Health Challenge Wales
Her Iechyd Cymru

Llywodraeth Cynulliad Cymru
Welsh Assembly Government

# Fframwaith Gwasanaeth Cenedlaethol

ar gyfer Pobl Hŷn yng Nghymru

# National Service Framework

for Older People in Wales

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# Foreword

Older people are a high priority for the Welsh Assembly Government, and issues relating to older people's health and wellbeing featured strongly in our groundbreaking Strategy for Older People in Wales, launched in 2003.

As promised in the Strategy, and following a period of formal consultation, we are now pleased to present this National Service Framework (NSF) for Older People in Wales, which, through the setting of national, evidence based standards, aims to improve health and social care services and equity of access for older people across Wales.

The NSF seeks to build on the good practice that we know already exists across Wales, and to facilitate the sharing of innovative and effective practice to the benefit of all our older people.

Many stakeholders, including, of course, older people, have been involved in the development of this NSF, and we thank them for both their contribution and enthusiasm. Implementation over the coming years will depend on effective partnership working at a local level, and between local services, the Welsh Assembly Government and other national bodies. Together we can strive to achieve the world class health and social care services which older people in Wales deserve and should expect.

**Dr Brian Gibbons AM**
Minister for Health & Social Services

**John Griffiths AM**
Deputy Minister

# Chapter 1 - Setting the Scene

## Introduction

Living to a ripe old age is something to which we all aspire, given, of course, that we are able to maintain our health and wellbeing, independence and financial security.

The prospect of old age, however, is often associated with negative ideas of decline, vulnerability, dependency and frailty, a perception which is now being roundly challenged. Although the incidence of certain degenerative conditions increases with age, there seem to be few inevitabilities about being older than any given age[1]. Many people continue - or start - to enjoy healthy, active and meaningful lives as they grow older, and for those who do have health or social care needs, these can and should be managed in a way that promotes quality of life, independence and individual choice.

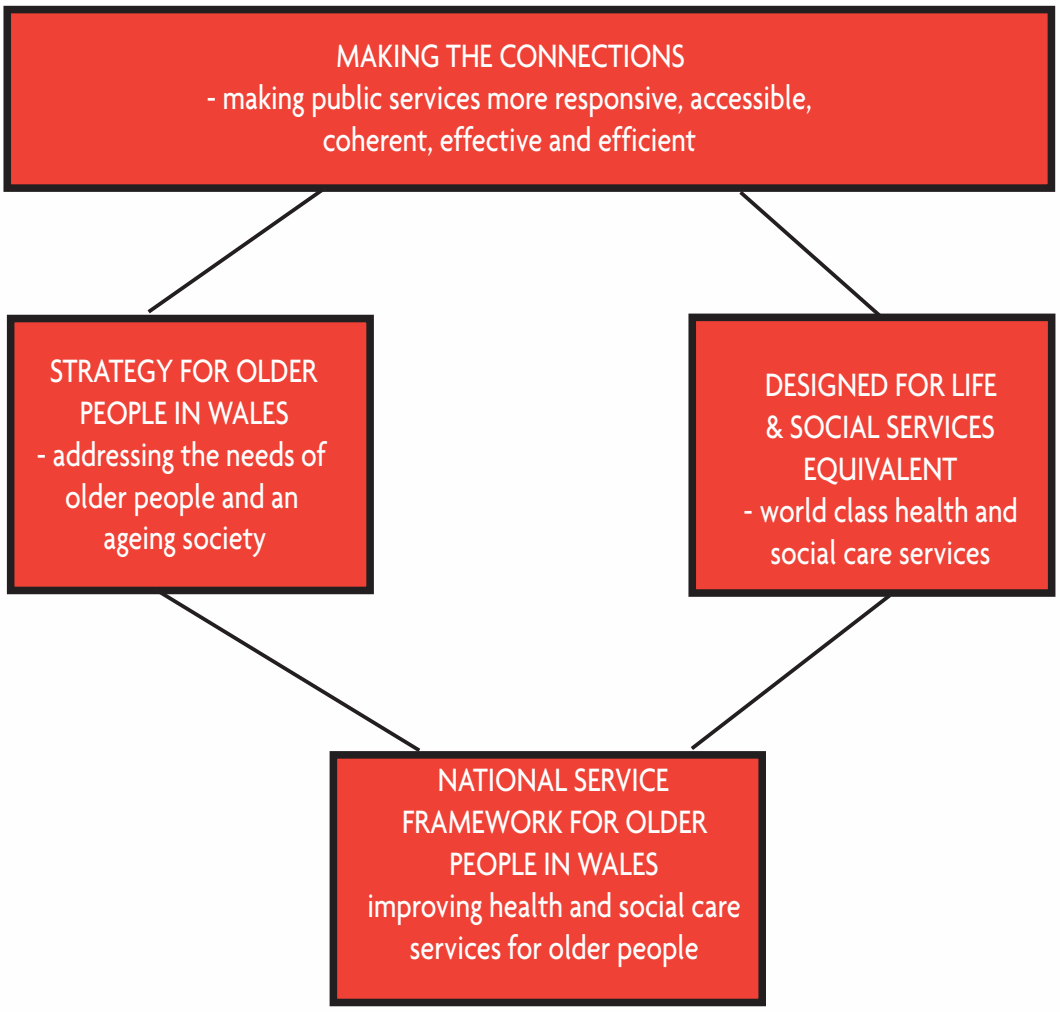
Research conducted by the Joseph Rowntree Foundation[2], revealed what today's older people consider to constitute 'comfortable, healthy ageing'. The major conclusion is that **courage** is perceived to be required to cope with the ageing process, either in fighting it, or adapting to the limitations it brings. The report suggests that "we need to be finding ways of making bravery less essential for what is a normal and natural part of life", through listening to older people about their experiences and addressing the factors they consider to contribute to comfortable, healthy ageing.

In Wales, the views of older people informed the development of the Strategy for Older People in Wales[3]. The Strategy addresses the very broad range of issues that people consider important to their quality of life in older age, recurrent themes being independence and good health, and access to quality health and social services when required. The Strategy made a commitment to the development of this National Service Framework (NSF) for Older People in Wales, and provides the overarching framework for its development and implementation, in terms of the broader older people's agenda.

The strategic context for the development of health and social care services is provided by the Welsh Assembly Government's 10 year strategy *Designed for Life*[4], and its social services equivalent due for publication in 2006.

The transformation of all public services in Wales is being guided by *Making the Connections*[5], which aims to make services more responsive to the needs of individuals and communities; more accessible to all and open to genuine participation; more coherent, delivering through simpler more joined-up structures; more effective in tackling problems and more efficient, recognising that getting the best value from the budget is key to improving services and investing in the front line.

The relationship between these initiatives is illustrated below:




National Service Frameworks are designed to improve standards and equity of access to health and social services across the country. They contribute to the achievement of the *Healthcare Standards*[6], and will be assessed as a 'developmental' element thereof.

The NSF for Older People in Wales, which has been adapted from the NSF issued in England[7], sets national standards designed to ensure that as we grow older we are enabled to maintain our health, wellbeing and independence for as

long as possible, and receive prompt, seamless, quality treatment and support when required.

As in the *Strategy for Older People,* the NSF addresses the health and social care needs of people from the age of 50 onwards, recognising that preparation for a healthy, active and independent old age needs to start as early as possible, and that the transition into 'old age' needs consideration and management. Older people are not a homogenous group and our experience of ageing varies from person to person; health and social care services should therefore be provided according to assessment of individual need, rather than according to a person's age.

A strict definition of 'old age' is therefore not given in this NSF, although age groups will be specified where necessary for the monitoring of certain action points and performance indicators.

## The Health and Social Wellbeing of Older People in Wales

Many older people in Wales remain healthy, active and independent with little or no reliance on health and social care services. However, increasing age is generally associated with increasing disability and loss of independence, and function impairments such as loss of mobility, sight and hearing[8].

The 2001 Census[9] shows that the proportion of individuals with a limiting long term illness (LLTI) increases markedly with age. Significantly lower rates are found in rural Wales and Cardiff, with significantly higher rates found in the South Wales Valleys. Even within local authority areas, however, there are electoral divisions with significantly higher LLTI rates.

The Census also asked people to rate their health status over the past year, and again, the tendency to rate one's own health as 'not good' increased with age. Interestingly, however, the number of older people reporting their health as 'not good' was around half of the number reporting to have a limiting long term illness, possibly indicating that older people see LLTI as part and parcel of ageing.

The most common health problems amongst older people and causes of hospital admission and mortality are respiratory and heart disease, cancer, stroke, diabetes and fractures. Existing National Service Frameworks for Coronary Heart Disease, Diabetes and Cancer are already in place to address those health issues, and Service Development and Commissioning Directives are being developed for Respiratory Disease and Musculo - Skeletal health. Prevention, treatment and care in relation to stroke and falls and fractures are covered within this NSF.

Other chronic health conditions affecting older people include incontinence and malnutrition. Incontinence is a distressing but often treatable condition which affects significant numbers of older people, particularly those within care homes. Malnutrition leads to physical weakness and poor health resulting from a lack of food, or a lack of the right types of food needed for good health.[10] Data suggests that older people are more at risk of malnutrition than others, whether in the community, hospital and other care settings. The prevalence has been estimated as between 11% and 44% in the general hospital population, but rises to 29% to 61% of older people.[11] Malnutrition is not inevitable with ageing but, as with incontinence, can be a side effect of other age related factors such as polypharmacy (multiple medication).[12]

Older people are therefore major users of health and social services. The Welsh Health Survey 2003/4 found that use of many health services increased with age, including the use of GPs and practice nurses, community based nurses, chiropodists, opticians and hospitals (except casualty departments). Estimates suggest that malnourished people have a 6% higher GP consultation rate, are given 9% more prescriptions and have a 26% higher admission rate than people who are well nourished[12]. Historically, experts have put the cost of under nutrition to the NHS at between £2b and £4billion per year; however a study to be published by the British Association for Parental and Enteral Nutrition, indicates that the costs are closer to £7billion[10].

Older people often have multiple chronic pathologies, requiring multiple medication, which, if not well managed, can lead to avoidable hospital admission and readmission. As well as being the main users of acute hospital services, older people tend to experience a longer length of hospital stay.

For those older people who need help with the tasks of everyday living, this help can come from a number of different sources, and for many people is provided by family, friends and neighbours. 6% of the Welsh population already provides this type of 'informal' care to older people, including an estimated 190,000 older people themselves.

Research carried out by Age Concern found that in Wales, 23% of women aged between 60-64 are involved in unpaid caring for others. Overall, caring carried out by those over 50 in Wales has been estimated to the value of at least £1billion.[13]

More formal social care may be provided either within people's own homes or within care settings, by a range of statutory, independent or voluntary service providers.

Despite increased provision of social care services, supply has been outstripped by demand. The social care system, faced with increasing demand and resource pressures, has had to tighten eligibility criteria and concentrate on those requiring the most intensive care packages, at the inevitable expense of preventative and early intervention to promote effective and sustainable independence.

There is a pressing need to redress the imbalance in order to promote equality and the health and wellbeing of older people, and to prepare positively for the impact of our ageing society.

## The Future - Our Ageing Society

The proportion of older people in the Welsh population has been steadily rising over the past 25 years and, with a steadily decreasing birth rate, is likely to continue rising in the future[14]. The proportion of the population aged 60 and over now accounts for nearly 1 in 4 people in Wales. Over the next 20 years, the overall population is projected to grow by just 3%, but the number of people of retirement age will increase by 11 %. The number of very old people, aged 85 and over, is projected to increase by over a third to 82,000. These demographic changes will significantly alter the overall balance of the population, and are likely to have most impact in certain communities such as remote parts of the Valleys.

Life expectancy, especially for men, has dramatically increased over recent years and by 2020 it is estimated that women will have a life expectancy of 87 years, and men of 84 years. This is a positive result of improvements in public and preventive health measures, advances in medical care and improvements in the socio-economic well being in the population[15]. The projections, however, are based on national averages, and statistics for 2000 - 2002 conceal significant variations across Wales, with a five year difference between the areas with the lowest life expectancies (Blaenau Gwent and Merthyr Tydfil) and that with the highest (Ceredigion).

Through the *Strategy for Older People in Wales*[3], the Welsh Assembly Government is planning ahead in anticipation of the impact of an ageing society, as well as improving the quality of life of today's older people.

So what impact will our ageing society have on health and social care services and related policy in Wales? This impact is not easy to predict.

Research undertaken by the Personal Social Services Research Unit (PSSRU) for the Wales Care Strategy Group[16] projected significantly increased demand on long

term care services by 2020. Demand for additional care home places could be minimised, however, by shifting the provision of care from institutional settings to domiciliary settings, through the provision of home care and community health care. Improving older people's health and reducing their dependency levels would further help to curb demand for care services.

The Wales Care Strategy Group and the *Review of Health & Social Care in Wales*[17], reach similar conclusions about the priorities to be addressed, based on the need to improve existing services and to achieve a fundamental shift towards services which promote people's health, wellbeing and independence and address their health and social care needs within the community wherever possible.

This reflects the Welsh Assembly Government's vision set out in *Well Being in Wales*[18], the aspirations of older people expressed in *When I'm 64... or More*[1], *and Designed for Life*[4] of a society where:

- people stay safe, healthy and independent for as long as possible;
- health and social care problems or potential problems are promptly identified and the person's holistic needs are assessed;
- social care and health needs, including chronic health conditions, are managed effectively within the community - avoiding crises and inappropriate hospital or care home admission;
- prompt access is available to quality diagnosis and specialist services when required, including acute hospital care;
- transition from acute services to more appropriate care settings is timely and co-ordinated;
- long term care provision is co-ordinated and effective;
- opportunities for return to full or optimum health and independence are maximised, in whatever setting the person is living.

The achievement of this vision requires a cultural shift placing greater value on old age and older people, and new ways of working at all points along the integrated care pathway, from prevention of dependency and ill health, to timelier intervention and support within a whole systems framework.

This is now commonly referred to as a *'virtuous circle'*[19], where the focus of all elements of the health and social care system is on helping people to stay safe, healthy and as independent as possible, in whatever setting they may live.

Many factors contribute to each stage of this virtuous circle, and will be addressed through the NSF, within the framework of the *Strategy for Older People*[3] above, *Designed for Life*[4] and its forthcoming social services equivalent, and *Making the Connections*[5].

## How will the NSF help to achieve this vision?

Implementation of the NSF for Older People is central to the achievement of this vision in Wales.

The NSF sets national, evidence based standards for the health and social care of older people, thereby helping to ensure that a good level of service is available everywhere in Wales. That is not to say that everyone in Wales will have access to the **same** services; local services will be developed to meet local priority needs, and there will always be pockets of excellent, innovative services to which other areas will aspire. However, older people have a right to expect that the minimum standards set out in this NSF will be delivered.

The NSF sets out a 3 stage programme to bring all services up to a minimum good standard in the shorter term, and to share and spread good practice to continuously improve services and strive towards excellence.

The NSF consists of 10 key standards, which set out the rationale and evidence base, followed by key actions required.

There are six cross cutting themes which underpin all of the standards:

- equity
- person centred care
- engaging older people and carers
- whole systems working
- promoting well being and independence
- management capacity

These have been used by the Healthcare Commission, Commission for Social Care Inspection and Audit Commission in their joint review of implementation of the NSF for Older People in England, and have been taken into account in the development of the NSF for Wales.

When older people need to access health or social care services, it is vital that these services are accessible and meet their individual needs. The standard on **Rooting Out Age Discrimination (pages 15 - 24)** aims to ensure that people are never discriminated against in accessing or receiving health or social care services due to their age, nor are faced with discriminatory attitudes from staff, intentional or not. Instead, service providers will be expected to design services in partnership with older people, and ensure that their needs are listened to and respected.

The **Person Centred Care** standard **(pages 25 - 36)** reinforces the central importance of the Unified Assessment and Care Management system in identifying and meeting individuals' holistic needs. This also relies on the appropriate personal and professional behaviour of staff, and on a whole systems infrastructure in which integrated health and social care services are planned and delivered.

The standard on **Promoting Health and Wellbeing in older age (pages 37 - 50)** reflects the increasing emphasis on helping people to stay healthy and independent for as long as possible. It calls for initiatives to address the social, economic and environmental determinants of health through Community Strategies and Health, Social Care and Well Being Strategies; availability of integrated health promotion activities of specific benefit to older people, reflected in the Healthy Ageing Action Plan[20]; support for individuals to take more responsibility for their own health and well being; and access to mainstream health promotion and disease prevention programmes, eg screening programmes, smoking cessation schemes, universal primary care services.

Once an individual's health or social care needs have been assessed, or need for further specialist assessment identified, it is important that the required services are available to respond to those identified needs, including 'low level' needs. The standard on **Challenging Dependency (pages 51 - 63)** states that wherever possible, those needs should be managed within a community setting, in or near the person's own home, enabling people to maintain their independence and avoiding the need for inappropriate hospital or care home admission. Some such services will be provided by primary and community health staff, some by social care services, and others by the voluntary or independent sectors.

Adding to these, the standard on **Intermediate Care (pages 65 - 72)** aims to develop a co-ordinated and integrated range of services that respond to more intense needs, which if not met within a community setting could lead to hospital or care home admission. Intermediate Care services also provide appropriate care environments to enable more timely transfer of care from acute hospital settings and support for people in regaining their independence.

When admission to acute hospital is required, access and assessment of need should be prompt and efficient, and ongoing treatment of care effective and responsive to the older person's needs. The standard on **Hospital Care (pages 73 - 94)** aims to ensure that emergency services and NHS Trusts provide such an effective response to older people's needs, in terms of both the clinical and non-clinical care provided. An older person's hospital stay should also occur within a continuum of care, with a return to an optimum level of independence as the ultimate objective.

Certain health conditions are more prevalent in older people, and specific measures to prevent and address these are provided in the standards on **Stroke, Falls and Fractures and Mental Health in Older People**. The standard on **Stroke (pages 95 - 108)** applies to all adults, and aims to reduce the incidence of stroke through lifestyle advice for all and specific advice and monitoring for those at high risk. The standard also aims to ensure that people who have had a stroke receive the best possible care in the immediate as well as longer term to maximise their chances of survival and recovery.

The standard on **Falls and Fractures (pages 109 -127)** also places emphasis on helping to prevent falls from occurring in the first place, and also on the prevention and treatment of osteoporosis which can greatly exacerbate the effects of a fall. Once an older person has fallen, the standard aims to ensure that any resultant fractures are treated promptly and effectively, that any other side effects such as loss of confidence are addressed, and that the person's likelihood of falling again is risk assessed and managed through a multi agency approach.

Older people with mental health problems should receive services in line with the Adult Mental Health NSF, however, the standard on **Mental Health in Older Age (pages 129 - 150)** addresses the specific issues faced by older people and their carers. The standard supports the promotion of mental wellbeing in the general population, as well as specific measures to prevent depression and dementia which are common in old age. The standard aims to improve the identification, treatment and care of older people with these conditions, and the transition of care for adults with an enduring mental illness as they enter old age. Services for younger people with dementia are also addressed within this standard.

The NSF for Older People in England was accompanied by a separate booklet entitled **Medicines and Older People**, which sets out the key role that effective management of medicines plays in the health and wellbeing of older people. This booklet has been revised and incorporated as a standard within the NSF for Older People in Wales **(pages 151 to 168)**.

The principles which underpin this NSF apply to all older people including residents of care homes. The long term care of older people is not, however, addressed in detail in this document. The Welsh Assembly Government has issued Guidance[21] on NHS responsibilities for meeting Continuing NHS Health Care Needs, along with a Framework for Implementation[22] to ensure consistent, equitable and appropriate application of the eligibility criteria across Wales. For older people living in or going into a care home, information on the funding of any nursing care provided is given in the document *NHS Funded Nursing Care in Care Homes in Wales: What it Means for You (2003).*[23]

The quality of care provided in care homes is inspected by the Care Standards Inspectorate for Wales (CSIW), in line with the Regulations and National Minimum Standards for Care Homes for Older People (2004)[24]. The Regulations and National Minimum Standards for Domiciliary Care Agencies (2004)[25] govern the standards of care provided in people's own homes. Local authorities also have responsibilities for older people receiving long term care, including assessment, care management and provision of services that are inspected by the Social Services Inspectorate for Wales (SSIW).

The main policy direction for the long term care of older people will be taken forward through the forthcoming social care policy directions paper.

# Chapter Two - The Standards

## Rooting Out Age Discrimination

**STANDARD -** ***Health and social care services are provided regardless of age on the basis of clinical and social need. Age is not used in eligibility criteria or policies to restrict access to and receipt of available services.***

### Rationale

One of the five key aims of the *Strategy for Older People in Wales*[3], reflecting the United Nations principles for older people, is to tackle discrimination against older people wherever it occurs, promote positive images of ageing and give older people a stronger voice in society.

Within this framework, the NSF for Older People will promote the adoption of pro-active, effective age equality measures to seek to challenge and eliminate both direct and indirect age discrimination, across all areas of policy and service provision in health and social care in Wales.

Age equality means securing the equal participation in society of people of every age, based on respect for the dignity and value of each individual. Age discrimination, on the other hand, is *"the practical manifestation of ageism, which is a form of prejudice as unacceptable as racism or sexism."*[26] Ageism results in exclusion for older people and deprives the rest of society of the benefits its older members could bring. It denies rights and forces older people into an inequitable experience of citizenship. Age discrimination is abusive. It also detrimentally influences older people's self-perception, erodes self-esteem and adversely affects the health and well-being of older people[1, 27].

Older people who are already vulnerable to forms of discrimination due to race, sexual orientation or disability may become the subject of 'double discrimination' as they grow older.

There is evidence to show that older people and their carers have experienced age-based discrimination in access to and availability of health and social care services[1, ,26, 27, 3, 28, 29]. This includes evidence of both direct and indirect age discrimination:

- **Direct discrimination** involves the presence of explicit discriminatory policies that disadvantage older people and / or restrict, and even exclude, access to services based purely on chronological age. Examples include:
  - Health services that apply an age bar to access to treatment and services or rehabilitation;
  - Cost ceilings for social care services for older people that are lower than for other adult services[32]
  - Social care spending disparities between younger and older adults[30]
- **Indirect discrimination** does not necessarily involve the presence of explicit policies but it manifests in established practices and in the use of derogatory language that particularly disadvantages, devalues and / or excludes older people. Although indirect discrimination is more difficult to identify and, therefore, to challenge, it does not mean to say that it is less damaging. Examples include:
  - Disbelieving older people's accounts of their medical or clinical symptoms or these being disregarded as a natural condition of their age[27];
  - The redefining of older hospital patients as financial risks to the extent that they are no longer viewed as human beings with health needs, but labelled as costly and inanimate 'bed-blockers'[31];
  - Inappropriate attitudes and behaviour of senior and front line staff towards older people[32].
  - Ascribing potentially reversible changes to the progressive and irreversible effects of ageing and accepting physical decline as inevitable. Such changes may simply be the result of nutritional deficiency, for example[33].

Decisions about treatment and care, however complex, should be made on the basis of each individual's needs not their age. Denying access to services on the basis of age alone is not acceptable. That is not to say that everyone needs the same health or social care, nor that these needs will be met the same way. As well as health needs, the overall health status of the individual, his or her assessed social care need and his or her own wishes and aspirations and those of his or her carers, must shape the package of health and social care.

The Fair Access to Care Services (FACS) Guidance issued by the Welsh Assembly Government in 2002[44], and revised in 2003, provides a framework for determining eligibility for all adult social care services. It requires all adults, irrespective of age, to be subject to the same eligibility processes with decisions based on assessed need. The framework is designed to ensure greater equity and fairer access to care services. It is therefore imperative that this guidance is implemented effectively across Wales.

Legislation to combat age discrimination in employment, in line with the Age Discrimination strand of the European Employment Directive, will apply by December 2006. However, there is a great deal that can be done to tackle ageism in other areas without a change in the law. *The Strategy for Older People in Wales* has been praised as an example of promoting equality across the Board[27], and it is acknowledged that implementation of standard 1 of the *National Service Framework for Older People in England*[7] has led to positive action in identifying and rooting out age discrimination in access to health and social care services[32, 34].

To support the implementation of standard 1 of the NSF in England, the Kings Fund issued a guide entitled *"Auditing Age Discrimination: A Practical Approach to Promoting Age Equality in Health and Social Care"*[32]

## Key Interventions

### Leadership and Ownership

Eliminating age discrimination requires strong and committed political, managerial and clinical leadership and essential to this is having named owners for all key elements of policy implementation. The Strategy for Older People called for each Local Authority Executive to designate an Older Person's 'Champion', and similar leadership is also required at **managerial** level within local authorities, NHS Trusts and Local Health Boards. Each Chief Executive must be responsible and accountable, where appropriate through a delegated named leader, for ensuring that older people, as the largest population group and main users of health and social services, become and remain a priority within their respective organisations and partnerships. They will be responsible for ensuring that older people's needs are reflected in local Health, Social Care and Wellbeing strategies, and are met by the policies and practices of their respective organisations.

### Policy and Service Review

In order to root out age discrimination the first step is to identify where it exists. This requires a review of both policy and practice, central to which are the views and experiences of older people. Ongoing reviews and action programmes should be part of the relevant corporate planning arrangements. The King's Fund guide on Auditing Age Discrimination[32] gives practical guidance on what to review, how to approach the review and how to effect resultant improvements. The guide proposes that the following should be subject to review:

- **Health policies -** national and local; age related criteria for admission and access to treatment; operational implications of policies for older people; recognition that older people could take longer to recover than younger patients.

- **Social care policies -** cost ceilings; spending differentials; access to services; staffing and training levels; focus on maintenance rather than empowerment and independence; transition between services based on an individual's chronological age rather than their changing care needs.
- **Custom and practice -** embedded in practice so best reviewed by older people themselves.
- **Access to specific services -** explicit age barriers; failure to recognise that certain services could benefit older people; services provided in such a way that deters access by older people.
- **Attitudes -** the most frequently reported aspect of age discrimination. Feedback from older people is essential in identifying the issues.
- **Privacy and dignity -** impacted on through facilities and practice
- **Environment -** mixed-sex wards; comparability of facilities for older people with those for younger people; accessibility and conformance with Disability Discrimination Act.
- **Information -** use of jargon; oral and written; anticipation of older people's and carers' information requirements
- **Staffing -** staff ratios and access to training - in comparison with services for younger people.

It is important to differentiate between areas where older people are treated differently, or receive a different kind of service simply because of their age and those which are the result of differences in need, complexity or the pattern of demand for a service.

Explicit policies and supporting guidance are important in raising awareness and understanding about age discrimination and providing a framework in which practice is undertaken on a fair and equitable basis. They must set out the key principles and aims that the organisation is striving to achieve in this area - in terms of long term objectives as well as short term goals. Advice on avoiding age discrimination and on promoting age equality should be included in:

- Service design and delivery
- Monitoring systems
- Benchmarking
- Continuous review, feedback and evaluation
- Professional development and training

The NHS and Local Authorities must also ensure that age discrimination guidance is incorporated into all contracts/service level agreements where services are being contracted out to independent providers, such as out of hours cover in the case of health services and residential or domiciliary services in the case of social care.

## Involving Older People

Older people have a fundamental right to be involved and able to participate in decision-making processes that affect their lives and choices. To ensure that older people are not discriminated against as a result of assumption or ignorance, agencies must encourage, enable and support older people to achieve this fundamental right in all aspects of their work.

All public services have become increasingly aware of the need to engage more in Public and Patient Involvement. The document *Signposts 2,* [35,] gives guidance to the NHS on putting public and patient involvement into practice in Wales. The document makes specific reference to involving older people. Local authorities are also engaged in public involvement activity, with many schemes for involving older people being funded under the *Strategy for Older People*[3].

Guidance on public involvement calls for:

- the creation of formal systems to support and develop effective public and patient involvement
- effective involvement and consultation over planned service changes
- inviting and listening to user feedback and complaints
- using feedback to inform service improvement
- integration with other systems and processes, such as clinical governance, performance management and communication
- staff training and development to help ensure effective public involvement.

The Age Concern Cymru EngAGE project is designed to forge links between decision makers and older people, through sharing good practice and practical ways of getting older people involved in planning the policies and services that affect their lives. This is being facilitated across Wales by EngAGE Regional Development Officers.

All health and social services must include older people as a priority group in their arrangements for public involvement and ensure that older people are visibly involved in setting, monitoring and evaluating standards.

## Advocacy

There are a number of different types of advocacy, including peer and professional advocacy, and that which is provided as a professional service by lawyers relating to legal matters. However, in the context of the NSF this standard focuses on independent citizen advocacy.

One definition of citizen advocacy is offered by A. Dunning[36]: *"Citizen advocacy is a one to one ongoing partnership between a trained volunteer citizen advocate and a person who is not in a strong position to exercise or defend his or her rights and is at risk of being mistreated or excluded. The citizen advocate should be free from conflicts of interest with those providing services to their partner and should represent the interests of their partner as if they were their own."*

Not all older people require an advocate. Most older people can speak up for themselves and adequately represent their needs and rights. However, at a time of crisis or vulnerability, even the most articulate can find him or herself at a considerable disadvantage. Not all will be able to rely on the support of a family member, carer or friend who can communicate on their behalf.

**SOME REASONS WHY OLDER PEOPLE WILL NOT SPEAK FOR THEMSELVES:**

- Preconceived, stereotypical ageist attitudes held by service providers which lead to age discrimination in the provision of services and/or medical treatments;
- A reluctance to complain that arises from cultural attitudes held by some older people that "those in authority know best";
- Fear that complaints will lead to losing what services the older person is receiving;
- Vulnerability and loss of confidence at a time of significant change, such as when entering a residential or nursing care home and during other life changing circumstances;
- A feeling that other age groups are more deserving;
- A fear that they will be seen as a burden.

In some instances, the relationship between the advocate and the older person may involve a longer-term commitment than merely advocating in cases where a crisis arises. Therefore, the length of the relationship must be determined according to the nature of the older person's circumstances and level of support needed. For example, this could include older people who experience the onset and progression of dementia and for whom asserting their own rights can become a growing challenge as confusion and memory loss develop.

A commitment is required from all professionals within the health and social care systems to listen to and be accountable to the older people they serve. Ultimately, they must recognise that in some instances professional decisions will need to be made with the participation of independent advocates, who are committed, trained, supported and scrutinised, representing the needs and rights of those older persons who find it difficult to speak up for themselves. The National Minimum Standards for Care Homes in Wales[24] (standards 8 and 11) require that service users are assisted in accessing advocacy services when required.

### Workforce Development

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 that is perceived as discriminatory.

It is therefore essential that those recruited are able to demonstrate appropriate skills, experience, knowledge and qualities for the work they are employed to undertake. Staff at all levels should receive the training and development necessary to build their knowledge base and foster positive attitudes towards ageing and older people. Vocational, pre-registration and professional qualification training for Health and Social Care staff must include age discrimination awareness and the promotion of age equality in compulsory modules.

**STANDARD -** *Health and social care services are provided regardless of age on the basis of clinical and social need. Age is not used in eligibility criteria or policies to restrict access to and receipt of available services.*

| Outcome | What to measure | How to measure |
|---|---|---|
| **Fair access** to health and social care services based on clinical and social need | equality indicators: age breakdown for access to key treatments, services etc | Age Discrimination review tool |
| Older people **receive** health and social care services which promote age equality | Qualitative indicators / older people's views | service user survey |
| Older people's wellbeing and health and social care needs are given high priority at both a local and national level | • Effectiveness of leadership at national and local level<br>• Mainstream policy reflects older people's needs | • evaluation<br>• Age Proofing tool |
| Older people are able to participate fully as citizens in service planning and monitoring at both a local and national level | • Availability and use of advocacy services<br>• Evidence of older service user involvement | • review<br>• review |

**Objective 1 - To strengthen organisational leadership and commitment to addressing older people's needs and rooting out age discrimination**

| Action | By when | By whom |
|---|---|---|
| **1.1 -** Each local authority, NHS Trust and LHB Chief Executive will identify a named leader for older people across the organisation, ensuring that older people become and remain a priority and to support the implementation of the NSF specifically. | September 2006 | Each local authority, NHS Trust, LHB Chief Executive |

| Action | By when | By whom |
|---|---|---|
| **1.2 -** The role and responsibilities of the named leader for older people will be communicated to all staff and two-way communication systems will be established. | September 2006 | Each local authority NHS Trust, LHB, |
| **1.3 -** The named leader will regularly report on implementation and monitoring of the entire NSF to the Cabinet / Board. | September 2006 and onwards | Older People's named leaders in each local authority, NHS Trust, LHB |

**Objective 2 - To ensure that organisational policies and practices do not discriminate on the basis of age.**

| Action | By when | By whom |
|---|---|---|
| **2.1 -** Each local authority, NHS Trust and LHB will establish or use an existing Scrutiny Group to review and monitor practice and relevant organisational policy to ensure compliance with this Standard. The Scrutiny Group must include older user and carer representation. | September 2006 | Each local authority, NHS Trust, LHB |
| **2.2 -** An audit of existing policy and practice will be undertaken and an action plan agreed by the Cabinet / Board, implemented and monitored, to ensure the phasing out of any age discrimination | End of March 2007 | Scrutiny Groups in each local authority, NHS Trust, LHB |
| **2.3 -** Explicit policies and supporting guidance to be provided by each organisation to set out the key principles and objectives in rooting out age discrimination, and to inform service design, delivery, commissioning, monitoring, review and staff development. | End of March 2007 | Each local authority, NHS Trust, LHB |

**Objective 3 - To ensure that older people are actively engaged and involved in health and social service planning and review**

| Action | By when | By whom |
|---|---|---|
| **3.1 -** older people and carers are included in any arrangements for public involvement (local authorities) and Patient/Public Involvement (PPI - NHS), including ongoing service monitoring and review. | End of March 2007 | National Assembly for Wales, local authorities, NHS Trusts, LHBs |

**Objective 4 - Advocacy services for older people are available, publicised and accessed when appropriate**

| Action | By when | By whom |
|---|---|---|
| **4.1 -** Independent advocacy services for older people are commissioned, publicised and accessed. | End of March 2008 | Commissioners to ensure availability; service providers to ensure advocacy services are accessed |

# Person Centred Care

**STANDARD -** *Health and social care services treat people as individuals and enable them to make choices about their own care. This is achieved through the unified assessment process, integrated commissioning arrangements, the integrated provision of services and appropriate personal and professional behaviour of staff.*

## Rationale

Person centred care is about ensuring that care provided to older people centres around them and their needs, rather than around the needs of service providers and planners.

Placing the person at the centre of care planning means that the person:

- is given the opportunity to express their views which are listened to and respected
- receives the care they need when it is needed, regardless of organisational boundaries, or
- understands why services may not be able to be provided
- knows where and how to access ongoing support and information

The outcome is that people receive care that is appropriate, timely, effective and seamless, reflecting their views, choices and individual needs. The care is delivered by competent and considerate staff, as perceived by the person receiving the care, as much as by the various service providers.

Consultation with older people, however, has highlighted that the care they receive is often not person centred[1, 19, 27]. As we grow older, our needs often become more complex and can fluctuate from day to day. We may require support from a variety of different services, but even if these are individually of high quality, with so many providers involved, there is a real risk of fragmentation, duplication and lack of direction and co-ordination. The quality of the services and care received can also vary according to geographical area or individual care provider[19, 37].

In order to achieve Person Centred Care, this standard focuses on:

- the personal and professional behaviour of staff,
- end of life care,

- the provision of information,
- and a whole systems infrastructure within which services are planned and provided.

- **Personal and professional behaviour of staff**

  Organisations and individual care providers can go a long way to achieving person centred care by ensuring that the care they provide is of high quality and meets the individual's needs. The relationship between the service user and care provider is fundamental, and should be viewed as a partnership.

  *The Fundamentals of Care Guidance for Health and Social Care Staff*[37] aims to drive up and improve the consistency, quality and delivery of health and social care across Wales. It covers 12 fundamental aspects of health and social care, and throughout reinforces the importance of communication, information, respect, choice and promoting independence.

- **End of Life Care**

  These personal and professional behaviours are particularly important when caring for people at the end of their life. However, evidence shows that older people suffer unnecessarily due to widespread underassessment of their needs, inadequate pain and symptom relief, and lack of access to palliative care. Although specialist Palliative Care services provide a person centred approach to the physical, psychosocial and spiritual care of the dying, these services tend to be provided only for people with cancer. They are also accessed more by young cancer patients than older patients, although it is not clear whether this is due to older people's more accepting attitudes to dying or due to age discriminatory barriers to their access[38].

  Medical advances mean that people with certain health conditions are able to remain at home and live longer than they might have previously done. Increasing numbers of people will be living with organ failure, frailty and dementia, rather than cancer, on which palliative care services have traditionally been based[39,40]. This will require end of life care to be considered as part of care pathway planning for people with those and other chronic and long term conditions, allowing for an unpredictable time of death[39].

- **Information**

  Older people and their carer(s) need timely, appropriate and up-to-date information so they can contribute to decisions about their own care, and negotiate their way more easily around available services[394].

However, through its various studies the Audit Commission has found that all too often older people and their carers receive a disjointed, confused response when they need and seek advice, and that the response they receive only meets their needs in part. A commitment to improve public information and the information infrastructure is being taken forward through *Informing Healthcare*[394] and *Informing Social Care*[395].

- **Whole systems infrastructure**

  The achievement of seamless, person centred care depends not only front line staff but on the infrastructure and systems within which they work. According to the Audit Commission, the range of health and social care services provided "must be delivered across organisational boundaries, with clear assessment processes, access routes, pathways through services and mechanisms to guide older people through. In short, services must work together as a single integrated whole system"[19].

  *The Review of Health and Social Care in Wales*[17], however, states that we are a long way from achieving whole systems working in Wales. Although some good examples were found, the Review did not find that integrated thinking systematically rolled out across the core health and social services was the norm. Instead it found that information exchange is impeded by differing systems and concerns for confidentiality, and that health and social care systems for planning, performance management, accountabilities and resource allocation are quite different.

  The Review therefore calls for "a redoubled effort to secure seamless service provision" and in "breaking down the barriers between health and social care". Rather than structural change, it calls for integrated thinking across health and social care and achieving the best possible national and local outcomes together. *Making the Connections*[5] is now driving this principle forward in Wales, The development of Health, Social Care & Wellbeing strategies and national standards are recognised as opportunities to address the issue in a whole systems way. It also reinforces the importance of implementing the Unified Assessment process, developing common and shared information systems for health and social care, a common performance measurement and management framework and joint funding schemes.

## Key Interventions

### Personal and Professional Behaviour

Front line staff have an important role to play in the delivery of person centred care. They must demonstrate appropriate personal and professional behaviour when caring for older people, central to which are good communication skills and respect for individuals. This includes awareness of the specific communication needs of older people eg, those with a sensory impairment, learning disability or those who would prefer to communicate in Welsh or other languages.

The personal and professional behaviours required of staff in order to provide person centred care are embodied in *Fundamentals of Care*[37]. This draws together a composite set of indicators from a range of statutory, mandatory and professional requirements and national policies, including National Minimum Standards, occupational standards and codes of conduct.

It covers 12 fundamental aspects of health and social care:

- communication and information
- respecting people
- ensuring safety
- promoting independence
- relationships
- rest and sleep
- ensuring comfort, alleviating pain
- personal hygiene, appearance and foot care
- eating and drinking
- oral health and hygiene
- toilet needs
- preventing pressure sores

Implementation of the principles and standards embodied in *Fundamentals of Care* across all health and social care services in Wales, is essential to the delivery of person centred care. It is therefore important that, as intended, *Fundamentals of Care* (or the more detailed standards and regulations on which it is based), is incorporated into training and staff development programmes for all health and social care staff in the statutory, voluntary and independent sectors, and into commissioning and monitoring of services.

## End of Life Care

Good end of life care is an important component in the care of all older people. The All Wales Pathway for the Care of the Dying should be adopted by all services to ensure good standards of care for older people in the later stages of their lives. End of life care should also be considered as part of care pathway planning for older people with long term and chronic conditions.

Age Concern has highlighted 12 principles constituting a 'good death'[41],

- To accept that death is coming and to understand what can be expected;
- To be able to retain control of what happens;
- To be afforded dignity and privacy;
- To have control over pain relief and other symptom control;
- To have choice and control over where death occurs (at home or elsewhere)
- To have access to information and expertise of whatever kind is necessary;
- To have access to any spiritual and emotional support required;
- To have access to hospice care in any location, not only in hospital;
- To have control over who is present and who shares the end;
- To be able to issue advance directives which ensure wishes are respected;
- To have time to say goodbye, and control over other aspects of timing;
- To be able to die when it is time to go and not have life prolonged pointlessly

Support should also be available for the bereaved, including bereavement counselling and advice on dealing with practical issues such as funeral arrangements and legal and financial affairs.

## Information

Older people have the right to make their own decisions about their own lives. Health and social care staff have a responsibility to support older people in this, both through effective verbal and written communication, and by providing appropriate and up-to-date information to them and their carers.

Older people may need information about how they can maintain and improve their own health and self manage any chronic conditions; their assessment, investigation, diagnosis, treatment, rehabilitation and care; effective use of any medication prescribed; life expectancy and end of life care; the range and contact points of local services available; any referral procedures or eligibility criteria; how to complain or make suggestions for improvement.

Health and social care organisations must ensure that such information is provided in a way that is understandable by the older person, and takes account of any specific communication needs relating to language or sensory impairment. The RNIB guide to making information accessible for communities in Wales *(Make it Accessible)*[42] addresses the specific information needs of people with sight loss.

Older people are increasingly users of information and communication technologies, and full use should therefore be made of the internet, email, text messaging and so on.

Across health and social care in Wales, the implementation of *Informing Healthcare and Informing Social Care* will address the improvements required to public information, as well as to the management and use of information and the information technology infrastructure. Implementation should ensure that the specific needs of older people are identified and addressed. Links should also be made with the developing Link-Age initiative which is designed to improve older people's access to information and services.

### Whole Systems Approach

Whole systems working is accepted as the way forward in ensuring seamless, person centred care, but it presents a major challenge to health and social care services which are organised around traditional organisational and professional roles. New ways of thinking and working are called for, and practical barriers to transcending organisational boundaries must be overcome. This must be addressed at both a national and local level[19, 17].

There needs to be a strong national commitment and infrastructure to underpin the development of whole system working, evident in integrated policy making and strategies, processes and systems that enable policy to be translated into practice. In terms of integrated policy making in Wales, the Welsh Assembly Government's vision is set out in *Well Being in Wales*[18] and the *Strategy for Older People*[3] is providing an overarching framework for integrated action for older people.

In line with the Wanless[17] recommendations, action is being taken at a national level to address systems and processes for integrated funding, performance management, information management, audit and regulation.

At a local level there needs to be a commitment from all stakeholders to integration in delivering person centred care. This requires a joint vision of what

integrated care for older people should be, a mutual understanding of each other's roles in achieving this vision, a sharing of actions, resources and associated risks, and an acceptance of the cultural, behavioural and procedural changes that need to be addressed.

This vision and plan of action will be developed, implemented and evaluated by a joint Older People's Planning Team, and reflected in local Health, Social Care & Well Being Strategies which each Local Authority and Local Health Board has a statutory duty to formulate and implement. The Planning Team should incorporate all stakeholders including service providers in the statutory, voluntary and independent sectors.

The plan of action will provide for integrated service delivery for older people where appropriate. The result, from the client's perspective, is that they receive a continuum of care with no delays, mistakes or repetitions, from a range of care providers who are all fully aware of their condition and needs. Integrated services can be delivered by:

- multi-agency, multi-disciplinary teams, under a single management structure with a single budget, joint priorities and joint information system;
- or by integrated provider networks, whereby the need for structural reorganisation is avoided, but the various providers work as a virtual team governed by joint priorities, protocols and accountabilities[43].

In order for services to be seamless and person centred, it is sometimes necessary for client information to be shared between different agencies. The need for such sharing of information should be fully explained to the individual, whose consent should be obtained before the information is shared under the governance of an Information Sharing Protocol. Guidance on the development of Information Sharing Protocols was issued in Welsh Health Circular (2003) 050, and is supplemented by a Confidentiality Code of Practice for Health & Social Care in Wales.

### Unified Assessment Process

The Unified Assessment process is underpinned by the principle of person centred care. Guidance on *"Creating a Unified And Fair System for Assessing and Managing Care"*[44] was issued by the Welsh Assembly Government in April 2002. The Guidance provides steps for development and implementation of the Unified Assessment process at a local level by local authorities and their NHS partners, and for effective management of assessed care needs.

Unified Assessment is designed to ensure that agencies take a **co-ordinated and holistic approach** to assessing and managing care. It must ensure that

- Assessment is valid, objective and fair;
- Assessment and care planning is person-centred and proportionate to need;
- The individual's views, and those of their carers, are fully incorporated into the assessment;
- Services are co-ordinated and integrated at all levels;
- Eligibility criteria are fair and standardised across Wales;
- Unmet needs are fully documented, with reasons why they cannot be met;
- Data about individuals can be anonymised and aggregated to enable statistical analysis for monitoring and planning purposes.

As such, effective implementation of the Unified Assessment process is central to achieving person centred care for older people in Wales. Shared evaluation and ownership of its outcomes is essential for the sustainable development of an integrated health and social care approach.

**STANDARD -** *Health and social care services treat people as individuals and enable them to make choices about their own care. This is achieved through the unified assessment process, integrated commissioning arrangements, the integrated provision of services and appropriate personal and professional behaviour of staff.*

| Outcome | What to measure | How to measure |
|---|---|---|
| Older people and their carers feel that they have choice and control over their lives and how their needs are managed | Views of older people in receipt of health & social care services and their carers | Service user survey |
| Older people feel that their individual needs, privacy and dignity are respected and valued by those providing them with health and social care | • Views of older people in receipt of health & social care services and their carers<br>• Complaints and compliments received<br>• Standards met - i.e. National Minimum Standards, Codes of Conduct, summarised in *Fundamentals of Care* | • Service user survey<br>• Routinely collected<br>• Routinely inspected |
| Older people receive the care they need when needed, regardless of organisational barriers | • Views of older people in receipt of health & social care services and their carers<br>• Number of Unified Assessments undertaken and resultant care packages delivered<br>• Effectiveness of joint planning, commissioning and service delivery | • Service user survey<br>• Routinely collected<br>• Making the Connections / Beecham Review |

| Outcome | What to measure | How to measure |
|---|---|---|
| Older people and their carers are able to easily access clear information and advice about health and social care matters, services and support. | • Views of older people in receipt of health & social care services and their carers<br>• Whether information provided meets accessibility criteria | • Service user survey<br>• review |

**Objective 5 - Staff demonstrate appropriate personal and professional behaviour, attitudes and competence in caring for older people**

| Action | By when | By whom |
|---|---|---|
| **5.1 -** Incorporation of *Fundamentals of Care* (or the more detailed standards and regulations on which Foc is based) into:<br>• Staff training and development<br>• Staff performance management systems<br>• Commissioning, contractual or service specification requirements<br>• Clinical governance arrangements | End of March 2007 | Education and training providers Care Council for Wales, NHS Trusts, LHBs, LAs Independent and voluntary sectors |

**Objective 6 - the care provided to older people at the end of their life promotes their dignity, privacy and personal preferences**

| Action | By when | By whom |
|---|---|---|
| **6.1 -** Implementation of the All Wales Care Pathway for the Dying for all older people being cared for at the end of life | End of March 2008 | LHBs, NHS Trusts, LAS, Independent and voluntary sectors |

**Objective 7 - Ensure open, easy access to relevant and clear information for staff, older people and carers about health and social care matters and services**

| Action | By when | By whom |
|---|---|---|
| **7.1 -** Partner health and social care organisations and older people jointly review the clarity, accessibility and appropriateness of information provided to older people, carers and staff. | End of March 2007 | LHBs, Local Authorities, NHS Trusts Older people Voluntary sector Independent sector |

**Objective 8 - Develop and implement effective, integrated and inclusive planning and commissioning mechanisms for older people's services**

| Action | By when | By whom |
|---|---|---|
| **8.1 -** Statutory organisations establish local joint planning and commissioning arrangements for older people's services. | September 2006 | LHBs and LAs, involving all key stakeholders |
| **8.2 -** Joint service and commissioning plans for the integrated care of older people are developed, implemented and evaluated (and inform local Health, Social Care & Wellbeing Strategies). | End of March 2007 | Joint older people planning and commissioning structures |
| **8.3 -** Service monitoring and evaluation mechanisms, which incorporate feedback from older service users and their carers, are developed and annual reviews integrated into planning and performance management systems | End of March 2007 and onwards | LHBs Local authorities NHS Trusts |

**Objective 9 - Ensure effective and whole systems implementation of the Unified Assessment and Care Management guidance**

| Action | By when | By whom |
|---|---|---|
| **9.1 -** Partner health and social care organisations ensure that sufficient steps are identified and taken to implement the Unified Assessment process effectively, and to evaluate its outcomes. | In line with Welsh Assembly Government Guidance | LHBs Local authorities NHS Trusts and other partners in care. |

# The promotion of health and wellbeing in older age

**STANDARD -** *The physical and emotional health and wellbeing of people over 50 is promoted through strong partnerships, with the aim of extending healthy life expectancy and quality of life.*

## Rationale

To be well and active in old age is something to which we all aspire, and the *Strategy for Older People in Wales*[3] promotes a vision of a healthy old age which challenges negative assumptions and expectations. It presents an alternative vision of good health, vitality, independence and active citizenship, and reduced impact of illness and disability on health and wellbeing.

The achievement of this vision requires a broad approach to health promotion which includes:

- **Initiatives to address the social, economic and environmental factors that influence health**, involving a multi-sectoral approach to maintaining and promoting health, independence and well-being in old age[45].
- **Availability of integrated health promotion activities of specific benefit to older people**, tailored where necessary to reflect diversity, lifestyles, individual identified needs and choice[46, 47, 48].
- **Within a conducive environment, support for individuals to take more responsibility for their own health and wellbeing**, recognising that since much health-related behaviour itself is socially determined, it is people's circumstances that are the most important determinant of health[49].
- **Access to mainstream health promotion and disease prevention programmes**. Older people should have timely access to universal primary care services, and equal access to screening and prevention programmes for common health problems such as coronary heart disease, diabetes and cancer, including smoking cessation schemes and hypertension management.

Promoting and maintaining health is still 'everybody's business'[50], and in addition to the mainstream health promotion work of the National Public Health Service, staff and volunteers from all the agencies whose work impacts on the lives of older people have a role to play, especially those who are involved in the unified assessment process.

Action can be taken by the NHS, local authorities and their partners to:

- work in partnership to develop healthy communities which value and support older people to live fulfilling lives, and recognise their contribution in paid work, voluntary work, as carers and as valued members of the community
- actively promote the health and wellbeing of older people, having identified and taken measures to remove the barriers to healthy living, such as access to facilities and services

Older people are not a homogeneous group and health promotion activity should take account of differences in gender, lifestyle, health status, sexual orientation, physical or learning disability, communication difficulties and the impact of cultural/religious beliefs. It is therefore vital to engage with local communities, ensure their participation, and work across agencies to identify and develop appropriate and accessible initiatives.

## Key Interventions

### Initiatives to address the social, economic and environmental factors that influence health and wellbeing

*The Strategy for Older People in Wales* is the overarching framework for the development of policies and programmes which promote health and independence for older people.

Implementation of the Strategy encompasses whole system plans to address the social, economic and environmental factors that influence the health of older people. These plans are expected to be reflected at local level. The Strategy includes plans for the development of policies and programmes on the following:

- promoting material wellbeing through tackling poverty and social exclusion amongst older people;
- promoting an adequate supply of special forms of housing which meet the varying and changing needs of older people, including those with disabilities, and ensure they can remain independent for as long as possible;
- promoting safety and security through reduction of crime and disorder;
- promoting mobility, activity, social contacts and access to community facilities through improved community transport and free local bus travel for disabled people and pensioners aged 60 and over. Also, the Welsh Assembly Road Safety Strategy proposes an assessment of safety problems for elderly people and development of solutions;

- promoting a positive image of older people and a greater understanding and respect between the generations through the Wales Centre for Intergenerational Practice;
- promoting employment through maintaining and increasing work opportunities for people aged 50 and over;
- promoting individual confidence and skills, economic and community activity through encouraging people over 50 back into learning;
- promoting community involvement through the establishment of local development centres for volunteering and community participation.

At local level the social, economic and environmental factors that influence health are being addressed through local Community Strategies and Health, Social Care and Well-being Strategies (HSCWB). The community strategies are the main framework for improving the economic, social and environmental wellbeing of each county borough council area. They provide the overarching framework for all the other plans relating to the area, including the health, social care and wellbeing strategies. It is essential that the needs of local older people are considered and reflected in these strategies.

The Welsh Assembly Government's document *Developing Health Impact Assessment in Wales* provides guidance on carrying out an assessment of planned policies and initiatives to assess their potential health benefits and disadvantages to the local population, and this can be used to assess the impact of local initiatives on older people. Further information and guidance are available at: www.whiasu.cardiff.ac.uk/index/html

### Health promotion activities that are of specific benefit to older people

There is an increasing emphasis on the adoption of healthy lifestyles from childhood, however, there is a growing body of evidence to suggest that health promotion and the reduction of risk factors for disease even late in life can have health benefits for the individual. These may include an improved sense of well-being, increased or maintained levels of functional ability, disease prevention, improved disease management and longer life[83, 51, 52].

The **Healthy Ageing Action Plan for Wales**[53] provides guidance for use at local level on evidence based health promotion interventions for older people. It is structured around the priorities within the various National Service Frameworks and health gain targets, and highlights the role of national and local statutory, voluntary and independent agencies.

The Action Plan refers to the development of the *Ageing Well in Wales* programme and projects, which encourage partnership working, investment in community and older people's groups and recognises the importance of older people in the design, development and delivery of programmes that enhance health and well being across Wales.

The Action Plan gives details of the available evidence base and recommendations for action in each of these areas:

- physical activity
- healthy eating
- emotional health and wellbeing
- stopping smoking
- sensible drinking
- sexual health
- home safety and warmth
- influenza immunisation
- opportunities for raising awareness and general health screening for older people

### Increasing physical activity

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[83, 54, 55]. Adapted exercise, even for very frail older people can help strength, mobility and balance, and can reduce the risk of falling. It can lower the risk of heart disease and stroke, reduce blood pressure, obesity and incontinence, and ease depression. Activity can and should include educational, creative and social pursuits as well as physical exercise[87, 56, 57, 58, 59].

Despite such benefits, many older people do not participate in any regular physical activity. The Healthy Ageing Action Plan therefore calls for or promotes the implementation of various new or existing schemes, which aim to improve older people's access to physical activity and exercise. Examples include the British Heart Foundation *Moving More Often Programme*, which is being piloted in care homes, the free swimming scheme for the over 60s introduced in November 2004, walking initiatives and the Green Gym Network.

## Improved diet and nutrition

Good nutrition is not only essential for the maintenance of health, but also for recovery from illness. Being overweight, underweight or malnourished can have a detrimental effect on an older person's health and wellbeing. 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[83, 60, 61].

Barriers to healthy eating include accessing affordable healthy food, the side effects of medication that can affect nutrient intake[12] and functional problems such as reduced ability to feed oneself following a stroke and the profound changes in eating ability that accompany the onset of dementia[11]. In addition, surveys have shown the importance of providing older people with dental treatment and advice on oral health[62] to enable them to eat a varied and healthy diet, and to retain their independence and dignity.

New research[10] reveals wide variations in awareness and treatment of malnutrition in primary care, with just over a third of GPs not recognising malnutrition as a significant problem. Very few GPs are aware of the availability of malnutrition screening tools and few make use of them. Yet between 10% and 40% of hospital inpatients are suffering from malnutrition when they enter hospital, which argues the case for improved nutritional screening in the community and in care home settings[63].

It is also important to recognise the need for adequate water intake for older people, (around 6-8 glasses a day) who may be more at risk of dehydration because of deteriorating kidney function, age related changes in hormone levels, taking diuretics and laxatives, and diminished thirst response. Good hydration lowers the risk of pressure sores, urinary infections, kidney and gallstones, constipation, heart disease, low blood pressure on standing, and cognitive impairment (caused by dehydration). It is also an essential part of the dietary management of diabetes[64].

The Action Plan therefore promotes the implementation of existing schemes, such as those outlined in *Food and Wellbeing*[65], the Food and Fitness Health Promotion Grant scheme and the NHS Nutrition and Catering Framework 2002, and calls for issues such as staff training for those working with frail older people, and access to affordable, healthy food, to be addressed.

## Initiatives to support and improve emotional health

Emotional wellbeing means having positive feelings about oneself and one's life, which can act as a protective factor against mild anxiety and depression. Schemes to promote social inclusion, befriending and volunteering initiatives, lifelong learning and other meaningful activity can all have a positive impact on the emotional wellbeing of older people. The availability of extra support or counselling at key times, for example during illness or following bereavement, can also help people to adjust and move on with their lives. Pre-retirement planning can help people adjust to the changes retirement brings. Physical activity can also help to increase a sense of wellbeing and improve mood[54, 66, 67, 68].

The Action Plan complements the health promotion elements of the NSF standard on Mental Health in Older People, the Adult Mental Health NSF and the forthcoming Mental Health Promotion Action Plan, and promotes the implementation of various new or existing schemes, such as extending the emotional health component of the Ageing Well scheme and identifying best practice in pre-retirement courses.

## Sensible drinking

The proportion of older people drinking over the recommended limits has been steadily increasing. Some older people may have a long term drinking problem, others' problems may start in old age, as an attempt to relieve pain, alleviate loneliness, boredom or bereavement, to replace meals or to keep warm. Alcohol misuse is often associated with depression and suicide, and can be a factor in falls, accidents, malnutrition and confusional states. Existing treatment approaches are effective with older people but may not be accessed for a number of reasons, including stigma[69, 70].

The Action Plan therefore promotes the implementation of schemes to address the causal factors of alcohol misuse, as well as those to help people to reduce their intake.

## Sexual Health

Ageist attitudes are strongly apparent in relation to older people and sexual health. Little research is available but it is suggested that although a declining interest in sexual activity is common with ageing, some people maintain the same level and others increase their level of sexual activity. Yet prejudice presents an almost insurmountable barrier for older people to discussing their sexual health needs if they are experiencing problems, or to asserting their right for privacy if they live with family or in a residential home[71]. There is also little awareness of the needs of lesbian, gay and bisexual older people[72]. The Action Plan therefore calls for further research into these areas, to increase our knowledge and understanding.

## Stopping Smoking

Although smoking prevalence falls with age, around 22 per cent of people aged over 50 still smoke. There are health benefits to stopping smoking at any age, and smokers who want help to quit can now access NHS Stop Smoking Services across Wales. However, there is some evidence that health professionals are less likely to raise the issue of stopping smoking with older smokers, and older people themselves may be less likely to accept evidence that smoking is bad for health[83].

The Action Plan therefore calls for all smoking cessation services to offer appropriate support for older people who want to quit, and for their participation to be encouraged.

## Safety promotion and health protection

The Welsh Assembly Government's annual Keep Well This Winter campaign is based on the three main themes of *Keep Well, Keep Warm and Keep Safe*.

**Keep Well -** includes the prevention of influenza and pneumococcal disease through immunisation programmes. Studies show that influenza immunisation among older people is cost effective[84, 73, 74, 75]. It is estimated that, if all older people in Wales were vaccinated against influenza, around 250 additional lives might be saved each year, and all people aged 65 and over are recommended to receive free vaccination. However, uptake of the vaccine overall in 2004-05 was 62.9%, falling short of the national target of 70%. Postal reminders and information packs, and personal advice from a doctor or nurse have been found to be effective in increasing uptake[83].

The Keep Well theme also encourages older people to eat a varied and balanced diet, to keep a well stocked store cupboard and to stay active.

**Keep Warm -** On average, 40,000 more people die in the UK in winter compared to the rest of the year. Over half of these deaths are related to the effects of cold weather on the blood, blood pressure and the respiratory tract. This increase is not seen in colder countries such as Finland and Russia, because they are better prepared to deal with cold weather[76]. In 2004-05 there were 1600 excess winter deaths in Wales.

**Keep Safe -** In addition to the risk of falls, (see chapter on Falls and Fractures) older people may be vulnerable to accidents caused by unsafe appliances, for example old electric blankets, and unsafe practices such as drying washing close to a fire. Older people, especially those living alone and those on low income may find it hard to maintain their homes. They may also be more vulnerable to rogue traders.

A number of initiatives are already in place to deal with the above issues, including the Home Energy Efficiency Scheme (HEES), Care and Repair schemes, and various local schemes for free electric blanket testing, fire safety in the home, general home safety advice, and community police initiatives which alert people to the dangers of rogue traders, and provide home safety locks. The Action Plan calls for continued active publicising of these schemes, in order to increase uptake.

Responsibility for implementation of the *Healthy Ageing Action Plan* is specified therein. The focus is on a partnership approach and shared responsibility, although certain agencies, such as the National Public Health Service (NPHS), have a specific role in health promotion and disease prevention. The NPHS delivers a wide range of health promotion initiatives through its Local Public Health Teams, and can provide guidance to other local agencies on developing and evaluating specific, evidence based health promotion initiatives.

### Within a conducive environment, support for individuals to take more responsibility for their own health and well-being

Health Challenge Wales is a new national focus to improve health. It presents a challenge to the nation, including individuals, to do what they can to improve their own health and that of their families. It encourages individuals to find out what they can do to improve their physical and mental health and to reduce their risks of disease. This may involve making lifestyle changes or taking up employment, learning opportunities or other forms of activity.

However it is recognised that empathy and understanding of people's motivation, and the social conditions which inform their decision making, are key to effecting change. The role of government at all levels is to help create the conditions necessary for people to lead healthy lives and improve their health[77].

Health Challenge Wales is a challenge to individuals, government at all levels, organisations and groups in the public, private and voluntary sector, and the media, to consider what they are currently doing, and what more they could do to improve health. For further information see www.cmo.wales.gov.uk/health-challenge

### Access to mainstream health promotion and disease prevention programmes

The prevention of health problems in older people requires timely and equal access to:

- universal primary care services;
- general health and disease specific screening and prevention programmes.

**Primary health care services**, including general practitioners and practice based teams, community pharmacies, dentists, opticians and podiatrists, provide a health screening role and a vital first point of contact for people when they become concerned about a potential health problem. These services can significantly improve the quality of life for older people by addressing problems with general health and foot care, oral health, vision and hearing, which are often assumed to be inevitable consequences of ageing.

At least three quarters of the older population may have foot problems[78] as the ability to care for one's own feet decreases with age, often due to impaired dexterity and visual impairment. This can lead to reduced mobility and disability[79], contributing to the increased likelihood of falls and social isolation, which can be prevented by timely access to podiatry services[78, 80]. 'Low level' foot care needs, eg, toe nail cutting services, can be provided by the voluntary sector with adequate training[80]. The important potential role of all therapy services will be promoted in the forthcoming Therapy Services Review, and reflected in *Designed for Life*.

Good oral health makes a valuable contribution to the general health and well being of the general population; edentate people (ie. those without their own teeth) report greater difficulty with eating and chewing a range of foods, and have lower energy, micronutrient, fibre and protein intake[62].

However, as people grow older they are less likely to visit the dentist; 46% of people aged 65 - 74, and 63% of people aged 75 and over had not seen a dentist for 10 years, whilst 30% of those aged 65 and over had not seen a dentist for 21 years[81]. There is a danger that denture wearers no longer see the need for dental care, however it is important that older people understand the important role of the dentist in ensuring that dentures fit well, and in the early recognition of oral cancers (which increase with age) and other diseases of the mouth.

Older people, including those in care homes, should have access to dental services including domiciliary dental care which is largely provided by the Community Dental Service (CDS). There are some excellent examples of CDS oral health screening programmes and domiciliary dental services to older people in care homes in Wales, however there is not an equitable service across Wales.

The loss of teeth is in no way an inevitable consequence of ageing, thanks to advances in dental techniques, technology changing public attitudes and expectations. However, this implies that there will a high restorative need in the future amongst the 'baby boomer' generation.[82]

Visual and hearing impairments are amongst the most common problems facing older people today[83]; in the 1998 Welsh Health Survey, 1 in 4 people over 80 reported having visual problems, even with glasses if usually worn, and 4 in 10 people over 80 reported having hearing problems, even with a hearing aid. Such impairments can lead to loss of confidence, social exclusion, falls and other accidents, yet often remain undiagnosed.

There are several causes of visual impairment in older age, many of which are preventable or treatable. Regular vision and eye health checks are therefore very important for older people, to enable the correction of impairments, achievement of optimum vision and early identification of the need for specialist assessment or treatment.

Community pharmacies are located across Wales in places where people live, work and shop, and are thus an important source of public health advice and self care support. The new Community Pharmacy Contract will provide opportunities to further enhance this role.

Timely and easy access to such primary care services is therefore very important to provide reassurance and advice to older people, to identify health problems at an early stage and to intervene with health promotion advice, preventive action, treatment or referral for specialist diagnosis and treatment. A more co-ordinated approach to the delivery of such services is envisaged, as well as improved access across Wales; *Designed for Life* commits that everyone will have access to an appropriate member of the primary care team within 24 hours, and much sooner in an emergency. It is important that such services are equally available to older people living in care homes.

### Screening

Regular health screening for older people used to be undertaken by GPs through the Over 75's Health Assessment. This does not form part of the new GMS contract, however, and new opportunities need to be sought for the proactive health screening of older people within primary care, linking to the Unified Assessment Process, in order to identify problems at an early stage.

The most common health problems amongst older people and causes of hospital admission and mortality are respiratory and heart disease, stroke, diabetes and fractures. Evidence based health promotion and disease prevention activities for these conditions are outlined in the National Service Frameworks (NSFs) for coronary heart disease and diabetes; in the NSF for Older People standards on Stroke and Falls & Fractures; and will be addressed in the forthcoming Welsh Assembly Government Strategies for Respiratory Disease and Musculo-Skeletal Health.

In relation to disease prevention, it should be noted that currently breast and colorectal cancer screening, smoking cessation and hypertension management have the best evidence for effectiveness in older people[84, 85, 86, 87, 88, 89, 90, 91]

**Breast screening: Bron Brawf Cymru / Breast Test Wales -**

The service offers women breast screening by mammography every three years. The programme will be extended, in a phased way so that women will eventually be automatically invited up to the age of 70 instead of the previous 50-65. Although older women may not automatically be invited, they are welcome to ask for screening every three years.

**Wales Smoking Cessation Services -** smokers who want help to quit smoking can access services across Wales, which are delivered through the NHS and provide free advice and support from specially trained staff. Further information about the services can be found at www.cmo.wales.gov.uk/content/work/tobacco/smoking-cessation-e.htm

**Exercise Referral Schemes -** currently there are a number of exercise referral schemes operating across Wales. These normally take the form of a referral from a health professional to a suitably qualified exercise professional. UK standards have been established to ensure the quality of these schemes and the Welsh Assembly Government will be publishing a good practice guide in 2006. The Welsh Assembly Government is also seeking to work with local partnerships to expand the number and scope of exercise referral schemes across Wales.

**STANDARD -** *The physical and emotional health and wellbeing of people over 50 is promoted through strong partnerships, with the aim of extending healthy life expectancy and quality of life.*

| Outcome | What to measure | How to measure |
|---|---|---|
| Increased uptake by older people of health promoting activities and services | Uptake of :<br>• flu vaccinations<br>• smoking cessation programmes<br>• cancer screening services<br>• targeted health promotion activities as per Healthy Ageing Action Plan | Routinely collected |
| Improved lifestyles amongst older people | • Self reported lifestyle issues eg. diet, exercise, smoking, alcohol and substance misuse | • Collected for Welsh Health Survey |
| Increased physical and emotional wellbeing amongst older people | • Perception of well being amongst older people<br>• Death rates from major causes<br>• Excess winter deaths<br>• Prevalence of major health conditions<br>• Accidental injuries<br>• Improved nutritional status | • Self reported physical and emotional health status - WHS<br>• Routinely collected ONS<br>• Routinely collected<br>• Routinely collected - Census, WHS.<br>• Routinely collected - WHS<br>• Routinely collected - National Diet and Nutrition Survey |

| Outcome | What to measure | How to measure |
|---|---|---|
| Increased life expectancy | Average life expectancy | Routinely collected by ONS |
| Improved access by older people to primary care services | Availability of and access to GPs and primary care teams, dentists, opticians, podiatrists, community pharmacists, NHS Direct | Routinely collected |

**Objective 10 - Promote the social, economic and environmental health of older people**

| Action | By when | By whom |
|---|---|---|
| **10.1 -** Local Community Strategies and Health, Social Care & Wellbeing Strategies propose clear actions which reflect the main themes of the Strategy for Older People, to promote and maintain the health and wellbeing of older people in their area. | End of March 2007 | Local Health, Social Care & Wellbeing Partnerships |

**Objective 11 – Specific health promotion programmes are developed to meet the needs of local older people**

| Action | By when | By whom |
|---|---|---|
| **11.1 -** Specific, comprehensive and accessible health promotion programmes are delivered to meet the needs of older people, and must:<br>• be informed by local assessment of older people's needs, priorities and preferences;<br>• be evidence based<br>• incorporate implementation of the Healthy Ageing Action Plan; | End of March 2007 | LHBs and NPHS in partnership with NHS Trusts and LAs |

| Action | By when | By whom |
|---|---|---|
| **Continued**<br>• be monitored and evaluated in terms of uptake by older people;<br>• encourage and support older people to take responsibility for their own health and wellbeing | | |

**Objective 12 - Ensure that older people have fair access to and benefit from mainstream health screening and disease prevention schemes**

| Action | By when | By whom |
|---|---|---|
| **12.1 -** Local commissioning strategies are designed to ensure that older people are able to access a comprehensive range of primary care services. eg<br>• GP and primary care team<br>• Dental services<br>• Eye care services<br>• Podiatry and other foot care services<br>• Community pharmacies<br>and mainstream disease prevention schemes, eg<br>• flu & pneumococcal vaccination,<br>• smoking cessation services,<br>• exercise referral schemes,<br>• programmes developed in support of the various NSFs and any other relevant screening and disease prevention programmes | End of March 2007 | LHBs, National Screening Programmes |

# Challenging Dependency

**STANDARD -** *A range of enabling, community based services is available to intervene promptly and effectively when older people's independence is threatened by health or social care needs, with the aim of challenging dependency and maximising wellbeing and autonomy.*

## Rationale

Many older people manage to remain fit, healthy and independent well into old age, and the NSF standard on Promoting Health and Wellbeing aims to support the achievement of this aspiration.

However, it can be more difficult for older people to maintain their independence and wellbeing when they are faced with increasing frailty, impairment or chronic illness which limits their ability to do things for themselves. 51% of people aged between 65 and 74 in Wales reported in the 2001 Census that they were suffering from a limiting long-term illness, and this figure increased to 63% of 75 to 84 year olds, and 76% of those aged over 85.

Based on figures from the English Health Survey 2000, applied to Welsh population projections, 43% of people over 65 had some form of disability, and this again increased with age. The most commonly reported difficulties associated with such problems include getting in and out of chairs, bed, dressing and using the toilet.

Even when faced with such difficulties, older people wish to maintain and manage their health, wellbeing and independence within their own home and family networks wherever possible, thus avoiding a decline into dependency on health and social services and perceived associated loss of control and autonomy[1, 92, 93].

Older people tend to live either alone or exclusively with other older people. The tendency to live alone increases sharply with age and almost half of the over 75 age group live alone. This increases the risk of social isolation and malnutrition, as people who live alone tend to also eat alone[94]. The potential for independent living or informal care provision is likely to be less for those living alone or with other older people. This has clear implications for formal care provision[95].

Almost two thirds of older households in Wales are outright owners and bear the main responsibility and costs for the repair and maintenance of their homes. The use of central heating and insulation reduces with age and is lowest for the very old despite their likelihood to need it more on health grounds[95].

Traditionally, health and social care services have focused on responding to critical and acute needs, intervening at times of crisis, rather than earlier in the care pathway when needs first become apparent. The challenge will be to allocate resources and configure services so that a more enabling health and social care system can be provided whilst still supporting those with more intense needs.

The need for a fundamental shift in the design and delivery of health and social care services, placing a greater emphasis on prevention of ill health and dependency, and earlier intervention within primary and community care when needs arise, was highlighted in the *Review of Health & Social Care in Wales*[17]. This was reinforced by the Report of the Wales Care Strategy Group[16], and is reflected as a key aim within *Designed for Life*, and its forthcoming social care equivalent policy document.

The desired scenario can be achieved through an enabling health and social care system which supports people to maintain and manage their health and independence when these become threatened, through early intervention, low level assistance, home adaptations and community based services. Although some older people may be reluctant to accept such help, rather than signalling a decline into dependency an enabling approach can help older people maintain their overall longer term independence and autonomy[92, 93].

When significant health or social care needs are first described or suspected in an individual, this should lead to the initiation of the Unified Assessment process, through which a holistic assessment of overall need and support required will be undertaken.

Unified Assessment may identify any number of health and social care needs, including need for assistance with personal care, daily living activities, relationships, support for carers, housing / home adaptations, safety and managing health conditions.

In order to construct a personal care plan to help meet the person's identified needs, including 'lower level' needs, there must be a range of local services and support networks available for them and their family / carers. These may be provided by community based health services and local authority social care and housing services, but may be more appropriately provided by voluntary sector or independent agencies.

The Assembly's Fair Access to Care Guidance urges local authorities to focus on longer term prevention as well as crisis intervention in their application of

social care eligibility criteria, and where low to moderate needs cannot be met by statutory services then alternative support should be available to avoid such needs going unmet.

Earlier intervention based on the principle of maximising autonomy and independence can result in improved quality of life for older people, and help to reduce avoidable pressure on acute services.

## Key Interventions

Redesigning the health and social care system through greater investment in prevention and community based early intervention will be a long term process requiring strong leadership and careful management[93].

That process is being driven by *Designed for Life*, including a commitment to ensure improved integrated commissioning of services. The forthcoming social care strategy will also guide and support local authorities and their partners in meeting the challenge. Further, detailed guidance and targets to support the strategic aim of promoting independence and ensuring earlier intervention will therefore follow as implementation evolves.

Meanwhile, as far as older people are concerned, the key needs that local health and social care communities will be expected to address were laid out in the Report of the Wales Care Strategy Group and are encapsulated by the Unified Assessment 'domains':

### Carers' needs

An estimated 190,000 older people in Wales act as the main carers to their partners and other older people, and this number is set to increase in the future. Carers play a crucial role in helping people to remain living in their own homes, and avoiding dependency on formal care services.

Yet caring can put a huge physical, emotional and economic strain on the carer, placing their own health and wellbeing at risk . The needs of carers should therefore be assessed and support provided to enable them to continue with their caring role, to maximise outcomes for the carer and the person cared for. *Caring about Carers, A Strategy for Carers in Wales*[393] set out the Welsh Assembly Government's commitment to supporting carers in Wales, which promotes the early identification of carers, assessment of their health needs, provision of timely information and advice and availability of respite services. Ongoing implementation and monitoring of the Carers Strategy is important to the achievement of this NSF.

## Activities of daily living

Increasing frailty, reduced dexterity and mobility may affect people's ability to undertake the normal activities of daily living, including getting in and out of bed, washing, grooming, dressing, eating and drinking, and instrumental activities such as meal preparation, shopping, housework or managing their affairs. This may prove particularly difficult following bereavement, if the bereaved person is unused to undertaking such tasks. The ability to retain some control over such activities is crucial to older people's sense of dignity, independence and wellbeing. Thus some may attempt to continue undertaking such tasks themselves, thereby placing themselves at increased risk of injury, malnutrition and depression or anxiety.

For many older people, help will be provided by carers, family, friends or neighbours, by voluntary sector or community support networks, or by the independent / private sector if the individual can afford and chooses to purchase it.

More formal assistance is provided by local authority community based services including home care, day care, meal provision, transport and adaptations. Yet the number of people receiving these services has continued to reduce despite increases in the numbers of people seeking assessment and the fact that our population is ageing.

Individuals who have been assessed as needing certain services, or those who act as carers, may be eligible for Direct Payments. Direct Payments are cash payments by local authorities direct to individuals who wish to manage their own support by purchasing the assistance or services that the council would otherwise provide. This promotes independence, choice and inclusion. The 2005 Direct Payments Survey shows that 122 older people were in receipt of Direct Payments compared with 81 in 2004. Wherever a person is assessed as needing social care services, the local authority should check whether there is a duty to offer a Direct Payment in respect of that service[97].

Support with enabling older people to adapt to the effects of increasing frailty can be provided by the Allied Health Professionals, particularly Physiotherapists who can help maintain mobility, and Occupational Therapists employed by both local authorities and health services. Their role currently tends to be focussed more on rehabilitation and reablement following a serious health incident such as a fall or a stroke, rather than on early intervention when difficulties with activities of daily living start to manifest. A potentially enhanced role for Therapists in providing assessment and early interventions is promoted in the draft Strategy for Therapy Services in Wales.

Aids and equipment, including simple items such as walking aids, and more complex, bespoke items, can greatly enhance people's ability to cope with increasing frailty, disability and sensory impairments. Such items may be provided by health or social services, or by voluntary sector agencies, however lack of co-ordination between these services can often lead to inefficiencies and delays in providing the equipment required. Research has also shown a very low level of equipment provision to the blind and partially sighted[98]. *Designed for Life* commits to the planning of Integrated Community Equipment services in all areas across Wales by 2007, and implementation by March 2008.

Local health and social care communities should ensure that services are available in the locality to respond to the full range of people's needs for personal care and other assistance with daily living. Such services must be based on the principle of enabling people to maintain their independence and autonomy, rather than on fostering dependency. Innovative solutions to the provision of such support, involving the voluntary sector and community networks, should be considered, to complement services provided by the statutory sector.

### Housing

- **Adaptations and maintenance -** if older people are to be enabled to remain living within their own homes, it is important that their home of choice provides a safe, comfortable, healthy and secure environment. Adaptations to people's existing homes, such as the installation of ramps, hand rails, a stair lift or shower, may be all that they require to enable them to remain living there independently. Such adaptations, along with maintenance and repair work, is increasingly undertaken by voluntary sector 'Care and Repair' agencies, working in strategic partnership with local authorities and other organisations from the statutory and voluntary sectors. In addition, the Rapid Response Adaptations Programme, operated by Care and Repair agencies, provides small scale but often vital repairs which allow older people to remain longer in their own homes as well as facilitating quicker hospital discharge. The importance of well heated and insulated homes to the continued health and wellbeing of all older people is outlined in the NSF Standard on Promoting Health & Well Being, however it is of particular importance to those older people who suffer from a chronic illness and restricted mobility. Increasingly, new housing and renovations are required to meet lifetime home standards, which should reduce the need for major adaptations or moving house when people grow older.
- **Assistive technology -** for those older people whose ability to remain within their own homes is threatened by fears for their personal safety, due to risk of wandering, fires or accidents, the ever evolving world of assistive

technology can provide innovative solutions and methods to remotely monitor their activity. Such technologies include motion, voice activated and remote controls, some purely for the convenience or reassurance of the user, and some which can detect and summon help in the event of a fall, accident, intruder, wandering, smoke / fire, unattended taps etc.

- **Specialist housing options -** various different housing options are and should be available to people as they grow older, designed to meet their particular needs. 'Home' need not be the same house within which they have lived for years; other housing options such as sheltered housing, retirement villages or extra care housing can enable older people to retain their independence, yet with the reassurance that support and help is close at hand should it be required.

Recommendations to address housing issues relating to older people, including those mentioned above, were made by the National Assembly's Social Justice and Regeneration Committee in their Policy Review into Housing for Older People (July 2004). These recommendations are being taken forward by the Welsh Assembly Government as joint housing, social care and health initiatives whilst the current National Housing Debate also focuses on independence and the housing needs of older people.

The Assembly's recent *Review of Housing Adaptations including Disabled Facilities Grants* was a wide-ranging examination of the effectiveness of current arrangements in these areas. Nearly all of the 37 recommendations have been accepted and will be implemented in due course.

### Income

Access to adequate income is rated highly by older people as a contributory factor to independence and quality of life in old age. This issue is addressed by other Strategy for Older People initiatives, including Link-Age, the development of one-stop shops for benefit advice, which aims to increase older people's awareness and take up of available benefits.

### Safety

Increasing frailty and dependence on others can increase older people's vulnerability to neglect or abuse, whether physical, sexual, mental or financial. Guidelines on the Protection of Vulnerable Adults *(In Safe Hands)*[99] issued in 2000 are designed to protect all vulnerable adults from such abuse through preventive action, the development of a culture of protection, and an effective multi agency response to the first indications of abuse. The Guidance is being implemented through locally agreed policies and procedures and is monitored at a national level by an Adult Protection Advisory Group.

## Physical and Mental Health Needs

An assessment of older people's health needs may indicate the requirement for health promotion advice and disease prevention, or access to specific health care. When required, access to specialist assessment, diagnostic services or treatment should be timely and appropriate. Wherever possible, minor and chronic health conditions should be managed within the community. Primary and Community health services, including community nurses, therapists, podiatrists, dieticians, audiologists, and community pharmacists, in conjunction with primary care, have a crucial role to play in providing such care, and will have an increasingly important role in the health and social care system of the future.

This includes the management of health conditions which can threaten older people's independence, such as the prevention and treatment of pressure sores, malnutrition, hearing impairment, eye care, oral health care, foot care, mental health problems, the management of continence and pain, and the promotion of self care. Early intervention and treatment can reduce the risk of health crises and the need for care home admission[100].

Older people, particularly those living alone are at greater risk of malnutrition, which increases their vulnerability to infections, their risk of hospital admission, their length of hospital stay and delays wound healing[63]; yet the issue is under recognised[12, 94]. Screening of older people's nutritional status in primary care and care homes would help to identify those at risk who would benefit from further assessment and nutritional support. There is a plethora of nutritional screening tools available, and the use of a validated nutritional status screening tool (eg. Malnutrition Universal Screening Tool - MUST[101]) would be advantageous.

The Welsh Assembly Government has funded a Wales Low Vision examination to provide in a primary care environment the examination of those patients experiencing visual deterioration through, in the main, degenerative eye disease. This LVA scheme is to provide such an examination and the fitting and supply of low vision aids to the population of Wales, locality based and by practitioners who have been trained and accredited as part of the scheme. Also, the Wales Eye Care Examination (WECE) is a specialist eye examination for older people, designed to investigate the presence or otherwise of eye disease in asymptomatic patients.

Incontinence is a major problem as people grow older. Urinary incontinence afflicts 24% of older people, and 30 to 60 % of people in care settings[102, 103]; faecal incontinence is less common, but clearly both can cause much distress and significantly affect an individual's quality of life, physical and emotional health and independence.

Continence problems amongst older people are often associated with other serious and chronic conditions - such as functional disability, impaired mobility, obesity, polypharmacy, cognitive impairment, urinary tract infections and cerebrovascular disease - and continence must be assessed and managed as integral part of any chronic disease management programme.

In many cases, if thoroughly assessed and diagnosed at an early stage, incontinence can be effectively managed and treated. Evidence based interventions including drug therapies, minimally invasive surgical interventions and behavioural therapies, are now available. However, a Healthcare Commission sponsored National Audit of Continence Care[104] in 2005 revealed inadequate assessment of the cause of people's incontinence, with management relying more on containment, using pads and catheters, than on treatment. Given the significant daily cost of containing continence in this way, and the cost pressures which sometimes lead providers to limit pad use, the audit highlights " a missed opportunity to assess, treat and reduce the numbers of incontinent people".[104]

It is therefore important that older people with incontinence undergo a thorough assessment leading to diagnosis of the cause, and effective management of the problem based on treatment and therapy where appropriate rather than merely on containment.

Each health and social care provider should have and implement a written policy for continence care for older people, based upon the good practice guidance for the provision of continence services issued by the Department of Health in 2000[105]. This incorporates the provision of integrated continence services at a local level, which will include:

- the identification, initial assessment and care of people with incontinence within primary care and the community - including Day Hospitals and rehabilitation services - care homes and hospitals;
- access to a local specialist continence service, and
- access to specialist surgery

NICE Guidelines are currently being developed for the management of urinary incontinence in women (due for publication December 2006) and the management of faecal incontinence in adults (due for publication September 2007). Meanwhile, an All Wales Integrated Care Pathway for Continence Management has been developed which identifies structures for achieving best practice in continence management.

In primary care, GMS practices are now rewarded for the care they provide through the new GMS Quality and Outcomes Framework. The Framework provides an opportunity for general practices to focus on achieving high quality standards in 4 domains, one of which is the clinical domain. This incorporates ten disease 'areas', most of which are more prevalent in older people, and it is anticipated that older people will benefit particularly from the focus on active management of those patients suffering from stroke, CHD, diabetes and hyperthyroidism.

- **Chronic disease management -** It is estimated that as many as 17.5 million adults may be living with a chronic illness in the UK. This equates to at least one person in three suffering with a long standing chronic condition[106] and accounts for over 25% of GP consultations in Wales. Age has a compounding effect on the prevalence of chronic diseases and multiple chronic illnesses are common in people aged over 75.

  Several 'managed care' initiatives are being trialled in England which involve the proactive management of patients with chronic illness in a community setting in partnership with secondary care. The approach also places emphasis on self care by patients and their carers.

  In Wales a Policy for Chronic Disease Management is being developed, focusing on chronic disease pathways supported by integrated community services. Implementation will represent a significant development in the way services are provided to many older people in Wales.

- **Expert Patients Programme (EPP) -** this is an NHS based training programme that helps people living with a long term health condition to develop new skills to manage their illness better on a day to day basis. Courses are delivered in local communities by trained tutors who themselves have experience of living with a long term condition.

  EPP courses do not provide any condition specific information or advice, but enhance such information provided by NHS professionals. The aim is to give participants the confidence to take responsibility for their own care, in partnership with health and social care professionals. They involve developing people's confidence, motivation and understanding of issues such as how to recognise and respond to symptoms, what to do in the event of an acute episode, the impact of diet and exercise, communicating their needs to others, medication and treatment options and pain management. Helping older people to develop such understanding and skills can reduce their reliance on health and social care services and significantly improve their quality of life[107].

Following the evaluation of two EPP pilot sites at Swansea and Gwynedd LHBs, the programme is now in the first stage of roll out, with a view to mainstream EPP throughout Wales by 2008. The focus is to improve equality of access to EPP courses in communities across Wales.

- **Medication -** as people grow older, their use of medicines tends to increase. Four in five people over 75 take at least one prescribed medicine, with 36% taking four or more (ie. polypharmacy)[108]. The *Medicines and Older People* standard, outlines the main risks of polypharmacy, including the possibility of adverse reactions, non-compliance and duplication, which can result in avoidable ill health, accidents and hospitalisation. It also sets out guidance for the better management of medicines for older people.

**STANDARD -** *a range of enabling, community based services is available to intervene promptly and effectively when older people's independence is threatened by health or social care needs, with the aim of challenging dependency and maximising wellbeing and autonomy.*

| Outcome | What to measure | How to measure |
|---|---|---|
| Older people are enabled to remain in their own homes wherever possible | • no. of older people remaining in their own homes in relation to care home admissions<br>• Effectiveness of housing and adaptations schemes | • routinely collected<br>• evaluation |
| Older people are enabled to maintain their independence and not become dependent on care services | • Number of older people using Direct Payments | • routinely collected |
| Services place a greater emphasis on earlier, preventive interventions and crisis avoidance | • Availability of 'lower level' services<br>• Increase in resource allocation to community services / evidence of shift<br>• Chronic Disease Pathways in place and their effectiveness | • review<br>• review<br>• review |
| More older people having full assessment and treatment, rather than containment, of their incontinence | • Number of continence patients with a documented explanation of their condition and treatment | • RCP National Audit |
| Carers of older people are supported in undertaking their role | • Views of carers | • carers survey |

**Objective 13 - To ensure that evolving national policy on the development of community based health and social services is adopted and reflected at a local level**

| Action | By when | By whom |
|---|---|---|
| **13.1 -** Local commissioning strategies reflect the principles of *Designed For Life* and its social care equivalent ie:<br>• an enabling approach to early intervention and community based services for older people,<br>• resulting in a range of statutory, independent and voluntary sector services available to meet older people's assessed health needs and needs for personal care and assistance with daily living. | End March 2008 | Local authorities, LHBs, NHS Trusts in conjunction with the voluntary and independent sectors |

**Objective 14 - prompt and efficient access to aids and equipment is ensured through the provision of Integrated Community Equipment Services**

| Action | By when | By whom |
|---|---|---|
| **14.1 -** each local health and social care community will develop integrated commissioning plans for the provision of aids and equipment services, in line with commissioning guidance | End of March 2007 | Local authorities, LHBs and NHS Trusts |
| **14.2 -** each local health and social care community will implement their planned integrated process for the provision of aids and equipment | End of March 2008 | Local authorities, LHBs and NHS Trusts |

**Objective 15 - incontinence in older people is effectively assessed, diagnosed, managed and treated in all care settings**

| Action | By when | By whom |
|---|---|---|
| **15.1 -** Each health and social care provider has and implements a written policy for continence care, which incorporates:<br>• the provision of integrated continence services (as defined in DH Good Practice 2000) for assessment, diagnosis, specialist treatment and care;<br>• implementation of the All Wales Integrated Care Pathway for Continence Management, and Continence Implementation Guide. | End of March 2008 | Local Authorities, LHBs, NHS Trusts, independent sector, CSIW |

**Objective 16 - Effective management of older people with long term and Chronic Conditions within the community**

| Action | By when | By whom |
|---|---|---|
| **16.1 -** Ensure that implementation of integrated care pathways, in line with national policy for the management of long term and chronic conditions, applies to older people | End March 2007 | LHBs, local Authorities, NHS Trusts |

**Objective 17 - Increase opportunities for older people to attend local Expert Patients Programme (EPP) courses in Wales.**

| Action | By when | By whom |
|---|---|---|
| **17.1 -** Expert Patient Programme courses to be routinely available to older patients in local communities throughout Wales. | End of March 2008 | Local Health Boards |

# Intermediate Care

**STANDARD -** *Intermediate Care is established as a mainstream, integrated system of health and social care which:*

- *enables older people to maintain their health, independence and home life;*
- *promptly identifies and responds to older people's health and social care needs, helping to avoid crisis management and unnecessary hospital or care home admission;*
- *enables timely discharge or transfer from acute hospital settings to more appropriate care settings which promote effective rehabilitation and a return to independence.*

## Rationale

The term 'Intermediate Care' encompasses a range of services managed within an established and co-ordinated system of care so that there is early engagement with need, based on assessment and provision of care. Such a service will help people to maintain their health and independence, through early engagement and assessment of need as identified through the processes of Unified Assessment. For some it will avoid inappropriate hospital or care home admission, by reducing delay which can lead to deterioration and crisis[100, 109, 110, 111, 112], and by providing an alternative community based system with timely access to expert assessment, diagnosis and care. For others it will ensure early discharge or transfer of care to a more appropriate setting following acute illness whilst promoting effective rehabilitation and other forms of support designed to maximise people's independence within the community[113, 114, 115, 116].

The development of Intermediate Care related services are integral to the Welsh Assembly Government's development of Health and Social Care in Wales[117]. Guidance on the development of such services was issued by the Welsh Assembly Government in December 2002[118]. This led to many innovative and valuable Intermediate Care schemes across Wales. However, such developments have been described in the Department of Health document 'Intermediate Care - Moving Forward[119] as '..a thousand flowers have bloomed'. This reflects the fact that the developments, although laudable, have not taken place within a co-ordinated and sustainable whole systems structure.

The Review of Health and Social Care in Wales[17] highlights the unsustainable imbalance within the current service with its over dependence on acute services. This has lead to a failure to engage and manage need to avoid crisis management.

Service reconfiguration is needed with a greater focus on 'whole systems' management leading to earlier intervention and management of need within primary and community care.

This builds on previous work including a literature review commissioned by the NBI from the University of York[120] and a review of capacity in the Health Services in Wales in 2002- *A Question of Balance*[121] - which call for a greater balance across the whole system of health and social care. The Wanless Review has identified chronic illness and the care of the older person as key areas of focus in the drive for structural reforms.

To maximize the individual's potential, the assessment needs to be holistic in the assessment of physical health, mental health and social care needs. In meeting the challenges of the modernisation agenda, Intermediate Care services must be integrated across all health and social care boundaries operating as whole systems integrated teams supported by sound network managerial and governance arrangements. Their operation will be underpinned by effective implementation of the Unified Assessment process.

In order for Intermediate Care to take its appropriate place within mainstream health and social care, a more strategic, whole systems and co-ordinated approach now needs to be taken, with a greater emphasis on early assessment and management of need, within the framework of local Wanless implementation plans, and local Health, Social Care and Wellbeing Strategies.

## Key Interventions

**The development of effective, whole systems Intermediate Care services requires:**

- an integrated approach to the local planning, commissioning, delivery and evaluation of Intermediate Care, based on local consultation and identified need;
- a range of services, underpinned by the Unified Assessment process, which:
  - help people to maintain independence and remain living within the community;
  - offer a rapid, community focussed assessment and response when health or social need becomes identified – from whatever source;
  - provide mechanisms which identify the need for specialist intervention and ensure prompt access to diagnosis and specialist services when required. Ensure access to emergency services if appropriate;

- provide timely transfer from the acute hospital setting to home or other appropriate care setting with a focus on rehabilitation and promoting independence.

- a single and easily available point of access into the service and clear statements of purpose and referral processes for each component, to ensure that people entering the service are appropriately assessed and managed.
- integrated teams or networks co-ordinating care and assessment, supported by sound network governance

### Local integrated planning, commissioning and evaluation

There are many different definitions and examples of Intermediate Care services in existence. This often leads to confusion amongst health and social care partners over what is meant by the term 'Intermediate Care' and where to start in identifying where best to target effort and resources[122].

Consultation with providers, carers and older person's representative groups will enable the commissioning of Intermediate Care services appropriate to the needs of the older population, including those residing in care homes. Such decisions must be based on sound information about client and patient flow, assessed need, unmet need, service bottlenecks, hospital admission and readmission rates, delayed transfers of care, and so on. This information and analysis and consultation will help to clarify where best to focus attention in developing Intermediate Care services. All localities, however, should have in place an Intermediate Care Strategy that addresses all elements of the Intermediate Care Service.

Local joint planning and commissioning of services providing Intermediate Care must be done in an integrated, whole systems way within the framework of the local Health, Social Care and Wellbeing Partnership and the Wanless implementation approach. This will result in an agreed integrated model developing Intermediate Care as a mainstream service, spanning the boundaries of social care, primary, community and secondary health care, and statutory, independent and voluntary sector provision.

### Intermediate Care: Ensuring a Range of Co-ordinated Services

Where their assessment indicates potential benefit, older people should be able to access a range of integrated Intermediate Care services. These services may be provided by statutory, independent or voluntary sector agencies, and will:

- **Help people maintain and manage their health and independence**

  Early engagement with the older person and prompt assessment of need will help problems to be responded to quickly and effectively, thereby preventing crisis or avoidable loss of independence. The Unified Assessment process is central to this.

Older people with a chronic illness can be supported by community based teams and /or the use of new technology or equipment, to manage their condition effectively within the community.

- **Provide a rapid response when needs arise**

  A significant deterioration in an older person's health or social circumstances often leads to an urgent hospital admission. However, where there is no overriding medical need for inpatient care, it may instead be possible for the person's needs to be rapidly assessed and met by a multi disciplinary / multi agency team within the community. This team may provide intensive support to the older person in their own home, or within a community hospital or facility, and where indicated provide rapid access to specialist and diagnostic services.

  The advantage of meeting the older person's needs in this way, thus avoiding an acute hospital admission, are thought to be several. The older person is able to remain at home, which is less disruptive to them and their families; the focus is on promoting and helping them to regain their independence; they avoid the hazards of hospitalisation, including the risk of hospital acquired infection, and they do not have to wait to be discharged whilst community equipment, support or home adaptations are arranged. This is also beneficial to acute service providers, as capacity is freed up for those with complex health needs. SaFF (Service & Financial Framework) targets in recent years have successively aimed to reduce medical emergency admissions through such initiatives as this.

  There are various examples of intermediate care teams which focus on providing this kind of rapid response service. Most such services feature a single point of contact, and input from a range of health, social care and housing professionals.

  There will be times when patients referred for Intermediate Care will have needs which require access to specialist and diagnostic services. Awareness of the presence of insidious illness will be a fundamental requirement of the Intermediate Care Assessment. This will be of particular importance to the Rapid Response Team. The development of assessment protocols and appropriate expertise is essential.

- **Provide prompt access to emergency, specialist and diagnostic services**

  If assessment protocols indicate, Intermediate Care must ensure that there is rapid access to diagnostic and specialist services. This level of expertise can only be achieved through ensuring a targeted and sustained program of education and training. Access to these enhanced services should be developed as part of the Intermediate Care service unless the results of the specialist assessment indicate the need for referral to another service.

- **Enable timely transfer from acute hospital**

  Successive SaFF (Service & Financial Framework) targets have aimed to achieve a reduction in delayed transfers of care. There are various reasons why an older person's transfer of care from an acute hospital setting can be delayed, but it is often due to the unavailability of an appropriate alternative. An older person may no longer require acute inpatient care, yet they may not be ready to return to home due to ongoing health and / or social needs.

  These needs can vary significantly from person to person and therefore a variety of Intermediate care services should be available to meet these needs. These should range from access to 'step down' beds, with varying degrees of staffing, to support for people to return to their own homes, with the necessary adaptations, equipment and professional input. Schemes such as those provided by Care and Repair Cymru undertake rapid adaptations of people's homes to enable them to return home safely. Intermediate Care services in enabling early discharge will need to engage all staff [including hospital] within the care pathway in delivering a seamless service.

## Ease of access

Each component of the Intermediate Care Service must be clearly defined in terms of purpose, referral criteria and referral routes. This accords with the Unified Assessment guidance, which requires Statements of Purpose to be provided for all health and social care services. It is essential that once an older person's health or social care needs have been identified and assessed, the professional leading the plan of care is aware of the range of service options available, and how to access them. In some localities, ease of access to Intermediate Care services has been ensured by arranging a single point of contact for advice and referral on to those services. This practice is highly commended. The management process of Intermediate Care will ensure that the needs of the individual are regularly reviewed and assessed. This will require a process which will react to changing need and provide appropriate care. This will need to engage with the occasional likelihood that the individual's needs cannot be met within Intermediate Care and referral to a more appropriate service is needed.

## Integrated working

Some of the services within Intermediate Care may be provided by fully integrated health and social care teams; others may be provided by multi disciplinary teams, which operate as part of a bigger 'virtual' team, governed by agreed protocols and network governance principles. Either approach represents a new way of working for many organisations and practitioners, and requires significant joint planning and evaluation at a senior practitioner/clinical and managerial level across all partner organisations.

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- *enables timely discharge or transfer from acute hospital settings to more appropriate care settings which promote effective rehabilitation and a return to independence*

| Outcome | What to measure | How to measure |
|---|---|---|
| Prompt, well co-ordinated community based response to intensification of an older person's health or social care needs. | • availability of 'step up' intermediate care services eg: Rapid Response, Crisis Intervention, intermediate care beds | • review |
| | • avoidable hospital admission rates;<br>• avoidable care home admission rates<br>• readmission rates; | • routinely collected |
| | • effectiveness of Chronic Disease Management | • review / evaluation |
| | • older people's views on responsiveness of services | • service user survey |

| Outcome | What to measure | How to measure |
|---|---|---|
| Older people are enabled to return to their optimum potential of wellbeing and independence as soon as possible following hospitalisation or respite care | • availability of 'step down' intermediate care services eg, Reablement teams, intermediate care beds<br>• delayed transfers of care;<br>• views of older service users | • review<br>• routinely collected<br>• service user survey |
| Seamless provision of care regardless of organisational boundaries | • flexibility of services to respond to individual needs<br>• ability of services to cope with fluctuations in individual need<br>• extent to which intermediate care services are mainstreamed<br>• effectiveness of joint working | • service user survey<br>• review<br>• review<br>• review |

**Objective 18 - ensure a strategic and integrated approach to the planning and delivery of local Intermediate Care services**

| Action | By when | By whom |
|---|---|---|
| **18.1 -** local commissioning strategies include a joint strategic plan for the delivery and evaluation of Intermediate Care services, based on a whole systems analysis of local need. | End of March 2007 | Local Health Boards, NHS Trusts, Local Authorities |
| **18.2 -** Services provided within Intermediate Care are commissioned and provided to:<br>• help older people to maintain their independence and manage chronic conditions within the community;<br>• make optimum use of available diagnostic and therapeutic technologies;<br>• offer a rapid, community based assessment and response when health or social needs arise;<br>• provide mechanisms to ensure prompt access to specialist, diagnostic and / or emergency services when required;<br>• provide timely transfer from the acute hospital setting to home or other appropriate setting, with a focus on rehabilitation and promoting independence<br>• respond to the changing social and clinical needs of the individual | End of March 2008 | Local Health Boards, NHS Trusts, Local Authorities, independent sector |
| Services must offer:<br>• A single and easily available point of access and clear referral processes<br>• Integrated teams or co-ordinated networks, supported by sound network governance | | |

# Hospital Care

**STANDARD -** ***When admission to hospital is necessary for older people, the care they receive is co-ordinated, efficient and effective in meeting their clinical and non-clinical needs.***

## Rationale

Older people are major users of hospital services, accounting for 41% of all hospital admissions in 2003/04 and for 42% of emergency admissions. Only a minority of older people with an acute illness are cared for by geriatricians; for most acute specialities, older people are the major client group.

Older people often suffer multiple pathologies, which makes their treatment and care needs different to younger groups. They tend to experience a longer length of stay in hospital, due to the complexity of their medical condition, longer recovery times, or due to delayed transfers of care to a more appropriate setting. Older people can also be very susceptible to the 'hazards' of hospitalisation, including falls, hospital acquired infections, impaired nutrition and hydration or pressure sores, which can prolong their length of stay as well as causing unnecessary morbidity and mortality. Hospitalisation can also result in increased dependency and often prompts the need for longer term care solutions. Such hazards therefore need to be avoided through high standards and competent staff, to achieve the optimum benefit from older people's hospital stays.

The need to achieve a more balanced health and social care system, thereby relieving pressure on acute hospital services, was called for in *A Question of Balance*[121] and is being addressed in Wales in line with the Wanless recommendations. Measures to provide appropriate alternatives to hospital admission are presented elsewhere in this NSF, including the development of Intermediate Care services and the more effective management of chronic diseases within the community.

However, when hospital admission is the best option for an older person, it is important that the services provided are of a high quality and meet the person's needs, within the whole continuum of care. The NSF standards on Rooting out Age Discrimination and Person Centred Care set out the general principles of quality care for older people, and apply equally to hospital care as to any other care setting. Older people are cared for within a range of hospital and pre-hospital settings from emergency ambulance through to specialist units. Quality of care depends not only on good health care but also on respect for the older person

as an individual, and continuity with pre and post hospital care. It is important that whilst in hospital, older people receive high quality care in modern facilities which promote privacy and dignity and encourage their confidence in the service they receive.

The care of older people in hospital is complex, and Trusts should adopt a **'whole system'** approach to ensure that the following principles are adopted throughout the older person's hospital stay, from admission through to discharge, and in any related outpatient visits:

- comprehensive early assessment
- access to specialist treatment, services and advice
- promoting health and independence
- high quality clinical care and treatment
- Fundamentals of Care
- appropriate attitudes, behaviour and competence of all staff
- unified assessment of holistic needs
- high quality non-clinical care, e.g.
  - appropriate environment - cleanliness, safety, privacy, accessibility
  - appropriate meal/drink provision

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 this age group. Given that older people are the predominant users of most hospital services, skills in their care must 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 will be underpinned with fundamental principles for the promotion of dignity.

## Key Interventions

### Whole hospital approach

A review of implementation of the NSF standard on General Hospital Care in England, undertaken by the Department of Health in 2003, revealed many good examples of progress with single issues in hospitals across England, but few examples of a co-ordinated approach to older people's services, including planning

at a strategic, corporate level within Hospital Trusts. NHS Trusts in Wales, which provide integrated hospital, community and mental health services, should adopt a co-ordinated Trust-wide approach to implementation of the NSF, incorporating a whole hospital approach to implementation of the specific standard on Hospital Care.

This requires regular consideration and evaluation at a senior level within the organisation of progress with implementation of the NSF for Older People, and statistics such as waiting times, response times, admission and readmission rates, bed occupancy rates, length of stay, delayed discharges (with consideration of complexity of needs), adverse drug reactions, nutritional status, complaints - specifically in relation to older people, will inform this evaluation. It also requires the need to consider secondary care within the continuum of care, in conjunction with partners in community and primary health care, intermediate care and social care.

### Pre-Hospital Emergency Care / Transport

The Welsh Ambulance NHS Trust plays a vital role in the care of older people, both in terms of first contact emergency services, and in more routine patient transportation. It is developing specific policies, procedures and clinical care protocols/pathways to address the needs of older patients, especially in respect of vulnerability issues.

### Elective Care

Referral rates for elective or planned care have increased over recent years, placing increasing pressure on acute services and their capacity to manage waiting lists and times. Waiting lists over the last 10 years have consistently been highest for Trauma and Orthopaedics, affecting a significant number of older people, given the high incidence of osteoarthritis and joint replacement needs in those aged over 65. Long waiting times for surgery are clearly not conducive with the aim of improving older people's quality of life and independence. The Welsh Assembly Government's *Orthopaedic Plan for Wales*[123] sets out 12 strategic directions and 39 key actions to improve access to orthopaedic services. This plan, and the 2009 Access project, focus on the management of demand and capacity across primary and secondary care to ensure acceptable waiting times for outpatient and inpatient admission, appropriate care for older people who are waiting for treatment, and effective discharge and rehabilitation systems.

Successive SaFF (Service & Financial Framework) targets have aimed to reduce waiting times for all inpatient / daycase treatment, and by 2009 the Welsh Assembly Government have committed that no patient in Wales will wait more than 26 weeks from GP referral to treatment, including waiting times for any diagnostic tests and therapies required[124].

### Emergency Admission

The emergency hospital gateway can have a number of different access points, the principal one being the Accident and Emergency Department. The purpose of A&E is to provide initial diagnosis and assessment and, as appropriate, immediate life-saving action, transfer to appropriate inpatient care or discharge with support if required (effective communication with primary care and social care partners will be essential to address care and vulnerability issues). Its potential for determining demand for acute sector beds and diverting admissions is therefore significant and needs to be understood and well managed.

To ensure an efficient and effective patient pathway for older people attending A&E, patient triage systems should be in place to identify older vulnerable patients who should be prioritized for admission. Assessment within A&E should cover cognitive and functional ability and home support requirements, as well as clinical need. Such an assessment would constitute a contact assessment or, if more indepth, an overview assessment under the Unified Assessment process.

The Service and Financial Framework (SaFF) target for 2005/6 was that 95% of patients should wait no more than 4 hours in A&E before being seen, treated and discharged. Various factors can impact on the achievement of this target, including bottlenecks caused by hospital bed capacity problems.[121] All older vulnerable patients remaining in Emergency Units should be reviewed by a specialist in old age medicine or nursing at least on a 4 hourly basis, and should receive the same quality of care as they would if admitted to a ward, e.g. with access to appropriate pressure relieving equipment.

The Welsh Emergency Care Access Collaborative Programme (April 2004 - September 2005) was designed in response to increasing A&E attendances, the need for alternative emergency care services, increasing trolley waits, hospital admissions and delayed discharges, to encourage and enable a partnership approach to local service improvement in emergency care, based on the principles of:

- Co-ordinating the patient journey
- Improving the patient and carer experience

- Optimising care delivery
- Enabling people to see themselves as part of the same system
- Managing demand and capacity

All NHS Trusts with their partners were involved in this programme, the effectiveness of which is being evaluated through overall programme measures linking to SaFF targets. As older people are the major users of emergency services, this programme is expected to deliver significant and ongoing improvements to emergency care for older people.

### Diagnostic services

Rapid access to diagnostic procedures and informed interpretation of the results is essential for timely assessment and direction of patients to the most appropriate care pathway.

### Early Assessment

Once stabilized, early assessment will identify what further care the older person requires. Early assessment will include examination, investigation, observation and multi-disciplinary assessment and can take place in an admissions unit, observation ward, acute general ward, rehabilitation ward or a specialist unit. There will be early/timely review by a specialist acute medical team.

Early specialist input to needs-based assessment is required for older people with atypical or complex disease presentation or multiple medical problems. Specialist input may be required from acute care specialists, geriatricians, specialists in stroke, falls and mental health and a wide range of other disciplines including specialist nurses, Allied Health Professionals (physiotherapy, occupational therapy, speech and language therapy, dietetics), pharmacists and social workers. In line with NSF standard on Rooting Out Age Discrimination, access to specialist assessment, treatment and care should be provided on the basis of clinical need and never denied on the basis of age alone. Discharge planning should also commence at this stage.

It is estimated that up to 40% of adults admitted to hospital are under-nourished on admission. Ideally all hospital inpatients should be screened for (risk of) under-nutrition on admission using a simple screening tool that Includes body mass index (BMI), percentage weight loss and considers the time over which nutrient intake has been reduced (e.g.the Malnutrition Universal Screening Tool - MUST[101]) [63].

### Admissions Units

Once the decision to admit has been made, patients may be initially admitted to an admissions ward. Various models operate throughout Wales, all of which have the aim of ensuring that patients are diverted quickly from the A&E department or are admitted quickly following GP referral to a more appropriate setting, where additional investigations may be undertaken whilst awaiting transfer to an appropriate ward.

The most successful admission units are those which are able to access diagnostic services rapidly, in order to expedite treatment and ensure patients are in the right place at the right time thereafter. Evidence suggests that where such units are not working optimally, the unit becomes simply another bottleneck leading to delays in accessing the right services and delayed length of stay.

### Ongoing Care on General Medical and Surgical Wards

Older people may be cared for in general medical and surgical wards, or in specialist wards or units, for, for example, gastroenterology or coronary care. Multiple transfers through the hospital system can impede the care older people receive, increase disorientation and affect discharge planning. This should be kept to a minimum, through effective bed management and patient pathways. Older people should only be transferred from acute wards in accordance with their clinical and rehabilitation needs, rather than due to service pressures.

From April 2005, the assessment of older people's health and social care needs should be undertaken within the Unified Assessment process. Wherever in the hospital the older person is being cared for, good management will involve assessment of and, where appropriate, individual care planning for the following areas:

| **Unified Assessment 'domain'** | |
|---|---|
| User's perspective | The individual's own views, expectations, requirements, values |
| Carer's perspective | Information for and from the family and carers Carer's assessment / carer family needs |
| Clinical background | Medical history of relevance to current situation<br><br>Current diagnosis/es |
| Personal Care and Physical Wellbeing | - Maintaining fluid balance<br>- Nutritional status (including swallowing screening)<br>- Pain experience<br>- Pressure area damage<br>- Managing continence<br>- Oral care<br>- Infection control<br>- Managing end of life care |
| Mental Health | - Acute confusion / delirium<br>- Depression<br>- Cognitive impairment<br>- Mental capacity<br>- Psychological care |
| Senses | - Sensory deficits<br>- Communication problems |
| Safety | - Falls and immobility<br>- Protection from abuse and neglect<br>- Medicines management and compliance |
| Activities and Instrumental Activities of Daily Living | - Rehabilitation potential<br>- Social circumstances |
| Environment and resources | - Awareness of available benefits<br>- Home safety/requirement for aids/ equipment |

This assessment will enable effective acute care of the older person whilst in hospital, including referral to other health specialties for more specialist / indepth assessment and care, and referral for specialist social need assessment if required, which together will inform their discharge planning and longer term care plan.

Nutrition and maintaining a fluid balance are of particular importance and requires a coordinated multi-disciplinary approach to ensure that good food is provided and consumed, 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 and be repeated weekly[63] to identify those patients with characteristics of nutritional concern.

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, such as diabetes. Assistance will need to be given to those who cannot adequately feed themselves and there are a number of simple but innovative schemes that can help ward staff quickly identify patients that need additional help e.g. the red tray scheme[125] and the use of supervised volunteer support. Patient focused standards for good nutritional care can be found in the NHS Nutrition and Catering Framework (2002), *Fundamentals of Care*[37] and *Food for Thought*[126].

For those at particular risk, a nutritional plan needs to be developed with the multidisciplinary team, appropriate food and fluid provided, food intake monitored and action taken if nutritional needs are not being met, including consideration of alternative means of feeding e.g. PEG, where swallowing difficulties have been identified after specialist assessment has been carried out

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 prevalence of co-existing diseases which will further increase their post-operative risk. The 1999 National Confidential Enquiry into Perioperative Deaths (NCEPOD)[127] report highlighted areas of poor practice which led to excess deaths in older age groups. Their recommendations should be adopted [see box overpage].

**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. Multi-disciplinary 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 needs 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.

Updated guidelines issued by the Resuscitation Council (UK)[128] in 2005, make it clear that every hospital should have clear and explicit policies relating to cardiac pulmonary resuscitation. This should include clear policies on 'do not attempt resuscitatation' orders. 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.

Older people are more likely to die in hospital than other age groups, but evidence collected for Age Concern's health campaign against age discrimination demonstrates that many older people do not have dignified deaths in hospitals[38]. As addressed in the standard on Person Centred Care, good care of the dying patient is extremely important to ensure person centred care until the end of life, and support for the bereaved. In line with action point 6.1, staff should be

trained in the breaking of bad news to patients and their families, the provision of palliative care, the cultural and religious aspects of death and support available to the bereaved.

### The Hospital Environment

The Person Centred Care Standard of this NSF stresses that positive, person-centred care is fundamental to successful treatment and care outcomes for older people within all care settings, including hospital environments. The quality of care expected is embodied in the Fundamentals of Care document[37]. Nurses and other members of the multidisciplinary team need to spend time in getting to know their patients as individuals, which includes knowledge of their biographical histories, their likes and dislikes etc, in order to adequately meet their social and psychological care needs. Sitting talking with an older person, identifying unmet needs, offering reassurance and supporting family members etc need to be viewed as being of equal importance to ensuring patients are toileted and fed. Intellectual and social stimulation should also be available within every hospital care environment.

The hospital environment and associated services will support the quality of care for older people. Wards and other care environments should be clean, allow for privacy and assist in promoting independence. In accordance with the Disability Discrimination Act, facilities must be accessible by all.

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 will be provided in ways which ensure that people's dignity is always maintained, and their cultural and religious needs are respected. Aids to mobility and daily living should be supplied to enable patients to be as independent as possible.

National Standards for Cleanliness of NHS Trusts have been developed, which, along with the Welsh Risk Pool standards for infection control, form the basis of the Healthcare Associated Infection Strategy for Hospitals in Wales, issued in July 2004. This Strategy aims to combat the increasing incidence of hospital acquired infections such as MRSA, to which the very old are particularly susceptible.

Wards where there is little opportunity for private discussion detract from the older person's right to privacy. A separate room will 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.

Older hospitals may care for older people on Nightingale wards, where staff can find it difficult to provide an appropriate environment for patients. Investment in new hospital buildings and upgrading of current hospital buildings will bring in more four-bedded bays, offering increased opportunities for privacy and reduced noise; rooms available for private conversations and social/intellectual stimulation; 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.

Mixed-sex wards can be embarrassing and for some older people insensitive to their culture and religion. The Government is committed to eliminating mixed sex accommodation and NHS Trusts will ensure single sex sleeping accommodation and toilets are provided. Replacing Nightingale wards will also help to meet this objective. Hospital facilities will therefore be flexible in offering privacy and in enabling staff to minimize the risk of exploitation of vulnerable adults whilst offering care in the most culturally appropriate and gender sensitive environment possible.

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, orientating patients to the new environment so that they can move safely in the ward but not wander out. The use of new technology such as pressure mats to enable the identification of a patient getting out of bed or chair or digital entry door systems will assist staff in minimizing risk to patients whilst reducing the need for close nursing observation.

Each NHS Trust should have a Designated Lead Manager and accompanying structure for the Protection of Vulnerable Adults, and should demonstrate a proactive approach to vulnerable adult protection and implementation of the *'In Safe Hands'* guidance[99], in liaison with colleagues in social services, the police and CSIW. Associated policies and procedures should be developed, e.g. in relation to safe discharge planning, the use of control and restraint, the administration of covert medicines etc.

Effective nursing leadership is essential in providing patient-focused care and ensuring a positive patient experience. Clinical leaders 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, the 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.

## Mental health care for older people – in general hospitals

Older people who are admitted to hospital with physical problems may also be suffering from depression, delirium, dementia or other enduring mental illness. Between 10-20% of older patients admitted to medical wards suffer with delirium and a further 4-10% develop delirium during their hospital stay[129]. For certain groups, e.g. older patients undergoing surgery for fractured neck of femur, prevalence may be as high as 60%[130]. For people aged over 65 admitted with delirium, mortality risk is doubled (11% death in hospital; 38% within a year), risk of readmission increases by half (34% in 6 months; 55% within a year) and the risk of institutionalization is tripled (31% within 6 months; 35% within a year)[131]. Prevalence rates of up to 53% for depression and 35% for dementia have been reported amongst older people in general hospital settings. Despite high prevalence, psychiatric illness is poorly detected by general hospital staff, indicating that opportunities for treatment are missed[132], e.g. rates of treatment for depression are as low as 9%[133].

Older people with mental health needs are particularly vulnerable in a general hospital setting and are likely to show psychological distress and anxiety, which may be perceived by staff as challenging behaviour. It is acknowledged that general nurses may have a poor awareness and understanding of dementia and other later life mental illnesses and appropriate care management[134]. This may lead to inappropriate and unnecessary use of sedative drugs that can reduce rehabilitation potential and significant unmet need, e.g. pain is frequently under-diagnosed and under-treated in patients with cognitive impairment who have difficulty in communicating their pain experience[135].

The care of older people with mental health needs in general hospital settings could be improved through a more holistic and integrated approach to addressing physical and mental health needs. This could be achieved through:

- Old Age Mental Health Liaison services, provided on a sessional basis or by a multi disciplinary team (including liaison mental health nurses)[136]
- training for multi disciplinary teams on the understanding and management of older people's mental health needs, including the management of challenging behaviour
- shared care of in-patient facility for patients with complex physical and mental health needs
- Nurse Consultants in mental health care of older people, providing clinical leadership and consultancy
- Clinical care pathways, e.g. for delirium treatment

- Specialist assessment tools, e.g. for depression/anxiety assessment, cognitive assessment, pain assessment etc.

A Geriatrician Liaison Service/Multi disciplinary team working from the general hospital setting into mental health is equally advocated to prevent unnecessary admissions of mental health in-patients into acute beds for physical health problems that could effectively be managed without transfer.

Both Mental Health and Geriatician Liaison Services could be extended to cover care homes to prevent unnecessary admission to general or mental health hospital settings.

Older people with a learning disability are also vulnerable within a general hospital setting. A study undertaken by the National Patient Safety Agency[137] confirmed that people with learning disabilities are more at risk of being involved in a patient safety incident, due to inappropriate use of physical intervention; lack of understanding of learning disabilities amongst general hospital staff; mis or undiagnosed illness; poor communication, and swallowing difficulties which can lead to poor nutritional status, dehydration and respiratory tract infections. The NPSA are undertaking further research with a view to developing solutions to the problems raised.

### Rehabilitation

The primary objective of rehabilitation involves restoration to the maximum degree possible, either of function (physical or mental) or role (within the family, social network or workforce)[138]. Rehabilitation will therefore be integral to the process of caring for people across the spectrum of acute care and continuing medical and social care[139]. Multi-disciplinary assessment, as part of the Unified Assessment process, will start as early in the acute phase of illness as possible with a view to determining the benefit to be gained from rehabilitation. A goal planning approach and ongoing review involving the patient and significant others are viewed as essential prerequisites to effective rehabilitation.

Where rehabilitation is part of the discharge planning process there needs to be an identified co-ordinator, who may be the named nurse at ward level or could be a named therapist. The co-ordinator will have all the necessary information available to enable effective communication with others throughout the discharge process.

Where potential for further improvement post-discharge is identified, rehabilitation will be an on-going process, provided in the most appropriate setting for the patient and over an appropriate timescale. Services can be provided in a variety of settings e.g. attendance at a Day Hospital providing out-patient rehabilitation or rehabilitation in the home carried out by a specialised community team, of which there are many examples across England and Wales.

## Continuing Assessment/ Long Term Care in a Hospital Setting

A minority of older people will require care in a hospital setting over an extended period of time if they suffer from a complex or unstable medical, physical or mental health condition that requires frequent supervision and management by a specialist multi-disciplinary team. Access to an NHS Trust Continuing Assessment/ Long-term Care bed will be via a specialist multi disciplinary assessment with input from a Nurse Assessor who will determine whether the patient meets nationally defined eligibility criteria for continuing care.

Long term care in a hospital setting should be for a finite period as a person's condition may alter over time and their needs may no longer be most appropriately met in hospital. Regular review by a multi-disciplinary team will be undertaken to ensure that the patient's condition is monitored and their needs continue to be best met within such a placement. Patients (where possible) and their families will be made aware that a review is taking place and participate fully in the process. They should also be informed of the appeal procedure.

The environment in which long-term care is provided is vital to the quality of life experienced by the patient. Long-term care settings will become home to some patients for considerable periods of time. A socially and environmentally enriched environment will reduce challenging behaviour, assist staff in providing person centred care and minimise secondary disability. Providers of long term hospital care will ensure dignity, privacy and the rights of patients and their families to make choices about their care as far as is practical.

## Discharge planning

Effective and co-ordinated planning for the discharge of patients from hospital to a more appropriate setting is essential to ensure continuity and person centred care for older people. Poor planning can delay the discharge process, extend length of stay and jeopardise outcomes for patients.

Revised Hospital Discharge Planning Guidance was issued in 2005. It requires LHBs and local authorities in Wales to ensure that all NHS Trusts have clear procedures for the discharge of patients from hospital to the next stage of care, and sets out the principles that local multi-agency policies must reflect:

- Planning for discharge needs to start prior to the hospital stay for planned admissions and as soon as possible during the hospital stay for other admissions.

- When planning discharge from hospital it is essential that the individual's interests and wishes are central to the planning process and are taken into account when considering future care options. The unified assessment and discharge process must be person centred and involve regular consultation with the patient and his/her family/carer/advocate.
- The discharge process should be co-ordinated by a named person who has responsibility for co-ordinating all stages of the patient's journey. The further development of care pathways will facilitate and support the management of discharge arrangements as an ongoing process.
- A whole systems approach to assessment, commissioning and delivering services will facilitate effective arrangements. Implicit within this is an ethos of multidisciplinary and multi-agency working.
- The ability to discharge effectively is dependent upon the availability of a range of services to meet ongoing or longer-term care needs.

All NHS Trusts should have Safe Discharge Planning procedures in place to ensure older vulnerable patients receive appropriate monitoring, support and care after leaving hospital. This should encompass the following assessments:

- the patient's mental capacity to decide their discharge destination
- home environment safety (including needs for aids, equipment and adaptation)
- carer's capability and willingness to provide care
- risk of self-harm/abuse
- the patient's eligibility for different sources of funding of care, including NHS Funded Nursing Care, Continuing NHS Health Care and local authority financial support.

**The older person may be discharged to:**

**Home/relative or carer's home:** the discharge plan should identify and arrange for any support required to enable the patient to return home, e.g. social care, primary health care, community support, housing, home adaptations.

**Intermediate care** (see NSF Standard)**:** arrangements should exist for the timely transfer of older people who are medically stable but need short-term care to intermediate care facilities in preparation for returning home, following assessment from the local Intermediate Care Team.

**Care Home:** access to a long-term care home facility will be through a detailed multi-disciplinary assessment and meeting which fully explores options for hospital rehabilitation or domiciliary support before placement is decided upon and considers the patient's and carer's wishes regarding future care.

Timely and appropriate transfer/discharge communication from hospital to primary care, partner agencies and/or care homes is essential to ensure safe and effective discharge and to help prevent readmission. All NHS Trusts should have protocols in place to ensure effective communication throughout the discharge planning process and on the day of leaving hospital.

### Out-patient services

Out-patient services should be in a setting appropriate to the patient's needs, balancing the need for consultation, examination and investigation facilities near the patient's home. Clinics will be arranged so that the older person will be reviewed at intervals by the consultant, and discharged from follow-up if not under active investigation or modification of treatment.

Access to out-patient facilities must be as easy as possible for the older person, with thought given to appointment times (older patients should not be kept waiting and may need later appointments), distances, wheelchair availability, transport etc.

A robust patient-centred appointments system should be in place that allows for vulnerability issues which may result in non-attendance at appointments, e.g. communication or memory problems, to be recorded and a copy letter to be sent to a named significant other (eg. a relative or carer) so that appointments can be kept.

Linked therapeutic/nurse led out-patient facilities should be available in each locality to extend the treatment, therapy and support available to older people. This should include referral to community based exercise programmes where appropriate, especially if patients were admitted for CHD, stroke, falls or back problems.

### Day hospital services

Day hospital services primarily have an assessment and treatment function. The older person must be assessed using a multi-disciplinary approach, with consultant input, and access to identified clinical support services as required.

Timings and transport will be flexible and efficient, to allow maximum use of the services and facilities available.

Close liaison is needed between day hospital, in-patient wards, primary care and social care, to provide a smooth pathway between the different parts of the service. Discharge from day hospital will be adequately planned for, with follow-up support from primary care and social care in place.

### Respite health care in hospital

Respite health care should be available for patients with unstable medical conditions who require frequent in-patient multi-disciplinary review and for patients with complex needs including challenging behaviour which cannot be managed in the care home environment. In-patient stays should be planned in advance so that carers can gain maximum benefit from the break that respite health care affords them. However, emergency respite health care should also be available in each area as a crisis intervention service aimed at preventing long-term hospitalisation of persons cared for.

### Service Models

All hospital staff should be competent in the care of older people. However, specialist attention from a range of disciplines may be necessary. Older people who have complex co-morbidities associated with older age are best treated by a dedicated specialist 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. There should be a specialist old age multi-disciplinary team with the following core members available to older patients in all hospitals:

- Consultants in old age (geriatric) medicine
- Specialist nurses / nurse consultants
- Physiotherapists, occupational therapists and speech and language therapists
- Dietitians
- Clinical Psychologists
- Social workers / care managers
- Pharmacists
- Access to dental services, audiologists, opticians, podiatrists and orthotics
- Volunteer support.

The above specialists in caring for older people with complex problems will have key roles in developing standards, protocols and guidelines for the care of older people in general hospitals; in clinical governance; and in ongoing training programmes for other staff, in order to disseminate good practice. This team

should be based around a specialist unit that will serve as a centre of excellence for developing and disseminating best multi-disciplinary 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.

Consideration will also need to be given to the accessibility of this specialist support for those whose continuing health care is provided in settings other than in hospital, such as in care homes or at home in the community.

Effective clinical leadership will be the key to the delivery of this NSF in the hospital setting. Clinical leaders (eg. Nurse/Allied Health Professional Consultants) will provide leadership and development for groups of wards, ensuring a positive patient experience and promoting dignity and privacy across services.

These mechanisms are required to ensure that older people receive the care they need in hospital. Different models of care can deliver these benefits, but Trusts should be able to demonstrate 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.

**STANDARD -** *When admission to hospital is necessary for older people, the care they receive is co-ordinated, efficient and effective in meeting their clinical and non-clinical needs.*

| Outcome | What to measure | How to measure |
|---|---|---|
| older people are able to **access** emergency and planned hospital care, treatment and diagnosis promptly when required | waiting times for key services and treatments<br><br>(**fair** access measured in the standard on Rooting out Age Discrimination) | routinely collected |
| the treatment and care delivered to older people results in effective **clinical outcomes** | • clinical effectiveness | • clinical audit<br>• Healthcare Standards Clinical Outcomes domain |
| older people's health, wellbeing and safety is **protected** whilst in hospital | **reduction in:**<br>• hospital acquired infection rates<br>• falls and other accidents on hospital premises<br>• medication errors and adverse drug reactions<br>• POVA incidents<br>• average length of stay<br>~~~~~~~~~~~~~~~~~<br>• nutritional status<br>• views of older service users | • routinely collected<br><br>• Healthcare Standards Healthcare Governance domain<br><br>• service user survey |

| Outcome | What to measure | How to measure |
|---|---|---|
| Older people feel that their individual needs, privacy and dignity are respected and valued by those caring for them in hospital | • views of older service users and their carers<br>• compliments and complaints received<br>• implementation of *Fundamentals of Care*<br>(link to Person Centred Care standard) | • service user survey<br>• routinely collected<br>• review<br>• Healthcare Standards Patient Experience domain |
| older people's care is **well co-ordinated** both within the inpatient setting and between care settings | **reduction in:**<br>• medical 'outliers'<br>• number of internal transfers an older person experiences<br>• delayed transfers of care<br>~~~~~~~~~~~~~~~~<br>• views of older service users and their carers | • routinely collected<br>• patient survey |

**Objective 19 - NHS Trusts take a strategic, co-ordinated approach to the management of hospital services to older people**

| Action | By when | By whom |
|---|---|---|
| **19.1 - Using a review tool to be provided**, NHS Trusts undertake a review of the effectiveness of the total patient journey for older people through their acute services, including:<br>• the interface with primary, community, intermediate, social and long term care;<br>• emergency access (inc. alternatives to A&E)<br>• elective care | End of March 2007 | **NHS Trusts** in conjunction with LHB, Local Authority, Voluntary Sector partners and older people |

| Action | By when | By whom |
|---|---|---|
| **Continued**<br>• clinical and non-clinical aspects of in-patient care<br>• management of risk<br>• the care of older people in general hospitals with mental health needs<br>• rehabilitation<br>• discharge and transfer of care planning | | |
| **19.2 -** In light of the above review, NHS Trusts regularly monitor key indicators and seek to achieve continuous improvement in their services to older people | Ongoing from 2007/8 | NHS Trusts |

**Objective 20 - NHS Trusts deliver specialist older people's services**

| Action | By when | By whom |
|---|---|---|
| **20.1 -** All NHS Trusts to have identified old age specialist multi disciplinary teams with agreed interfaces throughout the hospital for the care management of older patients with complex physical and/or mental health needs. | End of March 2008 | NHS Trusts |
| **20.2 -** All NHS Trusts to have appointed lead clinicians, including Consultant Nurses and Consultant AHPs, with responsibility for professional leadership and service/practice development for older people services. | End of March 2008 | NHS Trusts |
| **20.3 -** All NHS Trusts to have in place a Mental Health Liaison Service for older people with mental health problems in general hospital settings. | End of March 2008 | NHS Trusts |

**Objective 21 - NHS Trusts assess and manage risks associated with the hospitalisation of older people**

| Action | By when | By whom |
|---|---|---|
| **21.1 -** older people's nutritional status is assessed on admission using a validated assessment tool (eg. MUST[101]) and their hydration and nutritional needs are met. | End of March 2008 | NHS Trusts |
| **21.2 -** older people with incontinence undergo a thorough assessment to identify the cause, and access appropriate specialist services, treatment and care | End of March 2008 | NHS Trusts |
| **21.3 -** all NHS Trusts take action to reduce falls amongst older people within hospital settings, in line with the forthcoming All Wales Framework for the Prevention and Management of Patient Falls | End of March 2008 | NHS Trusts |
| **21.4 -** All NHS Trusts to have in place Designated Lead Managers Health to meet the requirements of *In Safe Hands* and to help promote a culture of protection. | End of March 2007 | NHS Trusts in collaboration with social services, the police and CSIW. |

# Stroke

**STANDARD -** *The NHS, working in partnership with other agencies where appropriate, take action to prevent strokes, and to ensure that those who do suffer 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 and appropriate longer term care.*

## Rationale

Stroke has a major impact on people's lives. It starts as an acute medical emergency, presents complex care needs, may result in longterm disability and can lead to admission to longterm care. It affects between 174 and 216 people per 100,000 population in the UK each year[142], and accounts for 11% of all deaths in England and Wales.. The risk of recurrent stroke within five years of a first stroke is between 30% and 43%[142] .

Stroke can affect people of any age, but is predominantly a disease of older people. Around two thirds of all strokes occur after the age of 65 years. The incidence of stroke doubles with each decade after the age of 55 years. The overall incidence rate is 0.2/1000 in people aged 45-54 but rises to 10/1000 in those aged over 85 years. Almost one in four men and nearly one in five women aged 45 years can expect to have a stroke if they live to their 85th year[143].

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[144].

Bamford et al[145], described 4 Sub-types of cerebral infarction

- Lacunar infarcts -LACI
- Total Anterior Circulation Infarcts - TACI
- Partial Anterior Circulation Infarcts - PACI
- Posterior Circulation Infarcts - POCI

This classification is extremely important, as there are different clinical outcomes for each sub-type:

- TACI - Negligible chance of good functional outcomes; high mortality
- PACI - More likely to have early recurrent strokes
- POCI - greater risk of recurrent stroke later in first year, best chance of good functional outcome
- LACI - many patients remained substantially handicapped

***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[146].

There is good evidence that effective and systematic programmes of prevention can identify those at risk and reduce the future incidence of stroke. Evidence also shows that people who have had a stroke are more likely both to survive and recover more function if admitted promptly to a hospital based stroke unit with treatment and care provided by a specialist co-ordinated stroke team within an integrated stroke service.

However, the Royal College of Physicians National Sentinel Audit of Stroke Care (July 2004)[147] identified gaps in the provision of stroke care in Wales. The document refers to the service under the umbrella of a Stroke Unit which has a multi-disciplinary team, including specialist nursing staff based in a discrete ward which has been designated for stroke patients. This includes Acute Stroke Units, which provide an intensive model of care and accept patients acutely but discharge early (usually within 7 days); and rehabilitation stroke units which accept patients after a delay of usually 7 days or more and focus on rehabilitation.

### Key findings from the Sentinel Audit

5 key basic features were chosen from the Stroke Unit Trialists Collaboration (SUTC) as markers of Stroke Unit Organisation:

- Consultant Physician with responsibility for stroke
- Formal links with patient and carer organisations
- Multi-disciplinary meetings at least weekly to plan patient care
- Provision of information to patients about stroke
- Continuing education programmes for staff

Data in the tables below identify the proportion of stroke units that have four or five of these five criteria:

| | **England (220)** | **Wales (20)** | **N. Ireland (13)** | **Islands (3)** |
|---|---|---|---|---|
| % with stroke unit | 82% (181) | 45% (9) | 85% (11) | - (0) |
| % of stroke units with 4 -5 key characteristics | 91% (164/180) | 100% (9/9) | 64% (7/11) | - - |
| Median (IRQ ) number of stroke beds in stroke units | 20 (15 - 29) | 21 (19 - 24) | 14 (10 - 22) | - |

**Key Messages - Stroke Units and Staffing**

- *85% of hospitals in Northern Ireland and 82% of hospitals in England now have a stroke unit but only 45% in Wales.*
- *The majority of stroke units meet most or all of the basic criteria used in this audit to define a stroke unit*
- *There are wide variations in the staffing levels between units*
- *Clinical psychology services for stroke patients remain rare*
- *Social workers are only attached to the multi-disciplinary team in two thirds of Hospitals*

The Audit report outlines some of the current practical issues around stroke care:

- There is some evidence that standards may be deteriorating for stroke patients being managed on generic rehabilitation units. It is imperative that stroke units do not improve at the expense of other elements of patient care.
- While stroke care is progressing in hospitals, development of services for patients in the community has been much slower to advance.
- A lot of work remains to improve working between primary and secondary care.
- Only half of hospitals in England and far fewer than that in Wales have established protocols for joint working

## Key Interventions

**This standard is based upon and must be read in conjunction with:**

- The Royal College of Physicians Clinical Guidelines for Stroke (Second Edition, June 2004)[148].
- The Royal College of Physicians National Sentinel Audit of Stroke (July 2004)[147].
- NICE Technology Appraisal 90 - Clopidogrel and modified release dipyridamole in the secondary prevention of occlusive vascular events.(May 2005)[149]
- AWMSG Protocol for Oral Antiplatelet Therapy Dec 2004

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

- **prevention**
- **immediate intervention – management of acute stroke**
- **early and continuing rehabilitation**
- **life-long services**

### Prevention of Stroke

The prevention of stroke depends on reducing risk factors across the whole population as well as in those at relatively greater risk of stroke. Actions to reduce the risk factors for stroke in the population are addressed in the standard on Promotion of Health and Well Being, and include increasing levels of physical activity, healthy eating, smoking cessation and managing high blood pressure. They build on *Tackling Coronary Heart Disease in Wales*, the National Service Frameworks for Coronary Heart Disease and Diabetes and the NHS Cancer Plan, together with the themes drawn together in *Improving Health in Wales*.

Each patient with an identified risk of stroke must have an individualised strategy for stroke prevention as soon as possible, ideally within 7 days[150, 151] which will include written & verbal advice as appropriate concerning the main risk factors:

| | |
|---|---|
| **lifestyle** | smoking[152, 153, 154],<br>excess alcohol including binge drnking[155, 156]<br>obesity and poor diet[157, 158]<br>high salt intake[159, 160]<br>lack of exercise<br>lack of concordance with medication regimes[161] |

| | |
|---|---|
| **cardiovascular disease** | hypertension (high blood pressure)[162]<br>atrial fibrillation (a form of irregular heartbeat)[163, 164, 165, 166]<br>coronary heart disease and peripheral vascular disease carotid stenosis (narrowing of the carotid artery)[167, 168, 169, 170, 171, 172, 173, 174, 175]<br>previous stroke or TIA |
| **metabolic conditions** | diabetes<br>hyperlipidaemia (high cholesterol level)[176]<br>side effects of medication eg. HRT |

It is estimated that about 40% of strokes could be prevented by regular blood pressure checks, treatment for hypertension and taking steps to improve overall health[177].

Practitioners need to take account of and plan effective prevention and management strategies for stroke in multi-ethnic communities where it has been shown there is a higher risk of stroke in some groups[178].

GP practices are encouraged to fulfil the 10 criteria identified in the Stroke/TIA section of the clinical domain of the Quality and Outcomes Framework of the General Medical Services (GMS) Contract, thus ensuring the development of a stroke register, and the instigation of all preventive measures.

Patients who have suffered a stroke remain at increased risk of a further stroke of between 30 & 43% within 5 years[142]. The risk of completing a stroke after the first year may be as high as 20% within the first month. Patients with TIA and stroke also have an increased risk of myocardial infarction and other vascular events. The risk of further stroke is highest early after stroke or TIA. Therefore, highest priority must be given to rapid delivery of evidence based secondary prevention.

After stroke, most patients will be prescribed one or often more drugs to reduce their risk of future stroke. This will only be effective if patients comply with this and other secondary prevention strategies. The standard on Medicines and Older People provides further guidance on ensuring compliance with medication regimes.

Where recovery is not possible, this must be recognised by staff. The care of the patient must be discussed with them as far as possible, and with their carers as appropriate. The principles of palliative care must 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. (Refer to section on end of life care, in Person Centred Care standard).

## Management of patients with a Transient Ischaemic Attack (TIA) or minor stroke

The term TIA is used where the symptoms and signs resolve within 24 hours. The risk of developing a stroke after a hemispheric TIA can be as high as 20% within the first month, with the greatest risk within the first 72 hours[150, 151].

The Stroke Prevention Research Unit identified four factors that could predict the risk of early stroke amongst people who have had a TIA, and they have developed the ABCD score[179] as a way of quantifying the risk (the higher the score, the higher the risk of early stroke):

**A**ge of the patient

**B**lood pressure

**C**linical features the patient presents with

**D**uration of TIA symptoms.

This could be a useful tool for clinical practitioners to identify those at high risk of stroke, and therefore needing emergency investigation and treatment.

Patients first seen in the community with TIA or with a stroke, but having made a good recovery when seen must be assessed and investigated in a specialist service (e.g. neurovascular clinic) as soon as possible within seven days of the incident[150, 151].

Those with a likely diagnosis of TIA must be prescribed aspirin (300 mg daily) or an alternative antiplatelet drug immediately[180], provided there are no contraindications.

Patients with more than one TIA in a week must be investigated in hospital immediately[181]. Those with persisting impairments who have not been admitted to hospital must be seen by a specialist rehabilitation team[182, 183, 184].

## Immediate intervention – management of acute stroke

Stroke is a medical emergency. With active management in the initial hours after stroke onset, ischaemic brain may be saved from infarction. It is therefore very important that the public as well as health professionals with whom the patient has first contact (eg. paramedics,GPs) are able to recognise the symptoms of stroke and ensure that the patient receives appropriate emergency treatment.

The Stroke Association actively promote awareness of and use of the FAST test[185] to recognise stroke. FAST requires an assessment of three specific symptoms of stroke, which, if present should result in a 999 call:

**F**acial weakness - can the person smile? Has their mouth or eye drooped?

**A**rm weakness - can the person raise both arms?

**S**peech problems - can the person speak clearly and understand what you say?

**T**est all 3 symptoms

The evidence suggests that all patients with stroke benefit from being managed in specialised stroke units in hospital and that those managed at home do less well. No randomised trials have shown that the availability of home care services for patients with acute stroke can improve patient outcomes or reduce costs[186].

### Acute Hospital Management

Patients who may have had a stroke will usually require urgent hospital admission, and treatment by specialist stroke teams within designated stroke units. The first stage of management is to make the correct diagnosis through careful case history taking, examination and investigation[187, 188, 189]

The diagnosis must always be reviewed by an experienced clinician with expertise in stroke[190, 191]

Brain imaging must be undertaken as soon as possible in all stroke patients, at least within 24 hours of onset unless there are good clinical reasons for not doing so[192, 193]. The National Sentinel Audit for Stroke 2004 revealed, however, that just 23% of stroke patients in Wales received a scan within 48 hours of the onset of symptoms; this should be a priority for improvement.

Brain imaging must be undertaken as a matter of urgency if the patient has:

- been having anticoagulant treatment
- a known bleeding tendency
- a depressed level of consciousness
- unexplained progressive or fluctuating symptoms
- papilloedema, neck stiffness or fever
- severe headache at onset
- indications for thrombolysis or early anti-coagulation

If the underlying pathology is uncertain, or the diagnosis of stroke is in doubt after computed tomography scan, magnetic resonance imaging must be considered[193].

## Immediate Interventions for Stroke

Immediate intervention to improve chances of survival and minimise the risk of complications must include:

- **Initial Screening and monitoring**

  The patient must be assessed on admission for:

  - their risk of aspiration using a validated swallow screening test[194, 195, 196, 197, 198, 199, 200, 201,] and in addition, feeding and nutritional status[202, 203, 204, 205, 206, 207, 208, 209, 210, 211, 212]
  - their needs in relation to moving and handling[213, 214]
  - risk of developing pressure sores[215].

  In addition, monitoring of:

  - consciousness level, blood pressure, pulse, heart rhythm, temperature, blood glucose, oxygen saturation and hydration

**General Interventions**

- Blood glucose, arterial oxygen concentration, hydration and temperature must be maintained within normal limits[216, 217, 218]
- Blood pressure must only be lowered in the acute phase when there are likely to be complications from hypertension. E.g. hypertensive encephalopathy, aortic aneurysm with renal involvement[219].
- Patients must be mobilised as soon as possible[217]
- Aspirin (300mg), orally or rectally, should be given as soon as possible after the onset of stroke symptoms if a diagnosis of primary haemorrhage has been excluded.
- Anti coagulation should be started in every patient with persistent or paroxysmal atrial fibrilation unless contraindicated.

**In the first 24 hours assessment must include:-**

- Screening for cognitive impairment
- Assessment for problems with communication

- Self care
- Swallowing

Patients with **significant** narrowing of the carotid artery will benefit from carotid endarterectomy (surgery to remove the blockage) within two weeks of initial onset of stroke symptoms, to prevent the occurrence of a major stroke[220, 221].

## Management of Acute Ischaemic Stroke

Thrombolysis has the potential to improve the outcome of patients with cerebral ischaemia, however, it is a high-risk treatment and must only be administered by personnel trained in its use, in a centre equipped to investigate and monitor patients appropriately[222, 223].

## Early and continuing rehabilitation

### Multi-disciplinary Assessment – referral for rehabilitation

The evidence indicates that early, expert, co-ordinated, intensive rehabilitation in a hospital stroke unit improves the long-term outcome for patients and their carers[224].

The Multidisciplinary Specialist Stroke Rehabilitation Team needs an appropriate skill mix including medical, nursing, dental, psychology and therapy staff with training and expertise in stroke and neurological disorders[217, 225]. All patients must be referred to a specialist stroke rehabilitation team as soon as possible after admission[217, 225].

### Within 5 days of admission

Multi-disciplinary baseline assessments must be carried out using a standardised, validated procedure or protocol. Results, goals and evaluation of rehabilitation must be documented in the care plan[224].

Strategies must be in place to prevent complications including:

- Positioning and support[227, 228, 229, 230, 231]
- Venous thromboembolism[180, 232],
- Bladder and bowel management[233, 234, 235, 236, 237, 238, 239]

Continuing rehabilitation must meet the needs of patients with the following difficulties:

- Mood disturbances – depression, emotionalism, anxiety
- Cognitive impairment, including memory, attention, praxis, executive function

- Spatial awareness( neglect / inattention
- Communication impairment (dysphasia, dyspraxia and dysarthria)
- Dysphagia
- Nutritional status
- Oral care
- Motor control /co-ordination
- Tone
- Sensory impairment and pain
- Daily Living
- Management of continence

The patient and his / her carer must be given access to other specialist services as required[240, 241]

### Discharge from hospital

Treatment and care from the specialist team must also include preparation for going home / transfer to another setting. Involvement of care management is to include:

- patient-centred goal planning
- giving advice and training to patients and their carers to help manage the effects of the stroke on their lives and providing written and verbal information and explanations about the medication, treatment and care needed.

Early supported discharge (ESD) for stroke patients, with comprehensive therapy services working as part of a specialist multiagency team, has been shown to reduce the length of hospital stay by an average of 8 days as well as reducing the odds of death or dependency in the short term without increasing carer strain. Patients receiving ESD services are more likely to be independent and living at home after a stroke than those who receive conventional services[242].

The Care Co-ordinator will be responsible for ensuring a smooth transfer between care settings which may involve:

- alerting potential need for integrated assessment process for any necessary adaptations to the home, ensuring repairs and improvements are identified, and essential work/equipment for safe discharge completed prior to leaving hospital

- Referral for/ provision of long term equipment and adaptations to support independent living, including communication aids, and if appropriate, adaptations for the home such as grab rails or stair lift to be provided under local joint arrangements.
- ensuring that patients can access co-ordinated, community based, specialist stroke rehabilitation services and community based exercise programmes after they leave hospital as and when they need them, in order to achieve ongoing rehabilitation goals, maintain function or to meet a new identified need.
- Multi disciplinary assessment and therapy to help adjustment back to the workplace. This must involve the Disability Employment Advisory Service and Job Agency Centre Staff.

Secondary prevention measures are a key part of the individual care plan:

- Treatment and lifestyle modification advice must be initiated in hospital, with the arrangements made for it to be continued to be reviewed after leaving hospital.
- GPs must be notified of the risk factors and steps that have been, or need to be taken by the primary health care team to reduce risk.
- Patients and their families must be provided with health promotion information, advice and details of all available local services to prevent further strokes and other health problems. Caerphilly Borough Council have produced a Stroke Directory which provides local information for stroke patients and their carers.

### Life Long Services

Improvement from stroke can continue over a long time, and rehabilitation must continue until it is clear that maximum recovery has been achieved. Some patients will need ongoing services, possibly for many years. These people and their carers must have access to a stroke care co-ordinator / specialist who can provide advice, arrange reassessment when needs or circumstances change, co-ordinate long-term support or arrange for specialist care.

A patient with reduced activity at six months or later after a stroke must be assessed to ascertain if a period of further targeted rehabilitation is required.

The voluntary sector has a particularly valuable role to play in supporting people who have had a stroke, along with their carers and families. *Designed for Life* requires local authorities and LHBs to work with the voluntary sector to develop services to help individuals to gain confidence and independence following a stroke. In particular, the Stroke Association provides Family Support and Dysphasia Support services.

Life long services must be within the unified assessment and care management arrangements and should include:

- Ensuring patients have up-to date information on the medical requirements of the DVLA. Driving ability must be reviewed and referral made to specialist driving assessment if required. This must include their need for any adaptations.
- information on support services to promote independence in the workplace, social/leisure activities, and access to financial advice and management
- availability of services to advise/support carers in their emotional/ psychological needs.
- liaison between health/social services/voluntary agencies to maintain individual skills and meet the individual needs of patients and carers.
- provision of advocacy services within the voluntary sector for all stroke patients with particular reference to those under 60. This could involve services provided by the Stroke Association e.g. dysphasia / family support or other organisations such as Connect, Age Concern and Supporting People,
- ensuring stroke patients are followed up by the specialist stroke rehabilitation team to prevent further strokes. This could be either in the patient's own home, in care homes, outpatient department, or in the hospital setting.

### Service models

An integrated multidisciplinary stroke service will comply to the models specified in The Royal College of Physicians Clinical Guidelines for Stroke (Second Edition, June 2004). and The Royal College of Physicians National Sentinel Audit of Stroke (July 2004).

This includes provision of specialist multi disciplinary services for each aspect of patient care in the following settings:-

- Acute Stroke Unit
- TIA /Neurovascular Clinic
- A Stroke Rehabilitation Unit (Inpatient facility)
- A Day Rehabilitation Unit (out-patient care)
- A mobile specialist stroke team able to provide domiciliary care which has primary care / community based specialist medical, nursing and therapy staff and is designed to interface with other intermediate care services.
- Long term care and support, wherever this is provided (eg. At home, in care homes or in hospital)

**STANDARD -** *The NHS, working in partnership with other agencies where appropriate, takes action to:*

- *prevent strokes,*
- *and to ensure that those who do suffer a stroke have access to diagnostic services, are treated appropriately by a specialist stroke service and with their carers participate in a multidisciplinary programme of secondary prevention, rehabilitation and appropriate longer term care and support.*

| Outcome | What to measure | How to measure |
|---|---|---|
| a reduction in the number of older people who have a stroke | • incidence of stroke<br>• effective management within primary care of those at risk<br>• stroke registers<br>• no of people being treated for risk factors | • routinely collected<br>• GMS monitoring |
| a reduction in the number of stroke mortalities | • stroke mortality rate<br>• effectiveness of early intervention | • routinely collected<br>• review |
| provision of stroke care services in accordance with clinical guidelines | accordance with extant clinical and organisational guidelines for stroke services | RCP National Sentinel Audit on Stroke Services |
| effective co-ordination of stroke care from prevention through to acute care, rehabilitation and longer term support | • views of service users and their carers<br>• effectiveness of joint working<br>• effectiveness of care pathways including availability of statutory and voluntary sector services | • service user and carer survey<br>• review<br>• review |

**Objective 22 - integrated stroke care pathways are developed and implemented to support the prevention of stroke and the effective treatment, care and rehabilitation of those who have a stroke**

| Action | By when | By whom |
|---|---|---|
| **22.1 -** Each local health and social care community to design and have in place a care pathway for stroke care from prevention through to rehabilitation and long term support, so that all patients have access to appropriate treatment including a multi-disciplinary stroke team.<br><br>Care pathways must incorporate:<br>• preventive action and active management within primary care of those at risk<br>• effective referral mechanisms to specialist assessment and treatment for those with suspected TIA or stroke<br>• prompt access to specialist acute stroke services in accordance with RCP guidelines<br>• access to multidisciplinary rehabilitation<br>• co-ordinated longer term services, support and advice | End of March 2007<br><br>(NHS SaFF target 2006/07) | NHS Trusts, LHBs, local authorities, in conjunction with the voluntary and independent sectors |
| **22.2 -** local health and social care communities act to continuously improve stroke services, in line with ongoing RCP National Sentinel Audits | 2007/08 and ongoing | NHS Trusts, LHBs, LAs, voluntary and independent sector |

# Falls and Fractures

**STANDARD -** *The NHS, working in partnership with Local Authorities and other stakeholders, takes action to prevent falls, osteoporosis, fractures and other resulting injuries, and to maintain well being 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 integration of falls and fracture services.*

## Rationale

Fractures are a major cause of pain, disability and death. The vast majority of fractures and injuries in older people are the result of falls[243].

Osteoporosis, a condition characterised by a reduction in bone mass and density increases the risk of fracture when an older person falls. Osteoporotic 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 two women and one in five men over 50 will experience an osteoporotic fracture[244]. Over 12,000 osteoporotic fractures occur in Wales each year[245]. Over 4,200 of these are hip fractures. 7% of people die within a month of this injury[246], with 25% dying within the following year. Half of survivors fail to regain their pre-fracture level of independence.

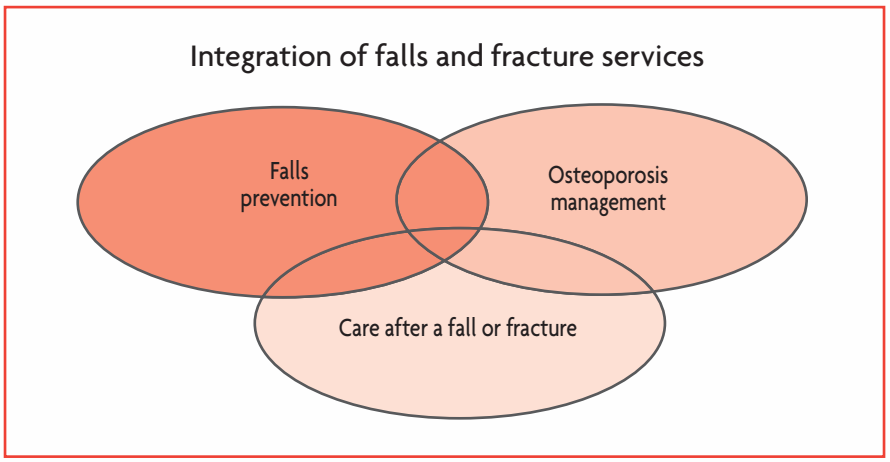
Hip fracture is the most common serious injury related to falls in older people, and in Wales this one injury leads to a total cost to Health and Social Services of £84 million each year[247]. One third of this cost is for acute care, and two thirds for social and medical aftercare necessary in the first two years after the injury. Fracture incidence and costs will rise by over 1% per annum simply as a result of the ageing of the Welsh population[248].

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
- loss of mobility leading to social isolation and depression
- increase in dependency and disability
- hypothermia
- pressure-related injury
- infection.

A fall can precipitate admission to long-term care. Fear of falling can provide a significant limitation on daily activities. Falls in later life are a common symptom of unrecognised health problems which need to be identified and managed.

One of the Health Gain Targets for Older People in Wales is to reduce hip fractures in the 75 and over age group by 10% by 2012; this standard is designed to enable the achievement of that target.




## Key Interventions

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

- falls prevention
- the prevention and treatment of osteoporosis
- improving the care and treatment of those who have fallen

### Falls prevention

Preventing falls in frail older people will save lives and decrease disability. A community-wide strategy, the provision of information, and timely advice and support to individuals are needed[249].

Falls services should be established within specialist multidisciplinary and multi-agency services for older people, to work with older people who are at high risk of falling[250].

## Population approach to falls prevention

Public health strategies should aim to reduce the incidence and the impact of falls, through actions to encourage appropriate weight-bearing and strength enhancing physical activity[250], to promote healthy eating (including adequate intake of calcium) and to reduce smoking in the general population. Access to regular sight and eye health checks are also important as poor vision is often a factor in falls[98].These are explored in more detail in the Standard on Promoting Health and Well Being.

A community strategy to prevent falls should also include attention to:

- Ensuring that pavements are kept clear and in good repair, and that there is adequate street lighting
- Making property safer - the housing bill currently proceeding through Parliament includes the 'Housing Health and Safety Rating System' which will be more risk-based, and will identify faults in dwellings and evaluate their potential effect on the health and safety of occupants and visitors

Information on community injury prevention in Wales is available from the Collaboration for Accident Prevention and Injury Control http://www.capic.org.uk and from Care and Repair Cymru. The *Keep Well This Winter* campaign also incorporates advice for older people about falls prevention. It stresses that lack of home maintenance and repairs are a major cause of falls in the home, exacerbated by the age of many properties in Wales and the difficulty for home owners on low incomes to undertake such repairs.

It advises older people to:

- arrange for small repairs or adaptations to the home to be undertaken, eg additional stair rails, grab or hand rails
- remove or repair frayed carpet edges to avoid tripping
- improve the lighting in dark areas
- avoid hazards or obstacles on the stairs and in walking areas
- rearrange furniture so that it's not in the way
- wear appropriate footwear, ie thin soled or flat shoes with an inbuilt heel
- consider asking their GP about hip protector underwear, if they are prone to falling
- take regular, weight bearing exercise

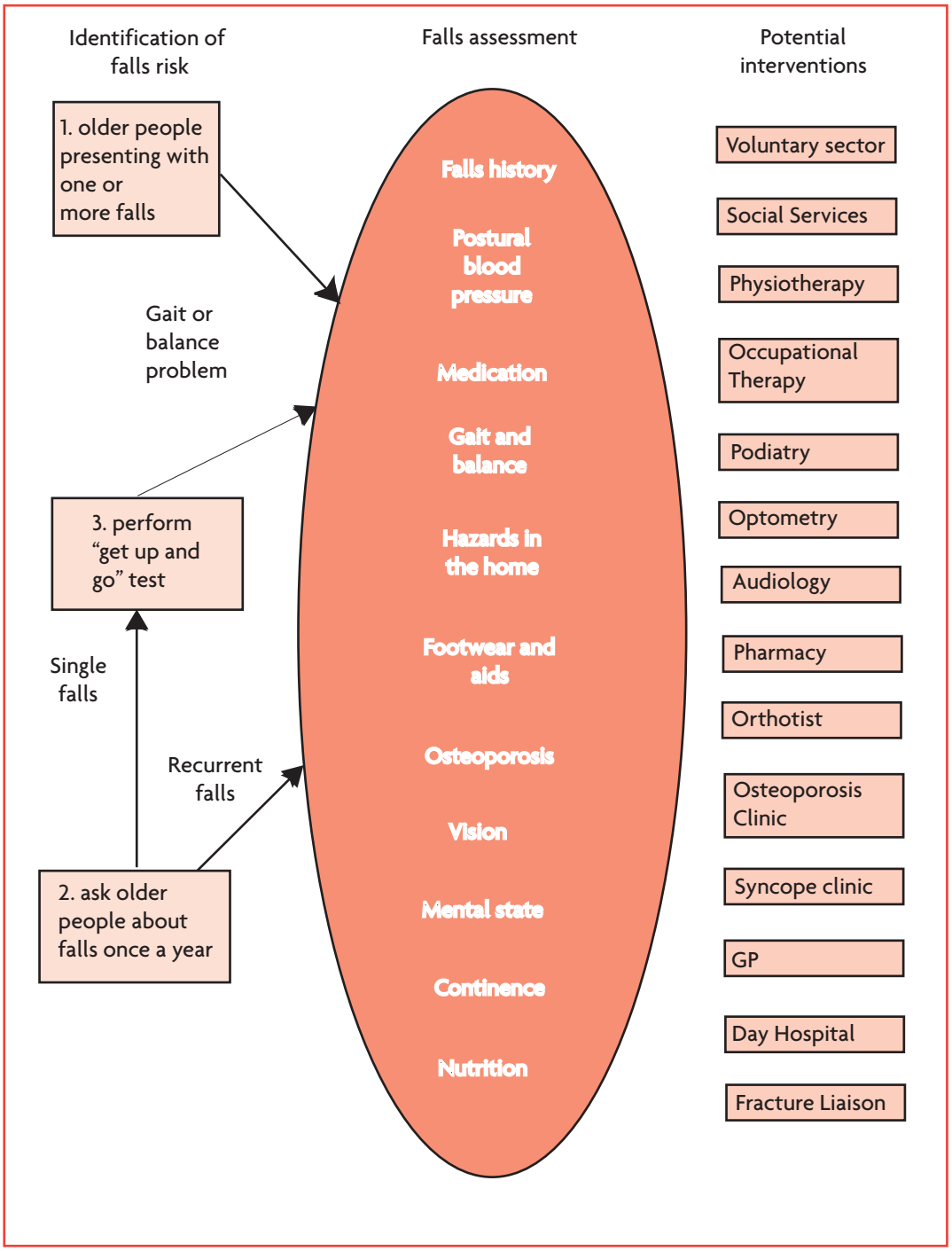
## Preventing falls in individuals

Preventing falls in older people depends on identifying those most at risk of falling, and co-ordinating appropriate preventive action[251]. Many people who fall do not seek medical help at the time, so older people should routinely be asked whether they have fallen in the last year, and fallers questioned about the frequency and mechanism of falls[250].

Older people should be offered a multifactorial falls assessment if they:

- present to a health care professional because of a fall
- report recurrent falls in the past year
- demonstrate abnormalities of gait or balance on 'get up and go' test[252, 253]

## Figure 2. Falls assessment



This identification of falls risk should form part of 'Contact' or 'Overview' elements of the Unified Assessment Process. Such an approach will identify one in six community dwelling over 75 year olds as being at risk of falling[254].

Identification of risk should trigger multifactorial falls assessment: an evaluation of falls risk and risk factors performed by a healthcare professional or professionals with appropriate competencies and experience.

This multifactorial falls assessment should constitute a 'Specialist' assessment which would build on other elements as part of the Unified Assessment Process, and should:

- identify and diagnose any risk factors for falls associated with an older person's health and environment, and identify actual contributory factors, 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 investigation and management of osteoporosis risk
- utilise tools to monitor the efficacy of interventions.

Many risk factors have been proven to be predictive of falls. The presence of more than one of the following factors increases the risk of falling[250]:

- falls history
- gait deficit
- balance deficit
- mobility impairment
- fear of falling
- cognitive impairment
- psychotropic and cardiovascular medications
- urinary incontinence
- home hazards
- multiple medications
- muscle weakness
- footwear and foot problems
- visual or hearing impairment
- malnutrition

Technological tools (e.g. computerised dynamic posturography, CDP) are available to assess the contributions and deficits associated with the balance organs (in the inner ears), eyes and muscles (postural control). They also allow assessment of the integration of sensory data at the brain. This comprehensive assessment enables a better informed choice of intervention to address the actual deficits identified[255].

Interventions[256] should be agreed with the older person. The most successful interventions are those which target both environmental hazards and an individual's personal medical and physical risk factors[257, 258].

Effective interventions are considered in detail in the NICE Guideline on Falls[250]. This review suggests that:

- multifactorial tailored intervention should be available to people identified as being at increased risk of falling. Successful programmes should offer the diagnosis and management of specific causes and risk factors, along with:
  - exercise, strength and balance training - individually tailored training is useful, especially for community dwelling older people identified as at risk of falling
  - home hazard assessment and intervention
  - vision assessment and referral
  - hearing support services eg Hear to Help programme
  - medication review with modification/withdrawal
  - home hazard assessment should be offered to older people being discharged from hospital following a fall, but is only effective when it occurs in conjunction with follow-up and intervention
  - older people who are taking multiple or psychotropic medication should have their medication reviewed and discontinued when appropriate
  - basic medical assessment should include heart rate and rhythm and postural blood pressure measurement. In patients with recurrent unexplained falls, carotid sinus massage or specialist cardiovascular assessment should be considered to identify those with cardiohibitory syncope who may benefit from pacemaker insertion.

Many local authorities provide a community alarm service, which involves the person at risk of falling wearing a pendant or bracelet which will alert the call centre when a fall has occurred.

### Preventing falls in service settings

Older people are at particular risk of falling in hospital and care homes. Falls in these settings must be recorded in registers. Advice on constructing a population falls register was included in the Information Strategy for Older People in England[259].

Critical incident analysis following a fall will develop awareness and a learning culture amongst staff and will ensure that action is taken to minimise future incidents.

An All Wales Framework for the Prevention and Management of Patient Falls, mainly targeted at inpatient settings, is currently under development.

### Osteoporosis management

Osteoporotic fractures are a major cause of pain, disability and death. Strategies to prevent or treat osteoporosis should focus on selective case finding, whereby people are identified for intervention because of previous fragility fractures or the presence of other major risk factors[260, 261].

Prevention and management of osteoporosis can have a significant effect on the numbers and costs of fractures[262, 263]. 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[261, 264].

Risk factors for osteoporosis include:

- previous fragility fracture, including X-ray evidence of vertebral fracture
- prolonged (›3 months[265]) corticosteroid therapy
- untreated premature menopause or male hypogonadism
- thyrotoxicosis, malabsorption, alcoholism, or rheumatoid arthritis
- strong family history of osteoporosis, including maternal hip fracture
- low body mass index ‹ 19kg/m2
- smoking
- prolonged immobility

Lack of sun exposure and poor diet mean that vitamin D deficiency and inadequate calcium intake are common in older people. These will contribute to bone loss, especially in people who are institutionalised or housebound[266].

The diagnosis of osteoporosis may be confirmed by:

- occurrence of multiple low trauma peripheral fractures, where other causes of bone fragility have been excluded
- radiographic evidence of vertebral fracture, or loss of height associated with vertebral fracture
- DEXA (Dual-energy X-ray Absorptiometer) bone density scan.

## Osteoporosis prevention

All patients should be offered lifestyle advice to reduce the risks of osteoporosis including advice on:

- adequate dietary calcium and sunlight exposure
- adequate energy and protein intake in people who are underweight
- regular weight bearing exercise and community based exercise programmes available
- stopping smoking
- avoiding alcohol

Where patients are identified as being at high risk of osteoporosis, investigations such as measurements of bone mineral density should be carried out in line with the Royal College of Physicians Clinical Guidelines[267, 268] on the prevention and treatment of osteoporosis. Results from such investigations will determine whether preventive treatment is appropriate.

## Osteoporosis treatment

Older people who are frail, malnourished or housebound or who have had previous fragility fractures may benefit from supplements of calcium and vitamin D to help prevent hip fracture, although there is now varying evidence about this[269, 270]. It is important to correct calcium and vitamin D deficiency when other forms of osteoporosis therapy are being used.

Other drug interventions including bisphosphonates, raloxifene, and teriparatide, will be most cost-effective when prescribed in carefully defined, high risk, older people[271]. Identifying these patients should be a priority in primary care[272].

The National Institute for Clinical Excellence (NICE)[271] recommends oral bisphosphonates as treatment options for the secondary prevention of osteoporotic fragility fractures:

- in women aged 75 years and older - without the need for DXA scanning
- in women aged between 65 and 74 - if osteoporosis is confirmed by DEXA scanning
- in women aged under 65, only if their bone mineral density is very low (a T score of -3SD or below) or if they have a confirmed diagnosis of osteoporosis and afore mentioned risk factors.

The NICE guidelines do not cover men.

The identification, assessment and management of such individuals should be the priority for fracture services in every trauma unit.

## Care after a fall

### Assessment in primary care

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 staff in primary care following a fall.

In addition GPs should take responsibility for assessing risk of osteoporosis (with attention to the criteria listed above), and identifying those who need prevention or treatment. Attention to fallers and especially to people who sustain a low trauma fracture is particularly important; allowing the primary care team to identify those in whom falls prevention and osteoporosis drug treatment will be most cost effective and most likely to achieve reductions in future fracture.

GPs should determine whether the older person should be referred:

- for falls assessment if they meet the criteria
- to hospital for treatment for specific injuries
- to intermediate care services for assessment and rehabilitation
- for open access X-ray to confirm vertebral fractures
- for DXA scan if this is likely to change treatment recommendations
- to a specialist osteoporosis service for further investigation, therapy or advice in complicated cases.

### Assessment in hospital

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

For people returning home from A&E, an initial falls assessment can be undertaken either in A&E or subsequently on an out-patient, day-patient or domiciliary basis.

Follow up comprehensive multifactorial assessment and tailored intervention should be available; this will need to take place in outpatient or day-hospital settings with access to full diagnostic and multidisciplinary facilities.

All older people presenting with a low trauma fracture or exhibiting high risk for osteoporotic fracture should be considered for treatment of osteoporosis, or for assessment of their bone mineral density (BMD). Those identified as having osteoporosis should be offered appropriate therapeutic interventions[273].

Older people with suspected hip fracture or other serious injury will receive immediate attention to pain relief and pressure area care, and be 'fast tracked' to an orthopaedic ward[123], within 2 hours of their arrival in A&E[274].

Operations for fracture repair will be carried out within 24 hours of admission, or as soon as the patient's medical condition permits, by experienced staff working during standard day-time hours, including weekends[275].

Patients will be provided with intravenous fluids around the time of presentation and surgery, and will receive attention to adequate nutrition including oral multinutrient supplements[276].

Patients will be mobilised within 24 hours following hip fracture repair, unless their medical or orthopaedic condition precludes this.

All older patients with hip fracture or other serious orthopaedic injuries should be referred to an 'orthogeriatric service' - a multidisciplinary team led by a specialist in medicine for older people[123].

The orthogeriatric service will:

- be integrated with other local falls and fractures services
- lead assessment of coexisting medical, psychological and social problems
- assess the patient's risk of falls and osteoporosis and advise on secondary prevention
- provide advice in respect of rehabilitation and discharge planning
- play a part in promoting the development of expedited discharge pathways including intermediate care services.

A variety of models of orthogeriatric services have been described[277]. The evidence in support of the development of orthopaedic rehabilitation wards away from the acute site is poorer than that for the development of orthogeriatric services to work alongside surgeons within the acute trauma setting[278].

The most appropriate models for integration of falls, fractures and orthogeriatric services should be agreed locally between the orthopaedic service, the hospital-based specialist service for older people, and intermediate care services.

## Rehabilitation

If an older person does not need admission to hospital or to an intermediate care service, other options should be available to primary care and A&E staff in case it is necessary to support them in the community. These include:

- occupational therapist assessment of risks in the home, advice and planning of equipment provision or home repair services
- support from a voluntary agency or good neighbour scheme
- care from statutory agencies
- assessment by a physiotherapist of their needs, which may include safety or mobility equipment.
- a programme of exercise

Discharge from hospital needs careful and early collaborative planning by the multidisciplinary teams, the patient and their carers. The orthogeriatric 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.

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. This should include referral to community based exercise programmes.

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]. Risk management should not encourage restriction of mobility; care practice in all settings should rather identify how older people can manage most safely.

Rehabilitation strategies[280, 281] should aim to:

- teach older people awareness of hazards and how to avoid them
- help older people regain the confidence to relearn and practise their previous skills in every day living, and to cope successfully with threats to balance
- increase stability during standing, transferring and walking through:

  - balance training
  - strengthening the muscles around the hip, knee and ankle
  - increasing the flexibility of the trunk and lower limbs
  - gait re-education
  - providing appropriate mobility and safety equipment
- teach older people 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 improving nutrition and preventing pressure sores should also be discussed
- improve the safety of the older person's environment by, with their consent, removing, replacing or modifying any hazards
- establish a network of community support and supervision 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.

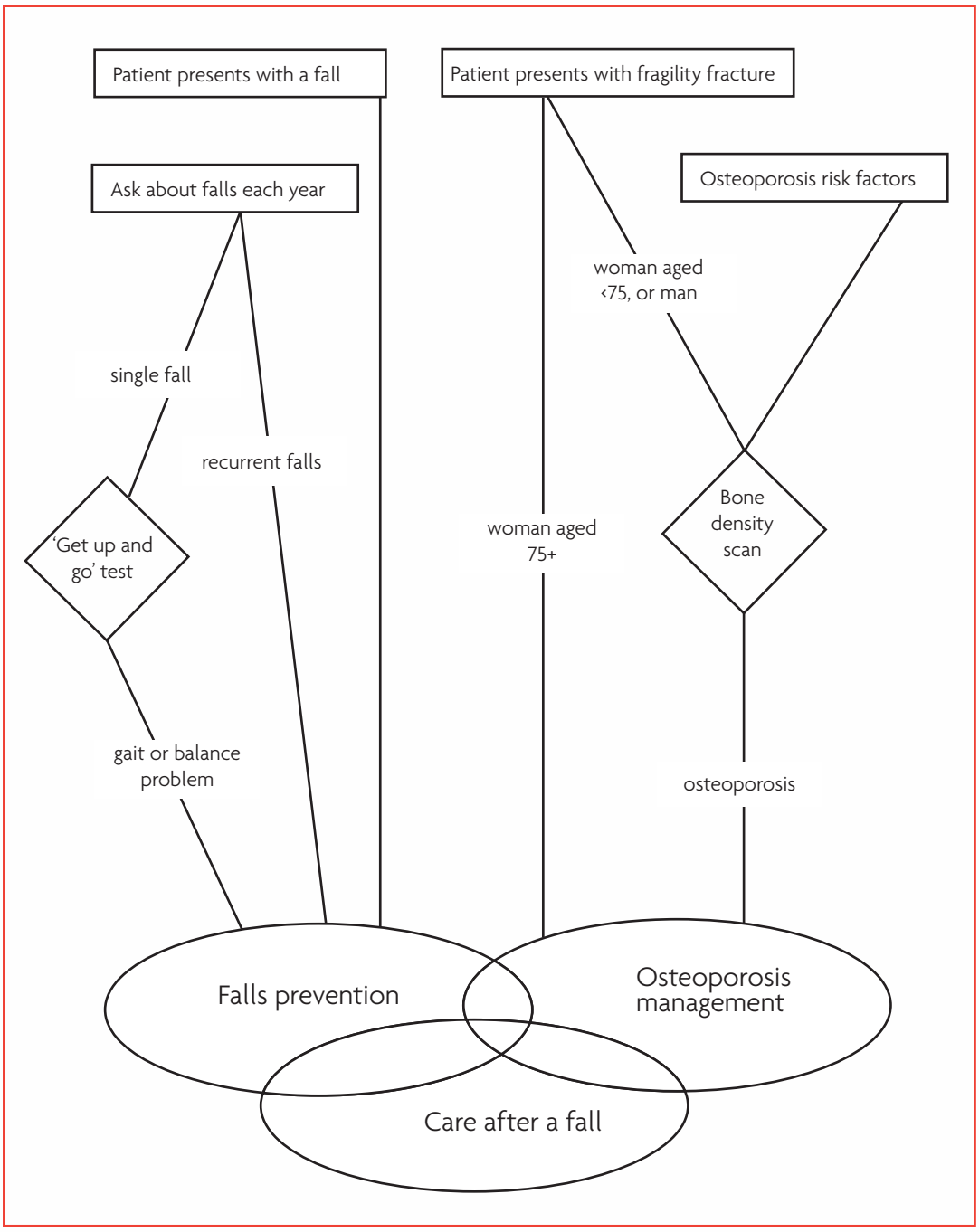
Older people who have fallen should be assessed and reviewed regularly to monitor their needs. Longer-term social and emotional support may be required to minimise any loss of independence caused by the effects of the fall. This may include provision of personal or domestic care services or introduction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

### Service Model

The NHS and Local Authorities 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.

The Unified Assessment Process will be used to promote older people's safety and independence (see Person Centred Care standard). Staff in community health, primary and social care settings should be trained to recognise when older people are at risk of falling, and are aware how to arrange falls or fracture assessment.

## Figure 3. Care pathway




The local health and social care system should ensure the integration of falls and fracture services. These should form a part of the services for older people in both hospital and community settings, including care homes, and may have their main operational base in an acute hospital, day hospital or intermediate care setting.

There are many models for falls and fracture services, but in practice these tend to include the following elements:

- a designated lead professional
- multidisciplinary teams working with older people in various settings
- provision for the medical management of falls, syncope and osteoporosis
- an orthogeriatric service
- a falls exercise programme
- health promotion

Falls and fracture services should be able to call on the skills and specialist expertise of:

- consultant in old age medicine
- GPs
- hospital nurses and community nursing services
- occupational therapists
- physiotherapists
- pharmacists
- dietitians
- orthotists
- Ear, Nose and Throat Specialist
- podiatrists
- optometrists, ophthalmologists and rehabilitation officers for the blind
- audiologists
- social workers
- trained bilingual workers to reflect the needs of local populations
- voluntary organisations

These professionals are unlikely to work exclusively within the falls or fracture services, and their other responsibilities will enhance interdisciplinary and partnership working.

Falls and fracture services should develop referral arrangements to medical and surgical sub-specialities, including cardiology, syncope assessment, specialist osteoporosis clinic, and assessment of bone mineral density (figure 2).

Protocols should be developed for the management of older people who have fallen through consultation and liaison with Local Health Boards and Trusts, social services and housing agencies.

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

Falls and fracture services should work with primary and social care professionals to ensure that appropriate support is in place before patients return home from A&E or trauma wards.

**STANDARD -** *The NHS, working in partnership with Local Authorities and other stakeholders, takes action to prevent falls, osteoporosis, fractures and other resulting injuries, and to maintain wellbeing 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 integration of falls and fracture services.*

| Outcome | What to measure | How to measure |
|---|---|---|
| reduction in number of falls amongst older people | • number of falls amongst older people - categorised by cause and location<br>• effectiveness of:<br>• community wide falls prevention strategies<br>• falls prevention in care settings<br>• identification and risk management of individuals at risk | • routinely collected<br>• review |
| reduction in number of hip, fragility and osteoporotic fractures amongst older people | number of hip, fragility and osteoporotic fractures amongst older people | • routinely collected |
| the treatment and care of older people who have fallen and those with a resultant fracture is provided in accordance with clinical and other good practice guidelines | • clinical audit | • review |
| older people who have fallen are enabled to return to their optimum potential of wellbeing and independence | • effectiveness of multifactorial falls assessment<br>• number of fallers who are able to resume functioning | • review<br>• service user survey |

**Objective 23 - To review local systems for the prevention and treatment of falls and fractures**

| Action | By when | By whom |
|---|---|---|
| **23.1 - as part of the commissioning strategy**, each local health and social care partnership to **review** the local service for falls and fractures, including:<br>• what is currently done to prevent falls ( on a multi factorial basis);<br>• how those at risk of falling are currently identified and managed;<br>• how those at risk of osteoporotic fracture are currently identified and managed;<br>• how those who have suffered a fragility fracture are currently identified and managed;<br>• how those who have fallen are cared for in the immediate and longer term, including rehabilitation;<br>• how the efficacy of interventions are measured and monitored;<br><br>**and agree priorities for action**. | End of March 2007 | LHBs, Local Authorities, NHS Trusts in partnership with independent and voluntary sectors. |

**Objective 24 - Take action to improve local services for falls prevention and the treatment and mental wellbeing of patients with fall related injuries**

| Action | By when | By whom |
|---|---|---|
| **24.1 -** Based on the findings of the review (23.1), develop and implement a community wide Falls and Fractures Strategy for the multi agency prevention and treatment of falls and fractures, incorporating:<br>• integration of Falls, fracture and orthogeriatric services in each locality so that all patients presenting with a hip fracture, fragility fracture or fall receive assessment and appropriate management in respect of secondary prevention;<br>• ensuring the provision of a bone densitometry service;<br>• ensuring that staff have the relevant competencies;<br>• the maintenance of falls registers and critical incident analysis in hospitals and care homes | End of March 2008 | NHS Trusts, Local Health Boards and Local Authorities in partnership with independent and voluntary sectors. |

# Mental health in older people:
## including Dementia in Younger Adults

**STANDARD -** *older people who have a high risk of developing mental health problems and others with related diagnosis have access to primary prevention and integrated services to ensure timely and appropriate assessment, diagnosis, treatment and support for them and their carers.*

### Rationale

Mental health problems are common in older people and can severely affect the independence and quality of life of individuals and their families. Older people can suffer from any of the mental health problems in adults of working age. In addition some problems, notably the dementias, are more common in later life. None are an inevitable consequence of ageing but in later life problems are often more numerous and the interactions more complex.

The Adult Mental Health Strategy for Wales (2001)[282], and the Adult Mental Health NSF for Wales (2002)[283], updated in 2005[284] provide the strategic framework and standards for mental health services in the 21st Century. Although targeted at adults of working age, the **principles** apply equally to mental health services for older people, ie to promote:

- good mental health, social inclusion and tackle stigma;
- service user and carer empowerment;
- opportunities for a normal pattern of daily life;
- equitable and accessible services;
- commissioning and delivery of effective, comprehensive and responsive services;
- effective client assessment and care pathways;
- a well staffed, skilled and supported workforce.

The Welsh Assembly Government is now taking a more integrated policy approach to adult and older people's mental health services, and this standard therefore aims to complement and dovetail with adult mental health policy.

Mental health problems in older people including dementia are major threats to the lives of individuals and their families. They result in very significant requirements for health and social care. Based on UK figures[285], the annual direct cost to the NHS in Wales of caring for people with Alzheimer's disease can be estimated to be at least £80-120 million. Taking into account the costs of informal

caring and the costs to all statutory agencies, the total cost of caring is in the region of £700 million. There is considerable variation around the country in mental health services in both health and social care for older people[286].

Recent data suggest that three quarters of people in non-specialist care homes have some degree of dementia[287]. If all types of home are included the figure may well exceed 90%[288]. It is by far the commonest reason for requiring institutional care and is therefore a major factor in social and health care.

**Black & Minority Ethnic Communities -** Older people from black and minority ethnic communities need accessible and appropriate mental health services[289]. 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. Inadequate communication may lead to distrust of agencies by some black and minority ethnic communities.

### Types of mental health problem

Depression and Dementia are the commonest mental health problems in older people but older people can also have all the other mental health problems experienced by adults of working age. These include psychoses, bipolar affective disorder, alcohol & substance misuse, anxiety, obsessive-compulsive disorder etc. Adults being treated for such problems must receive continuity of care as they grow older.

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. Depression in people aged 65 and over is especially under-diagnosed and this is particularly true of residents in care homes. Mental and physical health needs can also interact in older people making their overall assessment and management more difficult. 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.

**Depression** is a broad and heterogeneous diagnostic grouping, central to which is depressed mood or loss of pleasure in most activities. Other symptoms can include disturbed sleep, poor concentration or indecisiveness, low self-confidence, poor or increased appetite, suicidal thoughts or acts, agitation or slowing of movements, guilt or self-blame. Depressive symptoms are frequently accompanied by somatic symptoms and symptoms of anxiety.

**Anxiety** is characterised by symptoms such as apprehension, panic attacks, irritability, poor sleeping, avoidance, and poor concentration.

Depression may be triggered by a variety of factors such as bereavement and loss, life changes such as retirement, moving into an institution, social isolation, undertaking a caring role for a family member, increasing illness, frailty or sensory impairment. It can also be a side effect of some medication, or of alcohol abuse. Some late onset depression is associated with cerebrovascular disease. Depression can co-exist with dementia.

At any one time, around 10-15% of the population aged 65 and over will have depression . The prevalence rises in those attending GP practices (15 - 30%), and those who are hospitalised (15 - 50%). Carers are particularly vulnerable. Severe states of depression are less common, affecting about 3-5% of older people. Depression can severely affect the quality of life, may adversely affect physical health and is associated with increased mortality from both physical causes and indeed suicide. Older males have the highest risk of completed suicide in the population. Thus the common problems of depression and anxiety pose significant public health problems.

**Dementia** is a clinical syndrome characterised by a widespread and progressive loss of mental function, including memory, language and non-verbal skills. It results in impairment of judgement and activities of daily living and can cause marked behavioural change.

Dementia can result from a number of pathologies, the most common of which include:

- **Alzheimer's disease -** this accounts for 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 small vessel disease in the brain and accounts for up to 20% of cases of dementia. It has a more varied clinical picture depending on which parts of the brain are most affected. In any individual, Alzheimer's disease and vascular dementia can co-exist
- **dementia with Lewy bodies -** this accounts for up to 15% of dementia cases and is characterised by symptoms similar to Parkinson's Disease as well as hallucinations, and a tendency for mental function to fluctuate.
- **other conditions** such as Parkinson's Disease itself, excessive alcohol, fronto-temporal atrophy, space occupying lesions and metabolic causes account for the remainder.

The prevalence and incidence of dementia increase markedly with age[291]. According to the Alzheimer's Society in Wales, approximately 42,000 people in Wales have dementia. This represents 5% of the total population aged 65 and over, rising to 20% of the population aged 80 and over.

**Dementia in younger people -** Dementia can also occur before the age of 65; there are about 1000 people with dementia in younger age groups in Wales. Younger people with dementia are a significant minority with specific needs and circumstances. As dementia under the age of 65 is rare it is less likely to be specifically recognised or addressed by services. This causes a considerable additional burden for younger people with dementia and their families as they are unclear about where to access the support they need.

In families where someone develops dementia at a younger age there are more likely to be children and financial commitments dependent on the earnings of the person with dementia and their carer.

The issues facing younger people with dementia and their families are complex and may change quickly. There is a need for specific forms of information and emotional support, ongoing specialist involvement and monitoring[292].

The impact on staff providing support to younger people with dementia is frequently underestimated. The different and unfamiliar range of needs, the emotional impact of caring for someone of a similar age to themselves and the training implications warrant specific consideration.

### Substance Misuse

Older people are more susceptible to the effects of alcohol and there is greater potential for adverse interactions with other medications. Misuse of alcohol can be a reaction to life events or associated with other illnesses. It may also be part of a long established lifestyle with additional adverse effects emerging in later life.

In some cases older people may actively misuse prescribed or other medication. Inevitable cohort effects will mean that over time there will be increased numbers of older people with a history of drug misuse, which has in the past been viewed as a problem in younger people.

### Psychosis

This includes older people who suffer from schizophrenia and similar conditions. In addition symptoms of delusions and hallucinations commonly occur in older people who have a depressive illness, dementia or other organic illnesses.

### Mental Health Problems associated with Learning Disability

Most mental health problems are more common amongst people with learning disabilities than in the general population. Due to advances in medical care and social support, people with learning disabilities are increasingly likely to survive into old age[293]. However, they are also likely to have psychiatric morbidity. There are significant difficulties with early detection and diagnosis of mental health problems in people with learning disabilities. Individuals with a learning disability who develop dementia have very special needs. The health of people with Down's Syndrome and dementia often deteriorates quite rapidly.

Evidence shows that many mental health problems are preventable and /or treatable, and that their impact on both the individual and their families and carers can be reduced through appropriate care and support.

## Key Interventions

The maintenance of good mental health, effective treatment of mental health problems, and support for older people and their families, depends upon:

- The promotion of good mental health amongst the population in general;
- Specific measures aimed at preventing the onset of mental health problems common in old age;
- Early diagnosis of mental health problems in older people and assessment of need;
- Effective, person centred health and social care, delivered by integrated, seamless and comprehensive services, provided by the statutory, independent and voluntary sectors.

### Promoting good mental health

Mental health promotion places an emphasis on maintaining and promoting good mental health and wellbeing, helping individuals to develop the skills and resources they need to cope with difficult life experiences, and to avoid developing mental health problems. It also helps to promote an understanding of mental health issues, reducing the stigma associated with mental illness[294].

The Adult Mental Health Strategy for Wales[282], and Adult Mental Health NSF[283, 284], both aim to promote and improve the mental health of the general population through the delivery of evidence based, local Mental Health Promotion Strategies. Further guidance on action to promote the mental and emotional well being of older people is provided in the Healthy Ageing Action Plan[20]. *The Strategy for Older People in Wales*[3] identified broader initiatives to tackle social disadvantage, including poverty, unemployment, poor housing, homelessness and social exclusion.

Meaningful activity is an essential component of mental wellbeing. Older people should be offered, and actively encouraged to participate in, a choice of activities and lifelong learning opportunities appropriate to their individual needs within an appropriate setting promoting individuality and preserving personhood. Such activities should be available to residents of care homes as well as to the general population, and can be provided by a variety of statutory and voluntary sector organisations or community groups. *Designed for Life* calls for each LHB to develop the capacity of the voluntary sector to help support older people with mental health problems and their carers, by March 2008.

### Prevention

**Preventing depression -** Depression is often triggered by unexpected or uncontrollable life changes but several factors can protect against this. Factors such as physical fitness, positive coping behaviour, and social networks are important. Bereavement is a particularly difficult situation to deal with and can lead to severe depression. Timely bereavement counselling and ongoing support, often provided by the voluntary sector, can help minimise the depression experienced.

The NICE Clinical Guideline on Depression[295] calls for screening within primary care and general hospital settings of those at high risk of depression, such as those with a past history of depression, significant physical illnesses causing disability, sensory impairment or other mental health problems.

Caring for people with serious health problems can also put the individual at high risk of depression. Structured education and support programmes, including respite care, are effective in improving carers' mental wellbeing.

**Dementia -** At present dementia cannot be prevented, other than through avoidance of certain causes such as alcohol abuse and vitamin deficiencies. Maintaining a mentally, physically and socially active lifestyle and continuing lifelong learning may influence some of the factors associated with increased

risk of developing dementia. Hearing and visual deficits can be a cause of social isolation, loss of mental stimulation and low mood and their treatment may help to maintain cognitive function. Minimising the effects of stress and ensuring a balanced healthy diet (with no more than light to moderate alcohol consumption) is likely to help, but there is no conclusive evidence supporting vitamin or any other nutritional supplements.

Older people with a high burden of vascular risk factors are at increased risk of developing dementia, suggesting that treatment of hypertension, hyperglycaemia and hyperlipdaemia and thromboprophylaxis for atrial fibrillation might reduce risk. This emphasises the need for appropriate interventions within primary and secondary care to address these factors (in line with the National Service Frameworks for Coronary Heart Disease and Diabetes). NICE guidance on the treatment and care of people with dementia is under development and due for publication in November 2006.

### Timely Diagnosis and Assessment of mental health problems

Timely and accurate diagnosis of mental health problems supports older people and those caring for them in the understanding and management of the illness. Timely access to appropriate multi agency specialist services is vital in order to provide effective assessment, intervention and support for all the needs of both the client and carer.

The first indications of a mental health problem may be noticed by the individual, or anyone with whom they have contact including family, carers, friends, neighbours or other service providers. All health and social care staff, who may be alerted to such concerns, need to be aware of the symptoms of possible mental health problems and how to respond, including use of the Unified Assessment Process (UAP). UAP provides for a holistic assessment of the person's health and social care needs, to inform an individual's care plan. Where appropriate, a referral can be made for a specialist mental health assessment under the Care Programme Approach (CPA).

The Social Care Institute for Excellence (SCIE) Practice Guide on Assessing the Mental Health Needs of Older People[296] gives an overview of information and current practice to all those involved in assessing the social care needs of older people with mental health needs.

It is essential to ensure that older people using mental health services are involved in making decisions about their individual assessment and care plan and should have access to advocacy services including those suitable for people with a

cognitive impairment. The voluntary sector have a particular role to play in the provision of independent advocacy services.

Primary care teams have a vital role in timely recognition of mental health problems in older people, and, where appropriate, referral on to the multi agency specialist Community Mental Health service or an alternative primary care based enhanced service for depression. In the case of Depression and Anxiety, the role of primary care teams is clearly laid down in NICE Clinical Guidelines.

The Audit Commission National Report *Losing Time (2002)*[286], however, highlighted that the important role of GPs in early diagnosis was not always being realised. The follow up report, *Developing Mental Health Services for Older People*[297], issued in November 2004, reveals some progress but recommends the provision of clearer advice and training for GPs about the initial identification, and diagnosis of dementia in particular, and better general advice and guidance about available services, their benefits to users and carers, and how they can be accessed.

The provision of sound and timely information and advice to carers who may be concerned about an individual's mental health, can also come from other sources such as NHS Direct or voluntary sector organisations. Local Mental Health Planning Forums should consider alternative referral routes through to services, or open access facilities, to complement the more traditional primary care referral route.

**Timely diagnosis of depression –** This is clearly set down in the NICE clinical guidelines which equally apply to older people. These guidelines highlight the need to screen high-risk groups including those with significant physical illnesses causing disability, sensory impairment or other mental health problems, such as dementia.

Older people may be more likely to 'somatise' their depression, in other words to report the associated physical symptoms of aches and pains, and complain about fatigue, insomnia and poor appetite, rather than complaining of sadness. Health and social care practitioners therefore need to be alert to such physical symptoms and the possible underlying causes of depression or anxiety.

**Timely diagnosis of dementia -** For older people with suspected dementia, early diagnosis gives access to treatment, allows planning of future care, and helps individuals and their families come to terms with the prognosis[298, 299, 300]. 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. Dementia in younger adults 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.

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.

Initial diagnosis of dementia involves[291]:

- taking a history. This should include speaking to someone who knows the person well
- using assessment scales to aid diagnosis and to estimate the severity of cognitive impairment including specialist neuropsychological assessment where required
- carrying out a physical examination and investigations such as blood tests and neuroimaging
- being able to distinguish between dementia, delirium, depression and the effects of drugs. Memory loss, psychiatric symptoms and behavioural disturbances (such as depression, wandering, agitation, aggression, hallucinations and paranoid ideas) and problems with activities of daily living are often associated with dementia.

Memory clinics should be available for specialist diagnosis and management of dementia and related conditions; *Designed for Life* calls for this by March 2007.[286].

Dementia is a severe risk to independence and it is therefore particularly important that people diagnosed with dementia should be assessed for their social care and other needs, under the unified assessment process.

**- Younger people with dementia -** GPs should have the relevant skills, training and support to recognise the symptoms of dementia in all age groups and refer people to a specialist consultant who can make a diagnosis and provide ongoing medical supervision[292].

### Timely diagnosis of psychosis

Older people who have symptoms of psychosis should be identified early and be referred to specialist secondary care services. Recommendations are clearly set out in the NICE Clinical Guidelines for Schizophrenia.

### Assessment in Medical and Surgical Settings

Those with significant physical health problems are at higher risk of mental health problems[295]. Staff in general hospital settings should actively screen for such problems and have access to suitable mental health services such as Liaison Psychiatry which can provide specialist assessment where required. (see the Hospital Care Standard)

### Assessment in Care Homes

Residents of care homes are also at higher risk of mental health problems and should have access to assessment and care from primary care and multi-agency specialist mental health teams. The Care Standards Inspectorate for Wales (CSIW) have a role in ensuring that such requirements are met.

### Effective treatment and care

The principles underpinning effective services for older people with mental health problems are that they:

- are integrated and seamless, providing a whole systems response to assessed need;
- ensure continuity of care, and do not discriminate on the basis of age (see standard on Rooting Out Age Discrimination);
- are person centred (see standard on Person Centred Care);
- meet quality and clinical guidelines (eg. NICE Clinical Guidelines for schizophrenia, anxiety and depression. Dementia guidelines due late 2006);
- promote independence, and focus on helping people to stay at home.

Many services will be involved in the care of older people with mental health problems, including their GP and Primary Health Care teams; specialist community mental health teams, social care, domiciliary care, respite care, care homes, hospitals (including general and mental health units) and voluntary agencies.

It is the co-ordination of, and collaboration between, the different service components that makes the difference in service delivery, and ultimately will help to meet the holistic needs of older people with mental health problems.

The hub of the service will be **multi agency specialist community mental health teams**, whose core members will include consultant psychiatrists specialising in old age psychiatry; community mental health nurses; clinical psychologists; occupational therapists, social workers, home carers, physiotherapists and speech

& language therapists. Team members will preferably be co-located to aid team working and communication. These teams will offer a specialist health and social care service to older people with mental health problems, acting as a skilled resource to support those providing care and support for older people with mental health problems whether that may be in social care, primary, community or secondary health care, or in the care home sector.

The emphasis will be on assessment and management, maximising independence, enabling people to remain at home wherever appropriate, avoiding admissions and relocations wherever possible. This may involve outreach e.g. to care homes, to spend time assessing and modelling the management of challenging behaviour, or advising on care planning for all the residents with mental health difficulties. *Designed for Life* commits that by March 2007, the principles of crisis resolution / home treatment services will be extended to cover mental health in older people.

GPs will have a continuing role with the management of older people with mental health problems, with the support of the specialist team, underpinned by agreed shared care protocols. They will also support the health needs of older people when admitted to care homes.

### Hospital or Care Home placement

In-patient admission may be required for older people with severe mental health needs if there is a requirement for more intensive specialist assessment and intervention or there is risk to the safety of the client or others within the community. There should be appropriate access to a range of multidisciplinary statutory and voluntary interventions to support client needs including evidence based psychological and physical treatments, and therapeutic activity.

Hospital-based services, such as in-patient assessment units and day hospitals, need to be provided such that the often distinct needs of people with dementia and older people with other mental health problems can be met, without detriment to either group.

Discharge planning should commence as soon as possible to ensure a smooth and timely transfer of care back home or to an appropriate care setting.

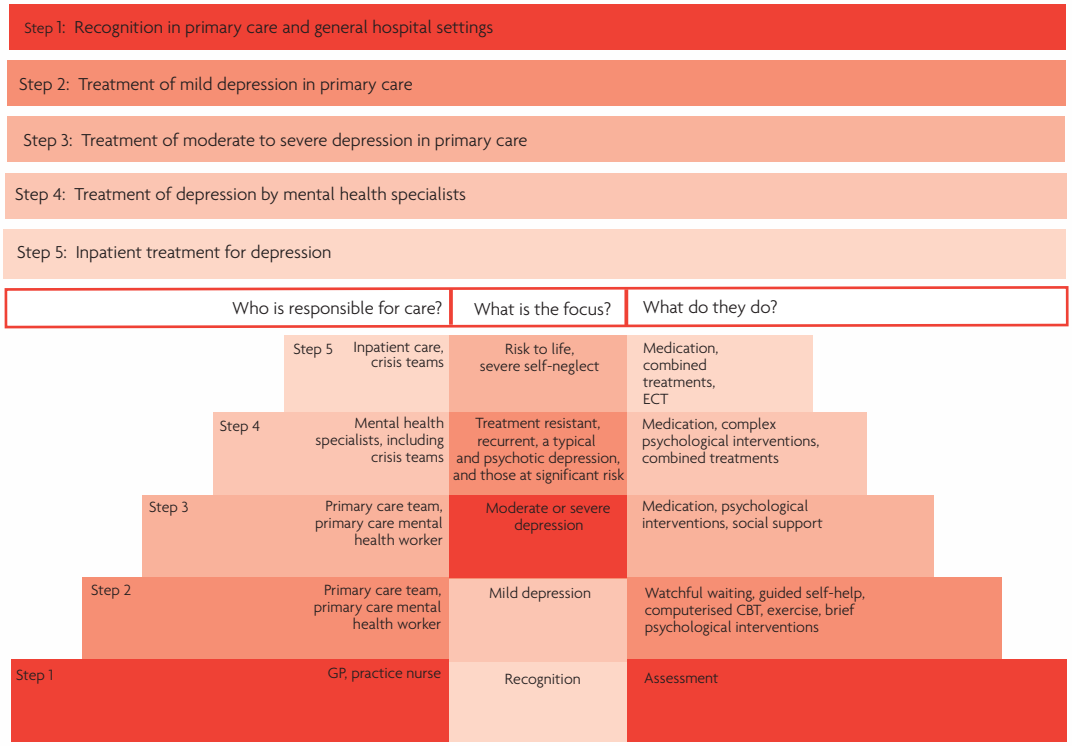
In a minority of older people with mental health problems a care home may be the appropriate option. The provision of care home places should include a range of facilities, adequately staffed with appropriate skills and supported by specialists when required.

## Management and Treatment of Depression

Care for older people with depression may include both clinical treatment and the management of relevant social care factors. With regard to clinical treatment, NICE Guidelines recommend a Stepped Care approach; this draws attention to the different service responses that are required to address the differing needs of depressed people

**The stepped care model**

The recommendations in this guideline are presented within a stepped care framework that aims to match the needs of people with depression to the most appropriate services, depending on the characteristics of their illness and their personal and social circumstances. Each step represents increased complexity of intervention, with higher steps assuming interventions in previous steps.




In summary, the NICE Guidelines recommend:

- making the diagnosis and giving the person and where appropriate, families and carers, 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 treatment options
- making appropriate referrals to statutory and independent sector organisations to help with fears, worries, distress, practical or financial issues that might affect the person or their carer
- prescribing antidepressant medicines taking into account the use of therapeutic dosages, anticipated side-effects, known contraindications of antidepressants and addressing compliance issues.

- offering psychological therapies alongside antidepressant drug treatment. The evidence suggests that the most effective psychological 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.

In addition, physical activity has been shown to be effective in reducing clinical symptoms in those diagnosed as severely, moderately or mildly depressed, so referral to local exercise programmes may be appropriate for some patients[301, 302, 303, 304].

The new GMS contract creates the opportunity for the provision of a primary care based enhanced service for depression.

Both age and co-existing dementia are specific patient characteristics highlighted in the guidelines as requiring particular attention.

### Management and Treatment of Dementia

Dementia is a severe risk to independence and may invoke significant care needs in addition to clinical treatment. The ability to carry out routine tasks such as dressing, washing, toileting and shopping is likely to deteriorate over time, and support with these tasks will need to be provided by carers (often an elderly relative), or health and social care staff within the person's own home or in a care environment.

The management and treatment of dementia involves:

- explaining the diagnosis to the older person and any carers and giving relevant information about sources of help and support, the likely prognosis and options for packages of care. Such support may come from specialist mental health teams, or from voluntary sector agencies such as the Alzheimers Society;
- agreeing a holistic care plan that addresses the person's health and social care needs with a focus on enabling independence;
- providing structured psychoeducation programmes for carers, to enable them to better understand the condition and the effects on the person's behaviour and functions, and how to be most effective in their caring role;
- 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;

- using non-pharmacological management strategies such as cognitive stimulation, cognitive rehabilitation and reminiscence, physical therapy, occupational therapy, ensuring good nutrition etc alongside drug therapy. These may be beneficial in reducing the impact or slowing down the progression of the disease;
- behavioural and pharmacological interventions for more serious problems, such as delusions and hallucinations, serious distress or danger from behaviour disturbance.

There has been concern about the prescription of antipsychotic drugs to older people with dementia, especially those in residential and nursing home care. Such drugs may hasten cognitive decline and may cause increased deaths. In dementia with Lewy bodies, side effects may be extremely serious. Although there is some evidence that the newer antipsychotic neuroleptic drugs have fewer side effects than the older drugs, there are also concerns about adverse effects. None are licensed for use in dementia and relevant professional guidance should be followed.

Referral to an appropriate specialist health service should be considered for those with suspected dementia, particularly:

- 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 anti-dementia 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.

Specialist treatment includes:

- anti-dementia drug treatment 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
  - judicious use of medication with the treatment being monitored and reviewed on a regular basis
  - individual and family counselling and support
- interventions for carers of people with dementia, for example structured advice/training, counselling services or short breaks
- assessment and treatment of dental care needs by Community Dental Service

Admiral Nurses are specialist dementia nurses, working in the community with families and carers of people with dementia. Their prime focus is to provide practical advice, emotional support, information and skills to family carers, and they also provide education, training and consultancy to staff caring for people with dementia. A Trailblazer project is currently underway in North Wales to raise awareness of and assess the feasibility of developing an Admiral Nursing service in the region.

Assistive technology has a potentially valuable role in enabling people with dementia and their carers to retain as much independence for as long as possible, within their own homes. Available technologies include voice activated systems, automatic lighting if the person gets up during the night, alert systems linked to call centres and so on. For older people with more advanced care needs, specialised dementia care housing, designed to meet the specific needs of residents, has proved effective in helping them to retain an element of independence and to avoid the need for hospital or care home admission. Such developments are being taken forward by a joint housing, health and social care Assembly officials group, in response to recommendations made by the Social Justice and Regeneration Committee's Policy Review of Housing for Older People, 2004.

All **younger people with dementia**, their families and carers should have access to comprehensive, specialist services from diagnosis to long-term care[292].

- Younger people with dementia should have access to a full range of specialist support services including home, day, respite and continuing care which recognises the different life circumstances and environment of younger people and their carers. Specialist counselling should also be made available.

- Good employment practice: Employers should adopt good employment practices which recognise dementia as grounds for early retirement and which protect a person's entitlement to pension rights and other benefits.
- Education, training and information: There should be appropriate education, training and information for all health and social services professionals to ensure an effective and sensitive response to the needs of people with dementia and their carers.

### Treatment of Psychosis

Once diagnosis is established modern treatment should be offered, including atypical anti-psychotics as set out in NICE guidelines. However caution needs to be expressed in treating older people who have psychosis together with cognitive impairment in view of concerns about an association of ant-psychotics with cerebrovascular events. Using the Care Programme Approach, the resulting care package should include the option of psychosocial interventions when appropriate in line with NICE guidelines and other best practice.

### Ageing with Severe and Enduring Mental Health Problems

To root out age discrimination in mental health service provision older people with enduring or relapsing mental health problems must be treated no differently from adults of working age with similar mental health problems. Older people should not find that their care programme changes just because they reach a particular chronological age. Care packages must continue according to need. It is acknowledged that this may pose a challenge to services which have traditionally been delivered according to age criteria, however, this conflicts with the concept of person centred care and must be addressed.

Care needs will be identified through annual review of the care plan. If transfer is necessary to a different service, transfer protocols must ensure that care packages are not stripped away. Clear protocols for assessment must be developed to ensure a referral pathway is provided. This referral pathway needs to be supported by a range of accommodation and support services in the community to meet needs and afford choice. This includes special units for enduring functional illnesses in care homes. It is essential to ensure that older people using mental health services are involved in making decisions about their individual assessment and care plan and should have access to advocacy services. It is vital that continuity of care between adult mental health services and older people mental health services is maintained, and protocols should highlight this.

### Treatment for co-existing physical health problems

Treating any co-existing physical illnesses, and improving the general health of older people who present with mental health problems will further improve their quality of life. Strategies for treatment and care should include enhancing social networks and sources of social support.

### Substance Misuse

Older people with problems of substance misuse require access to appropriate services based on need. Such services include modifications to service delivery that take into account the possibility of multiple problems including physical and mental frailty.

### People with a Learning Disability

There should be joint working between mental health services and learning disability services.

All mental health services should offer equal access to individuals with a Learning Disability. This will require mainstream mental health services to become more responsive to such special needs and to work with specialist learning disability services to provide facilitation and support.

People with a learning disability who have dementia and their carers should have access to appropriate assessment and early diagnostic services and the full range of medical, psychological and social interventions. These interventions should be adapted to meet their intellectual needs and a care pathway may be appropriate. As many of these individuals will be under 65 years of age appropriate specialist service provision is required across a wide age range.

### Service Planning and Commissioning

Local multi-agency structures will be responsible for the joint planning and commissioning of mental health services in response to local needs. They will also ensure that there are robust and transparent protocols and working arrangements regarding the interface between the different service components, including mental health services for adults of working age, and general hospital services

All agencies will be seeking to promote and implement innovations in good practice and evidence-based developments, through clinical governance reviews, through networks such as those provided by the All-Wales Improvement Network for mental health of older people, the Dementia Service Development Centre, and NLIAH, and through developing user and carer involvement.

**STANDARD -** *older people who have a high risk of developing mental health needs have access to primary prevention and integrated services to ensure timely and appropriate assessment, diagnosis, treatment and support for them and their carers*

| Outcome | What to measure | How to measure |
|---|---|---|
| improved emotional health amongst the older population | • self reported emotional well being<br>• effectiveness of local mental health promotion strategies<br>• availability of bereavement counselling | • routinely collected - Welsh Health Survey<br>• evaluation<br>• review |
| effective early diagnosis of mental health problems in older people and assessment of need | • improved awareness within primary care of mental health problems and services available<br>• number of GP practices providing enhanced services for depression<br>• availability of and access to primary care mental health services, including psychological therapies<br>• referral rates from primary care to specialist mental health services<br>• mental health needs identified via Unified Assessment (for specialist assessment under CPA) | • review<br>• GMS contract monitoring<br>• review<br>• routinely collected<br>• routinely collected |

| Outcome | What to measure | How to measure |
|---|---|---|
| Older people with mental health needs are enabled and supported to remain living within their own homes wherever appropriate | • number of older people with mental heath needs supported to live at home; | • carers survey |
| | • whether carers are receiving needs assessments and support; | • carers assessment info routinely collected |
| | • availability of community based services | • review |
| | • availability of specialist dementia care housing and telecare facilities | • review |
| | • hospital and care home admissions | • routinely collected |
| prompt access to a comprehensive range of effective and responsive mental health services for older people when required | availability of and access to | |
| | • services for older people with a cognitive impairment (memory clinics) | • review |
| (**fair** access measured in the standard on Rooting out Age Discrimination) | • crisis intervention services for older people | • review |
| | • community mental health teams for older people | • review |
| | • inpatient facilities | • review |
| | • intermediate care | • review |

| Outcome | What to measure | How to measure |
|---|---|---|
| **Continued** | ▪ long term care facilities<br>▪ tailored services for younger people with dementia<br>~~~~~~~~~~~~~~~~~<br>▪ reduction in delayed transfers of care<br>▪ reduction in suicide rate amongst older people | ▪ review<br>▪ review<br><br>▪ routinely collected<br>▪ routinely collected |
| The treatment and care of older people with mental health needs is provided in accordance with clinical (NICE) and other good practice guidelines | ▪ clinical audit<br>▪ Care Standards<br>▪ care environment<br>▪ views of older service users and carers<br>(links to Person Centred Care standard and Hospital Care standard) | ▪ routinely inspected<br>▪ routinely inspected<br>▪ service user survey |

**Objective 25 - the mental health and well being of older people and their carers is actively promoted**

| Action | By when | By whom |
|---|---|---|
| **25.1 -** Local Health Promotion Strategies include actions to improve the mental health and wellbeing of the general population, as well as specific actions to improve the mental wellbeing of older people and carers. | End of March 2007 | LHBs in partnership with local authorities |

**Objective 26 - comprehensive and integrated mental health services for older people, and services for younger adults with dementia, are commissioned and provided**

| Action | By when | By whom |
|---|---|---|
| **26.1 -** local commissioning strategies include a joint strategic plan for developing mental health services for older people (and younger people with dementia), incorporating arrangements for:<br>• timely diagnosis within primary care and referral for assessment;<br>• effective treatment, care and support - in community, inpatient and care home settings;<br>• effective liaison with general health, social care and housing services | End of March 2007 | LHBs and local authorities in conjunction with service providers |
| **26.2 -** A range of comprehensive and integrated statutory, independent and voluntary sector services are provided for older people with mental health problems which, as appropriate:<br>• support people to maintain their independence within the community;<br>• help avoid or minimise crisis;<br>• provide specialist advice and treatment;<br>• provide long term care | End of March 2008 | LHBs, local authorities, NHS Trusts, voluntary and independent sector service providers |
| **26.3 -** A range of specialist services and support is provided for younger people with dementia and their families | End of March 2008 | LHBs, local authorities, NHS Trusts, voluntary and independent sector service providers |

| Action | By when | By whom |
|---|---|---|
| **26.4 -** diagnostic and referral pathways and protocols are developed between primary care, secondary care, community care and voluntary services, for:<br>• older people with depression, anxiety and other functional mental illness<br>• older people with dementia<br>• younger people with dementia<br>These should complement the Unified Assessment / CPA processes | End of March 2008 | LHBs, NHS Trusts, local authorities and voluntary sector |

# Medicines and Older People

**STANDARD -** *Older people are enabled to gain maximum benefit from medication to maintain or increase their quality and duration of life*

## Rationale

As people get older, their use of medicines tends to increase. Four in five people over 75 take at least one prescribed medicine, with 36% taking four or more medicines[305].

Use of medicines is therefore a fundamental component of each of the NSF for Older People standards. There are common medicines elements for every standard, for example ensuring older people have ready access to the right medicine, at the right dose and in the right form, in line with *Remedies for Success*[306] (the Strategy for Pharmacy in Wales), NICE and All Wales Medicines Strategy Group (AWMSG) guidance and guidelines. Achieving greater partnership in medicine taking between patients and health professionals, improving choice and addressing the information needs of older people and their carers can help meet these standards.

There are, however, increasing challenges to ensure that medicines are prescribed and used effectively, taking into consideration how the ageing process affects the body's capacity to handle medicines. Multiple diseases and complicated medication regimens may affect patients' capacity and ability to manage their own treatment.

- **Many adverse reactions to medicines could be prevented –** they are implicated in 5-17% of hospital admissions and while in hospital 6-17% of older in-patients experience adverse drug reactions[307, 308, 309]
- **Some medicines are under-used** in older people (as well as in others). For example, anti-thrombotic treatments to prevent stroke, preventive treatment for asthma, and antidepressants[310] are not always prescribed for patients who would benefit
- **Under representation in clinical trials -** Older people are commonly under represented in clinical trials which contributes to uncertainty about the risks and benefits of medicines in older people, and may contribute to ageism and under treatment in clinical practice[311, 312, 313, 314, 315, 316, 317, 318, 319].
- **Medicines not taken as intended -** As many as 50% of older people may not be taking their medicines as intended[320]; even residents in care homes

may not receive medicines as prescribed[321]. Older people and their carers need to be more involved in decisions about treatment and to receive more information than they currently do about the benefits and risks of treatment. Older people and carers may have problems with reading, hearing and seeing as well as not being able to understand information. If parallel imports (ie. medicines labelled for use in a different country) are dispensed then the manufacturers' patient information leaflets and packaging must be in English[322]. All labelling should be clear.

Patients and carers need to be aware of the expected outcome of the medication (e.g. reduction in swelling, improved mobility) as well as the side effects and adverse reactions. Preventive medications are often not taken especially if symptoms are absent. For example, anti-arthritic treatments not taken when pain is absent even though the patient may be experiencing swelling. Neither the patient nor carer may be aware that swelling is a sign of the disease.

Patients will often not inform the doctor of the non-concordance and continue to order and receive supplies. The medicines regimen should, where possible, meet the needs of the patient and fit in with their lifestyle. If patients fully understand the effects of the medication they can use a more flexible approach to, for example, taking diuretics or anti-parkinsons drugs and be more honest about this with the prescriber.

- **Changes in medication after discharge from hospital -** following discharge changes to medication are frequently made by patients and GPs. These changes may be intentional but nonetheless unintentional changes are too frequent.[323, 324] The Royal Pharmaceutical Society of Great Britain is developing a toolkit to aid discharge planning. Electronic transfer of information would be of enormous value in preventing such problems.
- **Poor 2-way communication between hospitals and primary care -** full medication histories are not always provided to hospitals at admission. In secondary care communication needs to be improved to reduce the delay in transfer of medication recommendations to primary care; to ensure treatment that was only intended short-term, while the patient was in hospital, is discontinued on discharge; and to improve explanations for medication changes. In primary care, interpretation and prescribing of new medication on discharge is not always optimal.[324]
- **Repeat prescribing systems need improvement -** most of the medicines taken by older people are obtained on repeat prescription. Careful consideration needs to be given to the processes for ordering, synchronising

quantities, ensuring regular review of the need for each medicine, and monitoring that the medicine is being taken and the patient is benefiting from it.[325]

Inequivalence in repeat prescription quantities

- means that patients have to order different items at separate times, and may unintentionally receive the same medicine on separate prescriptions.
- causes wastage: campaigns for people to return unwanted medicines to pharmacies confirm that large amounts of medicines, probably worth in excess of £100m, are never taken. It has been estimated to account for 6-10% of total prescribing cost.[326]

- **Dosage instructions on the medicine label are sometimes inadequate** – such that neither patient nor carer has access to the correct dosage information, for example, "Take as directed" or "Take as required". The Royal College of Physician's (RCP) Sentinel Audit of Evidence Based Prescribing for Older People[310] showed that up to 25% of medicines were prescribed 'as required'[310]. It is also recommended that an indication of what the medicine is for, e.g. pain relief, dizziness, should be stated on the prescription and label.
- **Access to the surgery or pharmacy can be a problem -** many older people have difficulty getting to the doctor's surgery to collect their prescription, or to the pharmacy to have it dispensed. People who are housebound or who have limited mobility have particular difficulties in accessing advice and help with their medicines. Many pharmacies offer a collection and delivery service on request.
- **Carers' potential contribution and needs are often not addressed -** carers are in a position to support older people in medicine taking but their potential contribution is under used.
- **Formal carers** (employed to provide care) **and informal carers** (e.g. family and friends) **-** Local operating procedures often prevent social services staff from providing support. National Minimum Standards[327, 328] require formal carers to receive training in medicines and their use, if they are to be expected to help patients manage their medicines.

  Informal carers together with those they care for, could be more involved in, and consulted about, treatment decisions.[329] Their wealth of knowledge about the patient's health and any adverse changes is too often untapped.

  Formal and informal carers want to know more about possible side effects of treatment, which combinations of medicines should be avoided, and reasons for changes in medication[330, 331]. Some form of training for informal carers would be helpful to support them in their role.

- **Detailed medication review improves quality -** The primary aim of medication reviews must be to improve the quality of care. Studies in general practices and care homes have shown that in the case of reviews undertaken by pharmacists, a cost effectiveness benefit has also been demonstrated[332, 333].

  Medication review for older people usually results in a reduction in the number of prescribed medicines, although it may be appropriate to add to the regimen. 'Over the counter' medicines and complimentary treatments should also be taken into account during a medication review.

  Some long-term treatments can be successfully withdrawn e.g. diuretic treatment often needs to be continued long-term but can be stopped in about half of patients providing progress is monitored[334]

  Appropriate medicines management systems should be in place so that the medication needs of older people are regularly reviewed and discussed with individuals and their carers. Information and other support should be provided to ensure older people get the most from their medicines and that avoidable adverse events are prevented.[325, 335, 336]

  More than half of the NHS drugs bill in Wales is spent on medicines for people over 60[337] with patients in care homes receiving more medicines than those in their own home[338]. We need to ensure that this is spent in a clinical and cost effective manner, to maintain or improve the health of older people.

## Key Interventions

### Risk assessment

In order to make best use of available resources, methods of prioritising input and assessing the potential risk of medicines-related problems (MRPs) need to be in place[339]. Risk assessment should take place at two levels:

- First order – MRPs to be assessed as part of the Unified Assessment Process (UAP)
- Second order – where complex medicine related problems are identified through UAP, specialist assessment will be needed using a validated risk assessment tool. The Department of Health has accredited 6 assessment tools. These may be used off-the-shelf or to benchmark the development of other tools.[340]

  When assessing risk the whole of the supply system from prescribing to taking the medicine should be considered.

**Medicines-related** features known to be more likely to be associated with problems in older people are:

- a new medicine started in the last two weeks
- specific drugs, e.g. warfarin, non-steroidal anti-inflammatory drugs (NSAIDs), diuretics, digoxin, lithium, steroids, psychotropics
- taking four or more medicines
- recent discharge from hospital
- unsupervised use of over-the-counter or complementary medicines

**Social and personal** factors that may predispose to medicines-related problems include:

- social support –level of support available at home;
- physical condition –vision, hearing, mobility, nutritional state, dexterity, including ability to use memory aids e.g. reminder charts, medicine wheels, cassette boxes;
- mental state – confusion/disorientation, depression, ability to understand;
- language – ability to speak, read and understand English;
- poor health due to life-style e.g. obesity, smoking

### Effective Interventions

Appropriate prescribing for older people, and monitoring of their condition, are key objectives. However, it is not only prescribing but how medicines are used by patients that is important. Patients and their carers need more support for medicine taking. There are six main types of intervention:

- Prescribing advice/support
- Treatment monitoring
- Review of repeat prescribing systems
- Medication review (with individual patients and their carers)
- Education and training
- Risk management to reduce medication errors and adverse events

## Prescribing Advice/Support

Prescribing advice/support to individual prescribers and Local Health Boards (LHBs) can improve the quality and cost-effectiveness of prescribing by, for example, implementing clear policies relating to medicines in older people[325]. The British National Formulary (BNF) specifies that particular care is needed in relation to the prescribing of hypnotics, diuretics, non-steroidal anti-inflammatory drugs (NSAIDs), anti-parksinonian medicines, antihypertensives, psychotropics, lithium and digoxin[341] in older people. Computer systems can be programmed to prompt for this as well as for blood tests etc. Local protocols for risk assessment can build on existing work to target specific patient groups and individual patients.

Strategic prescribing advice to LHBs and NHS Trusts in Wales is provided by the All Wales Medicines Strategy Group. Locally, LHB and Trust Prescribing Advisory Teams provide advice and guidance to individual prescribers. General review of prescribing and monitoring of long-term continuous or intermittent medicines, and recommendations for action at both policy and individual level, have a place for patients of all ages.

Some advice would aim to reduce prescribing, for example, by targeting patients where medicines of doubtful therapeutic value are prescribed, or where medicines cause particular problems with side effects in older people, such as those with anticholinergic effects[342]. Other advice might increase prescribing, such as implementing NSFs and other clinical guidelines.

Prescribing advisory teams at all levels may also provide information, advice and policy development on the other interventions described in this section.

Prescribing advice needs to be supported by scientific evidence that addresses the needs of older people. If older people are to benefit from technological developments and therapeutic advances, the risks, benefits and optimal doses of medicines need to be adequately investigated in older populations.

## Monitoring of treatment

The goals of treatment monitoring are to ensure that the medicines are producing the intended effect, remain appropriate and to detect any medicines-related problems. Routine treatment monitoring should include a basic check that the patient is able to take the medicines and finding out if there are problems that indicate that changes in medication may be needed. Improved monitoring is needed for many older people and could be made more effective by better utilising contacts between health and social care professionals and patients.

All health and social care staff who come into contact with older people can play a part in monitoring treatment. An assessment tool that identifies the possibility of medication-related problems, and a list of risk factors, would enable health and social care staff to identify when a patient needs to be referred for more a detailed medication review.

Supplementary prescribers will be required to monitor patients according to a clinical management plan that has been prepared by the patient's doctor and supplementary prescriber.

The UAP will contribute to the process of problem identification. Where an overview assessment of an individual indicates a potential or actual need for support with medication, a more specialist assessment may be required to inform the care plan.

A key opportunity for intervention is the point at which medicines are dispensed in primary care, where simple screening questions used by community pharmacists have been shown to detect adverse drug reactions and concordance issues[343]. Opportunities exist for nurses and other professionals in primary care conducting health checks for older people to screen for medicines-related problems and refer them to the GP or pharmacist[335] for a more indepth assessment.

Treatment monitoring is particularly important after a new treatment is started, as this will often mean adding a new medicine to several existing ones. Where enquiry reveals new symptoms or a change in health, or a patient or carer reports them, the possible role of any new medicine should be explored.

### Review of repeat prescribing systems

Most general practice computer systems can target patients at higher risk of medication problems, and link medicines added to prescription records at different times to identify duplication of medication, enabling more effective reviews to be undertaken. There is a problem in care homes when changes to a patient's medication are not necessarily recorded at the general practice following a GP home visit[344]. This also applies to changes made by GPs and other prescribers following domiciliary visits to patients in the community. The need to ensure that repeat prescribing systems are accurately maintained is essential; the advent of supplementary prescribers will reinforce this need.

Review of repeat prescribing systems can improve both quality and control of prescribing, as well as enhancing individual patient reviews. The effective management of repeat prescribing remains a substantial task and research has identified the areas where improvement is needed.[325]

**Systems for ordering and producing prescriptions**

- mechanisms to ensure that requests for repeat medication result in accurate prescriptions;
- synchronisation of quantities and duration of treatments. Systems should recognise that some medicines are used 'when needed', e.g. painkillers, and in some the quantity used is inexact e.g. skin emollients. Patients may also drop or spill medication resulting in an earlier request for a repeat prescription; this could be an indication that the patient may be experiencing difficulties;
- mechanisms to flag up over- or under-ordering

**Clinical management**

- implementation of reviews and testing (e.g. urea and electrolytes, liver function tests, INR) at required times
- routine assessment of concordance

**Good practice in repeat prescribing systems**[345]

- *Written explanation of repeat prescribing process for the patient and carers*
- *Practice personnel with dedicated responsibility for ensuring that patient recall and regular medication review takes place*
- *Agreed written repeat prescribing policy*
- *Authorisation check made each time a repeat prescription is signed*
- *Training of practice staff on the elements of good practice and how to spot poor patient concordance*
- *Concordance check made on every repeat prescription*
- *Regular housekeeping changes made to keep records up to date*

Repeat prescribing is an appropriate responsibility for a supplementary prescriber.

## Medication Review

Research shows that the key problems with repeat medication are:

- Unnecessary therapy
- Ineffective therapy
- Poorly maintained records

- No, or inadequate routine monitoring
- Inappropriate choice of therapy/dosing schedule
- non-concordance[346, 347]

Periodic routine prescribing review for patients on repeat medication should occur regularly. Prescribing reviews may be conducted by the GP, practice nurse, pharmacist or in an interdisciplinary manner with the individual patient.

**Opportunities for a Medication Review**

An in-depth evaluation of all of the patient's medication (prescribed and non-prescribed) should be especially targeted at those older people known to be at higher risk of medicines-related problems, ie:

- **Newly prescribed medicines**
- **Some specific groups of medicines –** certain groups of medicines are known to cause problems in older people e.g. hypnotics, tricyclics, psychotropics, diuretics, non-steroidal anti-inflammatory drugs (NSAIDs). The amount of drug in the blood may need to be tested regularly for others e.g. digoxin, lithium.
- **Being prescribed 4 or more regular medicines (polypharmacy) -** is a particular risk factor in older people for adverse drug reactions and for re-admissions of older patients discharged from hospital[348, 349]
- **Post-discharge from hospital -** changes in medication after discharge may be intentional where the GP decides to modify the hospital's suggested treatment. However, unintentional discrepancies in medication are found in half of patients after they have left hospital[323. 324]. These include patients or the GP practice restarting medicines that were stopped in hospital, and duplication of treatment (for example, a medicine being prescribed by both its generic and branded names). By simply sending a copy of the discharge prescription to the community pharmacist, as well as the GP practice, the number of such discrepancies can be halved[323]
- Discrepancies are also reduced when a pharmacist processes discharge medication in general practices[350]. Direct communication between the community and hospital pharmacies, and electronic transfer of information should improve the process.
- **In care homes -** Sometimes admission to care home results in concordance not previously achieved. Patients' response to their medication should, therefore, be monitored closely and records maintained following the admission. Pharmacist-conducted medication review of all medicines showed that modifications to treatment were needed for half of the medicines prescribed; the most frequent

recommendation (47%) was to stop medication and in two-thirds of these cases there was no stated indication for the medicine being prescribed[351, 352, 353]. Longer-term follow-up showed the number of medicines prescribed for older people can be reduced with no adverse impact on morbidity or mortality[354]

- **Where medicines-related problems have been identified** through routine monitoring/assessment
- **Following an adverse change in health** such as dizzy spells, falls or confusion, medicines should be reviewed to determine whether they may have caused or contributed to the problem
- **Polypharmacy -** develops over time and medicines may be added to counter the side effects caused by others, or simply not discontinued when no longer needed[355]. There is evidence from randomised controlled trials of pharmacist-conducted medication review that these problems can be identified and resolved with the GP[356, 357, 358]. Such reviews benefit from access to information on medical and medication history in the medical record. Community pharmacists do not have remote access to patients' clinical notes and this limits their involvement in medication review services. The development of a single electronic patient-held medication record or electronic access to patient medication records would facilitate medication review in community pharmacy settings. Medication review schemes have been developed in a number of local areas as part of wider health gain strategies[359]. Review tools may be simple[360] or more detailed[361].

**Annual health assessments -** thorough review of medication should be part of any annual health assessment and part of any assessment carried out by district nurses prior to care planning

### Format of detailed medication review

The invitation to the review of an individual patient's medication should include both the patient and the carer, as appropriate.

Research[362] has shown that patients want:

- Specific time set aside for medication review.
- Someone to listen carefully to questions
- Clear explanations in simple language
- An open interaction where they could be honest about what they were actually taking, and the health professional would be honest about the consequences of taking (or not taking) the medicines.

Ask open questions to encourage the patient to provide more comprehensive response, for example,

- how do you take your medicine, when and how often?
- What is your daily routine for taking this medicine?
- If you have side effects from this medicine, what are they?
- What non-prescription medicines, including herbal and Chinese medicines, have you purchased, been given and / or taken?

The review should cover the following core areas:

- Explanation of the purpose of the review and the reason why periodic review is important. A patient guide to medication review is available from the Medicines Partnership[362].
- Compilation of a list of all medicines being taken or used: including prescribed medicines, over-the-counter medicines, herbal, homeopathic and Chinese remedies, and medicines swapped or shared between friends or partners
- Comparison of the list of medicines taken or used with the list of medicines prescribed
- The patient's (and carer's) own perception and understanding of the purpose of the medication, and any misconceptions
- The patient's (and carer's) understanding of, and concordance with, how much, how often, when and how medicines should be taken and any other medicines and food that should be avoided
- Application of 'Prescribing appropriateness indicators'[363] e.g. the indication for the drug is recorded and upheld by the British National Formulary
- Any side effects being experienced. Evidence suggests that older people's accounts of perceived side effects correlate closely with health professionals' assessments[364]. The review should include side effects which restrict people's lifestyles e.g. wakefulness at night or excessive diuresis affecting social life. Are some of the medicines being used to treat side effects of other medication?
- Review of any relevant monitoring tests, e.g. INR for patients on anticoagulants, Hb1Ac for diabetic patients; blood tests for disease modifying antirheumatic drugs, thyroid hormone levels, lithium levels.
- Checking for risk factors e.g. cholesterol testing
- Review of practical aspects of medicines use:
  - Is the patient experiencing any problems in ordering and collecting repeat prescriptions?

- Any problems removing medicines from containers? Older people may have particular difficulties with opening bottles, blister packaging and, to a lesser extent, with foil packaging.
- Any problems swallowing tablets? Does the patient need soluble tablets or liquids? If soluble tablets are prescribed what is the salt content? If the patient needs liquids is there a sugar-free formulation which is better for oral health?
- Ability to pour and measure liquid medicines
- Difficulties in reading labels. Provision needs to be made to help e.g. large print labels, dosage information cards. This might also highlight the need for an eye examination.
- Forgetting to take medicines is common. 'Memory aids' can be helpful for some patients.
- Some medication-related risk factors e.g medication hoarding, inappropriate medication storage, expired medication, therapeutic duplication and lack of medication administration routine are more readily identified and reviewed within the patient's own home[365, 366, 367]

- Concordance:
  - How is the patient actually taking the medicines?
  - Do they have any concerns, questions or issues about their medication that they want to raise?
  - Does the patient understand and accept the reasons for their medicines and the health consequences of not taking them?
  - What support is needed / available, including information and aids to memory and compliance?

**Possible actions following medication review**

- Referral to a doctor, pharmacist or nurse for further information about medicines and reasons for prescribing
- Provision of medicines support items, for example, medicines reminder charts or memory aids according to an assessment protocol
- Review current diagnosis
- Further investigations/information – this may include biochemical investigations or additional monitoring – for example creatinine levels, measure blood levels of individual drugs, such as lithium, digoxin
- Rationalisation of treatments according to clinical condition and current evidence based best practice.

- Referral to prescriber to consider if additional treatment or change of current medication is needed to help achieve clinical standards of care
- Patients' and carers' views must be engaged throughout the process.

### Education and training

Education and training about the usage, handling and storage of medicines is important for patients and their carers, for health and social care professionals and for local policy managers. This should be on going and include updates for research evidence and learning the lessons from audit or complaints, possible interactions with other medicines or certain food, and suicide risks associated with medication.

### Patients and carers

- A key theme of the Review of Health and Social Care in Wales is empowering patients to take an active role in managing their own care. Patients are not passive recipients of prescribing decisions. They have their own beliefs about medicines, how they work and how they are best used. Moreover, medicines taking has to fit within their normal daily lives.
- The Royal Pharmaceutical Society's Concordance Co-ordinating Group has brought together leaders from the professions, patients and the pharmaceutical industry, and has done a huge amount to define and promote the concept of 'concordance'. This is the idea that prescribing and medicine taking needs to be based on informed agreement between the patient, their doctor and other health professionals.
- Self-management training programmes for patients have also been shown to improve health outcomes. The Expert Patient Programme[368] provides opportunities for people who live with long-term chronic conditions to develop new skills to manage their symptoms on a day-to-day basis.
- Carers have stated that they do not have enough information about:
  - The medicines of the person they care for
  - The side effect of these medicines
  - Medical procedures e.g. injections, catheters
  - The diagnosis or prognosis of the illness or disability[369]

Programmes for carers on supporting medicines use have been provided in some parts of the UK[370], and should be considered in Wales. Patients and their carers want more information about medicines. There are a number of possible sources, such as patient support groups, and Patient Information Leaflets (PILs), which

accompany the medicine and on-line in the Electronic Medicines Compendium, PRODIGY patient leaflets, NHS Direct On-Line and Ask About Medicines Week. Sometimes the information needs to be interpreted. Local community pharmacists, and the NHS Direct helpline, can provide this support.

Research conducted by Sheffield University has highlighted that 4.9% of all NHS Direct callers ask for advice about medicines and 2.3% are calling about poisoning. In addition, nurses give 40% of all callers advice about medicines[371].

Analysis of the medicine related calls in Wales indicate that common enquiries about medicines are related to adverse drug reactions, drug interactions, administration and dosage and complementary medicines.

Information should be provided in different formats, such as audiotapes, videos, leaflets etc, and in different languages where appropriate. It is important to check that the information transmitted is understood. Practitioners may need to check understanding has occurred, especially early recognition of side effects.

People are currently used to their doctor being the main source of information and decisions about medicines. However, patients are often reluctant to share all the relevant information about their compliance or concordance with their doctor, this is particularly so with older people. Research indicates that pharmacist conducted medication review is well received by patients[372] and that patients need a clear explanation of this role supported by their doctor.

Although the doctor-patient relationship will continue to be fundamental, a gradual culture change needs to occur for some older people to more readily accept advice from pharmacists and nurses. This will become more important as repeat prescribing becomes the responsibility of the nurse or pharmacist supplementary prescriber. The role of patient and carer organisations will be important in supporting this change.

### All care staff working for health, social, private and voluntary organisations

Ongoing education and training is essential especially for all care staff.

Many care staff contribute to the daily living activities of older people living in their own homes. Depending on local policies, considerable support in medicines taking can be provided by these staff and training is essential for success.

Care staff with daily contact with older people should be monitoring and evaluating the capabilities of older people in their care and should be aware of the links between patient assessments and medicine taking. They should be aware of the action to be taken if they have any concerns about the older person in their care.

The Cardiff Medication Administration Scheme CARMAS, has community pharmacists and home care managers developing care plans for the administration of medicines to vulnerable people[373]. 'Compliance aids' such as Monitored Dosage Systems, multi compartment cassettes, can be helpful for some patients but should be preceded by rationalisation of medicines, patient education and proper assessment before they are initiated and their use must be regularly reviewed. Other simpler measures, such as memory aids are more helpful for many patients.

The Welsh Centre for Postgraduate Pharmaceutical Education (WCPPE) has developed training materials for pharmacists to use when training care staff[374] Other resources have been developed in other areas.

### Healthcare Professionals

All health care professionals need training to further develop consultation styles that are likely to meet the needs and preferences of older people and their carers. Staff also need to be aware of the links between their own patient assessments and medicine taking. For example, when Occupational Therapists assess whether a patient is able to unscrew lids and open packaging, this could be transferred to their capacity to open medicines containers and blister packs.

### Risk management to reduce medication errors

Medication errors are preventable events relating to medication that could potentially harm a patient and can occur at three levels: prescribing[375], dispensing[376] and medication administration[377].

Avoiding prescribing errors is particularly important in older people, given drug choice and doses often need to be adjusted because of altered renal or hepatic function; co-morbidities; polypharmacy and potential drug interactions[378, 379]. Some prescribing errors occur because of transcription or calculation errors. Again older people are particularly vulnerable to these types of errors because of the high volume of prescribing, frequency of multiple prescribers and prescribing across primary and secondary care sectors. Dispensing errors are less common but administration errors especially non-administration occur relatively frequently both in hospital and care settings[380, 381, 382, 383].

There is obviously a major role for education (particularly prescriber education and training) in improving prescribing and reducing drug errors[384]. In addition a whole systems approach to the complex task of medicines management in older people is needed[385]. Strategies to improve prescribing communication across care sectors and improve interdisciplinary management and support of prescribing need to be evaluated in older people. Several interventions involving information technologies have the potential to reduce medication errors[386]. Meanwhile, improved prescribing decision support and clinical pharmacy services need to be delivered consistently for all older people.

**STANDARD -** *Older people are enabled to gain maximum benefit from medication to maintain or increase their quality and duration of life*

| Outcome | What to measure | How to measure |
|---|---|---|
| Older people receiving four or more medicines are offered an annual medication review | • Medication reviews (annual) | Routinely collected |
| Older people do not suffer unnecessarily from illness caused by excessive, inappropriate or inadequate consumption of medicines | • Medication related hospital admissions<br>• Adverse drug reactions<br>• Medication errors | • review<br>• Routinely collected<br>• Routinely collected<br>• inspection |
| Older people are not denied access to medicines that would benefit them | | • review |
| Older people are well informed about the medications prescribed to them | Views of older service users and their carers | Service user and carer survey |

**Objective 27 - processes are in place to record and reduce medication errors**

| Action | By when | By whom |
|---|---|---|
| **27.1 -** All care settings have a process to record any medication errors and outcomes | March 2007 | NHS Trusts, local authorities, independent sector providers |

**Objective 28 - Transfer of care arrangements involve a review and communication of older people's medication**

| Action | By when | By whom |
|---|---|---|
| **28.1 -** NHS Trusts ensure that medication review is undertaken for all older people on hospital admission and discharge or transfer of care to another setting. This information must be communicated in an appropriate and timely manner to ensure continuity and effectiveness of care. | March 2008 | NHS Trusts, in liaison with other care providers to or from whom responsibility for care and medication is transferred |

**Objective 29 - staff are competent to undertake their role in relation to medicines**

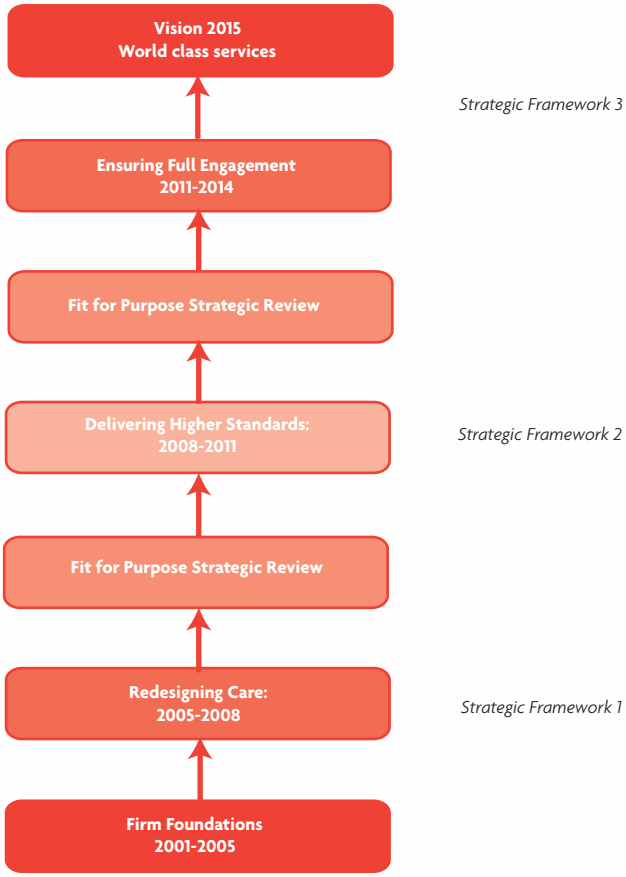
| Action | By when | By whom |
|---|---|---|
| **29.1 -** Staff employed to care for older people receive training as appropriate in the usage, handling, storage of medicines and the risks involved | March 2008 | NHS Trusts, local authorities, LHBs, independent sector providers |

# Chapter Three - Supporting Implementation

## Implementation Framework

The NSF for Older People in Wales represents the *Designed for Life* 2015 vision in respect of health and social care services for older people. It will also align with *Designed for Care*, the policy direction for social services to be published in summer 2006.

The timeframe for implementation of the NSF will align to that for *Designed for Life*, ie. it will be taken forward through a sequence of three-year frameworks. Targets will be set in key policy areas for each 3 year period. At the start of each stage a 'fit for purpose review' will take place in conjunction with service users, providers, commissioners and other partners to assess progress and ensure that the most effective approach and structure is in place:



### *Strategic Framework 1 : 2005 - 2008*

Targets for the first stage of NSF implementation (2005-2008) require a shift towards **preventing problems, improving access** to all elements of health and social care and **better designed, better delivered services**. The NSF sets out a broad agenda for action in relation to older people in all of these areas, and some of the emerging actions required as part of implementing the NSF were included in the *Designed for Life* targets for 2006/7 and 2007/8.

**During 2005/6,**

- local health and social care communities undertook joint baseline assessments of their services in relation to the draft NSF standards, which will help to inform their planning and commissioning of services during 2006/7;
- Revised interim Commissioning Guidance was developed by the Welsh Assembly Government to support the focus on improved commissioning during 2006/7; *(NB to be issued in March 2006)*

**2006/7 -** The first year of implementation will be very important in terms of establishing firm foundations for taking forward the NSF at a local level. The focus will be on establishing strong leadership to drive forward the older people's agenda and root out ageism; establishing local structures which will develop joint planning and commissioning of older people's services; and to start delivering improvements to services.

**2007/8 -** the commissioning plans developed during 2006/7 for improving older people's services in line with the NSF standards will be implemented.

### *Strategic Framework 2: 2008 - 2011*

The 'fit for purpose' strategic review in 2008 will provide an opportunity to review progress to date, and to set further specific targets and actions for 2008 - 2011, to drive continuing quality improvements in older people's services, as part of Designed for Life Strategic Framework 2: Higher Standards.

### *Strategic Framework 3: 2011 - 2015*

In 2011, the strategic review will help gauge what still needs to be done in order to achieve Vision 2015, which will inform the third strategic framework from 2011 - 2015.

**The detailed Implementation Plan for 2006 - 2015 is outlined at Appendix A**.

## Performance Management

As described in the NSF standard on Person Centred Care and in the implementation plan for 2006/7, statutory organisations will be required to establish local joint planning and commissioning arrangements for older people's services. Each local partnership will be responsible for implementation of the NSF in accordance with given time scales, and for reporting to the Welsh Assembly Government on progress by 31 March each year. Elements of the NSF are reflected in SaFF targets for 2006/7 and will be reported upon accordingly.

Although reporting and monitoring will largely be through NHS mechanisms, responsibility for implementation of the NSF is a joint requirement of the NHS and its local authority and other partners. The NSF is issued under a joint circular, and for local authorities is issued as guidance under Section 7 (1) of the Local Authority Social Services Act 1970.

The onus in 2006/7 and 2007/8 will be on self reporting by local Older People Planning Teams of progress against the action points. SSIW will take account of the NSF in their annual performance evaluation of local Social Services authorities, and the input of HIW and SSIW will be sought in relation to the 'fit for purpose' strategic reviews. In the longer term, measurement of key indicators, through data analysis and service user feedback, will provide evidence of outcomes.

The Welsh Assembly Government will provide regular formal progress reports as well as periodic update newsletters and workshops (see section on Communication).

## National and local implementation overview

Implementation of the NSF will need to be overseen at both a national and local level:

**National overview**

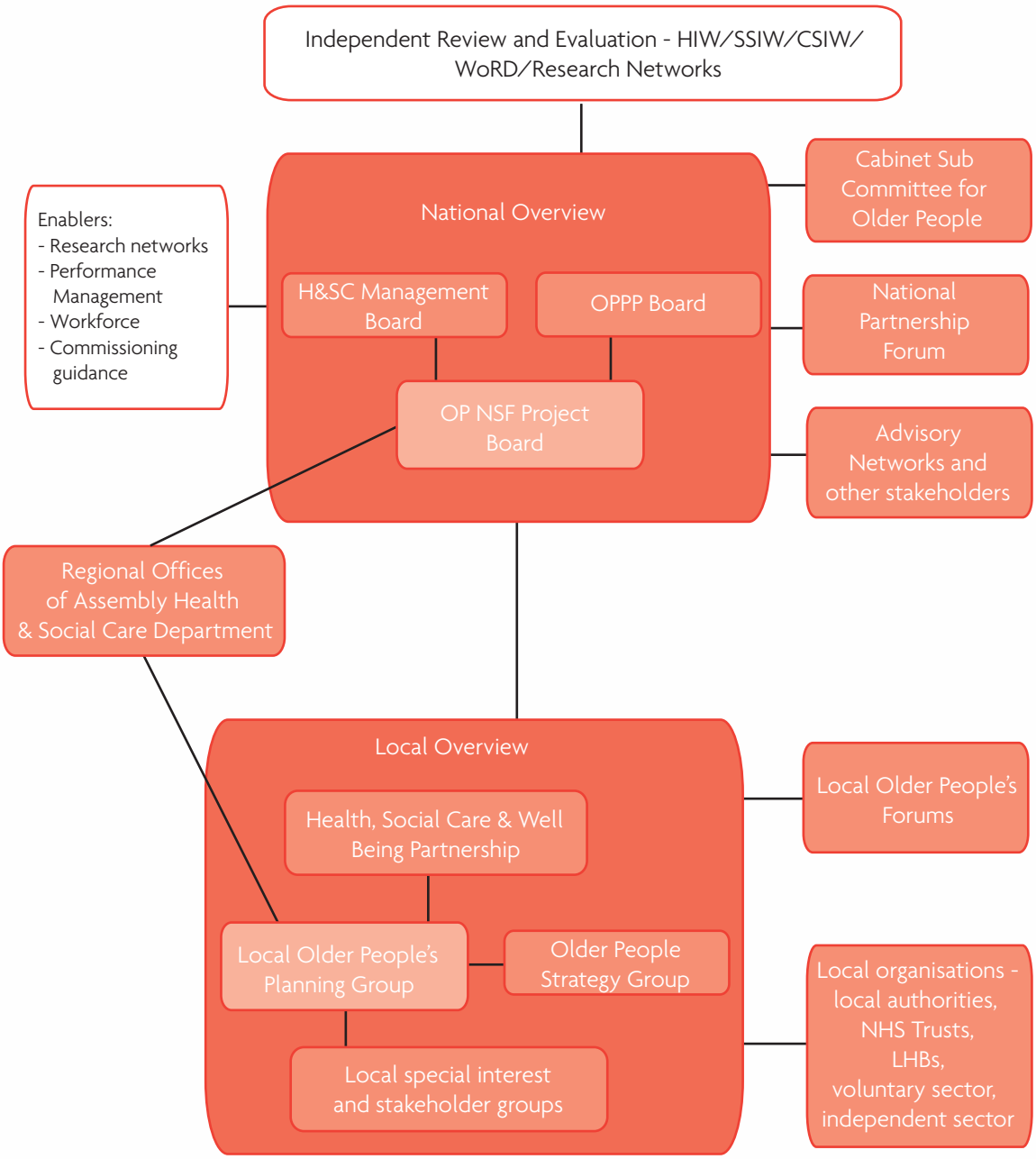
**Roles**

- Overview re older people's issues and policy (within Strategy for Older people framework)
- Maintaining links to mainstream health, social care and housing policy and a high profile within these for older people's issues
- Monitoring of local implementation of NSF
- Communicating with stakeholders on key issues and progress with implementation
- Ensuring links to supporting initiatives, 'enablers' - eg. workforce issues, IM&T, ongoing R&D; and organisations - eg. NLIAH, NPHS, WLGA, WCH
- Independent review and evaluation

**Local overview**

**Roles**

- Co-ordinating local joint action to implement, monitor and evaluate the effectiveness of the NSF, reporting to Welsh Assembly Government as required
- Engaging all appropriate local statutory, independent and voluntary sector service providers in NSF implementation
- Involving local older people and carers of older people in service planning and review
- Ensuring links with the Health, Social Care & Well Being partnership, Older People's Strategy Implementation etc


Independent Review and Evaluation - HIW/SSIW/CSIW/ WoRD/Research Networks
Enablers:
- Research networks
- Performance Management
- Workforce
- Commissioning guidance
National Overview
H&SC Management Board
OPPP Board
OP NSF Project Board
Cabinet Sub Committee for Older People
National Partnership Forum
Advisory Networks and other stakeholders
Regional Offices of Assembly Health & Social Care Department
Local Overview
Health, Social Care & Well Being Partnership
Local Older People's Planning Group
Older People Strategy Group
Local special interest and stakeholder groups
Local Older People's Forums
Local organisations - local authorities, NHS Trusts, LHBs, voluntary sector, independent sector

## Communication Strategy

The full NSF document is accompanied by an Executive Summary and a leaflet aimed at older people, which also includes key health promotion advice, information and useful contacts.

The performance management reporting arrangements will ensure regular, formal communication between the service and the Welsh Assembly Government regarding implementation of the NSF.

The Welsh Assembly Government will also communicate on progress, updates, ideas, issues, good practice examples from Wales and beyond etc, through the NSF website (www.wales.nhs.uk/nsf) and through electronic and paper newsletters.

These will be informed by contributions from stakeholders, who will also be encouraged to share information directly with other interested parties via relevant and linked networks, and through an NSF internet discussion forum.

Workshops and conferences will be arranged periodically to bring interested parties together to discuss, share ideas and learn about specific Older People NSF related issues and to obtain feedback on progress with NSF implementation.

Older people will be included as key stakeholders in all of the above arrangements, and specific efforts will be made to ensure that all information communicated to older people is accessible and appropriate. The NSF standard on Rooting out Age Discrimination outlines the importance of, and expected arrangements for involving older people at a local level.

A comprehensive programme of support for implementation will be provided by the National Leadership and Innovation Agency for Health (NLIAH) in conjunction with, amongst others, the National Public Health Service (NPHS) and Local Government Support Unit.

# Workforce Planning, Training and Development

The projected demographic changes, implementation of *Designed for Life*, its forthcoming social care equivalent and this NSF, will all have major implications for the health and the social care workforce in Wales across a whole range of service provision. Some of these implications will be specific to NHS Wales, some to social care providers and some will need to be tackled through joint strategies and initiatives where service provision interfaces.

The modernisation agenda is placing a greater emphasis on:

- **health promotion, prevention of ill health or dependence, and earlier assessment and intervention within the community**. This needs to be supported by a realigning of resources and roles, into primary and community care and public health;
- **understanding the interface between health and social care**. This needs to be supported by guidance, policies and training on joint working, and by shared learning;
- **making better use of resources**, maximising the clinical and professional skills of staff and improving recruitment and retention;
- **use of Information & Communication Technology**, such as the Electronic Patient Record, NHS Direct, other call centres, 'Hospital at Home' schemes, assistive technology. All may enable or require a change in working practice, and will have subsequent training implications.

The workforce implications of the health and social care modernisation agenda are being addressed by a strategic framework for social care, in conjunction with the SSIW and Care Council for Wales, and by the National Leadership and Innovation Agency for Health and National Workforce Development Unit, to be established during 2006.

It will be important that any workforce strategies address the specific workforce implications of an ageing population, which, in addition to the general workforce challenges of modernising health and social care, involve designing the workforce around the specific needs of older people and training and competence for all staff in the care of older people.

## Workforce Information and Planning

**Social care -** Workforce issues in social care are being tackled through a strategic framework at national, regional and local level which is based on collaborative partnership working.

The *Skills Foresight Plan for the Social Care Sector in Wales*[387], issued by the Care Council for Wales in April 2003 as part of the social care Workforce Development Strategy, lays out the shape and profile of the current social care workforce in Wales as well as the development and upskilling needs over the next three years. This shows that the social care workforce currently numbers 70,000 in Wales, across a range of statutory, private and voluntary sector employers, and comprises of 80% females. It is forecast that the workforce will need to grow by about 2%-3% annually (about 2,000 people) in the short to medium term, if service objectives are to be met. It also clearly sets out the retention challenges facing social care services, particularly in residential services for older people.

Also issued in April 2003, the Report of the Wales Care Strategy Group provides further information on the current and future shape of the care sector. Their projections show that if patterns of care and funding systems remain constant, demand for social care services is likely to increase by around 24%, which equates to 5,000 additional care home places and home support being provided for a further 15,000 people. This would require a further 2,010 staff. The Report also estimates that by 2010 there will be a 7.3 % increase in people living in long term health care settings, and by 2020 an increase of 18.4% to 2146 people.

However, the projections also show that shifts towards domiciliary care, and reduction in dependency rates of 1%, would lead to no increased demand for care homes despite the rising numbers of older people. To achieve this service shift, services would need to focus on supporting people to maintain their health, wellbeing and independence, to manage any chronic health conditions, prevent avoidable hospital admission through early intervention and to remain in their own home. This would need to be supported by a workforce appropriately deployed, skilled and qualified to deliver such services.

At a local level, local authority social services have workforce plans in place for the whole of the social care sector in their area, designed to ensure that services can be provided in line with their strategic service plans. These workforce plans will need to be updated and reviewed regularly to ensure that they continue to reflect local strategic needs and priorities for service provision, particularly the Health, Social Care and Well Being Strategy objectives.

**Health services -** Workforce information and planning for the NHS in Wales will be the remit of the National Workforce Development Unit to be established during 2006. Statistics on NHS staffing and vacancy levels inform the implementation of the NHS HR Strategy and Recruitment and Retention Strategy, which is being revised in 2005. Workforce planning data is also used to determine education and training levels for all NHS professional staff. Up until now this information has not been client group specific, except for medical staffing. The new electronic staff record which is due to be implemented throughout Wales by mid 2006 will provide data according to client group and should contribute to care group planning.

Workforce planning needs to support and enable the development of new services and treatments, keeping pace with advances in technology and medical knowledge, as well providing preventive services and continuing care within the community. This includes meeting the health needs of older people in care homes who are often the most frail, dependent, and complex of all patient groups.

It is unclear whether the new GMS contract will result in GPs coming forward to develop a special interest in the care of older people. Currently there are no GPwSI's (GPs with a Special Interest) in Elderly Care in Wales. If this model were to be promoted, there would be significant training implications.

Major national policy initiatives will drive changes to workforce design, development and training. These include Agenda for Change, for doctors, the UK Programme *Modernising Medical Careers*[388], the European Working Time Directive, the new consultant contract, GMS and GDS contracts; the new Pharmacy contract and developing Assembly Strategies for both Therapy Services and Community Nursing which will address the future role and requirements in relation to these staff groups which have a very important role to play in the care and independence of older people.

### New ways of working

To meet the challenges facing health and social care services, new ways of thinking about roles and methods of service delivery are required.

Most professions are giving consideration to how professional roles may need to change, and some new ideas have already been trialled, such as nurse and AHP consultants, supplementary prescribing, therapy assistants, health and social care workers. There may also be scope for redeveloping the role of Health Visitors for older people, which have all but disappeared in Wales but could provide preventive and health promotion advice as provided for young families. Such advice could also be built more into the roles of other health and

social care professionals. The drive to address changing roles must be supported by national guidance, training and funding, and in the case of the NHS, is being taken forward by the National Leadership and Innovations Agency, building on the *Skills for Health*[389] initiative.

Workforce issues at the service *interface* between health and social care are being considered as part of the Review of Health and Social Care, and it is likely that a number of those issues will relate to services for older people.

### Recruitment

Difficulties in recruiting to both the qualified and unqualified health and social care workforce have existed in Wales for some time. In both health and social care, Recruitment Strategies are being implemented in an attempt to tackle current and future shortages.

Efforts to achieve the NHS staffing targets for 2010 - ie. 700 more hospital consultants and GPs, 6,000 more nurses and 2,000 more other Health Care Professionals - are being made through various measures, including an increase in the number of student training places and return to practice initiatives.

National initiatives to support recruitment to the social care workforce are being implemented, to ensure greater co-operation between employers from all parts of the sector, and in recognition of the tendency for social care staff to circulate around or re-enter the sector. *Faces of Care*[390], a video which illustrates the different career opportunities within social care, has been used for career awareness, particularly in schools and colleges. Action is being taken by Regional Partnerships to address issues specific to their areas, for example, the need to attract more recruits who are Welsh speaking or from certain minority ethnic backgrounds.

The social work target of a 5-7% increase in registrations to 380 in Wales by 2007 is on track. However there is no guarantee that these new recruits will opt to work with older people post qualification; there will be a need to attract them into making this choice.

Recruitment to posts specifically involving the care of older people is seen as particularly problematic, due to the image and perception of the work. An understanding needs to be attained of why such a perception exists and how it can be tackled. The British Geriatrics Society stress the satisfying and rewarding aspects of working with older people, which need to be communicated to all potential staff groups. These include the rehabilitating of older people back to

health and independence following an illness; the combining of an often complex clinical challenge with human interest; dealing with the whole person and their family, within an integrated approach that involves working with other professions and agencies across the spectrum of social, primary, community and secondary care.

The general drive to raise the profile and image of older people, under this NSF and the Strategy for Older People, will also hopefully serve to attract more people into a career of caring for older people.

It is recommended that a joint marketing strategy be considered for careers in older people's services.

### Retention

If we are to retain staff in both health and social care services we must focus on good employer practices that acknowledge the particular demands of the work. We know that retention of staff is not just a pay issue but includes having good training and support systems and good supervision systems as well as flexible working practices.

There have been concerns about the high turnover level amongst the social care workforce particularly amongst new recruits to private and voluntary employers, and in domiciliary care[15].

Training opportunities and clear career pathways can assist in retaining staff and the Care Council's induction framework makes an important contribution to this agenda.

The extension of the new regulatory framework to social care staff will mean that for the first time ever social care will be put on a professional footing. It will mean that staff will be working within clear standards and codes of practice that are know and understood by all, including service users and that social care employers will also be bound by a common code of practice. This development is an important factor in the sector's ability to retain its staff.

### Skills, competence and performance management

Caring for older people requires specific skills and competence, the demonstration of which is particularly important if the NSF standards on Rooting out Age Discrimination and Person Centred Care are to be achieved.

An Older People's National Competency Framework has been developed by Skills for Health[17], which will be taken forward in Wales in conjunction with the National Occupational Standards for the Practice of Public Health. Work is also ongoing

by Health Professions Wales (to become part of the new Workforce Unit) on the development of competency based training for health care support workers.

The National Occupational Standards provide statements of competence for areas of work to ensure minimum standards across health and social care. They, together with other systems for defining functions and staff roles will be essential in describing generic, shared and specialist areas when working with older people and will have been developed and owned by employers. Other systems will include Codes of Practice, Codes of Conduct, the NHS Knowledge and Skills Framework[391], National Minimum Standards, Induction Frameworks and user and carer perspectives.

### Education, training and development

Education, training and development programmes at all levels and across all professional groups can effectively prepare staff for working with older people and with cultural, religious and language differences. It is important that appropriate opportunities are available for new and existing staff to enhance these particular core skills and that continuing professional development programmes are developed for staff to extend their skills into new specialties and roles.

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 and social work education and training
- undergraduate and postgraduate medical education
- pre and post registration education for nurses, health visitors and allied health professionals
- 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
- e-learning
- learning networks, sharing of good practice and ideas
- the availability of training places to meet demand and need
- joint training across health and social care and statutory, independent and voluntary sectors
- training for carers and expert patients

## Volunteers and unpaid carers

The voluntary sector provides a range of services to complement or supplement statutory services, including the provision of direct care, information, advice, support networks and independent advocacy. The voluntary sector is particularly active in supporting older people in Wales.

Through *Building Strong Bridges*[392], Wales is seeking to strengthen the relationship between voluntary and statutory agencies, and the role of voluntary agencies in health and social care. Research undertaken by the WCVA Volunteering Unit provides evidence of the value of volunteers' contribution to health and social care in Wales.

For many older people, assistance with care comes from family, friends and neighbours. The Report of the Wales Care Strategy Group[10] highlights that 6% of the Welsh population provides 'informal' care to older people and this includes an estimated 190,000 older people themselves who are acting as the main providers of care to other older people and especially partners. If these prevalence rates are maintained, the number of older people as carers will rise to around 260,000 in 2020.

*The Strategy for Carers in Wales*[393], recognises the importance of the carer role, and the need to ensure that carers are well-informed and properly supported. Undertaking the role of carer can be physically and emotionally stressful, often triggering ill health which can threaten the independence of both the carer and person being cared for. This and the Wales Care Strategy Group Report both stress the need to address the health and social care needs of carers, and for local authorities to undertake systematic assessments of carers' needs in accordance with the Carers and Disabled Children Act 2000.

**Objective 30 - effective workforce planning ensures that the right staff are available at the right time to provide the care and services required for older people**

| Action | By when | By whom |
|---|---|---|
| **30.1 -** Specific proposals for addressing the **workforce planning** implications of an ageing population within modernised health and social services, are developed and implemented | End of March 2008 | Welsh Assembly Government, Care Council for Wales, WLGA, National Workforce Development, Education and Commissioning Unit (NHS) |

**Objective 31 - staff recruitment, training and performance management policies and practices reflect the need for staff competence in caring for older people**

| Action | By when | By whom |
|---|---|---|
| **31.1 -** For staff employed to work with older people, appropriate competencies are reflected within:<br>• KSF outlines and Personal Development Plans - for NHS staff<br>• job descriptions, person specifications and development plans - for non-NHS staff | End of March 2008 | Local Authorities<br>Local Health Boards<br>NHS Trusts<br>Voluntary and Independent sector providers |
| **31.2 -** Appropriate education, training and development is provided for all staff involved in policy development or care/service delivery to older people, to help develop knowledge, skills and understanding and foster positive attitudes. This must include awareness of age discrimination and appropriate specialist training. | By September 2008 | Local Authorities<br>Local Health Boards<br>NHS Trusts<br>Voluntary and Independent sector providers<br>HE and FE establishments<br>Training providers |
| **31.3 -** Areas for staff development in the care of older people are linked to National Occupational Standards and, where possible, matched to accredited learning programmes mapped into the Credit Qualification Framework for Wales (CQFW) | By September 2008 | Care Council for Wales, National Workforce Development, Education and Commissioning Unit (NHS) HE and FE establishments<br>Training providers |

# Information Managment and Technology

Achievement of the NSF will require the development of an information infrastructure, systems and services to support provision and use of information to:

- empower service users, carers and the public in general;
- facilitate the provision of care; and
- enable performance management, service commissioning and planning.

These issues are being taken forward in Wales through the *Informing Healthcare*[394] and *Informing Social Care*[395] projects and associated developments.

| NSF requirement | Informing Healthcare | Informing Social Care | Linked to |
|---|---|---|---|
| **Information for the public, patients and carers,** to enable and encourage them to take a more proactive role in their own health and wellbeing. Includes need for information about:<br>• how to maintain health, wellbeing and independence;<br>• social problems and health conditions;<br>• available services;<br>• treatments and medicines | **Informed Patient Project**<br>• patient information and decision support<br><br>**Access to Knowledge (A2K)**<br>• electronic library (mainly for staff) | **Action 7** - to promote the opportunities provided by information systems to inform users and potential users of social care services. (stresses the importance of ensuring access to all - which is a particular issue for older people) | NHS Direct<br>Service Directories - UAP |
| **Supporting care delivery**<br>• integrated, seamless health and social care, underpinned by:<br>  • Unified Assessment<br>  • Information Sharing Protocols<br>• new ways of working<br>• quality, evidence based care | **Single Integrated Electronic Health Record (SIEHR)**<br><br>**Workforce Empowerment**<br>• Access to Knowledge (A2K)<br>• Access to Learning (A2L) - developing staff It and Health Informatics skills<br><br>**Confidentiality Project**<br>• Code of Practice<br>• All Wales ISP | **Action 6 -** Electronic Social Care Record;<br>**Action 8 -** Information governance and sharing protocols;<br>**Action 10 -** Staff training in IT and information management skills | Unified Assessment<br><br>GMS contract - practice based registers (eg. for stroke) to proactively manage people within primary care |
| **Supporting service planning, commissioning, performance management and evaluation**<br>• core data sets<br>• performance indicators<br>• independent joint review (HIW/SSIW/CSIW)<br>• research and development<br>• sharing good practice | **ILab** - performance indicators | **Action 2 -** local performance management, service planning;<br>**Action 3 -** collaboration at local and national level re information requirements and use;<br>**Action 4 -** national performance management framework;<br>**Action 5 -** good quality national data;<br>**Action 8 -** information governance and sharing - for planning purposes | WORD research networks<br><br>Data set development |

# Research, Development and Evaluation

The NSF standards are largely evidence based, and it is important that any subsequent developments are based on the most up to date evidence about effective interventions for older people.

Ongoing implementation of the NSF will therefore be supported by the R&D infrastructure in Wales, which is being created by the Wales Office of Research & Development (WORD). This includes the commissioning of a number of thematic and sectoral research networks to bring together academic and service based professionals to address areas of importance in research and development in health and social care.

Nine thematic research networks have now been commissioned. These include: Older People, Neurodegerative Diseases, Public Health, Emergency care, and Diabetes. WORD is also commissioning a Research Coordinating Centre which will manage a Patient and Carer Network to input into the research agenda, and a research professional network to work on research in primary and secondary care across Wales.

In 2005, WORD also launched a new funding scheme for researchers across the health and social care spectrum. This is an open, responsive scheme which seeks applications from researchers whose work covers the following policy priority areas:

- prevention and early intervention
- service organisation and delivery
- chronic disease management

One of the studies to successfully gain funding to date concerns prevention and intervention in the disablement process amongst older people in Wales.

Through the contract that WORD has with AWARD (the All Wales Alliance for Research and Development), some work of direct relevance to older people has been commissioned, including a study on the health promotion needs of older people, economic implications, aspects of the carers strategy, intermediate care and a study on the health and social care needs of gay, bisexual and transgender older people.

| ACTION POINT | REF | STANDARD | BY WHOM | BY WHEN |
|---|---|---|---|---|
| **Statutory organisations establish local Joint Older People Planning and Commissioning Teams** | 8.1 | Person Centred Care | Local Authorities and LHBs, involving all key stakeholders | **September 2006** |

**CRITERIA:**

Local Joint Older People's Planning Teams may reflect local structures and circumstances, but should incorporate the following criteria:

- The Team should be fit for purpose for its role, ie. implementation and monitoring of the NSF including the joint planning of and informing the commissioning of older people's services
- Membership should include the relevant LHB(s), NHS Trust(s), local authority, voluntary and independent sector organisations, older services users and carers*; (* although the Strategy for Older People defines older people as aged 50 and over, membership should include people over the age of 65)
- Chairmanship can sit with any partner organisation
- Clear structural links to local older people's fora to ensure regular consultation with local older people on service issues;
- Clear structural links to the local Health, Social Care & Well Being (HSCWB) Partnership, to ensure that older people's issues are addressed in the local HSCWB Strategy
- Clear structural links to the local Older People's Strategy Group, to ensure strong links between implementation of the Strategy and NSF

| ACTION POINT | REF | STANDARD | BY WHOM | BY WHEN |
|---|---|---|---|---|
| **Each local authority, NHS Trust and LHB Chief Executive will identify a named leader for older people across the organisation, ensuring that older people become and remain a priority and to support the implementation of the NSF specifically** | 1.1 | Rooting out Age Discrimination | Each local authority, NHS Trust and Local Health Board | **September 2006** |
| **CRITERIA:**<br>• The named leader should be at Board/Director level<br>• Local authorities should identify a Director level officer to 'partner' their existing Older People's Champion | | | | |

| ACTION POINT | REF | STANDARD | BY WHOM | BY WHEN |
|---|---|---|---|---|
| **The role and responsibilities of the named leader for older people will be communicated to staff and two-way communication systems established** | 1.2 | Rooting out Age Discrimination | Each local authority, NHS Trust and Local Health Board | **September 2006** |
| **CRITERIA:**<br>• The role and responsibilities should as a minimum reflect the guidance *Role of the Older People's Leader* (in the NSF toolkit)<br>• Two-way communication systems should allow for regular communication to staff from the Older People's Leader to raise awareness of older people's issues etc, and for staff to raise issues with the leader | | | | |

| ACTION POINT | REF | STANDARD | BY WHOM | BY WHEN |
|---|---|---|---|---|
| **The named leader will regularly report on implementation and monitoring of the NSF to the Cabinet/ Board** | 1.3 | Rooting out Age Discrimination | Each local authority, NHS Trust and Local Health Board | **September 2006 onwards** |
| **CRITERIA:**<br>• Evidence will be required that written reports are being submitted on at least a 6monthly basis to the Cabinet or Board (as appropriate) on implementation and monitoring of the NSF | | | | |

| ENABLER | ACTION POINTS SUPPORTED | BY WHOM |
|---|---|---|
| **A network of older people's leads and a discussion website will be established, enabling them to share news and ideas** | **1.1, 1.2, 1.3** | **Welsh Assembly Government** |

| ACTION POINT | REF | STANDARD | BY WHOM | BY WHEN |
|---|---|---|---|---|
| **Each local authority, NHS Trust and LHB will establish or use an existing Scrutiny Group to review and monitor practice and relevant organisational policy to ensure that they do not discriminate on the basis of age** | 2.1 | Rooting out Age Discrimination | Each local authority, NHS Trust and Local Health Board | **September 2006** |
| **CRITERIA:**<br>• Membership must include older service users and carers | | | | |

| ACTION POINT | REF | STANDARD | BY WHOM | BY WHEN |
|---|---|---|---|---|
| **Each local authority, NHS Trust and LHB will undertake an audit of existing policy and practice and agree an action plan to ensure the phasing out of any age discrimination** | 2.2 | Rooting out Age Discrimination | Each local authority, NHS Trust and Local Health Board | **End March 2007** |
| **CRITERIA:**<br>• The action should be agreed by the Cabinet/Board as appropriate<br>• The action plan should aim to phase out existing age discrimination by 2009<br>• Organisations should annually monitor progress | | | | |

| ENABLER | ACTION POINTS SUPPORTED | BY WHOM |
|---|---|---|
| **An audit tool will be provided as part of the NSF toolkit** | **2.2 Rooting out Age Discrimination** | **Welsh Assembly Government** |

| ACTION POINT | REF | STANDARD | BY WHOM | BY WHEN |
|---|---|---|---|---|
| **Each local authority, NHS Trust and LHB will set explicit policies and supporting guidance setting out the key principles and objectives in rooting out age discrimination, and to inform service design, delivery, commissioning, monitoring, review and staff development** | 2.3 | Rooting out Age Discrimination | Each local authority, NHS Trust and Local Health Board | **End March 2007** |
| **CRITERIA:**<br>• To reflect the Policies for Rooting Out Age Discrimination guidance provided in the NSF toolkit | | | | |

| ACTION POINT | REF | STANDARD | BY WHOM | BY WHEN |
|---|---|---|---|---|
| **Older people and carers of older people are included in any arrangements for public involvement including ongoing service monitoring and review** | 3.1 | Rooting out Age Discrimination | Each local authority, NHS Trust and Local Health Board | **End March 2007** |
| **CRITERIA:**<br>• To reflect guidance on Involving Older People, in NSF Toolkit<br>• Evidence will be required of involvement of older service users, and carers of older people | | | | |

| ENABLER | ACTION POINTS SUPPORTED | BY WHOM |
|---|---|---|
| **Guidance on involving older people included in NSF toolkit** | **3.1 Rooting out Age Discrimination** | **Welsh Assembly Government** |

| ACTION POINT | REF | STANDARD | BY WHOM | BY WHEN |
|---|---|---|---|---|
| **Incorporation of** *Fundamentals of Care* **(or the more detailed source standards and regulations) into:**<br>• **Staff training and development;**<br>• **Staff performance management systems**<br>• **Commissioning, contractual or service specification requirements**<br>• **Clinical governance arrangements** | 5.1 | Person Centred Care | Each local authority, NHS Trust, Local Health Board, voluntary and independent sector service provider | **End March 2007** |

| ACTION POINT | REF | STANDARD | BY WHOM | BY WHEN |
|---|---|---|---|---|
| **Partner health and social care organisations and older people jointly review the clarity, accessibility and appropriateness of information provided to older people, carers and staff** | 7.1 | Person Centred Care | Each local authority, NHS Trust and LHB, voluntary sector and independent sector organisations, older people, carers | **End March 2007** |
| **CRITERIA:**<br>• Compliance with Information for Older People Guidance in NSF Toolkit | | | | |

| ENABLER | ACTION POINTS SUPPORTED | BY WHOM |
|---|---|---|
| **Information for Older People Guidance in NSF Toolkit** | **7.1** | **Welsh Assembly Government** |

| ACTION POINT | REF | STANDARD | BY WHOM | BY WHEN |
|---|---|---|---|---|
| **NHS Trusts will undertake a review of the effectiveness of the total patient journey for older people through their acute services** | 19.1 | Hospital Care | NHS Trusts - in conjunction with LHB, local authority, voluntary sector partners and older service users and their carers | **End March 2007** |

**CRITERIA:**

A review tool will be provided in the NSF toolkit, to cover issues such as:

- the interface with primary, community, intermediate, social and long term care
- emergency access (including alternatives to A&E)
- elective care
- clinical and non-clinical aspects of in-patient care
- management of key risk areas;
- the care of older people in general hospitals with mental health needs
- rehabilitation
- transfer of care planning

| ENABLER | ACTION POINTS SUPPORTED | BY WHOM |
|---|---|---|
| **Review tool designed and issued as part of NSF Toolkit** | **19.1** | **Welsh Assembly Government** |

| ACTION POINT | REF | STANDARD | BY WHOM | BY WHEN |
|---|---|---|---|---|
| **All NHS Trusts to have in place Designated Lead Managers to meet the requirements of** *In Safe Hands* **and to help promote a culture of protection** | 21.4 | Hospital Care | NHS Trusts in collaboration with social services, the police and CSIW. | **End of March 2007** |

| ACTION POINT | REF | STANDARD | BY WHOM | BY WHEN |
|---|---|---|---|---|
| **Local authorities and Health, Social Care & Well Being Partnerships review their Community Strategies and HSCWB Strategies to ensure that they promote the health and well being of older people in their area** | 10.1 | Promoting health and Wellbeing | Local Authorities and HSCWB Partnerships | **End March 2007** |

| ACTION POINT | REF | STANDARD | BY WHOM | BY WHEN |
|---|---|---|---|---|
| **Specific health promotion programmes are delivered to meet the needs of older people** | 11<br><br>25.1 | Promoting health and Wellbeing<br><br>Mental Health | Each local authority, NHS Trust, Local Health Board, voluntary and independent sector service provider, NPHS | **End March 2007** |

**CRITERIA:**

- must be informed by local assessment of older people's needs, priorities and preferences
- must be evidence based
- must incorporate implementation of the Healthy Ageing Action Plan
- must include specific actions to promote the mental health of older people
- uptake and participation by older people is monitored and evaluated
- encourage and support older people to take responsibility for their own health and well being

| ACTION POINT | REF | STANDARD | BY WHOM | BY WHEN |
|---|---|---|---|---|
| **A joint commissioning strategy for older people's services is developed, informed by the local Older People's Planning Team** | D4L<br>8.2<br>12.1<br>14.1<br>18.1<br>23.1<br>26.1 | Person Centred Care Promoting Health & Wellbeing<br>Challenging Dependency<br>Intermediate Care<br>Falls & Fractures<br>Mental Health | Local commissioners | **End March 2007** |

**CRITERIA:**

- to be developed in line with interim Commissioning Guidance to be issued by the Welsh Assembly Government by March 2006 and to cover the pathway of care from prevention, early intervention, acute care, rehabilitation and longer term care or support, and specific services for:
  - falls and fractures
  - mental health in older people and dementia in younger adults
  - intermediate care
  - integrated community equipment

| ENABLER | ACTION POINTS SUPPORTED | BY WHOM |
|---|---|---|
| **Support for development of commissioning skills and strategies** | **8.2** | **NLIAH** |

| ACTION POINT | REF | STANDARD | BY WHOM | BY WHEN |
|---|---|---|---|---|
| **Each local health and social care community will design and have *in place* a care pathway for stroke care from prevention through to rehabilitation and longer term support, so that all patients have access to appropriate treatment including a multi-disciplinary stroke team** | 22.1<br><br>SaFF 2006/7 | Stroke | NHS Trusts, Local Health Boards, local authorities, voluntary sector organisations | **End March 2007** |
| **CRITERIA:**<br>• Compliance with the NSF standard on Stroke and current clinical guidelines<br>• The care pathway will improve access (from the 2004 RCP Sentinel Audit baseline)to acute stroke unit beds; multi disciplinary rehabilitation; longer term support services | | | | |

| ACTION POINT | REF | STANDARD | BY WHOM | BY WHEN |
|---|---|---|---|---|
| **All care settings have a process to record any medication errors and outcomes** | 27.1 | Medicines and Older People | NHS Trusts, local authorities, independent sector providers | **End March 2007** |

| ACTION POINT | REF | STANDARD | BY WHOM | BY WHEN |
|---|---|---|---|---|
| **Each local health and social care community will** *implement* **their planned integrated process for the provision of aids and equipment** | D4L<br><br>14.2 | Challenging Dependency | Local authorities, Local Health Boards, NHS Trusts, voluntary and independent sector providers | **End March 2008** |
| **CRITERIA:**<br><br>• Compliance with CESI guidance on effective service | | | | |

| ACTION POINT | REF | STANDARD | BY WHOM | BY WHEN |
|---|---|---|---|---|
| **Each local health and social care community will** *implement* **its integrated intermediate care programme** | D4L<br>18.2 | Intermediate Care | Local Health Boards, NHS Trusts, local authorities, appropriate voluntary and independent sector providers | **End March 2008** |
| **CRITERIA:**<br><br>Compliance with the NSF standard on Intermediate Care, ie. services must offer:<br>• rapid assessment of and response to need<br>• prompt access to diagnostics and specialists when required<br>• safe, timely and managed transfer from hospital to home or other appropriate care setting, with a focus on rehabilitation, promoting independence and prevention of inappropriate care home admission<br>• a single and easily available point of access and clear referral processes<br>• integrated teams or co-ordinated networks, supported by sound network governance | | | | |

| ACTION POINT | REF | STANDARD | BY WHOM | BY WHEN |
|---|---|---|---|---|
| **Each local health and social care community will implement its plans for the integration of falls & fractures services** | D4L 24.1 | Falls and Fractures | Local authorities, Local Health Boards, NHS Trusts, relevant independent and voluntary sector care providers | **End March 2008** |

**CRITERIA:**

Compliance with the NSF standard on Falls & Fractures, ie. Services must ensure that:

- there is a community wide strategy for the prevention of falls and fractures
- all patients presenting with a hip fracture, fragility fracture or fall receive assessment and appropriate management in respect of secondary prevention
- staff have the relevant competencies
- falls registers are maintained and critical incident analysis undertaken in hospitals and care homes

| ACTION POINT | REF | STANDARD | BY WHOM | BY WHEN |
|---|---|---|---|---|
| **Each local health and social care community will implement its commissioning plans for integrated community based mental health services for older people** | 26.2 | Mental Health in Older People | Local authorities, Local Health Boards, NHS Trusts, relevant independent and voluntary sector care providers | **End March 2008** |

**CRITERIA:**
Compliance with the NSF standard on Mental Health in Older People, ie:

- a range of comprehensive and integrated statutory, independent and voluntary sector services are provided which:
  - support older people with mental health problems, and their carers, to maintain their independence within the community
  - help avoid or minimise crisis
  - provide specialist assessment, advice and treatment
  - provide appropriate long term care

| ACTION POINT | REF | STANDARD | BY WHOM | BY WHEN |
|---|---|---|---|---|
| **A range of specialist services and support is provided for younger people with dementia and their families** | 26.3 | Mental Health in Older People | Local authorities, Local Health Boards, NHS Trusts, relevant independent and voluntary sector care providers | **End March 2008** |
| **CRITERIA**<br>Compliance with the NSF standard on Mental Health in Older People, ie:<br>• services are tailored to meet the specific needs of younger adults and their families | | | | |

| ACTION POINT | REF | STANDARD | BY WHOM | BY WHEN |
|---|---|---|---|---|
| **Diagnostic and referral pathways and protocols are developed between primary care, secondary care, community care and voluntary services, for:**<br>• **older people with depression, anxiety and other functional mental illness**<br>• **older people with dementia**<br>• **younger people with dementia** | 26.4 | Mental Health in Older People | Local authorities, Local Health Boards, NHS Trusts, relevant independent and voluntary sector care providers | **End March 2008** |
| **CRITERIA**<br>• these should complement the UAP and CPA processes | | | | |

| ACTION POINT | REF | STANDARD | BY WHOM | BY WHEN |
|---|---|---|---|---|
| **Local health and social care communities act to continuously improve stroke services** | 22.2 | Stroke | Local authorities, Local Health Boards, NHS Trusts, relevant independent and voluntary sector care providers | **2007/2008 and ongoing** |
| **CRITERIA**<br>• ie they address recommendations from the 2006/7 RCP National Sentinel Audit of Stroke services | | | | |

| ACTION POINT | REF | STANDARD | BY WHOM | BY WHEN |
|---|---|---|---|---|
| **Independent Advocacy services for older people are commissioned and publicised to the public and staff** | 4.1 | Rooting out Age Discrimination | Commissioned by local authorities and Local Health Boards | **End March 2008** |
| **CRITERIA:**<br>• Compliance with the NSF standard on Rooting out Age Discrimination | | | | |

| ACTION POINT | REF | STANDARD | BY WHOM | BY WHEN |
|---|---|---|---|---|
| **Implementation of the All Wales Care Pathway for the Dying for all older people being cared for at the end of their life** | 6.1 | Person Centred Care | LHBs, NHS Trust, LAs, voluntary and independent sectors | **End March 2008** |

| ACTION POINT | REF | STANDARD | BY WHOM | BY WHEN |
|---|---|---|---|---|
| **Local commissioning strategies reflect the principles of the social care equivalent to Designed for Life** | 13.1 | Challenging Dependency | Local authorities, LHBs, NHS Trust, voluntary and independent sectors | **End March 2008** |
| **CRITERIA:**<br>• reflects an enabling approach to early intervention and community based services for older people<br>• results in a range of statutory, independent and voluntary sector services available to meet older people's assessed health needs and needs for personal care and assistance with daily living | | | | |

| ACTION POINT | REF | STANDARD | BY WHOM | BY WHEN |
|---|---|---|---|---|
| **Each health and social care provider has and implements a written policy for continence care** | 15.1 | Challenging Dependency | Local authorities, LHBs, NHS Trust, voluntary and independent sectors, CSIW | **End March 2008** |
| **CRITERIA:**<br>To incorporate:<br>• the provision of integrated continence services (as defined in DH Good Practice 2000) for assessment, diagnosis, specialist treatment and care<br>• implementation of the All Wales Integrated Care Pathway for Continence Management, and forthcoming continence implementation framework | | | | |

| ACTION POINT | REF | STANDARD | BY WHOM | BY WHEN |
|---|---|---|---|---|
| **Expert Patient Programme courses to be routinely available to older patients in local communities throughout Wales** | 17.1 | Challenging Dependency | Local Health Boards | **End March 2008** |

| ACTION POINT | REF | STANDARD | BY WHOM | BY WHEN |
|---|---|---|---|---|
| **All NHS Trusts to have identified old age specialist multi disciplinary teams with agreed interfaces throughout the hospital for the care management of older patients with complex physical and/or mental health needs** | 20.1 | Hospital Care | NHS Trusts | **End March 2008** |
| **CRITERIA:**<br>• compliance with the NSF standard on Hospital Care | | | | |

| ACTION POINT | REF | STANDARD | BY WHOM | BY WHEN |
|---|---|---|---|---|
| **All NHS Trusts to appoint lead clinicians, including Consultant Nurses and Consultant AHPs with responsibility for professional leadership and service/practice development for older people's services** | 20.2 | Hospital Care | NHS Trusts | **End March 2008** |
| **CRITERIA:**<br>• compliance with the NSF standard on Hospital Care | | | | |

| ACTION POINT | REF | STANDARD | BY WHOM | BY WHEN |
|---|---|---|---|---|
| **All NHS Trusts to have in place a Liaison Mental Health Service for older people with mental health problems in general hospital settings** | 20.3 | Hospital Care | NHS Trusts | **End March 2008** |
| **CRITERIA:**<br>• compliance with the NSF standard on Hospital Care | | | | |

| ACTION POINT | REF | STANDARD | BY WHOM | BY WHEN |
|---|---|---|---|---|
| Older people's nutritional status is assessed on admission to hospital and their hydration and nutrition needs are met whilst in hospital | 21.1 | Hospital Care | NHS Trusts | End March 2008 |
| **CRITERIA:**<br>• use of a validated assessment tool (eg MUST[101]) | | | | |

| ACTION POINT | REF | STANDARD | BY WHOM | BY WHEN |
|---|---|---|---|---|
| **Older people admitted to hospital who are incontinent undergo a thorough assessment to identify the cause, and access appropriate specialist services, treatment and care** | 21.2 | Hospital Care | NHS Trusts | **End March 2008** |
| **CRITERIA:**<br>• compliance with the DH Good Practice 2000[105] | | | | |

| ACTION POINT | REF | STANDARD | BY WHOM | BY WHEN |
|---|---|---|---|---|
| **All NHS Trusts take action to reduce falls amongst older people within hospital settings** | 21.3 | Hospital Care | NHS Trusts | **End March 2008** |
| **CRITERIA:**<br>• compliance with the NSF standard on Falls and Fractures and the forthcoming All Wales Framework for the Prevention and Management of Patient Falls | | | | |

| ACTION POINT | REF | STANDARD | BY WHOM | BY WHEN |
|---|---|---|---|---|
| NHS Trusts ensure that medication review is undertaken for all older people on hospital admission and discharge or transfer of care to another setting. This information must be communicated in an appropriate and timely manner to ensure continuity and effectiveness of care | 28.1 | Medicines and Older People | NHS Trusts, in liaison with other care providers to or from whom responsibility for care and medication is transferred | **End March 2008** |

| ACTION POINT | REF | STANDARD | BY WHOM | BY WHEN |
|---|---|---|---|---|
| Staff employed to care for older people receive training as appropriate in the usage, handling and storage of medicines, and the risks involved | 29.1 | Medicines and Older People | NHS Trusts, local authorities, LHBs, independent sector providers | **End March 2008** |

| ACTION POINT | REF | STANDARD | BY WHOM | BY WHEN |
|---|---|---|---|---|
| **Specific proposals for addressing the workforce planning implications of an ageing population within modernised health and social services, are developed and implemented** | 30.1 | Supporting Implementation Chapter 3 | Welsh Assembly Government, Care Council for Wales, WLGA, National Workforce Development, Education and Commissioning Unit (NHS) | **End March 2008** |

| ACTION POINT | REF | STANDARD | BY WHOM | BY WHEN |
|---|---|---|---|---|
| **For staff employed to work with older people, appropriate competencies are reflected within:**<br>▪ **KSF outlines and Personal Development Plans - for NHS staff**<br>▪ **job descriptions, person specifications and development plans - for non-NHS staff** | 31.1 | Supporting Implementation Chapter 3 | Local Authorities<br>Local Health Boards<br>NHS Trusts<br>Voluntary and Independent sector providers | **End March 2008** |

| ACTION POINT | REF | STANDARD | BY WHOM | BY WHEN |
|---|---|---|---|---|
| **Appropriate education, training and development is provided for all staff involved in policy development or care/service delivery to older people, to help develop knowledge, skills and understanding and foster positive attitudes** | 31.2 | Supporting Implementation Chapter 3 | Local Authorities, Local Health Boards, NHS Trusts<br>Voluntary and Independent sector providers, HE and FE establishments, training providers | **End September 2008** |
| **CRITERIA:**<br>▪ this must include awareness of age discrimination and appropriate specialist training | | | | |

| ACTION POINT | REF | STANDARD | BY WHOM | BY WHEN |
|---|---|---|---|---|
| **Areas for staff development in the care of older people are linked to National Occupational Standards and, where possible, matched to accredited learning programmes mapped into the Credit Qualification Framework for Wales (CQFW)** | 31.3 | Supporting Implementation Chapter 3 | Local Authorities, Local Health Boards, NHS Trusts<br>Voluntary and Independent sector providers, HE and FE establishments, training providers, NWDECU | **End September 2008** |

### *Strategic Framework 2: Higher Standards 2008 - 2011*

In 2008/9, as part of the 'fit for purpose' strategic review, the Welsh Assembly Government will assess how well progress has been made to date in working towards the NSF standards.

The review will be partly informed by the implementation reports submitted by each local Older People Planning Team, and by additional feedback from older service users and carers. The review will include progress with the various initiatives referred to in the NSF as complementary to the NSF eg. the Unified Assessment Process, Carers' Strategy, *In Safe Hands* etc.

Key indicators will also be measured to assess progress in achieving key outcomes required.

The review will inform the actions and targets for continuous improvement of older people's services in Strategic Framework 2: Higher Standards 2008 - 2011.

### *Strategic Framework 3: Ensuring Full Engagement 2011 - 2015*

In 2011, the strategic review will help gauge what still needs to be done in order to achieve Vision 2015, which will inform the third strategic framework from 2011 - 2015.

## Policy Gateway Summary

## Appendix B

The Assembly Government wants to make its policy making more transparent and accessible to everyone it works with particularly those who have an interest in, or are affected by, Assembly Government policy. It is about making 'Made in Wales' policies that reflect our commitments to our duties and our values. The results below represent the agreed outcomes of the draft National Service Framework (NSF) for Older People in Wales being tested against the Assembly's Integration Tool that involved representatives from Directorates for: Primary & Community Health Service Policy; Older People & Long Term Care; Housing; Culture, Welsh Language & Sport; Agriculture & Fisheries . Those representatives agree this is an accurate overview of their collective comments.

*Key:* **U** – Undermining; **P** – Poor; **N** – Neutral; **F** – Fair; **G** – Good; **E** - Excellent

| *Wales: A Better Country Commitment* | **Overall Contribution** | | **Explanation** |
|---|---|---|---|
| 1. Promoting the Economy | U P N | **F** G E | **Fair -** It is not a core aim of the NSF to promote the economy, however it should make some direct or significant indirect contribution: improving the health and well being of people age 50 plus which includes employees; contributing to innovation and R&D. |
| 2. Action on social justice for communities | U P N | F **G** E | **Good -** The NSF will make a significant positive contribution to social justice by rooting out age discrimination and improving health and well being which can be a factor in social exclusion. |
| 3. Action in our built and natural environment | U P **N** | F G E | **Neutral -** The NSF does not contribute to the objective of protecting our built and natural environment |

| *Wales: A Better Country Commitment* | **Overall Contribution** | | **Explanation** |
|---|---|---|---|
| 4. Strengthening Wales' cultural identity | U P **N** | F G E | **Neutral -** The NSF does not make a significant contribution to strengthening Wales's cultural identity. There may be potential to contribute indirectly through promoting use of the Welsh language. |
| 5. Ensuring better prospects in life for future generations | U P N | F **G** E | **Good -** The NSF makes a significant positive contribution to ensuring better prospects in life for future generations through promoting lifelong learning, encouraging involvement and citizenship of older people |
| 6. Supporting healthy independent lives | U P N | F **G** E | **Good -** The NSF makes a very positive contribution to supporting healthy, independent lives. Some of the determinants of health are addressed in more detail in the Strategy for Older People. |
| 7. Promoting openness, partnership & participation | U P N | F **G** E | **Good -** The NSF makes a very positive contribution to promoting openness, partnership and participation, which is an underlying principle of the document. |

*Summary Comments:*

*This is a general summary of the Policy Gateway Session held on 17 June 2005.*

*There was general consensus about most of the points, although some debate over the extent to which the impact on the economy and cultural life of Wales should be considered. It was agreed to add further references within the NSF to these issues. However, it should be noted that the NSF falls within the overarching framework of the Strategy for Older People, which has a far broader remit.*

*A copy of the full result of the Policy Gateway assessment is available on the Assembly website www.wales.gov.uk on the 'Access to Information' home page under the 'Policy Gateway' link*

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% forms presented to community pharmacies by patients over 60 = 51.44
% items dispensed for the over 60s = 58.64%
Average items per form = 2.29
% total cost of medicines dispensed for the over 60s = 55.05

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