



Living well in later life

A review of progress against the National Service Framework for Older People

March 2006

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Executive summary



Society today has changed greatly in the last 20 years and as a result our idea of old age has changed. As the current debate on pensions highlights, we can expect to live longer, but, more than that, we expect to be able to continue to live active lives.

The UK has an ageing population. There is a higher proportion of older people in the community than ever before. A century ago only one in 20 people were over 65, today one in six are over 65. It is expected that, by 2051, a quarter of the population will be over 65 (Office for National Statistics, census data). While the expectations of older people are changing, the impact of these expectations on society are growing. An ageing population puts pressure on health and social care services, but it also places demands on other services such as transport, leisure and housing.

The National Service Framework (NSF) for Older People sets national standards to ensure that services of a high quality are available to all older people. Since the implementation of the national service framework (NSF) there have been significant developments in Government policy including: *Opportunity age – meeting the challenges of ageing in the 21st century*, a strategy by the Government on how to meet the needs of an ageing population, published in March 2005 and *Independence, wellbeing and choice: Our vision for the future of social care for adults in England*, the Department of Health's green paper, published in March 2005. This paper sets out a vision for social care for adults over the next 10 to 15 years and outlines how this might be realised. The changes in policy also include the publication in January 2006 of *Our health, our care, our say: a new direction for*

community services, the Government's white paper, which sets a new direction for the whole health and social care system. The white paper confirms the vision set out in *Independence, wellbeing and choice* and calls for a radical and sustained shift in the way in which services are delivered, ensuring that they are more personalised and that they fit into the busy lives people have.

The Healthcare Commission, the Commission for Social Care Inspection (CSCI) and the Audit Commission have worked in partnership to assess the progress of the NHS and local authorities in meeting the standards set out in the NSF, taking into account other developments in policy since the NSF and the impact these have had on the lives of older people.

By working together, the three commissions were able to build a picture of the whole system of services that older people use from care services to services that contribute towards wellbeing and quality of life. A whole system is a concept that describes how services are organised around the person that uses them and the interdependence of one service upon another.

This is the first collaborative in depth review carried out by the three commissions. This joined up approach to inspection enabled us to make an assessment of services provided by the NHS and local authorities across a geographical area and the extent to which they worked together as a well coordinated, whole system to improve the lives of local people.

This report provides a national snapshot of the state of services for older people at the time

of the review. It offers an opportunity to review what has already been achieved and establish what else needs to be done to ensure that standards are met and that services for older people continue to improve.

The scope of the review was broad, reflecting the enormous diversity within this group of people and their wide range of needs, interests and aspirations. This group includes the generations that felt the impact of the two world wars through to the baby boomers who are now in their 50s and 60s. For these reasons, any response to providing services, including care and support, needs to be individually tailored to the needs and aspirations of individuals. The review, therefore, had a strong focus on designing and delivering services around older people, and on the importance of working in partnership to achieve a flexible and holistic response.

In line with the NSF, an extensive part of the review focused on care and support services. Only about 15% of older people are in regular contact with care services at any one time, but this is a group who have not always received the best possible support. In comparison, they are significant users of healthcare services. Although people aged 65 and over make up only 16% of the population, they occupy almost two thirds of general and acute hospital beds and account for 50% of the recent growth in emergency admissions.

The NHS spent around £16 billion on people over the age of 65 in 2003/2004, accounting for 43% of the total NHS budget. In the same year social services spent around £7 billion, which was 44% of their total social services budget.

A good quality service is judged on whether it is economical and provides value for money as well as by the experiences of the people who use the service. An important part of this review is to ensure that these significant financial and other resources, are best used to provide real choices and better outcomes for older people and to help address some of the huge pressures the service faces.

Most older people will make very little use of care services, so the local inspections carried out as part of this review were broad enough to include the many issues that matter to all older people, from leisure and learning to transport and safety in the community. Even those older people who do require help frequently receive a response that focuses solely on their care needs at a time of crisis, rather than the many responses that give meaning to life such as being involved in their local community. This review focused on services used by people from the age of 50, reflecting the important contribution that a healthy midlife can make towards achieving an active, fulfilled later life.

The review

The evidence for this review was collected from a number of sources, including inspections of services for older people in 10 communities in England.

A local community includes health and local authority services within a defined geographical area. Inspection teams, made up of staff from the three commissions, inspected 40 NHS trusts and 10 local authorities in England. An important element of the

Executive summary continued

The 10 local communities inspected were:

Buckinghamshire	Leicester
Brent	Dorset
Liverpool	Portsmouth
Redcar and Cleveland	Wiltshire

inspections was research and discussion with older people on their views of local services, through surveys, focus groups and events.

The NSF has eight standards and each of these standards has a relationship to the others with consistent themes running throughout the NSF. As a result, five cross cutting themes were identified. These themes were then used to get a more complete overview of the impact of the NSF on the lives of older people, taking into account developments in policy since the NSF and the views of older people about services. These cross cutting themes were:

- tackling ageism and promoting equality
- involving older people
- designing and delivering services around older people
- living well in later life
- leading organisations through change

In addition to these themes, the local inspections focused on the three conditions included in the national service framework – stroke, falls and mental health. These conditions were used to get a view of the progress that has been made against all of the standards in the NSF.

This report consequently provides a national assessment of progress in health and social care services for older people using the findings from the local inspections together with other evidence and research.

Key findings

The National Service Framework for Older People is a 10 year programme. This report comes at a mid point in that programme and shows that while there has been some significant progress, further action is required in three key areas, without which sustainable improvement in the experiences of older people of public services is unlikely to be achieved. Three key areas are:

- Tackling discrimination through ageist attitudes and an increased awareness of other diversity issues.
- Ensuring all of the standards in the NSF are met including further guidance on the next steps in implementing the NSF from the Department of Health due to be published in April 2006.
- Strengthening working in partnership between all the agencies that provide services for older people to ensure that they work together to improve the experiences of older people who use services.

Tackling discrimination

Explicit age discrimination has declined since the NSF was published as a result of NHS trusts auditing policies on access to services and social services reviewing their criteria for

eligibility. These are the criteria a local authority uses to prioritise who receives social care services. Access to cardiac procedures and hip and knee replacements have improved since the NSF was published. Between 1999 and 2004 the number of hip replacements carried out on people aged between 65 and 74 increased by 39%, and for people 75 years and older, it increased by 22%. According to hospital episode statistics from the Department of Health, there has been a general increase in hip and knee replacements for the whole population but the increase is still significant for older people. The exception to this decline in explicit discrimination is mental health services where the organisational division between mental health services for adults of working age and older people has resulted in the development of an unfair system, as the range of services available differs for each of these groups. For example out-of-hours services for psychiatric advice and crisis management for older people are not as developed as those for adults of working age. Older people who have made the transition between these services when they reached 65 have said that there were noticeable differences in the quality and range of services available.

Despite these changes there is still evidence of ageism across all services. This ranges from patronising and thoughtless treatment from staff, to the failure of some mainstream public services such as transport, to take the needs and aspirations of older people seriously. Many older people find it difficult to challenge ageist attitudes and their reluctance to complain can often mean that nothing changes.

We found that some older people experienced poor standards of care on general hospital

wards, including poorly managed discharges from hospitals, being repeatedly moved from one ward to another for non-clinical reasons, being cared for in mixed-sex bays or wards and having their meals taken away before they could eat them due to a lack of support at meal times. All users of health and social care services need to be treated with dignity and respect. However, some older people can be particularly vulnerable and it is essential that extra attention is given to making sure that givers of care treat them with dignity at all times and in all situations. To fail to do this is an infringement of their human rights.

There is a deep rooted cultural attitude to ageing, where older people are often presented as incapable and dependent – particularly in the media. As there is an increasingly ageing population, there is a need for policy makers and those who plan and deliver public services to consider the impact of ageism and to take action to address this.

During our inspections of local communities, we also found that awareness of diversity issues was at an early stage of development, with more work required to ensure that older people from black and minority ethnic groups receive services that are culturally sensitive and responsive to their needs. The high levels of morbidity and mortality from certain diseases and the difficulties of access and appropriate and responsive services have been documented well in relation to black and minority ethnic groups. There is a need to improve information and community engagement and to have detailed information about the needs of the population when planning services. Appropriate steps should be taken to form partnerships with the local

Executive summary continued

black and minority ethnic groups representing older people, to ensure that this group of older people is fully engaged in the planning and development of services. Organisations which commission or provide health and social care should take account of diversity in all they do, take account of cultural and religious needs and embed this understanding into mainstream services for older people.

Sadly there are occasions when older people experience abuse and neglect by the people who are supposed to be caring for them. It is important that this risk is minimised. This can be done by care staff being aware of how and when abuse and neglect could occur and by taking action if this is identified. We found that the arrangements for safeguarding older people operated effectively in most areas and there were multi-agency policies and procedures. However, there is still room for improvement. It is vital that health and social care organisations continue to address this issue to ensure that opportunities for abuse and neglect are minimised and, when they are detected, that they are acted upon.

Standards set out in the national service framework

The National Service Framework for Older People and the developments in policy that have followed have placed an unprecedented focus on services used by older people. The inspections found a great deal of activity to improve the experiences of older people of public services. Staff in partner organisations were working together to establish new initiatives and new ways of working to do this. There has been progress in a number of areas.

Explicit age discrimination in access to services has been addressed by most health and social care services. All of the communities inspected as part of this review had made a significant effort to ensure that policies and criteria for eligibility did not discriminate against older people. The Audit Commission's review on national progress against the *NHS plan* in 2003 found that 76% of NHS trusts had reviewed their criteria for eligibility to services as required by the NSF.

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 have 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. The National sentinel stroke audit carried out by the Royal College of Physicians in 2004, and published in March 2005, showed that 82% of hospitals in England have a stroke unit and more people were treated in such a unit for part of their hospital stay than in the previous year.

The number of older people who have had flu vaccinations has increased. There has been a 2% increase in people over 65 being vaccinated against flu between 2002 and 2004.

The number of older people who have stopped smoking has increased. All of the communities inspected could demonstrate an increase in the number of people over 60 who had stopped smoking. This is in keeping with national trends which show the number of people aged 60 and over who set a quit date to stop smoking increased by 113.8% between

2001 and 2005, and of those who set a quit date and were successful there was an increase of 5% for the same period.

More people are being supported to live at home. Health and social care services in the communities that were inspected as part of this review were able to demonstrate that they were continuing to move towards supporting older people who are frailer to live at home independently. There was also a reduction in the number of older people admitted to care homes. This matches the national picture, which shows that the number of households receiving intensive home care per 1,000 of the population aged 65 and over, has steadily increased from eight to 11 between 1998 and 2004 (Department of Health Performance and Assessment Framework data 2005).

All of the communities inspected could demonstrate a reduction in delayed discharges from hospital over the past two years. The Department of Health's statistics show that there has been a 67% reduction in delayed transfers of care from 5,396 in 2001 to just 1,804 in 2005.

There is a growing interest in the wider wellbeing of older people, with services such as leisure and culture playing an increasingly important role, and strategic partnerships spearheading some innovative partnership developments.

The National Service Framework for Older People has led to some positive achievements but there is further work to do to meet the standards set out in the NSF. The key issues identified as a result of this review that need

further action are detailed below:

- The full implementation of the single assessment process across health and local authority partners. Older people should have a copy of their assessment and a personal care plan.
- A change in culture is required, moving away from services being service-led to being person centred, so that older people have a central role not only in designing their care with the combination and type of service that most suits them, but also in planning the range of services that are available to all older people.
- All aspects of mental health services for older people need to improve including person-centred care, age equality in access to the range of services available, treating people with dignity and respect, holistic care in mainstream services and a whole systems approach to the commissioning of integrated mental health services for older people.
- Integrated falls services are at an early stage of development and more work is needed for them to progress further in line with the five components of an integrated falls service as set out by the Department of Health.
- The management of medicines needs to be addressed, as many older people taking more than four medications are still not receiving a review every six months.

NHS trusts and local authorities need to work together to ensure that they are reviewing their progress against the NSF as part of a framework for managing performance.

Executive summary continued

Supportive and palliative care, underpinned by services that are person centred, promote physical, psychological and spiritual wellbeing. The NSF outlines personal and professional behaviours which are considered particularly important to end of life care. Services that are needed to promote dignified and effective end of life care are complex, requiring good coordination between organisations. They must appear seamless to users and carers, be easy to access and be totally reliable. We found that the provision of services for people at the end of their life was inconsistent, with integrated systems that were developed well in some areas but with room for improvement in others. The provision of out-of-hours support was patchy and a lack of practical support may mean some people have to be admitted to a hospital or hospice at the end of their life when they may have preferred to die at home.

Strengthening working in partnership

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

Sustainable change cannot take place unless all partner organisations have a shared view of the direction in which they want to move, and

how they plan to get there. Earlier research from the Audit Commission has shown that this shared vision has a powerful role to play if it is rooted in the views of older people. When older people are asked about the priorities that would most improve their lives, these often relate to issues beyond health and social care services, such as having a neighbourhood that is safe, access to transport, an adequate income and opportunities to meet with others. Therefore visions and strategies for older people must reflect these needs.

A lack of shared direction results in a poor use of resources and in a commissioning process that does not encourage change. It also results in the provision of an inconsistent and uncoordinated range of services.

There was evidence of some engagement with older people but they were not involved systematically in the design of services, nor were services tailored to their needs and aspirations. Health organisations and local authorities were not always effective in engaging with black and minority ethnic groups and with other older people whose voices are seldom heard.

While we found that some communities were implementing the NSF in innovative ways, these were not consistently available to older people, nor was learning from these initiatives shared or implemented more widely. Only if partner organisations work together to agree a shared vision and to map out a pathway to achieve this vision, will older people be able to experience services that are well planned and joined up. New initiatives from the Department for Work and Pensions, the Department of Health and the Social Exclusion Unit that aim to test integrated responses to older people, as well as

learning from the results of the SureStart initiative for children, will offer useful experience on which to build.

Most of the communities we inspected had a joint workforce development strategy. Workforce planning was fragmented and opportunities for joint training, building capacity and the development of new ways of working, such as generic health and social care workers, were not being used widely. A few of the communities were developing the health and social care assistant role but this was not widespread. Some organisations were experiencing significant difficulties in recruitment. The lack of a joint approach contributed to more problems.

Recommendations

Tackling discrimination

1. While progress has been made by health and local authorities in systematically tackling age discrimination, through audits of policy, and the reviewing of eligibility criteria, there is still evidence of age discrimination and ageist attitudes which have an impact on the lives of older people. These include the discrimination older people sometimes experience when care services fail to treat them with dignity and respect. Managers of NHS trusts, social services and providers of independent health and social care need to ensure that the human rights of older people are upheld at all times.
2. The needs of older people, including those from black and minority ethnic groups, are not always recognised. NHS trusts, local

authorities and providers of independent health and social care, need to ensure that all staff receive full and ongoing training on diversity issues, including attitudes to ageing, so that older people are treated with respect. They should respect diversity in all that they do, taking account of cultural and religious needs, and embed this understanding into mainstream services.

3. Progress has been made in establishing adult protection committees with an increased awareness in healthcare organisations and local authorities of the need to safeguard older people. However, there is more to be done. NHS trusts, social services and providers of independent health and social care need to:
 - review the operation of adult protection committees
 - promote effective working in partnership
 - ensure that information is comprehensive
 - ensure that the management of performance is effective
 - implement policies and procedures through training that are easily accessible

Meeting the standards set out in the national service framework

4. The National Service Framework for Older People provides a 10 year programme for the improvement of services for older people. Good progress has been made in some areas. However, a number of the standards have not been met within the timescales of the NSF. NHS trusts and local authorities need to take action to

Executive summary continued

ensure that the standards set out in the NSF for older people are met, including the *Next steps* update due to be published in April 2006 and the Department of Health's *Older people mental health service development guide*.

5. Wherever possible older people are supported to receive end of life care in the place in which they choose to die. However, sometimes a lack of appropriate community services means that they have to be admitted to hospital. There is a need for partner agencies to use the best practice models of end of life care to ensure that older people and their carers receive prompt access to well coordinated and effective care and respect at the end of their lives.

Strengthening working in a partnership

6. The effectiveness of partnership arrangements for services for older people is improving. However, partner organisations should ensure that partnerships have robust governance arrangements with clear lines of accountability in line with the Local Government Act 2000.

The Act places a duty on every local authority to prepare a strategy for the community to link all their strategic plans and to manage partnerships through a local strategic partnership. Strategic partnerships working for and with older people should include all the organisations that commission and provide services used by older people as well as older people themselves. This review has demonstrated the importance of a joined up approach to

planning, commissioning and delivering services that takes account of all of the things that are important to the health and wellbeing of older people. Older people have an important contribution to make in the shaping of services to ensure that they respond to their needs and aspirations. Providers of independent health and social care are also important partners within the strategic partnership, as they bring innovation and the potential to provide additional resources.

7. There has been some progress in promoting health and wellbeing for older people but this has not been the result of a joint strategy with a coordinated approach across health and local government. NHS trusts, local authorities and providers of independent health and social care need to work together to develop the promotion of good health and wellbeing. The Department of Health's white paper *Our health, our care, our say*, published in January 2006, has reinforced the role of the director of adult social care, working with the director of public health, in undertaking regular joint reviews of the local health needs.
8. Partner organisations are working together to develop a shared vision for services for older people. However, organisational change has slowed down progress in taking this forward, partly as a result of health policy, *Shifting the balance of power*, published in 2001, which changed the roles of health authorities and PCTs. There is a need for partner organisations to translate the shared vision into a shared strategy for services for older people and to use this to

inform joint commissioning. This should result in a comprehensive and coordinated range of services to meet the needs of the local population.

9. Partner organisations are engaging with older people. However, there is no systematic and coordinated approach to make the best use of resources. Partner organisations need to work together to ensure that there is a systematic and coordinated approach to engagement that recognises the diversity of the population being served.
10. Some partner organisations are working together to tackle recruitment and retention of staff. However, many do not and so they are targeting the same small pool of staff and creating unhelpful competition in the employment market. NHS trusts and local authorities need to work together to develop joint workforce strategies to become more effective in recruitment and retention across health and social care services.
2. National standards and measures for improvement have supported the improvement of performance management by health and local authorities. However, the performance of individual organisations in achieving national targets sometimes conflicts with improving the outcomes for older people across a whole system of care. For example, the requirement for acute hospital trusts to reduce waiting times for elective (planned) surgery has resulted in PCTs commissioning a disproportionate amount of acute hospital services compared to community services that could prevent emergency admissions to hospital. The Department of Health's white paper *Our health, our care, our say* makes a commitment to align how health and local authorities are being assessed on their performance. This should include the development of ways to measure outcomes for older people based on the performance of all partners working together.
3. Older people would particularly like to see improved access to podiatry and general foot care. Poor foot care can lead to poor mobility and result both in a loss of independence and in social isolation. The Department of Health could support improved access to good quality podiatry and general foot care services by requiring PCTs to commission adequate provision of these services.

Further work for central Government

Some of the progress needed to improve services used by older people can only come about through support from central Government, particularly in three areas. These are:

1. Following on from *Opportunity age*, the Government needs to develop a cross Government national programme of work to help shape a more positive culture on attitudes to ageing.

Further work for the Healthcare Commission, the Commission for Social Care Inspection and the Audit Commission

As well as recommendations for the organisations that provide services for older people and central Government, it is also important that the Healthcare Commission, the Commission for Social Care Inspection and the Audit Commission take action to ensure that there is continuous improvement of services for older people and the momentum from this review is continued.

Developing policies and tools at a national level, which will help to support the local implementation of the National Service Framework for Older People, is essential. The Healthcare Commission, the Commission for Social Care Inspection and the Audit Commission, as the regulatory bodies with responsibilities for assessment across healthcare, social care and local government will be taking the following actions, in consultation with partner organisations.

1. The Commission for Social Care Inspection will monitor progress against the recommendations in this report through the annual assessment of councils and the inspections of social services for older people.
2. The Audit Commission will monitor progress against the recommendations in this report through the older people's strand of corporate assessment, which is part of the Audit Commission's comprehensive performance assessment of local authorities.
3. As part of the Healthcare Commission's annual assessment of performance of NHS trusts – the annual health check – the Healthcare Commission will continue to monitor progress against key national targets, for example those relating to supporting older people to live independently at home. The requirement to treat all patients with dignity and respect will be assessed as part of the annual health check against the Department of Health's core standard on patient focus. The requirement to take the views of older people and their carers into account in designing, planning, delivering and improving healthcare services will also be assessed by the Healthcare Commission against the Department of Health's standard on accessible and responsive care, as will access to services.
4. The three commissions will develop improvement activities targeted at issues identified by this review. This includes developing and delivering a joint Commission for Social Care Inspection/ Healthcare Commission review of mental health services for older people.
5. Joint indicators will be developed to support improvement in key areas, including those areas where progress has been the slowest. These indicators will form part of the ongoing assessment of health and social care organisations and will be used to look at how services are improving year on year. The indicators will be developed in line with broader frameworks for assessing performance which are focussed on outcomes as outlined in the Government's white paper

Our health, our care, our say and will be used to underpin improved partnership working through the future development of local area agreements.

6. The Healthcare Commission currently supports a programme of national clinical audits. Audit projects aimed at improving the quality of clinical care and improving outcomes in services for older people will continue to be reflected in this programme – which currently includes audits of services for people who have had a stroke, services for people who have fallen and services for people with incontinence.

Introduction



“Services are getting better – gracious, yes. It’s easier to find someone to come and help you.”

The Healthcare Commission, the Commission for Social Care Inspection (CSCI) and the Audit Commission have worked together to carry out a review of the progress of the NHS, local authorities and other partners in meeting the standards set out in the National Service Framework for Older People, taking into account other developments in Government policy since the national service framework (NSF) and the impact this has had on the lives of older people.

This report highlights the findings and actions that are needed as a result of the review. It takes health, social care and wellbeing issues as its starting point – specifically the Department of Health’s National Service Framework for Older People¹ – but it casts its net wider to examine how well a wide range of services take account of the needs of older people. Older people themselves have played a big part in this report and their concerns and interests are reflected throughout the document.

A wide range of research is available which provides consistent messages about what older people say is important to them in terms of their health, general wellbeing, quality of life and what they expect from public services. The messages echo those raised by the older people who contributed to this review.

“Without back up, our horizons are very limited.”

The Audit Commission and Better Government for Older People, an organisation set up by Government to encourage local authorities to

engage more actively with older people and improve services for them, found a number of strong themes that ran through much of the existing research on the priorities of older people. These were:

- making a contribution, and being seen as a valuable member of the community (sometimes referred to as ‘interdependence’)
- tackling ageism and having a voice
- services that are well coordinated, or joined up
- a comfortable, suitable home
- a safe neighbourhood that has all the most important amenities
- getting out and about
- having useful, enjoyable ways of spending time – relationships, social networks, leisure and learning
- a decent income
- information about what is available
- keeping healthy, and having access to good quality care services if they are needed

This broader view of ageing and older people is evident in many of the local developments that illustrate this report as well as in national policy initiatives such as the Government’s white paper, *Our health, our care, our say*², in the Government’s *Opportunity age* strategy³, and the Government’s green paper, *Independence, wellbeing and choice*⁴. Also the consultation processes that support these – both of which are highlighted in appendix B, alongside a number of other key developments in policy have appeared since the publication of the NSF.

Introduction continued

The National Service Framework for Older People was published in March 2001 as a 10 year programme of action and reform. It sets standards for improving health, social care and other services in order to improve the experiences of older people of services in England. It was produced because there was a growing recognition that, despite many achievements, too often services failed older people, so the goal of the NSF was to initiate significant improvement. The NSF was heralded as the first ever comprehensive national framework to ensure fair, high quality and integrated services for older people.

The purpose of this report is to summarise the findings of 10 joint inspections of services for older people that were carried out across England in 2005 by the Healthcare Commission, the CSCI and the Audit Commission. These inspections formed the central part of a review of the impact of the National Service Framework for Older People, commissioned by the Department of Health. The report offers a national snapshot of the state of services for older people at the time of the review. It also sets out recommendations for the Government, for regulators and for those who commission or provide services for older people.

Since the NSF was launched in 2001 there have been many changes in national policy, in the NHS and local authorities, which have built on the NSF, taken forward the older people's agenda, and/or influenced the environment in which public services operate. These are shown in appendix B.

The review took account of these changes, among others, and considered the collective impact of the many developments that have aimed to improve both services and the quality of life for older people in recent years. The review was set in this wider context.

Although there have been many changes, these have moved in a broadly consistent direction. Four themes have emerged from recent developments. These themes have a relevance that goes beyond services for older people, as the growing emphasis on personalised services, choice, and the need to engage with users of services and citizens lies at the heart of the changes that are planned for all public services. The themes are:

Promoting wellbeing and active ageing

Older people want to remain active and involved in the community. Public services make an important contribution, by providing a range of services and activities that promote the mental and physical health of older people.

Choice, control and personalised services

Public services need to be tailored to the needs and aspirations of older people as individuals. This means that older people will have much greater choice about the services they use, and control over how, and by whom, these are delivered. Direct payments, or individual budgets, are an important mechanism for achieving greater flexibility.

Citizenship and inclusion

Older people are much more than passive users of care services – they are citizens with a contribution to make. Engaging older people in making decisions about the issues that matter to them is therefore essential.

Leadership and supporting change

Good leadership and programmes of change are needed in all organisations. The new directors of adult social care will play an important role in building partnerships, while local strategic partnerships and local area agreements will be central in setting a shared direction for all partner agencies.

The white paper, *Our health, our care, our say* builds on the above themes and sets out a challenging agenda for change, with a commitment to having more integrated services which are built around the individual, more services delivered closer to home in the community, and a focus on improving health.

As well as presenting a picture of the state of services for older people at the time of the inspections, this report also seeks to provide information and advice on how to improve services for older people. The findings from the inspections are therefore supplemented with examples from communities that were not part of the inspection, but may offer some insights into how some of the most common challenges might be tackled. More examples are available on the Healthcare Commission's website www.healthcarecommission.org.uk.

This report also provides a platform for the voices and views of older people collected by King's College London during our inspections. The findings of recent inspections of services for older people carried out by CSCI and from the Audit Commission's pilots of the older people's strand of comprehensive performance assessment, are also included throughout this report.

Findings on the views and experiences of carers are woven throughout the report, an approach that mirrors the approach of the NSF, which views the issues of carers as 'an integral part of the way in which services are provided for older people'.

The approach

This review had a broad scope. A number of approaches were necessary in order to review the standards set out in the NSF, as well as those issues highlighted by older people and other stakeholders as important, both since the publication of the NSF and for the future. The approach included:

- a scoping exercise to determine the breadth and depth of the review
- 10 inspections
- extensive consultation and engagement with older people
- analysis of national data
- visits to communities and services

Ten local communities were inspected to find out what services were like for older people.

Introduction continued

In total, 40 NHS trusts and 10 local authorities were included in the programme of inspection. A local community comprises of health services, social care services, and other responsibilities of the local authority such as leisure and community safety, that aim to improve wellbeing and quality of life within a defined geographical area. This definition of a community is used throughout the report.

The communities were selected because an inspection of social care services for older people was already planned or because they provided a range of urban/rural and north/south communities, as well as different types of councils.

The 10 local communities inspected

Buckinghamshire	Leicester
Brent	Dorset
Liverpool	Portsmouth
Redcar and Cleveland	Wiltshire
Greenwich	Medway

The inspections included the analysis of data, review of documents, interviews with key staff and focus groups, analysis of the case notes of older people and visits to observe a range of services. Each of the inspections focused in more detail on one of three areas – stroke, falls or mental health. This area was then used as a 'lens' through which services for older people in the community could be seen and assessed.

King's College London was commissioned for this review to obtain the views of older people and their carers as well as those who work with older people in local voluntary and community organisations. A team of older researchers, a group known as Older people researching social issues, obtained the views and experiences of older people in the 10 inspected communities using a variety of methods, such as holding public meetings for older people and distributing questionnaires. They interviewed 1,839 people face-to-face and received more than 4,000 completed questionnaires.

The teams carrying out the local inspections included inspectors from the Healthcare Commission, the CSCI, the Audit Commission, King's College London researchers, older people and advisers with professional expertise in one of the areas covered by the review.

The findings of the local inspections fed into ratings of performance for social services and, in some cases, contributed to the comprehensive performance assessment rating for the local authority. The findings did not have a direct impact on the assessment of the performance of healthcare providers for 2005/2006 but should help NHS organisations carry out a more accurate self assessment, which is part of the Healthcare Commission's new annual process to assess performance.

A report has been published for each local inspection and these can be found on the Healthcare Commission's website www.healthcarecommission.org.uk. Copies of the reports including the social care aspects are available on CSCI's website www.csci.org.uk.

Involving others in the review

Involving and listening to key stakeholders has been an important feature of this review and has involved a large number of organisations and groups.

An important part of this engagement process has been a strong emphasis on involving older people in the development of the work at all stages. Older people were involved in shaping the scope of the review through a series of meetings and workshops, and have fundamentally influenced the approach to developing the methodology and carrying out the inspections.

Professional bodies, groups and organisations at local, regional and national levels, as well as staff who have direct responsibility for implementing and delivering the NSF, have also been involved extensively in the shaping of the review and the local inspection process. Five stakeholder events were held around the country, which was attended by a total of 500 people.

A full list of all the organisations that were consulted is listed in appendix A.

Standards and themes

The NSF includes standards on specific service settings, generic issues, and conditions that are particularly significant for older people.

Most of the other NSFs published by the Government also relate to conditions that affect older people, so they are also relevant. These cover areas such as mental health (1999), diabetes (1999), coronary heart disease (2000), and long term conditions (2005).

The National Service Framework for Older People recognises that conditions such as stroke and dementia are not limited to older people and the standards and service models in the NSF should apply to those who need them, regardless of their age. There are eight standards, supplemented by guidance and milestones on medicines and older people.

The eight standards set out in the National Service Framework for Older People

Standard 1:	rooting out age discrimination
Standard 2:	person centred care
Standard 3:	intermediate care
Standard 4:	general hospital care
Standard 5:	stroke
Standard 6:	falls
Standard 7:	mental health in older people
Standard 8:	the promotion of health and active life in older age

Introduction continued

During the planning of the review, a number of themes were identified that run through the NSF and link all the standards together. The themes were chosen because they are key issues that underpin the successful delivery of all the

standards. By using these themes the inspections were able to build up a broad picture of services for older people in a community, and how these fit together, as well as focusing on some of the detail of delivering services.

Themes identified for the review	
<p>Tackling ageism and promoting equality</p> <ul style="list-style-type: none">• are older people at a disadvantage because of their age?• are some groups of older people more affected by discrimination than others? <p>Involving older people</p> <ul style="list-style-type: none">• to what extent do older people have a voice in the decisions and developments that affect them? <p>Designing and delivering services around older people</p> <ul style="list-style-type: none">• are the whole range of needs and aspirations of older people taken into account?• is the single assessment process contributing towards this?	<p>Stroke, falls and mental health services</p> <p>The review paid particular attention to looking at services related to stroke, falls and mental health. These areas were used as a 'lens' through which to assess services against all the standards and themes during the inspections.</p> <p>Living well in later life</p> <ul style="list-style-type: none">• are partner agencies working together to ensure that older people are able to live full, active, healthy lives?• what role are care services playing in helping older people to live independently? <p>Leading organisations through change</p> <ul style="list-style-type: none">• is partnership working helping to improve services for older people?• are organisational factors such as leadership, finance and workforce strong enough to support change?

Tackling ageism and promoting equality



“At the civic hall we are worried that they will cut dancing for older people, concentrating on the young. We don't like to complain but we know if someone else needs the room it gets cancelled. We are at the bottom of the list.”

Key messages

Overall there has been a reduction in explicit age discrimination in planning services, policies and provision of services except for older people with mental health needs.

A number of older people reported poor treatment that indicated ageist attitudes or practice.

Some gaps in service affect older people disproportionately, particularly if they have low incomes. These include transport, podiatry and dental care.

The impact of champions for older people in challenging age discrimination is difficult to assess.

Older people who live in rural areas are less likely to have access to a good range of services than those living in more urban areas. Community based care services are a particular area of concern because of difficulties in covering wide geographical areas.

Services for older people are at an early stage in addressing diversity issues, although the inspections highlighted some innovative developments.

This section is about how the 10 local communities have tackled ageism and discrimination, the gaps in service that have a particular impact on older people, the balance of services provided to urban and rural communities and how well organisations were meeting the needs of older people in diverse populations.

Discrimination can have profound and far-reaching consequences on the lives of older people. They may experience discrimination and disadvantage for a variety of reasons apart from their age. It may be on grounds of faith or sexual orientation, because they are black or disabled, or combinations of these. Social deprivation, too, has a significant influence on the experiences of people throughout their lives, as well as on their wellbeing in later life.

The forthcoming Commission for Equality and Human Rights will have broad powers to promote equality and respect for diversity and human rights, and will have a duty to promote equality as an end in itself. The Race Relations (Amendment) Act 2000 established a general duty for specified public authorities, requiring them to work towards the elimination of unlawful discrimination and to promote equality of opportunity and good relations in carrying out their functions. The Disability Discrimination Act 2005 also established a public sector duty to promote equality of opportunity for disabled people, (coming into effect in 2006) and the Equality Bill proposes a similar duty for public authorities relating to gender.

Access to services

Health and social care organisations have started to tackle age discrimination by auditing policies on access to services and reviewing criteria for eligibility. Older people have had quicker access to some operations and procedures since the NSF was published.

According to the Audit Commission's review on national progress against the *NHS plan*⁵, 76% of organisations surveyed had reviewed their criteria for eligibility to services, as required by the NSF. Of these, 38% had implemented necessary changes. The local communities inspected for this report had also taken action to identify and change policies that were explicitly ageist.

Assessing whether services are provided fairly between age groups is not straightforward, not least because many organisations cannot provide detailed data on who uses their services. In addition, for many health procedures used chiefly by older people, the comparison with younger age groups is unlikely to be helpful.

Access to cardiac procedures and hip and knee replacements by people over 65 have improved since the NSF was published. Information from the Department of Health's hospital episode statistics showed that between 1999 and 2004 the number of hip replacements carried out on people aged between 65 and 74 years increased by 39% and for people 75 years and older increased by 22%. The number of knee replacements carried out on people aged between 65 and 74 increased by 58% and for people 75 years and

older it increased by 63%. There has been a general increase in hip and knee replacements for the whole population as surgical procedures have increased to achieve the waiting time targets for admission to hospital. However, despite this there was a higher increase in access to hip and knee replacements for older people. Social deprivation negatively affects the access to treatment for older people. Nationally, there were fewer admissions of older people to hospital for both hip and knee replacements in poorer areas.

Likewise, access to procedures relating to heart failure has increased for older people. Elective (voluntary) admissions for people aged between 65 and 74 years have had a 54% increase, while there has been an increase of 129% for people who are 75 years and older. This indicates that, despite the general increase in the admissions of people of all ages to hospital for elective procedures, access by older people to these procedures, had also increased. This may be due to a revision of policies on age discrimination but this explanation is not conclusive, as the demand by older people for these procedures has risen.

Ageist attitudes

Progress has been made in tackling age discrimination through equal access to services depending on need. However, some examples of ageist practice or behaviour were still found in some services. In some acute hospitals, for example, older people were receiving poor treatment because of their age.

Tackling ageism and promoting equality continued

Although age discrimination audits had been carried out, this is only the first step in ensuring that older people can be confident that they will not be discriminated against because of their age. There was little evidence of staff receiving training to help them challenge ageist attitudes.

Many of the older people involved in this review had experienced ageist treatment, with some highlighting a negative change in attitude and availability of services following the transition from one service to another when they reached the age of 65.

Organisations had their own policies to promote equality and ensure fair access to services, but these were rarely brought together within a coordinated programme.

Older people highlighted a number of cases where they had received an inferior service, or had been prevented from using a service, purely on the grounds of their age. For example, one leisure centre had barred older people from using its equipment because an older man had suffered a heart attack during an exercise session. In a day centre, which catered for people with physical disabilities and older people, there was preferential funding for the group with physical disabilities, resulting in the older people having fewer activities and a less varied programme.

Mental health services

While there has been improvement in access to services for older people, there is further work to do to provide equal access to the full

range of mental health services that are available for adults of working age.

There are poorer and less integrated services for older people with mental health needs compared to those people with mental health needs aged under 65. The out-of-hours services for psychiatric advice and crisis management for older people were much less developed, and older people who had made the transition between these services when they reached age 65 said there were noticeable differences such as poorer quality, fewer services and less support.

“Older people were promised national healthcare from the cradle to the grave, and that’s not what they’re getting with dental care and chiropody.”

Although there were agreed protocols for treating dementia and depression and for managing people with dementia in acute hospitals in all the communities we inspected, their impact and the awareness of them by staff were limited. Older people with dementia frequently had unacceptably long waits for the provision of specialist long term care and the care they received when in hospital revealed a lack of understanding of their needs. We also found that older people with cognitive impairment did not have access to intermediate care and therefore were unable to benefit from rehabilitation to regain physical ability.

Dentistry

Many older people experienced difficulties in finding an NHS dentist, particularly in rural areas, meaning that opportunities for preventive dental healthcare and treatment were not available. Set against national data, which shows that older people from deprived areas tend to have higher rates of total tooth loss, there is a clear disadvantage to those who cannot afford to pay for treatment. From April 2006, however, primary care trusts (PCTs) will be given devolved budgets to commission NHS dental services, in an attempt to redress the chronic shortages in some areas.

Podiatry

Many older people referred to changes in podiatry services and how they now had to 'go private' or suffer very long waits for NHS treatment. Podiatry services appeared under resourced in all the areas inspected. Many older people spoke highly of the 'one stop shop' approach, whereby podiatry and other services were provided in day centres.

Services for the clipping of toe nails, which ran alongside more comprehensive podiatry services, were very important to by older people. Although these are not costly services, they are often provided by the independent sector, including voluntary organisations. We found that there were frequently delays in providing this service because of discussions on issues such as liability and training.

Transport

There was a lack of reliable and accessible transport in all the areas we visited. This continues to put older people at a disadvantage, preventing them from getting access to goods, services and social contacts. Compared with the national average, older people living in households which do not have a car, are more likely to have higher rates of mortality, and to end their days in residential care (Breeze et al 1999)⁶. National statistics show that a lack of access to transport is experienced disproportionately by older people, and especially by older women with disabilities (Davis 1998)⁷.

Champions for older people

Champions for older people have a responsibility to root out age discrimination and to promote the interests of older people and services within their own organisations and beyond. Many champions were clearly very committed, but they operate largely in isolation of one another, with little interaction, no real training or clear definition of roles and (among the professional champions) no time in their working week formally dedicated to the role. In one group meeting with older people no one could name or remember seeing a champion for older people.

The Department of Health established the network of champions for older people and provided central support with regular information bulletins and training on leadership.

Tackling ageism and promoting equality continued

However, this programme was only funded from 2001 to 2004. There is still a loose network of champions for older people but without central and local support and funding it is uncertain how long the network will remain and whether it can continue to have an effect in improving services for older people.

Equality and diversity

The local communities that we inspected that had significant black and minority ethnic populations, provided some services tailored to their needs. For example, in Leicester, specialist home care was provided and a group of 'peer educators' worked with older south Asian people to help raise awareness of risk factors for coronary heart disease and diabetes. However, in communities with lower numbers of black and minority ethnic older people, awareness was variable and appropriate services were underdeveloped. This is consistent with findings from the recent CSCI inspections of services for older people, which found that, of 18 councils, only three were performing well in providing services for black and minority ethnic older people.

Few of the local communities inspected had jointly developed strategies for equality and diversity, but in several areas this was being addressed through strategies for joint commissioning and working groups. There were some examples of good services. For example, the needs of older travellers were receiving particular attention in Wiltshire and Leeds, the latter having gained knowledge and understanding from the experience of

Romanian partners, in a European programme promoting development of services with and for older people in minority ethnic groups. In another area, the needs of gay and lesbian older people were being met through a 'gay and grey' support group. A group for transgender older people that meets in a service setting for all age groups was cited as being very supportive for its members, some of whom travelled long distances to access this specialist service. Such examples were comparatively rare, however, and there were some examples of distressing reports of same-sex couples experiencing insensitive treatment and behaviour.

Geographical issues – rural versus urban life

There are clear differences in the range of services available in urban and rural areas. With home care, for example, attracting and retaining the staff to provide care for people in remote villages was a challenge for providers of services. Older people often experienced services that were unreliable and fragmented.

“Older people are concerned about access to health from rural areas.”

In addition, some providers did not pay for the time staff spent travelling between households. In rural areas where distances between users of services are great, this is a significant problem.

This is an area where many local authorities are finding difficulties. This is in part due to problems of recruitment but is also linked to the need to develop a range of approaches to commissioning, many of which need to become more tailored to particular local conditions. The Care Services Improvement Partnership is carrying out a review of intensive home care and this will include looking at delivery of home care in rural areas. Local authorities are adopting a wide range of approaches to this problem, from focusing on large block contracts in rural areas to developing the capacity of smaller, local organisations. Other approaches in use or being considered include:

- recognising the additional costs of providing a rural service, including travel, through service level agreements
- moving away from opportunistic, spot purchasing towards a position where providers can predict demand more accurately and retain staff
- paying local people who are willing to provide support to a neighbour by using direct payments
- linking workforce planning, including recruitment, induction and training, with the independent sector
- changing the role of in house services so they become more specialist rather than directly competing with the independent sector
- working with black and minority ethnic groups to encourage them to become providers of services

- the use of a specific resource to provide a care 'hub' with less intensive services being delivered into the surrounding area

Older people also said that travelling long distances to health facilities such as community hospitals resulted in difficulties with visiting and attending appointments. There were concerns about out-of-hours services provided by some GPs as some older people had difficulties in accessing GPs at night and at weekends. One older person, whose friend telephoned the out-of-hours number on a Saturday, said: "It was horrendous – they didn't turn up until the next day, they had no notes and couldn't do anything for him".

Solutions that are innovative and creative are required to meet the challenge of delivering services in rural areas.

The following example highlights Leeds City Council's work to build capacity with black and minority ethnic groups in order to encourage the development of services that are sensitive to the needs and aspirations of black and minority ethnic older people.

Working with black and minority ethnic older people in Leeds

“It's a great project. We see things here from one side of the coin. But venturing into other cities in other countries, we see the other side. Then we can sum up and compare, and we know that Leeds are trying their best.”

A black and minority ethnic older person from Leeds, talking about the SEEM II European project

Background

Leeds City Council social services race equality forum has been working with older people from local black and minority ethnic groups to develop services with and for them. Organisations involved include Leeds Black Older People's Forum, the Sikh Welfare Trust and the Chinese community.

Extensive dialogue between faith groups and voluntary organisations led to development of 'neighbourhood networks' for black and minority ethnic older people, which have helped to improve communication, understanding and service development. This work is supported by the Services for Elders from Ethnic Minorities (SEEM) project – a European programme to develop and promote solutions to improve health and social care for people from these groups. The initiatives in Leeds address a number of areas, including improving information, developing neighbourhood network services and lunch clubs, home care, supporting carers, day services, including a 'Dementia Café' for people with dementia to meet, residential and nursing care, housing, consultation and involvement.

Successful outcomes include:

- Supporting older people to become service providers, information days in council offices, faith organisations, temples, gurudwaras and other venues.
- Promoting the benefits and employment opportunities for older people with the council.

- Mobilising resources by the council in the Sikh community to develop day centres for Sikh older people.
- Working with the Chinese community to develop services.
- Establishing successful networks with gypsy and traveller communities.

Since it opened the number of participants has increased steadily, demonstrating the need and importance of such services for black and minority ethnic older people.

Learning points

- It is important to engage with older people, faith and community leaders in black and minority ethnic groups.
- Enabling the community to become self-reliant by mobilising the services within that community is of greater, lasting value than funding specific services for specific communities. Such an approach helps to ensure sustainability.
- Undertaking careful analysis of a community's needs, before embarking on service development, helps ensure an understanding, an acceptance and a willingness to participate.

There are plans to develop extra care, sheltered housing and domiciliary care services.

Involving older people



“We’ve always said, respect our skills, and respect our experiences. They need to be paid for, so pay us a fee, pay for our transport because you want us there – not because you think you need us there, but because you want us there.”

Key messages

Older people do not feel that they had a voice in planning and shaping services – more than 95% of older people surveyed had not been asked for their views of the NHS or council services in the last year.

Around 80% of older people asked do not think that they influenced the planning of services.

There is very little evidence that inspected communities are building a shared vision based on the views and priorities of older people.

Many older people are sceptical about the value and impact of consultation and engagement exercises.

All inspected communities are involving older people in various ways, but this is not always systematic or carried out routinely.

Local authorities have mechanisms that are better developed than those in the NHS for engaging with older people. Some local authorities deal with the wider concerns of older people as citizens rather than exclusively as users of care services.

Most inspected communities are finding it a challenge to involve older people who are seldom reached, such as older people in black and minority ethnic groups, older people who are housebound and older people with mental health needs.

A person centred approach – where the needs of the individual guides the services – has a number of different aspects. Firstly, older people need to have a voice in building a vision for the future, in planning and developing services, and in influencing the most important aspects of community life. This is the subject of this section. Secondly, when they do need extra support, their needs and aspirations should be at the centre of any decisions made, as discussed in the next section.

Earlier work by the Audit Commission (2002)⁸ found that improving services across the whole system – that is, all the organisations that are involved in services – for older people

relied on all partner agencies having a shared sense of direction, rooted in the views and aspirations of local older people. A shared vision for the future that reflects the priorities of older people and their aspirations creates momentum for change.

However, good engagement with older people is important not just because services are likely to be better if people who use them and the people who pay for them are involved in their planning. Evidence also suggests that older people who take on active roles are more likely to report that they have better health and wellbeing than those who do not (O'Reilly and Caro 1994; Rozario et al. 2004)⁹.

Older people who contributed to the local inspections had very different individual experiences of being involved in decision-making. Of the people who responded to the survey carried out by King's College London as part of the inspection process, more than 95% said they had not been asked their views of NHS or council services in the last year. In addition, around 80% felt that older people had no influence in planning health and social care services or in monitoring their quality.

The views and aspirations of older people had not made a significant impact on the priorities and direction of all the partner organisations in the communities that were inspected. Few communities had a shared local vision for local older people that set out the direction for the future and the contribution of partner organisations in improving the lives of older people. When older people are involved in shaping vision and strategy, the scope of this tends to go beyond care services to include issues such as learning, leisure, transport and community safety, as these are the factors that research consistently shows make most difference to the lives of older people.

In some local authorities there were early signs that the views of older people were starting to make a difference, for example by influencing the approach of local authority to transport or community safety. However, this was rarely as part of an explicit vision that was shared with the NHS and other partners.

All the communities that were inspected were using a range of methods to consult and communicate with older people – at times

with them directly as local citizens, more frequently as users of services or patients, and sometimes with voluntary and community groups. There was a wide range of structures and mechanisms in place, including groups that related primarily to the local authority, as well as various patient and public involvement processes in the NHS. This point is echoed by the early findings from the Audit Commission's pilot corporate assessment inspections of local authorities, which found that a varied range of mechanisms for involving older people were in place, some of which were better established, and led more by older people than others.

In general, however, the diversity of groups and processes meant that the involvement of older people was not systematic or coordinated well and the impact of older people's involvement in making decisions was not always evident. In addition, the purpose of such activity was not explicit, and partner organisations were unclear whether they were:

- engaging with older people as citizens and tax payers
- involving older people in decision-making
- consulting on the detail of how services were delivered

In very few of the inspected communities were all partner agencies working together to maintain a debate with older people about a range of issues. Older people complained of duplication and 'consultation fatigue'. A lack of clarity about purpose and expectations led to confusion, and there was a widely held

Involving older people continued

perception that the views of older people were unlikely to be acted on.

Older people were frustrated at the ways in which consultation exercises have become more frequent, without necessarily becoming more meaningful. Not everyone was convinced that consultation was 'real' and some older people expressed the view that partner agencies were involving them only because they were obliged to do so.

“We don't get asked what we think, we would welcome more opportunity to say what we want from local health and social services.”

Older people were also sceptical of the value of consultation exercises carried out by voluntary organisations.

NHS organisations were, in general, less engaged with networks of local older people and less developed in their understanding and practice than local authorities, most of which have a track record of working with local communities and partners.

However, in the NHS there were good examples of involving older people in the redesign and improvement of services they had used. These included services for people with dementia and people who had a stroke. There were examples where older people could see the direct impact

of their contribution on the way that services were delivered.

There were some examples of partner organisations working to engage with their increasingly diverse older populations, but not in a very systematic way. Services for interpretation and translation were scattered and not widely known beyond specific groups or organisations. Many communities were struggling to engage with older people with mental health needs. Although older people with cognitive impairment might find it difficult to talk about abstract ideas or events, they were able to comment on services used on a day-to-day basis.

In some areas, communication with the voluntary and community sector acted as one route for local councils to consult and receive feedback, to think about local implementation of new systems and policies, and to gain support for local initiatives. However, engagement with voluntary organisations is not the same as involving older people – it is an additional route, not a substitute for direct communication. It is encouraging that all the inspected communities recognised this and were employing a range of methods to involve older people in direct debate about the shape of services.

The following example illustrates how one community is attempting to build a systematic, democratic approach to involving older people, as citizens, in debate about public services.

An example of involvement – Brighton and Hove Older People’s Council

“The older people’s council is a striking example of demonstrating the commitment to involvement”.

Background

Brighton and Hove Older People’s Council, is one of the first directly elected groups of its kind in the country. It is a real innovation and offers older people the chance to have a voice in the decisions that make an impact on their lives. The council’s nine members, each representing a zone of the city, are elected by older people in Brighton and Hove to represent their interests.

The older people council’s work covers a broad range of issues that are important to older people, from promoting lifelong learning to influencing planning decisions transport and community safety strategies and improving care services. Each member has a special area of interest and maintains close links with relevant decision-makers, such as local authority committees, NHS trust boards and city wide partnership groups. The nine council members work closely with a larger group of older people in Brighton and Hove, the Brighton and Hove Coalition of Older People – the pensioners’ forum. The pensioners’ forum is a diverse, fluid group with around 2,000 members, who campaign and provide information on issues of importance to older people, challenge age discrimination and stereotypes and create opportunities for older people to become involved in new activities. These include Silver Sounds, a Samba band, which has successfully raised the profile of older people in the city and beyond. The diversity of the pensioners’ forum provides an excellent reference group and sounding board for the older people’s council.

There is growing evidence that the older people’s council is making a difference. The needs and aspirations of older people are now considered routinely when decisions are made on planning and regeneration, and members of the council play an important role in promoting the value of the contribution of older people to the community.

Learning points

Leadership and commitment from elected members of all parties, working alongside older people, has been crucial in building and sustaining momentum.

The agenda of the older people’s council is set by older people, with a primary focus on issues of most importance to them, not on service priorities.

Offering opportunities to become involved and have fun helps build networks of older people, who can then be called upon to help in public engagement exercises.

The success of the older people’s council rests on the mandate it was given by Brighton and Hove’s older voters and also on the credibility of individual members – this can only be built over time, as members are seen to be making a difference.

The older people’s council’s next challenge is to work with the local authority, NHS and other partners such as Better Government for Older People to develop a local strategy for an ageing population.

Designing and delivering services around older people



“I was very happy with the...care. It’s the effect on my life because I’ve got people who care; it gives my feelings about human nature a leap – I realise I’m not just me, I’m a person.”

Key messages

Most older people valued the services they received and feel that their dignity is protected when using services.

There were a number of instances where older people were not treated with sensitivity and respect. Single sex wards and bays in hospitals were being used to accommodate men and women together, and there was poor understanding among acute hospital staff of the needs of older people with dementia.

While all communities were striving to implement the single assessment process, it had not been fully implemented in any of the communities, resulting in the continuation of lengthy, disjointed assessments that failed to address the whole range of needs and aspirations of older people.

Delays in transfers of care from hospital had fallen in all of the inspected communities.

The discharge of older patients from hospital was not always managed well and staff do not always respect the needs of older people and their wishes.

The procedures for protecting vulnerable adults were established in most communities but the monitoring, reporting and analysis of incidents of abuse and the outcome of investigations could be strengthened.

Many older people said they were reluctant to complain about services and not all (ranging from 27% in one community to 59% in another) are confident that their complaint would be listened to.

This section looks at the extent to which services are genuinely tailored to the needs and aspirations of individual older people, and identifies factors that contribute to this. It explores whether older people are treated with respect and sensitivity when they come into contact with services. It also assesses progress in implementing the single assessment process, with tackling delayed transfers of care, and the impact of these on older people. The section touches on how well older people that are vulnerable are protected, as well as looking at the use of direct payments, individual budgets, and systems for complaints.

Older people said at the events we held for them in each of the communities that they valued the services they received most of the time and expressed praise and gratitude towards the staff who delivered them. However, the inspections also revealed areas in which there was more to be done and where older people perceived that they had not been dealt with appropriately by care staff.

Hospital care

Conditions in hospitals sometimes had a significant impact on the experiences of older

Designing and delivering services around older people continued

people of being an inpatient. For example, there were many comments from older people about dirty wards, the strong smell of urine from unemptied bottles, and people waiting on trolleys. According to surveys of NHS patients, just more than 50% of respondents thought hospitals were clean, but this number dropped to around 40% when they were asked specifically about toilets.

The inspections carried out in the local communities confirmed that some older people still had unacceptably poor experiences of in hospital, and in particular:

- there were some wards and bays which, although designated as single sex, were regularly used for people of both sexes when the hospital was busy, and in some cases there were no plans to address this
- there were some instances of older people being moved from ward to ward, sometimes at night. These moves were not always for clinical reasons

Older people who are most vulnerable are most susceptible to poor treatment in hospital. As highlighted previously, there were particular difficulties for older people with mental health needs when cared for in general hospitals. The inspections found instances where people were not well monitored to ensure that they liked – or had even eaten – the food prepared for them, and meals were taken away untouched. In Buckinghamshire there is a training programme for nursing staff aimed at improving the care in hospital of older people with mental health needs.

The single assessment process

None of the communities that were inspected had introduced one model of single assessment across all partner organisations in the area. This is in line with CSCI's findings from inspections of services for older people in

Figure 1 – Progress of local authorities and partners in implementing one model of the single assessment process



Source: Padi 2156 Progress on NSF milestones: stage reached in implementing a single assessment process

2004/2005 that found only 6% of local authorities nationally had a single assessment process for health and social care (see figure 1).

Two of the inspected communities had introduced single assessment across the area using more than one model, and seven were at varying stages of piloting its implementation. The remaining community that we inspected plans to implement single assessment once IT systems are available in April 2006.

Older people emphasised the importance of receiving services that are well coordinated, or joined up. To achieve this, there should be one coordinated assessment of the needs and aspirations of older people. Multiple assessments mean that older people are likely to be asked the same questions repeatedly, while other important areas remain ignored. A shared approach reduces the likelihood of confusion and means that critical issues are more likely to be jointly understood and acted on. In addition, older people wanted their unique combination of experiences, aspirations and hopes for the future to be recognised, rather than have uniform solutions imposed on them that focused only on problems.

There was little evidence of an approach to assessment that genuinely placed the older person at the centre, and that focused on the issues that the older person saw as most important. CSCI reached a similar conclusion when it inspected services for older people in 18 councils between April 2004 and March 2005. It found that the views and aspirations of older people were not clearly recorded. But in the one local authority where staff had been trained to use the words of the older person in recording the assessment, this had led to a

much more personalised approach, as well as more creative packages of support.

Factors which were affecting implementation of the single assessment process included:

- project management of the introduction of single assessments did not pay enough attention to delivering the requirements of the national service framework (NSF) on time
- the lack of a shared electronic system for keeping records was seen as a major barrier for some although others were using paper-based systems as an interim solution
- testing of single assessments was limited, as most inspected communities were piloting but not yet using this method for all older people in their area
- interagency evaluation of the process was often incomplete and the process for doing so was not always agreed
- the introduction of new approaches to relevant groups of staff was often at an early stage
- multidisciplinary training of staff had started in most areas, although some reported difficulties in getting all partners to attend in sufficient numbers
- staff in hospitals and in GP surgeries were often the least engaged in the process
- there were difficulties and disagreements about what information could be shared between partners

The single assessment process is the foundation for building services around individuals, a key

Designing and delivering services around older people continued

objective of the white paper *Our health, our care, our say*. The limited progress on this was hindering the development of thinking and working with an integrated approach. The understanding by partner organisations of the change in culture which is needed to make single assessments work, was variable. Without a person centred approach and joined up working, there are poor results for older people, care planning is underdeveloped, the needs and aspirations of older people are ignored and delays are caused by the fragmented nature of the assessment process.

In some communities, the absence of a joint system for information had been used to justify a lack of progress, but in others this had not prevented some progress being made. In these communities at least some older people were benefiting from a joint process, even if it was paper rather than electronically based. For those older people who had experienced a single assessment there were early indications of the benefits that could be gained. In particular some older people said they liked being able to keep their shared record with them at home.

The inspections of local communities indicated that a single assessment process for older people was also thought to be bringing other benefits, in particular:

- more consistent and regular reviews of care and support
- greater coordination of systems to safeguard older people
- better systems to review prescribed medication

But these benefits are still just aspirations in many areas because of the substantial delays in realising the target of one coordinated assessment and review process. Four years after the publication of the NSF, the role of strong leadership in 'selling' and promoting the single assessment process at board level and in guiding changes in culture and operational delivery, is more important than ever. New approaches to delivering public services emphasise the importance of tailoring services to meet the needs and aspirations of individuals. *Our health, our care, our say, Independence, wellbeing and choice, and Opportunity age*, all set out clear objectives to ensure that older people have more control and choice over the services they receive. Person centred planning is described as one way to achieve this, building on the experience of using the single assessment process. It is therefore important to implement single assessment, and to increase understanding of the change in approach that this represents. Without this, older people are unlikely to receive a response that genuinely reflects their unique circumstances and preferences.

Information and communications

Older people valued being given the right information by staff in the right way and at the right time. However, the extent to which professionals took care to ensure that people understood why they had been referred for certain investigations or prescribed certain medication varied.

The inspections found incidents where communication had been poor and the information provided was inadequate. For example, when some older people were given a diagnosis, insufficient time was taken to deal with this sensitively, and little support was offered in adjusting to their changed health status.

“It took three weeks, day after day, to get help. No crossover. You have to find your way through the woodwork. You’re feeling isolated, at your lowest ebb.”

Many older people felt that professionals failed to take account of the in depth knowledge that they and their carers could provide, and underestimated their capability and understanding. For example, older people with physical disabilities reported that health and social care staff often assumed that this would mean that they were incapable of expressing their views themselves.

They also found it difficult to find out about services, particularly primary care and advice on benefits. There was a mixed response to web-based information services, although older people appreciated websites that target people over 50, with links to other relevant information. Most local authorities provided free newspapers, which were valued, as was information provided by voluntary organisations such as the Stroke Association and Age Concern. Several people commented

that they would expect GP surgeries or health services to be an appropriate place to find information, but this expectation was rarely met.

A recurrent theme was the need for timely information that was easily available and written in non-technical language. The difficulties for organisations of providing a highly complex range of information covering general advice and specific detail were also acknowledged. Some communities that were not part of the inspections have tackled this by producing signposting leaflets for older people. These bring together sources of further information and help on a wide range of issues, from sports and clubs to benefits advice and care services.

Some of the communities inspected provided good information to promote wellbeing. Partner organisations in Redcar and Cleveland, for example, had published a booklet called *Choose life, choose health* and another on the prevention of falls. In Portsmouth the innovative Prevention Network had made a real difference to the sharing of information and concerns between statutory organisations and local community and voluntary groups.

There are additional issues confronting people from minority ethnic groups, in particular if the older person does not speak English. Access to interpreting services is inconsistent and staff who speak minority ethnic languages are not always available to deliver ongoing care. Not all partner organisations recognise that it is inappropriate for older people to have to rely on relatives to communicate intimate personal and confidential matters to doctors, nurses or social workers. This is a particular problem in the NHS. Asking relatives to act as

Designing and delivering services around older people continued

interpreters for older people is not acceptable and should be discouraged. Even where there are clear policies about interpreting and translating, staff knowledge of them or adherence to them appears variable.

Hospital discharges and readmissions

The inspections of the local communities confirmed the national trend of falling numbers of older people delayed in hospital. The Department of Health's statistics show that there has been a 67% reduction in delayed transfers of care from 5,396 in 2001 to just 1,804 in 2005¹⁰.

However, some communities have struggled to provide the range of safe and suitable services outside hospital, which will help to avoid unnecessary stays in hospital and promote speedy discharge. Since 2004, as a way of strengthening partnership working to tackle this issue, local authorities have been required to reimburse hospitals where it was clear that the delay in discharge of a patient was their responsibility¹¹.

Although delays had fallen in all inspected communities, in some cases rapid discharge was only achieved at the expense of proper planning with the older person concerned. The inspections found that:

- while the majority of older people reported that they had had a timely and well organised hospital discharge (between 81% and 63% across the communities involved in the survey), a significant minority did not

- discharges and ward transfers of older people and their carers were sometimes done at inappropriate times

A CSCI special study report in 2005¹² followed up a group of patients who were studied in a previous report *Leaving hospital – the price of delays* (2004)¹³. One year on, they found that:

- in all places visited further steps had been taken to improve the speed and coordination of discharge, and developments in community services were evident everywhere
- older people were largely satisfied and grateful for services received, although family carers were more likely to voice grievances
- continuity of carers was a top priority for older people
- intermediate and rehabilitative services were universally appreciated by the users of services, but varied widely across the country in terms of their accessibility. A focus on rehabilitation results in sustained improvement and the maintenance of independence
- shortfalls in community health services undermine the potential to deliver good post hospital care and prevent admission in the first place
- the reimbursement scheme improved partnerships between health and social services, and these constructive partnerships have been sustained
- there should be a greater focus on providing practical and flexible support for

carers. The pressure on some carers was evident, particularly those who were caring for older people with both physical and mental health needs

The Department of Health's change agent team set out the components of a good discharge planning service¹⁴. These are shown in the table below.

Rates of readmission have increased over the past three years, particularly for people aged 75 and over. While this is not conclusive evidence of inequality, it is of concern that readmissions are increasing and that they appear to be increasing disproportionately among older age groups. Sometimes an older person may be readmitted to hospital but for a different reason than their original admission, and this is unavoidable. To explore this further, two disease areas were considered to look at readmissions – diabetes

and chronic obstructive pulmonary disease (often referred to as COPD, a condition which affects the ability to breathe easily).

Figure 3 shows the ratio of readmission to hospital within 30 days of discharge for people with diabetes as a percentage of the population between 1998/1999 – 2000/2001 and 2001/2002 and 2003/2004. There has been an increase in readmissions for all people between the ages of 50 and 75 and over. The readmission rates for people aged between 50 and 64 increased by 5%. For people aged 65 to 74 it increased by 6%. The increase in readmission rates for people with diabetes who are 75 years and older is highest at 10%.

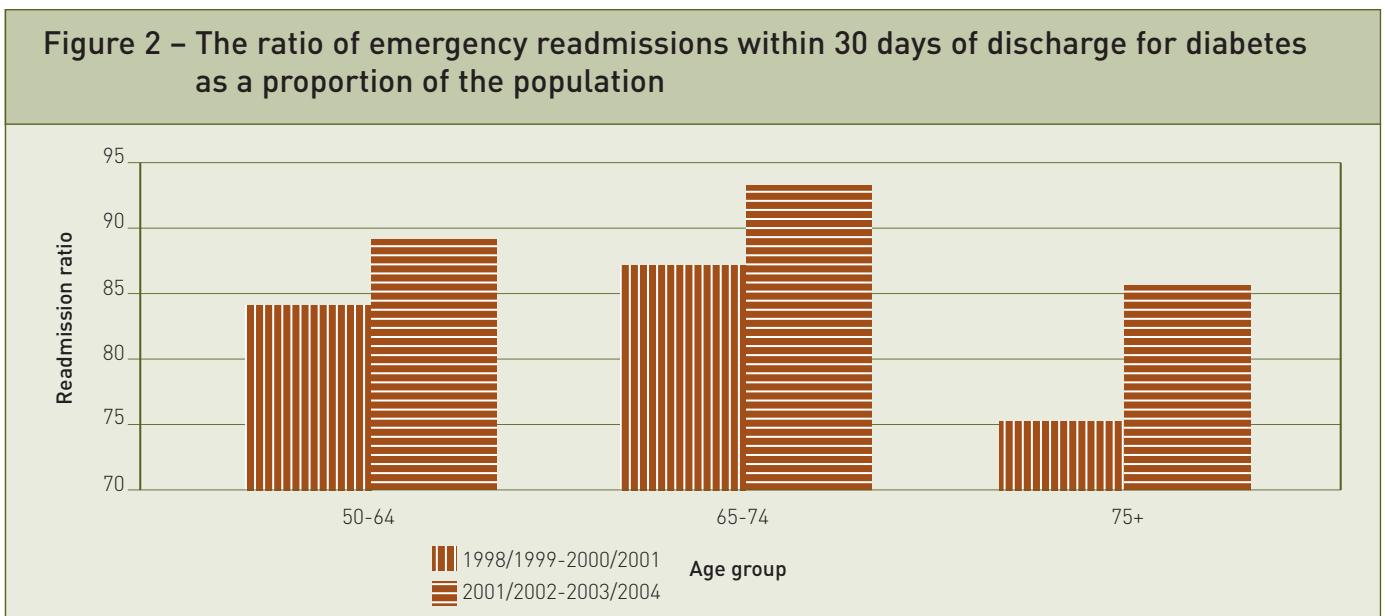
Figure 3 shows emergency readmission rates for people with chronic obstructive airways disease within 30 days from hospital as a proportion of the population.

A good discharge should include:

- a mix of professionals (social workers, nurses, therapists) working and located together in the same team
- a single line manager or coordinator
- an agreed multi-agency discharge policy including when and how to assess for eligibility for continuing healthcare funded by the NHS
- early referral so that planning for discharge starts as soon as possible
- early identification of an estimated discharge date that is communicated to all key people, including patients and carers
- coordinators based in wards who can oversee the discharge process, both for the 80% of patients whose discharge is straightforward, and the 20% who have more complex needs
- active involvement of patients and carers in the planning and decision-making process

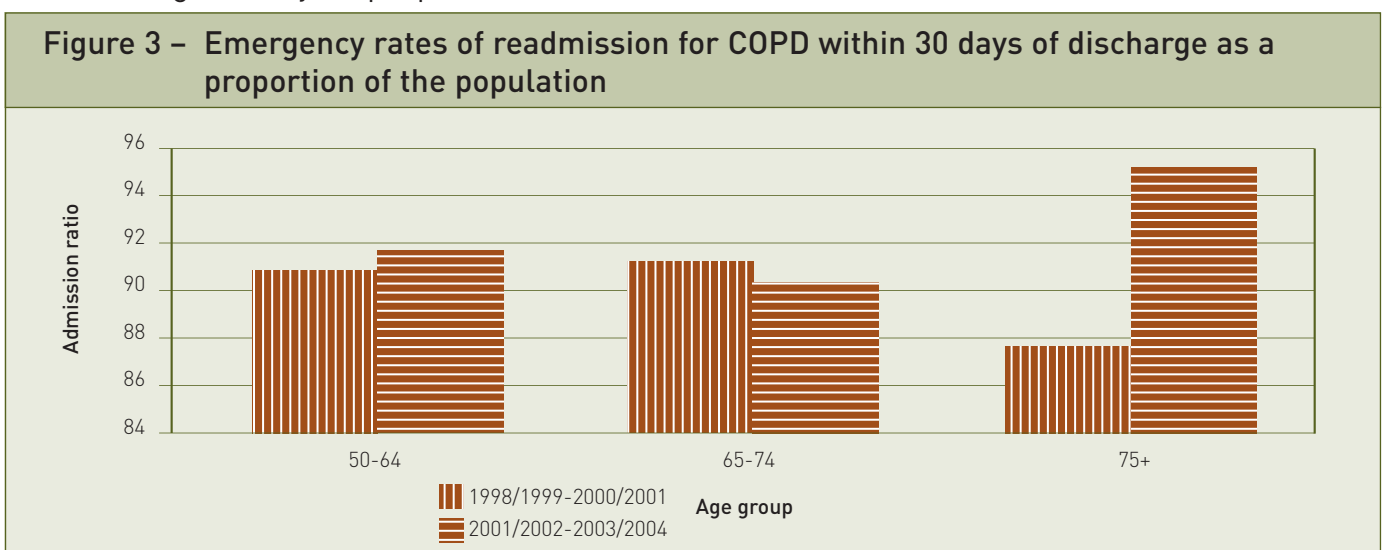
Designing and delivering services around older people continued

The following chart shows that rates of readmission for people with diabetes have increased significantly for all people aged over 50 between 1998 and 2004. The increase in readmissions for people over 75 is greatest.



Source: Median indirectly standardised 30 day emergency rates of readmission for diabetes (data pooled for 1998/1999-2000/2001 and 2001/2002-2003/2004)

This chart shows that rates of readmission for chronic obstructive pulmonary disease (COPD) had increased significantly for people over 75 from 1998 to 2004.



Source: Median indirectly standardised 30 day readmission ratios COPD (emergency admissions data pooled for 1998/1999-2000/2001 and 2001/2002-2003/2004)

Between 1998/1999-2000/2001 and 2001/2002, there was a small increase in readmissions to hospital following discharge 2003/2004 for people with chronic obstructive pulmonary disease who were between 50 and 64 years of age but only a slight improvement for people aged between 65 and 74 years of age. However, there is a significant increase in rates of readmission for people aged 75 years and older as readmission rates increased by 75%.

The increase in rates of readmission for specific conditions raises concerns about the quality of planning for discharge and communication between the hospital and community health and social services and/or the quality of community services for people with long term conditions to prevent further crisis. It is important that systems are strengthened to manage the care of people with long term conditions, particularly older people, so that readmissions to hospital can be avoided.

Services in hospital

Most hospitals have established multidisciplinary teams in wards designated for the care of older people. All have identified modern matrons or other nurse leaders with a specific responsibility for older people. However, in three of the inspected communities, there were no specialist teams that work across all wards throughout a hospital to ensure that older people receive good care.

Most general hospitals have training programmes for staff who are caring for older people in general wards but it is evident that some staff in general hospital wards require additional training to ensure that they treat older people with dignity and respect and afford them their privacy. This is particularly true of staff caring for older people with mental health needs.

Progress against the NSF target to increase the number of intermediate care beds and places by March 2002

As at March 31st 2005, there were 29,500 places benefiting more than 360,000 people.

Compared to 1999-2000:

- the number of intermediate care beds had more than doubled
- the number of intermediate care places in non-residential settings had almost trebled
- almost three times as many people benefited from intermediate care

The *NHS plan* aimed for an extra 6,700 places for intermediate care by March 2005, 5,000 residential and 1,700 non-residential places. Communities have delivered an extra 18,095 places – 270 % more than the combined target

Source: Statistical Summary to *Chief executive's report to the NHS* (May 13th 2005)

Intermediate care at home: redesigning roles in Greenwich

Background

Many services are struggling to recruit and retain staff. This is a particular problem for intermediate care, where in many parts of the country there are shortages of suitably qualified and experienced staff across the professions. Making best use of skills and time is therefore paramount. In Greenwich this problem is being tackled through the development of the intermediate care at home support worker role, to work alongside community intermediate care teams to ensure effective delivery of care plans based on outcomes. The main drivers for development of the role include:

- problems recruiting therapists and nurses, coupled with belief that frontline support workers could help meet this challenge
- the need to develop a more fulfilling and challenging role for some support workers, and to formalise opportunities for career development within the service
- previous positive experiences of enhanced support worker roles
- modernisation of Greenwich home care services
- it has the potential to reduce delays, waiting times and duplication in transfers

Twenty posts were recruited from the council's home care service. Successful candidates participated in a three day induction and training programme, which included shadowing and placements and staff now have enhanced skills.

Learning points

Easy access to the rapid response team to get equipment and support from professional staff, for example physiotherapy.

Flexible shift patterns developed to help continuity.

Enthusiastic response from staff to these developments.

A further important development for intermediate care in Greenwich has been the role of the modern matron, who gives professional support and clinical supervision to all the intermediate care facilities provided by an independent sector provider. The modern matron also supports staff development and training, the development of standardised documentation and provides professional supervision.

The future

Development of four senior intermediate care at home worker posts on a pilot basis, to offer career progression and a route into management. The senior role will have the opportunity to undertake national vocational qualifications level 3 and 4 (NVQ3/4) and would also pave the way for a similar post to be introduced across homecare.

Intermediate care

All the inspected communities had contributed towards meeting the national target to increase the availability of intermediate care, both in designated beds and at home. They had also increased the range of services to prevent avoidable admissions to hospital for older people and to reduce delays in discharging patients from hospital. These findings mirror the national picture, which is illustrated on page 45.

There is some variation in the level of services for intermediate care provided in the 10 local communities that were inspected. Not all have appointed a coordinator in intermediate care to lead the development of services, and access is not consistent across some of the communities. Health and social care teams are at different stages of becoming integrated fully. Despite this variation, older people generally value intermediate care. There are some excellent examples in four of the inspected communities of services being reorganised to give older people comprehensive and consistent care, delivered locally. These findings are similar to those reported by the University of Leeds, 2005¹⁵ in its recent evaluation of intermediate care services for older people.

An example of an intermediate care at home service in Greenwich is on page 46.

Social care services

The CSCI published a report on the state of social care in December 2005¹⁶. The findings of this report on services to older people in registered care homes and those receiving

services and care in the home present a mixed picture. Some of the registered care homes inspected were meeting a good proportion of the national minimum standards including trial visits, relationships, personal space, community contact and having a positive ethos. The biggest improvement from the previous year was in providing information in an accessible format. However, there were concerns in relation to the safety of residents, as many homes did not meet the standards for managing medicines, the recruitment of staff and safe working practices. In the same report home care agencies were reported as meeting 61% of the minimum standards. Areas of concern were lack of flexibility, short visits to users of services and the terms and conditions of the employment of home care staff.

Safeguarding older people

The arrangements for safeguarding older people operated effectively in most areas, and multi-agency policies and procedures had been updated in line with national guidance. Opportunities for training had been developed and staff were generally aware of how abuse occurred and the action to take when it was recognised. However, not all key staff had received training, particularly in the NHS. Most of the communities that were inspected had appointed adult protection coordinators, although some had found it difficult to fill posts. Some local authorities needed to improve the monitoring, reporting and analysis of incidents of abuse and the outcome of their investigations. Adult protection committees were in place, although some needed to take a tougher approach to setting standards and monitoring performance.

Key risk factors for the potential neglect or abuse of older people

- A poor and institutionalised environment.
- Low levels of staffing.
- High use of bank and agency staff.
- Little development and supervision of staff.
- Lack of knowledge of incident reporting.
- Closed and inward looking culture.
- Weak management at ward and locality level.

The Commission for Health Improvement, the former healthcare regulator, identified seven key risk factors for potential neglect and abuse of older people on hospital wards (see box above). The list was based on 35 clinical governance reviews carried out between 2001 and 2003, and two special investigations of serious service failure at North Lakeland Health NHS Trust in November 2002 and at Manchester Mental Health and Social Care Trust in 2003¹⁷.

Direct payments

Direct payments are payments given to individuals so that they can organise and pay for the social care services they need.

In several of the inspected communities there was little take up of direct payments by older people. The national picture, however, shows a sharp increase in the number of people aged 65 and over taking advantage of direct payments. The number of older people who are using direct payments rose from just 39 to 549 for each 100,000 people between 2002 and 2004¹⁸.

In Wiltshire, older people had been involved in developing the mechanisms to help people use direct payments, and social services had established 'champions' in each team to offer support. The involvement of older people in this way is likely to lead to a more acceptable approach.

The hallmark of a successful scheme lies in its flexibility and the availability of tailored support for older people. Some local authorities used direct payments to provide one-off services, for example to meet the needs of a carer for overnight respite or to meet the needs of older people from black and minority ethnic groups by providing culturally sensitive home care, or to provide support to older people who are terminally ill and their carers. In Portsmouth the local authority had developed a scheme that provided help with recruitment of carers and financial advice, and encouraged a pool of workers to be available to provide back up.

However, despite training and guidance, some staff continued to doubt the relevance of direct payments for older people, indicating a need for further training.

End of life care

The inspections found an inconsistent picture of services for end of life care, with well developed, integrated and effective services in some places, but room for improvement in others. It appeared that, wherever possible, people were helped and supported in their choice of place to die. However, the provision of out-of-hours support was patchy and a lack of practical support may mean that people have to be admitted to hospital or hospice at the end of their life when they may have preferred to remain at home.

Supportive and palliative care, underpinned by services that are person centred, aim to promote physical, psychological and spiritual wellbeing. The NSF outlines personal and professional behaviours which are considered particularly important to end of life care. Services that are needed to promote dignified and effective end of life care are complex, requiring good coordination between organisations. They must appear seamless to users and carers, be easy to access and totally reliable. Some models of best practice in end of life care have been developed nationally, these are:

- the gold standard framework: this framework promotes seven key tasks which focus on improving communication, continuity of care, advanced care planning and support for patients and carers
- the Liverpool care pathway for the dying patient: this pathway was developed to transfer the learning from hospices to other settings
- the preferred place of care plan: this is a patient held record of care where the

patient can record information including choices about care and other services

Out-of-hours care for older people dying at home was a particular issue for one inspected community, where there were too few specialist nurses to cover a wide geographical area, and there was no 24 hour district nursing service. In another community, an outreach nursing service from the acute hospital was being developed.

In two of the communities that were inspected there were problems accessing social care, partly as a result of difficulties in recruiting home care workers, and partly due to lack of clarity about whose responsibility it was to pay for the social care elements of end of life care. In the latter case the use of a pooled budget would help; in another inspected community a pooled budget for palliative care was being set up.

The inspections found a number of different ways of managing medication and pain control. In one inspected community small supplies of prescribed medication were kept in the homes of patients so that it was readily available where the condition of a patient was expected to deteriorate rapidly. In addition, special medication boxes, which can be used by GPs out of hours, were kept at community hospitals. These measures helped to ensure that patients could remain at home safely.

Complaints

Older people saw the way in which organisations responded to complaints as very important. This also influenced how likely they

Designing and delivering services around older people continued

were to complain in the future. Where older people felt that action had been taken to respond to their comments, they were generally satisfied. However, if they felt that their complaint had been ignored then the original cause of dissatisfaction remained and they felt even more negative about the service that had been provided to them.

One of the reasons why some people said they were reluctant to complain was the fear that this would affect the treatment that they or their relatives received. This fear was highlighted repeatedly in the inspections. Other older people were sceptical about the likely impact of complaining. The results of the survey of older people from the communities that were inspected present a mixed picture, with only 27% of older people in one area feeling that if they made a complaint it would be listened to, while in another, 59% felt they would be listened to.

There was also concern that systems to monitor the quality of services failed to include the views of people with mental health needs or with learning disabilities. This was seen as a particular problem in services such as home care, where a high proportion of those using the service had some level of cognitive impairment.

Medicines management

None of the communities that were inspected was fully meeting the standards set out in the NSF for the management of medicines. Most general practices are reviewing medication annually for people aged over 75 but

older people taking four or more medications are not always reviewed on a six monthly basis. Some PCTs are employing pharmacists to assist directly in the reviews of medication. Most communities that were inspected are able to provide some ward based dispensing of drugs when the patients are discharged, although this is not available universally.

Seven of the communities were actively working to extend the involvement of community pharmacists in helping older people to manage their own medication. This section has highlighted the need for more progress if older people are to expect services that genuinely respond to their unique combination of needs and aspirations.

The following example shows how partner organisations in Surrey have successfully implemented an electronic single assessment process.

Developing the electronic single assessment process throughout Surrey

Background

On behalf of its health and social care partners, Woking Borough Council, obtained funding from the Office of the Deputy Prime Minister for a project, promoting the independence of vulnerable older people. Part of a national programme Framework for multi-agency environment (FAME), the project aimed to support several health and social care initiatives relating to a range of services, including those for older people. A key aspect of the programme was the sharing of information across public services to enable customers to receive relevant, timely and efficient services, whichever agency they approached. Borough council officers, with colleagues from Surrey County Council, Surrey Heath and Woking PCT, North Surrey PCT, Ashford and St Peter's Hospitals NHS Trust and three general practices, developed an electronic single assessment process, which would benefit all partners and improve service outcomes for older people.

A pilot project was established around a general practice in West Byfleet and together with the technology partner appointed by the Office of the Deputy Prime Minister, an electronic single assessment process was developed and tested. Practitioners in health, social care and housing were involved in reviewing the business processes and workflows linked to the single assessment process, and embraced use of the electronic single assessment process tool enthusiastically. The electronic single assessment process has enabled the recording, sharing and referring of information in a secure electronic environment, with access levels appropriate to individual practitioners. It is now being implemented in Surrey Heath and Woking PCT

Surrey Heath Borough Council and Frimley Park Hospital NHS Foundation Trust.

Learning points

The electronic single assessment process developed in Woking has made creative use of the Office for the Deputy Prime Minister funding for e-government projects. It supports the strategic aims of all partner organisations, and could be replicated in other health and social care communities. It provides:

- an operational electronic solution that incorporates the Department of Health accredited FACE forms and guidance
- a secure network in which to share person identifiable information
- an information sharing protocol
- interface with Anite SWIFT social care system and Vision InPractice GP system
- process maps and workflows
- technical specification of requirements

The future

Phased introduction of the electronic single assessment process throughout Surrey is planned. The electronic single assessment process infrastructure and technology has the potential to facilitate and support other service areas, including children, other adults, mental health and community safety. The fundamental principle of the electronic single assessment process is its ability to give partners a shared view of the service user and, in doing so, to avoid duplication of effort, provide more focused and comprehensive assessments and improve outcomes for older people.

Stroke



“We have been involved in discussions and processes to remodel services; these have transformed what happens. A new strategy has been produced, and the benefits are seen in better informed services, in which patients are treated as individuals, not stereotypes.”

Key messages

Overall, the picture for comprehensive services around stroke was improving, with evidence of strong clinical leadership and good development of both acute services and those based in the community.

There was equal access to services for people who have had a stroke regardless of age. Some older people made a specific reference to this as they appreciated that there was no age barrier to appropriate care and treatment for a stroke.

All communities inspected provided an acute specialist stroke service.

Three of the communities inspected did not provide a stroke unit.

All of the communities inspected had agreed protocols for the referral and management of people who had experienced a mini stroke.

Not all of the communities inspected had stroke registers to identify people at risk of a first or subsequent stroke.

There were inconsistencies in the way the communities that were inspected implemented protocols to prevent a first or subsequent stroke.

The services used by people who have suffered a stroke and their experiences in using these services is the subject of this section. The NSF has a standard on stroke services. It is aimed at all people who have had a stroke and is not related to age. This section is not restricted to the national service framework standard on stroke. Stroke was used as a lens through which to assess services against all the national service framework standards and themes during inspections. It was clear that a lot of effort had gone into improving services for people who have had a stroke, and older people had been part of the process. In some cases, older people had helped to redesign services, with very positive outcomes. In Redcar and Cleveland, for example, a stroke care coordinator was appointed in response to older people identifying areas where their needs had not been met, and, in Medway, older people had not only been involved in a major

redesign of services, but were part of a process to ensure that services continued to improve.

Also in Medway the use of a diary was regarded as a valuable and effective means of communication between older people, their relatives and friends. The diary could help them to remember questions or comments for staff, and to feel more involved in their own care and treatment.

Specialist services for people who have had a stroke

All general hospitals caring for people who have had a stroke in the communities that were inspected provided an acute specialised service and operated according to clinical guidelines approved by the Royal College of Physicians.

A number of factors influenced how well older people recovered following a stroke. For example, the Stroke unit trialists' collaboration (2003)¹⁸ showed that spending time on a specialist stroke unit greatly improved outcomes in terms of death, dependency and the need for institutional care. Hospitals in three of the communities that were inspected did not have such a stroke unit open at the time of the inspection. People who had had a stroke in these communities were cared for on general wards with support from the specialised stroke team. A national sentinel stroke audit carried out by the Royal College of Physicians in 2004, published in March 2005, shows that 82% of hospitals in England have a stroke unit²⁰, also more people are treated in a stroke unit for part of their hospital stay compared to the previous year. In the communities that were inspected services were not always integrated across health and social care.

In some areas access to diagnostics was still problematic. MRI (magnetic resonance imaging) scanners which use radio frequency waves and a strong magnetic field rather than x-rays to provide clear and detailed pictures of internal organs and tissues – a valuable tool for diagnosing stroke – were not always fully staffed, leading to delays. In most places there was good integrated working, with timely acute assessment and rehabilitation following a stroke, and smooth transition from hospital to home.

Rehabilitation and advice

Rehabilitation and support services based in community were established or were being developed in all areas, with evidence of good links with acute units and effective interagency working providing a rapid response service. Many older people and their carers spoke highly of such services, particularly the input from therapists and the speedy provision of equipment and adaptations to the home to enable independent living. However, follow up by GPs was not always as effective as it might be. Medication was not always explained clearly, and some carers said that GPs were often unaware of the caring role and responsibilities they undertook.

Several people singled out the Stroke Association for praise, mentioning the information provided and its excellent volunteers who helped people navigate through the complex system for benefits. One older person commented “when illness strikes people are at a low ebb and least able to cope with the bureaucracy involved in accessing services and benefits. Skilled help at such a time is vital and valued”. A survey carried out by the Healthcare Commission and the Royal College of Physicians²¹ in 2005 found that almost one third of patients who wanted information from health and social services about stroke said that they had not received any since they left hospital.

A national sentinel stroke audit carried out by the Royal College of Physicians in 2004 found that 65% of people who were admitted to hospital had a physiotherapy assessment within 72 hours of admission and 52% had an assessment by an occupational therapist

within seven days of admission. However, respondents to a survey in 2005 following their discharge from hospital found that people were more negative about the rehabilitation provided to them after discharge, when compared to the 2004 survey about the experiences of patients in hospital.

Awareness and prevention

PCTs in all but one of the communities that were inspected had agreed protocols with their GPs for referring and managing people who have had a transient ischaemic attack (otherwise known as a mini stroke). However, not all general practices in all communities have established stroke registers of people at risk of stroke because of high blood pressure or other factors. Stroke registers can help to pinpoint individuals at risk of stroke, build up a local picture of care and treatment for stroke and assist development of prevention plans (integrated with acute and community services), and identify and support carers. As such, they are an important addition to the effective prevention, care and treatment of stroke.

There is evidence of inconsistency in some communities in the ways people who had already had a stroke were being treated to minimise the chance of them having a second stroke. Further work is needed to ensure that all general practices are aware of and are working to agreed protocols for managing people at risk of both a first and subsequent stroke.

The inspections found very little acknowledgment of the important role played by services that could contribute towards preventing stroke, such as leisure and

exercise services, although many were keen to develop their involvement.

A report by the National Audit Office, *Reducing brain damage: faster access to better stroke care*²² suggests that awareness of stroke and its causes is poor among the general population, with three quarters of people surveyed having little or no knowledge of the risk factors, and most people not associating the Stop Smoking campaign with stroke, believing it to be related solely to the prevention of cancer. Similarly, there was little awareness of the significance of high blood pressure as a risk factor for stroke.

The workforce

Some communities that were inspected were addressing issues around the workforce creatively and to good effect, with evidence of effective integrated working across agencies. Overall, staff said that they had access to training that was of good quality, with joint training taking place in many areas. Most staff had access to induction and ongoing training for stroke care and treatment. In Medway the employment of stroke rehabilitation assistants was having a positive effect on the services provided, enhancing partnership working and optimising input of the various team members. The assistants, who were well regarded by their coworkers, offered a more flexible service to older people, and helped to maximise the effective use of professional therapy staff. They were extending their role by running exercise groups, breakfast meetings and library runs, and were developing a programme of visits to older people once they left hospital, thus providing continuity, and a person centred service.

Falls



“Mum had one fall but I didn’t know how to contact people. The second time she fell I had the control centre number and they rang my mum on the intercom. She fell again and the paramedics came. Services were going to be arranged when she was discharged, but then they decided she would go into home.”

Key messages

Progress on developing integrated falls services was limited, with just two of the 10 communities that were inspected having a service in place.

Of the remaining eight communities, three did not have a strategy to develop an integrated service around falls and one

community had a strategy but no falls coordinator.

Lack of a strategy, or of clear lines of accountability, mean that the development of an integrated falls service was not given a high enough priority.

This section reviews services provided to older people who have had a fall or are at risk of having a fall. A fall in later life can result in a broken hip. There is a risk that without proper care and treatment this could lead to poor mobility, a lack of self confidence and social isolation. There is an national service framework (NSF) standard on falls but this section looks more widely at falls services across all of the NSF standards and cross cutting themes.

There were inconsistencies in the management and review of services around falls. For example, there was an expectation that protocols for dealing with falls to be used by all partners should be developed. Where communities had developed such protocols these were not routinely reviewed to check whether they were used by all partners or to measure the impact of their use.

The NSF states that NHS organisations, working in partnership with local authorities, should take action to prevent falls and reduce the resulting fractures or other injuries in older people. Older people who have fallen should receive effective treatment and rehabilitation and, with their carers, receive advice on prevention through a specialist service. Milestones to be achieved included an audit of procedures; putting in place risk management procedures by all local healthcare providers (health, social services and the independent sector), inclusion in relevant local plans of the development of an integrated service around falls, and the establishment of an integrated service by April 2005.

Components of an integrated falls service – Department of Health

1. Agreeing and implementing local priorities to reduce the incidence and risk of falls.
2. Ensuring appropriate initial assessment and response (for example to an emergency department or through intermediate care services, where the need for hospital assessment is not required) to those who have fallen.
3. Having a multidisciplinary falls team, so that people with recurrent falls, or one fall with serious consequences, have access to specialist assessment to identify and reduce risk factors for further falls and manage the consequences of the fall.
4. Having an osteoporosis service, and in particular diagnostic scanning, to reduce the risk of osteoporotic fracture and long term impact of falls.
5. Having rehabilitation services for those who have lost functional ability or confidence after a fall.

An Audit Commission review of progress against the *NHS plan* in 2003 found that only 4% of trusts had achieved the target to establish an integrated service around falls. While 62% of trusts were rated as 'at low risk of failure', 34% of trusts were rated as 'at high risk of failure'.

Many of the inspections found a lack of investment in services to address falls with little commitment beyond the introduction of 'sloppy slippers' programmes (projects to replace ill fitting slippers with ones that fit properly to help reduce the number of falls). Examples of good practice did exist, but, where these were identified, they were generally developed in isolation rather than through a coordinated strategic approach, leading in many cases to uneven provision of services across a community. Some of the communities that were inspected were exploring ways to ensure prevention is

prioritised in future. For example Buckinghamshire's community plan for 2006-2008 will include at least two targets around prevention, trips and falls, and safety in the home which will be cross cutting themes across the local authority. The role of local authorities in making sure that pavements and public areas are safe, and in offering opportunities for exercise to improve strength and balance was not recognised as part of a whole system approach to the prevention of falls.

While there was a drop in the number of older people admitted to hospital for fractured neck of femur (broken hip) between 1999/2000 and 2000/2001, the number between then and 2003/2004 steadily increased. Overall, there had been an increase of 4.1% between 1999/2000 and 2003/2004. This indicates that programmes for preventing falls have not yet had any effect on reducing admissions to hospital for a broken hip.

Rates of mortality for falls were higher in the most deprived areas compared to more affluent ones. This means that when older people were admitted to hospital following a fall, those in deprived areas did not recover as well as those in more affluent areas.

A common theme was the failure of communities to use data to inform the commissioning and provision of services addressing falls. Some communities simply did not collect data, for example on the needs of, expenditure on, or outcomes for older people who had fallen or were at risk of a fall. Others collected the data but it was not good enough to be relied on, or, where it was of good quality it was not used. However, ambulance services collected a wealth of information that could and should be used by partner organisations to help target resources. For example information collected by the ambulance service on where and how people fall could be used to target action on falls prevention such as medical assessment for undiagnosed conditions, pavement repair, improved lighting in public places or fitting a stair rail in a person's house. Analysis of data held by the ambulance service had started in one inspected community, and this had exposed increasing levels of need that the falls team was, at that time, insufficiently resourced.

Mental health



“The nurses said they weren’t qualified to deal with that kind of patient (older people with mental health problems). But it seemed to be as if most of the patients were that ‘kind’.”

Key messages

Most inspected communities were struggling to deliver a full range of integrated, good quality services to older people with mental health needs.

There was a lack of out of hours and crisis management services for older people.

There was poor care on general hospital wards (when admitted for physical illness or injury) as staff do not have the skills

and experience to care for older people with mental health needs.

There were inadequate intermediate care services for older people with mental health needs who require rehabilitation following physical illness or injury.

There was little evidence that services are being developed to promote good mental health, for example tackling loneliness and social isolation.

This section is about services for older people with mental health needs. There is a standard in the national service framework about meeting the needs of this group. However, during the inspections we used mental health as a lens through which to assess all services used by older people with mental health needs and their experiences of these services. This section reports on the findings from these inspections.

The national service framework states that older people who have mental health needs should have access to integrated mental health services, provided by the NHS and local authorities, to ensure effective diagnosis, treatment and support for them and their carers. The inspections found that there was limited progress in providing an integrated service to older people with mental health needs. Only four of the communities that were inspected had integrated community mental health teams for older people.

There was often no shared vision across health and local authorities for older people with mental health needs, leading to inadequate joint commissioning arrangements and a poor range of services. Some areas had developed a strong strategic vision and integrated plans, but lack of resources made it difficult to turn the vision into reality as many mental health services for older people were reported to be chronically under funded. Out-of-hours and crisis management services were particularly affected, with older people experiencing variable levels of provision. These services were generally less well developed than those available to working age adults.

There was wide variation in the ways in which mental health services were provided, even within areas, with many different organisations involved. These arrangements were often based on historic structures and were characterised by poorly developed links between the various service providers, leading to fragmentation and a piecemeal approach to

service planning and delivery. The goal of a person centred approach, with services designed around the older person, has still not been reached for older people with mental health needs.

Dementia and depression

Dementia affects more than 750,000 people in the UK – one person in 20 over the age of 65 and one person in five over the age of 80. Similarly, it is estimated that at any one time 10-15% of the population aged over 65 suffer from undiagnosed and untreated depression, with all the distress and impact on quality of life and physical health that this brings (Moriarty 1999)²³. The inspections found that while there was local agreement to the use of protocols for treatment of dementia and depression, use of these was not always consistent. Older people in most communities expressed concerns about the care and treatment that older people with dementia received when admitted to hospital for a physical illness. Staff on acute wards were frequently incapable of managing the needs of this particular group, having inadequate

understanding of the condition, or of the disorientation caused by strange environments and multiple moves.

People were not receiving adequate or sensitive help with eating and, as a result meals were being taken away uneaten. This has serious implications for nutrition, which is known to be a significant factor in the process of physical recovery. However, in Buckinghamshire this training need had been recognised and a new programme for staff had been implemented.

Intermediate care

The inspections found inadequate or no intermediate care services for people with mental health needs, particularly dementia. This means that people miss out on rehabilitation and the chance to return home. It has been estimated that three quarters of older people in care homes are affected by dementia. Many of them might have benefited from programmes of rehabilitation tailored to their needs, had these services been available. An evaluation of intermediate care

Buckinghamshire – South Bucks Dementia Project

Winner of the Queen Mother's Award for Health and Social Care, this project provides tailored services, which enable older people with dementia to remain, and be cared for, at home. This has provided continuity of care and environment for older people and reduced the need for hospital admission.

The project has grown steadily since its inception in 2003, taking nearly 100 referrals in the year to April 2005.

Health and social care teams work effectively together, providing a valuable service for people with dementia and their carers.

for older people carried out by Leeds University in 2005 also found that older people with mental health needs were being excluded from intermediate care. Models of intermediate care for people with cognitive problems should be developed to help them benefit from rehabilitation.

There were some examples of good practice in which the mental health needs of older people were being addressed in a sensitive and coherent manner.

For carers of older people with mental health needs the lack of community services, particularly crisis response, patchy access to appropriate respite or short break care and poor integration with other parts of the health and social care systems, sometimes led to pressure and strain. In Medway, the older person's partnership addressed this issue by using reimbursement funding to provide support services for carers of people with dementia – a good example of the creative use of resources.

In two of the communities that were inspected, Leicester and Buckinghamshire, inspectors found examples where specialist home care services provided support tailored to older people with mental health needs and their carers.

Carers of people with mental health problems reported that information and advice were often available in non-stigmatising ways from the voluntary and community sectors, and also from some skilled professionals. Some carers described receiving good quality statutory services that made a real difference in unfamiliar and worrying situations.

Activities and opportunities aimed specifically at maintaining mental health for older people are under developed. Many of the activities aimed at promoting general health and wellbeing, contribute towards good mental health. However, the inspections found little evidence that communities were developing systematic ways of tackling loneliness and social exclusion among older people in order to promote good mental health.

Living well in later life



“Crossing the road helped to bring back my confidence; the more you get out the better.”

Key messages

In almost all communities, a range of activities were available, but not as part of an explicit, coordinated approach to promoting the wellbeing of older people.

Strategies on wellbeing were at an early stage, although there were signs of a growing interest in this area, including from local strategic partnerships.

Older people emphasised the importance of contributing to the community, either formally, through a range of groups and activities, or informally, through helping friends, family and neighbours.

In almost all the inspected communities, except for a small number of inner city areas, older people highlighted transport as the key obstacle to their independence and wellbeing. However, only a few inspected

communities were able to show that they were taking coordinated action to tackle this.

Community safety and fear of crime were also key concerns for older people, and some innovative local initiatives have been developed. However, only a few inspected communities were addressing the concerns of older people, or involving older people in discussions on this issue.

Exercise classes and other opportunities for healthy living were widely available and valued by older people, as was the library service.

For frailer older people, services are continuing to shift towards providing a greater proportion of care at home, so that older people can continue to live independent lives.

This section covers the spectrum of services and opportunities that contribute towards the wellbeing and independence of older people as well as the extent to which partner organisations are working to draw these together into coordinated strategies to improve wellbeing. It touches on the contribution made by the services that all groups are likely to use to some extent, such as public transport, as well as the wide range of initiatives in areas such as leisure and learning, that aim specifically to improve the health and wellbeing of older people. It also focuses on the support and care services that aim to help older people, who are frail, to live as independently as possible in the community.

A minority of communities, usually led by the local authority, are developing strategies for older people that focus on citizenship and inclusion and incorporate the wide range of services and issues that make a difference to the lives of older people. This growing trend is in line with national policy, as well as with the views of older people. However these strategies were at an early stage of development, so it was too soon to comment on their impact on older people.

There was increasing interest from local strategic partnerships, the large partnership bodies led by the local authority, that bring together a wide range of partner agencies to

agree and implement priorities for the local area. One local strategic partnership was focusing on the prevention of falls, ensuring that older people have adequate heating in their homes and access to libraries. Another required all its subgroups, which look at issues such as crime or the environment, to consider systematically how their decisions affect older people.

Only a small minority of the communities that were inspected had explicit priorities for older people included in the community strategy, the overarching partnership strategy produced by the local strategic partnership. These tended to relate to social care targets, rather than to the aspirations of older people. In county areas, there is evidence of district councils becoming more involved with PCT partners, in promoting the health and wellbeing of older people.

The findings from the inspections are confirmed by early messages from the first pilots of the Audit Commission's new approach to comprehensive performance assessment (CPA) – the inspection process that assesses the performance of councils. From 2005, the comprehensive programme approach includes an element on the wellbeing of older people, and the pilots found that the understanding of councils and activities in this area were variable. Of the three pilot councils, one had recently published a strategy for older people that was based on the priorities of older people, one was carrying out preliminary work and the third had not yet started to consider the needs and aspirations of older people except in the context of care services.

Making a contribution

Many older people were actively involved in their local community. Older people highlighted the important role that they play in managing and delivering services and activities. For example, a social centre in one of the inspected communities was run in part by older people from the Indian community who had taken over premises from the local authority. Inspectors also met with a relatively newly established African group for older people that was working on a self help basis, with local authority support.

“I am the DIY man [in my block of flats] for example if there's [someone] who can't change the light bulb I do it for them.”

Older people said that spending time with others is an important part of maintaining an active life. The role of groups was particularly valued by those who had special needs in terms of language or disabilities, but also because they were often isolated, such as Vietnamese older people or older Africans, people who had been deaf since their youth, people who had a visual impairment and older gay men and lesbians. Such support and self help groups help to promote the wellbeing of older people. For example, a social group of south Asian women took its members on outings locally, to the seaside and on holidays abroad. A member said: “We get fresh air, a chance to get out of the house and our minds become fresh.”

Although not everyone was interested in becoming involved formally with local groups and organisations, many helped family members, friends and neighbours through informal arrangements, emphasising the importance of interdependence.

“I looked after my mother who had Alzheimer’s for 15 years and she died four years ago...That is why I joined the Alzheimer’s Society. I always feel I’m putting back what help I got with my mother.”

Transport

Older people suffer disproportionately from a lack of access to transport and older people are less likely than others to have a car. Transport therefore plays a crucial role in the lives of older people and they repeatedly stressed its importance. In rural areas poor bus services made it difficult for them to lead full social lives or to travel to health services, so isolation was an issue in some rural communities.

Problems with public transport were not confined to the countryside, however, as older people in some cities, towns and suburbs all mentioned this as an important issue. Criticisms included limited services, particularly in the evenings, buses that were

unsuitable for older people with mobility difficulties, and slow, indirect routes. In London, the free travel pass, the Freedom Pass, was much appreciated by older people, and viewed with envy by older people in other areas. In Liverpool, too, older people spoke positively of the local concessionary travel arrangements. Most transport strategies, however, failed to take the needs and aspirations of older people explicitly into account and did not involve older people in planning transport services.

Crime and community safety

Most inspected communities were taking action to address crime against older people. In some cases this was as part of a general initiative that benefited the whole community, such as ‘alley-gating’ (installing security gates on the alleys behind terraced housing in order to reduce burglary and other crimes). In others, developments targeted older people specifically, such as initiatives to tackle distraction burglary or rogue traders. These were often delivered in partnership with trading standards departments.

Some community safety partnerships included representatives from local older people’s groups to ensure that older people had a voice in discussions on community safety priorities. In other areas, however, the particular impact of fear of crime on the lives of older people was not well recognised.

The surveys of older people in the inspected communities found that older people had concerns about their personal safety,

especially in the evenings. This affects their quality of life and wellbeing. Older people reported their experiences of feeling unsafe, being subject to crime and a lack of personal security, both within their homes and in public spaces. Some of these reflected feelings that the areas where they lived were undergoing change, as long established communities became more fragmented, and that local policing was inadequate. However, the survey showed that the confidence of older people in going out alone in their area varied considerably across the inspected communities. In one rural county, 82% of older people felt safe, while in an inner city area, this was only true for 55% of the older people surveyed.

There were some more positive reports of older people benefiting from initiatives to tackle crime and fear of crime, such as providing transport from evening entertainment, and the installation of locks and security devices. An example of this is given below.

The Wiltshire 'Bobby Van'

The Wiltshire Bobby Van Trust is a registered charity comprising vans with drivers, which operates across the county and carries out repairs to the doors and windows of older people who have been victims of crime. The drivers are trained in victim support and crime prevention. The Bobby Van was the first project of its kind in the country and its impact has been significant, as there have been no repeat burglaries in the properties visited by the project.

Regeneration and housing

A number of inspections took place in areas where there had been major investment in regeneration, and also in areas where there was much expansion, new build and growth. In communities where major regeneration initiatives were underway, there did not appear to be a good understanding of the specific concerns of older people, nor any systematic way of giving older people a voice in discussions about regeneration. In Medway, however, the council was encouraging private developers to market new apartments to local people over 50, as well as to younger people, to create a balanced community in which people of all ages felt welcome.

In most of the communities inspected there were strong links between services for older people and the Supporting people programme, the initiative that aims to improve and develop housing related support to vulnerable groups. Although resources were an issue, there was an aspiration to use Supporting people as a way of developing more innovative ways of helping older people to remain in their own homes. The Supporting people inspections, which are being carried out by CSCI and the Audit Commission, found that Supporting people had stimulated many communities to review the focus and purpose of sheltered housing, in order to maximise the benefits to older people.

Most communities were commissioning extra care sheltered housing (housing that provides care services on site) but this was not always integrated within a wider vision for health and social care services.

Healthy living

In all the inspected communities there were usually many initiatives aimed at healthy living for older people. Older people valued these, but they rarely added up to a shared strategic approach to the wellbeing of older people. Although many excellent initiatives were in place that older people valued, services were not consistent and access was patchy.

Leisure, lifelong learning and library services were all providing services tailored to people over 50, ranging from exercise classes and walking groups to training in computer skills. Provision was often fragmented and disconnected from health and social care services. There was no overview of all the opportunities and services that existed, potentially leading to duplication or gaps in provision. In addition, older people rarely received information on the whole range of services, including leisure or learning opportunities that could make a real difference to their lives. Local strategic partnerships were beginning to address the need for overarching strategies, with specific reference in some to the needs of older people.

Some leisure facilities were only open at restricted times for older people who used concessionary rates. The survey carried out by King's College London as part of the inspection process, showed that only a minority of respondents felt that their local leisure services were attractive to older people, ranging from 24% to 31% across the communities surveyed.

Some inspected communities were also creating opportunities for older people and young people to work together on intergenerational projects using arts, reminiscence or other methods to strengthen understanding and respect between the generations.

The surveys of older people showed that libraries were well used as a source of information by older people. In some areas libraries provided a tailored service for people with disabilities. For example the library service was reported as very good for people with a visual impairment. In some communities a talking books service was available and highly valued. Older people also appreciated being able to renew books from home.

Although many older people participated in learning opportunities, the survey showed that only between 20% and 28% of older people saw these as relevant to them.

All of the communities that were inspected could demonstrate an increase in the numbers of people over 60 who had stopped smoking. This is in keeping with national trends as Department of Health statistics on NHS Stop smoking services show that the number of people 60 years and over setting a quit date increased by 113.8% between 2001 and 2005. Of those who set a quit date and were successful there is also an increase of 5% between 2001 and 2005.

A minority of the inspected communities were able to show that they were maintaining or monitoring blood pressure levels in people at risk of heart attack or stroke.

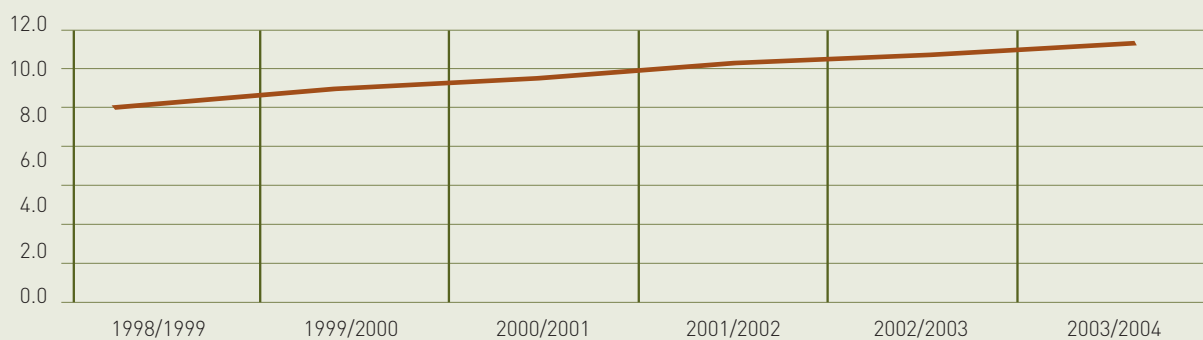
Living well in later life continued

There has been a small increase in the percentage of people aged 65 and over who have been vaccinated against flu. There is a gap between the percentage of older people vaccinated against flu in the most deprived areas (69.8%) and in the least deprived (72.2%) (figures for 2003-2004 taken from Compass screening database).

Living independently

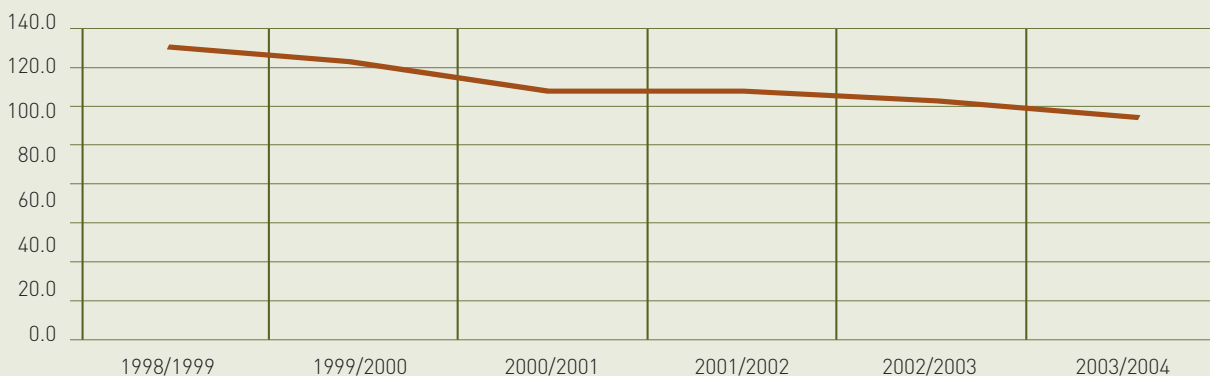
Care services in the communities that were inspected were continuing to move towards supporting frailer older people to live independently at home. There was also a reduction in the number of people admitted to care homes. This matches the national picture – see figures 4 and 5.

Figure 4 – Households receiving intensive home care per 1,000 population aged 65 and over



Source: Department of Health performance and assessment framework (PAF) data 2005

Figure 5 – Supported admissions of older people to residential and nursing care per 10,000 population aged 65 and over



Source: Department of Health performance and assessment framework (PAF) data 2005

In all the inspected communities, partner organisations were working together to increase the number of older people supported at home. A range of services and initiatives were in place to contribute towards this. In one area, an intermediate care service had successfully helped older people to move back to living independently even after they had spent some time in residential care. There was warm praise from older people for services that aimed to help them to live independent lives. In particular, intermediate care services were valued highly.

“We are happy and proud to live here.”

While many communities and partner agencies were clearly finding it difficult to refocus services towards independence and wellbeing, others had made significant progress in this direction. Merseyside Fire and Rescue Service had worked proactively to reach out to older people and to bring in other support from partner agencies, if required. Their approach goes beyond a narrow focus on fire safety to look at the range of issues affecting older people’s independence and wellbeing. The work by the service was also underpinned by recognition of the contribution older people make to improving safety in the home.

An example of illustrative practice by Merseyside Fire and Rescue Services is given at the end of the next chapter.

Leading organisations through change



“A nurse comes every fortnight to take blood samples from my mother. My father, who needs the same, because he is more mobile, he has to go to the hospital. Why can't the nurse do both?”

Key messages

In some inspected communities a shared vision was starting to emerge in partner organisations, based on the priorities of older people, but in most cases this was not translated into explicit strategies, action plans or commissioning decisions.

Leadership of the older people's agenda was noticeably stronger in local authorities than in the NHS.

Many partnership bodies were in a state of flux and governance and accountability were often unclear.

Good partnerships at a strategic level were rarely accompanied by equally good partnerships between frontline staff (or vice versa).

Joint commissioning was under developed in all inspected communities. While some services were commissioned jointly, these did not form part of a joint commissioning strategy.

None of the inspected communities had a shared system across partner agencies to monitor progress and impact.

Pooled budgets, which would allow creative use of shared resources, were under used, and there was limited evidence that resources were being used effectively to lever change, particularly in the NHS.

None of the inspected communities had a joint workforce development strategy and, although there were some innovative initiatives, these did not form part of a wider shared approach to workforce issues.

This section looks at the ways in which partner organisations were working together to improve services for older people. It sets out the extent to which partner agencies had clear shared goals and describes the structures and processes that they used to achieve these. It examines how successful communities have been in offering a balanced range of services and opportunities for older people. The section also looks at the factors that help change occur across a whole system, including having a shared way of monitoring progress, systems to check that money is used wisely and for making good use of information across agency boundaries, and

high calibre, well trained staff to deliver services to older people.

Very few of the communities that were inspected had attempted to work together with older people to agree what they wanted to achieve with and for them. A shared vision for older people that brought together all the many issues contributing to the wellbeing of older people (as distinct from a vision for health and social care services alone) was just starting to emerge in some of the inspected communities. There was evidence of a shift in perspective on older people in some local authorities, generally at a very senior level,

although this was not always reflected lower down the organisation, or within partner agencies, particularly the NHS. There was therefore no shared sense of direction or overarching goal for the work of partner agencies that guided how resources were used or priorities decided.

Only one of the 10 communities that were inspected was about to produce a shared strategy on older people. This had been developed through the local strategic partnership and was being consulted on at the time of the inspection.

“Money has gone into the hospitals, but no money has gone into the basic services, where it’s badly needed.”

The lack of a shared direction across partner agencies had implications in a number of areas. For example, the experiences of older people were that the services were confusing and incoherent. Those who planned services were not clear what they were trying to achieve. The example in figure 6 illustrates how one London borough, with its partners and with older people, is setting the direction for older people in their local area. This includes a focus on health and social care services, but in the context of a much broader approach that emphasises wellbeing and social inclusion.

The inspections highlighted a discrepancy in the strength and effectiveness of leadership

on the issues of older people between local authorities and the NHS. Within local authorities, there was a growing commitment, both from senior officers and from elected members, to improving the wellbeing of older people, and within this, to improving care services. All could demonstrate that services had shifted significantly in recent years, with more older people able to remain at home, and less use of residential care. At a senior level in local authorities and among elected members there was a growing understanding of the local authority’s community leadership role in working with its partners, to build communities in which it is possible to age well, and in some areas, strategies were under development that reflected this new thinking.

Within the NHS, however, the picture was less positive. The inspections highlighted examples of poor treatment of some older people in hospitals, of unequal access to some services and of variable involvement of older people in service planning, and these suggest that older people are not seen as a high priority by some NHS staff. Similarly, the narrow focus on meeting NHS targets on waiting times and reducing delayed discharges from hospital, sometimes at the expense of delivering good services to other older people, showed a limited understanding of the connections between the two. People aged 65 and over use two thirds of general and acute hospital beds. As the main users of hospital services it makes sense to improve the quality of service provided to older people as this will in turn help NHS trusts to achieve other NHS targets, including waiting times. Partnership working between local authorities and the NHS is likely to remain difficult until both partners

Figure 6 – Key objectives of ageing well in Lewisham

Valuing older people

Recognise the value of the input that older people make to the life of Lewisham by integrating older people into mainstream activities, including decision-making.

Finance

Enhance the financial security of all older people to enable them to play a full part in the life of Lewisham by improving information on benefits, concessions and other financial services, and enabling them to remain economically active for as long as they wish.

Health

Keep people as independent as possible for as long as possible by improving preventive services, and in the event of failing health, to provide high quality acute health and support services with choice and flexibility.

A safe environment

Enhance the feeling of safety and security both within the home and outside by providing accessible and affordable housing, accessible and safe transport systems and a safe environment.

Lifelong learning

Ensure that older people have full access to learning opportunities and information and that they are encouraged to play a full role in the learning of others, giving of their skills, experience and knowledge.

Relationships

Encourage intergenerational working as widely as possible; challenge age discrimination and promote a positive image of older people.

recognise the importance of improving services for older people, and acknowledge the benefits this will bring to the NHS and to the local authority, as well as to older people. In some of the inspected communities, the structures and groups in place to develop partnership working were in transition. Local implementation teams that had been set up to oversee the implementation of the NSF were changing their focus, for example by taking on a commissioning role. The changes affecting services for children were also having

an impact on the approach for older people, with some communities setting up or exploring the possibility of establishing partnership boards for older people. These were typically subgroups of the local strategic partnership, and operated in parallel with the recently established partnership boards for children.

The extent to which the independent sector was involved in planning services for the future was variable, and in a number of inspected communities these organisations

Leading organisations through change continued

said they wanted a stronger voice in partnership working.

The complexity of partnerships was an issue in some areas, particularly in large county areas where there were also district councils. There was sometimes confusion about the decisions that were taken at a local or a countywide level, as the various groups and structures did not clearly connect with each other.

Strong partnership working at a strategic, whole system level was not always mirrored by effective partnerships in the way that services were delivered. Partnerships were described as strong at both strategic and operational levels in only one community that we inspected, Redcar and Cleveland.

The variability of partnership arrangements for older people reflects findings from the Audit Commission that blurred lines of accountability within partnerships can lead to poor value for money.

The lack of a strong sense of direction affected the ability of inspected communities to take strategic commissioning decisions together in order to achieve shared goals. Joint commissioning was not well developed in any of the communities that were inspected and there was little evidence of partner agencies working together in a planned way to refocus services over time, using commissioning as a tool for change. In most cases there were examples of joint commissioning of individual services or initiatives taking place between social services and PCTs. However, this was rarely in the context of a shared commissioning strategy

for older people, although a number of communities were working on these at the time of the inspections.

In addition, the fragmented and inconsistent picture of services that emerged from the inspections indicated that learning and good practice were not being spread, nor data shared in order to target resources effectively.

This picture is reinforced by the findings of the 2004/2005 inspections of services for older people that were carried out by CSCI. They found that, of the 18 social services departments inspected during the year, only three had joint commissioning strategies with the NHS and only one had fully integrated its commissioning with the PCT.

Development of joint commissioning will need to include the Best value principles of challenge, comparison, consultation and competition, together with that of contestability – the notion of competitive provision, with the possibility of services being switched from provider to provider, and failing providers exiting the market – thus using competition to widen choice and improve performance and quality of services for older people.

Voluntary organisations commented on difficulties caused by short term funding for the services they provided, and late notification of funding decisions. This made planning and staffing of services difficult to sustain.

The Department of Health's white paper *Our health, our care, our say* sets out plans for a new joint commissioning framework for health and social services supported by an

alignment of the planning and budgeting cycle for the NHS with local government planning and budget setting. The recent guidance from the Government on commissioning a patient led NHS will provide new opportunities opening up the market of health and social care to a wider range of providers including the independent sector.

None of the inspected communities had developed measures jointly to gauge performance and the impact of the various services within their local communities. Cost and quality information was not being used systematically to shape services. Individual organisations had their own performance management and quality assurance frameworks, but without whole systems frameworks it is difficult to know whether services are:

- achieving their aims and predicted outcomes for older people
- being provided in the right quantity
- having a negative or positive impact on other services

It is also impossible, without information from across the system, to identify gaps in the provision of services, or to regularly measure outcomes across health and social care, and to use that data to inform future planning. There were some examples of work that had the potential to act as a platform for further development. Local area agreements were seen as a way of building a better understanding of the performance of whole systems performance in a number of communities, and in one, partners were about to agree shared performance indicators for older people's

services. In another, extensive use had been made of pooled budgets. All initiatives funded in this way were jointly performance managed across the NHS and the council.

There was some use of financial flexibilities such as the pooling of resources across the NHS and local authorities, made possible by section 31 of the Health Act 1999, which introduced a number of new partnership arrangements. About half of the inspection sites were using the opportunities provided for pooled budgets, most commonly for integrated community equipment services. There was little evidence that partner organisations were starting to align budgeting processes.

Local authorities had developed processes for ensuring they obtain value for money, as part of the Best value programme, but these processes were not seen in health services. There were no systems in place in the NHS to monitor spending by age across different services. This meant that it was not possible to identify how much was spent on older people across the NHS, and therefore to measure impact of investment on outcomes. It was also difficult to build a complete picture of investment in older people across the whole community and thus to take an overall view of how resources needed to shift in order to achieve service change. Local area agreements may help to provide this picture.

The inspections highlighted a number of factors that made whole system working more difficult. These are common themes that do not appear to have shifted significantly in recent years:

- financial pressures

Leading organisations through change continued

- lack of clear decision-making in partnerships
- incompatible IT systems
- organisational change
- different NHS and local authority boundaries
- different priorities for partners, particularly the emphasis by the NHS on meeting targets for waiting times
- little sharing of knowledge on what works well

Workforce issues

None of the communities that were inspected had a joint workforce development strategy; workforce planning was fragmented and opportunities for joint training, building capacity and the development of new ways of working, such as generic health and social care workers, were not being used widely. A few of

the communities inspected were developing the generic health and social care assistant role, but this was not widespread.

Some organisations were experiencing significant recruitment difficulties, particularly for home care and therapy staff, and these inevitably affected their ability to provide services of sufficient quality and quantity. The lack of a joint approach contributed to these problems. Individual agencies that target the same pool of staff wastes resources and sets up unnecessary and undesirable competition. In some instances poor terms and conditions and differential pay scales deepened the problems. Workforce planning developed on a single agency basis has an impact on other agencies across the whole system and is unhelpful

Older people highlighted the inadequate skills of some home care workers, with people commenting that many home carers did not know what the work demanded. Young care workers, in particular, were mentioned; there

Tackling recruitment and retention of key staff in Cambridgeshire

The National Skills Council, in partnership with the Open University and UNISON, developed a work-based foundation degree to help develop a health and social care generic workforce. This work area, with low pay and poorly developed training structures, often attracts people with few academic skills. To incentivise the scheme, entrants are taught literacy and numeracy skills – known to be relatively low in East Anglia. The normal national vocational qualifications

(NVQs) are available to these staff but allow access only to a nursing qualification, not to the specialist professions such as occupational therapy. This programme allows progression to a foundation degree after basic NVQ, and then into qualifications such as occupational therapy, physiotherapy and social work, or even to specialise in conditions such as diabetes and coronary heart disease. Seventy people went through the project in its first year.

is high turnover, they do not know what is expected of them and are ill equipped to cope with the demands and pressures of the job. Often, workers were not paid to attend training sessions.

The approach of Merseyside Fire and Rescue Service goes beyond a narrow focus on fire safety to look at the range of issues that affect the independence and wellbeing of older people. These services are also underpinned by the recognition of the contribution of older people to improving safety in the home.

Merseyside Fire and Rescue Service

“The knock-on effects of this work have been huge – the message is now that it’s about meeting the needs of older people, it’s not just about fitting smoke alarms.”

Background

In Merseyside, a high percentage of fire deaths were among older people. It was clear that older people would need special attention to reduce deaths and that fire fighters did not have the right skills or networks to carry out this work. The service has developed innovative ways of reaching out to older people in Merseyside. Fire safety has become one of a range of services in Merseyside that can help older people live independently and safely.

Advocates for older people

In 2003, the fire service appointed a team of specialist advocates to raise the profile of fire safety in the community and to work with people at highest risk. Five of the advocates work with older people and people over 60 were encouraged to apply for the posts. Advocates have been successful in building new partnerships with councils, the NHS, the pensions service and older people’s organisations. They offer fire safety advice to older people in various settings – in the local hospital, for example, as part of discharge support, and in outpatient departments. They visit sheltered housing and social clubs, emphasising the important contribution older people themselves can make by spreading the message to friends and neighbours. Reaching older people who may not be in touch with any services is a priority.

Fire support network

In 2000, the fire support network was established in Merseyside. A voluntary organisation, and supported by £570,000 in

funding from the Home Office’s active communities unit, it supports the work of the fire service, including generating fire safety checks in 8,000 homes each year. Around 85% of the 150 volunteers are older people. One initiative in which older volunteers have been particularly active is the After fire care project, in which they help to clean up smoke damage, restore treasured items such as family photos and refer people to other agencies.

Learning points

Establish a ‘can do’ culture which encourages innovation at all levels – change can happen in advance of formal strategies.

See failure as an opportunity to build learning.

Be clear about the purpose of partnerships and the expected outcomes.

Ensure that managers model new ways of working and have a visible role in new developments, to give clear messages to staff about the importance of change.

Base developments on good data, target interventions and track impact.

Recognise skills gaps and be creative about the sort of people who might fill them.

The future

Increase understanding of the impact of fire on physical and mental health, in addition to fire deaths, as a lever for stronger engagement by the NHS.

Fire deaths have fallen from 25 to less than 10 per year. The aim is to reduce this further.

Conclusions



This concluding section summarises the findings of the local community inspections, and highlights three key areas that require further action, without which sustainable improvement in the experiences of older people of public services is unlikely to be achieved. These are:

- Tackling discrimination, ageist attitudes and increased awareness of other diversity issues.
- Ensuring that all of the standards set out in the national service framework (NSF) are met, including those in the *Next steps* report from the Department of Health due to be published in April 2006. More information summarising the progress against the NSF and identifying specific areas for further action is provided at the end of this section.
- Strengthening working in partnership between all the agencies providing services for older people to ensure that agencies work together to improve the experiences of older people that use public services.

This section is followed by recommendations for further action to ensure that services used by older people continue to improve.

Tackling discrimination

Explicit age discrimination has declined since the NSF was published, as a result of NHS trusts auditing policies on access to services and social services reviewing their criteria, eligibility. These are criteria a local authority uses to prioritise who receives social care services.

Access to cardiac procedures and hip and knee replacements have improved since the NSF was published. Between 1999 and 2004 the number of hip replacements carried out on people aged between 65 and 74 increased by 39% and for people aged 75 years and older, it increased by 22%. According to hospital episode statistics from the Department of Health, there has been a general increase in hip and knee replacements for the whole population but the increase is still significant for older people. The exception to this decline in explicit discrimination is mental health services, where the organisational division between mental health services for adults of working age and older people has resulted in the development of an unfair system, as the range of services available differs for each of these groups. For example out-of-hours services for psychiatric advice and crisis management for older people are not as developed as those for adults of working age. Older people who have made the transition between these services when they reached 65 have said that there were noticeable differences in the quality and range of services available.

Despite these changes there is still evidence of ageism among staff across all services. This ranges from patronising and thoughtless treatment from staff, to the failure of some mainstream public services, such as transport, to take the needs and aspirations of older people seriously. Many older people find it difficult to challenge ageist attitudes and their reluctance to complain can often mean that nothing changes.

We found that some older people experienced poor standards of care on general hospital wards, including poorly managed discharge

from hospitals, repeated moves from one ward to another for non-clinical reasons, being cared for in mixed-sex bays or wards and meals being taken away before they could eat them due to a lack of support at meal times. All users of health and social care services need to be treated with dignity and respect. However, some older people can be particularly vulnerable and it is essential that extra attention is given to making sure that care givers treat them with dignity at all times and in all situations. To fail to do this is an infringement of their human rights.

There is a deep rooted cultural attitude to ageing, where older people are often presented as being incapable and dependent particularly in the media. As there is an increasingly ageing population, there is a need for policy makers and those who plan and deliver public services to consider the impact of ageism and to take action to address this.

During our inspections of local communities, we also found that awareness of diversity issues was at an early stage of development, with more work required to ensure that older people from black and minority ethnic groups receive services that are culturally sensitive and responsive to their needs. The high levels of morbidity and mortality from certain diseases and the difficulties of access and appropriate and responsive services have been documented well in relation to black and minority ethnic groups. There is a need to improve information and community engagement and to have detailed information about the needs of the population when planning services. Appropriate steps should be taken to form partnerships with the local black

and minority ethnic groups that represent older people to ensure that this group of older people is fully engaged in the planning and development of services. Organisations which commission or provide care and social services should take account of diversity in all they do and take account of cultural and religious needs, and embed this understanding into mainstream services for older people.

Sadly, there are occasions when older people experience abuse and neglect by the people who are supposed to be caring for them. It is important that this risk is minimised. This can be done by health and social care staff being aware of how and when abuse and neglect could occur and by taking action if it is identified. We found that the arrangements for safeguarding older people operated effectively in most areas with multi-agency policy and procedures. However, there is still room for improvement. It is vital that health and social care organisations continue to address this to ensure that opportunities for abuse and neglect are minimised, and when they are detected, they are acted on.

Meeting the standards set out in the national service framework

The National Service Framework for Older People, and the developments in policy that followed followed, have placed an unprecedented focus on services used by older people. The inspections found a great deal of activity to improve the experiences of older people of public services. Staff in

Conclusions continued

partner organisations were working together to establish new initiatives and new ways of working to do this. There has been progress in a number of areas.

Explicit age discrimination in access to services has been addressed by most health and social care services. All of the communities inspected as part of this review had made a significant effort to ensure that policies and eligibility criteria did not discriminate against older people. The Audit Commission's review on national progress against the *NHS plan* found that 76% of NHS trusts had reviewed their criteria for eligibility to services as required by the NSF.

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 have had a stroke 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. The National sentinel stroke audit carried out by the Royal College of Physicians in 2004, published March 2005, showed that 82% of hospitals in England have such a unit and more people were treated in these units for part of their hospital stay than in the previous year.

The number of older people who have had flu vaccinations has increased. There has been a 2% increase in people over 65 being vaccinated against flu between 2002 and 2004.

The number of older people who have stopped smoking has increased. All of the communities inspected could demonstrate an

increase in the number of people over 60 who had stopped smoking. This is in keeping with national trends which show the number of people aged 60 and over who set a date to stop smoking increased by 113.8% between 2001 and 2005, and of those who set a quit date and were successful, there was an increase of 5% for the same period.

More people are being supported to live at home. Health and social care services were continuing to move towards supporting older people who are frailer to live at home independently. There was also a reduction in the number of older people admitted to care homes. This matches the national picture which shows that the number of households receiving intensive home care, per 1,000 of the population aged 65 and over, has steadily increased from eight to 11 between 1998 and 2004 (Department of Health Performance Assessment Framework data 2005).

All of the communities inspected could demonstrate a reduction in delayed discharges from hospital over the past two years. The Department of Health's statistics show that there has been a 67% reduction in delayed transfers of care from 5,396 in 2001 to just 1,804 in 2005.

There is a growing interest in the wider wellbeing of older people, with services such as leisure and culture playing an increasingly important role, and strategic partnerships spearheading some innovative partnership developments.

The National Service Framework for Older People has led to some positive achievements

but there is further work to do to meet the standards set out in the NSF. The key issues in need of further action identified as a result of this review are detailed below:

- The full implementation of the single assessment process across health and local authority partners.
- Older people should have a copy of their assessment and personalised care plan. A change in culture is required, moving away from services being service-led to being person-centred, so that older people have a central role, not only in designing their care with the combination and type of service that most suits them, but also in planning the range of services that are available to all older people.
- All aspects of mental health services for older people need to improve including person-centred care, age equality in the range of services available, treating people with dignity and respect, holistic care in mainstream services and a whole systems approach to the commissioning of integrated mental health services for older people.
- Integrated falls services are at an early stage of development and more work is needed for them to progress including the five components of an integrated falls service as set out by the Department of Health.
- The management of medicines needs to be addressed, as many older people receiving more than four medications are still not receiving a review every six months.

NHS trusts and local authorities need to work together to ensure that they are reviewing their progress against the NSF as part of a framework for managing performance.

Supportive and palliative care, underpinned by services that are person-centred, promote physical, psychological and spiritual wellbeing. The NSF outlines personal and professional behaviours which are considered particularly important to end of life care. Services that are needed to promote dignified and effective end of life care are complex, requiring good coordination between organisations. They must appear seamless to users and carers, be easy to access and be totally reliable. We found that the provision of services for people at the end of their life was inconsistent, with integrated systems that were developed well in some areas but showing room for improvement in others. The provision of out-of-hours support was patchy and a lack of practical support may mean some people have to be admitted to hospital or hospice care at the end of their life when they may have preferred to die at home.

Strengthening working in partnership

There are examples of some excellent working in partnership both at a strategic and operational level. However, few of the communities inspected had a shared sense of what they wanted to achieve with and for older people, or how progress would be measured.

This lack of a clear direction resulted in fragmented services that confused older

Conclusions continued

people. The range of services that was available differed significantly between communities, and even within a single community.

Sustainable change cannot take place unless all partner organisations have a shared view of the direction in which they want to move, and how they plan to get there. Earlier research from the Audit Commission has shown that this shared vision has a powerful role to play if it is rooted in the views of older people. When older people are asked about the priorities that would most improve their lives, these often relate to issues beyond health and social care services, such as having a neighbourhood which is safe, access to transport, an adequate income and opportunities to meet with others. Therefore, visions and strategies for older people must reflect these needs.

A lack of shared direction results in a poor use of resources and a commissioning process that does not encourage change. It also results in the provision of an inconsistent and uncoordinated range of services.

There was evidence of some engagement with older people but they were not involved systematically in the design of services, nor were services tailored to their needs and aspirations. Health organisations and local authorities were not always effective in engaging with black and minority ethnic groups, and with older people whose voices are seldom heard.

While we found that some of the communities were implementing the NSF in innovative ways, these were not available consistently to older

people, nor was learning from these initiatives shared or implemented more widely. Only if partner organisations work together to agree a shared vision and to map out a pathway to achieve this, will older people be able to experience services that are well planned and joined up. New initiatives from the Department for Work and Pensions, the Department of Health and the Social Exclusion Unit that aim to test integrated responses to older people and learning from the SureStart initiative for children, will offer useful experience on which to build.

Most of the communities we inspected had a joint workforce development strategy. Workforce planning was fragmented and opportunities for joint training, building capacity and the development of new ways of working, such as generic health and social care workers, were not being used widely. A few of the communities were developing the health and social care assistant role but this was not widespread. Some organisations were experiencing significant difficulties in recruitment. The lack of a joint approach contributed to more problems.

Challenges and recommendations



This section identifies key areas for action by NHS and social care providers and commissioners of services and local authorities. Many of the recommendations require these organisations to work in partnership. We also highlight areas for further work by central Government and regulators. These actions are essential to ensure the continuing improvement of services for older people.

Tackling discrimination

1. While progress has been made by health and local authorities in systematically tackling age discrimination, through audits of policy, and the reviewing of eligibility criteria, there is still evidence of age discrimination and ageist attitudes, which have had an impact on the lives of older people. These include the discrimination older people sometimes experience when receiving care services that fail to treat them with dignity and respect. Managers of NHS trusts, social services and providers of independent health and social care had to ensure that the human rights of older people are upheld at all times.
2. The needs of older people including those from black and minority ethnic groups are not always recognised. NHS trusts, local authorities and providers of independent health and social care need to ensure that all staff receive full and ongoing training on diversity issues, including attitudes to ageing, so that older people are treated with respect. They should respect diversity in all that they do, taking account of cultural and religious needs, and embed this understanding into mainstream services.

3. Progress has been made in establishing adult protection committees with an increased awareness in healthcare organisations and local authorities of the need to safeguard older people. However, there is more to be done. NHS trusts, social services and providers of independent health and social care need to:

- review the operation of adult protection committees
- promote effective working in partnership
- ensure that information is comprehensive,
- ensure that the management of performance is effective
- implement policies and procedures through training through training that are easily accessible

Meeting the standards set out in the national service framework

4. The National Service Framework (NSF) for Older People provides a 10 year programme for the improvement of services for older people. Good progress has been made in some areas. However, a number of the standards have not been met within the timescales of the NSF. NHS trusts and local authorities need to take action to ensure that the standards set out in the NSF for older people are met, including the *Next steps* update due to be published in April 2006 and the Department of Health's *Older people mental health service development* guide.

5. Wherever possible older people are supported to receive end of life care in the place in which they choose to die. However, sometimes a lack of appropriate community services means that they have to be admitted to hospital. There is a need for partner agencies to use the best practice models of end of life care to ensure that older people and their carers receive prompt access to well coordinated and effective care and respect at the end of their lives.

Strengthening working in partnership

6. The effectiveness of partnership arrangements for services for older people is improving. However, partner organisations should ensure that partnerships have robust governance arrangements with clear lines of accountability in line with the Local Government Act 2000.

The Act places a duty on every local authority to prepare a strategy for the community to link all their strategic plans and to manage partnerships through a local strategic partnership. Strategic partnerships working for and with older people should include all the organisations that commission and provide services used by older people, as well as older people themselves. This review has demonstrated the importance of a joined up approach to planning, commissioning and delivering services that takes account of all of the

factors that are important to the health and wellbeing of older people. Older people have an important contribution to make in the shaping of services to ensure that they respond to their needs and aspirations. Providers of independent health and social care are also important partners within the strategic partnership, as they bring innovation and the potential to provide additional resources.

7. There has been some progress in promoting health and wellbeing for older people but this has not been the result of a joint strategy with a coordinated approach across health and local government. NHS trusts, local authorities and providers of independent health and social care need to work together to develop the promotion of good health and wellbeing. The Department of Health's white paper, *Our health, our care, our say*, published in January 2006, has reinforced the role of the director of adult social care working with the director of public health, in undertaking regular joint reviews of local health needs.
8. Partner organisations are working together to develop a shared vision for services for older people. However, organisational change has slowed down progress in taking this forward, partly as a result of the health policy *Shifting the balance of power*, published in 2001, which changed the roles of health authorities and PCTs. There is a need for partner organisations to translate the shared vision into a shared strategy for

Challenges and recommendations continued

services for older people and to use this to inform joint commissioning. This should result in a comprehensive and coordinated range of services to meet the needs of the local population.

9. Partner organisations are engaging with older people. However, there is not a systematic and coordinated approach that makes best use of resources. Partner organisations need to work together to ensure that there is a systematic and coordinated approach to engagement that recognises the diversity of the population being served.
 10. Some partner organisations are working together to tackle recruitment and retention of staff. However many do not and so they are targeting the same small pool of staff and creating unhelpful competition in the employment market. NHS trusts and local authorities need to work together to develop joint workforce strategies to become more effective in recruitment and retention across health and social care services.
1. Following on from *Opportunity age*, the Government needs to develop a cross-Government national programme of work to help shape a more positive culture on attitudes to ageing.
 2. National standards and improvement measures have supported the improvement of the performance management of health and local authorities. However, the performance of individual organisations to achieving national targets sometimes conflict with improving the outcomes for older people across a whole system of care. For example, the requirement for acute hospital trusts to reduce waiting times for elective (planned) surgery has resulted in PCTs commissioning a disproportionate amount of acute hospital services compared to community services that could prevent emergency admissions to hospital. The Department of Health's White paper *Our health, our care, our say* makes a commitment to align how health and local authorities are being assessed on their performance. This should include the development of ways to measure outcomes for older people based on the performance of all partners working together.
 3. Older people would like to see improved access to podiatry and general foot care. Poor foot care can lead to poor mobility and result in both a loss of independence and social isolation. The Department of Health could support improved access to good quality podiatry and general foot care services by requiring PCTs to commission adequate provision of those services.

Further work for central Government

Some of the progress needed to improve services used by older people can only come about through support from central Government, particularly in three areas. These are:

Further work for the Healthcare Commission, the Commission for Social Care Inspection and the Audit Commission

As well as organisations that provide services for older people and central Government, it is also important that the Healthcare Commission, the Commission for Social Care Inspection and the Audit Commission take action to ensure that there is continuous improvement of services for older people and the momentum from this review is continued.

Developing policies and tools at a national level, which will help to support the local implementation of the National Service Framework for Older People, is essential.

The Healthcare Commission, the Commission for Social Care Inspection (CSCI) and the Audit Commission, as the regulatory bodies with responsibilities for assessment across healthcare, social care and local government, will be taking the following actions, in consultation with partner organisations:

1. The Commission for Social Care Inspection will monitor progress against the recommendations in this report through the annual assessment of councils and the inspections of social services for older people.
2. The Audit Commission will monitor progress against the recommendations in this report through the older people's strand of corporate assessment, which is part of the Audit Commission's comprehensive performance assessment of local authorities.
3. As part of the Healthcare Commission's annual assessment of the performance of NHS trusts – the annual health check – the Healthcare Commission will continue to monitor progress against key national targets, for example those relating to supporting older people to live independently at home. The requirement to treat all patients with dignity and respect will be assessed as part of the annual health check against the Department of Health's core standard on patient focus. The requirement to take the views of older people and their carers into account in designing, planning, delivering and improving healthcare services will also be assessed by the Healthcare Commission against the Department of Health's standard on accessible and responsive care, as will access to services.
4. The three commissions will develop improvement activities targeted at issues identified by this review. This includes developing and delivering a joint Commission for Social Care Inspection /Healthcare Commission review of mental health services for older people.
5. Joint indicators will be developed to support improvement in key areas, including those areas where progress has been the slowest. These indicators will form part of the ongoing assessment of health and social care organisations and will be used to look at how services are improving year on year.

Challenges and recommendations continued

The indicators will be developed in line with broader frameworks for assessing performance which are focused on outcomes outlined in *Our health, our care, our say* and will be used to underpin improved partnership working through the development of local area agreements.

6. The Healthcare Commission currently supports a programme of national clinical audits. Audit projects aimed at improving the quality of clinical care and improving outcomes in services for older people will continue to be reflected in this programme – which currently includes audits of services for people who have had a stroke, services for people who have fallen and services for people with incontinence.

Moving forward



This report is presented at a time of continued change for services for older people and a sustained focus on its findings and recommendations will be required for lasting improvement. The Healthcare Commission, CSCI and the Audit Commission are committed to playing a central role in ensuring that the findings of this joint piece of work are taken forward to improve services for older people.

The three commissions have shared the emerging findings of this report with partner organisations including the Department of Health, the Department for Work and Pensions, Better Government for Older People, the Local Government Association and others to ensure that the conclusions of this report are reflected in:

- *Our health, our care, our say – a new direction for community services* Department of Health (January 2006)
- *A SureStart to later Life – ending inequalities for older people*, a Social Exclusion Unit Final Report (January 2006)
- the implementation arrangements for *Opportunity age* and *LinkAge Plus*
- work on the shared priority on older people between national and local government

The joint inspections of services for older people were one of the first collaborative initiatives across a number of regulatory bodies. This review aimed to build a complete picture of all the services across a geographical area and the extent to which these work together as a well coordinated

whole system to improve the lives of local people. This approach is likely to become increasingly important in the future, as regulators build a more sophisticated understanding of the way in which the totality of services combine to make a difference to quality of life. The Healthcare Commission, CSCI and the Audit Commission are committed to ensuring that the learning from the joint inspections helps to shape inspection and that the findings of this review contribute towards improving the lives of older people in the future.

Findings against the standards set out in the national service framework and areas for further action

The National Service Framework (NSF) for Older People was published in 2001. It is a 10 year programme for the improvement of services for older people, with standards and milestones for delivery. At the time of the review (2005), all of the milestones should have been reached. Progress against the milestones set out in the NSF has been assessed as part of this national review of services used by older people. Evidence has been drawn from the 10 local communities that were inspected and from supporting national data, as set out in the body of this report. Specific areas requiring action are mentioned under each standard, based on the findings of this review. However these are not comprehensive and organisations need to assure themselves that they are achieving all of the standards set out in the NSF.

Standard 1 Rooting out age discrimination

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

Healthcare organisations and social services had made significant efforts to ensure that policies and criteria for eligibility do not discriminate against older people. The exception to this was in mental health services for older people where the organisational division between adults of working age and older adults has resulted in an unfair service being provided to older people compared to that for adults of working age. Older people still experienced discrimination through the ageist attitudes of some staff in providing and planning services. There is a need for partner agencies to ensure that ageist attitudes are addressed as a programme of long term change and that mental health services for older people are reviewed to ensure that they are not disadvantaged. They should do this by mapping the provision of specialist health and social services provided to older people with mental health needs.

Health and social care organisations did not always support older people's champions and so are not getting the full benefit from these posts. NHS trusts and social services need to ensure that the local network of older people's champions is fully supported with information, training and communication facilities to enable them to be effective in

ensuring that the needs of older people are met in the planning and delivery of services.

Standard 2 Person centred care

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

Good progress was made in implementing a community equipment and continence service, although older people in some areas reported delays in obtaining equipment. In four communities there were integrated continence services across all partner organisations. The others were at varying stages of developing integrated continence services.

NHS trusts and local authorities were implementing plans to introduce a single assessment process and many have been piloting different models to help make an informed decision. However, the timescales in the NSF had not been met for implementing one model of the single assessment process across the community. The inspections found that, while older people were generally involved in planning their care, choice was limited by the range and flexibility of services.

Organisations had made variable progress in changing the ways they behaved and worked,

so that all older people are not yet genuinely treated as individuals with particular needs and aspirations.

NHS trusts and social services need to work together to implement the single assessment process fully and to promote its benefits widely in all organisations that are in contact with older people.

Standard 3 Intermediate care

Older people will have access to a new range of intermediate care settings to promote their independence, by providing enhanced services from the NHS and council 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.

This is an area where significant progress had been made as the growth of intermediate care services had exceeded the Government's target in the NSF. Delays in transfers of care had decreased considerably and more people with complex needs were being supported to live at home. Unfortunately, alongside the reduction in delayed discharges from hospital, the inspections found that many older people still experienced poorly managed arrangements for discharges from hospital. NHS trusts and social services need to improve the experiences of older people being discharged from hospital. They also need to build on good practice by developing intermediate care services further to

provide managed networks of care for people with complex needs. Intermediate care services were generally unable to meet the rehabilitation needs of older people with dementia who have experienced disease or injury. There is a need for hospital and community services to develop a range of intermediate care approaches that can meet these more complex needs.

Standard 4 General hospital care

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

Most general hospitals had specialist multidisciplinary teams, although the local inspections found that these teams did not always work across all specialties. However, we found that the basic care needs of older people were sometimes not met in hospital and older people with mental health needs did not always receive holistic care when admitted to a general hospital. There is a need for health service managers and managers of care homes to ensure that all staff in regular contact with older people learn how to care for people with mental health needs and to ensure that basic care needs are met.

In addition, hospital managers should pay particular attention to ensuring that:

- older people are not required, even when there is pressure surrounding available beds, to receive care in wards or bays that designated for the opposite sex

- older people are not moved from ward to ward for reasons other than clinical ones
- staff maintain good nutritional standards by assisting older people who are unable to eat and drink independently, and by ensuring that meals are not missed by patients who are taken from the ward for investigations and treatment (unless they are required to fast)

Standard 5 Stroke

The NHS will take action to prevent strokes, working in partnership with other agencies where appropriate. People who are thought to have had a stroke have access to diagnostic services, are treated appropriately by a specialist stroke service and subsequently with their carers, participate in a multidisciplinary programme of secondary prevention and rehabilitation.

Services for people who have had a stroke have improved. Community and hospital-based services have been developed well. More people were receiving care in a stroke unit for more than 50% of their stay in hospital and protocols were in place between hospitals and GPs for the referral and management of people who have had a mini stroke. However, not all of the communities had such a unit and there were inconsistencies in the way protocols were implemented to prevent a first or subsequent stroke. We also found that stroke registers were not being used in all communities to identify people at risk of having a stroke.

Primary care trusts and acute trusts need to ensure that people who have had a stroke receive care as set out in the Royal College of Physicians guidelines, and in particular should ensure that every acute trust has a stroke unit. NHS trusts, local authorities and independent providers of health and social care need to address the prevention of strokes as part of the wider agenda on healthy communities. The quality and outcome framework for GPs may help to increase the use of a stroke register. PCTs need to ensure that this is used as part of a prevention programme.

Standard 6 Falls

The NHS, working in partnership with local authorities, takes action to prevent falls and reduce fractures or other injuries in their population of older people. Older people who have fallen receive effective treatment and, with their carers, receive advice on prevention through a specialist falls service.

There were reports of some excellent models of integrated services dealing with falls across the country, however this is not yet widespread with only two of the communities having integrated services for dealing with falls. NHS trusts, local authorities and providers of health and social care need to set up integrated falls services where these do not exist. These services should coordinate the initiatives of the many organisations that have a role to play in preventing falls, and supporting people who have had a fall to regain their independence.

Standard 7 Mental health in older people

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

There were good local partnerships involved in planning and delivering mental health services to older people. However mental health services for older people were generally under developed and reported to be poorly resourced. Mental health services for adults of working age were managed separately from those for older people and this resulted in an unfair service for older people with mental health needs. There was also little evidence of work being done to promote good mental health in old age.

The promotion of good mental health should be part of a wider health promotion and wellbeing programme that recognises the importance of social inclusion, leisure and learning opportunities and the contribution that older people make as valued members of the community.

Standard 8 Living well in later life

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

Local authorities were providing exercise, leisure, libraries and learning opportunities, which were valued by older people. There was an increase in people over 60 who had stopped smoking, and an increase in flu vaccinations for older people. Some GPs were maintaining or monitoring blood pressure levels in people at risk of a heart attack or stroke. However, there was no strategic and coordinated programme of action that brought together the public health and wellbeing agenda across health and local government to promote healthy active life in old age and partner organisations need to work together to achieve this goal.

Medicines management

Ensure effective management of medicines so as to improve health.

PCTs were working with community pharmacists to review medication and to provide more information to older people to enable them to manage their own medication. However GPs were not carrying out reviews every six months of older people taking four or more types of medication. PCTs need to address this by ensuring that plans are in place to move towards this standard and that progress is regularly reviewed and reported.

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Appendix A: Meetings with key stakeholders

The project team for this review met with the following organisations to consult on the scope of the national review:

Age Concern	Help the Aged
Alzheimer's Society	Help the Hospices
Ambulance Service Association	Health Development Agency
Association of Directors of Social Services	MIND
Better Government for Older People (BGOP)	National Osteoporosis Society
British Geriatric Society	National Patient Safety Agency
Black Minority Ethnic Elders	NHS Modernisation Agency
Carers UK	NHS Wales and the Welsh Assembly
Care Services Improvement Partnership	Office of the Deputy Prime Minister (ODPM)
Change Agent Team	Policy Research Institute on Ageing and Ethnicity (PRIAE)
Chartered Society of Physiotherapy	Royal College of Nursing
College of Occupational Therapy	Royal College of Physicians
Dementia Voice	Royal College of Psychiatrists
Department Of Health	Royal College of Speech and Language Therapists
Department for Work and Pensions	Royal Pharmaceutical Society
Department for the Environment and Rural Affair (DEFRA)	Royal National Institute for the Blind
English Community Care Association (ECCA)	Royal National Institute for the Deaf
em POWER – the Charities consortium of users of prosthetics, orthotics, wheelchairs, electronic assistive technology and rehabilitation	Society of Local Authority Chief Executives
	The Stroke Association

Appendix B: Policy changes and influences since the national service framework

Policy changes
<i>Our health, our care, our say: a new direction for community services</i> , Department of Health, January 2006
<i>A sure start to later life: ending inequalities for older people</i> , Office of the Deputy Prime Minister, January 2006
<i>Commissioning a patient led NHS</i> , Department of Health, September 2005
<i>Independence, wellbeing and choice</i> , Department of Health, March 2005
<i>Opportunity age</i> , Department for Work and Pensions, March 2005
<i>Putting people at the heart of public services</i> , Office of Public Services Reform, 2005
<i>Improving services, improving lives: evidence and key themes</i> , Social Exclusion Unit Office of the Deputy Prime Minister, 2005
<i>Supporting people with long term conditions. An NHS and social care model to support local innovation and integration</i> , Department of Health, 2005
<i>Choosing health: making healthier choices easier</i> , Department of Health, November 2004
Community Care Act 2003, Department of Health
<i>Information strategy older people</i> , Department of Health, March 2002
<i>Fair access to care services</i> , Department of Health, 2002
<i>NHS funded nursing care</i> , Department of Health, October 2001
<i>Building capacity and partnership in care</i> , Department of Health, October 2001
<i>Local vision – a 10 year vision for local government</i> , Office of the Deputy Prime Minister, 2005

Race Relations (Amendment) Act 2000
Disability Discrimination Act 2005
Good practice guidance
<i>The business of caring</i> , King's Fund inquiry into care services for older people in London, 2005
<i>Older people, independence and wellbeing</i> , Audit Commission/Better Government for Older People
<i>Link-age</i> , Department for Work and Pensions, 2004
<i>All our tomorrows: inverting the triangle of care</i> , Association of Directors of Social Services/Local Government Association, 2003, ADSS/LGA, 2003
<i>No secrets: Guidance on developing and implementing multi-agency policies and procedures to protect vulnerable adults from abuse</i> , Department of Health, 2000
<i>Essence of care</i> , Department of Health, 2001 (updated 2003)
Organisational change
<i>Shifting the balance of power within the NHS: securing delivery</i> , Department of Health, 2001
<i>Democratic renewal</i> , 2001
Performance assessment frameworks
<i>Comprehensive performance assessment</i> , Government white paper, July 2002
<i>National standards, local action. Health and social care standards and planning framework 2005/2006-2007/2008</i> , Department of Health, 2004

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