Part B

Services for older people

Chapter 8
Prevention and health promotion

8.1 Key audiences

Primary care trusts and emerging GP commissioning consortia:

- commissioners of services for older people
- directors of public health and local authorities
- health promotion leads
- providers of community health services
- primary care teams.

8.2 Key issues and concerns

- Health and social care organisations should work in partnership to implement demonstrated best practice in prevention programmes that improve the quality of life of older people.
- Older people have a great deal to gain from effective preventive programmes and from health promotion.
- The evidence base about risk and benefit of prevention programmes and health promotion in the older population is limited.
- Prevention programmes for people of all ages do not necessarily include all the issues that are important to older people, and such programmes for older people in primary care are not adequately incentivised or geared towards older age groups.
- The management of long-term conditions is key to improving the health of older people.
- Case management, particularly using community matrons, can benefit older people.
- There is uneven access to and take-up of health promotion and prevention programmes between age groups.
- Age criteria exist for a number of screening programmes and these need to be justified by research evidence.
- Tools are being developed to target those who are most likely to benefit from preventive health programmes
- The use of technology such as Telecare can contribute to helping older people to stay safe and receive appropriate care.
- Older people may experience dual and/or multiple discrimination in relation to prevention and health promotion. Ethnicity, physical disabilities and learning disabilities are examples of factors that may result in unequal access to appropriate interventions and services.

- With the new responsibilities for local government, the new partnership arrangements led by upper tier local authorities will want to have oversight of health promotion and prevention activities for older people.

Working in partnership for best practice

> *"Health and social care organisations should work in partnership to implement demonstrated best practice in prevention programmes that improve the quality of life of older people." (Recommendation 4)*[144]

Older people have a great deal to gain from effective preventive programmes and from health promotion

Prevention services can bring benefits in two crucial areas: they can lead to better outcomes for older service users, and they can result in more efficient use of resources over the long-term via decreased demand on costly acute and social care services.[145] Interim and final reports evaluating the Partnerships for Older People Projects (POPPs) have provided evidence that care initiatives that focus on early interventions can have a positive impact on people's health.

This is particularly interesting in relation to older people since the mean age of users of POPPs projects was 75. The final POPPs evaluation also shows clear evidence of cost effectiveness. It states that when looking at the impact of the POPPs projects on the emergency bed-day use as compared to non-POPP localities, there were considerable savings as a result of POPPs projects, to the extent that for every extra £1 spent on POPPs services, there has been approximately a £1.20 additional benefit in savings on emergency bed days.[146] [147]

The evidence about the impact of POPPs on the quality of life of older people is more equivocal but a range of POPPs services appear to have improved users' quality of life, varying with the nature of individual projects; those providing services to individuals with complex needs were particularly successful, but low-level preventive projects also had an impact.

The evidence base about risk and benefit in the older population is still limited

Although there is evidence from POPPs and elsewhere about the benefits of prevention, it is also true to say that the evidence base about risk and benefit in the older population is still limited. This is significant as the clinical activities that are measured and rewarded by the Quality and Outcomes Framework (QOF) are mostly evidence based, and there may not be evidence one way or another about some of the interventions and approaches that may be of benefit to older people.

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[144] *Achieving age equality in health and social care*, Recommendation 4, Sir Ian Carruthers and Jan Ormondroyd, Department of Health, 2009
[145] *Putting the case - Older people's prevention services: An information sheet for regional health and social care providers,* Department of Health, October 2009
[146] *National Evaluation of Partnerships for Older People Projects: Interim Report of Progress*, PSSRU, 2008
[147] *National Evaluation of Partnerships for Older People Projects: Final Report*, PSSRU, 2010

The majority of trials focus on younger patients excluding older patients with co-morbidities, so evidence that is relevant to older people may simply not be generated.[148]

The evidence base relating to health promotion interventions for cancer and coronary heart disease for certain minority ethnic communities is extremely limited.[149]

The evidence base for socio-economic inequalities among older people is strongest in the field of health care, compared with other public services. However, the evidence is still limited and piecemeal.[150]

Prevention programmes do not include all the issues that are important to older people

The Quality and Outcomes Framework (QOF) (see Drivers and policy imperatives section below) provides incentives to deliver a number of health checks. However, the Centre for Policy on Ageing (CPA) reports that there is considerable unmet need among the older population that is ignored by the QOF.[151] [152]

For example, QOF domains do not include the identification and appropriate management of older people prone to falling, or the identification of those at high risk of osteoporosis fractures.

There are also concerns about the mechanism of 'exception reporting' whereby GPs can say that an indicator does not apply to a particular patient where evidence based guidelines are not applicable; GPs may concentrate on patients who are easier to treat, which may tend towards some exclusion of older people.

Management of long-term conditions

Older people are increasingly likely to experience multiple long-term conditions with advancing age, so the management of long-term conditions is a key component of preventing further ill-health and maximising opportunities to improve health. It is estimated that by 2025 there will be 42 per cent more people in England aged 65 or over. This will mean that the number of people with at least one long-term condition will rise by 3 million to 18 million (*Improving the health and wellbeing of*

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[148] *Ageism and age discrimination in primary and community health care in the United Kingdom, A review from the literature*, Centre for Policy on Ageing (CPA), 2009

[149] *Health promotion and prevention interventions in Pakistani, Chinese and Indian communities related to CVD and Cancer. A review of the published evidence in the UK, other parts of Europe and the United States*, Netto G, Bhopal R, Khatoon J, Lederle N and Jackson A, Heriot Watt University Edinburgh, 2008

[150] *Just ageing? fairness, equality and the life course. Socio-economic inequalities in older people's access to and use of public services*, Equality and Human Rights Commission and Help the Aged / Age Concern, 2009

[151] *Falls, fractures and strokes: how is primary care managing under the new GP contract?* Bayly J, *BGS Newsletter* (March 2005) cited *in Ageism and age discrimination in primary and community health care in the United Kingdom. A review from the literature*, CPA, 2009 www.bgsnet.org.uk/May06NL/13_falls.htm

people with long term conditions, Department of Health*).*[153] The same publication acknowledges that the personalisation aims of long-term conditions policy have long been talked about, but change is not happening fast enough and fundamental barriers persist. Local health and social care systems need to work together to identify what works well and to promulgate good practice to reduce variation.

Self-management and the role of the expert patient play a significant part in the management of long-term conditions.[154] Also see Chapter 6 Involving older people.

Case management

Promoting health and preventing ill health can be of particular benefit for older people, who may experience a range of health and social care problems. As the Department of Health states:

> *"Evidence has shown that intensive, on-going and personalised case management can improve the quality of life and outcomes for these patients, dramatically reducing emergency admissions and enabling patients who are admitted to return home more quickly."*[155]
>
> → www.dh.gov.uk/en/Healthcare/Longtermconditions/DH_4130655

Community matrons are important in offering personalised case management and are described by the Department of Health as "*the first step to creating an effective delivery system and implementing the wider NHS and Social Care Long Term Conditions Model*".[156]

> → www.dh.gov.uk/en/Healthcare/Longtermconditions/DH_4130655

The final evaluation of the POPPs projects commends proactive case coordination projects, where visits to A&E departments fell by 60 per cent, hospital overnight stays were reduced by 48 per cent, phone calls to GPs fell by 28 per cent, visits to practice nurses reduced by 25 per cent and GP appointments reduced by 10 per cent.[157]

Uneven access to and take-up of health promotion and prevention programmes

Also see Chapter 9 Access to primary and community health services

There is evidence of an uneven take-up of screening programmes, immunisation and other measures that might improve the health of older people. The following information is cited in a recent report.[158]

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[153] *Improving the health and wellbeing of people with long term conditions. World class services for people with long term conditions – information tool for commissioners*, Department of Health, 2010
[154] www.expertpatients.co.uk
[155] Department of Health website
[156] Department of Health website
[157] *National Evaluation of Partnerships for Older People Projects: final report,* PSSRU, 2010
[158] *Just ageing? fairness, equality and the life course. Socio-economic inequalities in older people's access to and use of public services,* Equality and Human Rights Commission and Help the Aged / Age Concern, 2009

- Mammography screenings – Women aged 65 and over from lower social classes are less likely to use mammography services.[159]
- Aneurysm screenings – Men aged 65-74 from deprived areas are less likely to attend aneurysm screenings.[160]
- Vaccinations – Women aged 62-83 from lower socio-economic groups (Patel et al., 2007)[161] and older people with lower occupational status are less likely to have flu vaccinations.[162]
- Eye tests – Women aged 62-83 from lower socio-economic groups are less likely to have eye examinations.[163] People aged 60 and over from lower income groups are more likely to cite the cost of glasses as a reason for not having more frequent eye tests.[164]

Some GPs appear reluctant to follow guidelines for cholesterol measurement and lipid lowering agents in people over 75. Also see Chapter 18 Cardiovascular disease.

GPs are less likely to discuss lifestyle changes like weight reduction, smoking, alcohol and safe drinking with older people than younger people.[165]

Also, GPs do not always assess the risk of falling among their older patients or know how to do such an assessment.[166] See Chapter 12 Falls.

A recent enquiry found a lack of awareness of the health needs of people with learning disabilities in primary care and noted that this is particularly important since primary care is the single point of access to health promotion and ill health prevention, as well as most healthcare and treatment.[167]

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[159] *Mammography uptake predictors in older women*, Family Practice, 19, 661-4, Harris T J, Cook D G, Shah S, Victor C R, DeWilde S, Beighton C and Rink E, 2002

[160] *Screening for abdominal aortic aneurysms: The effects of age and social deprivation on screening uptake, prevalence and attendance at follow-up in the MASS trial*, Kim L G, Thompson S G, Marteau T M, and Scott R A, Journal of Medical Screening, 2004.11, 50-3

[161] *Socio-economic position and the use of preventive health care in older British women: A cross-sectional study using data from the British Women's Heart and Health Study cohort*, Patel R, Lawlor D A and Ebrahim S, Family Practice, 2007: 24, 7-10

[162] *Factors influencing influenza vaccination uptake in an elderly, community-based sample*, Burns, V E, Ring C and Carroll D, Vaccine, 23, 2005: 3604-8.

[163] *Socio-economic position and the use of preventive health care in older British women: A cross-sectional study using data from the British Women's Heart and Health Study cohort*, Patel R, Lawlor D A and Ebrahim S, Family Practice, 2007: 24, 7-10

[164] *Older people and eye tests: Don't let age rob you of your sight,* Royal National Institute for the Blind, RNIB, London, 2007

[165] *Ageism and age discrimination in primary and community health care in the United Kingdom. A review from the literature*, CPA, 2009

[166] *Ageism and age discrimination in primary and community health care in the United Kingdom. A review from the literature*, CPA, 2009

[167] *Healthcare for all: report of the independent inquiry into access to healthcare for people with learning disabilities*, Sir Jonathan Michael and the Independent Inquiry into Access to Healthcare for People with Learning Disabilities, HM Government, 2008

Screening and age criteria

Many screening programmes include age criteria and these are frequently the subject of debate, particularly as evidence grows and attitudes change. Under the Equality Act, age limits for screening programmes should be able to be *"objectively justified"* by research evidence. Some commentators argue that the upper limit for breast cancer screening programmes does not have sufficient evidence. Breast cancer screening, smoking cessation and hypertension management have the best evidence for effectiveness in older people.[168]

The age criteria for national screening programmes are, by definition, set nationally. *Achieving age equality* Recommendation 3 is that the Department of Health and Advisory Committees satisfy themselves that age-based criteria comply with the legislation and Recommendation 4 specifically recommends that a programme of research is commissioned to advise on the upper limit of the breast cancer screening programme.[169]

Local NHS organisations need to ensure that programmes are well publicised and that the appropriate levels of services are commissioned and delivered in ways that maximise take-up by all age groups, including older people where they are eligible for inclusion in the screening programme.

At present, the following national screening programmes are in place, with age criteria as described below. See NHS Choices:

→ www.nhs.uk/Livewell/Screening/Pages/Checksover65s.aspx

- Cervical cancer - The cervical cancer screening invites women for screening from the age of 25. After the age of 65, women are not sent an invitation for cervical screening unless they have had a previous abnormal screening result from any of their last three screening tests. Women who have never been screened are entitled to request an examination, regardless of their age.
- Breast cancer - Breast screening continues by invitation from the age of 50 up to the age of 70 (this is being extended to include women aged 47 to 73 by 2012). Once over the screening invitation age, women are entitled to make their own screening appointments every three years.
- Bowel cancer - The UK's national bowel screening programme has an age span of 60-69. From 70 onwards, people can request screening, but are not invited automatically. There are plans to extend this screening programme to 75 at the end of 2010.
- The NHS Abdominal Aortic Aneurysm (AAA) Screening Programme – This programme's aim is to reduce deaths from abdominal aortic aneurysms (also called 'AAAs' or 'Triple As') through early detection. The condition is most common in men aged 65 and over. As part of the

[168] *Ageism and age discrimination in primary and community health care in the United Kingdom. A review from the literature*, CPA, 2009
[169] *Achieving age equality in health and social care*, Sir Ian Carruthers and Jan Ormondroyd, Department of Health, 2009

screening programme, all men will be offered screening when they reach 65.

- Vascular screening - The new UK vascular screening programme for 40-74 year olds was launched in April 2009. The upper age limit excludes a large number of people who may benefit as vascular problems intensify with age.[170]
- Diabetic retinopathy (not age based) – People with diabetes should already be attending yearly screening tests for sight-threatening diabetic retinopathy. Diabetic retinopathy screening usually takes place at the GP's surgery, local optometrist or local hospital. If evidence of retinopathy is found, patients will be referred to an eye clinic for treatment to help prevent future damage to their sight. If all is clear, they will just be invited to be screened annually.
- Glaucoma - The NHS offers free sight tests to anyone over 60, those already diagnosed with the condition, and those who are over 40 and are the parent, sibling or child of a person diagnosed with glaucoma.

The UK National Screening Committee (NSC) has not recommended population screening for prostate cancer as at present the available evidence of benefits does not outweigh the potential harm arising from screening.[171] [172]

The UK NSC has concluded that to date there is insufficient evidence to support screening for osteoporosis. This policy is due to be reviewed again in 2009/10 following review of NICE guidelines. The NICE advice from 2008 is that clinicians may initiate drug treatment with patients over 75 without scanning if he/she judges that there are clear risk factors.[173]

Immunisation

Immunisation against seasonal flu is available to all people over the age of 65 and to younger people if they are in clinically at-risk groups. All adults aged 65 and over are offered pneumococcal polysaccharide vaccine (PPV). It is also recommended for people at high risk of a pneumococcal infection.

Over 75 health checks

Since the introduction of the GP contract in 1990, GPs have been required to provide (among other services) health checks for all patients who have not seen their GP in the last three years or who have not had a health check in the past 12

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[170] *Ageism and age discrimination in primary and community health care in the United Kingdom. A review from the literature*, CPA, 2009

[171] *Prostate Cancer Risk Management Programme, NHS Screening Programmes,* Burford D C, Kirby M and Austoker J *2009*

[172] *Information for primary care: PSA testing in asymptomatic men*, 2nd ed, referenced in *Ageism and age discrimination in primary and community health care in the United Kingdom. A review from the literature,* CPA, 2009

[173] *Ageism and age discrimination in primary and community health care in the United Kingdom. A review from the literature*, CPA, 2009

months, and an annual consultation and domiciliary visit for all patients over the age of 75 years. The annual assessment should include all factors that affect health, including the person's physical and mental condition, sensory functions, mobility, use of medicines, and social environment.

There has been evidence that health checks for the over 75s have not been widely taken up, with only 12 per cent of over 75s in one survey being seen annually in the 1990s.[174]

Medication reviews

Medication reviews are recommended, and available free of charge, to people over the age of 75 and to people of any age who are taking medications for long term conditions and various other groups of people too.

Targeting those who are most at risk of emergency hospital admission

While promoting health and preventing illness may be of benefit to everyone, health and social care organisations need ways to identify which individuals are at particularly high risk of emergency hospital admission, so that these people can be offered intensive preventive care.

NHS organisations in England are able to use statistical tools, called 'predictive risk models', that can stratify a population according to individual risk of unplanned hospital admission in the next 12 months. These tools (such as Patients At Risk of Re-hospitalisation (PARR) Case Finding Tool and the Combined Predictive Model) use patterns in routinely collected data to make predictions about future risk at the individual level. The models are run using pseudonymous data (i.e. identifiable characteristics such as names and addresses have been removed) but the patient's GP is able to re-identify individuals and offer them preventive care, for example the input of a community matron.[175]

Using technology

The Prevention Programme seeks to raise awareness and use of Telecare devices, such as personal alarms and equipment to monitor health. These can help older people to remain independent in their own homes. While the use of telecare is at a relatively early stage, there are examples of its successful use in a number of places and there is scope to develop its use further.

Dual/multiple discrimination

In the context of promoting health and preventing ill health it is important to note that some older people may experience discrimination because of their age and because of another factor such as gender, ethnicity, disability, sexuality or beliefs.

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[174] *Problems found in the over-75s by the annual health check*, Brown K, Boot D, Groom L, and Williams E, Br J Gen Pract. 1997 January; 47(414): 31–35

[175] *Predicting who will need costly Care - How Best To Target Preventive Health, Housing and Social Programmes*, Lewis G, King's Fund, 2007

The risk of indirect discrimination is particularly high if people's individual preferences and cultural and other needs are not recognised and met.

Targeted health promotion initiatives can bring about positive changes in knowledge, health-related attitudes and behaviours, and health status. However, given the time and resources needed to develop such initiatives, health promotion initiatives which target the general population should also take measures to include minority ethnic communities. Wherever possible, the collection and analysis of ethnically disaggregated data should be viewed as an essential component of wider health promotion initiatives.[176]

Drawing on knowledge about people with learning disabilities generally, it is likely that older people with learning disabilities are particularly at risk of missing out on screening and other effective programmes for detecting ill-health and improving health.[177] Older people with learning difficulties seem to be less familiar with screening programmes and self examination (breast and testicles) than the general population as they do not pick this up so easily from mass media campaigns.[178]

Socio-economic factors may impact on older people's access to screening and other programmes designed to improve their health.

8.3 Drivers and policy imperatives

The NHS Operating Framework 2010-2011[179]

This strategy develops ideas that were set out in *Building a Society for all Ages.*[180] Amongst other measures, it proposed the introduction of the NHS Health Check (for heart disease, diabetes, kidney disease, stroke for people 40 – 70 years) and the NHS Mid-life LifeCheck be introduced (smoking, healthy eating, alcohol use, physical activity and emotional wellbeing).

NHS Health Checks are now being made available across the country for all 40 - 74 year-olds, in a programme that will be fully rolled out by 2012/13. These will check an individual's risk of heart disease, stroke, diabetes and kidney disease, and will offer support in reducing or managing that risk, with the necessary lifestyle advice and effective interventions (such as NHS Stop Smoking Services or weight management programmes) or through medication.

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[176] *Health promotion and prevention interventions in Pakistani, Chinese and Indian communities related to CVD and Cancer - A review of the published evidence in the UK, other parts of Europe and the United States*, Netto G, Bhopal R, Khatoon J, Lederle N and Jackson A, Heriot Watt University Edinburgh, 2008

[177] *Healthcare for all: report of the independent inquiry into access to healthcare for people with learning disabilities*, Sir Jonathan Michael and the Independent Inquiry into Access to Healthcare for People with Learning Disabilities, HM Government, 2008

[178] Older people with learning disabilities affected by cancer: Involvement and engagement work to inform a research agenda, Cancer Research Centre, University of Stirling, September 2007

[179] *The NHS Operating Framework 2010-2011* Department of Health, 2009

[180] *Building a Society for all Ages*, HM Government 2009

It is important to note that as they currently stand, these health checks are available only to people within the defined age groups, and others will not be included (although other health checks that form part of the Quality and Outcomes Framework include older people).

Prevention Package for Older People [181]

The Prevention Package (PP) for Older People, launched as part of *Building a Society for all Ages*[182] prioritises better preventive care for older people and a renewed focus within the NHS at local level to work in partnership with social care, local authorities and older people. It has a new focus on innovative healthcare, such as Telecare; better services for falls, fractures and osteoporosis; and a review of footcare services. It also makes an ongoing commitment to reduce waiting times for hearing tests and the fitting of aids. The strategy also refreshes Intermediate Care guidance and it will include plans for depression, continence care and arthritis services.

Be active, be healthy [183]

This plan sets out the Government's framework for the delivery of physical activity for adults, alongside sport and based upon local needs, with particular emphasis on the physical activity legacy of the 2012 London Olympic and Paralympic Games.

NHS Next Stage Review – High Quality Care for All [184]

Lord Darzi's review identified a number of immediate next steps which are directly relevant to prevention of illness and health promotion. For example, every primary care trust will commission comprehensive wellbeing and prevention services, in partnership with local authorities, with personalised services offered to meet the specific needs of their local populations.

National Service Framework for Older People [185]

Although the *National Service Framework (NSF) for Older People* has run its course and the dates for the milestones have passed, it is mentioned here as it was an early key document that shaped thinking about the prevention of ill health in older people. Standard 8 particularly applied:

> *"The health and wellbeing of older people is promoted through a coordinated programme of action led by the NHS with support from councils."*

Other NSFs, e.g. for coronary heart disease, are also largely of historical interest but they set the context for further development of preventive work.

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[181] *Prevention Package for Older People*, Department of Health, 2009
[182] *Building a Society for all Ages*, HM Government, 2009
[183] *Be active, be healthy*, Department of Health, 2009
[184] *NHS Next Stage Review – High Quality Care for All, Lord Darzi*, Department of Health, 2008
[185] *National Service Framework for Older People*, Department of Health, 2001

The Quality and Outcomes Framework [186]

The Quality and Outcomes Framework (QOF) is a voluntary annual reward and incentive programme for all GP surgeries in England, detailing practice achievement results. The clinical care domain of QOF consists of 80 indicators across 19 clinical areas (e.g. coronary heart disease, heart failure and hypertension), many of which are particularly relevant to older people.

8.4 What good age-equal practice might look like

Awareness of the potential benefits to older people of prevention and health promotion programmes

It is important to be aware that older people can benefit from many aspects of illness prevention and health promotion. For example, a report from the Chief Medical Officer in 2004 stated the benefits of physical activity in later life, such as:

- preventing cardio-vascular disease, diabetes and obesity
- maintaining mobility and independent living
- strength training can improve muscle strength, which is important for daily living, such as getting up from a chair or walking
- training to improve strength, balance and coordination can reduce the incidence of falls
- prevention of depression and aiding recovery
- improving cognitive function and reducing risk of cognitive impairment.[187]

Good management of long-term conditions in older people

A recent publication[188] sets out what a good service for people with long-term conditions would look like:

> *"Good outcomes and experiences for people with long term conditions (LTCs) include maximum health and wellbeing; control over what happens to them; confidence in managing their own condition and in using the services available; good relationships with professionals; and access to convenient, efficient services that meet individual needs and preferences. Successful outcomes for people with LTCs require a partnership between engaged, empowered individuals and a proactive, responsive and integrated system."*

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[186] *The Quality and Outcomes Framework*, Department of Health, 2003, regularly revised

[187] *At least five a week: Evidence on the impact of physical activity and its relationship to health.* A report from the Chief Medical Officer, Department of Health, 2004

[188] *Improving the health and well-being of people with long term conditions. World class services for people with long term conditions – information tool for commissioners*, Department of Health, 2010

All of this applies fully to older people with long-term conditions.

Sensitive case management

For older people, a case management approach may be very positive, but NHS organisations also need to be continually aware of ongoing concerns about confidentiality if and when they use predictive tools that draw on databases containing information about whole populations. Also, there is a need to ensure that personalisation remains at the heart of practice; good age-equal practice will take account of the views of individual older people, whose main concern may or may not include the avoidance of hospital admission. Also, individuals will vary as to how much input they welcome from health and social care professionals, even if such interventions are backed up by evidence that they contribute to better health.

Pay attention to the priorities of older people and the issues that most affect their lives

Good age-equal practice will ensure that the issues that matter to older people drive the agenda for health promotion and the prevention of ill-health. Older people's priorities may not precisely match national priorities (although they sometimes will). For example, osteoporosis is a significant issue for many older people, but is not explicitly amongst the highest priorities for screening or prevention.

It is also important to be aware that older people can experience indirect discrimination when significant problems of older people are ignored. For example, it is not widely known – and therefore seldom addressed – that around 10 per cent of older people living in the community suffer from malnutrition.[189]

Personalisation and promoting health

Individuals vary in their needs and priorities. Communities also differ in their beliefs, attitudes and priorities and individuals within communities may hold very different views. 'One size fits all' simply does not work for older people (or any other age groups) in relation to promoting better health. A good age-equal service will consider how diversity can be respected by involving people in the design and evaluation of appropriate programmes designed to improve health.
See Chapter 6 Involving older people.

Individuals may respond well to one-to-one help in maximising their health. The NHS Health Trainers Programme was launched in 2006 and has had considerable success, with more than two-thirds of clients reaching at least one of their personal health targets.[190]

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[189] *Malnutrition among older people in the community: policy recommendations for change.* European Nutrition for Health Alliance, British Association for Parenteral and Enteral Nutrition and the International Longevity Centre, 2006

[190] *Health Trainers – review to date*, Department of Health, June 2009 www.dh.gov.uk/dr_consum_dh/groups/dh_digitalassets/documents/digitalasset/dh_100718.pdf

It is not clear to what extent health trainers have reached out to older people, particularly those in the oldest age groups, although their role could be of particular benefit to older people.

There is no single point at which the needs of older people become different from those of younger people, but in some circumstances prevention programmes and health promotion activities may need to be different for older people, e.g. some older people may need gentle armchair exercises rather than exercising in a gym alongside young adults.

The Equality Act recognises that different treatment of people of different ages can be the most appropriate way of providing services and is not automatically harmful discrimination. The test for NHS commissioners and providers is that the difference needs to be able to be "*objectively justified*" by showing that it is the least discriminatory approach and is a proportionate means of achieving the legitimate ends. High quality services for older people should be able to demonstrate that they meet this test even where the service model retains a broad age-based pattern alongside comprehensive and fair assessment of the individual's needs and aspirations.

8.5 Case studies of illustrative / good practice

Development of Telecare service in Blackpool

Brief synopsis

Telecare is a service that enables people, especially older and vulnerable people, to live independently in their own homes. Services range from Basic Telecare services that require input from the user (i.e. to press an alarm button worn round the neck), through to Enhanced Telecare which consists of a range of discreet wireless sensors that are placed in a person's home and which automatically raise an alert to a Monitoring and Response Centre if they sense a problem.

Background

The Telecare project is continuing the work of Vitaline, which was set up to offer a 24-hour continuous monitoring response service for vulnerable people. Telecare is now an integral part of the social care assessment process and, in order for it to be used as a preventative measure, the eligibility criteria for the service have been set below the usual standard to encourage take-up. At the end of March 2008, there were approximately 1,000 basic Telecare units installed in people's homes and approximately 90 homes with Enhanced Telecare equipment installed.

Objectives

The objectives of the project are:

- to reduce the number of unscheduled admissions to hospital
- to increase quality of life for users by reducing anxiety levels and promoting independence.

How it works

Telecare offers an early intervention service that can:

- respond quickly to emergencies
- help to detect lifestyle changes that could indicate a deterioration in health
- improve quality of life by enhancing security and peace of mind
- allow individuals to have more freedom and choice about the services they receive.

Evaluation

The project is evaluated through detailed monitoring of service users' reported outcomes, which include:

- the delay of admission to residential care
- a reduction in the requirement for care-at-home hours
- a reduction in admissions to hospital
- the possibility of an earlier discharge from rehabilitative care.

Source: *Communities for Health. Unlocking the energy within communities to improve health,* Department of Health 2009.

→ www.dh.gov.uk/dr_consum_dh/groups/dh_digitalassets/documents/digitalasset/dh_107321.pdf

Get Fit to Keep Fit in Oldham

Get Fit to Keep Fit is aimed at people over 50. In partnership with Oldham Adult and Community Services, this project targeted residents who had not taken any physical exercise and who did not want to go to the leisure centre. Aimed at reducing isolation and helping people to access low-level fitness sessions together with healthy eating, an exercise and movement programme was followed by a healthy light lunch.

(Source: Communities for Health. Unlocking the energy within communities to improve health, Department of Health 2009.)

→ www.dh.gov.uk/dr_consum_dh/groups/dh_digitalassets/documents/digitalasset/dh_107321.pdf

Active Age Centres in Barking and Dagenham

Working in close partnership with a wide range of organisations, including the primary care trust, local third sector organisations, the North East London Mental Health Trust, Age Concern and the local faith forum, Barking and Dagenham Borough Council has developed Active Age Centres to deliver health-related messages at local level to targeted groups. They aim to prevent ill-health and promote good health by providing eight centres throughout the borough where older vulnerable people can access informal services and support.

There is a range of recreational and leisure activities for older people, including exercise, dance and sports. The emphasis is on encouraging older people to keep active. There are also more supportive services for those who need them.

(Source: Communities for Health. Unlocking the energy within communities to improve health, Department of Health 2009.)

→ www.dh.gov.uk/dr_consum_dh/groups/dh_digitalassets/documents/digitalasset/dh_107321.pdf

Older people and alcohol: tackling the hidden harm in the London Borough of Hammersmith and Fulham

Brief synopsis

Looking at a problem for which there is little national data and developing local action to help reduce health inequalities in this neglected area.

Background

The borough has high rates of alcohol misuse, with significant levels among older people, particularly men. Alcohol misuse is, therefore, a significant component of health inequalities in Hammersmith and Fulham. Currently, there are few specific local interventions to address this issue. It is also the case that nationally there is little specific guidance or an evidence base that covers addressing alcohol problems and older people.

Objectives

- to establish a clearer picture of need in relation to older residents of the borough who engage in harmful and hazardous drinking
- to raise awareness of the issue among health and social care staff
- to use the funding to build capacity within communities and services to address this problem.

How it works

This initiative is being integrated into the local alcohol strategy, which is being developed in conjunction with the primary care trust and a range of other partners. The initiative is also being designed to support delivery of the Local Area Agreement, which is expected to have a target on reducing alcohol-related admissions to hospitals, and a wider Health and Wellbeing Strategy, which is being developed by the council and primary care trust, together with other partners, including the third sector.

(Source: *Communities for Health. Unlocking the energy within communities to improve health*, Department of Health, 2009.)

→ www.dh.gov.uk/dr_consum_dh/groups/dh_digitalassets/documents/digitalasset/dh_107321.pdf

Health promotion activities at BME 50+ luncheon clubs in Luton

Objective

To improve levels of physical activity of black and minority ethnic (BME) groups in a luncheon club venue. This links to other improving leisure opportunities for all, promoting healthy living, tackling the key risk factors that affect health, improving services for carers and supporting independent living.

How it works

Each class runs for 45 minutes in areas of high deprivation and low life expectancy. There are eight Asian and four African Caribbean groups.

Impact

The groups are all doing well; the project was supported to November 2009. A retired GP measures blood sugar, blood pressure and body mass index. The project has experienced difficulty in getting African Caribbean men to participate.

Evaluation

Evaluation will be based on a questionnaire distributed to attendees.

(Source: *Communities for Health. Unlocking the energy within communities to improve health,* Department of Health, 2009.)

→ www.dh.gov.uk/dr_consum_dh/groups/dh_digitalassets/documents/digitalasset/dh_107321.pdf

POPPs case studies

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

8.6 Suggestions for quick wins / what you can do now

- Review the adequacy of local data used for determining local needs and for monitoring the uptake of services and initiatives.
- Ensure that health professionals are aware of and using opportunities to engage with older people about health promotion and prevention programmes to a similar extent that they would for younger people.
- Review current uptake of screening programmes by older people and, if necessary, work with local organisations of older people to increase awareness and take up of screening programmes and other measures designed to prevent ill health and promote good health.
- Pay particular attention to terminology about preventive health schemes. There has been an unfortunate tendency to refer to people who are admitted frequently to hospital as 'frequent fliers'. This is a frivolous and disrespectful term which may alienate older people.
- Community involvement in the design and delivery of interventions plays a valuable role in increasing the appropriateness and effectiveness of interventions: how far are your local communities involved in these ways?

Chapter 9
Access to primary and community health services

9.1 Key audiences

Primary care trusts:

- chief executives
- primary care commissioners (linking to the National Commissioning Board)
- emerging GP commissioning consortia
- community health service providers
- GPs
- dentists
- opticians.

Voluntary sector:

- chief executives.

9.2 Summary

The general practitioner (GP) is the gateway to services in the NHS. GPs are the first point of contact in the NHS for many older people, and frequently the main point of contact that an older person has with the health or social care professions. Older people are the main users of GP services, but these services are often not designed around older people. Older people have a high level of need for dental services, but access to NHS dental services is problematic for older people and prevention is rarely undertaken. Maintaining vision is vital to sustaining an active life and social contact. Optical, and other related services, have a key role in promoting good physical and mental health, but low vision services are fragmented and there is a wide disparity in the quantity and quality of services between different parts of the country.

Older people from minority ethnic groups, those with disabilities, and people in rural areas often find additional barriers to access due to geography, lack of suitable transport, physical and communication barriers. Older people in care homes have particular problems accessing a GP and healthcare for particular conditions.

There are a number of ways in which primary and community health services can be made more accessible to older people and so promote age equality.

In many cases these measures involve implementation of established good practice in improving access to primary care for all age groups and good practice in meeting the needs of people with mobility, sensory and learning disabilities. There is also a need, however, to ensure that new developments to improve access to primary care benefit older people and do not compound their problems in accessing GPs. Older people should be involved in planning future developments in primary care and in monitoring the implementation of current schemes.

9.3 Key issues and concerns

- Older people are the main users of GP services, but these services are often not designed around older people.
- Older people may need more time in a consultation to describe presenting problems and discuss treatments for multiple conditions.
- Older people appear reluctant to make use of out of hours services, are critical of the trend away from out of hours care being delivered by a familiar GP and would like to see more availability of home visits.
- Access to NHS dental services is problematic for older people.
- Low vision services are fragmented and there is a wide disparity in the quantity and quality of services between different parts of the country.
- Many eye problems in older people can be treated if detected in time.
- There is a lack of reliable and accessible transport services across the country which is experienced disproportionately by older people, limiting their access to health services.
- There is evidence that older people living in care homes have difficulty accessing the services of a GP and other primary care services.
- Carers often find that their caring responsibilities prevent them from accessing health services both for their own needs and on behalf of the person they support.
- Variations in access to primary care services can be compounded by other factors, such as race/ethnicity, disability and learning disability, and living in rural areas.
- With the new responsibilities for commissioning, both GP commissioning consortia and the National Commissioning Board will need to consider how they prepare for the implementation of the Equality Act.

Access to GP Services

Older people are the main users of GP services, but these services are often not designed around older people

Older people are the main users of GP services. People aged 65 and over visit their GP on average seven times a year compared with four visits on average for younger people.[191] Older people are likely to have at least one long-term condition and these are mostly managed in a primary care setting – 60 per cent of GP consultations relate to long-term conditions, such as arthritis, asthma, diabetes, heart disease or depression.[192]

The *National Service Framework for Older People*[193] outlined key roles for GPs in the management of stroke, dementia and falls. GPs are also key in the *Prevention Package for Older People*.[194] Despite this, GP services are not generally organised around the needs of older people and there are concerns that some current developments and changes to patterns of service delivery, which are aimed at improving access, are focused on the needs of younger working people and may adversely affect access for older people.[195]

Consultation times

Older people may need more time in a consultation to describe presenting problems and discuss treatments for multiple conditions and, because of the complexity, sometimes need more time to assimilate information.[196]

Out of hours services

Older people appear reluctant to make use of out of hours services, and are critical of the trend away from out of hours care being delivered by a familiar GP. Barriers include fear of travelling at night (to a treatment centre), reluctance to make excessive demands on out of hours health services and reluctance to use telephone advice services.[197]

Opening times and appointments

The GP Patient Survey 2006/7 found that levels of dissatisfaction increased with age around people not being able to book a GP appointment in advance

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[191] *Ageism and age discrimination in primary health care in the United Kingdom*, Centre for Policy on Ageing (CPA), October 2009
[192] *Indications of public health in the English regions. 9: Older people*, Association of Public Health Observatories and West Midlands Public Health Observatory, 2008 www.wmpho.org.uk/resources/APHO_OP.pdf
[193] *National Service Framework for Older People*, Department of Health, 2001
[194] *Prevention Package for Older People*, Department of Health, 2009 www.dh.gov.uk/en/Publicationsandstatistics/Publications/dh_103146
[195] *Primary Concerns – Older people's access to primary care*, Age Concern, 2008
[196] *Ageism and age discrimination in primary health care in the United Kingdom*, CPA, October 2009
[197] *A qualitative study of older people's views of out-of-hours services*, Foster J, Dale J and Jessopp L, British Journal of General Practice 51 (470): 719-23, 2001

and for the GP surgery not being open on a Saturday.[198] Older people express a strong desire for Saturday morning surgery appointments.[199]

Home visits

Older people have specifically expressed a desire for more home visits, though the proportion of consultations made as home visits has fallen from 22 per cent in 1971 to 4 per cent in 2006.[200] [201]

Access to dental care

Older people have a high level of need for dental services

There is evidence that older people are particularly vulnerable to nutritional and diet imbalances if their oral condition deteriorates. Poor oral health is also linked to infections, including aspiration pneumonia, to which older people are particularly susceptible; periodontal disease and diabetes; and cardiovascular disease and stroke.[202] [203]

The Community Dental Services treat a very small percentage of the total older population, suggesting considerable unmet need.[204]

Access to NHS dental services is problematic for older people

The level of contact between older people and dental services is relatively low, and definitely lower than for adults in general.[205]

There are variations in access to dental services for older people across socio-economic groups

Women aged 62-83 from lower socio-economic groups are less likely to have dental examinations.[206] People aged 60 and over from lower social classes and with lower education levels are less likely to use dental services.[207]

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[198] *Ageism and age discrimination in primary health care in the United Kingdom*, CPA, October 2009
[199] *Family doctor survey 2007*, BOPF Opinion research survey, no 7, Bristol Older People's Forum, 2007
[200] *Family doctor survey 2007 (*BOPF Opinion research survey, no 7*),* Bristol Older People's Forum, 2007
[201] *Primary Concerns – Older people's access to primary care*, Age Concern, 2008
[202] *Meeting the challenges of oral health for older people: a strategic review*; commissioned and funded by the Department of Health, *Gerodontology* 22 (Suppl 1): 1-48, Gerodontology Association, 2005
[203] *Improvements in NHS dental services deemed vital for older people*, Help the Aged, London, 2006
[204] *Ageism and age discrimination in primary health care in the United Kingdom*, CPA, October 2009
[205] *Meeting the challenges of oral health for older people: a strategic review*; commissioned and funded by the Department of Health, *Gerodontology* 22 (Suppl 1): 1-48, Gerodontology Association, 2005
[206] *Socio-economic position and the use of preventive health care in older British women: A cross-sectional study using data from the British Women's Heart and Health Study cohort*, Patel R, Lawlor D A and Ebrahim S, Family Practice, 24, 7-10, 2007

Prevention is rarely undertaken for older people.[208]

Access to NHS dental services is problematic for older people.[209] Those living in rural areas experience particular difficulties with limited access to preventive dental healthcare and treatment and there is a clear disadvantage to those who cannot afford to pay for treatment.[210]

The barriers older people face preventing them from receiving adequate dental care include mobility problems, illness, inconvenience, the scarcity of NHS dentists and the cost, or fear of the cost, of treatment.[211] [212]

Access to eye care

Eye care is important to older people

Maintaining vision is vital to sustaining an active life and social contact. Optical, and other related services have a key role in promoting good mental health.[213]

There is wide disparity in low vision services across the country

Low vision services are fragmented and there is a wide disparity in the quantity and quality of services between different parts of the country.[214]

There are variations in access to eye services for older people across socio-economic groups

Women aged 62-83 from lower socio-economic groups are less likely to have eye examinations.[215] People aged 60 and over from lower income groups are

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[207] *Factors influencing older people's self reported use of dental services in the UK*, Gerodontology, 16, 97-102, McGrath C, Bedi R and Dhawan N, 1999
[208] *Ageism and age discrimination in primary health care in the United Kingdom*, CPA, October 2009
[209] *Extracting the evidence: the oral health and dental care needs of older people: policy statement*, Help the Aged, 2008
[210] *Living well in later life: a review of progress against the National Service Framework for Older People*, Healthcare Commission, Audit Commission and Commission for Social Care Inspection, London: Healthcare Commission, 2006
[211] *Primary concerns: older people's access to primary care*, Age Concern England, Policy Unit, London, 2008,
[212] *Meeting the challenges of oral health for older people: a strategic review,* commissioned and funded by the Department of Health, *Gerodontology* 22 (Suppl 1): 1-48, Gerodontology Association, 2005
[213] *New Horizons – A shared vision for mental health*, Department of Health, 7 December 2009
[214] *Ageism and age discrimination in primary health care in the United Kingdom*, CPA, October 2009
[215] *Socio-economic position and the use of preventive health care in older British women: A cross-sectional study using data from the British Women's Heart and Health Study cohort*, Patel R, Lawlor D A and Ebrahim S, Family Practice, 24, 7-10, 2007

more likely to cite the cost of glasses as a reason for not having more frequent eye tests.[216]

There are variations in waiting times for cataract operations for younger and older people which indicates the possibility of age discrimination.[217]

Many eye problems in older people can be treated if detected in time

Between 20 per cent and 50 per cent of older people have undetected reduced vision, most of which can be corrected.[218]

Many people with wet age-related macular degeneration (AMD) reach treatment centres too late to prevent irreversible eye damage and blindness.[219]

Older people with macular degeneration have reported negative experiences in the provision of information and quality of interactions with ophthalmologists and health professionals. [220]

Location of services and transport

Transport to health services is a particular problem for older people

There is a lack of reliable and accessible transport services across the country in rural, urban and suburban areas. This lack is experienced disproportionately by older people, limiting their access to health and other services.[221] [222] [223]

Some developments may increase older people's problems with accessing services

There are concerns that plans to improve access to GP services by moving them into larger primary care centres or polyclinics will disadvantage older

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[216] *Older people and eye tests: Don't let age rob you of your sight, Royal National Institute for the Blind,* London, 2007
[217] *Ageism and age discrimination in primary health care in the United Kingdom*, CPA, October 2009
[218] *Ageism and age discrimination in primary health care in the United Kingdom*, CPA, October 2009
[219] *Ageism and age discrimination in primary health care in the United Kingdom*, CPA, October 2009
[220] *Ageism and age discrimination in primary health care in the United Kingdom*, CPA, October 2009
[221] *Living Well in Later Life,* Healthcare Commission 2006
[222] *The Independent Inquiry into Inequalities in Health report*, Acheson D, 1998
[223] *Ageism and age discrimination in primary health care in the United Kingdom*, CPA, October 2009

people's access unless transport and other issues are addressed.[224] There has been little evaluation of ways that interventions designed to improve access impact on different groups.[225]

NHS organisations could do more to assess accessibility of the siting of services

NHS organisations cite problems in assessing the accessibility of their sites due to lack of available data, though there are data sources that could be used.[226]

Dual and multi-discrimination

Variations in access to primary care services can be compounded by other factors, such as race/ethnicity, disability and learning disability, and living in rural areas.

The new equality legislation introduces protection from discrimination because of a combination of two protected characteristics (e.g. discrimination because of being an older black woman). Local health organisations will want to ensure that they avoid the potential for such discrimination. This may require a particular focus on action to address the issues outlined below.

Particular issues for Black and Minority Ethnic (BME) people

Older people from minority ethnic groups tend to be less aware of what services are available and how to access them. This is particularly true of communities who have arrived recently in the UK (such as Somali and Yemeni people).[227]

Black and minority ethnic (BME) patients, especially Chinese and Bangladeshi people, show far higher levels of dissatisfaction in access to general practice.[228] [229] [230]

Levels of spoken and written English tend to be lower amongst Chinese, Vietnamese, Somali, Pakistani and Bangladeshi older people.[231]

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[224] *Primary Concerns – Older people's access to primary care*, Age Concern, 2008
[225] *Ageism and age discrimination in primary health care in the United Kingdom*, CPA, October 2009
[226] *Accessibility Planning and the NHS: improving patient access to health services*, NICE, 2006
[227] *The health and social care experiences of black and minority ethnic older people*, Moriarty J, Race Equality Foundation, July 2008
[228] *Report of the National Improvement Team for Primary Care Access and Responsiveness* Department of Health, 2008
[229] *No patient left behind: how can we ensure world class primary care services for black and minority ethnic people, Department of Health, 2008*
[230] *Report on self reported experience of patients from black and minority ethnic groups*, Department of Health and Healthcare Commission, 2008

In BME communities there is a low level of awareness of the impact of visual impairment and services that may reduce sight loss or improve management.[232]

There is under-use of low vision services by BME groups.[233]

People of African-Caribbean descent are eight times more likely to develop glaucoma than the general population.[234]

Particular issues for older people with learning disabilities

People with learning disabilities find it much harder than other people to access assessment and treatment for general health problems that have nothing directly to do with their disability.[235]

There is insufficient attention given to making reasonable adjustments to support the delivery of equal treatment, as required by equality/discrimination legislation. Adjustments are not always made to allow for communication problems, difficulty in understanding (cognitive impairment), or the anxieties and preferences of individuals concerning their treatment.[236]

Many health service staff, particularly those working in general healthcare, have very limited knowledge about learning disability. *"They are unfamiliar with the legislative framework, and commonly fail to understand that a right to equal treatment does not mean treatment should be the same. The health needs, communication problems, and cognitive impairment characteristic of learning disability in particular are poorly understood. Staff are not familiar with what help they should provide or from whom to get expert advice."*[237]

Particular issues for older people with dual sensory loss

There are over 2.7 million people in the UK with a combined sight and hearing loss ranging from minimal to severe. The majority have acquired this dual sensory loss in adult life and are over 60 years of age.[238] Little attention is

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[231] *The health and social care experiences of black and minority ethnic older people*, Moriarty J, Race Equality Foundation, July 2008
[232] *People from Black and Minority Ethnic Communities and vision services: a good practice guide*, Joule N and Levenson R, Thomas Pocklington Trust, 2008
[233] *People from Black and Minority Ethnic Communities and vision services: a good practice guide*, Joule N and Levenson R, Thomas Pocklington Trust, 2008
[234] *People from Black and Minority Ethnic Communities and vision services: a good practice guide*, Joule N and Levenson R, Thomas Pocklington Trust, 2008
[235] *Healthcare for All - Report of the Independent Inquiry into access to healthcare for people with learning disabilities*, Michael J, 2008
[236] *Healthcare for All - Report of the Independent Inquiry into access to healthcare for people with learning disabilities,* Michael J, 2008
[237] *Healthcare for All - Report of the Independent Inquiry into access to healthcare for people with learning disabilities*, Michael J, 2008
[238] *National Service Framework for Older People,* Department of Health, 2001

paid to their needs when accessing services. For example, a 2006 survey found that only 16 per cent of deaf blind patients were offered longer appointments to allow for the use of alternative communication methods (e.g. deaf blind manual, British Sign Language). In addition 58 per cent did not receive letters or appointment cards from any NHS organisation in a format they could access themselves (e.g. large print, Braille), though this represents a significant improvement on the 90 per cent reported in 2001.[239]

Access to primary care services for those in residential care

There is evidence that the 400,000 older people living in care homes have difficulty accessing the services of a GP and other primary care services.[240]

A fifth of care homes have no regular visits from a GP.[241]

Most older people living in care are unable to initiate a referral for a medical review although they often have complex medical problems. They depend on care staff to act on their behalf and determine whether a presenting problem should be 'assessed, diagnosed and managed'.[242]

NHS trusts have varied policies on providing continence services to care homes and differences in provision could mean that clients do not receive a standardised assessment and that their treatment and management is subsequently poor.[243]

Residents of care homes with diabetes are likely not to be receiving adequate treatment for their condition.[244]

Chronic pain is widespread amongst the residents of care homes, yet many people have never talked to a doctor or nurse about their pain and how it might be treated.[245]

Carers

Carers often find that their caring responsibilities prevent them from accessing health services both for their own needs and on behalf of the person they

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[239] *Cause and Cure – Deafblind people's experience of the NHS*, Deafblind UK
[240] *Ageism and age discrimination in primary health care in the United Kingdom*, CPA, October 2009
[241] *Ageism and age discrimination in primary health care in the United Kingdom*, CPA, October 2009
[242] McMurdo E and Witham D, 2007, cited in *Ageism and age discrimination in primary health care in the United Kingdom,* CPA, Oct 2009
[243] *Ageism and age discrimination in primary health care in the United Kingdom*, CPA, October 2009
[244] *Ageism and age discrimination in primary health care in the United Kingdom*, CPA, October 2009
[245] *Pain In Older People - A Hidden Problem - A qualitative study,* Cairncross L et al, Patients Association / Picker Europe, 2007

support. It is important therefore that both carers, and the people they care for, are given as much choice and control as possible when accessing NHS services.[246]

9.4 Drivers and policy imperatives

The NHS Plan[247] focused on cutting waiting times to increase access to GPs and emergency and elective hospital services. However, this included the pledge that by 2004 everyone would be able to see a GP within 48 hours. Whilst increasing access for many who want urgent appointments, this policy has been criticised for having a perverse affect in that people now find it hard to book an appointment for a few days ahead with the doctor of their choice. Older people particularly value being able to see the same doctor and may often be prepared to wait.

Our Health, Our Care, Our Say[248] set out a strategy to deliver primary and community services in settings closer to home. This includes services such as physiotherapy which were often provided from larger hospital sites.

Lord Darzi's interim report on the NHS Next Stage Review committed the Department of Health in October 2007 to making five key improvements to primary care. These were: to extend opening hours, create 100 new GP practices, develop 150 GP-led health centres, link NHS payments to GPs with patient satisfaction and make information about GP practices available on the NHS Choices website.

High Quality Care for All[249] pledged to extend choice of GP practice for patients and to provide better information to assist people's choices. GPs were also to be rewarded for providing more accessible services.

The Carers Strategy[250] is being reviewed by the Coalition Government with an announcement expected in the autumn 2010. The previous Government's strategy notes that the Quality and Outcomes Framework (QOF) provides pay incentives to GPs when they meet certain criteria in relation to carers: *"the practice has a protocol for the identification of carers and a mechanism for the referral of carers for social services assessment."* The strategy also states that, in the longer term, the Government will discuss with GPs and other health professionals the measures that can be taken to give a sharper focus to the distinct needs of carers.

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[246] *Carers at the heart of 21st-century families and communities*, Department of Health, 2008
[247] *The NHS Plan*, Department of Health, 2000
[248] *Our Health, Our Care, Our Say*, Department of Health, 2006
[249] *High Quality Care for All*, Department of Health, 2008
[250] *The Carers Strategy*, Department of Health, 2008

Disability Discrimination Act (DDA)

Since the 1995 Act service providers such as GP or dentist surgeries, walk-in centres, out of hours services and pharmacies have not been able to discriminate or offer a poorer quality of service to disabled people because of their disability. The Equality Act builds on this.

9.5 What good age-equal practice might look like

The National Improvement Team for Primary Care Access and Responsiveness (NIT) identified 10 common factors displayed by the best GP practices and their primary care trusts (PCTs):

1. Being responsive to patients and the public: listening to what patients say and then acting on it and backing action with evidence.
2. Good relationships between PCTs and practices: working together towards the same goals.
3. Strong PCT management of poor performance: identifying poor performers and helping them improve.
4. Opening at the right times: in the evenings and at weekends as well as routinely during weekdays.
5. Information for patient choice: giving patients information about the range and quality of local services available.
6. Increasing capacity of general practice: PCTs boosting patient choice by contracting with commercial, voluntary and mutual providers.
7. Positive approach to new models of care: being willing to explore new ways of delivering primary care services.
8. Capacity planning within practices: planning capacity and designing services to reflect the needs of registered patients and getting the most out of invested resources.
9. Development of talent and innovation: welcoming new technologies and skill mixes.
10. Strong leadership and teams with vision: having inspirational leaders (GPs and other clinicians) and developing a clear vision for how the whole practice team will work to improve services.

→ www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_084970?PageOperation=email

In addition *No patient left behind: how can we ensure world-class primary care for black and minority ethnic people?*[251] reviews why patients from black and minority ethnic backgrounds find it more difficult to access GP services and makes recommendations for improvement.

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[251] *No patient left behind: how can we ensure world-class primary care for black and minority ethnic people*? Department of Health, 2008

→ www.library.nhs.uk/commissioning/ViewResource.aspx?resID=301558

There are many practical steps which GPs and other service providers could take to better enable access for older people. Commissioners and providers could consider:

Promotion of services to older people

- Older people could be made more aware of the benefits of accessing services such as dentistry and eye care.
- Services could be promoted as 'old-age friendly'.
- Information about services could be provided in appropriate formats and languages for older people, including those from BME communities.

Planning location and transport

- Key indicators of access – such as percentage of households without access to a car and percentage that are 30 or more minutes from their GP surgery by public transport could be monitored.[252]
- Existing data sources, such as surveys by scrutiny committees or LINks, community needs surveys and annual GP patient surveys could be used to greater effect.
- Local health organisations should engage with local transport providers and older people to explore a range of transport options.
- All facilities should have adequate parking with designated spaces for disabled patients.
- A phone should be available in the surgery or clinic so that patients can call a taxi or other transport when they are ready to leave.

Improve physical access to service premises

- Doors which are easy to open and wide enough for wheelchair access and waiting areas that have space for a wheelchair to manoeuvre and turn.
- Ramps in place of steps.
- If there is an entryphone, ensure instructions are clearly marked and there are alternative arrangements for people with physical impairments.

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[252] *Report of the National Improvement Team for Primary Care Access and Responsiveness*, Department of Health, 2008

- Plenty of seating in the waiting area.
- Accessible toilet which is clearly signed with a wash basin and bin.
- Way-finding around larger clinics is facilitated, including the use of older people working as volunteers to provide assistance.

Appointments and reception

- Reception staff who are cheerful, friendly, kind (but not patronising), helpful and flexible – for example someone may need to be escorted to the treatment area if they are visually impaired.
- Finding out what assistance people may need when they book their appointment – for instance if they may need an interpreter.
- Staff who have sufficient time to be patient with those who cannot hear well or who need things explaining more than once.
- Staff who understand how to use a Textphone or Typetalk so that people who are deaf or hard of hearing can use these to make appointments.
- Privacy in the reception area to avoid personal matters being overheard.

Information and communication

Written information

- Information printed on standard-weight paper so that older people can easily hold and turn the pages.
- Offering information which is specifically tailored to the needs of older people (such as Age Concern and Help the Aged leaflets).
- Printed information in text size of at least font 12 (preferably 14), so it can be read comfortably by older people without spectacles.
- Text broken up into small chunks, using bullet points and illustrations.
- Locally relevant information with local contact details where available.
- Information translated into languages other than English where local BME groups have indicated this would be useful.
- The offer of alternative formats for the visually impaired – large print versions or information on tape. Also tapes or CDs in other languages.

IT

- Only 30 per cent of people aged 65 and over have ever used the internet. Any moves to increase opportunities to make online bookings should ensure that those without internet access are not disadvantaged and are still able to access the same range of appointments.

- GPs should avoid using 084 numbers. Older people do not like the additional functions offered by such numbers, especially if it means being held in a queue, and they much prefer to speak to another person to make their appointment or resolve their query than to use a push-button choice of options. In addition, the cost of such numbers can act as a barrier.

Face to face

- Many older people prefer to receive information verbally (face-to-face). This could be from a health professional or older people themselves could be trained to provide information to their peers in GP surgeries and other settings.
- Good quality interpreting services can raise the quality of care for people with limited proficiency in English. Quality, and availability, of interpreting services needs consideration and people should not have to rely on family members.
- Bilingual workers are an especially important resource. Where used some services have been able to achieve equal levels of access across different ethnic groups.
- Access to an advocacy service is an important part of a comprehensive information service that promotes informed choice. Primary care trusts can usefully work in partnership with local authorities and voluntary sector organisations to develop and promote advocacy schemes for older people.

Systems

In addition there are changes that could be made to appointment systems, times and locations including:

- Review when demand for services is highest and ensure that staff levels and working hours correlate as far as possible.
- Have appointment systems that allow people to book ahead if they wish to.
- Make longer appointment times available for those who need them.
- Increase availability of home visits for those who need them.

- Hold Saturday morning surgeries.

Involving older people

- GPs and PCTs could involve local older people as a key patient group when designing services or buildings, either through specific focus groups or through ongoing relationships with service users.

- Older people could also be involved in evaluating new patterns of service delivery to ensure they are meeting the needs of older people.
- Older people, including black and minority ethnic (BME) elders, could be involved in preparing information and reviewing current information provided to ensure it is accessible and relevant.

9.6 Case studies of illustrative / good practice

Holme Valley Transport Scheme

The Holme Valley Transport Scheme, developed in 2001, was designed to enable elderly, disabled and other vulnerable individuals, living in an isolated and rural locality, to be transported to and from primary care settings for essential and routine healthcare and treatment. The scheme serves a population of approximately 30,000, in an area of approximately 30 square miles, in the Holme Valley and the surrounding district of Holmfirth, West Yorkshire. The scheme is free of charge to users. It is managed and run from Honley Surgery and utilised by the other surgeries along the Holme Valley.

People with transport and/or access problems miss, turn down or choose not to seek medical help. Such people tend to be elderly, immobile, isolated and vulnerable. Access to primary care facilities is a longstanding problem, and it was often felt that patients were visited at home not necessarily for an acute medical reason, but because the patient had transport difficulties when accessing medical services. Indeed, public transport and access has always been a problem in the area and, as a consequence, small pockets of rural deprivation have developed in which the community members can be very isolated.

In order to develop the scheme Honley Surgery has worked in partnership with the following agencies:

- The Yorkshire Primary Care Research Network that facilitated and supported the research and development of the scheme.

- The Kirklees Pennine Rural Transport Partnership, an organisation whose aims are to raise the profile of rural transport issues and deliver transport improvements in South Kirklees.
- The Countryside Agency, a statutory body working to make the quality of life better for people in the countryside.

The scheme has been appraised by the Department of Transport as a National Model of Best Practice for tackling social exclusion.

The scheme has provided the following benefits for patients:

- improved personal independence
- reduced isolation
- improved physical health and activity
- improved social wellbeing and psychological health
- improved awareness of health and lifestyle.

The Holme Valley Transport Scheme became a registered charity in May 2007. (Registered No: 1119261.)

Further information
Helen Kitching, Honley Surgery
helen.kitching@GP-B85022.nhs.uk | 018484 303366

The North Hill Practice, Colchester

The North Hill Practice in Colchester has increased its capacity and skills mix through the addition of two nurse practitioners, both of whom have authority to refer and prescribe as appropriate. The first nurse practitioner is responsible for the care of older people and is predominantly community based, covering three local residential homes. The second focuses on patients aged under 75 who have a long-term condition. She triages new patients, runs her own daily clinics and sees patients on a weekly basis via pre-booked appointments, helping them to retain their independence and better manage their conditions in their own homes.

These two members of the practice team have significantly increased the number of appointments available to patients, decreased demand for GP home visits from five a day to five a week and freed up more GP time for specialist service management.

(Source: *Report of the National Improvement Team for Primary Care Access and Responsiveness*, Department of Health, 2008)

Improving access for older Chinese patients - Limehouse Practice, Tower Hamlets

The Limehouse Practice in Tower Hamlets, East London, has a significant number of Chinese patients, many of whom are older and speak little or no English. The practice has recruited a Cantonese-speaking advocate who provides these patients with a range of services including:

- a drop-in where patients can get help booking appointments and understanding letters they have received from the hospital or other health professionals
- fixed sessions on Tuesday and Thursday afternoons so that patients can match appointments and receive an interpreted consultation with a trusted advocate
- telephone advice and help for patients and their families
- active involvement with local Chinese associations to raise awareness of services provided by the practice and help local people access primary care services generally.

(Source: No patient left behind: how can we ensure world class primary care services for black and minority ethnic people? Department of Health, 2008*)*

Health Guides Project, East London

This project trains groups of local people to act as health guides within their community, using their own language. The aim is to give accurate information and guidance to people from marginalised communities, including encouraging people to manage their own health and take care of themselves and their families.

It has proved immensely popular. One of the health guides said: *"Such a simple idea – why has it never been done before?"* There is substantial interest from local people in training to be health guides, with a high completion rate of 90 per cent, and 200 local people have now been trained. They are local Bengali, Somali, Turkish/Kurdish, Congolese, and Nigerian people from Tower Hamlets, Newham or Hackney.

Trained health guides have been running sessions in their communities since December 2004. They work in pairs to deliver sessions in community settings (community centres, schools, mosques, clubs) to groups of people from their own communities at different times of the day, evenings or weekends as appropriate. More than 300 sessions have been delivered to date in East London, benefitting up to 5,000 people. In addition, the health guides have the opportunity to hear the concerns of local people at the grassroots level and feed the information back to decision-makers.

(Source: *No patient left behind: how can we ensure world class primary care services for black and minority ethnic people?* Department of Health, 2008.)

Working in residential care homes and nursing homes in Hartlepool

Hartlepool is a small town of 93,000 people situated on the northeast coast of England with one per cent of the population living within a care environment.
Over the past five years North Tees and Hartlepool Foundation Trust and Hartlepool Social Services department have been forward thinking and proactive in their provision of services for the older person in care/nursing homes.

Nursing and social care services teams work within an integrated service and have been implementing the Gold Standards Framework for care homes since April 2009. The integrated team consists of a specialist Macmillan nurse for palliative care and four community matrons working solely within the care home environment. Their role is to engage with residents, for reactive care and case management for long-term conditions, together with three social care officers who support residents with their social care needs. Linked to the team is a community specialist mental health nurse for the older person. The team also has access to a community pharmacy assistant.

The vision of the team is to ensure that all residents receive timely, appropriate and holistic care regardless of their diagnosis (cancer, dementia, end of life care, long-term conditions), preventing unwanted and unnecessary hospital admissions at the end of life.

The team works with residents, their families and care home staff to develop and support the process of advance care planning and establish preferred place and priorities of care. The team works closely with services such as district nursing, out of hours team and the hospital discharge teams.

The Macmillan nurse has developed an education programme for all care/nursing staff to enhance their end of life care skills. The team meets on a regular basis to discuss any clinical/nursing or social concerns and to develop strategies for individual resident's care and offer support and advice for all residents, their families and care/nursing home staff.

Strong clinical and managerial leadership has enabled the team to be confident and proactive and to provide high quality end of life care for the people of Hartlepool living within the care environment.

Further information
Sue Burke, Macmillan Nurse for Care and Nursing Homes - Hartlepool
sue.burke@nhs.net | 07740 512069

The Joseph Rowntree Foundation has published lessons for policy and practice on information, advice and advocacy for older people based on work in Newcastle

→ www.jrf.org.uk/publications/information-advice-advocacy-for-older-people

9.7 Suggestions for quick wins / what you can do now

- Consider the 10 factors identified by the National Improvement Team as contributing to making primary care services accessible and work with colleagues, primary care trusts and older people and their representatives to look at how your services could be amended to comply.
- Analyse the results of patient surveys, including segmentation of the results by age and other factors such as ethnicity, and agree action plans with practices to implement any necessary changes.
- Primary care trusts could introduce rewards for GP practices that make demonstrable changes to improve access for older people.
- Involve older people, including those who are disabled and black and minority ethnic people, in plans and pilots to develop local primary care services (polyclinics etc).
- Involve older people in work to look at what improvements might be made in access to those facilities where there are indications of problems (for instance from annual GP patient survey).
- Promote the benefits for older people of services such as dentistry and eye care.
- Review arrangements for providing access to GP services in care homes.
- Implement guidance on providing more accessible information to older people as outlined above.

9.8 Useful resources

The BMA document *Developing General Practice: Listening to Patients*, June 2009, was produced with involvement from Help the Aged and Age Concern and some disability organisations. It sets out useful guidance and practical advice. See:

→ www.bma.org.uk/employmentandcontracts/independent_contractors/managing_your_practice/listenpatient.jsp

The Royal National Institute for the Blind provides guidance on designing websites in order to ensure maximum accessibility. The site also has guidance on producing accessible information. See:

→ www.rnib.org.uk/Pages/Home.aspx

Commissioning Better Dental Services for Older People, September 2006, Bristol South and West Primary Care Trust, has some useful recommendations. See:

→ www.avon.nhs.uk/dental/publications/Reports_and_Strategy/Dental_and_Older_People_Report/commissioning%20better%20dental%20services%20for%20older%20people%20sept%2006.doc

Chapter 10
Footcare services

10.1 Key audiences

Primary care trusts and emerging GP commissioning consortia:

- commissioners of services for older people
- directors of public health and local authorities.

NHS trusts and NHS foundation trusts:

- managers of services for older people.

Community health services:

- senior staff.

Nursing homes:

- managers.

Older people voluntary sector organisations:

- chief executives.

10.2 A definition of footcare services

The Department of Health[253] defines footcare services as:

Services that could be provided by a trained lay person or carer:

- Toenail cutting - cutting and filing toenails safely, and keeping them at a length which feels comfortable.
- Skincare - smoothing and moisturising dry and rough skin, checking for cracks and breaks in the skin and signs of inflammation, looking for signs of infection or other obvious early problems and referring for further professional advice.

Services that should be provided by a health professional:

- Reviewing footwear to assure safety and stability.

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[253] *Footcare services for older people*, Department of Health, 2009

- Advising on suitability and how and where to obtain appropriate socks, shoes and other footwear.
- Prevention advice - keeping feet clean, dry, mobile, comfortable and warm and promoting good foot health advice based on each individual's lifestyle and circumstances.
- Signposting – knowing when to refer to podiatrists or other healthcare professionals and raising other health and social care risks with appropriate professionals including health and safety issues, social exclusion and benefit rights.

10.3 Key issues and concerns

Summary

- Footcare services are important for the wellbeing and continued mobility of older people, but foot problems are given low priority in the NHS and footcare services appear to be under resourced which affects older people disproportionately.
- Footcare problems affect a large proportion of older people.
- The provision of NHS footcare services does not meet the need.
- Provision of footcare services is variable across the country.
- There may be some evidence of multiple discrimination in access to footcare services for older women from lower socio-economic backgrounds.
- Access to footcare may be even poorer for those in residential care.
- There is a need for commissioners to ensure older people have equitable access to basic footcare.
- There is evidence for the cost-effectiveness of footcare services.

Footcare is particularly important to older people

Footcare services are important for the wellbeing and continued mobility of older people and levels of available services affect older people disproportionately.[254] Without access to footcare older people can be left in pain, housebound and at increased risk of falls and in extreme cases unable to mobilise.[255] Currently only 17 per cent of men and 13 per cent of women aged 65 to 74 meet the Chief Medical Officer's recommendations for physical activity, and these figures drop considerably among over-75s.[256]

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[254] *Ageism and age discrimination in primary and community health care in the United Kingdom - a review from the literature*, Centre for Policy on Ageing (CPA), 2009
[255] *Primary concerns: older people's access to primary care*, Age Concern Policy Unit, 2008
[256] *Footcare services for older people*, Department of Health, 2009

Footcare problems affect a large proportion of older people

Nearly one third of older people are unable to cut their own toenails, severely impacting on their ability to remain active and mobile.[257]

NHS footcare services do not meet need

In a review of progress against the *National Skills Framework for Older People* (NSF), podiatry services appeared under resourced in all the areas inspected.[258] Older people reported they had to use private services or wait very long times for NHS treatments. In the same review, people reported frequent delays in providing low-cost services such as toenail clipping.

A survey found that 58 per cent of older people needing footcare services had used private services, while 35 per cent were getting a service from the NHS. (One per cent had used a voluntary sector service and six per cent had received no service at all.) This report also found eligibility criteria for NHS footcare services had been tightened.[259]

Between 1996 and 2005 there was a 20 per cent drop in new episodes of care for NHS chiropody.[260]

Providing footcare services, which support the health and wellbeing of older people, should primarily be a responsibility for public services.[261] Age UK is concerned that payment can be a barrier to access and recommends that commissioners ensure that all who need footcare services are able to access them, regardless of ability to pay.

Rationing of footcare services can also occur through older people's inability to access services out of the home.[262]

There is variable geographical provision of footcare services

A public health observatory report on older people's health[263] found wide variation between regions in the care episode rate, the highest being in London and West Midlands and lowest in East of England and South East regions. Age Concern has also found very significant geographical variations in access to NHS services and consequent use of private services. *"Only 22*

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[257] *Primary concerns: older people's access to primary care*, Age Concern Policy Unit, 2008
[258] *Living well in later life: a review of progress against the National Service Framework for Older People*, Healthcare Commission, Audit Commission and Commission for Social Care Inspection, 2006
[259] *Primary concerns: older people's access to primary care*, Age Concern Policy Unit, 2008
[260] *NHS Chiropody Services Summary Information for 2004-05, England,* Health and Social Care Information Centre, 2005
[261] *Impact assessment of guidance on footcare,* Department of Health, 2009
[262] *Foot morbidity and exposure to chiropody - population based study* Harvey I, Frankel S and Marks R, British Medical Journal 315 (7115, 25 October 1997): 054-1055
[263] *Indications of public health in the English regions. 9: Older people*, Association of Public Health Observatories and West Midlands Public Health Observatory (APHO), 2008 www.wmpho.org.uk/resources/APHO_OP.pdf

per cent of older people who needed footcare in the South West region had used an NHS service compared to 59 per cent in the Northern region." [264]

The Department of Health has carried out a review of footcare services across the country to see what is available to older people. It has found plenty of good examples of services, but sometimes these are delivered in an uncoordinated way.[265]

Access to footcare in care homes may be poorer than in the community

A study of the treatment of people with diabetes in care homes found that 62 per cent of older people with diabetes had paid for their own chiropody.[266]

There is a need for commissioners to ensure older people have equitable access to basic footcare

The principal issue is that discrimination could be seen to be implicit in the general lack of priority for, and under investment in, community services, such as footcare services, that benefit older people. The *NSF for Older People* referred to one form of discrimination being a low overall rate of interventions that are relatively more important for older people and this is likely to be the situation in many parts of the country for footcare services.[267]

The need is for low-level, basic footcare. This could involve as little as teaching individuals how to care for their own feet. Such low-level services do not normally attract the attention of commissioners. Good footcare leads to reduced pain, increased mobility, increased self-esteem, increased participation in leisure and cultural activity and increased physical activity. In turn this can lead to wider positive outcomes such as older people remaining independent for longer and a reduction in falls.[268]

There is some evidence for the cost-effectiveness of footcare services

Despite the low priority given to foot problems in the NHS, health economic assessment suggests that the cost effectiveness of chiropody surpasses other interventions. One study found the apparently low benefit, but low-cost service of chiropody to be a potentially cost-effective use of NHS resources.[269]

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[264] *Primary concerns: older people's access to primary care,* Age Concern Policy Unit, 2008
[265] *Footcare services for older people*, Department of Health, 2009
[266] *Diabetes in institutionalised elderly people: a forgotten population?* Benbow S J, Walsh A and Gill G V, British Medical Journal 314 (7698, 28 June 1997) : 868-1869
[267] *Ageism and age discrimination in primary health care in the United Kingdom*, CPA, May 2009
[268] *Impact assessment of guidance on footcare*, Department of Health, 2009
[269] *Chiropody and the QALY: a case study in assigning categories of disability and distress to patients*, Bryan S, Parkin D, Donaldson C, Health Policy 18 (2) : 169-1851991

10.4 Drivers and policy imperatives

The importance of assessing needs for footcare (as part of the Single Assessment Process) was highlighted in the *NSF for Older People*[270], and again in *A new ambition for old age.*[271]

The *NHS Next Stage Review* points out that because people are living longer there is a need to proactively identify and mitigate health risks. This includes supporting people to take responsibility for their own health and helping them to live independent and fulfilling lives.[272]

In 2006 the regulatory body, the Commission for Healthcare Audit and Inspection, called for the Department of Health to improve access to both good quality podiatry and general footcare services by requiring primary care trusts to commission adequate provision of services.[273]

The then Government's 2009 strategy *Be active, be healthy: A plan for getting the nation moving* highlights the value of physical activities like walking and dancing to encourage older people to be more active.

The *Prevention Package for Older People*[274] encourages local health and social care commissioners to give priority to services that maximize health, wellbeing and independence in later life and re-emphasises the benefits of commissioning appropriate services in response to the cross-Government Ageing Strategy and the Equalities Act.

10.5 What good age-equal practice might look like

Commissioning an adequate amount of good basic footcare services (as outlined above) would promote age equality and avoid the possibility of discrimination through under-prioritising a service that is particularly beneficial to older people.

Successful models of footcare provision have the following characteristics:

- robust governance arrangements
- the development and maintenance of individuals competent to carry out footcare activities
- robust pathways of care with clear guidance on when people access podiatry or footcare services – i.e. access criteria, referral policies, policy on transfer between services
- regular service reviews, including patient satisfaction surveys

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[270] *National Service Framework for Older People*, Department of Health, 2001
[271] *A new ambition for old age*, Department of Health, 2006
[272] *High Quality Care For All – NHS Next Stage Review Final Report,* Lord Darzi, Department of Health, 2008
[273] *Footcare services for older people,* Department of Health, 2009
[274] *Prevention Package for Older People*, Department of Health, 2009

- evidence of meeting infection control standards
- appropriate and safe environment for provision of footcare services
- clear information about whether this service is free at the point of use or requires a financial contribution from the individual
- relevant mandatory training, including health and safety and safeguarding. [275]

Key actions for commissioners include discussions with all providers of footcare services regarding:

- which footcare interventions are already being delivered locally
- how well these services are performing
- which groups or communities are most at risk of being unable to access the service
- where there are gaps and under-provision
- where there is scope for better coordination between services
- ensuring that services are designed and delivered so that they are age-appropriate, especially in responding to the needs of older people and their carers.

It is also vital to include older people, particularly those most at risk of exclusion, in needs assessment and the commissioning process.

10.6 Case studies of illustrative / good practice

Social services home care and podiatry

Best Foot Forward is a joint footcare initiative between Gloucester Primary Care Trust's NHS podiatry service and the county council home care service. Home care assistants are trained by NHS podiatry to provide footcare in people's own homes. The initiative has the added benefit of improving job satisfaction for home care assistants, who are overseen by the podiatry service.

Further information
Chris Boden, Head of Gloucestershire Podiatry Services
chris.boden@glos.nhs.uk

[275] *Footcare services for older people*, Department of Health, 2009

Age Concern and PCT partnership

The Feet First service is provided by Age Concern Surrey in partnership with Woking Borough Council and Surrey Primary Care Trust to support older and disabled people in the local community. Feet First provides simple footcare which includes nail care, filing of callus, advice on self-care and guidance on suitable footwear.

The remit of the service is to provide footcare to the level which a well and able adult could do for themselves; it does not offer podiatry/chiropody treatment. The general aims are to ensure comfortable feet to help keep people mobile and independent with a reduced risk of falling and prevent, where appropriate, deterioration of foot health to a level where professional input is necessary.

The success of the service has led to increased demand and extension into other areas. Staff undergo a six-week validated training programme through local NHS podiatry departments.

Further information
Runette Theunissen
theunissen@surreypct.nhs.uk

Commissioning additional podiatry services

Following a comprehensive review and options appraisal, Westminster Primary Care Trust has commissioned additional footcare services from the current NHS podiatry service. The service will be delivered by trained footcare assistants who will benefit from supervision by registered podiatrists and easy access to qualified staff where clinical needs change beyond their scope of practice. Service delivery will benefit from a skills mix, internal governance and communication systems.

Further information
For details contact Mark C Brogan
mark.brogan@westminster-pct.nhs.uk | 020 7316 6807 or 07771 794045

Commissioning new roles

A Suffolk community healthcare staff training programme has created 100 new 'generic worker' posts to support seven areas of care: aspects of podiatry, occupational therapy, physiotherapy, nursing, medicines management, nutrition and mental health. Participants undergo specific training in anatomy, physiology, common foot conditions, footwear and footcare, ending with clinical practice and a competence assessment.

Generic workers can help service users manage their own footcare as well as possible by offering advice on self-management and information on where to go for further care or to buy equipment, if necessary.

Further information
Simon Bamford simon.bamford@suffolkpct.nhs.uk | 01473 275215 or 07940 471778
Jane Benten
01473 322143

10.7 Suggestions for quick wins / what you can do now

- Review provision of basic footcare and chiropody services with all local providers and older people to seek the best solutions to improve provision locally.
- Investigate inequalities in access to footcare services and seek solutions to improve access for all.
- Train existing staff that have regular contact with older people, e.g. healthcare assistants and community and practice nurses, in basic footcare.
- Ensure that footcare services are included in the Joint Strategic Needs Assessment.
- Implement Department of Health guidance on commissioning footcare services.[276]

[276] *Footcare services for older people*, Department of Health, 2009

Chapter 11
Hearing services

11.1 Key audiences

Primary care trusts and emerging GP commissioners:

- commissioners of services for older people and ear, nose and throat (ENT) services
- directors of public health and local authorities
- providers of community health services
- GPs.

NHS trusts and NHS foundation trusts:

- managers of services for older people
- audiology service managers.

11.2 Key issues and concerns

Summary

- Historically hearing services had long waits and were under-prioritised, but this situation has recently improved.
- The majority of people with hearing loss are in the older age group.
- Hearing problems can compromise safety and independence.
- Many older people who could benefit from a hearing aid do not have one.
- There are a significant number of older people with dual sensory loss and their needs are often neglected by service providers.

The majority of people with hearing loss are in the older age group

Historically hearing services had long waits and were under-prioritised, which impacted on older people in particular, but this situation has recently improved. More people will need hearing services as the population ages.[277]

[277] *Hearing services for older people*, Department of Health, 2009

Hearing problems can compromise safety and independence

Hearing problems can cause difficulty hearing fire alarms, traffic and pedestrian crossings etc. Other practical problems include hearing doorbells, telephones and other devices, and difficulty with communication can lead to social isolation.[278] Audiology services can particularly support older people to live independently.[279]

Many older people who could benefit from a hearing aid do not have one

Only approximately two million people in the UK use a hearing aid but over 4 million more could benefit from one. This figure includes nearly 20 per cent of people aged between 51 and 60; 36 per cent of people between 61 and 70; 80 per cent of 71 to 80 year-olds and 92 per cent of those aged over 80.[280]

There are a significant number of older people with dual sensory loss and their needs are often neglected by service providers

There are over 2.7 million people in the UK with a combined sight and hearing loss ranging from minimal to severe. The majority have acquired this dual sensory loss in adult life and are over 60 years of age.[281] Little attention is paid to their needs when accessing services. For example, a 2006 survey found that only 16 per cent of deaf blind patients were offered longer appointments to allow for the use of alternative communication methods (e.g. deaf blind manual, British Sign Language), in addition 58 per cent did not receive letters or appointment cards from any NHS organisation in a format they could access themselves (e.g. large print, Braille), though this represents a significant improvement on the 90 per cent reported in 2001.[282]

11.3 Drivers and policy imperatives

Improving Access to Audiology Services in England,[283] sets out a vision for all people with hearing and balance problems, including older people, for: *"high-quality, efficient services delivered closer to home, with low waits and high responsiveness to the needs of local communities, free at the point of access"*.

11.4 What good age-equal practice might look like

As hearing loss and speedy access to hearing aids has a particular impact on older people, primary care trusts can promote age equality through the

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[278] *Ageism and age discrimination in primary and community health care in the United Kingdom - a review from the literature*, Centre for Policy on Ageing (CPA), 2009
[279] *Hearing services for older people*, Department of Health, 2009
[280] *Audiology services: fifth report of session 2006–07, Report, together with formal minutes, oral and written evidence*, (HC 392 2006/07), Parliament, House of Commons Health Committee, TSO, 2007
[281] *National Service Framework for Older People*
[282] *Cause and Cure – Deafblind people's experience of the NHS,* Deafblind UK
[283] *Improving Access to Audiology Services in England*, Department of Health, 2007

continuing improvement of audiology services and ensuring that their design is appropriate to meet the needs of older people.

Huge progress has been made generally in waiting times for audiology assessments in England. At the end of November 2009, fewer than 200 people (0.6 per cent) had been waiting more than six weeks. The average wait for an audiology assessment (end of 2009) is under two weeks. Where improvements have been made that have resulted in a better experience for people with hearing and balance problems, these have resulted from changes to the way that services are provided, where they are provided and who provides them, such as:

- delivering services in primary care settings that are close to patients' homes, providing more convenient and more accessible care
- assessing falls risks while assessing and diagnosing balance disorders, improving home safety and enabling independent living.[284]

Commissioners could review local audiology services with older people, GPs and providers of the service to ensure that older people are benefiting from the reduced waiting times and are not waiting longer than others for audiology assessments. It will also be important to ascertain where delays and shortfalls occur for older people and to seek remedies.

It is also important to ensure that services and information are accessible to older people who have dual sensory loss. Healthcare staff need to be able to identify patients' support and communication requirements.

There is a range of tools to help commissioners and providers improve audiology services available on the Department of Health 18-week website, including:

- The national framework *Improving access to audiology services*[285] outlines actions which can help the NHS to change service provision in order to improve access

The Quality Enhancement Tool (QET) for audiology is a web-based assessment tool.

→ http://audiology.globalratingscale.com/Default.aspx?ReturnUrl=%2fMainMenu.aspx

[284] *Hearing services for older people,* Department of Health, 2009
[285] *Improving access to audiology services*, Department of Health, 2007

Audiology departments can self assess themselves against five quality criteria. This provides an effective benchmarking tool that aims to improve, year on year, the quality of the service being provided, which includes the quality of the patient experience.

11.5 Case studies of illustrative / good practice

Key learning and outcomes from pilot projects seeking to improve audiology services are shared via the NHS Improvement website:

→ www.improvement.nhs.uk/audiology

11.6 Suggestions for quick wins / what you can do now

- Review local audiology services, with older people, against the Department of Health national framework *Improving access to audiology services.*[286]
- Involve voluntary groups such as Royal National Institute for the Deaf and Age UK to ensure that audiology services have considered the specific needs of older people.
- Ensure that large print (at least 14pt) is used in all letters, appointment cards and information leaflets and that larger print versions are available.

[286] *Improving access to audiology services*, Department of Health, 2007

Chapter 12
Falls

12.1 Key audiences

Primary care trusts and emerging GP commissioning consortia:

- commissioners of community and hospital services, especially those for older people
- directors of public health
- providers of community health services
- GPs.

NHS trusts and foundation trusts:

- medical directors
- care of the elderly physicians
- directors of nursing
- allied health professionals
- accident and emergency departments.

12.2 Key issues and concerns

- Falling is a serious and frequent occurrence especially in people aged 65 and over.
- Hip fractures are the most frequent fragility fracture caused by falls and the commonest cause of 'accident' related death, but are often not managed well.
- Falls are a significant cost to local health and care services.
- Good clinical practice can reduce death and disability resulting from hip fractures and prevent future falls and fragility fractures, but despite evidence-based guidance on preventing and treating falls in older people there is poor recognition, diagnosis and management of those at risk.
- Commissioning of falls services is very variable.
- There are economic benefits of effective interventions to prevent and manage falls.
- There are potential discrimination issues in relation to falls that primary care trusts and providers need to consider.

Falling is a serious and frequent occurrence in people aged 65 and over

Each year, 35 per cent of over-65s experience one or more falls. About 45 per cent of people aged over 80 who live in the community fall each year. Between 10 and 25 per cent of such fallers will sustain a serious injury.[287] The consequences for an individual of falling or of not being able to get up after a fall can include:

- psychological problems, for example a fear of falling and loss of confidence in being able to move about safely
- loss of mobility leading to social isolation and depression
- increase in dependency and disability
- hypothermia.[288]

Falls, and fear of falling, have a significant human cost. Fewer than half of older people with a hip fracture return to their usual place of residence and for some it is the event that forces them to leave their homes and move into residential care.

Hip fractures are often not managed well

Hip fractures are the most frequent fragility fracture caused by falls and the commonest cause of 'accident' related death.[289]

There is a consensus that surgery for hip fracture should be carried out within 24 hours of presentation to accident and emergency (A&E) and that if this is delayed beyond 48 hours there is evidence to show that there is an increase in mortality and morbidity. Recent audits have shown up to 31 per cent of patients around the country are delayed beyond the 48 hours target.[290] [291] Most patients returning home from A&E after a fragility fracture are not offered a falls risk assessment and only 22 per cent were referred for exercise training to reduce future falls. Forty per cent left hospital without an adequate assessment of their osteoporosis.[292] [293] Even after recovering from hip

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[287] *Falls and Fractures,* Department of Health, 2009
[288] *National Service Framework – for Older People, Department of Health*, 2001
[289] *National Clinical Audit of falls and bone health in older people*, RCP/Healthcare Commission, 2007
[290] *National Clinical Audit of falls and bone health in older people,* RCP/Healthcare Commission, 2007
[291] *The National Hip Fracture Database Preliminary National Report*, British Orthopaedic Association and British Geriatrics Society, 2009
[292] *National Clinical Audit of falls and bone health in older people,* RCP/Healthcare Commission, 2007
[293] *The National Hip Fracture Database Preliminary National Report*, British Orthopaedic Association and British Geriatrics Society, 2009

fracture surgery, less than 50 per cent of people were on appropriate osteoporosis treatment.[294]

Cost to health and social care services

In addition to the individual costs, falls are a significant cost to local health and care services including:

- ambulance call-outs to pick up people who have fallen
- A&E attendances
- inpatient treatments for fractures and other trauma
- rehabilitation and other long-term follow up care and support. [295]

The numbers are large. A local authority and PCT population of 300,000 may currently include 45,000 people aged over 65. Of these:

- 15,500 will fall each year
- 6,700 will fall twice or more
- 2,200 fallers will attend an A&E department or minor injuries unit
- a similar number will call the ambulance service
- 1,100 will sustain a fracture, 360 to the hip.[296]

Despite evidence-based guidance on preventing and treating falls in older people, there is poor recognition, diagnosis and management of those at risk

Good clinical practice, based on national standards and evidence-based guidelines, can reduce death and disability resulting from hip fractures and prevent future falls and fragility fractures.[297] Despite evidence-based guidance on preventing and treating falls in older people there is poor recognition and diagnosis of those at risk. For instance, few GPs assess the risk of falling among their older patients or can do the required assessment.[298] Only 39 per cent of primary care trusts are compliant with NICE guidance on secondary prevention of osteoporotic fragility fractures.[299] For the minority of patients

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[294] *National Clinical Audit of falls and bone health in older people*, RCP/Healthcare Commission, 2007
[295] *Falls and Fractures – Developing a Local Joint Strategic Needs Assessment*
[296] *Falls and Fractures*, Department of Health, 2009
[297] *National Clinical Audit of falls and bone health in older people*, RCP/Healthcare Commission, 2007
[298] *Ageism and age discrimination in primary health care in the United Kingdom,* CPA, May 2009
[299] *National Audit of the Organisation of Services for Falls and Bone Health,* RCP and HQIP, March 2009

who attended a falls clinic, the falls and fracture risk assessments and treatment offered were better.[300]

Commissioning of falls services

Commissioning of falls services is very variable, rarely providing a coordinated falls and fracture strategy. There is low representation of falls and bone health in public health strategies.[301] A Royal College of Physicians (RCP) audit showed that only 20 per cent of Directors of Public Health Reports include falls and only 8 per cent report fracture rates.[302] The most recent RCP audit found that only 23 per cent of Joint Strategic Needs Assessments (JSNAs) included bone health or fractures.[303]

It is also important to be aware that there are many links between physical and mental health conditions in older people. A 2003 survey reported that the highest primary diagnosis, relating to dementia as co-morbidity, was for fracture of the femur. This indicates a need to develop links between mental health services and the falls strategy.[304]

There are economic benefits of effective interventions

Health and social care services have a joint interest in developing effective falls and fracture preventative services. There are economic benefits for both of effective interventions.[305] [306]

Discrimination

The principal issue is that discrimination could be seen to be implicit in the general lack of priority for, and under-investment in, community services, such as integrated falls services, that benefit older people.[307] *The National Services Framework for Older People (NSF)* referred to one form of discrimination being a low overall rate of intervention that is relatively more important for older people, and this is likely to be the situation in many parts of the country. The service for those who have had a hip fracture is also poor in many parts of the country.[308] [309] There is a need to ensure that falls services are equally accessible to all age groups.

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[300] *National Clinical Audit of falls and bone health in older people,* RCP/Healthcare Commission, 2007
[301] *Ageism and age discrimination in primary health care in the United Kingdom*, CPA, May 2009
[302] *Audit on Falls and Bone Health,* Royal College of Physicians, 2005-6
[303] *National Audit of the Organisation of Services for Falls and Bone Health,* RCP and HQIP, March 2009
[304] *A Pilot Survey - The Mental Health Needs of People Aged 65 years of Age and Over in an Acute Medical Setting*, Hopkin C, Kaiser P, Scholes J, Boaler S, 2003
[305] *Falls and Fractures*, *Review findings*, Department of Health, 2009
[306] *High Impact Actions for Nursing and Midwifery*, Department of Health et al, 2009
[307] *Ageism and age discrimination in primary health care in the United Kingdom,* CPA, 2009
[308] *National Clinical Audit of falls and bone health in older people, RCP/Healthcare Commission,* 2007

Dual/multiple discrimination

People with falls and fractures often have dementia, delirium or cognitive impairment and so have a degree of pre-existing disability. They often also have visual impairment. Those from poor socio-economic backgrounds or from some minority ethnic groups are likely to be less well informed about investigations and services.

12.3 Drivers and policy imperatives

The National Service Framework for Older People[310] highlighted falls as a significant issue for older people. Standard six set out an aim to:

> *"Reduce the number of falls which result in serious injury and ensure effective treatment and rehabilitation for those who have fallen."*

The standard set for the NHS and others is:

> *"The NHS, working in partnership with councils, takes action to prevent falls and reduce resultant fractures or other injuries in their populations of older people.*
>
> *"Older people who have fallen receive effective treatment and rehabilitation and, with their carers, receive advice on prevention through a specialised falls service."*

Whilst the NSF standards were set some years ago, there is still a need to maintain the focus on reducing falls and improving treatment of those who have fallen.

NICE has published the following relevant guidance:

> *NICE Clinical Guidance 21 Clinical practice guideline for the assessment and prevention of falls in older people.*
>
> *NICE Technology Appraisal (TA) 87 The clinical effectiveness and cost effectiveness of technologies of the secondary prevention of osteoporotic fractures in post-menopausal women.*
>
> *NICE Technology Appraisal (TA) 161 Review of treatments for the secondary prevention of osteoporotic fragility fractures in post-menopausal women.*

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[309] *The National Hip Fracture Database Preliminary National Report,* British Orthopaedic Association and British Geriatrics Society, 2009
[310] *National Service Framework for Older People,* Department of Health, March 2001

The National Hip Fracture Database was established in 2007 to focus attention on hip fracture both locally and nationally, benchmark its care across the country, and use continuous comparative data to create a drive for sustained improvements in clinical standards and cost effectiveness. See:

→ http://www.nhfd.co.uk/

12.4 What good age-equal practice might look like

The Department of Health has set out a comprehensive guide to effective interventions for health and social care organisations to prevent, treat and reduce the impact of falls in older people.[311] The Royal College of Physicians also makes recommendations to improve the care of those who have fallen and sustained a fracture.[312]

These set out the following aims and guidance:

PCTs will want to aim to reduce falls and fractures by:

- Preventing frailty and promoting bone health through encouraging physical activity and a healthy lifestyle - reviewing the range of therapeutic exercise options available locally and promoting evidence-based programmes in collaboration with local authorities through the joint commissioning and planning processes.
- Preventing accidents by reducing unnecessary environmental hazards – reviewing problems and solutions locally in collaboration with local authorities through the joint commissioning and planning processes.
- Commissioning community or hospital-based clinics which can perform the range of risk factor assessments necessary to offer an individual targeted treatment plan to reduce falls and fractures.

PCTs will want to aim to improve patient outcomes and improve efficiency of care after hip fractures through:

- Commissioning a patient care pathway for the secondary prevention of falls and fractures, including a fracture liaison service that targets the high-risk group of patients presenting with a first fragility fracture.
- Ensuring that prompt surgery can be offered for patients with hip fractures. They could encourage hospitals to apply the approach developed by the NHS Institute for Innovation and Improvement -

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[311] *Falls and Fractures*, Department of Health, 2009
[312] *National Clinical Audit of falls and bone health in older people*, RCP/Healthcare Commission, 2007

Delivering Quality and Value - Focus on: Fractured Neck of Femur (2006):

→ www.institute.nhs.uk

- Early intervention to restore independence – through falls care pathways, linking acute and urgent care services to secondary prevention of further falls and injuries.

A number of evidence-based inputs are identified to deliver these objectives:

- case-finding systems in hospital and community settings to identify high-risk fallers
- following recommendations set out by the National Hip Fracture Database[313]
- adherence to NICE appraisal guidance with monitoring by local audit
- identified clinical leaders including a consultant with job plan commitment
- a fracture liaison service to ensure initiation of secondary prevention medical treatments for osteoporotic fragility fractures
- targeted use of validated home safety assessments
- widespread and accessible evidence-based exercise programmes.

Promoting advice on exercise

It is worth noting that there is strong evidence for the promotion and provision of safe, effective exercise that includes strength and balance training (such as Tai Chi), to prevent falls.[314] Work by Help the Aged and others[315] found gender differences in preferences in relation to exercise programmes – more women prefer group-based to home-based interventions. Also research published by Help the Aged[316] suggests that older people respond best to health promotion programmes that stress the benefits of improving strength and balance rather than focusing on the risk of falls.

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[313] *The National Hip Fracture Database Preliminary National Report,* British Orthopaedic Association and British Geriatrics Society, 2009

[314] *Falls and Fractures – Exercise training to prevent falls*, Department of Health, July 2009
[315] *Falls and falls prevention amongst older people: socioeconomic and ethnic factors - Report to Department of Health*, Todd et al, 2008
[316] *Encouraging Positive Attitudes to Falls Prevention in Later Life*, Yardley and Todd, published, 2005

What does a good non-discriminatory age-equal service look like?

- Medical staff treat all fractures in older people according to clinical need and in line with best practice, providing advice on prevention of further falls and fractures and referring to other services where necessary. Falls are viewed as preventable and not an inevitable consequence of ageing.
- There is a presumption that older people are discharged to their own homes following a fall and fracture. This will require robust discharge planning including assessment and provision of any adaptations that may be needed and follow up support and prevention advice.
- The assessment, interventions and outcomes for older people who have had falls and fractures are audited and analysed to ensure that any differences with other groups can be justified by need.

12.5 Case studies of illustrative / good practice

NICE has a shared learning database with examples from organisations that have implemented the falls guidelines:

→ www.nice.org.uk/usingguidance/sharedlearningimplementingniceguidance/examplesofimplementation/examples_of_implementation.jsp

The NHS Institute has a collection of useful examples to help improve care for those with hip fracture, including local action plans, example pathways and job descriptions of key staff:

→ www.institute.nhs.uk/quality_and_value/high_volume_care/fractured_neck_of_femur_facts.html

University Hospitals of Leicester Trust

The trust aimed to implement changes in the management of elderly fallers within the Emergency Department (ED) and the Trust, based on NICE guidance with emphasis on local practice and resources. They carried out an audit of the ED in 2004 based on the local Falls Pathway.

This revealed very poor compliance and many instances of inappropriate management. They found that the assessment and management of patients presenting with falls to the Emergency Department had been inadequate on a number of fronts including:

- failure to construct a proper falls history
- failure to provide multi-factorial assessments
- failure to inform and educate on falls prevention programmes.

The following changes were made:

- A consultant in the ED established a liaison role with the geriatricians and formed a 'Falls Interest Team' within the ED.
- Community matrons were seconded to the ED from the PCT to help with managing the elderly fallers.
- An ED falls pathway of care was established
- A Directorate of Services for Elderly People (DSOP) was established.
- A one-day training conference on assessment and management of elderly fallers was established.
- A Department of Health-funded 'Pacesetters' programme within University of Hospitals Leicester, observed care of frail elderly patients in the ED and helped to raise awareness.

A second audit was conducted after two years to monitor progress and assess the efficacy of the changes made. This showed huge improvements.

(Source: NICE shared learning database.)

Further information
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Tameside and Glossop Primary Care Trust

The PCT had twice the national average rate of fractured neck of femurs - a break typically suffered by older people who have a fall. To tackle this a whole systems approach strategy was implemented involving the local council, crime prevention unit, Age Concern Tameside, local care homes, ambulance service, sports and leisure services, acute and primary care, health and social care services, and the social housing team. This has brought benefits to many older people who have avoided falls-related serious injury. Since its launch in 2004, the strategy has helped reduce the number of falls with serious facture rates to below the national average.

As part of the PCT-led strategy, a falls prevention steering group is active in ensuring falls prevention work is embedded in a wide range of community-based activities.

For example, the crime prevention unit now runs regular ‘Crucial Crew’ events to raise awareness of some self-protection issues among older people. National Falls Prevention Day now extends to a week of activities mainly delivered across Tameside by the Healthy Living lead at Age Concern Tameside. Age Concern Tameside also introduced regular ten-week falls

prevention programmes throughout the year. Supported by the PCT, the Healthy Living Community Falls Group offers education on falls prevention, recognising falls risks and signposting vulnerable people to other services. All the help and advice delivered is by professionals and team members who have training or suitable experience in falls prevention; dignity and respect is embedded throughout the project. Activities are aimed at a multicultural population and demonstration of various forms of physical activity is often undertaken by ethnic minority service users, particularly on major event days, to encourage as many people as possible to access falls prevention services.

Further information
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12.6 Suggestions for quick wins / what you can do now

- Make falls a key performance indicator reported to the trust board.
- Ensure that hospital trusts are participating in the national hip fracture database and audit:

  → www.nhfd.co.uk/
- Include fracture rates and falls in Annual Director of Public Health Reports.
- Prioritise falls and fractures for early inclusion in each area's joint strategic needs assessment (as recommended in *Falls and Fractures,* Department of Health 2009).
- Set up a multi-agency falls steering / working group and establish a plan to revise services in line with NICE guidance and the Department of Health's effective interventions guide.[317]
- Conduct a mapping exercise to get a clear picture of existing services and how they link together and where the gaps are. This can form the basis of a plan for establishing a comprehensive, multidisciplinary falls service.
- Appoint a falls coordinator at a senior level in the PCT.
- Commission a Fracture Liaison Service.

[317] *Falls and Fractures*, Department of Health, 2009

- See *Eight Questions you should ask of your Trust today* - Fractured Neck of Femur at

  → www.institute.nhs.uk/quality_and_value/high_volume_care/fractured_neck_of_femur_facts.html

- Involve older people in audit to ensure the service is accessible to older people and designed to be age appropriate.
- Plan an activity around National Falls Awareness Week:

  → www.ageuk.org.uk/get-involved/events-and-challenges/national-falls-awareness-week/

12.7 Useful resources

The Department of Health guidance, *Falls and Fractures - Developing a local joint strategic needs assessment,* provides a template for assessing local needs and services. This is part of the resources comprising the older people's prevention package:

→ www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_103146

Chapter 13
Continence

13.1 Key audiences

Primary care trusts and emerging GP commissioning consortia:

- commissioners of services for older people
- directors of public health and local authorities
- providers of community health services
- GPs.

NHS trusts and foundation trusts:

- medical directors
- clinical leads for elderly care medicine
- clinical leads for urology
- clinical leads for women's health
- clinical leads for gastrointestinal surgery
- care of the elderly physicians
- directors of nursing
- allied health professionals.

Nursing homes:

- managers.

13.2 Key issues and concerns

- Despite the existence of good practice guidelines on continence services from the Department of Health since 2000, and a milestone for integrated continence services in the *National Service Framework for Older People*, these services are often unavailable to those who need them.
- Where services do exist they are not integrated and often substandard.
- Urinary incontinence is particularly prevalent in women and older people.
- Faecal incontinence is prevalent in very elderly people and those in residential care.

- Incontinence is a common reason for entering a care home.
- Incontinence places a considerable stress on carers and is often the main reason for the breakdown of the caring relationship between an older person and their carer.
- It is not just the physical aspect of incontinence that is distressing but also the psychological and social effects.
- Continence is often a treatable condition.

Lack of availability of comprehensive continence services

Despite the existence of good practice guidelines on continence services from the Department of Health since 2000, continence services are often unavailable to those who need them [318] and are neglected, underfunded and not integrated.[319]

Incontinence is a particular issue for older people

Urinary incontinence is particularly prevalent in women and older people. Between 1 in 10 and 1 in 5 women over 65 have urinary incontinence and between 1 in 14 and 1 in 10 men aged over 65 have urinary incontinence.[320]

1 in 3 people in residential homes, nearly 2 in every 3 in nursing homes and 50 per cent to 66 per cent of those in general wards for older people, and older people's mental health wards, have urinary incontinence.[321]

17 per cent of very elderly people have symptoms of faecal incontinence and in residential care about 25 per cent have faecal incontinence.[322]

Incontinence is second only to dementia as the main reason for entering a care home. For carers, incontinence can be the 'last straw' and is often the main reason for the breakdown of the caring relationship, leading to admission to residential care.[323]

It is not just the physical aspect of incontinence that is distressing but also the psychological and social effects. The impact on older people's quality of life and loss of dignity is shocking – and unnecessary. Incontinence has been linked in various studies to depression and even suicide.[324] [325]

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[318] *National Service Framework for Older People*, Department of Health, 2001
[319] *National audit of continence care for older people (65 years and above) in England, Wales and N Ireland*, Wagg A, Peel P, Lowe D and Potter J, Royal College of Physicians, 2006
[320] *Good Practice in Incontinence Services*, Department of Health, 2000
[321] *Good Practice in Incontinence Services*, Department of Health, 2000
[322] *Good Practice in Incontinence Services*, Department of Health, 2000
[323] *Good Practice in Incontinence Services*, Department of Health, 2000
[324] *Indications of public health in the English regions. 9: Older people*, Association of Public Health Observatories and West Midlands Public Health Observatory (APHO), 2008 www.wmpho.org.uk/resources/APHO_OP.pdf
[325] *Incontinence – Help the Aged Policy Statement*, Help the Aged, 2008

Continence is often a treatable condition and continence services are particularly important to older people.[326] [327]

Guidance on continence services is often not implemented

An audit by the Royal College of Physicians in 2006 (the most recent though another is due to report in 2011) showed that whilst there is some basic infrastructure for these services, there remains inadequate access to integrated services and when someone is identified as having a problem they do not necessarily get an assessment. Only 66 per cent of primary care sites, 56 per cent of hospital sites, 63 per cent of mental health care sites and 69 per cent of care homes offered an integrated continence service.[328]

In hospitals, only half of the patients with urinary incontinence have a history taken and a specialist assessment done. In only 34 per cent of cases is a diagnosis documented. Fifty-eight per cent of patients are not actively treated, but are either given pads or are catheterised. This is not in line with Department of Health recommended good practice.[329]

NHS trusts have varied policies on providing continence services to care homes and differences in provision could mean that clients do not receive a standardised assessment and that their treatment and management is subsequently poor.[330]

A large number of care homes and community services put a restriction on the numbers of continence pads per person per day.[331]

It is still not unusual for patients in hospital wards to have to use commodes, rather than staff taking them to the toilet when needed.[332]

Older people still complain about delays in call bells being answered, resulting in the person being unable to use the toilet when it is needed. Older people report subtle or not so-subtle pressure to use incontinence pads, or even to soil their bedding, rather than make repeated or urgent requests to use the toilet.[333]

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[326] *Good Practice in Continence Services*, Department of Health, 2000
[327] *National Service Framework for Older People,* Department of Health, 2001
[328] *National audit of continence care for older people (65 years and above) in England, Wales and N Ireland*, Wagg A, Peel P, Lowe D and Potter J, Royal College of Physicians, 2006
[329] *National audit of continence care for older people (65 years and above) in England, Wales and N Ireland*, Wagg A, Peel P, Lowe D and Potter J, Royal College of Physicians, 2006
[330] *Continence care and policy initiatives*, De Laine C, Scammell J and Heaslip V, Nursing Standard vol 17, no 7, 2002
[331] *National audit of continence care for older people (65 years and above) in England, Wales and N Ireland*, Wagg A, Peel P, Lowe D and Potter J, Royal College of Physicians, 2006
[332] *Behind Closed Doors: using the toilet in private*, British Geriatrics Society, 2006
[333] *The Challenge of dignity in care – Upholding the rights of the individual*, Levenson R, Help the Aged, 2007

13.3 Drivers and policy imperatives

The Department of Health indicates that all necessary policy with respect to continence is in place; what is lacking is implementation of that policy.[334] *Good Practice in Continence Services*[335] sets out the evidence base, procedures, guidelines and targets for an integrated continence service across primary, community and acute care.

The *National Service Framework for Older People*[336] re-emphasised the importance of integrated continence services to support older people and their carers and stressed that they should be established as a priority (NSF Standard 2). The NSF included a milestone that all local health and social care systems should have established an integrated continence service by April 2004. (More recent RCP audits would suggest that these are still not in place in many localities.)

The *Essence of Care*[337] benchmarks support good practice in continence services.

The NICE guidance on continence services refers largely to *Good Practice in Continence Services*[338] and in addition provides:

- Guidance on commissioning a urinary continence service:

→ www.nice.org.uk/usingguidance/commissioningguides/uiwomen/CommissioningAUCService.jsp

- Guidance on commissioning a faecal continence service:

→ www.nice.org.uk/usingguidance/commissioningguides/faecalcontinenceservice/CommissioningFaecalContinenceService.jsp

- Clinical Guideline 40 – *The management of urinary incontinence in women*, 2006
- Clinical Guideline 49 – *Faecal incontinence: the management of faecal incontinence in adults*, 2007.

The Dignity in Care Campaign stresses the need for people receiving services to be involved in decisions about their personal care and to "*enable people to maintain the maximum possible level of independence, choice and control*" (Dignity Challenge Point 4).

It is anticipated that guidance on continence services will be added to the *Prevention Package for older people* from the Department of Health:

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[334] *National audit of continence care for older people (65 years and above) in England*, Wales and N Ireland, Wagg A, Peel P, Lowe D and Potter J, Royal College of Physicians, 2006
[335] *Good Practice in Continence Services*, Department of Health, 2000
[336] *National Service Framework for Older People*, Department of Health, 2001
[337] *Essence of Care*, NHS Modernisation Agency, 2003
[338] *Good Practice in Continence Services*, Department of Health 2000

→ www.dh.gov.uk/en/Publicationsandstatistics/Publications/dh_103146

13.4 What good age-equal practice might look like

Making continence services a priority and ensuring that an integrated continence service is in place would be an effective means by which local health organisations could demonstrate their commitment to promoting age equality.

Good Practice in Continence Services[339] sets out what commissioners and providers need to do in order to provide integrated continence services. It also sets targets and provides guidance for residential care and nursing homes and for inpatient care.

It is also important for primary care trusts to work with local authorities on wider issues to promote continence, such as the provision of public toilets.

The 2006 Royal College of Physicians audit of continence services[340] stressed the following issues that needed addressing:

- People with continence problems should be treated once a problem is identified. To neglect or ignore a problem once detected is clearly inadequate care. This is a point of action for all healthcare staff, in all settings.
- Integrated continence services for all adults, contained in "Good Practice in Continence Services" and reiterated in the National Service Framework, should be the goal, but remains a distant one in most areas. A considerable amount of organisational change is still required to meet the target. Commissioners of services need to bear this in mind when specifying their needs.
- All staff should be trained in basic assessment and management of this troublesome condition. Training should be accessible to all and should be made a mandatory component of basic training for staff.
- Handover between staff caring for older people with continence problems relies upon adequate documentation to maximise efficient use of resources. However, documentation of continence assessment and management for older people is wholly inadequate. This is clearly an example of substandard practice and should be relatively easy to improve upon.

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[339] *Good Practice in Continence Services*, Department of Health, 2000
[340] *National audit of continence care for older people (65 years and above) in England, Wales and N Ireland*, Wagg A, Peel P, Lowe D and Potter J, Royal College of Physicians, 2006

- In each service there should be a designated lead with responsibility for organisational change towards an integrated continence service. Commissioners need to ensure that provision, probably across provider units, with the relevant skilled staff is available to their population.
- People should have a proper assessment in order to get an accurate diagnosis. A lack of proper assessment will lead to either unnecessary treatment or inappropriate reliance upon containment of the problem. The needless use of pads is expensive and potentially undignified.
- Catheters should only be used for the management of incontinence after a thorough assessment of the problem and where other methods have either failed or the patient is too frail or too distressed to tolerate other more labour-intensive measures.

The British Geriatrics Society *Behind Closed Doors* Dignity Campaign provides action plans and tools to ensure that people, whatever their age and physical ability, are able to choose to use the toilet in private in all care settings:

→ www.bgs.org.uk/index.php?option=com_content&view=category&id=60&Itemid=169

13.5 Case studies of illustrative / good practice

Model documents

The Royal College of Physicians provides generic continence policy material, assessments and care pathways:

→ https://audit.rcplondon.ac.uk/continence2006/modules/page/Page.aspx?pc=1301&mid=56&pmid=0

Using technology to promote continence in a home setting

The following example, from Hanover SmartChoice, a service that helps care providers assist older people and people with disabilities to maintain their independence and remain safely in their own homes, demonstrates how assistive technology can help restore dignity.

Mrs J is a resident of an Extra Care scheme. When carers noticed an increase in her incontinence, the standard approach was for carers to enter her room at night and feel her bed to see if she had soiled herself. This was unsatisfactory for all. The solution was to use an enuresis pad which issues an alert if Mrs J is incontinent. This allows for carers only to enter her room when an incident occurs, and if she is incontinent she is assisted with her

toilet needs and bedclothes are changed straight away. It also enabled carers to examine records of alerts. They could see that a pattern of incontinence developed between 2 and 3am. Using this information carers can now assist Mrs J to the toilet at 1.30am and promote her continence.

Source: SCIE *Dignity in Care Practice Guide*

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

13.6 Suggestions for quick wins / what you can do now

- Look at results of the 2009 - 2011 Royal College of Physicians' audit with all stakeholders and make an action plan to improve.
- Ensure that there is a suitably trained clinical nurse specialist for continence management in all acute and community trusts.
- Ensure that local hospitals have multi-disciplinary consultant-led teams to coordinate continence services.
- Audit local hospitals and nursing homes to ensure that older people are not using commodes or incontinence pads inappropriately and that assistance is given to take people to the toilet when required.
- Review policies on rationing of continence pads in community, hospital and residential care settings.
- Audit and review use of catheters for incontinence in hospital settings.
- Ensure there is a designated lead in the primary care trust for continence services.

Chapter 14
Mental health (including dementia)

14.1 Key audiences

Primary care trusts and prospective GP commissioning consortia and outposts of the National Commissioning Board:

- chief executives
- commissioners of mental health services
- commissioners of services for older people
- frontline staff.

NHS trusts and NHS foundation trusts:

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

Third sector providers:

- chief executives
- frontline staff.

14.2 Introduction

This section includes both functional mental health and dementia. Both are important for older people and those who commission and deliver older people's services, whether in a specialist mental health setting, in hospitals, residential care and nursing homes, or in people's own homes. The population of older people is growing and, while poor mental health is not an inevitable part of ageing, a number of mental health conditions are common in old age, but may, nevertheless, be unrecognised or under-treated. In older people there may also be co-morbidities, with mental health and physical health conditions or frailty being present at the same time, so the mental health needs of older people may be complex.

14.3 Key issues and concerns

Age discrimination

- Mental health remains the area of health services in which age discrimination persists to the greatest extent. However, it can be addressed through a focused local approach.
- The combination of an ageing population and the under-diagnosis of mental health problems in older people add up to an urgent need to end age discrimination in mental health.
- Dual/multiple discrimination can be a significant issue for older people with mental health problems.

Demographics and prevalence

- The number of older people is rising and that will result in a greater number of people with mental health problems.
- Dementia is mainly a condition experienced by older people.
- A number of other mental health problems are more common in older people than in younger age groups; depression is particularly common. However, poor mental health is not an inevitable part of ageing.
- Co-morbidity of physical and mental health problems occurs frequently in older people.

Lack of awareness of the mental health needs of older people

- In the context of a historic lack of priority for the needs of older people, there has been a lack of awareness of their needs, which have often been considered only in terms of dementia.
- Mental health problems, particularly depression, and dementia are often unrecognised and under-treated in older people.
- The mental health needs of older people who are in hospital for any reason should be considered.
- There is limited availability of good quality national or local data in relation to the quality of specialist older people's mental health services.

The need for age-appropriate, non-discriminatory services

- New services have been focused on working age adults so older people have limited access to services that would meet their needs (talking therapies, crisis resolution etc). However, there is evidence that older people can benefit from a range of specialist mental health services.

- There is a lack of age-appropriate services for older people and for younger people with dementia.
- There are important differences in the nature, meaning, treatment and care needs of mental health problems developing in later life.
- There are concerns about the quality of care for older people for both functional mental health problems and dementia.
- Improved mental health care in care homes would be very beneficial.
- Liaison psychiatry is most often a service available only to adults of working age, although it is likely to be a benefit, if available, to older people too.

Age discrimination

The persistence of age discrimination

Mental health was recognised as an area of persisting age discrimination in the recent review by Sir Ian Carruthers and Jan Ormondroyd, whose recommendations include the need to consider how to achieve non-discriminatory, age-appropriate services.[341]

Specifically, *Achieving age equality* recommends*:*

> *"Every provider and commissioner of mental health services will need to consider how to achieve non-discriminatory, age-appropriate services, drawing on insights from reports such as Equality in Later Life and other sources of good practice."*

A recent authoritative paper stated unequivocally that there is age discrimination in mental health. It also stated that in relative terms, at least, older people with mental illness are worse off now than 10 years ago. [342]

Essentially, the problem is that improvements in services for adults of working age have improved faster than services for older people, and the increasing number of older people has not been matched by proportionate increases in funding, so the gap has therefore widened.

There remains local variation in the way that services are organised, with some areas discriminating directly by age in continuing to operate a

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[341] *Achieving age equality in health and social care*, Sir Ian Carruthers and Jan Ormondroyd, 2009

[342] *The need to tackle age discrimination in mental health. A compendium of evidence,* prepared by Anderson D, Banerjee S, Barker A, Connelly P, Junaid O, Series H and Seymour J, on behalf of the Faculty of Old Age Psychiatry, Royal College of Psychiatrists, 2009 www.rcpsych.ac.uk/PDF/Royal%20College%20of%20Psychiatrists%20-%20The%20Need%20to%20Tackle%20Age%20Discrimination%20in%20Mental%20Health%20Services%20-%20Oct09.pdf

compulsory transfer to older people's services at age 65 (or some other age) and local commissioning decisions, possibly inadvertently ageist, resulting in under-provision for older people's mental health services. In fact, mental health services for older people provide one of the few remaining examples, within the NHS, of the continued existence of explicit institutional 'direct' age discrimination – a fact that was noted in 2006 by the Healthcare Commission, Commission for Social Care Inspection (CSCI) and Audit Commission.[343] This direct age discrimination results from the age-based division into mental health services for adults and older people's mental health services.[344]

Older adults with mental health needs have not benefited from some of the developments in services experienced by younger adults and developments in services for older people do not always fully meet their mental health needs. The Healthcare Commission noted poor access to out-of-hours and crisis services, psychological therapies and alcohol services. Services for younger adults indirectly discriminated against older adults, even when, in theory, there was no obstruction to their access (for example, by providing services that are open to older people, but are not sensitive to their age-related needs).[345]

However, that is unlikely to be the whole story and specialist mental health services may be necessary in old age even if access to general mental health services is improved for older people. A paper from the Royal College of Psychiatrists points out that when there was a single, age inclusive approach to all in mental health, there were instances of serious neglect of older people that resulted in the need for old age specialist services. They state that inertia in a previous era, the manner in which mental health policy has been framed, interpreted and commissioned in the immediate past and present, and failure to respect and value older people are all relevant explanations for age discrimination in mental health.[346]

Research commissioned by the Department of Health to explore the extent of age discrimination in mental health services found that despite a stated belief that older people should be able to access the same services as those under 65 years, often older people's teams did not know about services, such as supported employment or assertive outreach, which were managed by teams for working-age adults.

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[343] *Living well in later life: a review of progress against the National Service Framework for Older People,* Healthcare Commission, Commission for Social Care Inspection (CSCI) and Audit Commission, 2006

[344] *Ageism and age discrimination in mental health care in the United Kingdom – a review from the literature*, Centre for Policy on Ageing (CPA), 2009

[345] *Equality in Later Life - A national study of older people's mental health services, Healthcare Commission*, 2009

[346] *The need to tackle age discrimination in mental health. A compendium of evidence,* prepared by Anderson D, Banerjee S, Barker A, Connelly P, Junaid O, Series H and Seymour J, on behalf of the Faculty of Old Age Psychiatry, Royal College of Psychiatrists, 2009

The Mental Health Foundation (MHF) has also noted that older people with mental health problems in England do not receive the same level or quality of care as younger people.[347] The MHF states that it is important that eligibility and access to such care should not be age-based, but rather what is most suited to addressing the particular problem that develops for each individual. They state that age should play no part in allowing or restricting access to the most appropriate care and treatment.

Addressing age discrimination in mental health services – evolving views

As the Centre for Policy on Ageing (CPA) Review indicates, there is no universal agreement on whether older people's mental health services should be organised as a separate service or as a specialism, with protected funding, within adult psychiatric services. Opinions may vary as to whether the recognition of the specialty may be inherently age discriminatory or a case of reasonable age-based differentiation and therefore a proportionate means of achieving a legitimate aim. However, the Royal College of Psychiatrists believes it is essential that services sensitive to different needs continue to be provided and that specialist older people's mental health services, with unique expertise meeting a particular set of needs characteristic for later life, continue to be provided comprehensively in all commissioning areas. Failure to provide these services would deny older people access to services specifically designed to meet their need.[348] This is in line with the views of the Faculty of Old Age Psychiatry of the Royal College of Psychiatrists. [349]

The Equality Act recognises that different treatment of people of different ages can be the most appropriate way of providing services and is not automatically harmful discrimination. The test for NHS commissioners and providers is that the difference needs to be able to be "*objectively justified*" by showing that it is the least discriminatory approach and is a proportionate means of achieving the legitimate ends. High quality mental health services for older people should be able to demonstrate that they meet this test even where the service model retains a broad age-based pattern alongside comprehensive and fair assessment of the individual's needs and aspirations.

Dual/multiple discrimination

In the context of mental health, there are many ways in which people can experience either additive or cumulative discrimination. Different organisations identify sectors of the community or mental health conditions where they see

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[347] *All things being equal – Age equality in mental health care for older people in England,* Mental Health Foundation, April 2009

[348] *Age Discrimination in mental health services: making equality a reality*, Royal College of Psychiatrists' position statement and compendium of evidence, 2009

[349] *The need to tackle age discrimination in mental health. A compendium of evidence,* prepared by Anderson D, Banerjee S, Barker A, Connelly P, Junaid O, Series H and Seymour J, on behalf of the Faculty of Old Age Psychiatry, Royal College of Psychiatrists, 2009

a gap or not enough attention. There are issues of concern for black and minority, ethnic (BME) communities, as well as issues about discrimination relating to gender, sexuality and disability.

While there is an extensive literature about race and health, including mental health, many studies do not distinguish between older and younger BME people so it can be difficult to establish differences. However, it is likely that the issues that pertain to BME people with mental health problems of all ages are at least as relevant to older people, with the possibility that language and cultural issues may be of even greater significance to older age groups. It is also suggested that BME groups report age-related changes at an earlier age and that health differences by ethnicity are actually greatest among older people. [350]

Also Asian and black Caribbean families may have differing ideas about changes that can be attributed to 'ageing' and those that may be attributed to dementia and so may be less likely to ask for help at an early stage. The existence of stigma about mental health problems in old age can be higher in some communities than others.[351]

Older people are more likely than younger age groups to experience mental health problems alongside physical disabilities, with the possibility of experiencing discrimination related to both.

Living in a rural area can also be associated with geographical and social isolation for older people. In rural areas, the proportion of people over 75 is already at the level that we expect to see in the rest of the country in 20 years or more. This creates extra challenges for rural communities and those planning health and social care.

Demographics and prevalence

Prevalence of mental health problems in older people

Mental health problems are present in 40 per cent of older people who attend their GP, in 50 per cent of older adult inpatients in general hospitals, and in 60 per cent of residents in care homes. Just over a quarter of admissions to mental health inpatient services involve people over the age of 65.[352]

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

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

[352] *Equality in Later Life - A national study of older people's mental health services*, Healthcare Commission, 2009

Recent figures show that the rate to admitted care for people aged 75 and over was 425 per 100,000 population, which was 71.4 per cent higher than the overall rate of access to admitted care:[353]

Roughly one third of all mental health service activity in England is concerned with the care and treatment of people over the age of 65, but services tend to be geared towards the needs of younger adults. Dementia affects about 570,000 people in England. At the current rate the number of people with dementia will double in the next 30 years and the cost to the country will rise from £15.9 billion this year to £34.8 billion by 2026.[354] Dementia is the most strikingly age-related medical diagnosis with 2.2 per cent developing before age 65, 1.3 per cent at age 65-69, but 32 per cent over 90.[355]

A recent report from the Alzheimer's Society stated that people with dementia over 65 years of age are currently using up to one quarter of hospital beds at any one time.[356] Another recent article showed that in medical admissions to hospital in people over 70, 42.4 per cent of these had dementia, and 50 per cent of those had not been previously diagnosed. The authors concluded that the rising prevalence of dementia will have an impact on acute hospitals and extra resources will be required for intermediate and palliative care and mental health liaison services. [357]

Even more recently, it has been suggested that the number of people with dementia, and the costs associated with it, are higher than previously estimated.[358]

Delirium (acute confusion) is predominantly a condition of later life and affects up to 50 per cent of older people admitted to hospital. It is significantly more common in people over age 65 and people with dementia. The risk of

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[353] *Mental Health Bulletin - Third report from Mental Health Minimum Dataset (MHMDS) annual returns, 2004-2009,* The Health and Social Care Information Centre, 2009 www.ic.nhs.uk/statistics-and-data-collections/mental-health/nhs-specialist-mental-health-services/mental-health-bulletin--third-report-from-mental-health-minimum-dataset-mhmds-annual-returns-2004-2009

[354] *Improving dementia services in England - an interim report* by the Comptroller and Auditor General, National Audit Office, HC 82 Session 2009–2010.14, January 2010

[355] *The need to tackle age discrimination in mental health. A compendium of evidence,* prepared by Anderson D, Banerjee S, Barker A, Connelly P, Junaid O, Series H and Seymour J, on behalf of the Faculty of Old Age Psychiatry, Royal College of Psychiatrists, 2009

[356] *Counting the cost – caring for people with dementia on hospital wards,* Alzheimer's Society, 2009

[357] *Dementia in the acute hospital: prospective cohort study of prevalence and mortality,* Sampson E L, et al, The British Journal of Psychiatry (2009) 195: 61-66. doi: 10.1192/bjp.bp.108.055335

[358] *Dementia 2010, The economic burden of dementia and associated research funding in the United Kingdom*, Alzheimer's Research Trust, University of Oxford, 2010 www.dementia2010.org/reports/Dementia2010Full.pdf

developing delirium after age 65 is 3 times higher and rises rapidly with increasing age thereafter.[359]

Depression in older people is both very common and often goes unrecognised although depression in later life is strongly linked to ill-health and disability. While dementia has been the highlighted age-related condition, the number of people over age 75 with depression will increase by 30 per cent and those over 85 by 80 per cent by 2026. The prevalence of depression in people aged over 64, averaged across Europe, is 13.5 per cent, being almost three times more common than dementia and increasing with age after 65, especially in those living alone with poor material circumstances.[360]

The Royal College of Psychiatrists reports that while the rate of suicide at all ages in the population declined between 1997-2006, the proportion over age 65 has not changed, while that in younger people has reduced. Depression is by far the most common associated mental illness and present in 80 per cent of people over the age of 74 who commit suicide.[361]

However, recent figures on suicide in the UK show a decrease in suicides amongst both males and females over the age of 75, with the rates for men now being the lowest rate across the three male age bands.[362]

Psychosis is much more common in older people than younger adults, with 20 per cent of people over age 65 developing psychotic symptoms by age 85 and most are not a precursor to dementia. These high rates of hallucinations and paranoid thoughts remain high in people of 95 years of age without dementia.[363]

Neuroses and personality disorder, conversely, are less common with increasing age. Eating disorders and use of illicit substances are predominantly conditions of younger people though a significant increase in older people needing treatment for substance misuse, if only by virtue of ageing, is predicted.[364]

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[359] *The need to tackle age discrimination in mental health. A compendium of evidence,* prepared by Anderson D, Banerjee S, Barker A, Connelly P, Junaid O, Series H and Seymour J, on behalf of the Faculty of Old Age Psychiatry, Royal College of Psychiatrists, 2009

[360] *The need to tackle age discrimination in mental health. A compendium of evidence,* prepared by Anderson D, Banerjee S, Barker A, Connelly P, Junaid O, Series H and Seymour J, on behalf of the Faculty of Old Age Psychiatry, Royal College of Psychiatrists, 2009

[361] *The need to tackle age discrimination in mental health. A compendium of evidence,* prepared by Anderson D, Banerjee S, Barker A, Connelly P, Junaid O, Series H and Seymour J, on behalf of the Faculty of Old Age Psychiatry, Royal College of Psychiatrists, 2009

[362] *Suicide rates in the United Kingdom 1991-2008,* ONS Statistical Bulletin, January 2010 www.statistics.gov.uk/pdfdir/sui0110.pdf

[363] *The need to tackle age discrimination in mental health. A compendium of evidence,* prepared by Anderson D, Banerjee S, Barker A, Connelly P, Junaid O, Series H and Seymour J, on behalf of the Faculty of Old Age Psychiatry, Royal College of Psychiatrists, 2009

[364] *The need to tackle age discrimination in mental health. A compendium of evidence,* prepared by Anderson D, Banerjee S, Barker A, Connelly P, Junaid O, Series H and Seymour J, on behalf of the Faculty of Old Age Psychiatry, Royal College of Psychiatrists, 2009

Substance misuse, particularly alcohol misuse, has been identified as a cause of dementia in 10 per cent of younger patients. As a potentially preventable, and in some cases treatable, form of dementia, alcohol-related brain impairment represents an area of considerable concern.[365]

Co-morbidity occurs more frequently in older people

Physical co-morbidity is much more common in later life and has implications for the treatment of some mental health conditions. There are many links between physical and mental health conditions in older people. A 2003 survey reported that the highest primary diagnosis, relating to dementia as co-morbidity, was for fracture of the femur. This indicates a need to develop links between mental health services and the falls strategy.[366]

Also see Chapter 12 Falls.

When coronary heart disease (CHD) and depression co-exist, the conditions interact, resulting in worse outcomes. Patients with CHD and depression have an approximate two-fold increase in morbidity and mortality.[367] [368] [369]

In one study, older patients with depression following a myocardial infarction were much more likely to die in the first four months after the event.[370] Depression in late life was an independent risk factor for heart failure among elderly women in another study.[371] Review evidence suggests that depression increases mortality and morbidity in ischaemic heart disease.[372]

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[365] *Services for younger people with Alzheimer's disease and other dementias, Royal College of Psychiatrists*, Council Report CR135, 2006
[366] *A Pilot Survey - The Mental Health Needs of People Aged 65 years of Age and Over in an Acute Medical Setting*, Hopkin C, Kaiser P, Scholes J, Boaler S, 2003
[367] *Depression as a Risk Factor for Mortality in Patients with Coronary Heart Disease: A Meta-analysis,* Barth J, Schumacher M, Herrmann-Lingen C, Psychosomatic Medicine 2004: 66:802-813
[368] *Depression as an aetiologic and prognostic factor in coronary heart disease: a meta-analysis of 6,362 events among 146,538 participants in 54 observational studies*, Nicholson A, Kuper H, Hemingway H, Eur Heart J 2006, 27(23):2763-2774
[369] *Prognostic association of depression following myocardial infarction with mortality and cardiovascular events: a meta-analysis*, van Melle J P, d Jonge P, Spijkerman T A et al, Psychosomatic medicine 2004: 66:814-822
[370] *The significance of depression in older patients after myocardial infarction,* Romanelli J, Fauerbach J, Buch D, Ziegelstein R, Journal of American Geriatric Society, 50, 817-822, 2002
[371] *Depression and risk of heart failure among the elderly: a prospective community-based study*, Williams S, Kasl S, Heiat A, Abramson J, Krumholz H and Vaccarino V, Psychosomatic Medicine, 64, 6-12, 2002
[372] *Relationship between depression and other medical illnesses*, Roose, S P, Glassman A H and Seidman S N, JAMA, 286, 1687-1690, 2001

Mental health problems, particularly depression and dementia, are more common and have a worse outcome in the 60 per cent of older people who suffer from a long-term illness.[373]

Lack of awareness of the mental health needs of older people and poor access to services

Poor mental health is not an inevitable part of old age

Neither depression nor dementia, or any other mental health problem, is a natural or normal part of ageing.[374]

Lack of awareness of the mental health needs of older people

Particular challenges include lack of awareness of the mental health needs of older people and proper diagnosis in primary care and in acute hospitals, as well as variable quality and availability of the full range of services.[375]

There are also concerns about the low level of awareness of and training about dementia and other mental health problems in non-specialist staff.[376]

Poor data on older people's mental health

The Healthcare Commission found that there was limited availability of good quality national or local data in relation to the quality of specialist older people's mental health services. Nationally available data did not provide a robust basis on which to compare the performance of different areas in meeting older people's mental health needs, or to provide the boards of trusts with sufficient information to be confident about the extent to which they are providing good quality non-discriminatory care.[377]

Untreated depression

Unrecognised and untreated depression is a key issue and a lack of awareness of depression in older people has also been noted for some time now, for example in the *National Service Framework for Older People*[378] and *Forget me Not.*[379] A recent report refers to the high rates of depression and low rates of its identification in primary care in both older people who are living at home and those in residential care.[380] The Department of Health is working with the Royal Colleges of Psychiatrists, General Practice and Nursing and

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[373] *Equality in Later Life - A national study of older people's mental health services,* Healthcare Commission, 2009
[374] *Living Well with Dementia: A National Dementia Strategy,* Department of Health, 2009
[375] *Equality in Later Life - A national study of older people's mental health services,* Healthcare Commission, 2009
[376] *Better prepared to care – The training needs of non-specialist staff working with older people with mental ill-health,* Levenson R, Joule N, Mental Health Foundation, February 2007
[377] *Equality in Later Life - A national study of older people's mental health services,* Healthcare Commission, 2009
[378] *National Service Framework for Older People*, Department of Health, 2001
[379] *Forget Me Not: Mental Health Services for Older People*, Audit Commission London, 2000
[380] *New Horizons – Towards a shared vision for mental health,* Consultation, Department of Health, 23 July 2009NB

the British Psychological Society to develop appropriate training initiatives to improve the rate of identification and treatment of depression in older people living both in the community and in residential care.

Care homes

Access to good mental health care in care homes would be an enormous benefit and immediate attention to this area would reach some of those older people with the greatest level of need. A recent paper stated that delivering older people's mental health services to care homes improves quality of life and reduces prescribing of antipsychotic drugs, use of GP time and days spent in hospital.[381]

Access to a range of treatments

There is evidence that psychological therapies are effective with older people and their carers in the management of a wide range of mental and physical conditions.[382] However, older people may be disadvantaged in terms of access to the whole range of treatment options from which they could benefit. There has tended to be an unwarranted reliance on pharmacological treatments, while access to talking therapies and crisis services has not always been available to older people who need it. For more information on psychological therapies for older people, see the website of the Improving Access to Psychological Therapies programme[383] and the faculty of old age psychology (PSIGE www.psige.org.uk)

Under-diagnosis of dementia

There are long-standing concerns about dementia services for people of all ages, and this has been recognised by the *National Dementia Strategy*, which includes as one of its aims "*to ensure early diagnosis, support and treatment*".[384]

In 2007, a report from the National Audit Office stated that only 31 per cent of GPs felt they had enough training to diagnose and manage dementia.[385]

A recent report from the Alzheimer's Society[386] noted that dementia is still greatly under-diagnosed. It is estimated that only a third of people with any form of dementia actually get a formal diagnosis. In some cases GPs did not take symptoms seriously or told people that it was just a natural sign of ageing; or conversely, a diagnosis was not made where younger people were showing symptoms because it was believed that dementia is an illness only

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[381] *The need to tackle age discrimination in mental health. A compendium of evidence,* prepared by Anderson D, Banerjee S, Barker A, Connelly P, Junaid O, Series H and Seymour J, on behalf of the Faculty of Old Age Psychiatry, Royal College of Psychiatrists, 2009
[382] *Effectiveness of psychological interventions with older people,* Woods B et al. In (eds) A. Roth and P. Fonagy, What works for whom? A Critical Review of Psychotherapy Research, NY Guilford Press, 2004
[383] www.iapt.nhs.uk/special-interests/older-people/
[384] *Living Well with Dementia: A National Dementia Strategy*, Department of Health, 2009
[385] *Improving services and support for people with dementia*, National Audit Office, 2007
[386] *Dementia out of the Shadows,* Alzheimer's Society, 2008

associated with old age. There was also evidence of doctors being reluctant to diagnose a condition where it is difficult to do so with absolute certainty and, in some cases, GPs did not have the necessary skills to identify the symptoms in order to make a referral to a specialist for a full assessment and possible diagnosis.

The need for age-appropriate, non-discriminatory services

Older people often have different treatment and care needs

Because of differences in the nature of treatment and care needs of older people with mental health problems, and differences in what having mental health problems can mean to different age groups, older people often have different care and treatment needs from younger people with mental health problems. Meeting the complex needs of older people requires specific professional skills. In addition, services have to be structured in such a way that they can respond to this complex mix of social, psychological, physical and biological factors.

Inequitable services for dementia for different age groups

Dementia services are usually part of older people's mental health services, although there are specialist services for people with early onset dementia in some parts of the country. Younger people with dementia undoubtedly face particular issues that older people may be less likely to face (such as employment, responsibilities for a young family etc) but many of the issues facing people with dementia and their carers are similar for all ages. Services for people with dementia need to be person-centred and responsive to people whatever their age.

Concerns about the quality of dementia care

In 2007, two years before the publication of the National Dementia Strategy, the National Audit Office (NAO) produced a report.[387] The NAO report was critical about the quality of care received by people with dementia and their families. It found that the size and availability of specialist community mental health teams was extremely variable, and that confidence of GPs in spotting the symptoms of dementia was poor and lower than it had been in 2000. They also commented on deficiencies in carer support. The report concluded that overall services are not currently delivering value for money; that spending is late – too few people are being diagnosed or being diagnosed early enough; and that early intervention is needed to improve quality of life. Finally it concluded that services in the community, care homes and at the end of life are not delivering consistently or cost effectively against the objective of supporting people to live independently as long as possible in the place of their choosing.

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[387] *Improving services and support for people with dementia,* National Audit Office (NAO), 2007

The Alzheimer's Society has pointed out that there is unacceptable variation in the quality of dementia care in an acute hospital setting and that people with dementia stay in hospital longer than other people who go in for the same procedure. As well as the cost to the person with dementia, increased length of stay is placing financial pressure on the NHS. For all these reasons, they point to the need for better awareness of the needs of people with dementia in acute hospitals, and better care in the acute setting.[388]

Specialist services

Older adults, like younger adults, are likely to benefit from specialist community mental health approaches, such as assertive outreach, out of hours support, crisis care, rehabilitation and home treatment, and access to psychological therapies. Achieving equity of access and a range of services tailored to the needs of older people may require the development of different approaches and not simple duplication of services.

Older people whose primary need is for specialist services, such as substance misuse services or forensic mental health care, should not be denied access to and care from these services on the basis of age.

Transitions

While it is increasingly recognised that the mental health needs of older people do not suddenly become different from those of younger adults, it is also widely acknowledged that different phases of life may be accompanied by different mental health issues, and be best addressed in different ways at different stages.

Generally, people who grow old with enduring mental health problems should remain under the care of the working age adult service with which they are familiar unless their needs would be better met by the older people's service, in which case good transition becomes important.[389]

People who experience their first episode of mental health problems after the age of 65 are usually seen in the first instance by the older people's service and, unless an early onset dementia service is available, people of any age with dementia will usually be seen by the older people's service. However, the needs of the individuals should be carefully considered in all cases.[390]

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[388] *Counting the cost – caring for people with dementia on hospital wards,* Alzheimer's Society, 2009

[389] *Links not boundaries: service transitions for people growing older with enduring or relapsing mental illness*, Royal College of Psychiatrists, College Report CR135, 2009

[390] *Services for younger people with Alzheimer's disease and other dementias*, Royal College of Psychiatrists, Council Report CR135, 2006

The Mental Health Foundation suggests that it may be necessary to develop entirely new specialist services e.g. for transition from one phase of life to next or employment to unemployment/retirement etc.[391]

Liaison psychiatry

Up to 70 per cent of acute hospital beds are currently occupied by older people and up to half of these may be people with cognitive impairment, including dementia and delirium. Levels of depression in general hospital wards are also high (around 30 per cent). Both depression and dementia may hinder recovery and rehabilitation. The majority of these patients are not known to specialist mental health services, and their problems are not diagnosed. General hospitals are particularly challenging environments for people with memory and communication problems. People with dementia and depression in general hospitals have worse outcomes in terms of length of stay, mortality and institutionalisation.

However, the needs of older people with a mental disorder in the general hospital are often poorly met and liaison psychiatry is most often a service available only to adults of working age. The Royal College of Psychiatrists points out that liaison psychiatry for working age adults is a developed speciality which has an established multidisciplinary model of service delivery with recommended staffing levels and training programmes, but none of these standards exist for older people. They state that failure to deliver this quality of service for older people represents an ageist policy.[392]

Liaison psychiatry for older people is also commended as a "*high impact change*" under the broader heading of '*Manage variation in service users' discharge processes*'.[393]

→ www.mentalhealthequalities.org.uk/silo/files/10hics-supplementary-guidance.pdf

Also, see Objective 8 of the National Dementia Strategy:

> *"Objective 8: Improved quality of care for people with dementia in general hospitals. Identifying leadership for dementia in general hospitals, defining the care pathway for dementia there and the commissioning of specialist liaison older people's mental health teams to work in general hospitals."* [394]

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[391] *All things being equal – Age equality in mental health care for older people in England,* Mental Health Foundation, April 2009
[392] *Who cares wins: Improving the outcome for older people admitted to the general hospital: guidelines for the development of liaison mental health services for older people*, Royal College of Psychiatrists, 2005
[393] *10 high impact changes for mental health services. Supplementary guidance for Older People Mental Health Services*, CSIP, 2007
[394] *Living Well with Dementia: A National Dementia Strategy*, Department of Health, 2009

14.4 Drivers and policy imperatives

National mental health strategy is being reviewed and so though New Horizons[395]provides helpful material, it is not a statement of government policy. The *National Service Framework (NSF) for Mental Health*[396] and the *NSF for Older People*[397] have run their course and the dates for the milestones have passed. However, the NSFs were key documents that shaped thinking in their time and information about these and other documents is presented here as context for the more recent drivers.

National Institute for Health and Clinical Excellence Quality Standards on Dementia

The publication of the quality standards for dementia care in June 2010 by the National Institute of Health and Clinical Excellence[398] set out the standards that all commissioners and providers should work to implement.

National Service Framework for Mental Health: modern standards and service models[399]

This NSF addressed the mental health needs of working age adults up to 65. It set out national standards, national service models, local action and national underpinning programmes for implementation, and a series of national milestones to assure progress, with performance indicators to support effective performance. However, since it applied only to adults of working age, it had no impact on standards and service models in relation to the mental health of older people, and some would argue that it therefore perpetuated age discrimination in mental health.

It should be noted that in 2005 the National Directors for Older People's Services and for Mental Health supported the start of an initiative to combine forces across mental health and older people's services to ensure that older people with mental illness do not miss out on the improved services that younger adults or those without mental illness had seen.[400]

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[395] *New Horizons – A shared vision for mental health*, Department of Health, 7 December 2009
[396] *National Service Framework for Mental Health,* Department of Health, 1999
[397] *National Service Framework for Older People* Department of Health, 2001
[398] *Quality Standards for Dementia Care* NICE 2010 http://www.nice.org.uk/aboutnice/qualitystandards/stroke/strokequalitystandard.jsp
[399] *National Service Framework for Mental Health: modern standards and service models* Department of Health, 1999
[400] *Securing better mental health for older adults,* Department of Health, 2005 www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4114989

As the Healthcare Commission noted in 2009,[401] despite the significant achievements of the NSFs for Mental Health and for Older People there has been less emphasis on mental health services for older people than on those for younger adults. The Healthcare Commission also noted that the mental health standard from the *NSF for Older People* has yet to be delivered, yet the framework comes to the end of its 10-year lifespan in 2011.

The Healthcare Commission (HCC) further noted at the time that the *New Horizons* project, led by the Department of Health, was working on the successor to the existing *NSF for Mental Health*, which expires in 2009. The HCC recommended that this project should steer the strategic direction for mental health services towards including adults of all ages and tackling age discrimination in mental health services.

National Service Framework for Older People (NSFOP)[402]

In addition to Standard One on rooting out age discrimination, Standard Seven of the NSFOP specifically aimed to promote good mental health in older people and to treat and support those older people with dementia and depression.

Standard Seven states:

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

NHS Next Stage Review – High Quality Care for All[403]

Lord Darzi's Review, with its emphasis on personalisation, is as relevant to mental health services as to all other health services. Lord Darzi's proposal to pilot personalised health budgets may be of particular importance for people with long-term mental health conditions.

2.1 Carers at the heart of 21st century families and communities: a caring system on your side, a life of your own[404]

The carers' strategy sets out the previous Government's agenda for the care and support of carers and it included a commitment to funding several

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[401] *Equality in Later Life - A national study of older people's mental health services*, Healthcare Commission, 2009

[402] *National Service Framework for Older People,* Department of Health, 2001
[403] *NHS Next Stage Review – High Quality Care for All*, Department of Health, 2008
[404] *Carers at the heart of 21st century families and communities: a caring system on your side, a life of your own*, Department of Health, 2008

aspects of carer support. It also promised a more integrated and personalised support service for carers through easily accessible information, targeted training for key professionals to support carers, and pilots to examine how the NHS can better support carers. Given the importance of carers to older people with mental health problems (and the fact that many carers are, themselves, older people), this strategy is of considerable importance.

Carers Direct has been established – an information, advice and support service for carers (www.nhs.uk/carersdirect freephone 0808 802 0202).

Skills for Care, working with Skills for Health, have been commissioned to develop a training framework for key professionals which will be disseminated in Autumn 2011.

Demonstrator sites looking at ways that the NHS can better support carers were established in 2009. They will be subject to independent academic evaluation and the findings will be published in Autumn 2011.

NHS Constitution[405]

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. 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. It states:

> *"You have the right not to be unlawfully discriminated against in the provision of NHS services including on grounds of gender, race, religion or belief, sexual orientation, disability (including learning disability or mental illness) or age."*

Government Mental Health Strategy

The previous Government published its mental health strategy, *New Horizons* but the Coalition Government has announced it is producing a new mental health strategy. However the key themes of improving the mental wellbeing and mental health care of older adults that emerged during the consultation that led to *New Horizons* are important, including the need for:

- action to challenge ageist attitudes in society and to promote positive mental health in older age

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

- well informed commissioning to ensure that the complexity of needs of older adults is met by all sectors working together
- tailored, specialist approaches and a workforce with specialist skills – one size does not fit all
- action to eliminate discrimination and inequalities in service provision and quality of care for older adults.

The latest report[406] covers a lifetime – from laying down the foundations of good mental health in childhood, through to maintaining resilience into older age. It also emphasises the importance of prevention through to effective treatment and recovery.

Living Well with Dementia: A National Dementia Strategy[407]

This is a five year plan with three aims:

1. To ensure better knowledge about dementia and remove stigma.
2. To ensure early diagnosis, support and treatment.
3. To develop services to better meet changing needs.

The implementation of the dementia strategy will address some of the issues about age discrimination in relation to dementia care. The Department's goal is for people with dementia and their carers to be helped to live well with dementia, no matter what stage of their illness, or where they are in the health and care system. The strategy is age-inclusive.

Improving dementia services in England - an interim report, 2010

In January 2010, the National Audit Office (NAO) published a report[408] that asserted that despite the Department of Health stating, since 2007, that dementia is now a national priority, it has not been given the levers or urgency normally expected for such a priority and there is a risk that value for money will remain poor unless these weaknesses are addressed urgently.

The report points out that the timing of the National Dementia Strategy prevented the inclusion of dementia in the Department's tier 1 Vital Signs indicators for the NHS, through which it monitors performance, and other levers built into the NHS's devolved management arrangements, such as joined-up commissioning and comprehensive performance information, are not yet fully developed. Changes at a local level are taking place slowly because local leadership on the issue has still to be developed and there is no formal performance monitoring of progress built into the system. The NAO

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[406] *New Horizons – A shared vision for mental health*, Department of Health, 7 December 2009

[407] *Living Well with Dementia: A National Dementia Strategy*, Department of Health, 2009

[408] *Improving dementia services in England - an interim report*, NAO, 2010

also expresses concerns that the strategy is likely to cost much more than the estimated £1.9 billion over ten years.

14.5 What good age-equal practice might look like

There have been many recent attempts to set out what good practice in older people's mental health services would look like. Since these usually focus on personalised services and an equitable approach, they tend to set out the key components of age-equal practice as part of their vision, even if only implicitly.

In 2005, *Everybody's Business*[409] asked what might an older person's mental health service that is fit for purpose look like. It concluded that it would be a service which:

- recognises the dignity of individual service users. It respects and values their diversity as well as acknowledging their major role in the process of planning and developing services.
- is grounded in respect for all those people who engage with these services, not only those using them but also their supporters and carers.
- provides the practical advice and information service users and their carers need as well as developing a consistently high quality, comprehensive package of care and support which minimises bureaucracy.
- makes sure that the best and most effective treatments are widely and consistently available.
- is open to everyone. It responds to people on the basis of need not age and ensures that wherever older people with mental health problems are in the system they are not discriminated against and have their mental health needs met.

There was some concern as to how this was being implemented without a clear thought to the needs of older people and so a subsequent briefing on age equality was written for guidance[410] .

Other characteristics or descriptors of non-discriminatory services for older people include the summary of work for the *New Horizons* publication:

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[409] *Everybody's Business: Integrated Mental Health services for Older Adults: a service development guide*, Department of Health, 2005
[410] *Age Equality - what does it mean for older people's mental health services?* Minshull, P. CSIP 2006

Prevention and public health interventions

1. *Older People, i.e. those over 65, have equal access to an appropriate range of health promotion, prevention and early intervention programmes and services, including programmes such as physical activity, healthy eating, smoking cessation etc.*

2. *Local suicide prevention plans will address the needs of people over 65. The refreshed National Suicide Prevention Strategy will underline this.*

Primary care

1. *The mental health needs of people over 65 will be recognised equally within primary care as those of younger people, for example with the same rates of recognition and treatment of depression, including psychological therapies, and, where necessary, referral to secondary care services. Although 20 per cent to 40 per cent of older people in the community show symptoms of depression only 4 per cent to 8 per cent will consult their GP about this problem. This is particularly true for older men. However, GPs are often seeing these individuals for physical health problems. Even when depression is identified, studies show lower levels of treatment and referral to secondary care services than for younger adults.*

2. *The mental health needs of older people in residential care will be recognised and treated to an equal extent as those of younger adults living in the community.*

Mental health services

1. *All older people have the same access in relation to assessed need services as younger adults, that is range, quality, choice and timeliness, to culturally-appropriate mental health services. This includes general and specialist services or approaches, for example community mental health teams, crisis resolution and home treatment services, assertive outreach services, Improving Access to Psychological Therapies (IAPT) and psychological services, inpatient care and intensive care services, alcohol and drug treatment services and intermediate care and continuing services.*

2. *Older people have access to services which meet their needs not only for mental health problems, including dementia, but also for communication problems, physical illness and physical frailty. Services are provided within an appropriate environment, by appropriately-trained staff offering a comprehensive and appropriate range of interventions.*

3. *People of all ages with dementia have equal access to appropriate services.*

4. *Older people are equally involved in the planning of their own individual care, service planning, foundation trust membership etc, for example Putting People First.*

5. *Carers of older people have equal access to assessment, information, advocacy, services and support.*

6. *Older people with learning disabilities have equal access to services (see Valuing People Now).*

7. *Older people in the criminal justice system have equal access to appropriate services.*

8. *Older people have equal access to social support, such as individual budgets, range of accommodation, domestic support etc.*

9. *Mental health services have clear protocols for the transfer of individuals from adult to specialist older people's services. These make it clear that age may be a guide but not an absolute marker for determining which service is most appropriate (see the New Horizons consultation document for common features of these protocols).*

Physical health problems, primary care and general hospital care

1. *Mental health needs of older people with long-term physical conditions are equally identified and treated in primary care and acute medical services.*

2. *Older people with mental health problems have their individual physical health needs identified, assessed and treated as speedily, frequently and effectively as younger adults in primary care and acute medical services.*

Organisations

1. *Provider policies are all impact assessed to ensure that they are non-ageist.*

2. *All statutory, independent and voluntary sector services dealing with older people include in their strategy documents and operational plans the statement that decisions about treatment and care should always be made on the basis of each individual's need, not their age.*

3. *Provider management arrangements should ensure that the needs of older people are represented throughout the structure at board, director, governor and membership level. Research, audit and evaluation grant-giving bodies, academic institutions, commissioners and provider organisations should ensure equal levels of research, evaluation and audit of services for older people as for younger adults.*

Research, audit and evaluation

Grant-giving bodies, academic institutions, commissioners and provider organisations should ensure equal levels of research, evaluation and audit of services for older people as for younger adults.

A Royal College of Psychiatrists position statement sets out an approach based on needs, not age; routine access to specialist older people's services; equal access to services that are not part of older people's services where that is more appropriate; and personal choice.[411]

Other key features, essential to good age-equal practice are as follows:

Leadership

Also see Chapter 3 Leadership and motivation.

Good leadership is important in all aspects of healthcare, and particularly in the commissioning and provision of mental health services. In their recent study, the Healthcare Commission found that the trusts that appeared to have a more robust and cohesive development plan for their older people's mental health service, and evidence of progress, were characterised by two aspects. Firstly, they had senior clinical leadership with both internal and external stakeholder involvement and, secondly, they had strong central governance structures.[412]

Similar sentiments had been expressed in 2005. *Everybody's Business* [413] identified the need for strong leadership across health, social services, local authorities and voluntary organisations to co-ordinate and direct improvements in health and care services for older people with mental health problems.

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[411] *Age discrimination in mental health services: making equality a reality*. Royal College of Psychiatrists' position statement, PS2/2009
www.rcpsych.ac.uk/PDF/PS2_2009_for%20websitex.pdf
[412] *Equality in Later Life - A national study of older people's mental health services,* Healthcare Commission, 2009
[413] *Everybody's Business: Integrated Mental Health Services for Older Adults: a service development guide,* Department of Health, 2005

Whole systems working and commissioning

Five factors have been identified as being important to the mental health of older people, whether they are living in the community or in residential care:

- stigma and discrimination
- participation in meaningful activity
- relationships
- physical health, including the ability to carry out everyday tasks
- poverty.

These factors can only be addressed by multi-agency interventions at multiple levels.

A whole-systems approach to dementia care

The National Dementia Strategy recommends three ways to improve the care of older people with mental health problems in general hospitals, all of which relate to care across the whole system:

- a senior clinician in the general hospital to take the lead for quality improvement in dementia care in the hospital
- the development of an explicit care pathway for the management and care of people with dementia in hospital, led by that senior clinician
- commissioning specialist liaison older people's mental health teams to work in general hospitals.

These principles would apply equally to the other mental health problems commonly experienced by older adults in hospital.

Personalisation and responsiveness

Mental health services for older people need to respond to the needs of the person and not just the age of the person. There is considerable experience from mental health trusts who have developed formal agreements between working age adult and older adult mental health services. These make it clear that age should be used as a guide, not an absolute marker, when decisions are made about which service would be most appropriate.

Personalisation and supporting older people to exercise choice and control can lead to greater independence and an increased sense of wellbeing.

The Royal College of Psychiatrists has set out key principles to define the specialist expertise that is required and the needs that are best met by older people's mental health services. These principles set out the need for a personalised approach, where age does not define needs and wherein an older person could have some choice about where their needs might best be

met (i.e. within older people's mental health services, or elsewhere). Similarly, these principles highlight that there may be younger people for whom older people's mental health services would be most appropriate.[414]

Good age-equal practice in the treatment and care of people with dementia

Early diagnosis and treatment of dementia

Given that currently only about one third of people with dementia receive a formal diagnosis at any time in their illness, good, age-equal practice in dementia services would ensure that appropriate mechanisms are in place, with a suitably trained workforce, to diagnose dementia and provide prompt support and care at the earliest possible stage for people with dementia and their families and carers.

Configuration of services for people with dementia

Commissioners need to consider carefully how best to configure services for both younger and older people with dementia, paying due heed to whether age-related services are a proportionate means of achieving a legitimate aim. However, there can be no justification for the services that are offered to one age group to be more extensive or more comprehensive than those offered to another age group with comparable levels of need.

Investing in services for people with dementia

The NAO advocated a 'spend to save' approach, with upfront investment in services for early diagnosis and intervention, and improved specialist services, community services and care in general hospitals resulting in long-term cost savings from prevention of transition into care homes and decreased hospital stay length.[415]

Also see section above, *A whole-systems approach*

14.6 Case studies of illustrative / good practice

Increasing Access to Psychological Therapies (IAPT)

The IAPT Pathfinder sites, Buckinghamshire PCT, Stoke PCT, East Riding and Hertfordshire, have demonstrated that older people can and will access psychological treatments provided that appropriate, proactive approaches are

[414] *Age Discrimination in mental health services: making equality a reality. Royal College of Psychiatrists' position statement and compendium of evidence,* 2009

[415] *Improving services and support for people with dementia,* NAO, 2007

used to raise their awareness of the service and engage them with it, and to ensure staff have the correct training.

→ www.iapt.nhs.uk/special-interests/older-people

Mental health leaflets for older people in Luton

Local research and evidence funded by Partnerships for Older People Projects found that people with mental health challenges wanted to make more informed choices about their lives and care. The leaflet provides information to residents with dementia, and delivers specific care pathways Luton-wide. This activity links with supporting people to live independently and improving mental health services. Three thousand leaflets were produced, as a one-off project. Areas where leaflets were distributed will be monitored to gauge the level of uptake.

(Source: *Communities for Health: Unlocking the energy within communities to improve health.* Department of Health, 2009)

Depression in Later Life project – Yorkshire & Humber

The Depression in Later Life project was developed through a partnership between YHIP (Yorkshire and Humber Improvement Partnership) and Age Concern (Yorkshire and Humber). The aim of the project was to create a greater awareness and understanding of depression in later life amongst GPs, service providers and older people in the region. The evidence base for the project was developed through an extensive questionnaire exercise, which included all of the above stakeholder groups, and for which a high return rate was achieved. The findings of the questionnaires were used to shape a training and information sharing programme and resulted in the development of a training course for staff working with older people, a referral protocol, and wide dissemination of information materials.

A key finding of the project was that older people from black and minority, ethnic (BME) communities were particularly disadvantaged in accessing support to recognise and deal effectively with depression. The project therefore developed a DVD film for community development workers to use with Urdu- speaking BME elders to encourage discussion of the issue and highlight some simple steps that could be taken to alleviate depression. The research evidence also demonstrated that simple low level preventative services, often provided by local voluntary organisations, provided the most effective ways of supporting older people to deal with depression. The project has documented case studies to demonstrate the value of these preventative services, and how investing in them will provide effective results for older people.

Further information
Heather Stephenson, Regional Manager - Yorkshire & Humber Age Concern and Help the Aged
heather.stephenson@ace.org.uk

Making connections, not assumptions

This ground-breaking project was set up to address service difficulties in meeting the needs of older south Asian women suffering mental health problems, including dementia. It was formally launched on 12 October 2009.

The project is of particular importance due to the increased suicide rates of south Asian women over 65 and the fact that minority ethnic groups are (largely) unaware of dementia/associated symptoms.

A stakeholder event was held in November 2007, where South Asian women identified that they wanted partnership working, increased awareness about mental health, activities and emotional support.

The project has made connections and challenged assumptions that it would be challenging to engage with older south Asian women. Key relationships have been made with partners across health, social care and the third sector. In particular, in-depth relationships were established with two women's luncheon groups – Kushamdid in Ashton and Oldham Pakistani Centre.

For example:
With Kushamdid an artist was engaged to work with the women to co-produce a culturally appropriate information poster – which was piloted in some GP practices in Oldham/Tameside. The posters were produced in major south Asian languages.

At the Oldham Pakistani Centre, part of the engagement focused on a pilot of an Urdu life story template and the use of culturally-appropriate information in the Oldham life story training.

As a result of the project:

- Closer partnership working has been established with the community mental health development workers in local NHS organisations.
- Better links/communications across care pathways are being established with different partner organisations.
- Mental health awareness training has been carried out around depression and dementia and the women report being more confident about accessing services.
- All key stakeholders have signposting sheets with appropriate information/telephone numbers.

- Access to translated self-help materials (written and audio format) is available on the project's website.
- The women from Kushamdid are now involved in other Trust initiatives.
- A DVD has been produced to extend the learning about the project, especially around engagement issues.
- There are plans for future sustainability.

The project was initially funded by the Care Services Improvement Partnership (CSIP), a collaboration between Pennine Care, NHS Tameside and Glossop, Tameside Metropolitan Borough Council, Oldham Community Health Services, Oldham Partnership, NHS North West and Khushamdid.

Further information
Polly Kaiser
polly.kaiser@nhs.net or polly.kaiser@nmhdu.org.uk
0161 909 8200

→ www.penninecare.nhs.uk/services/making-connections

Mr R – a man with Alzheimer's disease

Mr R is an 86-year-old man who suffers from moderately severe Alzheimer's disease and lives with his wife. He was admitted to the general hospital with a severe chest infection and, while awaiting a bed, spent several hours on a trolley in pre-admission areas. He was incontinent and his wife found it difficult to get him drinks. He was very confused and because the staff were busy Mrs R attended to her husband who repeatedly attempted to get off the trolley and leave.

During his admission he was moved between three wards and at times was resistive to care despite recovery from the infection. The medical team recommended he move into long-term care as he would be too difficult for his wife to manage. His wife was very distressed at the suggestion and wanted her husband to return home. He was referred to the older people's mental health liaison team, a multidisciplinary team working in the general hospital. Mr R and his wife were seen the same day though he had now been in hospital for three weeks.

The liaison team social worker was able to get access to immediate specialist domiciliary help for Mr and Mrs R and to link with the community mental health team, enabling Mr R to return home successfully the next day. Mrs R wrote a letter of thanks saying that everyone in this position should be referred to the team to prevent the indignity they had experienced.

Mr and Mrs R were fortunate that this hospital is one of the few in the country (despite national guidance) to have a specialist older people's liaison mental health team. Even so, it is only available during office hours and does not have sufficient staff to cover the Emergency Department. In most areas the

mental health assessment would have had to wait days or weeks for someone from the older people's community service to attend, and securing a safe and prompt discharge would have been much more difficult to achieve.

(Source: *The need to tackle age discrimination in mental health. A compendium of evidence.*[416])

Other case studies

Dementia Information Portal (users need to register)

→ www.dementia.dh.gov.uk/userLoginRequired/?pageID=1&referer=%2F&invalidUser=1&restricted

Department of Health Care Networks

→ www.dhcarenetworks.org.uk/

National Equalities in Mental Health Programme

→ www.mentalhealthequalities.org.uk/

14.7 Suggestions for quick wins / what you can do now

- Commissioners and providers will need to give priority to Recommendation 2 in the recent review of age equality by Sir Ian Carruthers and Jan Ormondroyd, which stated that every provider and commissioner of mental health services will need to consider how to achieve non-discriminatory, age-appropriate services.[417]
- Ensure teams working on local implementation of mental health services for older people and the National Dementia Strategy are in explicit agreement about how the local approach to implementation both ends age discrimination and promotes age equality.
- Review the Joint Strategic Needs Assessment (JSNA) and ensure that it is clear on a realistic model for future local needs for mental health services for both dementia and functional mental health services.
- Link in with Quality and Productivity challenge work which looks at length of stay in acute hospitals (given the large number of older people with mental health problems who can be discharged earlier)

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[416] *The need to tackle age discrimination in mental health. A compendium of evidence,* prepared by Anderson D, Banerjee S, Barker A, Connelly P, Junaid O, Series H and Seymour J, on behalf of the Faculty of Old Age Psychiatry, Royal College of Psychiatrists, 2009

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

to ensure it helps reduce discrimination and unfavourable treatment of older people. Sources of advice include the Department of Health's work on a cost-benefit analysis of increasing the rate of identification and treatment of depression by GPs. The analysis assumes initially longer GP consultations, treatment costs (both medication and psychological) and additional training for GPs. The costs are potentially considerably outweighed by the health benefits including reduced morbidity from long-term physical conditions (the full economic case will be available on the website www.dh.gov.uk/newhorizons). Primary care organisations will wish to examine how this work can be applied at a local level.

- It has been suggested that some older people would welcome contact with staff who are closer to their own age than is usually the case, as older staff may be better able to understand the issues and experiences of older people.[418] Service managers may wish to review whether this option is open to older people at a local level.

14.8 Useful resources

Dementia Services Guide, NHS London, October 2009

Designed to support commissioners in London to commission dementia services, but has national relevance. See:

→ www.healthcareforlondon.nhs.uk/assets/Mental-health/HealthcareforLondon_Dementia-services-guide.pdf

For up-to-date and detailed information about the mental health needs of black and minority ethnic, older people and the psychiatric services offered to this group, see *Psychiatric Services for Black and Minority Ethnic Older People*.[419]

Age Discrimination in Mental Health Services: Making equality a reality, Royal College of Psychiatrists, October 2009

This report states that access to services must be based on need. It outlines a number of guiding principles and recommendations for action. These include the development of a toolkit that allows self-assessment of services based on need, not age.

→ www.rcpsych.ac.uk/PDF/PS2_2009_for%20websitex.pdf

[418] *All things being equal – Age equality in mental health care for older people in England,* Mental Health Foundation, 2009
[419] Royal College of Psychiatrists, CR 156, 2009

NICE guidance on various mental health conditions

For example:

Depression in Adults (updated 2009)

→ http://guidance.nice.org.uk/CG90

Depression with a chronic physical health problem, CG91, 2009

→ http://guidance.nice.org.uk/CG91

Delirium. CG17 2010

→ http://guidance.nice.org.uk/CG/Wave17/21

Chapter 15
End of life care

15.1 Key audiences

Primary care trusts and emerging GP commissioning consortia:

- commissioners of services for end of life care and for community and hospital services for older people
- directors of public health and local authorities
- GPs
- community based palliative care teams
- community services providers
- frontline staff e.g. district nurses.

NHS foundation trusts and NHS trusts:

- medical directors
- palliative care teams
- care of the elderly physicians
- clinical directorate management teams
- nurse managers
- managers of allied health professionals (e.g. physiotherapy, occupational therapy, dietetics).

NHS ambulance trusts

- medical directors
- service development managers.

Third sector and independent providers of end of life services

- chief executives
- management committee members/trustees.

15.2 Key issues and concerns

End of life – an issue for old age equality

It is an obvious but often overlooked fact that for most people the end of life occurs in old age.

- Of the 500,000 people in England and Wales who die every year, over 80 per cent are aged 65 or over.[420]
- The ratio of women to men of those aged 65 and over is falling. In 1983 there were 155 women aged 65 and over for every 100 men of the same age, compared to the current sex ratio of 130 women for every 100 men for this age group. By 2033 it is projected that the 65 and over sex ratio will have fallen still further to 117 women for every 100 men.[421]

Primary care trusts and healthcare providers will need to ensure that their end of life services meet the requirements of equality legislation. Any differences in access to end of life services would need to be able to be "*objectively justified*" i.e. would need to be a proportionate means of achieving a legitimate aim.

Ageism and age discrimination at the end of life

- Ageism and age discrimination are thought by older people to be prevalent at the end of life.
- There are particular concerns about older people who are unable to speak for themselves and have no-one to speak up for them.
- Older people are not always enabled to make a choice about end of life care and where they die, perhaps not even to the limited extent that younger people can do so. The reasons for this are complex.

Discrimination and disadvantage

In 2005 Help the Aged published a report from the University of Sheffield [422] which reviewed the available evidence of the circumstances, experiences and preferences of older people in relation to end of life care. The report concluded that many older people and their carers experience systematic disadvantage and discrimination at the end of their lives, although that is not to say that individual staff held ageist attitudes.

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[420] *Mortality Statistics: Deaths registered in 2007, Office for National Statistics,* 2008
[421] www.statistics.gov.uk/cci/nugget.asp?ID=949
[422] *End-of-life-care – Promoting comfort, choice and well-being for older people*, Seymour J, Witherspoon R, Gott M, Ross H, Payne S with Owen T, Policy Press, 2005

To supplement the University of Sheffield report, Help the Aged also published a further report[423] which included articles by seven older people about their experiences of dying, together with an overview of research evidence.

A further report from Help the Aged in 2006 found that some older people felt that ageism was responsible for the disrespectful and sometimes patronising way older people in need of care are treated. Particular concern was voiced about the care of vulnerable older people who had no family to speak up for them and people with dementia.[424]

Inequalities in relation to choice about appropriate end of life care and preferred place of death

It has been reported that of those who were aged 65 and over when they died, 59 per cent died in a hospital, 19 per cent died in a care home, 16 per cent died at home, and 4 per cent died in a hospice.[425] However, these figures do not indicate the proportion of older people who die in their preferred place, nor how the figures differ for over 65s compared to other age groups.

While it cannot be assumed that all older people wish to die at home (and for many, care homes are their homes at the end of life), it seems that older people may not always be able to choose where they would prefer to die, nor are they always enabled to receive the specialist palliative care services they may need at the end of life. These difficulties are not uniquely experienced by older people but there are various historical factors about the development of specialist palliative care which may result in older people having less choice about the kind of care they get at the end of life, and where it is delivered. See section on palliative care, below.

The higher proportion of older people dying in care homes and the lack of development of palliative care in these settings is another reason why older people may be less likely to receive good quality end of life services.[426]

Decision-making at the end of life

- There are particular concerns about the impact of ageism and age discrimination on decision-making at the end of life – particularly in relation to decisions about resuscitation and clinically-assisted nutrition and hydration.
- Age should never be the determining factor in deciding when to withdraw or withhold potentially life-saving or life-extending treatments or procedures.

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[423] *Dying in Older Age – reflections and experiences from an older person's perspective,* edited by Owen T, Help the Aged, 2005
[424] *Listening to older people - Opening the door for older people to explore end-of-life issues***,** Help the Aged, 2006
[425] *Dying and death, Age Concern Policy Position Paper,* 2008
[426] *Dying and death, Age Concern Policy Position Paper*, 2008

Older people often express concerns about decision-making at the end of life, particularly on life-and-death decisions on whether resuscitation should be attempted, and on whether clinically-assisted nutrition should be commenced or continued. These concerns are wide-ranging, with some older people fearing that they will be denied treatment from which they feel they may benefit, while others fear that they may be given certain treatments beyond the point when they might benefit.[427]

Honest and open communication with patients and their carers at the end of life is extremely important. Patients should be encouraged to think about and record their wishes for end of life care, where appropriate, and where they have capacity to do so.

Detailed guidance on end of life care is available from the General Medical Council, other regulators and professional bodies, and should be referred to as appropriate.

Older people and palliative care

- Older people do not always have access to specialist palliative care that other age groups have.
- Most people receiving specialist palliative care have a diagnosis of cancer – but older people often die of other causes and may have co-morbidities and need more complex care.
- Older people with a diagnosis of cancer are less likely to be referred to or use specialist palliative care services than other adults with cancer.

Older people do not always have the same access to specialist palliative care services that are available to other age groups. Age Concern points out that since 33 per cent of all deaths are of people aged 85 and over, it could be expected that a similar percentage of people over 85 would gain access to specialist palliative care services.[428] In fact the percentage ranges from 9 per cent to 15 per cent.[429]

This may be partly because the development of specialist palliative care as a discipline was rooted in the modern hospice movement, and the care that they provided for cancer patients. It is only fairly recently that has there been a real push to make such care available to people with conditions other than cancer. Even recently, 90 per cent of people who receive specialist palliative care have a diagnosis of cancer, but cancer is the principal cause of death in only 25 per cent of cases.[430]

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[427] *Listening to older people - Opening the door for older people to explore end-of-life issues*, Help the Aged, 2006
[428] *Dying and death, Age Concern Policy Position Paper,* 2008
[429] *Minimum data sets for specialist palliative care,* National Council for Palliative Care, 2007
[430] *Dying and death, Age Concern Policy Position Paper,* 2008

There may be other explanations for why older people have used a relatively low level of specialist palliative care services. It is sometimes suggested that one reason for older people not receiving specialist palliative care is that they more often develop chronic illnesses which have not traditionally been the focus for specialist palliative care. But even older people with cancer may not have been referred to or may not use specialist palliative care.[431]

A further issue is older people are more commonly affected by multiple medical problems of varying severity. The cumulative effect of these may be much greater than any individual disease, and typically lead to greater impairment and needs for care at the end of life.[432]

Age Concern notes that it has also been suggested that the lower levels of palliative care for older people may be due to a greater acceptance of death and more time to plan with a resulting reduced need for support. However, Age Concern has suggested that the lack of development of palliative care services for conditions more prevalent in older people or in settings where they are more likely to die, together with more limited access when they have the same diagnosis as younger people, is the result of underlying ageist attitudes and of the lives of older people being undervalued.[433]

Although there has been some change, older people remain under-represented in inpatient hospices, and with increasing age they are less likely to receive care for their final illness in a hospice. This may well signify discrimination which needs to be addressed, but it should be borne in mind that many older people (as well as people of other ages) would wish to access specialist palliative care in their own homes or other community settings, rather than in an acute care setting.

End of life care and people with dementia

Also see Chapter 14 Mental health (including dementia).

There is strong evidence to suggest that people with dementia receive poorer end of life care than those who are cognitively intact, in terms of provision of palliative care. For example, few people with dementia have access to hospice care.[434]

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[431] *The effect of age on referral to and use of specialist palliative care services in adult cancer patients: a systematic review,* Burt J, Raine R, Age and Ageing 2006 35(5):469-476; doi:10.1093/ageing/afl001

[432] *Better Palliative Care for Older People*, edited by Davies E and Higginson I J, The World Health Organization Europe, 2004

[433] *Dying and death, Age Concern Policy Position Paper,* 2008

[434] *Living Well with Dementia: A National Dementia Strategy*, Department of Health, 2009

Pain control at the end of life

Pain control can be a particular issue at the end of life, particularly if people are in residential settings.[435] There is evidence that older people tend to under-report their symptoms and doctors tend to under-treat pain in older people for both patients with cancer and those with other diagnoses.[436]

There are also particular issues for controlling pain in older people with dementia, whose condition makes it harder to communicate about their experience of pain, as a result of which clinicians may have difficulty in making an assessment of their pain.

Dual/multiple discrimination

> *"Variations in the quality of end of life care exist across the country and there is concern that among certain groups of dying patients, such as the old, those with non-cancer diagnoses, people from black and minority ethnic (BME) backgrounds and those in rural areas, there is an unacceptable level of variance."* [437]

In the context of end of life care, it will be important to be aware of the possibility of discrimination resulting from age in combination with other factors that are associated with "*protected characteristics*". Effective monitoring of access to and uptake of services (e.g. by BME groups) will be useful.

There is relatively little evidence in respect of inequalities in end of life care and age and race. However, a number of studies have looked at the needs of both BME patients and carers in end of life care and have found that there are factors associated with faith, culture and language which mean that closer attention needs to be paid in order to fully meet their needs. Even now, there are relatively few people from BME communities using care homes or hospices and this could be due to a range of factors including language, cultural and religious issues. However, as an article on the NHS Evidence website explains, it may be that BME patients are still choosing not to access these services, whether through the voluntary sector or the NHS, or it may be that primary and secondary care providers are failing to refer them to these services.[438]

These issues need to be explored more fully at a local level.

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[435] *Pain In Older People - A Hidden Problem. A qualitative study,* Picker Europe, commissioned by the Patients Association, 2007
[436] *Better Palliative Care for Older People*, edited by Davies E and Higginson I J, The World Health Organization Europe, 2004
[437] *End of Life Care Strategy – Equality Impact Assessment*, Department of Health, 2008
[438] *Palliative care and ethnic minorities in Britain* www.library.nhs.uk/Ethnicity/ViewResource.aspx?resID=284112&tabID=290

Lesbians, gay men, bisexuals and transgender (LBGT) people may also experience multiple discrimination at the end of life. There needs to be attention paid to how advocacy services and bereavement counselling can be developed and tailored to meet the specific needs of older lesbians and gay men.[439]

Transgender people and those close to them can experience particular problems at the end of life, particularly in relation to gender recognition and the status of the deceased person.[440]

15.3 Drivers and policy imperatives

End of Life Care Strategy - promoting high quality care for all adults at the end of life

In 2008 the Department of Health published the *End of Life Care Strategy - promoting high quality care for all adults at the end of life.*[441] Its aim is to provide people approaching the end of life with more choice about where they would like to live and die, and it is also about improving the care that all adults at the end of life and their family and carers receive. It encompasses all adults with advanced, progressive illness and care given in all settings. It is explicit about the need to address inequalities in the provision of end of life care and it states:

> *"In the past, the profile of end of life care within the NHS and social care services has been relatively low. Reflecting this, the quality of care delivered has been very variable. Implementation of this strategy will make a step change in access to high quality care for all people approaching the end of life. This should be irrespective of age, gender, ethnicity, religious belief, disability, sexual orientation, diagnosis or socioeconomic deprivation. High quality care should be available wherever the person may be: at home, in a care home, in hospital, in a hospice or elsewhere."*

A useful resource that sets out ten actions for implementing the National End of Life Care Strategy has been published by the King's Fund:[442]

→ www.kingsfund.org.uk/publications/leeds_castle_eolc.html

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[439] *Lifting the Lid on Sexuality and Ageing*, Gay and Grey in Dorset, Help and Care Development Ltd, 2007
[440] *End of Life Care Strategy – Equality Impact Assessment, Department of Health*, 2008
[441] End of Life Care Strategy - *promoting high quality care for all adults at the end of life*, Department of Health, 2008
[442] *Delivering better care at end of life. The next steps. Report from the Sir Roger Bannister Health Summit*, Leeds Castle, 19–20 November 2009, Eds. Addicott R, Ashton R, King's Fund, 2010

Mental Capacity Act 2005

The Mental Capacity Act (MCA) came into force in 2007 and is supported by the Mental Capacity Act Code of Practice. It protects people who cannot make decisions for themselves due to a learning disability or a mental health condition, or for any other reason. It provides clear guidelines for carers and professionals about who can take decisions in which situations. The Act states that everyone should be treated as able to make their own decisions until it is shown that they are not. It also aims to enable people to make their own decisions for as long as they are capable of doing so. Those who are working with people who are coming towards the end of their lives will need to be particularly aware of the provisions of the Mental Capacity Act and the Code of Practice. See:

→ www.dca.gov.uk/legal-policy/mental-capacity/mca-cp.pdf

National Service Framework for Older People[443]

Although the *National Service Framework (NSF) for Older People* has run its course and the dates for the milestones have passed, it is mentioned here as it was an early key document that set standards that are relevant to end of life care, notably:

Standard One, rooting out age discrimination
Standard Two, person-centred care
Standard Four, general hospital care.

The *NSF for Older People* included a checklist for ensuring dignity in end of life care within Standard Two (person-centred care). This list highlighted the importance of information and communication, control of painful and other distressing symptoms, rehabilitation and support as health declines, social care, spiritual care, complementary therapies, psychological care and bereavement support.

The NSF also acknowledged that access to palliative care was limited for older people and that this can be age discriminatory.

NHS Next Stage Review – High Quality Care for All

Lord Darzi's Review[444] introduced no new targets, but made it clear that the emphasis on personalisation must be seen to apply equally at the end of life. The report noted:

> *"The necessity for greater dignity and respect at the end of life was movingly described by the end of life groups, as well as the desire to have round the clock access to palliative services."*

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[443] *National Service Framework for Older People*, Department of Health, 2001
[444] *NHS Next Stage Review – High Quality Care for All, Department of Health*, 2008

Living Well with Dementia: A National Dementia Strategy

Part of the vision of the National Dementia Strategy[445] is to:

> *"enable people with dementia and their carers to live well with dementia by the provision of good-quality care for all with dementia from diagnosis to the end of life, in the community, in hospitals and in care homes."* (page 21)

Objective 12 of the National Dementia Strategy specifically relates to improved end of life care for people with dementia.

> ***Objective 12: Improved end of life care for people with dementia.*** *"People with dementia and their carers to be involved in planning end of life care which recognises the principles outlined in the Department of Health End of Life Care Strategy. Local work on the End of Life Care Strategy to consider dementia."*

Paragraph 14 of the National Dementia Strategy states:

> *"Those involved in developing the Strategy worked closely with other emerging policy initiatives such as the NHS Next Stage Review, the Carers' Strategy, End of Life Care Strategy and Putting People First. For example, the Next Stage Review local clinical pathway groups and the SHA vision process were informed by the evidence that was collected for the National Dementia Strategy. The objectives of this Strategy are complementary to such programmes of work and delivering the National Dementia Strategy will help to deliver these other goals."*

End of Life Care for People with Dementia – Commissioning Guide

NICE & the National End of Life Care Programme have developed a resource to help statutory and voluntary health and social care in England commission integrated end of life care services for people with dementia. [Follow the weblink to find bibliographic details http://www.endoflifecareforadults.nhs.uk/publications/eolc-for-people-with-dementia-commissioning-guide]

15.4 What good age-equal practice might look like

Treating people as individuals

Good practice for older people (and others) at the end of life depends to a great extent on treating people as individuals, which accords closely with the

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[445] *Living Well with Dementia: A National Dementia Strategy*, Department of Health, 2009

current emphasis on personalisation in health and social care. Research shows that people want to be treated as individuals, not primarily as patients or as *older* people; they want to be treated with respect and to be involved in decisions relating to their treatment and care; they want health and social care professionals to talk to each other, so that care might be planned appropriately; and they want decisions relating to treatment and care at the end of life to be equitable, rather than based on postcode, ability to a pay or the ability of the individual, or the individual's family, to articulate need.[446]

Identifying people who are approaching the end of life

Clinicians and those delivering care should be aware of the possibility that someone may be approaching the end of life and provide opportunities for having sensitive discussions about preferences for end of life care. It is important to undertake effective care planning and advance care planning to ensure that their needs and preferences are respected and met as fully as possible. Increasingly, GP practices have in place registers to support the identification of all people who are approaching the end of their lives. If they do so, many of the people who will be identified will be older people, and they will therefore be better placed to receive an age-equal service that meets their needs. To ensure that everyone gets access to end of life care who requires it, these registers should be in place across the country. These registers should also be accessible to other service providers, to ensure that they are alerted to, and can cater for the specific needs of people at the end of their lives.[447]

Enabling people to choose their preferred place of death

Whilst a majority of people at the end of life express a wish to die at home, nearly 60 per cent die in hospital. A significant reason for this is the lack of service provision in the community. With limited access to appropriately skilled care, many people at the end of life are admitted to hospital for relatively routine treatment. Frequently, there is then a lack of sufficient support in place in the community, as well as problems gaining prompt access to an ambulance, to enable them to be discharged. Putting in place comprehensive 24/7 community medical and nursing cover, which can also provide a rapid response to emergencies, would enable the handling of many crisis episodes within the community setting, and would provide the necessary support to allow people to die at home.[448]

In 2007 the National Audit Office (NAO) concluded that services in the community, care homes and at the end of life were not delivering consistently or cost effectively against the objective of supporting people to live

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[446] *Listening to older people - Opening the door for older people to explore end-of-life issues*, Help the Aged, 2006
[447] *Impact assessment of the end of life care strategy*, Department of Health, 2008
[448] *End of Life Care Strategy – Equality Impact Assessment*, Department of Health, 2008

independently as long as possible in the place of their choosing. The NAO advocated a 'spend to save' approach, with upfront investment in services for early diagnosis and intervention, and improved specialist services, community services and care in general hospitals resulting in long-term cost savings from prevention of transition into care homes and decreased hospital stay length.[449]

One of the ways in which this might be best achieved is for NHS commissioners to work with local authorities and with providers of residential care in order to improve end of life care in residential care homes, and avoid unnecessary hospital admissions. Older people and their organisations would be valuable partners in this work.

Since services have tended to engage with younger people on issues of choice and have tended to be less aware of age-equality in this context, it is important to ensure that older people are enabled and supported to make choices to the same extent as younger people.

Improving ambulance services for people at the end of life

Ambulance services, and patient transport providers, play a key role in enabling people at the end of life to access health care and to die in the place of their choice. However, people at the end of life who are waiting for booked transport to take them back to their home (including care homes) after a hospital admission can experience substantial waits for an appropriately equipped and staffed vehicle, which could potentially be diverted to emergencies. This can result in some older people dying in hospital who could otherwise die at home. This issue could be addressed by reviewing the number of vehicles and staff so that an adequate service can be provided to people at the end of life, which will, in itself benefit many older people.

There are also concerns that information on a person's preferences for care are not always disseminated to ambulance crews, leading to medical interventions that are not consistent with the person's wishes. This issue requires ambulance trusts and other services responsible for care, to have procedures in place to ensure that crews have access to details on the particular care needs and preferences of people who are at the end of life.[450]

Improving the environment

The environment in which care is delivered has a substantial impact on people's perceptions of the overall quality of care provided at the end of life, both for those who are dying and their relatives and carers. However, in hospitals (where most people die) the environment is often poorly designed, and does not enable care to be delivered with appropriate dignity and respect.

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[449] *Improving services and support for people with dementia*, NAO, 2007
[450] *Impact assessment of the end of life care strategy,* Department of Health, 2008

Putting in place a programme of improvements to hospital environments, such as the development of palliative care suites and areas for relatives and carers, will provide substantial improvements in the quality, and experience, of care.[451]

Some environmental issues are particularly important to older people, such as their experience of mixed sex wards. The Centre for Policy on Ageing (CPA) notes that while it might generally be assumed that older patients would be those least happy with mixed sex wards, older patients are more likely than younger patients to be placed in a mixed sex environment.[452]

See also Chapter 5 High quality care for all.

More recently, the Department of Health has noted:

> *"Women, older people and some minority ethnic groups are more likely to worry about being in mixed-sex accommodation. Older people represent the largest users of NHS services and account for two thirds of NHS hospital admissions. They are most likely to find mixing 'not at all acceptable'."* [453]

Support for carers, including bereavement support

The time up to and after the death of a loved one is very difficult and can have long-term effects on the health of carers and relatives. Comprehensive support should therefore be available to carers and relatives to enable them to cope. This is particularly important since the carers of older people at the end of life are often in the older age groups themselves.

Ensuring that organisations dealing with people at the end of life have comprehensive information available on how to access bereavement support services will also improve the care that the bereaved receive.[454]

Ensuring a whole system approach

The end of life care strategy notes the importance of a whole-system and care pathway approach. This encompasses many of the components of good practice identified above, from identifying those who are nearing the end of their lives to care for bereaved people, and all the stages in between. There is much documented good practice to draw on, and this is available on the website of the National End of Life Care Programme:

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[451] *Impact assessment of the end of life care strategy*, Department of Health, 2008
[452] *Ageism and age discrimination in secondary health care in the United Kingdom. A review from the literature*, CPA, 2009
[453] www.dh.gov.uk/en/Healthcare/Samesexaccommodation/Whysame-sexaccommodationmatters/DH_110635
[454] *Impact assessment of the end of life care strategy,* 2008

→ www.endoflifecareforadults.nhs.uk/eolc

Essentially, many of the features of appropriate whole-system approaches to end of life care are similar for people of all ages. However, an age-equal approach will require commissioners and providers to consider whether older people and their carers have any particular needs in addition to those that are common across age groups.

15.5 Case studies of illustrative / good practice

Marie Curie Cancer Care

The Delivering Choice Programme, Marie Curie Cancer Care.

The Marie Curie Delivering Choice Programme helps local providers and commissioners of care to develop the best possible local services for palliative care patients, regardless of diagnosis, so that they are cared for in the place of their choice. This has highlighted the benefits of taking a whole-systems approach to the delivery of end of life care The programme has funded and managed seven projects across the UK - in Lincolnshire, Leeds, Tayside (Scotland), Barnet (north London), south-east London, Somerset and Northumberland, Tyne and Wear. More localities have adapted the Delivering Choice Programme methodology independently using the programme toolkit and consultancy service.

Further information
nicky.agelopoulos@mariecurie.org.uk

Bereavement Centre at St Thomas' Hospital

St Thomas' Hospital - part of Guy's and St Thomas' NHS Foundation Trust - has, with the support of Guy's and St Thomas' Charity, set up a dedicated bereavement centre. Specially commissioned artwork has created a calm and peaceful environment and the centre enables bereaved people to access a range of help and support in a single location following the death of a loved one. The centre's staff work closely with the local authority to offer a service that enables families to deal with the notification of death, registration process and informing different government services all from one place. This is a significantly improved service, saving users distress and time.

Further information
James Lowell,
james.lowell@gstt.nhs.uk

15.6 Suggestions for quick wins / what you can do now

- **Work with local partners to understand the needs and experiences of older people regarding end of life care**

While a huge amount is known about the needs and preferences of older people in relation to end of life care, less may be known about the specific needs and experiences of older people in particular areas, taking into account local demographic factors such as ethnicity and rurality. Joint work between NHS organisations, local authorities, the third sector and older people and their organisations should enable better joint work and joint planning on end of life issues.

- In particular (and as suggested by the equality impact assessment of the end of life care strategy), care homes, hospices, extra care housing, etc, should consider collecting information about each resident's ethnicity, religion, language and culture to ensure that they are able to meet the needs of people from BME communities. Information on other equality standards will be similarly valuable. (Appropriate consents to record, store and share this information must be obtained in compliance with the Data Protection Act).
- **Review the provision of specialist end of life care and palliative care**
  Using the Joint Strategic Needs Assessment process, review, with the involvement of older people and their organisations, the extent to which local provision for specialist and palliative care is adequate to meet the end of life care needs of people of all ages and with all terminal conditions, and in ways that are appropriate to people of diverse cultures and faiths.
- In particular, those involved in such reviews may wish to refer to the definitions of supportive care, palliative care and specialist palliative care services, as set out by the National Council for Palliative Care.

  → www.ncpc.org.uk/download/PalliativeCareExplained.doc
- It may also be useful at a local level to compare the pathway of older people and younger people with similar conditions at the end of life, to assess whether there is evidence of age discrimination.

15.7 Useful resources

National Council for Palliative Care:
Creative Partnerships: Improving Quality of Life at the End of Life for People with Dementia, January 2008

Progress with Dementia – Moving Forward: Addressing Palliative Care for People with Dementia, August 2007

Chapter 16
Urgent and emergency care

16.1 Key audiences

Primary care trusts and emerging GP commissioning consortia:

- commissioners of acute medical services including older people
- commissioners of services for older people in the community
- commissioners of accident and emergency services
- directors of public health
- Director of performance
- GPs and practice-based commissioners.

NHS trusts and NHS foundation trusts:

- managers of acute medical services for older people
- medical directors
- directors of nursing
- directors of duality and safety
- managers of A&E services.

Local Authorities

- Directors of adult social services.

Nursing homes:

- managers.

Older people voluntary sector organisations:

- chief executives.

Ambulance services

16.2 Key issues and concerns

Summary

Older people, and in particular those over 80, make up a significant proportion of those who attend accident and emergency departments (A&E). They are also more likely to be admitted to hospital from A&E than are younger people. Reducing inappropriate emergency admissions by providing targeted care and assessment for older people in A&E departments, intermediate care and better support in the community leads to a better experience for older people and is cost-effective.

If older people are urgently admitted to hospital it is important that they get the maximum benefit. This includes having a comprehensive assessment leading to appropriate access to specialist facilities such as intensive care and specialist clinicians. Also see Chapter 5 High quality care for all.
It is particularly important that discharge is planned throughout the older person's stay in hospital and that they, their carers and all those involved in their care collaborate to ensure that they are fully prepared to be discharged to the most appropriate place with the support they need. The rate of readmission to hospital within a month of discharge is relatively high amongst older people, and is highly variable between hospitals, which suggests that more could be done to improve the quality of their care and discharge planning. Proposals to address this appear in the Revision to the NHS Operating Framework 2010-2011[455].

Key points

- Older patients can experience poor care in A&E departments.
- Older patients are more likely than younger patients to be admitted to hospital if they attend A&E.
- Addressing the continuing rise in emergency admissions is likely to have economic benefits and improve the experience of older people.
- Comprehensive assessment of older people being admitted in an emergency can improve the quality of their care and reduce lengths of stay in hospital.
- The rates of hospital readmission within 28 days of discharge for older patients are high and increasing.
- Discharge planning is often not adequate for older people.
- Intermediate care can prevent unnecessary admission, expedite appropriate hospital discharge and avoid long-term admission to care homes.
- Old age specialist teams can considerably improve outcomes.

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[455] *Revision to the NHS Operating Framework* Department of Health June 2010

- Changes to the payment system planned for 2011-2012 aims to reduce readmissions and improve reablement and post-discharge support.

Older patients can experience poor care in A&E departments

Evidence of age discrimination in the provision of hospital accident and emergency services is unclear, but individual high profile examples of poor care in Accident and Emergency departments, particularly affecting older people and resulting in the deaths of patients, can and do occur.[456]

Older patients are more likely to be admitted to hospital from A&E

Older people are increasingly frequent users of A&E departments and often have complex medical and social needs over and above the clinical cause of attendance.[457] There is no convincing evidence that older people use A&E inappropriately, although social isolation and chronic disease are associated with an increased risk of attendance.[458]

Older patients are much more likely than younger patients to be admitted to hospital from A&E due to their reduced functional reserve which may result in significant impairment of daily living activities following relatively trivial illness or injury.[459]

Studies report 46-48 per cent of over 65s are admitted to hospital from A&E compared with 14-20 per cent of younger patients.[460] [461] [462]

Addressing the continuing rise in emergency admissions is likely to have economic benefits and improve the experience of older people

Reducing emergency admissions would have benefits for older people and for the health economy. However, the number of emergency admissions is still rising in many parts of the country.[463] [464]

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[456] *Investigation into Mid Staffordshire NHS Foundation Trust*, Healthcare Commission, 2009 www.cqc.org.uk/_db/_documents/Investigation_into_Mid_Staffordshire_NHS_Foundation_Trust.pdf

[457] *Repeat attendance by older people at accident and emergency departments,* Bentley J, Meyer J, J Adv Nurs. 48: 149-56, 2004

[458] *The Older Person in the Accident & Emergency Department* (Best practice guide Document 3.2 Revised March 2008), British Geriatrics Society, 2008 www.bgs.org.uk/Publications/Compendium/compend_3-2.htm

[459] *The Older Person in the Accident & Emergency Department* (Best practice guide Document 3.2 Revised March 2008), British Geriatrics Society, 2008

[460] *Transforming emergency care in England*, Alberti G, Department of Health, 2004

[461] *Older people's use of Accident and Emergency services,* Age and Ageing, Downing A and Wilson R, 34 (1): 24 – 30, 2005

[462] *The Older Person in the Accident & Emergency Department* (Best practice guide Document 3.2 Revised March 2008), British Geriatrics Society, 2008

Improved multidisciplinary assessments in A&E departments, including psychiatric assessment (see Chapter 14 Mental health including dementia), and the availability of intermediate care alternatives can help to reduce emergency admissions and ensure older people receive the most appropriate care. In addition, services in the community can help prevent A&E attendances and emergency admissions. The evaluation report of the Partnership for Older People Projects (POPPs) concluded that projects designed to promote the health, wellbeing and independence of older people in the community can reduce overnight hospital stays by over 40 per cent and A&E attendances by nearly 30 per cent.[465] The report also concluded that POPPs services appear to have improved users' quality of life.

Comprehensive assessment of older people being admitted in an emergency can improve the quality of their care and reduce lengths of stay in hospital

A study found that comprehensive screening and assessment of older people who had been admitted to hospital in an emergency improved clinical effectiveness and reduced lengths of stay.[466] Falls and delirium are both common causes of A&E attendance for older people and of subsequent admissions.[467] Delirium is often not recognised by clinicians and is poorly managed.[468]

The rates of hospital readmission within 28 days of discharge for older patients are high and increasing

Concerns have been expressed at the increasing proportion of hospital patients aged 75 and over who are readmitted as emergency admissions within one month of discharge.[469] [470] There was a 27 per cent increase in the numbers of older people being readmitted within a month between 1998/9 and 2006/7. It is not clear how much of the higher rate for older people results from increased frailty and how much from poorer standards of care or from

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[463] *The Older Person in the Accident & Emergency Department* (Best practice guide Document 3.2 revised March 2008), British Geriatrics Society, 2008 www.bgs.org.uk/Publications/Compendium/compend_3-2.htm

[464] *Rise in admissions will be unsustainable for PCTs*, Health Service Journal, HSJ 21.1.10, 2010

[465] *National Evaluation of Partnerships for Older People Projects – Final Report*, Windle et al, PSSRU, Department of Health, 2009

[466] *The older persons' assessment and liaison team 'OPAL': evaluation of comprehensive geriatric assessment in acute medical inpatients,* Harari D, Martin FC et al, Age and Ageing. 2007, November;36 (6):670-5, Epub 2007 Jul 26

[467] *The Older Person in the Accident & Emergency Department* (Best practice guide Document 3.2 revised March 2008), British Geriatrics Society, 2008 www.bgs.org.uk/Publications/Compendium/compend_3-2.htm

[468] *The prevention, diagnosis and management of delirium in older people*, BGS and RCP, 2006

[469] *One voice: shaping our ageing society*, Age Concern and Help the Aged, 2009 Harrop A, Jopling K and contributors

[470] *One voice: shaping our ageing society*, Age Concern and Help the Aged, 2009 Harrop A, Jopling K and contributors

premature or insufficiently well-planned discharge procedures. However, the high, and increasing, rates of hospital readmission within 28 days of hospital discharge, for older patients, is a clear indication of problems with the hospital care or discharge procedures for this group. This would appear to be a case of indirect discrimination, where universally applied policies are particularly disadvantageous to older people.[471]

Discharge planning is often not adequate for older people

In 2006 the Healthcare Commission found that "*Rapid discharge was only achieved at the expense of proper planning with the older person concerned".* Studies of hospital discharge from the older person's perspective find that older people do not fully participate in planning their discharge and feel disempowered in terms of exercising any real choice in decisions about their transfer to the community.[472] [473] Risk management and safety are often priorities for staff planning discharge, and matching plans to existing services, but they fail to take into account longer term life-planning issues of importance to older people.[474]

A national report on rehabilitation and remedial services for older people stressed the importance of comprehensive assessment for older people who may require additional support to regain their best possible functional independence and confidence, compared to younger adults, to reduce the risk of readmission to hospital or being 'misplaced' in long term care.[475] An audit of nursing home placements in England and Wales found 90 per cent of records contained no physiotherapy or occupational therapy reports of pre-admission assessments.[476] Older patients, aged 81 and over, are much less likely than younger patients to feel they have been given adequate information about what to do if they are worried about their condition after leaving hospital.[477]

Intermediate care can prevent unnecessary admission, expedite appropriate hospital discharge and avoid long-term admission to care homes

Evidence that the intermediate care function is effective has begun to emerge from a number of major research programmes, although conclusions are mixed. It has been shown to reduce the use of acute hospital admissions in

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[471] *Ageism and age discrimination in secondary health care in the United Kingdom*, CPA, October 2009
[472] *Delayed transfer from hospital to community settings: the older person's perspective,* Swinkel A and Mitchell T, Health and Social Care in the Community 17 (1): 45-53, 2008
[473] *Using qualitative research in systematic reviews: older people's views of hospital discharge,* Fisher et al, Social Care Institute for Excellence (SCIE), 2006
[474] *Using qualitative research in systematic reviews: older people's views of hospital discharge*, Fisher et al, SCIE, 2006
[475] *The way to go home: rehabilitation and remedial services for older people* (Promoting independence 4), Audit Commission, 2000
[476] *Ageism and age discrimination in social care in the United Kingdom,* CPA, October 2009
[477] *Ageism and age discrimination in secondary health care in the United Kingdom*, CPA, October 2009

some areas and to enable people to regain skills and abilities in daily living, thus enhancing their quality of life.[478] [479]

Old age specialist teams can considerably improve outcomes

The early involvement of old age specialist teams, when a hospital admission is being considered, improves outcomes, reduces lengths of stay and avoids inappropriate admissions.[480] [481] This is also preferred by patients.[482] Old age specialists can also coordinate care for older people and help to ensure that they access other appropriate specialist health professionals.

16.3 Drivers and policy imperatives

Revision to the Operating Framework for the NHS in England 2010/11

In the *Revision to the NHS Operating Framework 2010-2011*[483] there are two proposals to address the level of readmissions. Firstly there is an intention that hospitals become responsible for patients for 30 days after discharge so that from 1 December 2010, if a patient is readmitted within that time, the hospital will not receive any further payment for the additional treatment. In addition it is planned that the 2011-2012 tariff for hospital care will cover re-ablement and post discharge support, including social care.

Emergency care

The Department of Health's 10-year strategy, *Reforming Emergency Care* (October 2001), is driving the changes in emergency care. The strategy is based on six key principles:

- Services should be designed from the point of view of the patient.
- Patients should receive a consistent response, wherever, whenever and however they contact the service.
- Patients' needs should be met by the professional best able to deliver the service needed.

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[478] *Early discharge hospital at home,* Shepperd S and Doll H et al, *Cochrane Database of Systematic Reviews* 2009, Issue 1 Art. No: CD000356 DOI: 0.1002/14651858.CD000356.pub3
[479] *Intermediate Care – Halfway Home: Updated guidance for the NHS and Local Authorities*, Department of Health, 2009
[480] Urgent care pathways for older people with complex needs – *Best Practice Guidance*, Department of Health, 2007
[481] *The Older Person in the Accident and Emergency Department – Best Practice Guide*, British Geriatrics Society, 2008
[482] *The Older Person in the Accident and Emergency Department – Best Practice Guide,* British Geriatrics Society, 2008
[483] *Revision to the NHS Operating Framework 2010-2011*, Department of Health June 2010

- Information obtained at each stage of the patient's journey should be shared with other professionals who become involved in their care.
- Assessment or treatment should not be delayed through the absence of diagnostic or specialist advice.
- Emergency care should be delivered to clear and measurable standards.

Transforming Emergency Care[484] highlights the need to pay particular attention to older people in A&E.

The British Geriatrics Society's *Best Practice Guidance* on the *Older person in the Accident and Emergency Department* (latest version 2008) sets out how to deliver high quality care to older people in A&E departments. These guidelines stress the need for a comprehensive, multidisciplinary assessment of older people in A&E and following an admission from A&E.

Intermediate care

The *National Service Framework (NSF) for Older People* (Standard Three) stated that:

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

The NSF also noted that:

> "*An essential component of intermediate care services is that they should be integrated within a whole system of care including primary and secondary health care, health and social care, the statutory and independent sectors*."

The most recent Department of Health Guidance on intermediate care[485] updates the 2001 Guidance.[486] This provides a definition and clarification of intermediate care and renews the emphasis on those at risk of admission to residential care. It also stresses the need to include people with dementia or mental health needs, adds the need for timely access to specialist support as

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[484] *Transforming Emergency Care***,** Department of Health, 2004
[485] *Intermediate Care – Halfway Home: Updated guidance for the NHS and Local Authorities,* Department of Health, 2009
[486] *Intermediate Care* – Health Service/local authority circular HSC 2001/001, Department of Health, 2001

needed and focuses on the need for joint commissioning of a wide range of services to fulfil the intermediate care function including social care reablement.

Discharge

Standard four of the *NSF for Older People*[487] stresses the need to pay particular attention to discharge planning for older people in hospital.

The Department of Health Guidance *Discharge from hospital: pathway, process and practice*[488] provides the most comprehensive guidance on hospital discharge and updates and builds on the 1994 guidance and workbook. This guidance notes that particular attention should be given to assessments of older people's needs when being discharged from hospital and stressed the use of the Single Assessment Process (SAP) for older people. This has recently been updated with good practice guidance on discharge for older people:[489]

The previous Government's carers' strategy[490] introduces a new commitment to run pilots looking at the ways in which the NHS can better support carers. Demonstrator sites looking at ways that the NHS can better support carers were established in 2009 and they will be examining good practice in actively involving carers in diagnosis, care and discharge planning. They will be subject to independent academic evaluation and the findings will be published in Autumn 2011.

16.4 What good age-equal practice might look like

Also see Chapter 8 Prevention and health promotion.

In order to promote age equality, primary care trusts might work to improve:

- The quality of care and level of dedicated expertise available to older people in A&E departments and the early stages of acute admissions.
- The availability of intermediate care to meet the needs of older people including those with dementia and mental health problems.
- The high level of readmissions of older people after one month.
- The experience of discharge for older people and their carers.

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[487] *National Service Framework for Older People*, Department of Health, 2001
[488] *Discharge from hospital: pathway, process and practice*, Department of Health, 2003
[489] *Ready to go – Planning the discharge and transfer of patients from hospital and intermediate care*, Department of Health, 2010
[490] *Carers at the Heart of 21st Families and Communities*, Department of Health, 2008

Emergency care

The British Geriatrics Society provides a best practice guide on the care of older people in A&E.[491] This states that clinicians should ensure that the clinical care provided for older patients is based on clinical need and not arbitrary age-defined criteria and that there should be equity of access to the full range of investigation and treatment facilities. It also stresses the need for emergency care to be patient-centred and makes the following recommendations:

- Patients who come to A&E will want to be seen promptly and have the opportunity to be assessed by a doctor in private, in surroundings which take account of their hearing as well as their physical, emotional and cognitive states.
- There should be an understanding of the particular health problems of elderly patients from ethnic minority groups, particularly with reference to linguistic, cultural and religious differences.
- If admission is to be arranged, patients and their carers should be informed of their management plan and prognosis.
- Where applicable, advance directives and lasting powers of attorney should be respected and in cases where patients lack capacity, carers, next of kin, friends and independent mental capacity advocates may be consulted as outlined in the Mental Capacity Act.

These guidelines also recommend that local commissioners and providers should ensure the following:

- Minimal delays for older people in A&E prior to assessment.
- Adequate facilities available to make patients feel comfortable in A&E e.g. food, drink, appropriate chairs/beds for the elderly.
- Adequate toilet facilities.
- Timely transfer from A&E directly to acute geriatric medicine wards, acute medicine units, geriatric medicine rehabilitation or specialist stroke beds.
- Appropriate admission of patients with acute mental health problems.
- Admission areas for overnight observation where discharge may be unsafe.

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[491] *The Older Person in the Accident & Emergency Department* (Best practice guide Document 3.2 revised March 2008), British Geriatrics Society, 2008

- Referral from A&E for urgent multidisciplinary assessment to provide care support, based on the level of need, either at home or in a residential home, nursing home or interim care facilities.
- That responsibilities for meeting the needs of older patients are clear and comprehensive so that individuals do not fall between services.

Whilst no single model of care has been shown to be the most effective, 'fast-track' systems for older patients with fractured neck of femur and stroke are examples of beneficial developments.[492]

It is also effective to site staff in A&E who can provide initial assessment for frail elderly patients. This may be a physiotherapist, occupational therapist, social worker, specialist nurse or any combination of these individuals who can then access/pass the referral on for further assessment in the appropriate setting including:

- primary care
- falls clinic
- transient ischaemic attack (TIA) clinic
- day hospital
- rapid assessment geriatric clinic
- intermediate care and social care to provide urgent support and/or rehabilitation when indicated.[493]

The Department of Health provides guidance on a care pathway for older people with complex needs caused by falls, confusional states or hip fracture.[494]

Intermediate care

The Department of Health has recently updated guidance on the development and provision of intermediate care.[495]

Factors that have been shown to lead to the successful development of the function of intermediate care are:

- good clear leadership
- good co-ordination

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[492] *The Older Person in the Accident & Emergency Department* (Best practice guide Document 3.2 revised March 2008), British Geriatrics Society, 2008
[493] *The Older Person in the Accident & Emergency Department* (Best practice guide Document 3.2 revised March 2008), British Geriatrics Society, 2008
[494] *Urgent care pathways for older people with complex needs*, Department of Health, 2007
[495] *Intermediate Care – Halfway Home: Updated guidance for the NHS and Local Authorities,* Department of Health, 2009

- a single point of access to the service
- the capacity to accept risk.[496]

It is important that intermediate care is accessible and appropriate for people with dementia. It is good practice to ensure that there is mental health support for intermediate care teams.

Discharge

Recent Department of Health guidance on discharge puts forward 10 key steps to achieving safe and timely discharge. These steps are based on the good practice previously identified and evaluated by practitioners:[497]

→ www.dh.gov.uk/en/Publicationsandstatistics/Publications/dh_103146

Readmissions

Suggestions for reducing the readmissions rate include:

- agree outcomes for target group, such as reduced attendance at A&E with robust data collection and evaluation
- have an integrated care coordination service to deliver case management alongside statutory and voluntary partners
- incentivise GPs to use simple case-finding systems
- demonstrate financial impact of reduced admissions – care coordination pays for itself. [498]

16.5 Case studies of illustrative / good practice

Reducing emergency admissions using the Methodology for Ensuring Seamless Healthcare (MESH) Birmingham

NHS Birmingham East and North has been working with Healthcare at Home to redesign patient care pathways and deliver services to adult patients in the community. These services provide an enhanced supported discharge team, long-term and ambulatory care, sensitive condition care, home chemotherapy and a family liaison service to support patients who are at the end of life. The services are all unique in their design but are also supported by a 24-hour nurse triage telephone and rapid response team, with the aim to support patients and their relatives during difficult times.

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[496] *Intermediate Care – Halfway Home: Updated guidance for the NHS and Local Authorities,* Department of Health, 2009
[497] *Ready to go – Planning the discharge and transfer of patients from hospital and intermediate care*, Department of Health, 2010
[498] *Health Service Journal*, 5 November 2009

This is a pilot which is supported by robust IT systems to provide up-to-date information on progress and audit results to the NHS. Evidence suggests that for older people, who are more likely to experience adverse events in hospital, home-based healthcare has the potential to avoid exposure to infection and gives the benefit of offering care in familiar surroundings. The care pathways provided by these teams are designed with these benefits in mind.

Further information
Jill Doyle, Healthcare at Home, Service Delivery Manager
jilld@hah.co.uk

Reducing emergency admissions South Staffordshire

An Accident and Emergency Diversion and Discharge Support Service is provided in seven hospitals across South Staffordshire. Most of the referrals are from Social Care and Health through their access teams. The service was developed to reduce emergency admissions to hospital, to support older people on discharge from hospital, and to prevent unnecessary admissions to hospital, respite or care homes. Amongst services provided is an initial assessment, linked to SAP and including risk of falling.

Further information
Katharine Orellana, Development Officer, Age Concern and Help the Aged
katharine.orellana@ace.org.uk

Brent POPP Integrated Care Coordination Service

The Integrated Care Coordination Service (ICCS) is an extension of an existing care coordination service, which became a fully integrated team of staff from social and healthcare agencies, and voluntary and community sector organisations (VCOs). The aim of the ICCS is to move from reacting to case referrals to proactive case-finding to maximise prevention.

It is a ‘holistic’ service targeted at older people over 65 who may be at risk of avoidable hospital admission, premature admission to institutional care, or simply causing concern due to medical, physical, emotional or social issues. It uses the Emergency Admission Risk Likelihood Index (EARLI) tool to proactively 'case find' older people in need of some help. It address people's needs by undertaking assessments and then coordinating a range of interventions responding to identified needs – operating across health, social care and other organisational boundaries as required. The involvement of the service can typically extend to three months.

Interventions include odd jobs around the home, assistance with moving into more appropriate accommodation, benefits and pensions advice or referrals to health and social care providers, podiatrists, occupational therapists etc.

(Source: Partnerships for Older People (POPPS) report: www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/@ps/documents/digitalasset/dh_111353.pdf)

Reducing emergency admissions – virtual wards Croydon

Croydon Primary Care Trust has developed and piloted the use of 'virtual wards' for people at highest predicted risk. In essence, virtual wards use the systems, staffing and daily routine of a hospital ward to provide case management in the community.

Virtual wards copy the strengths of hospital wards: the virtual ward team shares a common set of notes, meets daily, and has its own ward clerk who can take messages and coordinate the team. Each virtual ward has a capacity to care for 100 patients in their own homes. The day-to-day clinical work of the ward is lead by a community matron. Other staff include a social worker, health visitor, pharmacist, community nurses and allied health professionals.

This is a summary of a case study by Dr Geraint Lewis, previously Specialist Registrar in Public Health, Croydon Primary Care Trust.

Further information
geraint.lewis@nuffieldtrust.org.uk

Improving intermediate care for people with dementia – Bristol

Bristol's intermediate care teams have psychiatric nurse support and there has been training on working with people with dementia. Bristol's short-term reablement service provides focused intensive domiciliary support, which includes support for people with dementia. Bristol also makes use of a specialist independent care home which provides intensive residential reablement for up to eight weeks for people with dementia, predominantly post-discharge from hospital.

Source: Regional findings from SW Review in respect of intermediate care: objective 9.

Discharge to care homes - Joint working between a health board, hospital trust and the independent sector Bridgend

A number of concerns were highlighted through complaints in relation to the discharge of vulnerable older patients from hospitals back to care homes. In collaboration with the trust's dignity champion for older people, the aim was to evidence incidents of unsatisfactory discharge from wards within the trust to care homes and to improve the discharge of older people. The health board worked with care homes to collate information, including examples of poor discharge, and present these to the trust. The trust provided key staff contact details to care homes to encourage better communication. The trust also identified areas where further training was required and a number of workshops for both care home and ward staff are planned with the aim of building improved trust and communication in relation to discharge planning.

There has been a significant reduction in the reporting of unsatisfactory hospital discharges.

Further information
Leanne Lewis, Nurse Assessor NHS Funded Care
leanne.lewis@bridgendlhb.wales.nhs.uk

16.6 Suggestions for quick wins / what you can do now

The Department of Health has produced tips for quick wins in improving responses to older people who need emergency care and in reducing that need. It is recognised that some of these actions are already in place in some parts of the country, but recommended that these become embedded as the standard mainstream approach.

- **Long-term conditions management**
  Identify patients with complex long-term conditions who are most at risk of unplanned hospital admissions. Adopt a case management approach, typically with a community matron, to anticipate, coordinate and join up their health and social care. This can improve the quality of life and outcomes for patients, prevent exacerbation of their condition(s), reduce emergency admissions and enable those who are admitted to return home more quickly.
- **Establish medicines reviews in care homes by community pharmacists or general practitioners**
  This will reduce drug side effects in residents, which account for a large number of emergency hospital admissions from care homes.

- **Care home escalation policy**
  Agree escalation policy with care homes and local general practitioners for responding to medical crises in care homes. This will improve outcomes for patients and reduce unnecessary referral to emergency departments and admission to acute hospital beds.
- **Rapid access to intermediate care**
  There should be a single point of contact for access to intermediate care services, available on a 24/7 basis. This will provide alternative admission for patients who need rehabilitation (loss of ability in activities of daily living) but do not clinically require hospital admission.
- **Falls service**
  Following a fall, all emergency patients without life-threatening illness or need for surgery should be referred to the local falls service for multidisciplinary assessment and management. This will reduce the need for hospital admission, improve outcomes for patients and reduce the risk of further falls or fractures.
- **Stroke assessment unit**
  Create a geographically-defined stroke assessment unit to which patients are rapidly transferred following an emergency response. This will minimise time in the emergency department for these patients and improve patient experience and outcomes.
- **Acute confusion**
  Emergency response staff should be trained in basic assessment of patients who seem confused, with early transfer to staff trained in managing people with confusion. This will help patients who are particularly vulnerable in emergency departments get quickly through the system.
- **Other conditions**
  Patients with falls or with multiple health problems who need admission should be fast-tracked to old age specialist teams within 24 hours of admission. This will ensure that needs are addressed, with early transfer to intermediate care if appropriate.[499]

[499] *8 tips for quick wins – Improving responses for older people*, Ian Philp and George Alberti et al, Department of Health, 2005

Chapter 17
Cancer

17.1 Key audiences

Primary care trusts and emerging GP commissioning consortia:

- chief executives
- directors of public health and local authorities
- commissioners of services for older people/cancer/acute care
- providers of community based health services

NHS trusts and NHS foundation trusts:

- chief executives
- directors of nursing
- medical directors
- head of cancer services
- cancer clinicians.

Cancer networks:

- cancer network directors
- cancer network primary care leads.

Third sector providers of services for people with cancer:

- chief executives.

17.2 Key issues and concerns

The Coalition Government has announced a refresh of the Cancer Reform Strategy (CRS)[500] focusing on the need to improve outcomes. The CRS said that there is some evidence that older people receive less intensive treatment than younger people even when they are fit enough to do so.[501] [502] The CRS clearly stated that age should not be a barrier to treatment. The assumption

[500] *Cancer Reform Strategy*, Department of Health, 2007
[501] *British Journal of Cancer*, Lavelle et al, 96; 1197-12-3, 2007
[502] *Age and Ageing*, Peake et al, 32; 171-177, 2003

should be that older patients should receive the same level of treatment. This issue has been further highlighted by the work of the National Cancer Equality Initiative (NCEI). Among the issues highlighted by the literature are:

- Cancer is more common in later life.
- Older people receive less active and intensive treatment than younger patients.
- Older people can often tolerate similar treatment regimes to younger people.
- Older people with cancer are more likely to be admitted as emergencies.
- Professional attitudes can be a barrier that may impede older people getting access to a full range of treatment options.
- Older people do not always get comprehensive information about treatment options in a manner which is appropriate and comprehensible.
- The difficulties for older people in accessing appropriate cancer services may be compounded by socio-economic deprivation, gender, sexuality, race and disability.
- The decrease in cancer mortality in older people has been less marked than for younger people.

Cancer is more common in later life

Cancer is predominantly a disease of older people – only 0.5 per cent of cases registered in 2006 were in children (aged under 15) and 26% were in people aged under 60.[503] Around one-third of all cancers are diagnosed in people over 75 who form just 7 per cent of the population.[504] However, this group is less extensively investigated and receives less treatment than younger patients; reduced levels of intervention are not wholly explained by appropriate adjustment for co-morbidity or frailty.[505]

For most cancers, such as breast, colorectal, lung and prostate, the risk of cancer increases with age.[506] However, the link between increasing age and increasing risk of developing cancer appears to be poorly understood by the public. For example a recent study found that over 50 per cent of women wrongly believe that the risk of breast cancer does not vary with age, with only one per cent correctly believing that the oldest women are at greatest risk.

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[503] *NHS Choices website* www.nhs.uk/nhsengland/NSF/pages/Cancer.aspx
[504] NHS Scotland, 2001, Review cited in Centre for Policy on Ageing (CPA) *Ageism and age discrimination in secondary health care in the United Kingdom*, October 2009
[505] *Ageism and age discrimination in primary health care in the United Kingdom,* October 2009
[506] *Cancer Reform Strategy Equality Impact Assessment,* Department of Health, 2007

Lack of awareness that they are still at risk of developing breast cancer appears to be one of the major reasons why older women with breast cancer present later and with more advanced disease than younger women.[507]

Older people receive less active and intensive treatment than younger patients

Disease-specific survival rates decline with age.[508]

Fewer diagnostic procedures and less treatment are carried out with advancing age.[509]

Older patients are less likely to receive a full investigation, as indicated by histology, and also less likely to receive definitive surgery or chemotherapy.[510] [511]

Older women are less likely than younger women to receive 'standard' management for breast cancer. Older women are less likely than younger women to have surgery for operable breast cancer, even after accounting for differences in general health and co-morbidity. Women aged 70+ are less likely to be diagnosed via needle biopsy and triple assessment, or receive radiotherapy than younger women. When compared with a 65-69-year-old, a woman aged 80 or older is five and a half times less likely to receive triple assessment for operable breast cancer and 40 times less likely to undergo surgery. Even women as young as 70-74 are over seven times less likely to receive radiotherapy following breast conservation surgery.[512] [513]

Older people are less likely to receive breast conserving surgery and lung cancer resection.[514]

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[507] *Cancer Reform Strategy*, Department of Health, 2007
[508] *Ageism and age discrimination in secondary health care in the United Kingdom*, Centre for Policy on Ageing (CPA), October 2009
[509] *Reducing cancer inequality: evidence, progress and making it happen – a report by the National Cancer Equality Initiative*, Department of Health, March 2010
[510] *Ageism and age discrimination in secondary health care in the United Kingdom*, CPA, October 2009
[511] Macmillan Cancer Support's response to the *APPG on Cancer's Inquiry into cancer inequalities*, Clarke J, June 2009
[512] *Ageism and age discrimination in secondary health care in the United Kingdom*, CPA, October 2009
[513] Age Concern/Help the Aged's *Response to the National Review of Age Discrimination in Health and Social Care,* July 2009
[514] *Social variations in access to hospital care for patients with colorectal, breast, and lung cancer between 1999 and 2006: retrospective analysis of hospital episode statistics*, Raine et al, 2010BMJ 2010;340:b5479

Older people can often tolerate similar treatment regimes to younger people

Some elderly people can tolerate chemotherapy, surgery, and radiotherapy just as well as younger patients, and regimens and protocols can be modified in less-fit patients.[515]

Older people with cancer are more likely to be admitted as emergency cases

Older people (over 80s), patients from deprived areas and women are more likely to be admitted as emergency cases.[516]

Professional attitudes can be a barrier that may impede older people's access to a full range of treatment options

Oncology professionals may have negative attitudes towards older people.[517] [518]

Late presentations amongst older people are common resulting in significantly higher mortality for some cancers as symptoms may be dismissed as a sign of old age by health professionals.[519] [520]

Older people do not always get comprehensive information about treatment options in a manner which is appropriate and comprehensible

Older people may be more likely to follow their doctor's recommendations without question, but the way in which treatment options are presented can influence their choice.[521]

One of the key barriers to equality is poor communication - information not being given appropriately.[522]

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[515] *Ageism and age discrimination in primary health care in the United Kingdom*, CPA, October 2009
[516] *Social variations in access to hospital care for patients with colorectal, breast, and lung cancer between 1999 and 2006: retrospective analysis of hospital episode statistics*, Raine et al, 2010BMJ 2010; 340:b5479
[517] *Ageism and age discrimination in secondary health care in the United Kingdom*, CPA, October 2009
[518] *Macmillan Cancer Support's response to the APPG on Cancer's Inquiry into cancer inequalities*, Clarke J, June 2009
[519] *Myths and biases related to cancer in the elderly*, Berkman B, Rohan B and Sampson S, 1994, Cancer 74 (7, Suppl): 2004-2008
[520] *Ageism in chemotherapy*, The Internet Journal of World Health and Societal Politics 6 (1), Dockter L and Keene S, 2009, cited in *Ageism and age discrimination in primary health care in the United Kingdom*, October 2009
[521] *Ageism and age discrimination in primary health care in the United Kingdom*, CPA, October 2009
[522] *Macmillan Cancer Support's response to the APPG on Cancer's Inquiry into cancer inequalities*, Clarke J, June 2009

Older people experience language barriers, including generational language barriers and complex language/jargon barriers in addition to barriers for those whose first language is not English.[523]

The difficulties for older people in accessing appropriate cancer services may be compounded by socio-economic deprivation, gender, sexuality, race and disability

Services can be ethnocentric and fail to provide appropriately for black people. For example, prostheses (limbs and breasts) are often not the right colour and wigs are not appropriate for African and Caribbean people.[524] There can be a lack of information about skin care after treatment for black people and a lack of appropriate dietary advice which takes into account various black and minority ethnic (BME) diets.[525]

There are 25,000 older people with learning disabilities in the UK and this is set to rise over the next decade. People with learning disabilities have higher rates of cancer than the general population and particular needs when accessing services.[526]

These factors can compound issues for older people in accessing cancer services. Problems in ensuring appropriate communication of information about cancer treatments and services to those who may have language or comprehension difficulties, due to race or disability, is of particular concern. Local health organisations will want to ensure that they avoid the potential for dual or multi discrimination. This may require a particular focus on action to address the issues outlined above.

The decrease in cancer mortality in older people has been less marked than for younger people

Compared with Europe and America little progress has been made in the last decade in cancer death rates in the over 75s in the UK, and the gap in death rates between over and under 75s is getting wider.[527] The 2nd CRS Annual Report noted that the decrease in cancer mortality in older people has clearly been less marked than for younger people, and this is a matter of concern now being investigated further.

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[523] *Cancer inequalities – Focus groups with people affected by cancer – report*, Macmillan Cancer Support, June 2009
[524] Cancerbacup, 2006 http://path-finderhd.com/conf/blackpool/Cancer%20Services%20Engaging%20with%20BME%20communities.ppt
[525] Personal communication Meena Patel Cancer Programme Manager Afiya Trust December 2009
[526] *Healthcare for All, Report of the Independent Inquiry into access to healthcare for people with learning disabilities*, Sir Jonathan Michael, 2008
[527] *Ageism and age discrimination in secondary health care in the United Kingdom*, CPA, October 2009

Projects undertaken by trusts to specifically tackle cancer inequalities are significantly more likely to be focused on awareness and early detection, rather than on treatment, patient information or living with and beyond cancer.[528]

The Cancer Reform Strategy[529] recognised that some of the measures being taken may, at least initially, widen inequalities. This includes measures to improve awareness of prevention messages as well as the signs and symptoms of cancer, which are likely to be disproportionately acted upon by the informed and articulate. The strategy also noted that expanding screening will benefit everyone who is eligible, but groups with lower levels of uptake will experience less benefit.

In order to tackle these inequalities, the CRS set up the National Cancer Equality Initiative (NCEI) to improve data collection, identify research gaps and spread best practice.

Access to screening

The recent review of age discrimination in health and social care recommended that the Department of Health and the Breast Cancer Screening Advisory Committee ensure there is evidence to justify the age criteria for breast cancer screening.[530] This is being examined at national level. However, people above the age range for breast (70) and bowel (69) cancer screening can self-refer. This right should be communicated to older people, together with their increasing risk of developing the disease.

17.3 Drivers and policy imperatives

The Government will publish a refresh of the *Cancer Reform Strategy*[531] in the winter 2010-11 focusing on the drive to improve outcomes. The *Cancer Reform Strategy* acknowledged inequalities in cancer incidence, access to services and outcomes according to deprivation, race, age, gender, disability, religion and sexual orientation and places a high priority on ensuring that action is taken to reduce these inequalities.

Through NCEI, the *Cancer Reform Strategy* set in train work to explore best practice and what can be done to reduce age inequality in cancer care. The strategy states: "*In the meantime, we do not believe that age should be used as a barrier to treatment. The assumption should be that older patients should receive the same level of treatment. The only acceptable criteria for not giving a clinically-appropriate and cost-effective treatment should be poor patient*

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[528] *Inquiry into equalities in cancer*, All Party Parliamentary Group on Cancer, 2009 www.appg-cancer.org.uk
[529] *The Cancer Reform Strategy,* Department of Health, December 2007
[530] *Achieving age equality in health and social care*, Sir Ian Carruthers and Jan Ormondroyd, Department of Health, 2009
[531] *Cancer Reform Strategy*, Department of Health, December 2007

health or a patient themselves making a choice not to receive further treatment. We will explore ways of making this more explicit when guidance is issued on interventions where clinical trials may have excluded older people."

The strategy also stated that "*people affected by cancer should be offered high quality information, at key points in their cancer journey, tailored to their individual needs*". And noted that "*some patients will need additional support to understand and act upon the information they are given"*.

17.4 What good age equal practice might look like

Key principles and practical guidance for reducing inequalities in commissioning cancer services, as set out by the National Cancer Equalities Initiative (NCEI), would be put into practice:

→ www.cancerinfo.nhs.uk/images/stories/ncei_docs_/final_principles__guidance_doc.pdf

In addition, throughout 2009, NCEI held events with key stakeholders and professionals across the six equality strands, including age and socio-economic deprivation. The events have informed practical actions which are included in an NCEI report.[532]

It is also important to ensure that:

- Information is evidence based, balanced, regularly updated and written in plain language. Also that it is culturally sensitive and available in a variety of formats. It should include personalised details and be locally customised and suitable to the patient's needs at a given point in time. The Department of Health is working with Macmillan Cancer Support to pilot a range of approaches to formally assessing frailty in older people when considering treatment options.[533] [534] Also see *Useful resources* section later in this chapter for cancer information materials.
- There is adequate access for older people from BME communities to interpreting and advocacy services in order to promote informed choice on treatment. The Cancer Patient Experience Survey, taking place in spring 2010, will provide data sufficient to get a comprehensive view of whether, and to what extent, experience varies by age, gender, deprivation and ethnicity. It will also seek information on patients' sexual orientation and disability.[535]

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[532] *Reducing cancer inequality: evidence, progress and making it happen – a report by the National Cancer Equality Initiative*, Department of Health, March 2010
[533] Macmillan Cancer Support's response to the *APPG on Cancer's Inquiry into cancer inequalities*, Clarke J, June 2009
[534] *Cancer Strategy,* Department of Health, 2007
[535] *Reducing cancer inequality: evidence, progress and making it happen – a report by the National Cancer Equality Initiative*, Department of Health, March 2010

- Staff are trained in advanced communication skills. (Since July 2008 nearly 3,000 senior cancer healthcare professionals have been trained by *Connected* - advanced communication skills training programme.)
- Systems for care navigation are set up that particularly help and support those who are currently falling through the gaps in cancer care, including older people.[536]
- Treatment decisions are based on assessment of biological rather than chronological age, so that older people who are sufficiently fit are offered active treatments.[537]
- Information about local variations in access to cancer treatments and screening and mortality by age is regularly monitored and reported. Data related to cancer and equalities will soon be made available by NCEI through the National Cancer Intelligence Network (NCIN).

17.5 Case studies of illustrative / good practice

Don't Be a Cancer Chancer campaign - Manchester

This campaign targets the areas of Manchester where cancer causes the greatest loss of life. The campaign strapline is strong and simple: '*Catching it early could save your life*'. It uses a range of eye-catching materials containing the key messages, including posters, leaflets, car stickers, tissues, beer mats and toilet rolls.

The campaign is supported by NHS Manchester, the Christie Hospital and Manchester City Council. Funding has also been used for a campaign bus to visit sites, including shopping centres and supermarket car parks, to make it easier for people to access information and chat with advisers.

In local initiatives designed to complement the campaign, residents have also been supported in working with health professionals to help educate the local community and develop new approaches to the promotion of early patient presentation.

Further information
Julie Jerram, Programme Manager
0161 234 4276

[536] *Macmillan Cancer Support's response to the APPG on Cancer's Inquiry into cancer inequalities*, Clarke J, June 2009
[537] *Reducing cancer inequality: evidence, progress and making it happen – a report by the National Cancer Equality Initiative*, Department of Health, March 2010

Cancer Help for Ethnic Communities service (CHEC) Bristol and South Gloucestershire

The CHEC service is for black and minority ethnic (BME) people with cancer, at any stage of their illness, who live in Bristol or South Gloucestershire. This is just one service that the NHS offers to assist in meeting the needs of BME people and ensuring that a person is not disadvantaged as a result of individual needs relating to their culture or ethnicity.

Anyone can make a referral to the CHEC service if they are aware of someone from a BME background who is affected by cancer. Referral forms are available to download from the service's website and referrals can also be made by telephone. Once a referral has been received, the support and development worker will make contact to offer a visit at home, hospital or wherever the person may be. Referrals usually receive a speedy response though this may be affected by factors such as the need for an interpreter.

Once the CHEC worker has met with the service user, they will agree a support plan together, taking into consideration the needs of other family members and/or carers. Each case is assessed on its own merit, and needs are identified accordingly but examples of support CHEC has provided include:

Emotional support – telephone calls and home visits.

Practical support – helping the patient to access charity grants and – where necessary – helping them to complete applications; making referrals to appropriate agencies such as Care Direct for social care needs, Avon & Bristol Law Centre or Immigration Advice Service for legal and immigration advice or the Benefits Agency for benefits assessment; advice and assistance with applications.

Language support – arranging for interpreting or translation where appropriate.

General advice and information – his has often included introducing the patient to services they may not have known about such as hospices, Macmillan Cancer Support and local minority ethnic community groups and agencies who can provide additional support.

Cancer awareness sessions – where groups of people can learn more about cancer, the risk factors and the services available to them.

General support and advice for other healthcare professionals and others involved with the care of the patient.

An evaluation of the CHEC service carried out in 2006 by the University of the West of England concluded that it is cost-effective and that it is helping to improve cancer care for BME people.[538] The service regularly receives positive feedback from patients, their families and other healthcare professionals.

Further information
Marion Burrell, Support & Development Worker
Cancer Help for Minority Ethnic Communities
Hosted by Bristol Community Health
Serving Bristol and South Gloucestershire NHS areas
marion.burrell@nhs.net
0117 982 8549

PRIDE Process – NHS Bury

NHS Bury aims to transform the way services in the community are commissioned and provided, with great emphasis on dignity and respect through the PRIDE model (personal, respect, inclusion, dignity and experience). PRIDE provides a systematic process to gather experiences and uses this to identify opportunities for improvement. It also offers insight on what a service feels like from the patient's perspective and ensures their needs are met.

Frontline clinical staff work with patients and carers to improve the cancer end of life care pathway by providing seamless care for patients and their carers/families. Through working directly with clinical staff, the aim is to understand the reality of the service experience for staff, patients and carers. The initiative is looking at:

- what a 'good' service looks and feels like from a patient's/carers' and staff perspectives
- how to ensure that the individual's journey through a care pathway is seamless with a continuity of standards and experience received.

NHS Bury has now identified the eight key metrics which they are arranging to place in contracts to ensure that future services are commissioned according to users' needs.

Further information
Elaina Dinerstein, Organisational Transformation
Telephone: 0161 762 7983

→ www.bury.nhs.uk

[538] *Cancer Help for Ethnic Communities (CHEC) An evaluation of the service*, Naidoo et al, 2006

Care coordination - Bridges Support Service West Midlands

The Bridges Support Service is based in Sandwell (West Midlands). The service is managed by Murray Hall Community Trust, a registered charity, and is just one of their programmes. Staff costs are funded by local primary care trusts (PCTs). The service currently supports people in Sandwell and Heart of Birmingham PCT areas and the Birmingham East and North NHS areas.

Following referral people are put in touch with a care coordinator who links people with the services they need. The Bridges assessment is integrated with the Single Assessment Process (SAP), where this is appropriate and is in use. This is important as people do not always want different people coming to assess them, so district nurses and others can assess and refer to Bridges without a new assessment process having to take place. Bridges has developed what is called a 'narrative-based assessment' where patient and carers are given the opportunity to share their story so that assessors understand their supportive care needs.

Bridges Support Service supports people with cancer and palliative care needs, by providing:

- a range of social support
- carer support
- domestic help
- respite care
- child care
- transport to hospital appointments
- volunteer befrienders
- information
- advocacy
- complementary therapy
- support tailored to individual needs (e.g. finding a dog-sitting service)
- staff who act as key workers in small number of cases. (Bridges Care Coordinators support patients and their carers; all referrals are treated as cases.)

Key points for success are:

- flexibility about route in/referral process
- easy to access
- integrated into SAP
- not means tested

- links in to supportive care pathway (developed locally)
- hand-held resource (the directory)
- holistic – not restricted to health/social care issues
- run by voluntary sector, which enables it to cross boundaries
- high level of user involvement in all aspects(user involvement has been key in the development of the service)
- narrative-based assessments - supports Bridges' person-centred care model.

Further information
Manjula Patel, Manager
bridges.support@nhs.net

The Macmillan Mobile Information Service

The Macmillan Mobile Information Service in the London, Anglia and South East Region offers a flexible and adaptable service to the region's diverse population. Its remit is to reduce the inequality of access to cancer information and support.

The service is set in safe, welcoming environments, with anonymity if required. It includes a mobile information centre that visits high streets in the region, and an indoor Infozone that can provide information in a variety of settings. Cancer information specialists also talk to community groups.

The service brings face-to-face cancer information and support to older people so that they don't have to travel distances to other sources of support. It also supports community organisations working with older people through a programme of talks, and information stands, manned by specialists, at health events and awareness activities targeted at the older population.

Further information
Rowena Howell, Operations Manager, Mobile Cancer Information Service (London, Anglia and the South East Region)
020 8222 9043
rhowell@macmillan.org.uk

17.6 Suggestions for quick wins / what you can do now

- Commission the cancer network to report on current inequalities in cancer care and use of screening services, specifically including age, and age together with other characteristics, and propose actions.

- There is variation of rates of treatment of older people by trust, so a local audit could be undertaken of intervention rates for a range of procedures (surgery, chemotherapy and radiotherapy) and tests, by age, to assess your current situation.
- Promote cancer awareness for older people and information about age-related risks. Particular attention should be paid to BME and refugee communities and other groups who may not be aware of the signs of cancer, the treatments available, or their risk factors.
- Promote to people above the routine screening age ranges their right to self-refer for breast (over 70) and bowel (over 69) cancer screening programmes. Particular attention should be paid to promoting the benefits of screening to BME and refugee communities and other groups who may not understand, or be aware of, the screening programmes.
- Providers could consider how they can best audit information delivered to individual patients and whether this is meeting patients' needs. Particular attention should be paid to the needs of at-risk groups including older people, (as recommended by the Cancer Reform Strategy 2007), and those with other protected characteristics, in order to avoid dual or multiple discrimination.

17.7 Useful resources

Macmillan Directory of Information materials

This directory for people affected by cancer has details of over 1,000 leaflets, booklets, books and audiovisual materials on cancer. All the items listed were produced in the UK within the last five years and are available nationwide. Some are available in languages other than English. The books and audiovisual materials have been reviewed by over 200 people affected by cancer.

The directory is available free from Macmillan Cancer Support on 0800 500 800, or you can order online:

→ be.macmillan.org.uk

Cancer and Diet Information Project – Cancer Equality

This is a three-year project funded by the Department of Health to develop dietary information for people from Asian, African, Caribbean and Chinese communities whose lives are affected by cancer:

→ www.cancerequality.org.uk/

The NHS Cancer Screening website

This site has a number of resources for promoting screening programmes to the public, including information targeted at people with disabilities and material in languages other than English:

→ www.cancerscreening.nhs.uk/index.html

Chapter 18
Cardiovascular disease

18.9 Key audiences

Primary care trusts and emerging GP commissioning consortia:

- commissioners of services for older people
- commissioners of acute services
- directors of public health and local authorities
- providers of community health services
- GPs.

NHS trusts and NHS foundation trusts:

- medical directors
- care of the elderly physicians
- cardiology unit clinicians and managers
- stroke unit clinicians and managers
- directorate management teams
- emergency care leads.

Ambulance trusts:

- medical directors
- frontline staff
- service managers.

18.2 Key issues and concerns

Summary

In both primary and secondary care, there has been evidence of under-investigation, under-diagnosis and under-treatment of cardiovascular disease (CVD) in older people and these differences were not justified by the levels of need in older people. However, there are some more recent indications that older people are now getting better access to cardiac surgery and that outcomes are improving for older people.

Historical concerns about age discrimination in relation to CVD

A recent review of the literature in relation to primary care referred to sources that showed that:

- Older people, compared with younger people, were more likely to receive both delayed and fewer diagnostic interventions; fewer prevention drugs; fewer prescriptions for drugs that are known to be effective cardiac treatments; and have more limited access to specialist care facilities.[539] Research commissioned by the House of Commons Health Committee inquiry into health inequalities found that, in 2005, patients aged 75 years and over with coronary heart disease were less likely to be prescribed a beta blocker, aspirin or an ACE inhibitor.[540]
- There was evidence of gender and age inequality in the prescribing of preventive cardiovascular therapies to older people in primary care.[541]
- GPs appear reluctant to follow guidelines for cholesterol measurement and lipid lowering agents in people over 75.[542]
- In relation to secondary prevention of coronary heart disease in older people, older age was related to a lower prevalence of drug use, particularly statins.[543]
- Older people with heart failure are denied potentially beneficial treatments available to younger patients; services remain underdeveloped for management of heart failure with largely unseen demand for investigations, clinical assessment and care.[544]

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[539] *The influence of patient's age on clinical decision-making about coronary heart disease in the USA and the UK*, Adams A, Buckingham C D, Arber S, McKinlay J B, Marceau L and Link C, Ageing and Society 26 (2): 303-322, 2006
[540] *House of Commons Health Committee study,* Parliament, 2008
[541] *Evidence for a gender and age inequality in the prescribing of preventative cardiovascular therapies to the elderly in primary care*, Usher C, Bennett K and Feely J, Age and Ageing 33 (5): 500-502, 2004
[542] *Preventive health care in elderly people needs rethinking*, Mangin D, Sweeney K and Heath I, British Medical Journal 335 (7614, 11 August): 285-287, 2007
[543] *Secondary prevention of coronary heart disease in older British men: extent of inequalities before and after implementation of the National Service Framework*, Ramsay S E, Morris R W, Papacosta O, Lennon L T, Thomas M C and Whincup P H, Journal of Public Health 27 (4): 338-344, 2005
[544] *Barriers to accurate diagnosis and effective management of heart failure in primary care: qualitative study*, Fuat A, Pali A, Hungin S and Murphy J J, British Medical Journal 326 (7382, 25 January 2003) : 196-200

(The above references are all cited in *Ageism and age discrimination in primary health care in the United Kingdom – a review from the literature*, Centre for Policy on Ageing [CPA] 2009.)

In secondary care:

> *"There is clear and widespread evidence of age discrimination in the hospital-based investigation and treatment of heart disease and in the instigation of secondary prevention regimes following treatment."* [545]

The CPA review of age discrimination in secondary care also indicated that:

- Patients with acute myocardial infarction (heart attack) who are aged 75 and over have been much less likely to have an echocardiogram, exercise tolerance tests or cardiac catheterisation study.[546]
- The differences in how older people with CVD are diagnosed and treated are so marked that they are unlikely to be accounted for by co-morbidity or frailty in the older patient. (General conclusion from CPA review of age discrimination in secondary care.)

In addition, there is evidence nationally and regionally that the age standardised admission rate for revascularisation varies, with people aged over 80 getting poorer access than younger groups, although the extent of this varies across the country. The Association of Public Health Observatories (APHO) concludes that:

> *"The difference between regions does not demonstrate that any is too ready or too reluctant to undertake this procedure in older people."* [547]

All these differences in treatment are potentially evidence of possible age discrimination. Primary care trusts (PCTs) will want to work with the providers to ensure that there is not hidden discrimination in their locality and that differences between age groups can be justified.

An improving picture

There are, however, more positive developments in the treatment of coronary heart disease (CHD), which may indicate that age discrimination in relation to CVD is now being addressed more effectively. Recently, the *Sixth National Adult Cardiac Surgical Database Report* (2008) presented the following

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[545] *Ageism and age discrimination in secondary health care in the united kingdom. A review from the literature*, CPA, 2009

[546] *Age- and sex-related bias in the management of heart disease in a district general hospital,* Dudley N J, Bowling A, Bond M, McKee D, Scott M M, Banning A, Elder A T, Martin A T and Blackman I, *Age and Ageing* 31 (1): 37-42, 2002

[547] *Indications of public health in the English regions. People, Report 9 Older people, 2008*

statistics that indicate better access and better outcomes for older people who undergo coronary artery bypass grafts (CABG):

- The mean age of patients undergoing isolated CABG has increased from just over 63 years in 2000 to just over 66 in 2008.
- In 2008, 25 per cent of all patients undergoing coronary artery bypass surgery were over 75 years of age. This has increased from 10 per cent in 1999.
- There is a gradually increasing number of patients over the age of 80 years undergoing CABG, and they made up 4.4 per cent of all operations in 2008.
- Despite the increase in the age of the patients, mortality has fallen from 1.9 per cent in 2004 to 1.5 per cent in 2008. There has been a marked fall in the mortality of patients over the age of 75 from 5.0 per cent in 2004 to 3.4 per cent in 2008.
- Increasing age is strongly associated with longer in-hospital post-operative stay and reduced medium-term survival. However, the medium-term survival rate for patients over 80 years is better than 65 per cent at five years.[548]

The latest (2008) British Cardiovascular Intervention Society (BCIS) audit on interventional cardiology shows differentially better results in reducing mortality in older people after a heart attack.[549]

Also, primary angioplasty or primary percutaneous coronary intervention (PPCI), has been proven to lead to better longer-term outcomes for patients suffering a heart attack, with less risk of having a stroke and less risk of having a further heart attack.[550] Encouragingly, the Equality Impact Assessment of the National Guidance on the treatment of heart attack found that there was no significant evidence that older patients were more likely to be treated with thrombolysis than PPCI. Twenty per cent of those aged less than 80 received thrombolysis, 23.8 per cent of those aged 80 or more were treated with this strategy.[551]

Stroke and stroke prevention

> *"The presence of ischaemic and/or coronary heart disease may be associated with the occurrence of a transient ischaemic attack (TIA -*

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[548] www.scts.org/sections/audit/Cardiac/index.html
[549] www.bcis.org.uk/pages/page_box_contents.asp?pageid=705&navcatid=11
[550] *Treatment of Heart Attack National Guidance, Final Report of the National Infarct Angioplasty Project (NIAP),* Department of Health, 2008
[551] *Equality Impact Assessment Treatment of Heart Attack National Guidance***,** Department of Health, 2008
www.dh.gov.uk/dr_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_089453.pdf

mini-stroke) or with stroke. It is not surprising therefore to find evidence, in routine clinical practice, of under-investigation and under-treatment of carotid disease in older patients with TIA and stroke." [552]

The publication of the quality standards for stroke care by the National Institute of Health and Clinical Excellence[553] set out the standards that all commissioners and providers should work to implement.

Historical concerns about age discrimination in relation to stroke

Inequalities in access to appropriate diagnosis and treatment appear to have persisted in spite of a growing body of evidence that has overturned the traditional perception that stroke is simply a consequence of ageing which inevitably results in death or severe disability. There has also been evidence of age discrimination in relation to access to stroke units.[554] Also, a recent article suggests that older patients referred to a neuro-vascular clinic were less likely to receive diagnostic investigations and lifestyle modification advice than younger patients.[555]

Also, older people are less likely to receive cholesterol-lowering treatments recommended for the secondary prevention of stroke, despite the treatment being equally effective across age groups. Although rates of secondary drug prevention are generally low, 26.4 per cent of patients aged 50-59 received treatment compared with 15.6 per cent of patients aged 80-89 and just 4.2 per cent of those aged 90 or more.[556]

Improvements in stroke care

However, there are signs of overall improvements in stroke care. A progress review in 2006 found that more good quality care than ever before is available to people who have had a stroke. All of the general hospitals caring for people who had had a stroke in the communities inspected provided a specialist stroke service, which operated according to the clinical guidelines for best practice approved by the Royal College of Physicians. Seven of the 10 communities inspected also had a stroke unit. [557]

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[552] *Ageism and age discrimination in secondary health care in the United Kingdom. A review from the literature*, Centre for Policy on Ageing (CPA), 2009
[553] *Quality Standards for Stroke Care* NICE 2010 http://www.nice.org.uk/aboutnice/qualitystandards/stroke/strokequalitystandard.jsp
[554] *Secondary prevention for stroke in the United Kingdom: results from the National Sentinel Audit of Stroke*, Rudd A G, Lowe D, Hoffman A, Irwin P and Pearson M, Age and Ageing 33 (3): 280-286, 2004
[555] *Do older patients receive adequate stroke care? An experience of a neurovascular clinic*, Kee Y-Y K, Brooks W, Bhalla A, Postgrad Med J; 85:115-118, 2009
[556] *Sociodemographic variations in the contribution of secondary drug prevention to stroke survival at middle and older ages: cohort study*, Raine R, et al, BMJ; 338:b1279, 2009
[557] *Living well in later life: a review of progress against the National Service Framework for Older People*, Healthcare Commission (HHC), Commission for Social Care Inspection (CSCI) and Audit Commission, 2006

More recently published reports also give indications of improved standards overall, even though it is not always possible to ascertain whether the improvements have benefited all age groups equally. For example, the Royal College of Physicians' National Sentinel Stroke Audit found that, overall, every single standard that was measured in 2006 and again in 2008 has improved. Of particular note are the changes in accessing stroke unit care, imaging, speech and language therapy, physiotherapy and occupational therapy.[558]

Recent information from the National Audit Office[559] indicates that the Department of Health's strategy for stroke care has increased the priority and awareness of the condition and started to improve patients' care and outcomes, although it does not give information relating to the experience or outcomes for different age groups. It notes that further work needs to be done in tackling the variations in the extent to which services have been reconfigured to improve access to emergency stroke care. Also, improvements in acute care are not yet matched by progress in delivering more effective post-hospital support for stroke survivors and their carers. There is a need for better joint working between health and social care, community care and care homes and other services including benefits and employment services.

Attitudes

Historical differences in the treatment of older people with CVD may reflect the attitudes of different groups of staff. The CPA report on age discrimination in secondary care describes a 2006 study by Bowling *et al*. comparing the responses of cardiologists, care of the elderly specialists and GPs to a set of hypothetical patients presenting with possible heart-related symptoms. This study found that care of the elderly specialists are much less likely than cardiologists to refer a patient for an angiogram or revascularisation and also less likely than a GP to refer a patient to a cardiologist. Those most influenced by age made a range of comments, such as:

> *"If they are in their 90s with chest pain and angina I might be less likely to refer."*
>
> *"I would be less likely to prescribe for an older patient."*
>
> *"Age has a definite influence. I'd be more likely to refer a 65- than a 95- year-old because they probably wouldn't survive surgery at that age."*

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[558] *National Sentinel Stroke Audit. Phase II (clinical audit) 2008 - Report for England, Wales and Northern Ireland*, Royal College of Physicians, April 2009
[559] *Progress in improving stroke care,* National Audit Office, 2010

"They wouldn't want an angiogram if they were over 70." [560]

On the face of it, it appears from the quotations above that age discrimination was a factor here, with care of the elderly specialists offering fewer choices to their patients, but some might argue that care of the elderly specialists offer a more 'age appropriate' service based on a more holistic approach.

There is evidence in the CPA review of age discrimination in primary care that GPs experienced specific problems in diagnosing and treating older patients with heart failure. Uncertainties about clinical practice, a lack of confidence in establishing an accurate diagnosis, and a lack of awareness of research in a complex and rapidly changing field can be as damaging to older people as outright age discrimination.

Dual/Multiple discrimination

Factors that may contribute to dual/multiple discrimination need to be considered in the context of CVD as there are a range of factors that may be relevant to achieving equal access to appropriate treatment. *The National Service Framework for Coronary Heart Disease*[561] recognised that "*many people with CHD are not receiving treatments of proven effectiveness*" and there are "*unjustifiable variations in the quality and access to some CHD services*". Such variations appear to relate to factors such as gender and ethnicity.

Gender

Variations in treatment that appear to be age-related are compounded by gender, for example in the investigation and treatment of heart disease in older women, who may experience discrimination both as a result of their age and their gender.[562]

Similarly, an age and gender bias exists in the prescription of important secondary preventive therapies in primary care that may lead to increased mortality from ischaemic heart disease in these groups.[563]

Ethnicity

South Asian people born in India, Bangladesh, Pakistan or Sri Lanka are approximately 50 per cent more likely to die prematurely from coronary heart

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[560] *Variations in cardiac interventions: doctors' practices and views*, Bowling A, Harries C, Forrest D and Harvey N, Family Practice 23 (4): 427-436, 2006

[561] *National Service Framework for Coronary Heart Disease*, Department of Health, 2000

[562] *Age- and sex-related bias in the management of heart disease in a district general hospital,* Dudley N J, Bowling A, Bond M, McKee D, Scott M M, Banning A, Elder A T, Martin A T and Blackman I, *Age and Ageing* 31 (1): 37-42, 2002. Quoted in *Ageism and age discrimination in primary health care in the United Kingdom – a review from the literature,* 2009

[563] *Ageism and age discrimination in primary health care in the United Kingdom – a review from the literature*, CPA 2009

disease than the general population. The death rate is 46 per cent higher for men and 51 per cent higher for women.[564] However, this does not explain the reasons for the higher rates of premature death. These differential rates need to be understood and addressed at a local level.

A 2004 study[565] found that prevalence of cardiovascular disease increased significantly between 1999 to 2004 in Pakistani men (from 4.8 per cent to 9.1 per cent) and Indian women (from 2.3 per cent to 4.2 per cent).

According to a 2004 study, the prevalence of stroke was highest among people who were aged 55 and over and black Caribbean men had the highest prevalence (11.5 per cent) while among women aged 55 and over the highest prevalence was among Bangladeshi (11.9 per cent) and Pakistani (10.1 per cent) people.[566]

However, in spite of high rates of CVD in some minority ethnic groups, there has, for a long time, been evidence that some black and minority ethnic (BME) groups do not access the full range of services for CVD in a timely manner. This may be due to reasons far more complex and subtle than actual discrimination, such as atypical presentation in some ethnic groups, leading to slower triage and access to appropriate treatment. For example, a study of Bangladeshi patients in east London, showed that there were no significant differences between Bangladeshi and white patients in the time from pain onset to hospital arrival but once in hospital it took almost twice as long for Bangladeshi as for white patients to receive thrombolysis.[567]

People with learning disabilities

Increasingly, people with learning disabilities are living longer and, as they age, they will often have greater health problems than other people of their age, or they may, at a younger age, have problems that are associated with old age in the general population. For example, 50 per cent of people with Down's Syndrome also have a congenital heart condition. However access to prevention, screening and treatment is often poorer for people with learning disabilities than for other people. They may also suffer from "*diagnostic overshadowing*" (the term used by the Disability Rights Commission and others to describe the tendency to attribute symptoms and behaviour associated with illness to the learning disability, and for illness to be overlooked). People with a learning disability are far less likely than other

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[564] *Heart disease and South Asians: delivering the National Service Framework for coronary heart disease*. British Heart Foundation/Department of Health, 2004
[565] *Health Survey for England 2004: The Health of Minority Ethnic Groups,* National Statistics/The Information Centre, 2004
[566] *Health Survey for England 2004: The Health of Minority Ethnic Groups,* National Statistics/The Information Centre, 2004
[567] *Bangladeshi patients present with non-classic features of acute myocardial infarction and are treated less aggressively in east London, UK*, Barakat K, Wells Z, Ramdhany S, Mills P G, and Timmis A D, Heart; 89(3): 276–279, March 2003

people to have regular health checks from their GP or take part in health screening programmes.[568]

18.3 Drivers and policy imperatives

The National Service Framework for Coronary Heart Disease

The National Service Framework for Coronary Heart Disease (NSF CHD), published in March 2000, set out a strategy to modernise CHD services over ten years. It detailed 12 standards for improved prevention, diagnosis, treatment and rehabilitation, and goals to secure fair access to high quality services. Many of these standards have now been implemented, and current good practice would, in some instances, go beyond the NSF CHD's original standards. It is important to ensure that relevant standards are applied in a non-discriminatory and age-appropriate manner.

National Service Framework for Older People

In addition to Standard One (Rooting out age discrimination), Standard Five of the *National Service Framework for Older People* (NSFOP) [569] specifically applied to strokes. The aim of this standard is to reduce the incidence of stroke in the population and ensure that those who have had a stroke have prompt access to integrated stroke care services. It stated:

> *"The NHS will take action to prevent strokes, working in partnership with other agencies where appropriate.*
>
> *"People who are thought to have had a stroke have access to diagnostic services, are treated appropriately by a specialist stroke service, and subsequently, with their carers, participate in a multidisciplinary programme of secondary prevention and rehabilitation."*

National Stroke Strategy

The National Stroke Strategy[570] is intended to provide a quality framework to secure improvements to stroke services, give guidance and support to commissioners and strategic health authorities and social care, and inform the expectations of patients and their families by providing a guide to high quality health/social care services. It includes a ten-point plan for action, covering the following areas:

1. Awareness: action to improve public and professional awareness of stroke symptoms

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[568] *Healthcare for All - Report of the Independent Inquiry into access to healthcare for people with learning disabilities*, Sir Jonathan Michael, 2008

[569] *National Service Framework for Older People*, Department of Health, 2001

[570] *National Stroke Strategy,* Department of Health, 2007

2. Preventing stroke
3. Involvement: are people with stroke informed partners in their care planning?
4. Acting on the warnings: about transient ischaemic attacks (TIAs)
5. Stroke as a medical emergency: getting people to the right hospital quickly
6. Stroke unit quality
7. Rehabilitation and community support
8. Participation: assistance to overcome physical, communication and psychological barriers to engage and participate in community activities
9. Workforce
10. Service improvement.

High Quality Care For All – NHS Next Stage Review Final Report

Amongst its many proposals, Lord Darzi's *Next Stage Review* [571] proposed raising awareness of vascular risk assessment through a new *Reduce Your Risk* campaign.

Building a Society for all Ages (2009)

Building a Society for all Ages [572] is a consultation document, published in 2009, which sets out the Government's strategy for making improvements to older people's lives. Two of its proposals are particularly relevant to CVD:

- NHS Health Check (for heart disease, diabetes, kidney disease, stroke) to be introduced in 2009/10 for people 40 – 70 years. This is now part of a consultation on new rights within the NHS Constitution.
- Introduction (in 2009/10) of a pilot scheme for NHS Mid-life LifeChecks - looking at smoking, healthy eating, alcohol use physical activity and emotional wellbeing. This is described as a vascular risk assessment and management programme for people in England who will be offered a check once every five years to assess their risk of heart disease, stroke, kidney disease and diabetes, followed by individually-tailored advice to support them in managing or reducing their risk.

The strategy also refers to *Be Active, Be Healthy*[573] which sets out the Government's framework for the delivery of physical activity for adults, alongside sport and based upon local needs, with particular emphasis upon

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[571] *High Quality Care For All – NHS Next Stage Review Final Report*, Lord Darzi, Department of Health, 2008
[572] *Building a Society for all Ages*, HM Government, 2009
[573] *Be Active, Be Healthy*, Department of Health, 2009

the physical activity legacy of the 2012 London Olympic and Paralympic Games.

NICE Guidelines

There are a number of NICE Guidance publications relevant to CVD, with further guidance in production. See

→ www.nice.org.uk/guidance/index.jsp?action=byTopic&o=7195&set=true

18.4 What good age-equal practice might look like

In addition to applying the most up-to-date standards for the prevention, detection and treatment of CVD in the general population, age-equal practice in relation to CVD would:

- ensure that ageist attitudes do not stand in the way of appropriate CVD services for older people. This may require recurrent audits of the care offered to older people with or at risk of CVD and, where necessary, training and development for staff at all levels
- pay particular attention to groups who are most at risk of developing CVD (e.g. people in lower socio-economic groups, some minority ethnic groups)
- ensure that BME groups who tend to have poorer access to appropriate treatment and care are offered appropriate services, with particular reference to language and cultural factors
- review barriers to care and provision of appropriate information on services, providing appropriate bilingual services for effective communication
- review pathways for stroke and CVD to ensure that they are appropriate for people of all ages. This may mean having some services that are targeted at specific ages but this needs to be "*objectively justified*" by evidence
- provide a specialist stroke service for patients of all ages with access based on need and not age.

The national guidance on the treatment of heart attacks notes that, from April 2008, all acute NHS trusts are required to use the Standard NHS Contract for acute services for their agreements with PCTs. This includes a requirement not to discriminate between patients on the grounds of gender, age, ethnicity, disability, religion, sexual orientation or any other non-medical characteristics

and to provide appropriate assistance for patients who do not speak, read or write English or who have communication difficulties.[574]

18.5 Case studies of illustrative / good practice

Reviewing the stroke pathway - NHS South West

NHS South West is the best for achievement of stroke targets – probably due to its clinically-led peer review exercise in 2008, which covered the entire stroke pathway in every PCT and involved baseline assessments, site visits and meetings with commissioners and providers.

The context for reviewing the stroke pathway was the *National Stroke Strategy for England* (December 2007), which set out a ten-year plan designed to make stroke services among the best in the world, and includes 20 quality markers. The South West Strategic Health Authority set a three-year goal for delivery of the strategy and commissioned a detailed, clinically-led peer review of stroke services. Its aim was to provide a structured, accurate and credible baseline evaluation of the stroke pathway in each of the 14 health communities, to enable PCTs to commission changes to meet the requirements of the framework of quality markers.

The review produced detailed information on stroke services which has been incorporated into three-year PCT action plans to commission new services consistent with the ambitions within the Stroke Strategy. These action plans are monitored regularly by the Strategic Health Authority and will be reviewed on an annual basis by a clinical team over each of the next three years.

At the time of the review in NHS South West, none of the other nine strategic health authorities in England had undertaken a systematic peer review of their entire stroke care pathway. However, it is clear that reviewing the whole pathway – and not just the acute services part of it – is hugely beneficial in raising awareness of stroke and how to commission and provide the best possible services to treat people who have strokes.

Although strokes can occur in younger people, 80 per cent of those who suffer strokes are over the age of 65, and the average age for suffering a first stroke is 74.[575] Therefore undertaking this kind of review can provide a firm foundation for the provision of high quality, age-appropriate services.

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[574] *Treatment of Heart Attack National Guidance, Final Report of the National Infarct Angioplasty Project (NIAP),* Department of Health, 2008

[575] *Population-based study of event-rate, incidence, case fatality, and mortality for all acute vascular events in all arterial territories, Oxford Vascular Study, Rothwell P M, Coull A J, Silver L E, Fairhead J F et al.* The Lancet, London: 19 November, 2005. Vol. 366, Iss. 9499; pg. 1773, 11 pgs

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Reviewing the stroke pathway
East Lancs PCT and local hospitals

East Lancs PCT and local hospitals (ELHT) have developed a joint mechanism for the care of stroke patients across the whole journey pathway from secondary to primary care. A protocol has been developed for the transfer of care from the acute sector following a stroke, to care of stroke patients in the community by a multidisciplinary team led by consultant community geriatricians. The mechanism and proforma devised ensures a seamless transfer of care and information.

In addition, through the maintenance of a stroke register, every stroke patient discharged from the hospital has a six-month multidisciplinary and consultant follow-up in the community, leading to maximising the rehabilitation potential and prevention of further risk, and secondary prevention. This is an example of multi-agency (health, social and voluntary bodies) joint-working to provide care across the whole journey pathway for people who have had a stroke.

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18.6 Suggestions for quick wins / what you can do now

- Work with local older people's organisations to raise awareness of CVD risk factors and treatment options and to plan and evaluate local services.
- Review local pathways for the treatment of CVD (including strokes) with an explicit consideration of meeting the needs of people of all ages.
- Audit use of CVD services and procedures by age, gender and ethnicity and discuss the results with older people's groups.

- Audit access to specialist stroke services by age group, to ensure that services are not discriminating against any particular age group and discuss the results with older people's groups.
- For stroke units - how does your local unit rate on the Royal College of Physicians' *National Sentinel Stroke Audit*?

Chapter 19
Sexual health

19.1 Key audiences

Primary care trusts and emerging GP commissioning consortia:

- commissioners
- directors of public health and local authorities
- GPs.

NHS trusts and NHS foundation trusts:

- medical directors
- sexual health departments
- directors of nursing.

19.2 Key issues and concerns

- Sexually-transmitted infections are rising in older age groups but this is often not recognised by health professionals.
- Information on sexual health and health-related behaviour in older people is limited.
- Specialist services are often designed and targeted at younger people and this can act to exclude older people.
- There is a low level of awareness of sexually-transmitted infections among older people.
- Gay and lesbian older people and transgender older people can suffer from the double impact of ageism and homophobia, or from prejudices about gender identity.

Sexually-transmitted infections are rising in older age groups

A collaborative study, reported in 2008, which included researchers from the Health Protection Agency (HPA) West Midlands, showed an increasing rate of sexual infections in people aged over 45 years in the West Midlands. The study looked at regional data for the period 1996-2003 and focused on five sexually-transmitted infections (STIs) – chlamydia, genital herpes, genital warts, gonorrhoea and syphilis. In this period, 4,445 STI episodes were reported among over 45s. Overall, males and those aged 55-59 were significantly more likely to be affected.

Rates for all five STIs were significantly higher in 2003 compared to 1996, and the cumulative rate of infection more than doubled from 16.7 per 100, 000 of the population in 1996 to 36.3 per 100,000 of the population in 2003:

→ www.hpa.org.uk/webw/HPAweb&HPAwebStandard/HPAweb_C/1214808547294?p=1204186170287

This study provided evidence of significant increases in attendance at genito-urinary medicine (GUM) clinics by older people and noted that current public health policy and sexual health programmes do not adequately cater for older people. It also noted that sexual risk-taking behaviour is not confined to young people but also occurs among older people.

A Health Protection Agency report in 2008 found an increasing number of adults aged 50 years and over have accessed HIV care over the past decade (from 1,679 in 1998 to 8,722 in 2007). In 2007 these older adults accounted for 15 per cent of all persons accessing HIV-related care.[576]

Information on sexual health and health-related behaviour in older people is limited

There is a relatively low level of awareness of the prevalence of sexually-transmitted infections, including HIV, among older people. This may reflect societal attitudes that assume older people are relatively sexually inactive, or sexually active only within long-term, stable relationships.

Studies have shown that older people seeking advice on sexual problems are most likely to see their GP, but that many do not seek help, either because they believe their symptoms are due to normal ageing or because of embarrassment. However, health professionals may not be aware of older people's sexual health needs, or may be reluctant to discuss a topic which they do not feel to be legitimate.[577] The majority of older people surveyed reported receiving very little information on sexually-transmitted disease and HIV.[578]

A recent study in London found that the majority of people over 50 living with HIV in the UK have been diagnosed in the last decade, rather than being long-term survivors. The group would include both people who had acquired HIV in their 50s and late presenters. There is evidence that HIV testing among those at risk of HIV in the UK should target people in their 40s and 50s as well as younger people.[579]

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[576] *HIV in the UK,* Health Protection Agency (HPA), 2008 www.hpa.org.uk/web/HPAweb&HPAwebStandard/HPAweb_C/1227515299695

[577] *General practitioner attitudes to discussing sexual health issues with older people*, Gott M, Hinchliff S and Galena E, Social Science & Medicine 58 (11): 2093-2103, 2004

[578] *Indications of public health in the English regions, 9: Older people*, Association of Public Health Observatories (APHO) and West Midlands Public Health Observatory, 2008 www.wmpho.org.uk/resources/APHO_OP.pdf

[579] *HIV and ageing*, Elford J et al, Fourteenth BHIVA Conference, Belfast: abstract O19, 2008

Dual/Multiple discrimination

In the context of sexual health, the double discrimination of ageism and homophobia can prevent people from seeking and finding the help they need.[580]

Terrence Higgins Trust, in conjunction with Age UK and funded by the Joseph Rowntree Foundation, is conducting the first in-depth research into people living with HIV aged 50 and over. The project, 50Plus, will report in the summer of 2010 and represents the views and concerns of more than 400 older people with HIV, set alongside a literature review and comparative research into services in the US, which are developing in response to expressed needs of people with HIV. Research reports and presentations will be made available from the Terrence Higgins Trust website.[581] Given that most people with HIV already face multiple discrimination, as gay men or migrants on top of their stigmatised HIV diagnosis, the interaction of these issues with age discrimination is expected to be complex.

It is also important in sexual health services, as in any other health services, to be aware that older people generally want their sexuality to be recognised and respected, and to be treated in a non-discriminatory manner whether they are heterosexual, gay, lesbian or bisexual. The same applies to transgender people.

19.3 Drivers and policy imperatives

The National Strategy for Sexual Health and HIV (2001)

In 2001, the Government published the *National Strategy for Sexual Health and HIV*.[582] This was a major milestone: it placed sexual health and HIV firmly on the national agenda and set out an ambitious 10-year programme to tackle sexual ill-health and modernise sexual health services in England. The strategy comes to an end in 2011 and consideration is being given to what further action will be needed to continue to make improvements to sexual health.

Since the strategy was published, sexual health has been identified as a priority area for action in the NHS. Targets and indicators mostly applied to younger age groups, and related to issues such as teenage pregnancy and the prevalence of chlamydia. (Also see Part C Services for Children and Younger Adults.) However, the 48-hour genito-urinary medicine access target is included in the Operating Framework for 2009/10 as a standard to be maintained, and applies to all age groups who use sexual health services.

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[580] *Out and healthy,* Age Concern (undated) www.ageconcern.org.uk/AgeConcern/out-and-healthy.asp
[581] www.tht.org.uk/
[582] *The National Strategy for Sexual Health and HIV*, Department of Health, 2001

In 2007, the Government commissioned an Independent Advisory Group (IAG) to undertake a review of progress in implementing the 2001 sexual health and HIV strategy. The IAG subsequently commissioned the Medical Foundation for AIDS and Sexual Health (MedFASH) to work with them in developing the strategy review. Their report was published in July 2008[583] and its findings were welcomed by the Government.

The IAG report highlights priority action in five key areas:

- prioritising sexual health as a key public health issue and sustaining high-level leadership at local, regional and national level
- building strategic partnerships
- commissioning for improved sexual health
- investing more in prevention
- delivering modern sexual health services.

The IAG report highlights that sexual health is a very broad area, which affects and impacts upon most of the population.

NHS Next Stage Review – High Quality Care for All

Lord Darzi's *Next Stage Review* [584] makes specific mention of sexual health as one of the immediate next steps in commissioning personalised services to promote wellbeing:

> *"Every primary care trust will commission comprehensive wellbeing and prevention services, in partnership with local authorities, with the services offered personalised to meet the specific needs of their local populations. Our efforts must be focused on six key goals: tackling obesity, reducing alcohol harm, treating drug addiction, reducing smoking rates**, improving sexual health** and improving mental health."* (Emphasis added.)

These documents provide the general policy direction for sexual health services in England. There are few references to targeting older people or designing age-appropriate services for older people but local primary care trusts and their partners will want to consider how to address age equality in the future design of sexual health services within the context of national policy.

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[583] *Progress and priorities – working together for high quality sexual health*, produced for the Independent Advisory Group on Sexual Health and HIV by the Medical Foundation for AIDS and Sexual Health (MedFASH), 2008

[584] *NHS Next Stage Review – High Quality Care for All*, Department of Health, 2008

19.4 What good age-equal practice might look like

Good age-equal practice in sexual health will be focused on the following areas:

Raising awareness of sexual health issues for older people

A good age-equal sexual health service will be aware of the misleading nature of age stereotypes in relation to sexual behaviour and sexual health. It will ensure that the sexual health workforce is properly trained and aware of the diverse characteristics of older people and the range of lifestyles and behaviours that exist among them. The multidisciplinary team will include staff who are able to relate well to older people.

Information and advice on sexual health for older people

Information and advice on sexual health will be offered to older people in ways that recognise the diversity of their lifestyles and sexual behaviours. Care will be taken to ensure that the language and images used in public health messages and information are appropriate for people of all ages, tailored to different audiences as needed, and address barriers that may prevent people from accessing information.

It may be appropriate and most effective to target health information at the needs of very specific audiences: for example, older men who may have concerns about erectile dysfunction will have different information needs than younger women who may want to avoid pregnancy. Publicity and information about sexual health and sexual health services must be relevant to older age groups as well as to younger people, bearing in mind that age differentiation may be justified where it is a proportionate means of achieving a legitimate aim.

Promoting access to sexual health services for older people

Older people are not a homogenous group, and there is no point at which the needs of older people become identifiably distinctive. However, in many areas of health, including sexual health, age may have some bearing on the prevalence and nature of health issues and people's lifestyles. Attempts to make services accessible to young people may possibly have the unintended consequence of deterring older people from using them. In particular, where sexual health services are specifically targeted at younger age groups, older people may feel that services are not aimed at them, and they will be reluctant to access them.

Given the relatively high level of contact by older people with primary care services, GPs and other primary care professionals may be particularly well placed to enable access to sexual health services, either through services appropriately delivered in a primary care setting or by advice and referral to appropriate specialist services.

Specialist sexual health services

At present, specialist sexual health services are mostly oriented towards younger people. However, primary care trusts and their partners will wish to consider how to ensure that they are designed to enable older people to access such services when they need to do so.

19.5 Suggestions for quick wins / what you can do now

- Commissioners will wish to consider how best to target older people, as well as younger people, for HIV testing.
- Outreach – consideration may be given to discovering how to reach out to older age groups with information about sexual health and sexual health services. In particular, dialogue with third sector organisations and local older people's organisations may be useful.
- Review information and publicity material about sexual health services to ensure that they are appropriate for all ages. In particular, language and images should be reviewed to ensure that older people feel included. Consideration should be given to whether there is a need for specific material to target older age groups.
- Consider age-specific services – commissioners will wish to consider how to enable access by older people to specialist sexual health services. This might mean exploring whether it would be justifiable and proportionate to hold specific clinics and services for older age groups.
- Deployment of older workers – although there is no specific evidence available on this issue in relation to sexual health, it may be thought reasonable to consider the possible advantages of including older workers in the sexual health team, as some older people may prefer to talk about sensitive matters with people who are closer to their own age.