about and access to services for older people in particular.

Financial implications of the NSF

9. The NSF Standards cover a range of health and social care services. Some, like intermediate care, have significant financial implications. Others mainly require changes in working practices rather than large-scale investment and others will simply require that older people get their fair share of and access to resources available.

10. Investment in intermediate care and the expansion of community equipment services will underpin the care for those who have had a stroke (Standard 5), or have fallen (Standard 6), and help older people to remain independent (Standard 3).

11. The service models proposed for stroke (Standard 5), falls (Standard 6) and mental health (Standard 7) require service redesign. They are based on the available evidence of best practice, and many areas have put such services and organisations in place without substantial new financial resources. Nevertheless, significant management input may be required to reconfigure and make organisational changes to services. Because of this, changes are being phased in over the first four years of the NSF.

12. Ensuring fair access, eliminating age discrimination (Standard 1), promoting person-centred care (Standard 2), and ensuring evidence-based practice in hospitals (Standard 4) are centred around giving older people fair access to the NHS based on priority of clinical need. As such they may demand refocusing of resources that will be met in the short term from the substantially increased levels of funding for the NHS over the next three years, announced in the NHS Plan:

- increased numbers of NHS hospital beds - 7,000 more NHS beds, including over 2,000 in general and acute wards. 30% increase in adult critical care beds
- investment in new hospital building and local primary care facilities
- increased funding for cleaner hospitals and better hospital food
- increased investment in information technology
- increased funding for training
- increased funding for extra staff.

13. Ensuring an integrated approach to health and social care (Standard 3) will require additional training for some health and social care professions, particularly on implementing a single assessment process. Existing plans to increase funding for training and development and to increase investment in information technology will assist in this process. Where such targeted assessments have been introduced, available evidence indicates that they can reduce demand and inappropriate care, freeing up resources for further investment.

Workforce

14. Implementing the NSF will require a workforce:

- of the right numbers
- with the right skills and diversity
- at the right time.

15. As key priorities evolve and new ones emerge, there will be the need for active co-operation and partnership at all levels between professional bodies, educational and training organisations, NHS workforce development confederations, social services, and the voluntary and private sectors.

Workforce requirements of the NSF

16. The NSF will increase requirements for staff, particularly in respect of:

- delivering the single **assessment** process
- joint review of **equipment services** for older people to ensure that provision is sufficient and non-discriminatory
- increasing the provision of i**ntermediate care** services
- developing s**troke services**
- introducing the **falls service** model and putting in place a lead or co-ordinator in every Health Authority
- improving **mental health** services for older people.

17. These identified pressures have been considered within current workforce planning set out in the NHS Plan.

More Staff

18. The NHS Plan provides for increases in NHS staffing, 7,500 more consultants (including an estimated 140 specialists in old-age medicine, 85 old age psychiatrists and a range of other specialists of particular relevance to older people) at least 2,000 more GPs, 20,000 extra nurses and 6,500 additional allied health professionals and other health professionals by 2004. Of these, around 7,800 nurses and 2,500 members of the allied health professions, pharmacists and other professional staff will be involved in the care and support of older people.

19. This expansion is coupled with increases in staff in training to ensure continued and longer-term expansion. There will be at least 550 more GP training places by 2004 and increases in undergraduate medical school places. 5,500 more nurses and 4,450 more members of the allied health professions, pharmacists and other professional staff will also be trained each year by 2004. The numbers of specialist registrar places in old age medicine at present will support around 60% growth in consultants by 2009 (over 1,200 by that date). From those currently in training, a growth in the numbers of old age psychiatrists to 670 by 2009 is estimated. The new Care Group Workforce Team for Older People's Services will help to clarify the numbers and types of staff, and the skills they will need to deliver the NSF standards of care.

Recruitment and retention

20. To ensure the future workforce the profile of NHS careers is being raised with school children, building on the successful national recruitment campaign in 2000, "Joining the Team – Make a Difference" focused on nurse recruitment, but extended to attract people into other NHS professions. This is backed by the NHS Careers advice service for potential new entrants, and advising those considering a return to working in the NHS.

21. Pay is an important factor both for existing NHS staff and for those thinking of a career in health care. Offers and awards from April 2001 have reflected Pay Review Bodies' recommendations, accepted in full, and underline a continued commitment to modernisation and a steady and affordable investment in staff pay. The importance of providing a range of flexible working arrangements has also been recognised through the "Improving Working Lives" initiatives.

22. To tackle immediate NHS staff shortages, approaches have included, international recruitment, the development of "NHS Professionals" an in-house agency providing temporary staff, and the introduction of more flexible retirement arrangements.

23. Parallel action is being taken to improve the recruitment and retention of staff within the social care workforce. A Workforce Summit was held last year which brought together all the interested parties in the social care arena, including employers organisations, staffing organisations and the National Training Organisation for Social Care (TOPSS), to discuss a joint plan for how this may be done. As part of this plan, work is underway to raise the profile of social care and promote career pathways within the various sections of social care. TOPSS are also promoting the Care GNVQ and informing Careers Advisors of the various career opportunities within social care.

Improving workforce planning

24. The strategy to ensure that there are the right numbers of staff with the right skills to deliver high quality services into the future will be driven by a new National Workforce Development Board (NWDB) and its underpinning structures.

25. The Board will oversee new workforce development arrangements, which will be designed to ensure full integration across staff groups and care providers, and across service, workforce and financial planning at local, regional and national levels.

26. New Care Group Workforce Teams will support the NWDB. Their remit will be to look at all services for a particular client group, to consider the skills and competencies needed to deliver high quality care, by which staff, in what numbers and in which settings, and to make recommendations. One of the first of these

Teams will be dedicated to services for Older People. This team will support delivery of the NSF, working with the Older People Taskforce. A parallel review on primary care will report to Ministers at the end of March 2001.

Education and training

27. The goals of training and development work are:

- to ensure that generalist staff in health and social care services are competent in key areas of caring for older people
- to provide specialist training in areas where particular experience is needed.

28. In consultation with the relevant professional bodies, work in this area will need to ensure that undergraduate and pre-registration programmes – across all professions – properly prepare staff for working with older people and with cultural and religious differences, that appropriate opportunities are available for existing staff to enhance these particular core skills and that continuing professional development programmes are developed for staff to extend their skills into new specialities and roles. This work wil recognise the new opportunities for nurses and members of the allied health professions to develop into new roles, including at advanced practitioner or consultant level.

29. The implementation of the NSF for older people will therefore have implications for the whole range of education and training, for example:

- NVQ and other vocational training
- professional social work education and training
- undergraduate and postgraduate medical education
- pre-and post-registration education for nurses, midwives and allied health professions
- continuing professional development
- management and leadership development
- re-entry, induction and skill programmes for new staff, those rejoining the workforce and for staff recruited from other countries.

Research and Development

30. Research and development (R&D) is vital to the further development, successful implementation and evaluation of this NSF.

Key actions

31. Within the overall health and social care R&D agenda:

- older people's health and social care services will receive targeted research funding in 2001/02 and beyond
- the association of many cancers, heart disease and stroke with increasing age is well recognised and will be a major consideration in development of research in these areas
- gaps in knowledge about health and social care services for mental health problems among older people, such as dementia and depression, will be addressed
- research will be needed to consider implementation and the impact on users of new structures proposed to promote closer working between health and social care.

A research strategy for older people

32. A strategic review of NHS R&D funding identified research on ageing, and age-associated disease as a priority. The consequent Working Group's report *Ageing and Age-associated Disease and Disability* is available on the Department of Health's R&D website at http://www.doh.gov.uk/research. The External Reference Group advising the Department of Health on this NSF also considered future research needs and made recommendations which complemented those of the Topic Working Group.

33. The overarching aims of the R&D strategy for older people will be to support research on how to:

- reduce disability and the need for long-term care by maximising independent living and social functioning and improving rehabilitation services
- enhance the well-being of older people and their carers and promote understanding of the needs of older people from black and minority ethnic communities
- inform the choices of individual users of health and social care services
- provide those who deploy health and social care resources with knowledge about the most cost-effective and equitable means of meeting those choices and best practice

- encourage the development and evaluation of innovative practice in health and social care.

34. research on older people will respect the diversity of human culture and conditions and take ful account of ethnicity, gender, disability, age and sexual orientation in its design, undertaking and reporting.

35. This strategy will be implemented through:

- **An Advisory Network** - advice on developing and implementing this strategy will be taken from scientific experts and researchers in a wide variety of disciplines as well as those using findings of research to improve clinical decisions and service delivery for older people, and users themselves. The strategy will also take account of the burden of disease, potential benefits, policy priorities and the responsibilities and work of other funders

- **A directed portfolio of research** on older people - the portfolio director will work with the National Director for Services for Older People and take account of research that has implications for older people under existing portfolios

- **A Funders Forum on Ageing Research** - A national forum of key funders of research on health and social care related to older people has been established and will meet twice a year. The Forum's overall aim will be to stimulate and facilitate multidisciplinary working and develop research activities across the boundaries between research funders.

Immediate action

36. Immediate research priorities for older people's services will include:

- **a longitudinal study of ageing** - this will cover a representative sample of about 13,000 people aged 50 and over and will collect information on health, economic and social networks. Development work on the study has already begun and the first wave of interviews will take place in 2001/02. This will provide a crucial resource for exploring issues related to the dynamics of ageing and quality of life for older people

- **an evaluation of intermediate care** - the development of intermediate care is a key part of the wider programme to improve services for older people. The programme will be independently evaluated to assess the quality, effectiveness and costs of a variety of services to reduce avoidable hospital admission, promote timely discharge and rehabilitation, and minimise dependence on long term care. Findings from the evaluation will feed back into the implementation process from spring 2002.

- **a programme of research on Continuity of Care** - the aims of this research include assessing the impact of continuity of care, or lack of it, on patient outcomes. This will make an important contribution to improving the quality of services for older people

- **building on the existing programme of research on social care relevant to older people** - research will take forward the development of evidence-based approaches to joint assessment, service planning and front line delivery. It will be designed to answer basic questions about the need for, and access to, services as well as ways of improving care management and the costs of domicilliary, residential and nursing care. The research will focus on outcomes and user and carer perspectives. It will lower services for black and minority ethnic older people.

- **research to modernise hearing aid services**.

37. The NSF standards will also give rise to the need for further research which will need to be considered against other priorities for research focussing on older people. Examples are research to evaluate the introduction of specialist falls services, evaluation of the roles adopted by and impact of clinical leaders (Modern Matrons) and nurse and therapy consultants, and research into who might benefit most from the specialist services described in this NSF.

Clinical and Practice Decision Support Services

38. The Department of Health has supported the development of a range of clinical and practice decision support services.

The Cochrane Collaboration

39. The Cochrane Collaboration prepares, maintains and disseminates systematic reviews of research on healthcare. Extensive databases are incorporated in The Cochrane Library, containing controlled trials, systematic reviews and protocols of reviews relevant to this NSF.

The NHS Centre for Reviews and Dissemination

40. The NHS Centre for Reviews and Dissemination at the University of York provides information through systematic reviews, principally in the areas of clinical and cost effectiveness.

41. The Centre has published four *Effective Health Care Bulletins* of relevance to older people – covering stroke rehabilitation, management of cataract, preventing falls and subsequent injury in older people, and total hip replacement. These publications, which are based on a systematic review plus expert advice with rigorous peer review, examine the effectiveness of health care interventions from the perspective of the decision maker.

42. The Centre maintains three databases. 'DARE' provides abstracts of quality assessed systematic reviews; 'NHS EED' contains economic evaluations of health care interventions; and 'HTA' gives brief details of publications and projects by health technology assessment organisations (within and beyond the UK). All databases are available at http://www.nhscrd.york.ac.uk/welcome.htm.

PRODIGY

43. PRODIGY is a computer-based decision and learning support tool for GPs, offering a series of recommendations for the treatment of a condition. Used during the consultation, the GP enters a diagnosis, in response to which PRODIGY can suggest a range of therapy options to prescribe, as well as specific non-drug advice, patient information leaflets or recommending a referral. There is also a wealth of clinical background information for use outside the consultation, as either reference or learning material.

44. As *Information for Health* is implemented clinical decision support systems, like PRODIGY, will be incorporated into electronic records in health care so that clinicians and care providers have access to evidence-based information at the point of care. Similar developments are likely in relation to social care with the implementation of *Information for Social Care*.

Clinical Evidence

45. *Clinical Evidence* is published by BMJ Publishing Group[368] (P). It contains the latest international scientific research on the treatment of a wide range of clinical conditions, in a straightforward question and answer format – identifying what works and what does not. Much of the information is based on reviews undertaken by the NHS Centre for Reviews and Dissemination and the Cochrane Collaboration. It is updated every six months and Issue 4 has most recently been published. *Clinical Evidence* covers common conditions, including those which affect older people.

Health Care Needs Assessment

46 . The Health Care Needs Assessment[i] was published in 1994 covering twenty important conditions which represent over one third of the burden of disease in nd. Although now several years old, the assessments are still valuable in highlighting key issues for those involved in planning or delivering services.

National Institute for Clinical Excellence

47. The National Institute for Clinical Evidence (NICE) was established in 1999 to provide guidance on new and existing technologies and to develop clinical guidelines and clinical audit.

48. The present programme of appraisals includes, among others, the following which are of particular relevance to older people:

- hip prostheses for total hip replacement (2000)
- new advances in hearing aid technology (2000)
- laporoscopic surgery for hernia and colorectal cancer (2000)
- zanamovir/oseltamivir in the prevention and treatment of influenza (2000)
- donepezil, rivastigmine and galantamine for Alzheimer's disease (2001)
- a range of cancer drugs (some completed 2000/01 and some still in progress)
- photodynamic therapy for age-related macular degeneration (in progress).

49. NICE inherited a programme of both clinical guidelines and clinical audit development, developed through Department of Health funding direct to a number of professional bodies. Again, a number are particularly relevant to older people.

50. For example, clinical guidelines are being completed on:

- pressure ulcer risk assessment/prevention
- range of cancers.

51. And have recently been commissioned on:

- supportive care
- the management of common medical emergencies in primary care
- preoperative investigation.

52. And within the inherited work programme clinical audit methodologies are being completed on:

- falls
- stroke
- evidence based prescribing for older people
- leg ulcers.

53. The next phase of the programmes for appraisals and for clinical guidelines and clinical audit will take full account of this National Service Framework. Priorities for consideration include:

- the identification in primary care of vulnerable older people who would benefit from an assessment within the local single assessment framework
- guidance on the thresholds for referral from primary care to specialist services
- guidance about the identification of those older people who present to emergency services and who would benefit from referral to the various elements of specialist services for older people e.g. day hospital, intermediate care, mental health services and falls services
- clinical guidelines and a clinical audit methodology for a comprehensive falls service
- the identification of older people who are at the end of life, and require palliative and supportive care.

54. The implementation of clinical audit is a requirement of clinical governance, and for doctors is likely to be a prerequisite for revalidation. The Commission for Health Improvement will review progress on clinical governance through a 4 yearly cycle of visits to NHS organisations.

55. NICE can be contacted at http://www.nice.org.uk CHI can be contacted at http://www.doh.gov.uk/chi

Social Care Institute for Excellence

56. The Social Care Institute for Excellence (SCIE), which will be established by the end of summer 2001, will review information about what works in social care and produce guidelines on best practice. Its remit will cover the whole of social care, including the needs of older people.

57. SCIE will work closely with similar health care organisations, for example NICE, when drawing up its guidelines. SCIE's main database, the electronic Library for Social Care (eLSC), will have links with the National electronic Library for Health (NeLH).

National electronic Library for Health and the electronic Library for Social Care

58. The *Information for Health* strategy announced the development of a national electronic library for health offering fast and easy access to best evidence and open to clinicians, managers, patients and the public. NHS Direct Online was launched as the patient gateway in December 1999. In November 2000, a pilot NeLH launched with access to the Cochrane Library, *Clinical Evidence* and a database of NICE guidance.

59. A specialist 'branch' library for older people, which will offer access to relevant material and an interactive forum for discussion, is among the priorities for NeLH in 2001.

60. Over the next year, NeLH and elSC will work together to improve seamless information sharing of evidence-based information across health and social care.

61. The information strategy for older people described in the next section will address the information infrastructure required to make the evidence-based information described in this section available at the point of care.

Information

62. An information strategy to support the NSF and the rest of the older people's programme will be developed by summer 2001, with a target date for implementation of December 2002.

63. The aims of the strategy will be to:

- improve health and social care delivery
- access agreed protocols and guidance
- audit clinical and practice performance against standards and benchmarks
- review performance through national performance assessment mechanisms.

64. It will ensure that the generic information systems developed through the *Information for Health* and Information for Social Care implementation programmes support the needs of older people.

65. The Information Strategy for Older People (ISOP) will support the NSF in the following key areas:

- **Information for patients, carers and the public** - ISOP will support the NSF by ensuring that provision of information at local and national levels meets older people's needs, including those from black and minority ethnic older people. This will build on existing information services provided by libraries, voluntary organisations and local services and the co-ordination of national health services, like NHS Direct and NHS Direct On Line, with Care Direct when it is piloted in 2001/02 and rolled out in subsequent years.

- **Information to support care** - ISOP will underpin the other NSF standards by ensuring that:

  - the common language being developed through the *Information for Health* and *Information for Social Care* programmes includes data items which cover dignity, privacy, disability and social care

  - information systems support multi-sector and multi-disciplinary single assessment, the production of personal care plans that can be held by patients or their carers, and assessment of rehabilitation potential

  - electronic records support stroke, falls and mental health service models, and care pathways generally (appropriate links will be made with the Mental Health Information Strategy, particularly around the development of common datasets)

  - agreed written protocols and clinical decision support systems are available to staff, patients and carers, at the point of care.

- **Information to support clinical governance, performance monitoring and health improvement** - a key principle of *Information for Health* is that information to support clinical audit, performance monitoring and health improvement should be produced as a by-product of the information required to support the delivery of care. Implementation of the Information Strategy for Older People will include a data set development programme, which support the production of aggregate data for quality, management and health improvement purposes. In the long term, these data will be obtained from electronic records. In the short term, services will rely on existing systems.

66. The Information Strategy for Older People will also consider what analytical tools and services are required to support benchmarking and comparative analysis.

ANNEX I: Glossary

Age discrimination	Action which adversely affects the older person because of their chronological age alone. Discrimination can also mean positive discrimination, that is action taken to promote the bests interests of the older person. But the term age discrimination is generally used in the negative sense in this NSF.
Allied Health Professionals	Grouping of clinical professionals who are registered by the Council for Professions Supplementary to Medicine (soon to be the Health Professions Council), for example, physiotherapists, occupational therapists, speech and language therapists, dietitians.
Anti-platelet Agent	Type of anti-clotting agent that works by inhibiting blood platelets. Anti-platelet drugs include aspirin.
Antipsychotic drugs	Drugs used to treat psychosis, including schizophrenia.
Assessment	A process whereby the needs of an individual are identified and their impact on daily living and quality of life is evaluated.
Assistive equipment technology	Equipment that enables children and adults who require assistance to perform essential activities of daily living to maintain their health and autonomy and to live as full a life as possible.
Atrial fibrillation	Irregular electrical activity in the atria (the receiving chambers of the heart) leading to irregular contraction of the heart muscle with less efficient pumping of blood round the body.
Atypical disease	A disease that is not typical or does not conform to type.
Avoidable admission	Admission to an acute hospital which would be unnecessary if alternatives e.g. rapid response services were available.

Best Value	The performance regime for all local government services, including Personal Social Services. Councils are required to review all their services over a five-year period, and seek continuous improvement in services and related indicators, including both nationally set indicators and ones set locally by the council. Best Value performance indicators are structured into five domains which together describe all aspects of performance; these are national priorities and strategic objectives, cost and efficiency, effectiveness of service delivery and outcomes, quality of services for users and carers and fair access.
Bone mineral density	Reflects the size of the holes that form the honey comb inner section of bones. It is measurable with dual energy X-ray absorptiometry.
CABG	Coronary artery bypass graft. A heart operation in which blockages to the coronary arteries are bypassed by grafting on a length of artery or vein to ensure the blood supply to the heart muscle.
Cardiac rhythm abnormality	Abnormal heart rhythm that may be associated with less efficient pumping of blood around the body.
Care management	A process whereby an individual's needs are assessed and evaluated, eligibility for service is determined, care plans are drafted and implemented, and needs are monitored and re-assessed.
Care manager	A practitioner who, as part of their role, undertakes care management.
Care package	A combination of services designed to meet a person's assessed needs.
Care pathway	An agreed and explicit route an individual takes through health and social cares services. Agreements between the various professional involved will typically cover the type of care and treatment, which professional will be involved and their levels of skills, and where treatment or care will take place.
Care planning	Care planning is a process based on an assessment of an individual's assessed need that involves determining the level and type of support to meet those needs, and the objectives and potential outcomes that can be achieved.

Care Programme Approach (CPA)	The formal process (integrated with Care Management) of assessing needs for services for people with severe mental health problems prior to and after discharge from hospital.
Carer	A person, usually a relative or friend, who provides care on the voluntary basis implicit in relationships between family members.
Carotid artery	Blood vessel taking blood to the brain.
Carotid sinus syndrome	Fainting thought to be caused by overstimulation of the carotid sinus, a normal dilation of the carotid artery.
CHI	The Commission for Health Improvement is an independent body covering England and Wales established to provide independent scrutiny of local efforts to assure and improve quality in the NHS, help tackle local service problems and help to monitor the NHS's efforts to address inappropriate variations in service standards.
Chronic degenerative disease	A long standing illness which contributes to increasing disability, e.g. osteoarthritis, motor neurone disease or Parkinson's disease.
Chronic illness	A longterm or permanently established illness.
Clinical governance	A framework through which NHS organisations are accountable for continuously improving the quality of their services and safeguarding high standards of care by creating an environment in which excellence in clinical care will improve.
Clinicians	Qualified healthcare professionals, including doctors, nurses, and the allied health professions e.g. dietitians, podiatrists (chiropodists), occupational therapists, physiotherapists, and speech and language therapists.
Cognition	The higher mental processes of the brain and the mind, including memory, thinking, judgement, calculation, visual spatial skills and so on.
Cognitive impairment	Cognitive impairment applies to disturbances of any of the higher mental processes, many of which can be measured by suitable psychological tests. Cognitive impairment, especially memory impairment, is the hallmark and often the earliest feature of dementia.

Commissioning	The process of specifying, securing and monitoring services to meet identified needs. Commissioning is more commonly used to describe the strategic, long-term process by which this takes place as opposed to the short term, operational, purchasing process.
Community equipment services	Community equipment services provide the equipment, including assistive technologies, that play a vital role in enabling disabled people of all ages to maintain their health and independence.
Community health services	Health services provided to someone in their own home or in the local community.
Co-morbidity	Other co-existing illness in addition to the particular illness which is currently most significant.
Corticosteroid therapy	Treatment for a variety of conditions through the use of synthetic steroids. One of the possible side effects of corticosteroid therapy is to weaken bone mineral density making people more susceptible to osteoporosis.
Councils	Councils are directly elected local bodies which have a duty to promote the economic, social and environmental well-being of their areas. They do this individually and in partnership with other agencies, by commissioning and providing a wide range of local services.
Day hospital	A hospital where patients receive day care only, continuing to live at home.
Dedicated ward	A hospital ward that specialises in the care a particular group of people.
Dehydration	Loss of water from the body.
Direct payments	Cash payments from social services in lieu of community care services.
Domiciliary care	Care provided in an individual's own home.
ECT	Electroconvulsive therapy (or electroconvulsive treatment). A treatment for very severe depression, which involves passing a brief electric charge through the brain of the patient. The treatment is given with the patient under a general anaesthetic and with a muscle relaxant.

Elected member	Someone who is elected to serve on a council.
Elective surgical treatment	Planned surgery e.g. hip or knee replacement or cataract removal.
Expert patient programme	A programme to help people with long-term medical conditions to manage their own health, with specialised support from health care professionals and other agencies.
Health Act flexibilities	Powers in the 1999 Health Act that allow the NHS and local councils to form operational partnerships and enable pool budgets, lead commissioning and integrated provision of services.
Health and social care communities	Local health authority, local council, NHS Trusts, primary care groups and trusts and the independent sector.
Health Improvement Programmes (HImPs)	HImPs are overarching, strategic documents which set out local health strategies for a health and social care system. They are developed by Health Authorities, working with local councils and other key stakeholders, involving local communities.
HES	A DH maintained database containing personal, medical and administrative details of patients admitted to, and treated in, NHS Hospitals in England for the purpose of statistical analysis. It is securely maintained and carefully administered to ensure the confidentiality of its subjects.
Home safety check	A check made by, for example, an occupational therapist to ensure that an individual is safe and can manage in their own home.
Hyperglycaemia	Elevated blood glucose concentration. This occurs in diabetes.
Hyperlipidaemia	Elevated level of lipids (e.g. cholesterol) in the blood. These are associated with increased risk of coronary heart disease.
Hypertension	Raised blood pressure.
Independent sector	Includes both private and voluntary organisations.

Intermediate care	A short period (normally no longer than six weeks) of intensive rehabilitation and treatment to enable patients to return home following hospitalisation, or to prevent admission to long term residential care; or intensive care at home to prevent unnecessary hospital admission.
Integrated continence services	Includes identification, assessment and care of people with incontinence, including help to maintain continence. Services are organised across primary care and specialist services.
Joint Investment Plans (JIPs)	Agreed between health and local authorities, JIPs are detailed three-year rolling plans for investment and reshaping of services.
Long-term care	Refers to support services provided over a prolonged period of time or on a permanent basis to adults who have difficulties associated with old age, long-term illness or disability. Care may be provided in residential settings such as nursing homes or in people's own homes over a prolonged period of time or on a permanent basis.
Malabsorption	Faulty absorption of nutrients such as calcium into the body.
Male hypogonadism	A condition characterised by deficient production of the hormones secreted by the gonads.
Modifiable risk factor	Factor associated with increased disease incidence, e.g. smoking or high blood pressure, that can be reduced by advice and/or treatment.
Multidisciplinary	Multidisciplinary refers to when professionals from different disciplines - such as social work, nursing, occupational therapy, work together.
Multidisciplinary assessment	Multidisciplinary assessment is an assessment of an individual's needs that has actively involved professionals from different disciplines in collecting and evaluating assessment information.
Multi-sectoral	Multi-sectoral refers to different sectors – such as statutory agencies, voluntary organisations, private or for-profit businesses - planning or working together.
National Care Standards Commission	A new, independent national body for the regulation of social care services and private healthcare. The National Care Standards Commission will be legally established this year and will take on its regulatory responsibilities from April 2002.

Neuroleptic drugs	A group of drugs which are used in the treatment of psychotic symptoms such as delusions and hallucinations, or, in small doses, in the treatment of agitated or aggressive behaviour associated with dementia.
NICE	The National Institute for Clinical Excellence is a Special Health Authority which promotes clinical excellence and the effective use of available resources in the health service.
Old age medicine	The medical speciality which is concerned with the diagnosis, treatment and care of older people.
Osteoporosis	A condition that literally means porous bones. As bones become less dense, they become more fragile so that a minor bump or fall can cause a fracture.
PCTA	Percutaneous transluminal coronary angioplasty. Angioplasty of the coronary arteries i.e. the introduction of a balloon on a catheter through the skin, into a blood vessel and into the coronary arteries to widen them.
Performance Assessment Frameworks	Performance Assessment Frameworks are designed to give a general picture of NHS and social care performance. Six areas are covered for the NHS: health improvement; fair access to services; effective delivery of healthcare; efficiency; patients and carer experience and the health outcomes of NHS care. Five areas are covered for social care: national priorities and strategic objectives; cost and efficiency; effectiveness of service delivery and outcomes; quality of services for service users and carers; and fair access.
Performance indicators/ measures	Provide a way of comparing performance: over time, between similar organisations (for example health authorities, trusts or councils), or sometimes between different services. They will normally be expressed as rates or percentages to allow comparison.
Personal Social Services (PSS)	Personal care services for vulnerable people including those with special needs because of old age or physical disability. Examples of services are residential care homes, home help, and social workers who provide help and support for a wide range of people.
Postural hypotension	A fall in blood pressure associated with rising from a lying to a sitting position or a sitting to a standing position.

Pressure related injury	Area of damage to the skin or underlying tissue which has occurred as a result of prolonged pressure to that area.
Pressure sore	Also known as pressure ulcer, decubitis ulcer or/and bed sores are areas of local damage to the skin and underlying tissue due to a combination of pressure sheer and friction.
Primary care	Services provided by family doctors, dentists, pharmacists, optometrists and opthalmic medical practitioners together with district nurses and health visitors, with administrative support. Primary care teams are now grouped within Primary Care Groups/Trusts, which have responsibility for commissioning specialist services as well as for providing primary care, working closely with Social Services.
Primary prevention	The prevention of the development of a condition e.g. stroke, by avoidance of the lifestyle factors known to contribute to its development, e.g. smoking. See also secondary prevention.
Protocol	A plan detailing the steps that will be taken in the care or treatment of an individual.
Providers	Organisations, or designated parts of organisations, that provide health or social care services.
Referrals, Assessments and Packages of Care (RAP)	A Personal Social Services statistical return, covering the services provided or purchased by councils with social services responsibilities for adults and older people, principally supporting people living in their own homes. The return also collects information on referrals to social services departments and the assessment processes leading to somebody receiving social services.
Rapid response	A service designed to prevent avoidable acute admissions by providing rapid assessment/diagnosis for older people referred from GPs, A&E, NHS Direct or social services and (if necessary) rapid access on a 24-hour basis to short-term nursing/therapy support and personal care in the patient's own home, together with appropriate contributions from community equipment services and/or housing-based support services.
Rehabilitation	A programme of therapy and reablement designed to restore independence and reduce disability.

Residential care	Residential care refers to nursing homes and residential care homes that provide around-the-clock care for vulnerable adults who can longer be supported in their own homes. Homes may be run by local councils or independent organisations. Admissions to residential care can be made on a temporary or permanent basis.
Resuscitation	Immediate cardiopulmonary support for person who has stopped breathing or whose heart has stopped beating effectively.
SaFFs	Service and Financial Frameworks set out the levels of NHS activity and resources to support the local contribution to the national and local priorities set out in the NHS Plan and in local Health Improvement Programmes.
Secondary care	Care traditionally provided from a hospital setting in support of the primary care team, e.g. surgery, specialist medical services including old age medicine and mental health services.
Secondary prevention	Interventions designed to identify and treat factors such as high blood pressure or problems with balance which, unmodified, may lead to more serious problems. See also primary prevention.
SERMS	Selective oestrogen receptor modulators which are used for the prevention on non-traumatic vertebral fractures in post-menopausal women at increased risk of osteoporosis.
Service user	A person who is receiving health and/or social care services.
Skin care	Regular skin inspection to identify signs of pressure vulnerability and instigation of preventative care measures.
Skin damage	See pressure sore.
Social care	Social care is provided by statutory and independent organisations and describes a wide spectrum of activities which support and help people live their daily lives. It can include: intimate personal care, managing finances, adapting housing conditions, and help attending leisure pursuits.

Social services	Social services are provided by150 local authorities in England through their Social Services Department. Individually and in partnership with other agencies they provide a wide range of care and support for people who are deemed to be in need.
Social Services Inspectorate (SSI)	SSI is a professional division within the Department of Health. The inspectorate brings professional and management expertise to: • providing policy advice with the Department of Health • managing the Department's links with councils with social services responsibilities and other social care agencies • inspecting the quality of social care services and • assessing the performance of local councils with social services responsibilities including Best Value
Specialist assessment	An assessment undertaken by a clinician or other professional who specialises in a branch of medicine or care e.g. stroke, cardiac care, bereavement counselling.
Specialist services	A service which specialises in the care of particular groups of people, for example those with mental health problems
Step-down unit	A unit which provides residential rehabilitation.
Syncope	Unexplained loss of consciousness.
Testamentary capacity	Refers to a person's ability to handle their financial affairs, most specifically the act of making a Will.

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April 2001 to March 2002	**June 2001** • Local arrangements for implementing the NSF are established. **July 2001** • Jointly appointed co-ordinators for intermediate care designated, framework for user/carer involvement agreed, baseline exercise complete. **October 2001** • Audits of all age related policies complete. **January 2002** • Intermediate care joint investment plan is agreed. **March 2002** • 1500 additional intermediate care beds compared with 1999/2000 baseline. • 40,000 additional people receiving intermediate care services promoting rehabilitation compared with 1999/2000 baseline. • 20,000 additional people receiving intermediate care preventing unnecessary hospital admission compared with 1999/2000 baseline
April 2002	• Strategic and operational plans will include initial action to address identified age discrimination. • Councils will have reviewed their eligibility criteria for adult social care to ensure they do not discriminate against older people. • Single assessment process will be introduced. • Information provided to older people is reviewed and action plans developed to correct shortcomings – reflected in *Better Care Higher Standards* charters. • Specialist multidisciplinary teams will be identified and interfaces for care of older people throughout hospitals will be agreed. • Structures identifying nursing leaders with responsibility for older people will have been developed. Specialist/Nurse Consultant, and Clinical Leaders (Modern Matrons) will have been considered. • Every general hospital, which cares for people with stroke, will have plans to introduce a specialised stroke unit from 2004. • People over 75 will have an annual review of medicine and those with 4 or more medicines will be reviewed 6 monthly. • All hospitals will have a “one stop dispensing/dispensing for discharge” schemes.

October 2002	• Analysis of levels and patterns of key intervention rates will have been carried out to help establish best practice benchmarks.
April 2003 to March 2004	**April 2003** • From 2003/04 local health systems can demonstrate year on year improvements in moving towards benchmarked intervention rates. • Systems exploring user/carer experience will be in place in NHS and PSS organisations. • NHS organisations will have systems in place to analyse complaints from older people and carers. • Strategic and operational plans will include the development of an integrated continence service. • Skills profile of staff who care for older people in general hospitals will be completed. Plans to address identified gaps will be completed. • Hospitals caring for people with stroke will have established clinical audit systems to ensure delivery of the RCP clinical guidelines for stroke care. • Risk management procedures will be in place in all providers of health and social care to reduce risk of older people falling. • Local health systems will demonstrate year on year improvement in measures of health and well being of older people. • Strategic and operational plans will include a programme to promote healthy ageing and to prevent disease in older people.
	March 2004 • 5000 additional intermediate care beds and 1700 non-residential intermediate care places compared with 1999/2000 baseline. • 150,000 additional people receiving intermediate care services that promote rehabilitation compared with 1999/2000 baseline. • 70,000 additional people receiving intermediate care which prevents unnecessary hospital admission compared with 1999/2000 baseline.

April 2004	• Systems to explore user and carer experience in PCTs to be in place. • Single integrated community equipment services will be in place. • Integrated continence services will be in place across all health and social care systems. • GP practices, using agreed protocols, will be identifying, treating and managing patients at risk of stroke. • GP practices, using agreed protocols, will be identifying and treating people who have had a stroke. • GP practices will be using agreed protocols for rapid referral of patients with TIAs to local specialist services. • GP practices will have established clinical audit systems for stroke. • 100% of all general hospitals caring for people with stroke will have a specialised stroke service. • Strategic and operational plans will include the development of an integrated falls service. • Strategic and operational plans will include the development of an integrated mental health service for older people. • GP practices, using agreed protocols, will be diagnosing, treating and caring for older people with depression or dementia. • Protocols are in place across health and social care systems for the care and management of older people with mental health problems. • PCG/Ts will have schemes in place so that older people get more help from pharmacists in using their medicines.
April 2005	• All health and social care systems will have established an integrated falls service.

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