Part A

Organisational and system readiness

Chapter 3
Leadership and motivation

3.1 Key audiences

Strategic health authorities

Primary care trusts:

- chief executives
- chairs
- medical directors
- executive directors
- non-executive directors
- chairs of professional executive committees
- leaders of practice-based commissioning teams and emergency GP commissioning consortia.

NHS trusts and foundation trusts:

- chief executives
- chairs
- medical directors
- executive directors
- clinical directors
- non-executive directors.

Independent and third sector organisations:

- chief executives
- management committee members/trustees.

3.2 Key issues and concerns

- Leadership from the top of the organisation – both from executives and non-executives – can make a real difference to the motivation and effectiveness of the organisation in tackling age discrimination and promoting age equality.
- The new legal duty on promoting age equality starts from 2011 and so leadership to demonstrate organisational commitment to the duty is a vital early step. The duty is on public bodies to have due regard to the

need to eliminate discrimination, advance equality of opportunity and foster good relations in the exercise of its functions in relation to eight protected characteristics, including age. It applies to people of all ages.

- The Coalition Government has clearly stated its commitment to implementation of the ban on age discrimination in the provision of services and the exercise of public functions in 2012 under the Equality Act 2010. Procurement of services from statutory, third sector and independent sector provides is a public function. This ban applies in relation to people aged 18 or over.

Why leadership is important in tackling age discrimination and promoting age equality

In the NHS, as in other services, local leadership is an essential ingredient of transformative change. Effective leadership at all levels of local organisations can motivate and support staff at all levels to end the unfairness of discrimination and promote age equality by improving the quality of care for all people.

The (then) Healthcare Commission (HCC) emphasised the importance of good leadership at all levels in promoting the dignity of older people in hospitals.[7] Leading on dignity is an important aspect of promoting age equality.

Leadership is also essential in promoting a culture where older people and those who commission and provide services for them are valued.

A report to the Secretary of State for Health by Sir Ian Carruthers and Jan Ormondroyd in October 2009[8] stated:

> *"Leaders of health and social care organisations, including the boards of those organisations and Elected Members, will want to set out a clear commitment to their staff and the wider public to meeting the requirements of the age discrimination ban and the public sector equality duty and demonstrate how the health and social care sector can show leadership in tackling ageism in society." (Recommendation 17)*

Effective leadership can also set the tone for effective involvement of older people and impacts beyond the boundaries of the organisation into wider work across health and local government and its partnerships with third and private sector providers. See Chapter 6 Involving older people

Management and leadership

In the past few years there has been a growth of interest in the impact of good leadership in the NHS as a means of driving forward change. A report from the

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[7] *Caring for dignity, A national report on dignity in care for older people while in hospital*, Healthcare Commission, 2007

[8] *Achieving age equality in health and social care,* Sir Ian Carruthers and Jan Ormondroyd, Department of Health, October 2009

King's Fund and Royal College of Physicians[9] notes that the terms 'management' and 'leadership' are often used interchangeably, but they can usefully be differentiated, and there is a clear role for both.

In the context of medicine, management has been described as 'working with people and processes to produce predictable results'.[10] In contrast, leadership is usefully thought of as focusing on establishing the conditions for more radical change. Age equality requires a change in mindset and so leadership is key. In fact, it is the combination of clinical and managerial leadership in health that is crucial when tacking age discrimination, as the interaction between organisational systems and clinical professional behaviour is where there is the greatest potential to address discrimination and promote age equality.

Leadership in mental health services

The report to the Secretary of State for Health by Sir Ian Carruthers and Jan Ormondroyd in October 2009[11] referred extensively to evidence of age discrimination in mental health services. There is much to suggest that leadership is one of the keys to addressing this.

A report on older people's mental health services published by the HCC[12] strongly emphasised the importance of effective leadership:

> *"Effective leadership to develop older people's mental health services, with senior clinical leadership and strong central governance structures, is required across all health and social care organisations that work with older people, as well as all policy-making organisations. Commissioners' and providers' leaders should work together using the World Class Commissioning approach to deliver improved whole system outcomes. Commissioners and providers should have clearly identified actions for older people's mental health services in the National Dementia Strategy and the Equality Bill."*

In their visits to six trusts, the HCC found two that had made concerted efforts to address the age discrimination encountered by older people when accessing services, and who were delivering services based on need, not age. In the trusts where they found evidence of high quality care, with staff who felt involved, there was a sense of strong clinical and managerial leadership. These trusts tended to have psychiatrists specialising in old age in managerial roles at senior levels, who were able to provide leadership and bring older people's issues directly to the trust's board.

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[9] *Understanding doctors – harnessing professionalism*, Levenson R, Dewar S and Shepherd S, King's Fund, 2008
[10] *Physicians as leaders in the improvement of healthcare systems*, Reinertsen J L, Annals of Internal Medicine, vol 128, no 10, pp 833–8, 998
[11] *Achieving age equality in health and social care,* Sir Ian Carruthers and Jan Ormondroyd, Department of Health, October 2009
[12] *Equality in Later Life - A national study of older people's mental health services*, Health Care Commission, 2009

The visits to a sample of six representative trusts demonstrated the importance of clinical leadership, the involvement of skilled management, and integrated working across organisational boundaries.

See Chapter 14 Mental health including dementia

Leadership and developing a learning culture

Good leaders ensure that their organisations make continual improvements, and that staff at all levels learn from both positive and negative feedback. In *Making things better? A report on reform of the NHS complaints procedure in England* [13], the Health Service Ombudsman noted that, in her experience, "*clear, positive leadership is essential for the development of an open learning culture in which complaints are welcomed and resolved and lessons learned*".

In the context of age discrimination, leaders will try to ensure that their organisations are vigilant about the possible contribution of the subtler forms of age discrimination to sub-optimal care.

Leadership for equality

The Race Relations (Amendment) Act 2000 requires all local authorities to assess the impact of their services and new/revised policies. Many councils and primary care trusts have already gone beyond this requirement and developed an impact assessment which takes into account all areas of diversity: age, disability, race, gender, religion/religious belief and sexual orientation. The Equality Act will make this a requirement. Local leaders can ensure that impact assessments are fully utilised in making services more age-equal and equal in all the other required areas.

3.3 Drivers and policy imperatives

The White Paper Equity and excellence: Liberating the NHS[14]

The White Paper includes a clear commitment to promoting equalities and specifically mentions the implementation of the ban on age discrimination in 2012. The obligations of the Equality Act in relation to public bodies and to organisations working under contract to public bodies mean that new organisations that come into existence over the next few years and are responsible for the commissioning and provision of health care will need to comply with the legislation.

The Government Equalities Office are currently consulting on proposals on the single duty and procurement to not impose additional processes on public bodies in this regard or prescribe a procurement process.

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[13] *The Health Service Ombudsman for England, 2nd Report* - Session 2004-2005
[14] *Equity and Excellence: Liberating the NHS*, Department of Health, 2010

National Service Framework for Older People

The National Service Framework for Older People (NSFOP)[15] advocated a cultural change in services so that older people and their carers are treated with respect, dignity and fairness. Cultural change on this scale clearly requires effective and visionary leadership. As the NSFOP stated:

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

Although some of the means by which this was implemented immediately after the publication of the NSFOP have now moved on, the principle of establishing – and maintaining – strong clinical and managerial leadership remains as important as ever.

High Quality Care for All

Lord Darzi's report, *High Quality Care for All,*[16] makes a statement about the importance of empowering frontline staff to lead change that improves quality of care for patients by "*placing a new emphasis on enabling NHS staff to lead and manage the organisations in which they work"*.

Lord Darzi also talks about enhancing professionalism and refers to investment in new programmes of clinical and board leadership, with clinicians encouraged to be practitioners, partners and leaders in the NHS. In addition, Lord Darzi states that a strengthened Clinical Excellence Awards Scheme will encourage and support clinical leadership of service delivery and innovation.

The Sure Start model

Sure Start, a programme to tackle social exclusion of children and families, has also provided a possible model for older people. Lessons from Sure Start emphasise the importance of leadership at national, regional and local levels.

> *"Changes to existing attitudes and assumptions can only be achieved only through strong and clear leadership at local and national level."*[17]

This report also points out that the leadership and support of key partners such as voluntary organisations, local authorities and government creates the environment where local people can emerge as leaders and make a real difference.

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[15] *National Service Framework for Older People*, Department of Health, 2001
[16] *High Quality Care for All – NHS Next Stage Review Final Report,* Department of Health, 2008
[17] *A Sure Start to Life: Ending Inequalities for Older People*, Social Exclusion Unit, 2006

3.4 Promoting age equality: good practice

The report to the Secretary of State for Health by Sir Ian Carruthers and Jan Ormondroyd in October 2009[18] noted:

> *"Evidence shows that good leaders can make a real difference in shaping the culture of their organisation to promote age equality and prevent age discrimination. Their responsibility is twofold. Leaders need to ensure that the systems and processes they are responsible for are geared to delivering and demonstrating age equality. Even more importantly, leaders need to be visible and vocal on this issue: age discrimination, like other forms of discrimination, can proliferate when leaders fail to make it clear that it is not to be tolerated silence can be read as permission."*

In the NHS context, visible, board-level engagement with this agenda will be crucial. Leaders of healthcare organisations, including the boards of those organisations, will want to set out a clear commitment to their staff and the wider public to meeting the requirements of the age discrimination ban and the public sector equality duty. They may do this in a number of ways, including:

- Boards may consider identifying a champion for age equality to give a strong signal within the organisation about the importance of this issue and to ensure that the board receives regular reports about progress in tackling age discrimination and promoting age equality. It will be essential to ensure that age discrimination is considered alongside the other protected characteristics identified in the Equality Act. This may link with existing older people champions and dignity and respect champions.
- Chief executives and chairs may wish to consider how to ensure that boards receive appropriate training and development to support their commitment to age equality.
- Modelling good practice – leaders and managers can show the way in challenging age discrimination and ageism wherever they encounter it. This sends a strong signal to staff that age discrimination is not acceptable.
- Older people and their organisations will be engaged by commissioners throughout the commissioning cycle and by service providers in giving feedback and in monitoring services. Also see Chapter 6 Involving older people.
- Local NHS organisations will maintain policies and practices that do not discriminate unlawfully against older people. They will also review their policies and practices to consider whether older workers have any particular needs that can be appropriately met within the framework of the new legislation.
- Visible public commitment to age equality that is not limited to health and social care but also addresses wider stereotypes and ageist attitudes.

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[18] *Achieving age equality in health and social care,* Sir Ian Carruthers and Jan Ormondroyd, Department of Health, October 2009

- Leaders will demonstrate that their organisations value staff who work with older people and who carry out tasks that older people particularly value, such as personal care in health settings.

3.5 Suggestions for quick wins / what you can do now

- Make explicit what the board needs to know – have you reviewed governance arrangements to ensure that your board receives regular information on age equality?
- Appoint a champion for age equality at board level, to work closely with the existing network of dignity champions.
- Communicate clear values – ensure that mission statements and similar documents include a clear commitment to age equality, alongside other equality issues.
- Report progress – a report on progress in eliminating age discrimination and promoting age equality can be published in your organisation's annual report and website.
- Mine data – have you fully used existing data to understand the needs and views of older people and their carers? For example, what do local and national surveys tell you about the views and experiences of older people? Are complaints, comments and suggestions routinely analysed to highlight issues that may show age-related experiences?
- Use positive imagery of older people – do you have positive images of older people, showing their diversity? Diverse images can be used to attract older staff and volunteers, and to give clear messages about non-discriminatory treatment and care for older people.
- Hold celebratory events with local authority and other partners about age and ambition and equality.

Chapter 4
Partnerships to end discrimination and promote equality

4.1 Key audiences

Primary care trusts and emerging GP commissioning consortia:

- boards, especially chairs and chief executives
- directors of public health
- commissioners of services for older people.

NHS trusts and NHS foundation trusts:

- boards, especially chairs and chief executives.

Voluntary and third sector organisations:

- chief executives.

Independent sector organisations:

- chief executives.

4.2 Key issues and concerns

- Effective partnership working between health and social care organisations is essential to properly end age discrimination and promote age equality.
- Work with the public, voluntary and third sector organisations is important.
- Information on the outcomes from effective partnership working in improving services and contributing to ending age discrimination is limited.

Effective partnership working is essential to properly end age discrimination and promote age equality

Achieving age equality in health and social care[13] is clear that effective partnership working between health and social care organisations is essential to properly end age discrimination and promote age equality. Recommendation 19 is that "*Local*

[13] *Achieving age equality in health and social care*, Carruthers and Ormondroyd, Department of Health, 2009

social care and health commissioners and providers will want to work together to implement the age provisions in the Equality Bill."

The White Paper *Equity and excellence: Liberating the NHS*[14] highlights the crucial responsibility of NHS organisations to work in partnership with each other and externally and identifies a new role for local authorities in bring all stakeholders together.

Partnership working to end discrimination needs to operate at both the following levels:

a) Partnership working between members of staff in providing care to individual patients, which is often called care coordination. This is focused on different health and care staff working together to provide a joined-up service to the patient or service user. It is especially important in supporting older people who often have complex care needs requiring health and social care services. This includes working between:

   - different professionals in hospital and the community
   - across primary and secondary care
   - health and social care staff working together, including staff employed by independent providers and third sector organisations and volunteers.

Also see Chapter 8 *Prevention and health promotion*, and Chapter 5 *High quality care for all* for the importance of partnership working when discharging older people from hospital settings.

b) Partnerships between organisations in prioritising, commissioning, designing and delivering services to the community that are seamless and integrated. This can include structural or organisational integration but many approaches to organisational partnerships are based on collaborative working between different organisations from the statutory, independent and voluntary sectors, including those involved in services associated with good health and wellbeing (such as crime prevention, transport, benefits, leisure etc). High quality services for older people require effective working between organisations because they often have complex needs.

Work with the public and voluntary and third sector organisations is important

Work with the public, patients, service users and carers needs to be central to the partnership working between local authorities and the NHS. Further details of this are included in Chapter 6 Involving older people.

Voluntary and third sector organisations can add value to the commissioning process and to the co-design of services in a number of ways, including their ability to work across public sector boundaries, and so help with partnership working, and by capturing the experience of users and providing feedback on the services

[14] *Equity and excellence: liberating the NHS*, Department of Health, 2010

commissioned. They can also provide innovative services that support older people.

Although there are pockets of excellent practice, there is little general evidence of widespread involvement of the voluntary sector in the Joint Strategic Needs Assessment (JSNA) process and there is a need for primary care trusts and local authorities to support capacity building in the third sector in order that the contribution of voluntary sector partners can be realised.[15]

Information on the outcomes from effective partnership working in improving services and contributing to ending age discrimination is limited

A review in 2006 found there were examples of some excellent working in partnership both at a strategic and operational level. However, only a few communities inspected had a shared sense of what they wanted to achieve with and for older people, or how progress would be measured. This lack of a clear direction resulted in fragmented services that confused people who tried to access them. The range of services that was available differed significantly between communities and even within a single community.[16]

The information on the outcomes from effective partnership working in improving services and contributing to ending age discrimination is limited. For example the Audit Commission concludes that formal partnership arrangements have had little or no impact on reducing the number of older people who fall and break a hip, or on the length of time they spend in hospital for some common conditions[17].

4.3 Drivers and policy imperatives

The framework for local partnership working

The key forum for partnership working in a locality is the **Local Strategic Partnership (LSP)** which is a collection of organisations from the public, private and voluntary sector who have agreed to work together so that different local initiatives and services support each other and work together, and there is a locality-wide framework for specific partnerships, such as joint work between health and adult social care. The local authority is the lead player in the LSP, which operates at a strategic level but remains close enough to local people to allow them to be involved in decisions that affect their communities.

Some LSPs will want to be active in providing leadership for work across sectors to end age discrimination and to actively promote age equality, and so they may be an appropriate forum to help agree the local action plan to prepare for 2012.

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[15] *Third Sector Involvement In Health And Social Care Commissioning - Report Of A Scoping Study,* Levenson R, Jeyasingham M, Joule N – unpublished LTCA, 2009

[16] *Living well in later life: a review of progress against the National Service Framework for Older People*, HCC, SCIE and Audit Commission, 2006

[17] *Means to an End – Joint financing across health and social care – Health national report*, Audit Commission, 2009

LSPs are responsible for ensuring that **Local Area Agreements (LAAs)** address the local priorities. LAAs are agreements between central government and the locality and are selected from 198 nationally collected indicators. The national indicators are grouped into four headings, one of which is *Adult health and wellbeing and tackling inequalities and promoting equality*. For example Norfolk has selected Indicator 125 *Achieving independence for older people through rehabilitation/intermediate care* based on a need identified in their JSNA. See:

→ http://norfolkdata.net/ResourceUploads/SynergyJSNA&LAA.pdf

Although not specifically about age discrimination, these indicators cover services where the literature reviews by the Centre for Policy on Ageing have identified evidence of potential age discrimination.

In November 2009 the results of the **Comprehensive Area Assessment (CAA)** were published for every locality in England. The CAA is a new way of assessing how well public services are working together to meet the needs of local people. Led by the Audit Commission it provides an annual snapshot of quality of life in each area based on the assessments of six inspectorates, including the Care Quality Commission. They specifically consider the progress in delivering LAAs. Many of the indicators relate to the health and wellbeing of older people and to building inclusive communities. The CAA also identifies areas of specific concern (red flags) and areas of exceptional performance (green flags).

National cross government strategies for later life

In July 2009 the Government published the latest version of its *Building a society of all ages* strategy, about the changing age profile of society, which is led by the Department of Work and Pensions. The strategy provides a context for work in all sectors on ending age discrimination and specifically highlights its importance in improving the quality of public services for people in later life. It highlights how the health and social care system needs to change in response to the changing population profile of an ageing society.

Total Place is a programme of 13 pilot localities which were launched in the 2009 Budget through which local agencies work together to deliver better public services at lower cost. The approach is to look both at the 'demand side' of what the public wants and needs and the 'supply side' of how agencies can work together to deliver local priorities. Pilots that specifically focus on the needs of older people include Bradford, where agencies are looking at promoting independence for older people discharged from hospital, and Bournemouth, Poole and Dorset, where the emphasis is on collaboration with older people to deliver improved public services.

The legal provisions for joint working between health bodies and local authorities

"The statutory duty of partnership on NHS bodies and local authorities was established under the Health Act 1999 and later the Health and Social Care (Community Health and Standards) Act 2003. The NHS Act 2006 more recently reinforced this legislation, further enabling the Health Act Flexibilities (HAFs) set

out in the 1999 Act. NHS bodies and local authorities can now more easily delegate functions to one another to meet partnership objectives and create joint funding arrangements." Audit Commission, *Clarifying joint finance arrangements,* 2008.

Partnership working in health and social care

Local democratic legitimacy in health set out an enhanced role for local authorities with greater responsibilities in four areas:

- leading joint strategic needs assessments (JSNA)1 to ensure coherent and co-ordinated commissioning strategies;
- supporting local voice, and the exercise of patient choice;
- promoting joined up commissioning of local NHS services, social care and health improvement; and
- leading on local health improvement and prevention activity.

The NHS Operating Framework for 2010-11 set out the crucial role that partnership working plays in improving health and wellbeing. The Operating Framework highlights opportunities that partnership working provides to deliver key goals such as keeping older people independent. It highlights links between the Vital Signs indicators and the JSNAs, LAAs and CAAs and identifies the increasing importance of integrated ways of working in improving services.

Our health, our care, our say published in January 2006 established a new direction for the health and social care system by focusing on the personalisation of services and delivery of care as close to the patient as possible. It led to a range of specific policies that support joint working between the NHS and social care.

The subsequent legislation included the *Local Government and Public Involvement in Health Act, 2007* which placed a duty on upper tier local authorities and primary care trusts to undertake **Joint Strategic Needs Assessments (JSNAs)** from April 2008. The JSNA identifies the health and wellbeing needs of the local community and forms the basis for the commissioning plans for primary care trusts and local authorities. The guidance stresses that JSNAs will be most effective if communities are involved throughout the process, including design, content, use and feedback.[18]

The Review of Age Discrimination commissioned the University of the West of England to undertake an analysis of JSNAs in the South West. It found that six of the thirteen JSNAs mentioned age discrimination and across all JSNAs there was further work to be done in translating the identification of need into commissioning intentions and plans.[19]

World Class Commissioning guidance makes it clear that *"partnerships hold the key"* to making commissioning effective in transforming services. Competency 2

[18] *Guidance on Joint Strategic Needs Assessment,* Department of Health, 2007
[19] *Achieving age equality in health and social care – Annex*, Department of Health, 2009

specifically relates to primary care trusts building capacity and capability in partnership working, though all the competencies should be underpinned by a collaborative approach with local authority partners. Recommendation 12 in *Achieving age equality in health and social care* was that ending age discrimination and achieving age equality be built into World Class Commissioning competencies.

Partnerships for Older People Projects (POPPs) was launched in 2005 to develop and evaluate services and approaches for older people aimed at promoting health, wellbeing and independence, and preventing or delaying the need for higher intensity or institutional care. Led by local authorities, innovative projects would be developed through partnerships with health and voluntary agencies and co-designed with older people. The national evaluation was published in January 2010 and concluded that improved relationships resulted from effective partnership working, though there were some problems involving GPs, and that local authority-led partnerships were successful at reducing demand on secondary services. LAAs were important in embedding and sustaining POPPs.

The programme of **Integrated Care Pilots** (ICP) is exploring different ways in which health and social care services can be integrated to improve local health and wellbeing. On 1 April 2009 the Department of Health announced 16 pilot sites across the country which are developing new models of care for their communities. Each pilot involves partnership between a range of organisations, such as primary care trusts, acute trusts, clinicians and social care professionals, local authorities, service user groups and voluntary bodies. See:

→ www.dh.gov.uk/en/Healthcare/IntegratedCare/index.htm

There have been a number of pilots of integrated management and organisational structures between health and social care. Care trusts were introduced in 2002 to provide better-integrated health and social care. By combining both NHS and local authority health responsibilities, care trusts can increase continuity of care and simplify administration. There are five care trusts that combined primary care trusts and adult social services and these have used their integrated structures to focus on improving services to older people. Other primary care trusts and local authorities have created key joint appointments for senior managers covering health and social care.

Joint finance and pooled budgets are options available for primary care trusts and local authorities to combine budgets to help achieve better services and better value for money. The most commonly used formal arrangement is the pooling of functions and resources under section 75 of the NHS Act 2006.

In October 2009 the Audit Commission published a review of joint finance. It concluded that pooled funds are rarely used for older people's services, though they are common for community equipment services that benefit older people. It was concerned about a lack of evidence on the benefits of partnership working. For example, its analysis suggests *"that formal partnership arrangements have had little or no impact on reducing the number of older people who fall and break their hip, or on the length of time they spend in hospital for some common conditions"*.

Specific areas for improvement proposed by the Audit Commission include:

- Draw up written joint funding or partnership agreements and regularly review these in light of performance and changing circumstances.
- Set and monitor measurable outcomes for service users for all their partnership agreements.
- Develop clear and synchronised financial frameworks that cover, for example, budget-setting, governance, financial planning, financial timetables and risk-sharing.[20]

4.4 What good age-equal practice might look like

Good age-equal practice in partnership working is no different from general good partnership working but with a specific focus on age issues.

Building age equality into the wider partnership working between health and social care was a key recommendation in *Achieving age equality in health and social care*. Thus the explicit consideration of age appropriate services, opportunities to promote age equality and actions required to end age discrimination can be part of local partnership working. Effective age-equal practice in partnership working should cover the principles that have been identified as central to wider collaborative working. For example the Partnership Readiness Framework identifies the following nine principles:

1. Building and agreeing **shared values and principles** with a vision of how life should be for people who use services.
2. Agreeing **specific policy and service shifts** that the partnership arrangements are designed to achieve.
3. Being prepared to explore **new service options** and not be overly tied to existing services or providers.
4. Being clear about what aspects of service and activity are inside and outside **the boundaries of the partnership** arrangements.
5. Being clear about **organisational roles** in terms of responsibilities for and relationships between commissioning, purchasing and providing in order to derive a coherency that draws upon all appropriate expertise.
6. Identifying **agreed resource pools**, including pooled budgets, and agreeing to put to one side unresolvable historical disagreements about financial responsibility.
7. Ensuring **effective leadership**, including political and other senior level commitment to the partnership agenda.
8. Providing sufficient dedicated partnership **development capacity** rather than it being a small and marginalised part of everyone's role.
9. Developing and sustaining **good personal relationships**, creating opportunities and incentives for key players to nurture those relationships in order to promote mutual trust.[21]

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[20] *Means to an End – Joint financing across health and social care – Health national report, Audit Commission,* 2009

[21] *Partnership Readiness Framework,* Greig R and Poxton R, Institute for Applied Health and Social Policy, King's College London, 2000

There are a range of sources of advice and examples on effective partnership working including:

- the Improvement and Development Agency Partnership and Places Library contains many examples of successful partnerships:

  → www.idea.gov.uk/idk/laa/home.do

- The Integrated Care Networks site sponsored by the Department of Health has a range of information about integrated working in health and between health and social care:

  → www.dhcarenetworks.org.uk/Integration/

It is good practice to ensure there are ongoing partnerships with organisations of older people locally and to involve them throughout the commissioning cycle, including in needs assessment, provision of services and monitoring services.

In their *State of Care report* in February 2010, the Care Quality Commission highlighted three key factors for 'joined up working' between health and social care:

- the extent to which outcomes for people are improving as a result of joined-up care, especially whether people are staying healthier for longer, whether they are being supported to live independently at home, and whether their stays in hospital and/or residential care are being kept as short as possible
- whether health care and social care services are sharing information effectively
- strategic approaches to joining up care, including shared agreements, partnership working and strategic flexibilities.

4.5 Case studies of illustrative / good practice

Dorset - engaging older people in designing services

Dorset was awarded a green flag by the CAA process for its work on engaging older people in designing services, building on the work of its Partnership for Older People's project

→ *http://oneplace.direct.gov.uk/infobyarea/region/area/areaassessment/pages/localpriority.aspx?region=54&area=339&priority=4380*

Bournemouth and Poole – Integrated Care Pilot – dementia service

In Bournemouth and Poole organisations are working together on a care pilot to deliver integrated services to people with dementia.

→ www.commissioningsupport.org/cs/groups/childrens_health_commissioning/media/p/1406.aspx

Torbay – joint working to improve service integration

In response to poor Comprehensive Performance Assessment and adult social care assessment ratings, Torbay Care Trust and Torbay Council joined forces and resources to improve their organisational performance and outcomes for local people. Their test for service integration was to identify a fictional older person, 'Mrs Smith', and how they could overcome service fragmentation and lack of co-ordination to meet her needs. They assessed how she fitted into the jigsaw of health, social care, the primary care trust and council, and how integrated staff and innovative joint financing arrangements would improve services for her and other users.

Since 2006, urgent (25 per cent of all) intermediate care cases can see therapists within four hours. In 2008, 99 per cent of community equipment was delivered within seven days and 97 per cent of care packages were in place within 28 days of assessment (an increase of 9 and 30 per cent respectively since 2006). (Source: *Means to an End*, Audit Commission, 2009)

Integrated working between health and social care

Case studies on integrated working between health and social care from Torbay, Knowsley and North East Lincolnshire are described in *Only Connect: policy options for integrating health and social care* by Chris Ham, Nuffield Trust, April 2009:

→ www.nuffieldtrust.org.uk/members/download.aspx?f=%2fecomm%2ffiles%2fOnly_Connect_1April09.pdf

4.6 Suggestions for quick wins / what you can do now

- Review membership of existing groups that look at the needs and services for older people to ensure that a wide range of statutory, third sector and independent sector organisations are represented.
- Ensure older people, and the organisations that represent them, are actively involved in the JSNA process.
- Use the 'Partnership readiness check' in the audit tool, which is part of the 'Achieving age equality resource pack' to help review where you are now.

- Ensure that the proposed approach to age equality is discussed by local partnership groups such as the LSP or a joint commissioning group for older people.

Chapter 5
High quality care for all

5.1 Key audiences

Primary care trusts and emerging GP commissioning consortia:

- chief executives
- leads on quality/personalised care
- commissioners of services for older people
- commissioners of acute health services.

NHS trusts and NHS foundation trusts:

- chief executives
- clinical directorate management teams
- medical directors.

5.2 Key issues and concerns

The White Paper *Equity and excellence: Liberating the NHS* and the consultation paper *Transparency in outcomes*,[22] build on the work by Lord Darzi. His report, *High Quality Care for All*,[23] set out a vision in which high quality care is central to the NHS. Quality is defined in terms of safety, effectiveness and patient experience:

> *"High quality care is care where patients are in control, have effective access to treatment, are safe and where illnesses are not just treated, but prevented."*[24]

Transparency in outcomes sets out the role of the NHS Outcomes Framework at a national level but notes that locally, there is a need for measures of structure, process and outcome.

The document proposes five domains of outcomes within the NHS Outcomes Framework:

> **Domain 1:** Preventing people from dying prematurely
> **Domain 2:** Enhancing quality of life for people with long-term conditions

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[22] *Equity and excellence: Liberating the NHS* and *Transparency in Outcomes* Department of Health, 2010
[23] *High Quality Care For All – NHS Next Stage Review Final Report*, *Lord Darzi,* Department of Health, 2008
[24] *High Quality Care For All – NHS Next Stage Review Final Report*, *Lord Darzi,* Department of Health, 2008

Domain 3: Helping people to recover from episodes of ill health or following injury
Domain 4: Ensuring people have a positive experience of care
Domain 5: Treating and caring for people in a safe environment and protecting them from avoidable harm

It highlights the potential for discrimination in the first domain because the usual measure of premature death focuses on death in people under 75. premature mortality among older people is addressed in two ways in the proposed Framework – through the fifth domain and by including some indicators that do not relate to age, such as health life expectancy at 65.

Achieving age equality in health and social care[25] recommended that:

> *"The Department [of Health] and the health and social care system ensure that work to prevent harm and waste and spread innovation within the system should be designed to help promote age equality and that measures to end age discrimination are implemented so that they improve quality and productivity." (Recommendation 20)*

There is some evidence that high quality care can be maintained in a time of financial constraint and that promoting quality can help reduce costs.[26] [27]

The *NHS Next Stage Review* promotes a *Quality Framework*, consisting of seven steps, that encourages NHS local organisations and others to:

- Bring clarity to quality
- Measure quality
- Publish quality performance
- Recognise and reward quality
- Raise standards
- Safeguard quality (through clinical leadership and empowered patients)
- Stay ahead.

In order to ensure high quality care for all, organisations will need to ensure that services are age appropriate and promote equality (including equality in terms of age). There are a number of areas which currently may give rise to concerns in this respect.

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[25] *Achieving age equality in health and social care*, Sir Ian Carruthers and Jan Ormondroyd, Department of Health, 2009
[26] *Does improving quality save money? A review of evidence of which improvements to quality reduce costs to health service providers*, Øvretveit J, The Health Foundation, 2009
[27] *Can quality and productivity improve in a financially poorer NHS?* Crump B and Adil M, BMJ: 339:b4638, 2009

Clarifying quality

In order to achieve the goal of high quality care for all it is important to understand the aspects of quality and person-centred care that are important to older people. Surveys and reports of older people's views consistently find that the following issues most concern older people when receiving NHS care:

- personalised care (being treated as an individual)
- retaining control over their routine
- maintenance of privacy and dignity (including single sex accommodation)
- healthcare professionals who communicate with them and listen to them
- joined up care.

Measuring quality

Use of data on the quality of services for older people

There is a large amount of information collected about the quality of services for older people, although this does not always reflect the issues that are a priority for older people themselves. There is also a considerable amount of information available about how older people experience the quality of health services, but this is not always analysed or used by primary care trusts and service providers to make the changes that would improve the experience, effectiveness of care and the safety of older people when using health services.

Older people are less likely to complain

Complaints are a useful source of data on the quality of services[28], but a Care Quality Commission survey of older people[29] found that that only 27 per cent of older people in one area felt that their complaints would be listened to. One of the reasons some people were reluctant to complain was the fear that this would affect the treatment that they or their relatives received.

Patient experience - older people's perspectives on quality

Lord Darzi states that patient experience "*can only be improved by analysing and understanding patient satisfaction with their own experiences*". [30]

Personalisation

Older people want to be treated as individuals and receive care that is tailored around their needs. They want to be offered treatment choices, backed up with information, and recognition of their preferences. Concerns have been expressed, however, that some of the high profile aspects of personalisation such as personal

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[28] *Seeing the person in the patient – the point of care review paper,* King's Fund, Goodrich J and Cornwell J, 2009

[29] *Good practice in services for older people,* Care Quality Commission www.cqc.org.uk/_db/_documents/Good_practice_in_services_for_older_people.pdf

[30] *High Quality Care for All – NHS Next Stage Review Final Report,* Lord Darzi, Department of Health, 2008

health budgets may not have been designed around the needs of older people and require detailed evaluation before being rolled out.[31]

Privacy, dignity and single sex accommodation

The following concerns undermine dignity and are not uncommon experiences for older people in hospital settings:[32] [33] [34]

- being addressed in an inappropriate manner
- neglect of patients' appearance and clothing
- exposure, lack of privacy in personal care, and mixed wards.

Being in single sex accommodation and having access to single sex bathing, washing and toilet facilities is one of the most important considerations for older patients in maintaining their privacy and dignity. Older people in general, and women over the age of 65 in particular, are more likely to find mixing "*not at all acceptable*" compared to other age groups.[35]

The Care Quality Commission (CQC) Inpatient Survey indicated that 32 per cent of respondents 'mind' sharing a mixed sleeping area, and that among women, older people and some ethnic minorities this figure rises steeply.[36]

The 2006 survey of NHS inpatients reported that nearly 23 per cent of older respondents had shared a room or bay with patients of the opposite sex.[37]

Being placed in mixed sex accommodation is a common complaint received by the Healthcare Commission from older people.[38]

Communication

Older patients are those least likely to be critical of any particular hospital situation, so it is particularly worrying that these same patients are less likely than those in middle age and early old age to describe their hospital care as "*excellent*" and most likely to feel talked over "*as though they were not there*" by medical staff. [39]

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[31] *Waiting for Change: How the NHS is responding to the needs of older people,* Help the Aged/ Age Concern, 2009
[32] *Dignity in Care Practice Guide,* SCIE 2006 – 2009 www.scie.org.uk/publications/guides/guide15/index.asp
[33] *On our own terms - The challenge of assessing dignity in care*, Help the Aged/Picker Institute, 2008
[34] *Caring for Dignity - a national report on dignity in care for older people when in hospital,* Commission for Healthcare Audit and Inspection, 2007
[35] *Privacy and Dignity – A report by the Chief Nursing Officer into mixed sex accommodation in hospitals,* Department of Health, 2007
[36] *Delivering same-sex accommodation: a progress report,* Department of Health, 2009
[37] *State of healthcare 2007*, Healthcare Commission, 2007
[38] *Caring for Dignity - a national report on dignity in care for older people when in hospital,* Commission for Healthcare Audit and Inspection, 2007
[39] *Ageism and age discrimination in secondary health care in the United Kingdom*, Centre for Policy on Ageing (CPA), October 2009

Older patients in hospital may feel worthless, fearful or not in control of what happens, especially if they have impaired cognition, or communication difficulties.[40]

Valuing staff

Staff that feel valued generally provide higher quality care to their patients.[41] It is important that providers of care to elderly people ensure that staff feel valued and supported. Overall, less than a third of NHS staff are satisfied with the extent to which their trust values their work, although this has increased substantially since 2007.[42]

Seamless care

Joined up care is a priority for older people.[43] [44] [45] Older people, who are more likely to be users of both health and social care than younger people, are particularly vulnerable to falling through gaps when services are not sufficiently integrated.

Safer care for older people

The quality of technical care is often taken for granted by older patients, and good or bad experiences are described more in terms of how staff relate to patients.[46] There are, however, some particular concerns about the safety of NHS care which require attention to ensure the quality of care for older people is promoted.

Falls in hospital and other NHS settings

A patient falling is the most common patient safety incident reported to the National Patient Safety Agency (NPSA) from inpatient services. In an average 880 bed acute hospital there will be around 1,260 falls every year resulting in estimated costs of about £92,000 for an average acute trust.[47] Older people are more vulnerable to falls and those aged over 65 years occupy more than two thirds of hospital beds.

Older people often do not receive optimum care and preventative advice when they are admitted to hospital following a fall in the community.[48] Whilst it is important to prevent further falls in hospital, it is also important to ensure that older people are

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[40] *Older people's and relatives' experiences in acute care settings: systematic review and synthesis of qualitative studies*, Bridges J, Flatley M and Meyer J, International Journal of Nursing Studies Vol 47 January 2010, p89-107
[41] *Seeing the person in the patient – the point of care review paper*, King's Fund, Goodrich J and Cornwell J, 2009,
[42] *National NHS Staff Survey 2008 – Summary of key findings,* Care Quality Commission, 2009
[43] *Older People's definitions of quality services,* Qureshi H and Henwood M, Joseph Rowntree Foundation, 2000
[44] *Your Health Your Care, Your Say,* Opinion Leader Research, *2006,*
[45] *Waiting for Change: How the NHS is responding to the needs of older people,* Help the Aged/Age Concern, 2009
[46] *Older people's and relatives' experiences in acute care settings: systematic review and synthesis of qualitative studies,* Bridges J, Flatley M and Meyer J, International Journal of Nursing Studies Vol 47 January 2010, p89-107
[47] *Slips, trips and falls in hospital*, National Patient Safety Agency, 2007
[48] *National Audit of the Organisation of Services for Falls and Bone Health of Older People,* RCP and HQIP, 2009

enabled to move around safely in order that they can get the best from rehabilitation programmes. Also see Chapter 12 Falls.

Medication safety

Medication safety incidents were the second largest group of patient safety incidents reported to the National Reporting and Learning Service (NRLS) in 2006. Elderly patients are particularly vulnerable to medication related incidents.[49] The number of medication incidents (most commonly wrong dose, omitted or delayed medicines or wrong medicine given) was disproportionately high in those aged 75 – 94 years. The most vulnerable group (apart from children aged 0- 4 years) is those aged 80 – 84 years.[50]

A number of factors contribute to making older people more vulnerable to medication errors, including:

- the way the body handles medicines changes as people get older, making older people more susceptible to harm from dosing errors
- choice of formulation may be important, particularly in older people with swallowing difficulties
- older people are more likely to have multiple conditions leading to confusing drug regimes.[51]

The Department of Health highlighted the following issues as being particularly relevant to medicines management in older people:

- many adverse reactions to medicines could be prevented
- some medicines are under-used
- medicines are sometimes not taken
- inequivalence in repeat prescription quantities causes wastage
- changes occur in medication after discharge from hospital
- there can be poor two-way communication between hospitals and primary care
- repeat prescribing systems need improvement
- dosage instructions on the medicine label are sometimes inadequate
- access to the surgery or pharmacy can be a problem
- carers' potential contribution and needs are often not addressed
- detailed medication review minimises unnecessary costs
- some long-term treatments can be successfully withdrawn.[52]

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[49] *Safety in doses: Improving the use of medicines in the NHS,* National Patient Safety Agency, 2009
[50] *Safety in doses: Medication safety incidents in the NHS,* National Patient Safety Agency, 2007
[51] *Safety in doses: Improving the use of medicines in the NHS,* National Patient Safety Agency, 2009

Hospital acquired infections

C. difficile infection is more common in older people. Over 8 in 10 cases occur in people over the age of 65. This is partly because older people are more commonly in hospital. Also, older people seem to be more prone to this infection and C. difficile infection is also more likely in people who have a weakened immune system or other underlying health problems.

Urinary tract infections are the second largest single group of healthcare associated infections in the UK and make up 20 percent of all hospital acquired infections.[53]

Pressure ulcers

Pressure ulcers are more likely in high risk groups such as the elderly, obese, malnourished and those with certain underlying conditions. The presence of pressure ulcers has been associated with an increased risk of secondary infection and a two to four fold increase of risk of death in older people in intensive care units.[54]

Effectiveness of care for older people

Access to effective treatments

Effectiveness of care is about understanding success rates from different treatments for different conditions.[55] There is some evidence that older people do not get equal access to some treatments due to age-related assumptions about their ability to undergo a treatment or benefit from it.[56]

Nutrition

Malnutrition in older people is under-recognised and common. Age Concern has described the growing risk of older people being malnourished or their nutritional status getting worse during an admission to hospital.[57] Malnutrition is associated with poor recovery from illness and surgery.[58] Yet the National Institute for Health and Clinical Excellence (NICE) found that only about one-third of patients were screened for malnutrition on admission to hospital.[59]

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[52] *Medicines and Older People: Implementing medicines-related aspects of the NSF for Older People*, Department of Health, 2001

[53] *Trends in Rates of Healthcare Associated Infection in England 2004 to 2008*, National Audit Office (NAO), Health Protection Agency, 2009

[54] *Predictive factors of in-hospital mortality in older patients admitted to a medical intensive care unit,* Bo M, Massaia M et al, Journal of the American Geriatrics Society, 51 (4): 529-33, 2003

[55] *High Quality Care for All – NHS Next Stage Review Final Report*, Lord Darzi, Department of Health, 2008

[56] *Ageism and age discrimination in secondary health care in the United Kingdom*, CPA, October 2009

[57] *Hungry to Be Heard,* Age Concern England, 2006

[58] *Disease related malnutrition*, Stratton R et al, CABI Publishing, 2003

[59] *Nutritional Support for Adults: Oral Nutrition Support, Enteral Tube*, NICE and the National Collaborating Centre for Acute Care, 2006

A common complaint received by the Healthcare Commission from older people was that they were not given appropriate food or help with eating and drinking. The Commission underlined the need for commitment to nutrition by healthcare organisations.[60] Older people following a major illness, such as stroke, those with other co-morbidity and those with mental illness have a greater risk of poor nutritional status associated with worse outcomes.

Dual/Multi-discrimination concerns

Black and minority ethnic older people in hospital have similar views to older people as a whole on the important aspects of quality care, though they also identify the following as particular issues:[61] [62]

- Food – not just food preferences and nutrition, but also hospitals' difficulties in providing special diets
- Communication – made more difficult by the lack of interpreters and the apparent inability of staff to cope with 'ethnic' accents or forms of speech
- Staff insensitivity and racism – especially in relation to religious needs and coupled with the more common complaint about respectful forms of address
- They are also more likely to be concerned about a lack of seamless care.

Most gay (older) people want their sexuality to be taken into consideration by those providing services and they want to be treated with respect and equality.[63]

People with learning disabilities often experience poorer quality care.[64] [65] There is an increasing group of people with learning disabilities living into older age with complex health needs. Commissioners and services providers need to ensure that those providing services have a better understanding of the needs of people with learning disabilities and that the quality of the service for them is closely monitored and improved.

5.3 Drivers and policy imperatives

Measuring and reporting quality

A key theme of the Government's reforms is to increase the transparency of information on the performance of the NHS, especially in the outcomes of

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[60] *Caring for Dignity - a national report on dignity in care for older people when in hospital,* Commission for Healthcare Audit and Inspection, 2007
[61] *Good Practice Guide*, Social Care Institute for Excellence (SCIE)
[62] *The health and social care experiences of black and minority ethnic older people*, Moriarty J, 2008, Race Equality Foundation
[63] *Gay and Grey in Dorset, Lifting the Lid on Sexuality and Ageing*, Help and Care Development Ltd, 2007
[64] *Healthcare for All – Report of the Independent Inquiry into access to healthcare for people with learning disabilities,* Michael J, 2008
[65] *Death by indifference,* Mencap, 2007

treatment. The consultation document *Transparency in outcomes* sets out the national framework proposed for measuring health outcomes. It has a specific section on measuring outcomes among people of different ages

The Department of Health published guidance on the framework for quality accounts early in 2010:

→ www.dh.gov.uk/qualityaccounts

From April 2010, all providers of acute, mental health, learning disability and ambulance services will be required to produce a quality account. Further work is underway to develop quality accounts for primary care and community services providers with the aim to bring these providers into the requirement by June 2011.

The Department of Health, Monitor, Care Quality Commission and NHS East of England have also developed a toolkit of useful guidance and case studies to help NHS providers prepare their quality accounts. You can access the toolkit at:

→ www.dh.gov.uk/qualityaccounts

Patient experience

Essence of Care was launched in February 2001 and was designed to support the measures to improve quality set out in *A First Class Service*. It is a tool to help practitioners take a patient-focused approach to sharing and comparing practice, thus identifying best practice and developing action plans to improve care. It contributes to clinical governance at local level. The *Essence of Care* benchmarks are used widely through local NHS organisations and are constantly revised.

Personalisation

Standard Two of *the National Service Framework for Older P*eople[66] aimed to ensure that older people are treated as individuals and that they receive appropriate and timely packages of care which meet their needs as individuals, regardless of health and social services boundaries.

Lord Darzi set out a vision for improving quality in the NHS in which the personalisation of services is central.[67] Personalisation means different things to different people but the following definition may be useful:

> *"Personalisation reinforces the idea the individual is best placed to know what they need and how those needs can be best met. It means that people can be responsible for themselves and can make their own decisions about what they require, but that they should also have information and support to*

[66] *National Service Framework for Older P*eople, Department of Health, 2001
[67] High Quality Care for All – NHS Next Stage Review Final Report, Lord Darzi, Department of Health, 2008

enable them to do so. In this way services should respond to the individual instead of the person having to fit with the service."[68]

One way in which it has been proposed that care could be personalised is through the use of personal health budgets which help people to get the services they need to achieve their health outcomes, by letting them take as much control over how money is spent on their care as is appropriate for them. It does not necessarily mean giving them the money itself. Personal health budgets could work in many ways, including:

- a notional budget held by the commissioner
- a budget managed on the individual's behalf by a third party
- and a cash payment to the individual (a 'healthcare direct payment').

Primary care trusts already have extensive powers to offer personal health budgets, either as a notional budget or held by a third party. The Health Act 2009 permits piloting of healthcare direct payments, and these are currently underway.

Equity and excellence: Liberating the NHS[69] reemphasises personalisation of care in terms of tailored provision, personalised care planning and a more personal approach to nursing, particularly for people with long-term conditions, in addition to personal health budgets.

Dignity

The *National Service Framework Next Steps* report[70] aimed to ensure that, within five years, all older people receiving care services will be treated with respect and dignity. The report acknowledges the need for wide-reaching culture change and zero tolerance of negative attitudes towards older people.

The strategic vision within the previous government's carers' strategy *Carers at the heart of 21st-century families and communities*[71] states that "*carers should be treated with dignity and respect both as carers and as individuals in their own right*". (page 34) The Coalition government believes that the ambitions set out in this strategy hold good and has announced its intention to refresh the strategy in terms of identifying the priorities for the next four years (2011-15). These will be published after the outcome of the Spending Review is made known in Autumn 2010.

The *NHS Constitution* states that patients have the right to be treated "with dignity and respect, in accordance with your human rights."[72]

The 2010/11 operating framework required all providers of NHS care to publish a declaration before the end of March 2010 that they have virtually

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[68] Carr, 2008, *Personalisation – a rough guide*, Adult Services Report 20, Social Care Institute for Excellence
[69] *Equity and excellence: Liberating the NHS,* Department of Health, 2010
[70] *National Service Framework Next Steps*, Department of Health, 2006
[71] *Carers at the heart of 21st-century families and communities*, Department of Health, 2008
[72] *The NHS Constitution*, Department of Health, 2009

eliminated mixed sex accommodation, and have plans in place for continued delivery of this commitment.

→ www.dh.gov.uk/en/Publicationsandstatistics/Lettersandcirculars/Dearcolleagueletters/DH_112180

In August 2010, Andrew Lansley announced new steps to ensure that NHS organisations can be held to account for managing their beds and facilities to eliminate mixed sex accommodation where there is no clinical justification. From January 2011, routine reporting of NHS organisations' breaches will be introduced and published and commissioners will be expected to apply sanctions to NHS organisations who declare a breach.

Communication

The NHS Constitution states that patients have the right to "*be involved in discussions and decisions about your healthcare, and be given information to enable you to do this*".[73]

Seamless care

Standard Three of the *National Service Framework for Older People*[74] aimed to provide integrated services to promote faster recovery from illness, prevent unnecessary acute hospital admissions, support timely discharge and maximise independent living.

Safety

"Safety challenges" highlighted include focusing on the reduction of C. difficile infection, venous thrombo-embolism (VTE) and pressure ulcers.

Effectiveness

Standard Four of the *National Service Framework for Older People*[75] aimed to ensure that older people receive the specialist help they need in hospital and that they receive the maximum benefit from having been in hospital.

5.4 What good age-equal practice might look like

Measuring and publicising the quality of care for older people

Use of information

Analyse data sources by age to understand the concerns and experiences of older people using health services. This could include:

- national patient surveys
- Local Involvement Networks (LINks) surveys

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[73] *The NHS Constitution*, Department of Health, Department of Health, 2009
[74] *National Service Framework for Older People*, Department of Health, 2001
[75] *National Service Framework for Older People*, Department of Health, 2001

- serious untoward incidents
- complaints.

Share this information with older people and other partners to see where and how improvements can be made.

Complaints

Older people may need encouragement and support to make complaints. The Department of Health guide to the new complaints procedure[76] provides advice on how to support complainants, including the use of Patient Advice and Liaison Services (PALS) and the Independent Complaints Advocacy Service (ICAS).

Local health organisations might ask themselves the following questions:

- Are complaints policies and procedures user-friendly and accessible?
- Are complaints dealt with early, and in a way that ensures progress is fully communicated?
- Are older people, their relatives and carers reassured that nothing bad will happen to them if they do complain?
- Are PALS and ICAS services sensitive to the needs and concerns of older people?
- Is there evidence of audit, action and feedback from complaints?

Local NHS organisations might also want to consider how they can use the new NHS and social care complaints process to achieve rapid resolution of individual cases of potential discrimination as recommended by the Review report *Achieving age equality in health and social care* – a report to the Secretary of State for Health.[77] (Recommendation 18)

Improving patient experience

A focus on making improvements in the following areas would improve the quality of care for older people:[78]

- assistance to maintain personal hygiene
- eating and nutrition
- privacy
- communication
- pain
- autonomy

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[76] *Listening, Responding, Improving – A guide to better customer care*, Department of Health, 2009
[77] *Achieving age equality in health and social care*, Sir Ian Carruthers and Jan Ormondroyd, Department of Health, October 2009
[78] *On our own terms - The challenge of assessing dignity in care*, Help the Aged/Picker Institute, 2008

- personal care
- end of life care
- social inclusion.

The King's Fund *Point of Care Programme*[79] is conducting work on transforming patients' experience of care and has gathered resources and research reports to support this.

Dignity

Help the Aged provides a useful table outlining what should be measured to assess whether health and social care services support the dignity of older users.[80]

The *Dignity Challenge* sets out national expectations of what constitutes a service that respects dignity:

→ www.scie.org.uk/publications/guides/guide15/challenge/index.asp

The *SCIE Dignity in Care Practice Guide* (Social Care Institute for Excellence) has useful guidance, examples from practice and other resources designed to assist organisations to meet the Dignity Challenge which sets out what people can expect from a high quality service that respects dignity.

→ www.scie.org.uk/publications/guides/guide15/index.asp

In addition local health organisations can:

- Ensure that treating older people with respect is fundamental to training and induction for all staff (including domestic and support staff) and followed up by supervision and zero tolerance of negative attitudes towards older people. *Achieving age equality in health and social care*[81] recommended that local statutory organisations should build into their contracts with providers of training programmes (including third sector and private organisations) the need for an explicit focus on age equality that supports staff in providing high quality services to people of all ages. (Recommendation 16).
- Ensure that the service is person-centred and not service or task-oriented.
- Ensure that service users are asked how they would like to be addressed and that staff respect this.
- Work to ensure that mixed sex accommodation, and its impact, is minimized in hospital areas where older people are treated.

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[79] www.kingsfund.org.uk/research/projects/the_point_of_care/
[80] *On our own terms - The challenge of assessing dignity in care,* p8-9, Help the Aged/Picker Institute, 2008
[81] *Achieving age equality in health and social care*, Sir Ian Carruthers and Jan Ormondroyd, Department of Health, 2009

- Ensure there is access to good quality interpreting services. People should not have to rely on family members.[82]
- Develop better end of life care for older people. See Chapter 15 End of Life Care.
- Develop better services for people with dementia and their carers. See Chapter 14 Mental health including dementia.
- Support intergenerational community activities to tackle preconceived ideas and discrimination against older people.

The Royal College of Nursing (RCN) has a *Dignity Campaign* including a support network and useful resources:

→ www.rcn.org.uk/newsevents/campaigns/dignity

[82] *The health and social care experiences of black and minority ethnic older people*, Moriarty J, Race Equality Foundation, 2008

Communication

Staff who connect with older patients, recognise older people's individual identity and involve patients in shared decision-making consistently link to more positive experiences for patients.[83]

Tools, such as *Essence of Care* benchmarking factors, can be used to document how staff communicate with patients, what information has been given and to check that it is in a format people can understand.

Equipment can be used to facilitate communication with those who have difficulty hearing or speaking, such as Royal National Institute for the Deaf (RNID) listeners, speech amplifiers and small whiteboards.

Safety

To improve the safety of health care for older people it is important to focus on:

- preventing falls
- learning from, and reducing, medication incidents
- reducing hospital acquired infections including C. difficile and urinary tract infections
- preventing pressure ulcers.

Preventing falls

The NPSA report[84] has useful guidance on preventing falls in hospitals. Also see Chapter 12 Falls.

Learning from, and reducing, medication incidents

The NPSA recommend that incidents should be reviewed on an age-related basis to identify risks peculiar to older people.[85] The Agency also says that initiatives to help reduce medication incidents involving elderly patients should include:

- a review of local arrangements for managing medication-related therapy for patients with swallowing difficulties
- a review of processes associated with medication concordance and compliance in elderly patients, particularly the use of patients' own medicines and compliance aids.[86]

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[83] *Older people's and relatives' experiences in acute care settings: systematic review and synthesis of qualitative studies*, Bridges J, Flatley M and Meyer J, International Journal of Nursing Studies Vol 47 January 2010, p89-107
[84] *Patient Safety Observatory, 2007, Slips, trips and falls in hospital*, National Patient Safety Agency
[85] *Safety in doses – Improving the use of medicines in the NHS,* National Patient Safety Agency, 2009
[86] *Safety in doses – Improving the use of medicines in the NHS,* National Patient Safety Agency, 2009

Reducing hospital acquired infections including C. difficile and urinary tract infections

Further guidance on reducing infection is likely following these issues being flagged in the NHS Strategy 2010 – 2015 and in the *High Impact Actions* report.[87]

Preventing pressure ulcers

Further guidance on reducing pressure ulcers is likely following this being flagged in the NHS Strategy 2010 – 2015 and in the *High Impact Actions* report.[88]

Effectiveness

In order to ensure that older people receive the most effective care it will be important to ensure that decisions on access to treatments for older people are based on good clinical evidence rather than age-related assumptions about treatments. Increasingly, the evidence base should include effectiveness of care and treatment from the perspective of older people. Older people should be involved in commissioning and monitoring services, ensuring that quality indicators and outcomes are relevant to older people.

Quality and productivity

NHS Evidence has a resource section on quality and productivity setting out examples of how to improve both quality and productivity. There are a number of examples relating to the care and treatment of older people:

→ www.library.nhs.uk/qualityandproductivity

Nutrition

The effectiveness of care is assisted and enhanced by ensuring good nutrition and hydration in hospital. There are many initiatives around the country aiming to improve the way that older people are provided food in hospitals. One is the red tray system for identifying patients who require assistance at mealtimes. Food served on a red tray provides an effective signal to staff without compromising the patient's dignity.

The system is being monitored and refined, but has been found helpful in promoting individual care and staying alert to changing nutritional requirements. Designating patients who receive a red tray is part of initial and continuing assessment, and a daily updated list of patients due to receive food on red trays can be included in shift handovers and provided for kitchen staff. A red tray is also a simple reminder to staff to check the patient's notes for guidance on any specific help or nutritional needs.

Other ways to improve the provision of food to older people include:

- protected mealtimes – avoiding routine clinical activities at mealtimes to enable a focus on the food and eating

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[87] *High Impact Actions for Nursing and Midwifery,* Department of Health et al, 2009
[88] *High Impact Actions for Nursing and Midwifery,* Department of Health et al, 2009

- using volunteers to assist at mealtimes on wards – socialising with patients and helping them to eat where required
- use of the *Malnutrition Universal Screening Tool* (MUST) and personalised dietary care plans.

5.5 Case studies of illustrative / good practice

Volunteers and Mealtimes project

United Bristol Healthcare NHS Trust

The Trust has introduced a range of initiatives to improve nutrition and dignity at mealtimes, including the *Volunteers and Mealtimes* project, established on one ward to provide more assistance to elderly patients. The project set out to recruit volunteers to make mealtimes on the ward a more social occasion.

Following its success, more mealtime volunteers were recruited, each one attending a multi-professional half-day programme of training. The hospital is considering extending the idea to other wards.

Further information
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jayne.weare@ubht.nhs.uk

Facilitating dignified communication

Ashford and St Peter's Hospitals NHS Trust

The trust's Communication Group looks at how the communication needs of patients can be met. Clinical care indicators monitor the fundamentals of care and the patient communication interview, undertaken by the Patients' Panel, highlights any areas of concern or best practice regarding communication.

The group has undertaken extensive work to address the communication needs of individuals, in particular those with communication difficulties, and is currently building up a supply of equipment within the trust to facilitate more effective and dignified communication. These include Royal National Institute for the Deaf (RNID) crystal loop listeners, wipe-clean A4 boards and speech amplifiers.

Further information
Harriet Stephens, Lead Nurse, Practice Development. Tel 01784 884940.
harriet.stephens@asph.nhs.uk

Nutrition

Accrington Victoria Hospital

At Accrington Victoria Hospital, every patient in the intermediate care stroke rehabilitation ward has an assessment of nutritional status on admission. The *Malnutrition Universal Screening Tool* (MUST)and a comprehensive multi-disciplinary assessment help to categorise patients into low, medium or high risk of malnutrition and to develop individualised dietary care plans.

Regular assessments and reviews are performed through multi-disciplinary evaluation and with the involvement of the patient and relatives, nutritional support is considered and given in the form of oral liquid nutrition, oral dietary supplements or intravenous or naso-gastric/peg administration where indicated. The choice of meals from patient of black and minority, ethnic (BME) communities includes both an acceptable vegetarian and halal meat diet (significant Muslim population).

In addition, personalised dietary care plans are based on choice of meals with due regard to religious and cultural backgrounds. People with dementia and those with severe disabilities from a physical illness such as a stroke, require help with feeding and this is achieved by awareness training, education and time for ward staff. An audit of nutrition in the elderly followed by a re-audit of patients admitted to the ward has helped to identify best practice.

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Implementing Dignity in Care

Luton and Bedfordshire NHS Trust

The Dignity Champion set up training and workshops and a pilot scheme took place on three wards. The implementation of the Dignity in Care initiatives spread to everyday practices via the establishment of a dozen Dignity Champions in the trust and at least one Dignity Lead on each ward.

When the Champions first met to discuss their role, they each made a pledge. This was followed up at each subsequent meeting to assess progress. The effects of good practice have spread with the result that gender separation exists on wards, 16 dignity pledges are being followed through by the Dignity Champions, a new quiet room has been set up for patients and relatives and a faith room has also been introduced.

(Source: Opinion Leader, *Dignity in Care Campaign Case Studies*, Nov 2009 p14, Department of Health)

Dignity in toileting

University Hospital of North Staffordshire, Stoke-on-Trent

The Dignity Champion, a matron at the University Hospital of North Staffordshire, found there was a general acceptance of the use of commodes amongst patients and staff in wards for older people. She was of the opinion that commodes are the most undignified pieces of equipment available to hospital staff yet they are commonly used for transport in addition to toileting.

On taking on her ward in 2008, one of the Dignity Champion's main aims was to reduce the number of commodes in use. She has succeeded in this at the same time as encouraging staff to take patients to the toilet if they are able to walk there, or transporting them on the new ARJO Steadys, a type of lightweight mobile chair, rather than toileting by the bedside which is now the exception rather than the rule.

Staff are now accustomed to transporting patients in the ARJO Steadys and patients are more than willing to use them. They generally only need one member of staff per patient unlike commodes that require two.

The Dignity Champion was successful in obtaining funding for additional ARJO Steadys on her four wards. She now has two per ward and plans for more. They are easy to use and to keep clean and hygienic. Patients and staff alike are in favour of the great improvement in dignity and privacy on the wards as a result of the use of the new equipment. The Dignity Champion has discussed this improvement with a consultative group that she meets on a regular basis, the Newcastle 50+ Forum, and they too have applauded the enhanced patient care.

(Source: Opinion Leader, *Dignity in Care Campaign Case Studies*, Nov 2009 p14, Department of Health)

Preventing falls in York

York NHS Trust

York NHS Trust conducted one of the largest studies of multifaceted interventions to prevent falls in hospital in six elderly medicine wards and two community hospitals, to achieve a significant reduction in the number of falls. The aim was to change the perception that falls are normal.

The study involved staff routinely looking for reversible risk factors for falls, and doing something about them. Assessments were made as straightforward as possible. For example, staff would stand at the end of the bed and hold up a pen and ask the patient: "What am I holding?" This indicated if there were any major eyesight problems.

The care plan gave the names of types of medication that might cause falls, so checking for them was easier. Urine was tested on the ward to find possible urinary tract infections, which could affect mobility and cause confusion. Blood pressure was checked with the patient both lying down and standing up. There was a yellow sticker to put inside patients' notes that alerted doctors if a patient had fallen.

Inappropriate footwear was a big problem: many patients were wearing loose or 'sloppy' slippers, some had very unsafe footwear, or slippers had become wet or soiled and patients had to rely on hospital-provided foam disposable slippers which tear and hang off the feet. The hospital secured a small budget to buy some properly fitting slippers, in a range of sizes, for giving to patients when there are no relatives able to bring suitable footwear in. A repeat audit found a big reduction in unsuitable footwear.

The physiotherapists had found that nurses tended to tidy the walking aids into one corner where the patients couldn't reach them. Staff made sure that patients who could safely use a walking aid on their own had one labelled with their name and kept within easy reach.

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(Source: *Slips, trips and falls in hospital*, Patient Safety Observatory, 2007, National Patient Safety Agency)

Seeing yourself as an older person

This practice example is underpinned by the assertion that exploring one's own feelings and expectations about older age is an important component in being able to develop relationships with older people and challenge ageist attitudes. Using principles developed with student nurses, hospital nursing staff were asked to think about and then draw themselves, aged 80. Nurses were then invited to explain any aspects of their drawing to their colleagues.

Through this exercise similarities and differences in attitude around older age emerged, e.g. whether nurses drew themselves as being alone, with one other person or as part of a wider community. The physical characteristics of ageing were an obvious focus of the pictures.

A discussion ensued around carer attitudes and how ideas about capacity and need can be based on physical appearance rather than conversations with the older person themselves. Nurses commented on how the exercise was enjoyable and thought-provoking. Using this simple but powerful tool in a safe and facilitated place, ward nurses were able to examine their attitudes and ambivalences about ageing and how the care offered to older people is thus affected.

Further information
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(Source: *Picture this, using drawing to explore student nurses' perceptions of older age*, Roberts S, Hearn J and Holman C, Nursing Older People, July vol 5, p1418)

Connecting with older people in hospitals

Working in an acute environment with a high throughput of patients, multiple transfers for individual patients and a focus on time-based targets can militate against connection with older people. Nurses in practice were enabled to know and hold in mind the older people they are caring for through a supported practice by which nurses introduced themselves to patients at the beginning of the shift. Nurses were encouraged to enquire how patients were and if an older person was new to the ward, how they would like to be addressed. This "*simple*" connection was challenging to the practice of some nurses and stimulated discussions around priorities and time pressures. Ongoing support was necessary to facilitate working in a different way and provide an appreciative stance to these morning conversations.

Further information
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(Source: Best Practice for Older People in Acute Settings (BPOP): Guidance for Nurses, Bridges J, Flately M, Meyer J and Nicholson C*,* RCN Publishing Company/City University London, 2009)

5.6 Suggestions for quick wins / what you can do now

- Look at last year's Annual Health Survey results to analyse how older people are experiencing the quality of the service.
- Seek other local information about older people's experiences of using health services (for example from local voluntary organisations or LINks).
- Review complaints from older people (65+) over the past two years and report trends to the primary care trust board.
- Work with local older people to seek solutions on how to address their main concerns about quality of services.
- Appoint older people's/dignity champion to the board.
- Ensure that medication, and other patient safety incidents, are reviewed on an age-related basis, discussed in clinical governance meetings and trends reported to the board.

5.7 Useful resources

Best Practice for Older People in Acute Care Settings (BPOP)
Guidance for Nurses (2009) Written by Dr Jackie Bridges, Dr Mary Flatley, Professor Julienne Meyer and Dr Caroline Nicholson, City University London. Available as CD and booklet.

Dignity Champions *Toolkit for Action*

→ www.dhcarenetworks.org.uk/dignityincare/Topics/Browse/ToolkitForAction/

Privacy and dignity – A report by the Chief Nursing Officer into mixed sex accommodation in hospitals
Makes recommendations and practical suggestions for improving the situation with regard to mixed sex accommodation.

→ www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_074548.pdf

Help the Aged/Picker Institute, 2008, On our own terms - The challenge of assessing dignity in care
Help the Aged provides a useful table (p8-9) outlining what should be measured to assess whether health and social care services support the dignity of older users.

Chapter 6
Involving older people

6.1 Key audiences

- chief executives and boards of primary care trusts and emerging GP commissioning consortia, NHS trusts and NHS foundation trusts
- primary care trust directors of commissioning
- governors of NHS foundation trusts
- GP commissioners
- Patient,carer and public engagement leads
- all healthcare professionals
- LINks hosts and third sector organisations.

6.2 Key issues and concerns

General

- Patient and public engagement is now a mainstream activity, underpinned by statutory responsibilities for both commissioners and providers.
- Involving/engaging older people and carers is beneficial for NHS organisations.
- In spite of well established and published good practice in engaging with older people, the picture remains patchy.
- Tackling ageism is part of involving/engaging older people.
- Non-executive directors in primary care trusts, NHS trusts and governors in foundation trusts can provide leadership in engaging older people and their carers
- Some older people may tend to be excluded from engagement activities, particularly when age is compounded by other factors such as disability or ethnicity. Primary care trusts and hospital providers need to ensure that they are proactive in listening and responding to black and minority ethnic communities and 'seldom heard' groups.

About involving older patients and their carers in their own treatment and care

- Involving individuals in their own care is an integral part of patient-centred care and is an aspect of a personalised approach to healthcare. It also makes sense to involve their carers and families in many instances

- Information for older people and carers may need to be geared to their particular needs and provided in appropriate formats.
- Help may be needed to support older people in making choices.
- Advocacy can be helpful in supporting older people and carers to make their voices heard.
- Self-management needs to be fine-tuned to meet the needs of older people.

About working in partnership with patients, carers and the public

- Local Involvement Networks (LINks) and Overview and Scrutiny Committees (OSCs) are important means of engagement and local scrutiny. See Recommendation 19 of *Achieving age equality in health and social care.*[89]
- The third sector continues to engage older people in ways that are both appropriate and acceptable to their needs.
- It is important to engage older people, both as individual patients and carers, and as members of the public/members of communities.
- No single method or approach is adequate to engage with patients, carers and the public.
- Co-production, co-design and a rights-based approach are important principles underlying the involvement of older people.
- Involvement is a process, not an event. A range of methods will be appropriate for different purposes; ample material is available to inform the choice of approach.

General issues and concerns

Patient and public engagement is now a mainstream activity, underpinned by statutory responsibilities

The growth of patient and public involvement in healthcare has a long history, but it is only relatively recently that it has moved into the mainstream, with a strong commitment from Government and with statutory obligations to engage with patients and the public. See 'Drivers and policy imperatives' in this section.

However, there is evidence that, in spite of a range of established good practice in engaging with older people across the public services, the picture remains patchy.[90] [91] [92]

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[89] *Achieving age equality in health and social care*, Sir Ian Carruthers and Jan Ormondroyd, Department of Health, 2009
[90] *Review of Older People's Engagement with Government, Report to Government*, Sir John Elbourne, Department of Work and Pensions, 2008
[91] *Living well in later life: a review of progress against the National Service Framework for Older People*, HCC, CSCI and Audit Commission, 2006

Involvement and engagement with older people is not only desired by many older people and their organisations. It is also extremely useful for NHS organisations, who would otherwise lack a major source of intelligence about local needs and how services are perceived and experienced by local people. This is recognised within Competency 3 of *World Class Commissioning.*[93]

As older people are major users of health services, their participation is vital. However, user consultation and involvement structures for older people's services tend to be less well targeted than those for younger age groups.

Tackling ageism is part of involving/engaging older people

Tackling ageism and promoting age equality are essential foundations for the successful engagement of older people. If older people feel that they are being disrespected or not taken seriously, they will find it difficult or impossible to engage successfully with NHS organisations at either an individual or community level. A 2006 report found that there was still evidence of ageism across all services. This ranged from patronising and thoughtless treatment from staff, to the failure of some mainstream public services to take the needs and aspirations of older people seriously. The report noted that there is a need to improve information and community engagement and to have detailed information about the needs of the population when planning services.[94]

Leadership for patient and public engagement

Good leadership is essential to the effective engagement of older people and carers. Non-executive directors in primary care trusts and NHS trusts, and governors in foundation trusts, can take a leadership role in promoting effective engagement.

Also see Chapter 3 Leadership and motivation.

Dual discrimination

In the context of patient and public involvement it is important to note that some older people may tend to be excluded from engagement activities, particularly when age issues are compounded by other factors such as disability or ethnicity. For example, frail older people and residents of care homes and older people with dementia have tended to be less involved than other groups of older people. Similarly, older people whose first language is not English may experience indirect discrimination in relation to engagement with the NHS if their particular needs are not recognised.

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[92] *A stronger local voice, Concluding the review of patient and public involvement Recommendations to ministers from Expert Panel*, Department of Health, 12 May 2006 www.dh.gov.uk/dr_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_4137042.pdf

[93] *World Class Commissioning,* Department of Health, 2007

[94] *Living well in later life: a review of progress against the National Service Framework for Older People,* HCC, CSCI and Audit Commission, 2006

Involving older patients and their carers in their own treatment and care

Involvement of individuals is part of personalisation

Involving individuals in their own care is an integral part of patient-centred care and is an aspect of a personalised approach to healthcare. Carers and families can play an important role in personalisation as they can help people they support exercise choice and control. People of all ages need to be enabled and empowered to be as involved as they wish in their own healthcare by a number of means, as outlined below. There is evidence that this leads to better outcomes and in many situations is a cost effective intervention. However there is little data on whether the benefits of involvement are different for older people.

The provision of appropriate information in accessible formats

There may be particular issues for some older people who may be more likely than younger people to need larger print or other media. Care should be taken to ensure that information is appropriate and accessible for all ages, bearing in mind that in spite of increasing computer use amongst all ages, older people may be less likely to have access to online information. In the context of seeking information about hospitals, internet information was much more commonly mentioned by those aged under 60 (51 per cent) than by those in the older age group (19 per cent).[95]

It is important to consider the specific information needs of older people and carers in terms of form and content, particularly the needs of older people with additional needs. Not doing so may be regarded as a failure to promote equality under the new public sector equality duty in the Equality Act.

Types of information

A recent report states that different groups of people value different types of information but the literature suggests that the majority of patients will be interested in both technical and interpersonal aspects of care and they will want 'stories' and 'data' as well as contextual information about their local health service, including the staff.[96]

→ www.hsmc.bham.ac.uk/publications/policy-papers/Supporting_patients-PP4-4.pdf

Choice of provider, with assistance and advice in making choices

While choice can be beneficial for all age groups, people may need help and support in making choices. The choices available to older people may also be constrained by mobility problems that may be more common among older age groups. It is also important to ensure that systems such as Choose and Book are

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[95] *Patients' experience of choosing where to undergo surgical treatment - Evaluation Of London Patient Choice Scheme*, Coulter A, Le Maistre N and Henderson L, Picker Institute Europe, July 2005

[96] *Supporting patients to make informed choices in primary care: what works?* Ellins J and McIver S, in association with NHS West Midlands, University of Birmingham Health Services Management Centre, Policy paper number 4, May 2009

accessible to older people, some of whom may have difficulties in using telephone keypads to select from a menu of options.

A recent King's Fund report states that even though choice of hospital has been on offer since January 2006, there is very little evidence available about whether patients have been actively choosing where to have their treatment. The King's Fund reports that data from the Department of Health's National Patient Choice Survey shows an upward trend in patients recalling being offered choice from their GP: 45 per cent of patients referred for treatment recalled being offered a choice by their GP in September 2007 compared to 30 per cent in May 2006. The conclusion is that awareness of choice has been growing, but is still low.[97]

One study found that younger people (under 60) were slightly more likely to be willing to travel for faster treatment (61 per cent) than those in the older age group (56 per cent). Younger people were more willing than older people to consider going to an alternative hospital to their 'home' hospital (88 per cent of those aged under 60, compared to 76 per cent of those over 60).[98]

Help in making decisions

Many people – including older people – can benefit from help in making decisions about the benefits and burdens of treatment, and the relative merits of different treatment options. There are a number of decision aids available to assist patients. Decision aids are structured tools for helping people to make healthcare decisions. Some consist of evidence-based information about different options and their outcomes. It is important to offer age-appropriate decision aids.

A report asserts that evidence-based patient decision aids facilitate the process of making informed decisions about disease management and treatment. Decision aids can improve a patient's knowledge and level of involvement in treatment decisions. They also give patients a more accurate perception of risk and encourage appropriate use of elective procedures.[99]

Advocacy

Independent advocacy may be of benefit to older people in empowering them to be involved in their own healthcare and in shaping future services. The Department of Health website states:

> *Advocacy services assist people in getting heard and getting the services they need. Advocacy also assists services in becoming more responsive and meeting the needs of people more effectively.*

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[97] *Free choice at the point of referral,* King's Fund Briefing, 2008

[98] *Patients' experience of choosing where to undergo surgical treatment - Evaluation Of London Patient Choice Scheme*, Coulter C, Le Maistre N and Henderson L, Picker Institute Europe, July 2005

[99] *Where are the patients in decision-making about their own care?* Coulter A, Parsons S and Askham J, World Health Organization 2008 and World Health Organization, on behalf of the European Observatory on Health Systems and Policies, 2008

→ www.dh.gov.uk/en/SocialCare/Deliveringadultsocialcare/Advocacy/index.htm

Also, independent advocates from a wide range of backgrounds can help people to understand their rights to be treated fairly and to challenge decisions where they are not treated fairly. This can play an important part in ending age discrimination.

Carers and others close to older people can also play a part as informal advocates.

Self-management and expert patients

Educating patients about self-management can improve their knowledge and understanding of their condition, coping behaviour, adherence to treatment recommendations, sense of self-efficacy and symptom levels.[100]. A report from the Health Foundation as part of their Quest for Quality and Improved Performance Programme (QQIP) stated that self-management education programmes have been largely successful in improving knowledge and coping skills.[101]

The Expert Patients Programme (EPP) is a lay-led self-management programme that has been specifically developed for people living with long-term conditions. See:

→ www.expertpatients.co.uk

Self-management programmes - whether as part of the EPP or any other programme - should be offered at times and places that are attractive to older people, and should be fine-tuned to meet their needs. Simplistic assumptions that older people cannot self-manage would be ill-founded and could be regarded as discriminatory. For example, a review of the literature on self-management of diabetes care concluded that the cognitive impairment associated with relatively uncomplicated type 2 diabetes in older adults is unlikely to adversely affect self-management of the illness.[102]

Work is currently underway by the Picker Institute Europe to look at self-management support among older adults. See:

→ www.pickereurope.org/selfcare

Involving individuals at all stages of life

It is important to ensure that the involvement of individuals in their own care continues throughout old age, including at the end of life. A publication by Help the Aged[103] found that some people felt unprepared for their relative's death, due to a lack of transparency in discussing prognosis, decision-making, treatment and care. One of the report's recommendations was that listening to older adults, expressing

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[100] *Where are the patients in decision-making about their own care?* Coulter A, Parsons S and Askham J, World Health Organization 2008 and World Health Organization, on behalf of the European Observatory on Health Systems and Policies, 2008

[101] *Patient-focused Interventions: A review of the Evidence*, Coulter A and Ellins J, The Health Foundation, 2006

[102] *Cognitive Functioning and Self-Management in Older People With Diabetes*, Asimakopoulou K, and Hampson S E, Diabetes Spectrum, April 2002, vol. 15 no 2 116-12

[103] *Listening to older people - Opening the door for older people to explore end-of-life issues*, Help the Aged, 2006

compassion and concern, and enabling continuity and familiarity of care should be seen as priorities. Clearly, these are activities that require the involvement of older people.

Working in partnership with patients and the public

At the level of the local community there are two specific legal entities that put forward the public's voice in shaping health and social care locally – Local Involvement Networks (LINks) and Overview and Scrutiny Committees (OSCs). Recommendation 19 of *Achieving age equality in health and social care*[104] refers to the use of local scrutiny processes and bodies such as Health Overview and Scrutiny Committees to provide transparency and build public confidence. It also refers to the involvement of members of the public in the work through LINks, forums and other networks. The work of the review of age discrimination has shown that many LINks are interested in how they can engage to help end age discrimination and equality.

Local Involvement Networks (LINks)

Local Involvement Networks (LINks) aim to give citizens a stronger voice in how their health and social care services are delivered. Run by local individuals and groups and independently supported, the role of LINks is to find out what people want, monitor local services and to use their powers to hold them to account.

LINks are made up of individuals and community groups, such as faith groups and residents' associations, working together to improve health and social care services for each upper tier local authority (usually co-terminous with a primary care trust).[105]

Overview and scrutiny committees

The powers of Overview and Scrutiny Committees (OSCs) were extended in 2001 beyond local authority services to cover the scrutiny of local health services. Upper tier councils with social service responsibilities are required to establish local arrangements to scrutinise health services provided or commissioned by local NHS bodies. They have the authority to refer specific issues to the Secretary of State, who may seek the advice of the Independent Reconfiguration Panel (IRP).[106] See:

→ www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_4066238.pdf

Although OSCs have no formal role in relation to ensuring equality, many local OSCs will seek reassurance that changes in health services do not have age discriminatory consequences and will be especially interested in reviewing the Equality Impact Assessment for any proposal. Additionally, OSCs also gather

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[104] *Achieving age equality in health and social care*, Sir Ian Carruthers and Jan Ormondroyd, Department of Health, 2009
[105] *Listening and responding to communities – a brief guide to Local Involvement Networks,* Department of Health, 2008
[106] *Overview and scrutiny of health – Guidance*, Department of Health, 2003

community views and information from a range of third sector organisations working with older people.

No single method or approach is adequate to engage with patients, carers and the public

A range of methods are used to engage patients, carers and the public including:

- the provision of information to support people to become involved
- surveys, questionnaires and opinion polls, including deliberative polls
- citizens' juries
- patients' and citizens' panels (meeting and/or by electronic means
- public meetings
- going out to local groups and community events to engage in dialogue
- focus groups
- formal consultations.

There is no single method that is appropriate for engaging patients, carers and the public and, indeed, it is unhelpful to begin by thinking about methods. Rather, when planning activities to involve patients and the public, you should first think about the purposes of doing so and what you and they can hope to get out of it.

It is usually important to seek patient and carer feedback as part of involvement and engagement, making use of both quantitative survey data and qualitative patient stories. Older people may have specific issues on which they wish to engage and may require particular methods to enable them to do so, particularly those who have additional needs. Failure to properly address these concerns would be a failure to promote age equality and could be seen as age discrimination.

NHS organisations that are seeking to engage older people should ensure that they are aware of issues that are important to older people from sources such as the annual patient survey, carer experience surveys (for example the survey published by the Information Centre http://www.ic.nhs.uk/pubs/psscarersurvey0910) and other surveys that may be carried out within their organisation. Also see Chapter 5 High quality care for all.

Engaging older people about age discrimination and equality requires careful thought about what tools and methods to use. Age discrimination may not be well understood, not least because what some people may regard as discrimination is simply poor quality service for people of all ages. From the engagement workshops undertaken by the age discrimination review team, it is clear that effective engagement about age discrimination requires an interactive process combining listening and responding to people's views and sharing information about the nature and evidence for age discrimination.

NHS Evidence's specialist collection on patient and public involvement is a good place to find further information on the wealth of material on how to engage with communities and methods for doing so. See:

→ www.library.nhs.uk/PPI

Social marketing

Social marketing is a systematic process that utilises a range of marketing techniques and approaches to achieve a particular social good (rather than commercial benefit), with specific behavioural goals clearly identified and targeted. Drawing on commercial marketing techniques, social marketing has been around for many years but has relatively recently become more prominent in relation to the NHS.

It can be argued that the concept of social marketing is at one end of the spectrum of patient and public engagement, since it is about understanding values, beliefs and behaviours in order to market key health messages, rather than to engage on what the priorities for health messages should be. However, in another sense, social marketing can be seen as a means of engaging with the local community in order to better understand their concerns. It would, however, be important to ensure that social marketing approaches did not exclude or discriminate against older people.

The Department of Health published *Ambitions for health: a strategic framework for maximising the potential of social marketing and health-related behaviour*. It sets out how the Department of Health plans to work together with key leaders in the public health community to embed social marketing principles into health improvement programmes.[107]

Co-design and co-production

Increasingly, NHS organisations are engaging with local people as equal partners, and the terms co-design and co-production are gaining currency. The thinking behind both terms is an equal and reciprocal relationship between professionals and service users and/or the wider community. It has been said that where activities are co-produced, both services and neighbourhoods become far more effective agents of change.[108]

It is important to consider how to ensure that older people and carers are enabled to be fully involved in co-design and co-production and how to overcome any barriers that minimise their opportunities to do so.

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[107] *Ambitions for health: a strategic framework for maximising the potential of social marketing and health-related behaviour*, Department of Health, 2008

[108] *The Challenge of Co-Production*, *How equal partnerships between professionals and the public are crucial to improving public services,* Boyle D and Harris M, NESTA, 2009

6.3 Drivers and policy imperatives

Cross-government policy on engaging with older people

Building a Society for All Ages[109]

Issued as a consultation document in July 2009, *Building a Society for All Ages* is the Government's strategy for making improvements to older people's lives. It is broad in its scope and implicitly promotes the active involvement of older people in all aspects of economic and social life and makes reference to the importance of ending age discrimination in improving public services for older people.

Review of Older People's Engagement with Government - John Elbourne – Report to Government[110] *and Empowering Engagement: a stronger voice for older people*[111]

A review of older people's engagement with government[112] was followed in 2009 by the Government's response.[113] Although largely concerned with establishing a UK Advisory Forum on Ageing at a national level, it also referred to setting up regional (and local) structures for feeding into this forum. It also referred to encouraging the appointment of local authority champions and setting up local forums where they do not already exist. Mention was made of plans to put in place regional coordinators to strengthen the network of local authority forums and to champion older people. The Government also said that it would provide guidelines for the strategic engagement of older people for the benefit of local authorities and other organisations.

General policies about engagement and involvement in the NHS

NHS duty to involve [114] [115] [116]

Legislation which came into force in 2003, placed a duty on certain NHS organisations to involve and consult people when it comes to making changes to services.

Section 242 of the consolidated NHS Act 2006 placed a duty on NHS trusts, NHS foundation trusts, primary care trusts and strategic health authorities to make arrangements to involve patients and the public in service planning and operation, and in the development of proposals for changes.

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[109] *Building a Society for All Ages,* HM Government, 2009
[110] *Review of Older People's Engagement with Government – Sir John Elbourne – Report to Government***,** Department of Work and Pensions, 2008
[111] *Empowering Engagement: a stronger voice for older people,* Department of Work and Pensions, 2009
[112] *Review of Older People's Engagement with Government, Report to Government*, Sir John Elbourne, Department of Work and Pensions, 2008
[113] *Empowering Engagement: a stronger voice for older people,* Department of Work and Pensions, 2009
[114] Section 242, NHS Act 2006
[115] Local Government and Public Involvement in Health Act, 2007
[116] *Department of Health Guidance – Real Involvement*, 2008 and *Real Accountability, 2009*

Although these duties strengthened the voice of communities, NHS managers have not always been clear when they have to involve people and how best to do this. The changes to the law introduced by the Local Government and Public Involvement in Health Act 2007 aim to make this clearer.

A strengthened 'duty to involve' came into force on 3 November 2008. The duty requires certain NHS organisations to involve users of services in the planning and provision of services.

In addition a new duty on primary care trusts and those strategic health authorities (SHAs) who commission services (currently this is London SHA commissioning highly specialised services), to report on how consultations they have undertaken have shaped commissioning decisions locally, came into effect in October 2009.

Real involvement: working with people to improve services

Provides statutory guidance for NHS organisations on the updated duty of involvement and advice about the new duty of reporting on consultation and best practice on embedding involvement in organisations.

When developing and considering proposals for changes in the way services are provided, or when making decisions affecting the operation of services, the organisations to which the duty applies are under a duty to involve. The duty applies where the proposals or decisions have an effect on the way in which services are delivered to users or on the range of health services available to users.

In applying all of the legislation and guidance NHS organisations will wish to ensure that they are not excluding or discriminating against older people.

NHS Constitution[117]

The NHS Constitution was published on 21 January 2009. It was one of a number of recommendations in Lord Darzi's report *High Quality Care for All*. The core purpose and values of the NHS are reinforced by placing a duty on providers and commissioners of NHS services to have regard to the new NHS Constitution. From 19 January 2010, following the successful passage of the Health Act through Parliament, all providers and commissioners of NHS care are under a new legal obligation to have regard to the NHS Constitution in all their decisions and actions. The Constitution brings together a number of rights, pledges and responsibilities for staff and patients.

The **first principle** on which the NHS Constitution is based states that:

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[117] **NHS Constitution,** Department of Health, 2009

> *The NHS provides a comprehensive service, available to all irrespective of gender, race, disability, age, sexual orientation, religion or belief.*

This resonates with the duties to end age discrimination and promote equality in the Equality Act. The NHS Constitution is also particularly pertinent to patient and public engagement in several places e.g.:

> ***Principle 4:*** *NHS services must reflect the needs and preferences of patients, their families and their carers.*
>
> ***Principle 7:*** *The NHS is accountable to the public, communities and patients that it serves.*

Also, one of the pledges in the NHS Constitution states:

> *You have the right to expect your local NHS to assess the health requirements of the local community and to commission and put in place the services to meet those needs as considered necessary.*

The NHS Constitution also has a section entitled *Your Involvement in your healthcare and in the NHS,* which states:

> ***You have the right*** *to be involved in discussions and decisions about your healthcare, and to be given information to enable you to do this.*
>
> ***You have the right*** *to be involved, directly or through representatives, in the planning of healthcare services, the development and consideration of proposals for changes in the way those services are provided, and in decisions to be made affecting the operation of those services.*

There is also a commitment to provide patients with the information that is needed to influence and scrutinise the planning and delivery of NHS services and to work in partnership with patients, families and carers, carers and representatives.

Carers at the heart of 21st century families and communities: a caring system on your side, a life of your own[118]

The Government's Carers' Strategy encourages partnership working between the health, social care and third sectors.[119]. It is important to ensure that the views of carers are sought as well as those of patients and the general public.

World Class Commissioning[120]

World Class Commissioning is a vision for commissioning for better outcomes, backed up by a set of defined organisational competencies. Several of these are particularly pertinent to the need to engage with patients and the public, notably

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[118] *Carers at the heart of 21st century families and communities: a caring system on your side, a life of your own HM Government,* 2008
[119] *Carers at the heart of 21st century families and communities: a caring system on your side, a life of your own,* HM Government, *2008*
[120] *World Class Commissioning*, Department of Health, 2007

Competency 3: (Engage with public and patients), although other competencies are relevant too. *Achieving age equality in health and social care* specifically makes a recommendation about WCC:

> *"The Department of Health should ensure there are clear and emphatic references to ending discrimination in relation to the eight protected characteristics (including age) and advancing equality in the 2010/11 World Class Commissioning assurance process."* [121]

6.4 What good age-equal practice might look like

Engagement with older people as an ongoing process

At a local level, NHS organisations will engage with older people as a regular and routine part of their work. Older people at local events across England to discuss age equality during 2009 as part of the consultation on *Achieving age equality in health and social care*[122] emphasised that they wished to be involved at the earliest possible opportunity, and not just at the stage of a formal consultation, as they wished to maximise their influence when options were genuinely at a developmental stage.

Involving older people in commissioning

Older people should be involved, as would other age groups, at all stages of the commissioning cycle, although different approaches to engagement may be necessary for each of the main stages. A document that has been developed to assist commissioners to engage with patients and the public sets out three stages of the commissioning process, and identifies two purposes for patient and public engagement in each, as follows;

- Strategic planning:
    - Engaging communities to identify health needs and aspirations
    - Engaging public in decisions about priorities
- Specifying outcomes and procuring services:
    - Engaging patients and carers in service design and improvement
    - Patient-centred procurement and contracting
- Managing demand and performance management:
    - Capture and use of patient and carer experience data
    - Patient-centred monitoring and performance management.

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[121] *Achieving age equality in health and social care*, Sir Ian Carruthers and Jan Ormondroyd, Department of Health, 2009

[122] *Achieving age equality in health and social care*, Sir Ian Carruthers and Jan Ormondroyd, Department of Health, 2009

The e-cycle[123] has been developed by David Gilbert, Director of InHealth Associates, on behalf of the Department of Health. It is based on work carried out with Croydon Primary Care Trust.

Contact with third sector organisations

Voluntary and third sector organisations can add value to the commissioning process and to designing service delivery in a number of ways, including their ability to work across public sector boundaries, and so help with partnership working, and by capturing the experience of users and carers and providing feedback on the services commissioned. They can also provide innovative services that support older people. There is little general evidence, however, of widespread involvement of the voluntary sector in the Joint Strategic Needs Assessment (JSNA) process and there is a need for primary care trusts and local authorities to support capacity building in the third sector so that the contribution of voluntary sector partners can be realised[124]

Good age-equal practice will, therefore, include engagement with third sector organisations who can contribute in some way to improving services for older people, either by involvement in commissioning or as providers.

Contact with older people's organisations

In 2006 a major review also found there was evidence of some engagement with older people but they were not involved systematically in the design of services, nor were services tailored to their needs and aspirations. Health organisations and local authorities were not always effective in engaging with black and minority ethnic groups and with other older people whose voices are seldom heard.[125]

Good age-equal practice would include regular contact with local organisations of older people such as older people's forums (which might have a variety of names at a local level). These can add an extra dimension to contact with organisations that represent the interests of older people at a national and regional level.

6.5 Case studies of illustrative / good practice

A number of helpful case studies on using patient feedback can be found in *Using patient feedback: a practical toolkit*.[126] See:

→ www.pickereurope.org/usingpatientfeedback

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[123] *The e-cycle - Developing patient and public engagement to support commissioning,* October 2008

[124] *Third Sector Involvement In Health And Social Care Commissioning - Report Of A Scoping Study*, Levenson R, Jeyasingham M, Joule N, unpublished LTCA, 2009

[125] *Living well in later life: a review of progress against the National Service Framework for Older People*, HCC, CSCI and Audit Commission, 2006

[126] *Using patient feedback: a practical toolkit*, Picker Institute Europe, 2009

Other case studies:

Getting feedback to improve care

West Cheshire Primary Care Trust (PCT)

The PCT wanted to know what people thought of their services. As part of the work to find out about the experiences of the community, they held a number of focus groups and ran a deliberative event.

By taking a simple approach, the PCT got detailed information about people's experiences that they could then use to make services more responsive. For example, the trust found out that people on low incomes didn't know that if they took a taxi to an out-of-hours service they would have their fare reimbursed.

(Source: *Involving people and communities: a brief guide to the NHS duties to involve and report on consultation*. Department of Health 2008)

Selecting a new healthcare provider

NHS South Birmingham

When NHS South Birmingham needed to appoint a new GP provider, they wanted to get the perspective of patients to ensure they made the best choice. Patients were invited to establish a panel to advise on setting up the new practice. Two representatives of the patients' panel also joined the primary care trust (PCT) project team for the appointment of the new provider. The Patient and Public Involvement (PPI) manager provided them with support throughout the process, from agreeing the service specification to interviewing potential providers and making a recommendation to the PCT board.

The panel received feedback on the tendering process and agreed how it would work with the new provider. Patients were also involved in choosing a suitable new site for the practice.

(Source: *Involving people and communities: a brief guide to the NHS duties to involve and report on consultation*. Department of Health 2008)

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Involving Indian women in Derby

Older Indian women from two women's social groups in Derby have taken part in a successful session to help them design services in the NHS. Through story-telling

and role play, the women identified the issues they wanted changed. The session also encouraged participation in existing health forums such as the Derby City Health Panel and the Derby City Local Involvement Network (LINks). The engagement team from Derby City Primary Care Trust played a key role within the session and are committed to running further sessions with the women's groups to explore what practical improvements can be made to health services in the city.

(Source: Newsletter from Age Concern East Midlands Black and Minority Ethnic Elders' Project. Accessed October 2009)

Nottingham Chinese Welfare Association and Nottingham Primary Care Trust (PCT)

The Nottingham Chinese Welfare Association has engaged with the Nottingham Primary Care Trust initiative Change Makers, a new programme to raise awareness of cancer symptoms, so that people benefit from early diagnosis and treatment. Two sessions were held, one on breast cancer, and one on bowel and lung cancer. The newly formed LINks also attended the sessions.

6.6 Suggestions for quick wins / what you can do now

- Involve older people in a review of information on local services to ensure that all information is in formats that are accessible for older people.
- Analyse annual patient survey and any other available material to better understand the issues and concerns of older people. Ensure that third sector organisations with an interest in older people are involved in the Joint Strategic Needs Assessment process.
- Consider how your organisation can help to build the capacity of third sector organisations to be engaged on health and social care issues at a local level.
- Review the level and nature of your organisation's contact with older people's and carers' organisations, and engage in discussion with them about how they would like to be involved with your organisation's ongoing work.

Chapter 7
Developing a workforce to deliver age-equal services

Note: this section of the guide is about the contribution of the workforce to delivering the new legislation in the Equality Act in promoting age equality and banning age discrimination in the provision of services and exercise of public functions. It is not primarily about implementing the *Employment Equality (Age) Regulations 2006* as it is assumed that the necessary measures in relation to that legislation have already been put in place.

7.1 Key audiences

- human resource directors
- chairs and boards of primary care trusts and emerging GP commissioning consortia, NHS trusts and NHS foundation trusts.

7.2 Key issues and concerns

- *"Demographic change, with increasing life expectancy and declining birth rates means that our population is ageing and will continue to do so well into the middle of the 22nd century."* [127]
- In order to achieve best practice and go beyond basic compliance with the law, NHS organisations should consider both employees and volunteers when they consider how to achieve a workforce that can deliver non-discriminatory, age-equal services.
- In some settings and services, older people may particularly appreciate the contribution of older workers.
- Older workers may have particular needs and preferences at work e.g. for flexible working (although workers in other age groups may have similar needs for different reasons).
- All ages in the workforce benefit from training to equip them to treat and care for the increasing numbers of patients in the older age groups in a respectful and knowledgeable manner, and in order to contribute to the ending of age discrimination and the promotion of age equality.

  "Negative attitudes and narrow assumptions about age but particularly about older people, are an important cause of age

[127] *Age diversity in the workforce - why every organisation needs a strategy*, Briefing 2005 – Issue 1, NHS Employers, 2005

discrimination. Action to shape attitudes through training and professional standards is therefore critical." [128]

Demography and the changing workforce

- Nearly one fifth of all workers in the industrialised world are over 50. By 2030 half the UK population will be aged over 50, with one third over 60.
- The proportion of older people is growing, partly because the post war baby boom generation is now entering old age.
- Britain is a maturing society, with lower birth rates and proportionally fewer school leavers entering the labour market.[129]

This means that both in terms of supply and demand, older people are extremely important members of the workforce of health (and other) organisations. Nevertheless, stereotypically ageist attitudes may persist about older people at work. A recent report indicated that stereotypically older people are viewed as warmer and more moral, but less competent whereas younger people are considered to be more capable but less warm and less moral.[130]

The contribution of older workers and volunteers

Older workers and volunteers have the benefit of experience and accumulated knowledge. They are often well placed to advise and mentor younger workers.

It is also sometimes reported anecdotally that older workers who work in 'frontline' posts may be particularly appreciated by some older patients, who may prefer to be cared for by, and to communicate with, staff nearer their own age. The published evidence for this is relatively scant although there are academic articles that support this view.[131] [132]

The relative lack of published evidence should not deter NHS organisations from taking seriously the possibility that some older people prefer to be cared for by people near to their own age. The occasions when older people state their preferences on this matter are limited, often quite informal and are unlikely to be recorded in academic publications, so this issue may appear to be under-researched and/or subject to publication bias. Local commissioners and providers will therefore wish to bear this in mind, and will wish to take steps to understand and respond to local needs and preferences, while also complying with the non-discrimination provisions of employment legislation.

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[128] *Achieving age equality in health and social care*, Department of Health, 2009
[129] *Age diversity in the workforce- why every organisation needs a strategy*, NHS Employers Briefing, Issue 1, 2005
[130] *Attitudes to age in Britain 2004-08*, Department of Work and Pensions Research Report 599, http://research.dwp.gov.uk/asd/asd5/report_abstracts/rr_abstracts/rra_599.asp
[131] *Patient preferences for psychological counsellors: Evidence of a similarity effect*, Furnham A, Swami V, Counselling Psychology Quarterly, Volume 21, Issue 4, December 2008, pages 361 - 370
[132] *Older Adults' Preferences for Age and Sex of a Therapist*, Lauber B M, Drevenstedt J, Clinical Gerontologist, Volume 14, Issue 2, March 1994, pages 13 – 26

Older people's preferences for older workers may be particularly relevant in services where younger people are generally (though not necessarily accurately) seen as the main potential users e.g. sexual health, substance misuse etc. It may also be the case in some aspects of mental health services, such as talking therapies, where older people may feel that staff who are close to their own age may be more able to relate to their own experiences.

Support for older workers and volunteers

If older workers and volunteers are to be fully able to play their part in delivering the personalised care that older people (and others) require, they may need particular kinds of support. In many respects the needs of older workers and volunteers are similar to workers of all other ages. However, some older people in the workforce prefer to work part time or flexible hours (as do some of their younger colleagues). Sensible and progressive employment polices will benefit all ages. Some – though by no means all – older workers may wish to continue to work and use their skills, while not wishing to retain all the responsibilities they had earlier in their career. For these reasons, employers need to discuss with their workforce how best to support the needs and aspirations of workers of all ages.

Practical advice on developing an age strategy that addresses these, and other, points can be found in *Briefing 35 – Developing an age strategy: a step-by-step guide*.[133]

Training and development

Training and development is at the heart of enabling the health and social care workforce to deliver an age-equal and age-appropriate service, and to eradicate unjustified age-discrimination. This is a very clear message in *Achieving age equality in health and social care:*[134]

> *"An understanding of the new legal requirements set out in the Equality Bill and, crucially, of how these requirements align with the professional values and ethical obligations of health and social care professionals, needs to be clearly conveyed by education and training programmes at all levels of the system and at all stages in the careers of health and social care professionals. All health and social care education and training curricula and programmes will need to be delivered in accordance with the public sector equality duty and the age discrimination ban and this will affect commissioners, providers and assurers of education.* ***All organisations responsible for education and training in health and social care will need to ensure that their curricula and programmes enable staff and trainees to apply the law effectively in time for its commencement. We recommend that the providers of education develop ways of involving older people in the delivery of education programmes, especially to trainees at an early stage in their learning."*** **(Recommendation 15)**

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[133] *Briefing 35 – Developing an age strategy: a step-by-step guide*, NHS Employers, 2007
[134] *Achieving age equality in health and social care*, Sir Ian Carruthers and Jan Ormondroyd, Department of Health, 2009

And

> ***"Local statutory organisations should build into their contracts with providers of training programmes (including third sector and private organisations) the need for an explicit focus on age equality that supports staff in providing high quality services to people of all ages." (Recommendation 16)***

There is a need for more research on the features of a workforce that will deliver an excellent high quality age equality/non-discriminatory service, but it is reasonable to assume that the general and well-recognised features of a high quality workforce are likely to lead to high quality non-discriminatory/equal care.

Age equality training does not stand alone

While specific age equality training is likely to be necessary and useful, it should not be designed in isolation from other aspects of training that will also help to deliver age-equal and age-appropriate services, for example:

- wider equalities and diversity and human rights training
- dignity and respect training
- training on the involvement of patients and the public (including older people).

Training at different stages

Training opportunities should be available and actively promoted throughout the careers of NHS staff and should be available to develop the workforce irrespective of the age of the worker.

There are opportunities for training on age equality at all stages of the careers of health and social care workers, such as:

- induction training
- pre-registration education and training for professional staff
- post registration education and training for professional staff/continuing professional development
- short courses for non-professional staff.

Professional codes and regulation

Achieving age equality in health and social care[135] recognises the importance of professional regulation and codes of practice in advancing equality and ensuring that age discriminatory behaviour is clearly identified as unacceptable and a failure in professional standards. (See Recommendation 14.) Education and training at a local level will need to utilise existing and emerging professional standards in the content of age equality training.

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[135] *Achieving age equality in health and social care,* Sir Ian Carruthers and Jan Ormondroyd, Department of Health, 2009

Training for all kinds of staff to deliver non-discriminatory and age-appropriate services

All types of staff (including those who are registered with a professional body and those who are not) are likely to benefit from training that helps them meet the needs of older patients and to eradicate unjustified age discrimination. This is particularly so as there remains evidence of ageist attitudes in many parts of the NHS, even though it is almost a decade since the National Service Framework for Older People (NSFOP) declared that age discrimination must be eradicated.

> *"The key to eliminating age discrimination in the National Health Service is seen by many to be the raising of awareness of ageist attitudes through education and training both during the pre-qualification period and in post. With older people forming an increasing proportion of patients, the physiological changes associated with ageing should receive increased emphasis in mainstream pre-clinical education and training for all medical staff."*[136]

Recommendation 15 of *Achieving age equality in health and social care*[137] noted that all organisations responsible for education and training in health and social care will need to ensure that their curricula and programmes enable staff and trainees to apply the law (i.e. the Equality Act) in time for its commencement.

Training in conditions that are more prevalent in older people, such as dementia, should be available to all staff and not only those who specialise in working with older people. Indeed, the needs of non-specialist staff for training that equips them to be aware of conditions such as dementia is particularly important.[138]

The content of training

Age Concern and Help the Aged have pointed out that in 2003-04, people aged 65 or over occupied 65 per cent of acute beds and accounted for 63 per cent of all finished consultant episodes, yet current education and training systems do not reflect the majority of patients that healthcare professionals will be working with. They suggest that core skills should cover essential aspects of:

- malnutrition
- incontinence
- mental health and dementia
- dignity and human rights
- care with compassion
- safeguarding and neglect

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[136] *Ageism and age discrimination in secondary health care in the United Kingdom – a review from the literature,* Centre for Policy on Ageing (CPA), 2009
[137] *Achieving age equality in health and social care*, Sir Ian Carruthers and Jan Ormondroyd, Department of Health, 2009
[138] *Better prepared to care – The training needs of non-specialist staff working with older people with mental ill-health,* Levenson R and Joule N, Mental Health Foundation, 2007

- end of life care
- co-morbidities.[139]

Training should also address the needs of carers (many of whom are older people).

While training on the physiological aspects of ageing is essential, training on the positive aspects of old age and on challenging ageist attitudes are equally important components. It is important that training to address ageist attitudes is undertaken by all kinds of staff, including doctors. In the review quoted above, the Centre for Policy on Ageing (CPA) notes that there is some evidence of ageist attitudes held by health practitioners and that doctors may be more ageist than other NHS staff. However, it may be that doctors are the ones most aware of the complexities in the treatment of older people. Ageist attitudes among medical staff may do no more than reflect ageist attitudes in society at large.

7.3 Drivers and policy imperatives

Demographic factors

As discussed above, one of the drivers for change is that there will simply not be enough workers under the age of 65 to carry out all the functions that are required within the NHS. Therefore in addition to a moral case and the legal requirement to be non-discriminatory in employment, it is a fundamental business and operational issue that NHS organisations need to recruit and retain older workers.

Legislation

The Employment Equality (Age) Regulations 2006

The law on age discrimination - whether direct or indirect - applies to employees, job seekers and trainees. It covers the areas of recruitment, terms and conditions, promotions, transfers, training, terminations and retirement. It also prohibits harassment, bullying and victimisation on the grounds of age.

Equality Act

The Act streamlines, harmonises and strengthens existing legislation on discrimination. It combines the existing legislation, covering the so-called 'protected characteristics' such as race, disability and gender, and it introduces two important additional requirements that focus on age.

- A new equality duty on public bodies and others carrying out public functions. The duty applies in relation to age as well as to seven other protected characteristics.
- A ban on age discrimination against adults in the provision of services and exercise of public functions. The existing legislation is about age discrimination in employment but this extension means that it will be

[139] *Response to the National Review of Age Discrimination in Health and Social Care Call for Evidence*, Age Concern and Help the Aged, July 2009

illegal to discriminate in the core activities of the NHS and local authorities – delivering health and social care services to communities and individuals.

In order to comply with the letter and the spirit of the Equality Act, NHS organisations will wish to have an age-diverse workforce to ensure that they can offer services in a non-discriminatory and age-appropriate manner.

See Chapter 2 Definitions, the legal framework and implementation

A high quality workforce: NHS Next Stage Review

In 2008, the Department of Health published *A High Quality Workforce: NHS Next Stage Review*. This report stated that supporting all staff at local level was the main driver for improving services. It also noted that 60 per cent of the staff who will deliver NHS services in 10 years time are already working in healthcare, and it was crucial to boost their training and skills. As well as setting out the role of nurses, doctors, and other health scientists and health professionals, Lord Darzi's report also made important observations about the importance of teamwork. The report states that the core principles that inform all the planned changes outlined in the document are the following:

- focused on quality
- patient-centred
- clinically-driven
- flexible
- valuing people
- promoting life-long learning.

7.4 What good age-equal practice might look like

- NHS organisations would support their workforce in delivering person-centred care, with dignity and respect. They would view age equality as an important aspect of essential good practice in delivering services that are non-discriminatory and that are appropriate for people across the whole age spectrum.
- At times of organisational change, full consideration would be given to whether the skills and competencies needed to deliver age-equal services to older people are being retained. This is important since older people are significant users of many types of health service. Equality impact assessments of proposed organisational and workforce changes should take this into account.
- Commissioners and providers of services for older people would work closely with older people and their organisations in order to meet the needs of older service users in ways that are age-appropriate while not being unjustifiably age-discriminatory. Also see Chapter 6 Involving older people.

- NHS organisations would work with local authority and third sector and independent organisations to explore opportunities for shared training and development on age equality and related areas of training and development.
- Organisational development initiatives would take account of how team working and evolving job plans can help to promote good practice in delivering age-equal services.
- Commissioners and providers of services for older people would be aware that older people are not a homogenous group and that their needs and preferences will reflect individual priorities as well as variables such as disability, gender, race/ethnicity, belief, sexuality and gender identity.
- NHS organisations, like all employers, will be aware of the *Employment Equality (Age) Regulations 2006*. Age-equal practice will go the extra mile to ensure that not only workers but also volunteers of all ages have equal access to training and development, and career opportunities. This guide does not set out the details of the legislation, but there are many resources available to help with implementation, including the NHS Employers website. See:

  → www.nhsemployers.org/Pages/home.aspx
- Employers in the health sector would have a clear idea of the needs of the communities that they serve, including the present and foreseeable age profile of the population, with additional data about ethnicity, gender etc. They will have a workforce strategy that aims to meet those needs in a way that promotes age equality for its workforce and age appropriateness for its service users. The strategy will take into account areas of potential dual/multiple discrimination e.g. where older workers may experience age discrimination compounded by another form of discrimination (e.g. race/ethnicity, gender, disability, religion, sexuality).
- NHS organisations would regularly conduct age-profiling of their workforces. Age-profiling helps organisations to understand whether the organisation's age profile reflects the demography of the local population, and to plan appropriate action where necessary.

7.5 Case studies of illustrative / good practice

Evidence from other sectors, as well as from some health and social care organisations, may inform NHS organisations. See, for example, the Department of Work and Pensions Age Positive website:

→ www.dwp.gov.uk/age-positive

from which some of the case studies below have been abridged. Other case studies can be found on the website of the Employers Forum on Age:

→ www.efa.org.uk/default.asp

Although these case studies tend to emphasise the benefits to older workers, the references to customer service and customer satisfaction indicate that there are likely benefits for the users of services as well as the providers of services.

Actively recruiting older workers
Asda Stores

Asda works to recruit a colleague base which reflects the local population and has found that actively recruiting older workers mirrors its customer base more closely, ultimately providing better customer service. When this initiative began in one of its stores there were fears from some that productivity in the stores would drop, and that there would be more absences, more staff off sick and less motivation; in fact the reverse happened.

A great deal of effort has gone into creating a range of flexible working options that reflect the fact that a large proportion of the company's older employees do not want to hold down a full-time job. As well as offering unpaid leave for grandparents and carers, Asda also allows employees to take what has been called 'Benidorm leave', where their job is kept open for them while they take a few months off during the winter. Another innovation is the 'seasonal squad', where people can choose to work for the 10 busiest weeks of the year over Christmas, Easter and the summer holidays without having to leave and rejoin the company.

The business benefits for Asda of an age-diverse workforce are as follows:

- mirrors their customer base more closely, providing better customer service
- older workers have professional and life experience to share with other colleagues
- continuity of staff and experience
- extra flexibility
- reduced labour turnover, which reduces new recruit training costs
- improved customer satisfaction survey results and staff satisfaction.

Recruiting the right staff
Newham College

Newham College of Further Education is one of the UK's largest colleges. Over 30 per cent of its 500-strong workforce is over the age 50. The college takes active steps to ensure that it attracts staff from all age groups by placing targeted advertising in a variety of publications. It works closely with its advertising agency to ensure that adverts do not include or imply age limits or age restrictions to ensure that as many suitable candidates apply as possible.

To ensure that the college makes recruitment decisions purely on the basis of suitability for a role, age information given by candidates on their application forms is only used for monitoring purposes and is removed before the selection/interview process. Interview panels decide on a pre-set list of questions based on the requirements of the job, to ensure consistency (and no age-bias). A member of the human resources department is also present at every interview panel and ensures that good practice is maintained. The college also recognises the value of training and developing its staff.

Working without a retirement age
South Downs NHS Health Trust

South Downs NHS Health Trust provides services to people living mainly in Brighton and Hove. It employs over 2,000 staff ranging in age from 16 to 74. The organisation is committed to promoting equality and diversity and tackling age-related discrimination. It has introduced and promoted a range of options to attract and retain older workers, including the removal of the mandatory retirement age and the introduction of more flexible retirement options.

The trust recognises the importance of training and development in motivating and retaining staff. It encourages staff development through lifelong learning programmes for people who may not have had opportunities in education when they were younger. This helps to develop learning and study skills as well as confidence.

The business benefits for South Downs NHS Health Trust of a sound approach to age diversity include:

- avoids losing skilled people through retirement
- develops people into the hardest to recruit posts who may not otherwise have fulfilled their full potential, benefiting both the organisation and the individual
- improves recruitment and retention rates (number of staff aged over 65 increased from 17 when the policy was introduced in 2003 to 26 in 2004)
- encourages open discussion to ensure that issues are managed respectfully should they arise in the future
- presents the trust to the public as a positive employer to work for.

Agewell initiative
Sandwell Primary Care Trust

This case study, reported on the NHS Employers website,[140] describes the Agewell initiative, a midlife future planning course to help local people make more informed choices about their retirement. As part of this, the team runs a course on Midlife Future Planning. This was developed as a result of information gathered from the national pre-retirement pilots, which took place in 2001-2003. These were funded by the Department of Health and overseen by the Health Development Agency.

The findings from the pilots highlighted the need for individuals to have access to appropriate information to enable them to make informed lifestyle choices, whether that was to retire or continue working. The following actions were taken:

- Working with the primary care trust's Improving Working Lives (IWL) team, the midlife future planning coordinator looked into the issues around retirement and flexible retirement options for older workers within the trust.
- Focus and discussion groups took place with older employees to look at the findings from the pre-retirement work and to discuss how they felt it would benefit them as individuals. The groups concluded that a two-day course would enable people to take in the important and large amount of information, and that guest speakers could be invited to present on specific subjects, such as health, finance and physical activity.
- Some of the members from the focus groups later went on to pilot and evaluate the Midlife Future Planning course.
- In the beginning there were resource implications in terms of money to produce the training materials and resources.
- Buy-in for the course was achieved through the Improving Working Lives (IWL) initiative. They established that there was a need for the course through writing to all employees aged 50 and over and asking if they would be interested in attending. With this information the trust funded Agewell to deliver the course for its staff and it is now part of the trust's learning and development programme. In response to feedback, the course has now been made available to people over the age of 45, and sometimes younger for those retiring early.
- Courses are now also delivered to other trusts and also within the private and voluntary sectors.

The key lessons learned from this project are:

- Many people want to work or have to work after retirement age.
- The course benefits the employer and leads to discussion between employee and employer about future training needs and retirement options.

[140] www.nhsemployers.org/SharedLearning/Pages/TheMidlifeFuturePlanningCourse.aspx

- Remaining both physically and mentally active is very important to many individuals.
- Giving people informed choices at an earlier age enables them to take control of their future years.

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Meal Mates volunteers
NHS Gloucester, Brockworth

In 2009, NHS Gloucestershire and Age Concern Gloucestershire launched a pilot Meal Mates volunteering service in two community hospitals to improve the meal time experience for patients, particularly older patients. The project aims to provide patients with practical and moral support at mealtimes, to improve their experience and to make mealtimes as comfortable, sociable and enjoyable as possible, whilst also supporting good nutrition. Meal Mates visit the hospital at mealtimes and help with simple things, such as ensuring that patients are comfortable and have any special utensils that they need. They also help patients enjoy their meals by simply being there and chatting with them, offering encouragement and a friendly face.

Before launching the pilot scheme at two hospitals, a service level agreement was drawn up with Age Concern and a proposal for the project was set out. Meetings were held with other volunteers to talk over the scheme and to draw on their experiences.

After a three-month pilot scheme, the operation is now up and running in one of the hospitals. The pilot will be reviewed before the scheme is rolled out to the other Gloucestershire Community hospitals as planned. One lesson learned is that a volunteer coordinator will need to be in place for each site to ensure the smooth running of the scheme. There is also a plan to train any interested volunteers who may wish to help with feeding.

Information abridged from case study in Department of Health Dignity in Care Case Studies, February 2009:

→ www.dhcarenetworks.org.uk/_library/Resources/Dignity/Dignity_Champion_Case_Studies.pdf

7.6 Suggestions for quick wins / what you can do now

- NHS Employers suggests that organisations should – if they are not already doing so – review their HR processes for compliance, carry out an age profile of their staff, and develop creative strategies for attracting, recruiting, retaining and managing staff of all ages.[141]
- Audit age out of policies – the Employers Forum on Age recommends that employers ensure that their employment, training, communications and other policies are age neutral and do not disadvantage particular age groups.
- Ensure top-level involvement - the Employers Forum on Age suggests the establishment of an age champion to keep age on a board's agenda and build age awareness into all aspects of the business. Although the role of older people's champions has largely been subsumed into the work of dignity champions, a champion on age equality in the workforce can be a very useful asset at board level.[142]
- Hold celebratory events to support an age-diverse workforce.
- Recognise and celebrate the achievements of workers of all ages – particularly those whose work may be under-recognised, such as older workers.
- Discuss with your local volunteer bureau how opportunities for older volunteers can be extended and supported.

[141] *Age diversity in the workforce- why every organisation needs a strategy*, Briefing 2005 – Issue 1, NHS Employers, 2005

[142] *A toolkit for older people's champions: A resource for non-executive directors, councillors and older people acting as older people's champions*, Department of Health, 2004