

# **ADDING LIFE TO YEARS**

Report of the Expert Group on Healthcare of Older People

“The Chief Medical Officer will lead an Expert Group to improve the care of older people in NHS acute and primary care services. This will include action to reduce delays in discharging patients from hospital.”

*Our National Health*  
*A plan for action, a plan for change*  
December 2000

### **The Remit of the Expert Group**

To provide an overview and description of the major health problems of older people; a description of the journey of care for older people, including delayed discharge; an investigation and description of allegations of negative discrimination on the grounds of age (ageism) in NHSScotland; and examples of good practice and recommendations.

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**Chief Medical Officer**

Publication of this report fulfils a commitment given in the Scottish Health Plan, *Our National Health – a plan for action, a plan for change*. It was commissioned because of serious concerns about the healthcare of older people.

The first step in tackling this task was to constitute the Expert Group itself, ensuring that as far as was possible, it drew on the skills, knowledge and opinion of as wide a spectrum of patients' groups, carers, voluntary and professional groups as was available in Scotland. It has been a real privilege to chair this diverse and lively assembly who have tackled the work with vigour and enthusiasm. The group met first in April 2001 and subsequently for five further full days of discussion and debate, including a meeting of the group and over a hundred invited participants. The agenda for each meeting was agreed in advance with the group itself providing structured papers, evidence and debate both from its own experience and by bringing in further advice as required. Group members were asked to report regularly on progress to their parent bodies and to ensure that all issues of concern were covered. The public was invited, via newspaper advertisements, to complete a structured questionnaire. A specially commissioned MORI poll sought the views of 500 older people on their recent experiences of the NHS. The results are summarised in this report.

The Group has examined specific concerns raised by older people themselves. Like ageism – discriminating against people because they are old. Like sharing mixed-sex wards, a particular issue for ethnic minority patients. Like nutrition and the quality of food in our hospitals. Concerns, too, about what was happening to older people whose discharge from hospital had been delayed because suitable care, in their own homes, or in care homes, could not be arranged.

All of these issues are addressed in this report and action is already in hand within the NHS to deliver improvements. The report has identified much to be proud of in terms of services for older people in NHSScotland. But, rightly, it also points out where the NHS needs to improve. There is clearly much work still to do.

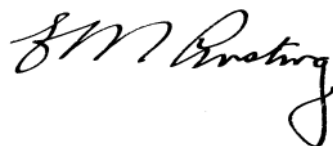
But there are also wider concerns about the long-term needs of older people as patients in NHSScotland. Scotland's population is stable but we are growing older. As a nation we should be planning now for increasing numbers of older people in future. Although most older people are healthy, health problems increase with age and our NHS must be there to deal with them. Already older people are – quite rightly – the main users of many of our community and hospital services.

There has been a failure, over the last three or four decades, to adapt our health services to a gradual but very substantial increase in the numbers of older patients being treated.

This report sets out to put that right, and to go further, by pointing out what must be done now to meet the challenges that lie ahead. It puts older people and their care right at the top of the NHSScotland agenda, and challenges the Scottish Executive, the NHS, health professionals and patients themselves to play their part in responding to that challenge.

It is a report that has been developed, tested and written from the patient's point of view. It has messages for every part of the NHS: primary care, community services, acute care and longer-term care. The message from Scotland's older people is clear: involve patients, listen to patients, work with patients.

Its recommendations build on much that the Executive has already done to improve the lives and care of older people, such as the Scottish Health Plan, the Joint Future Group and the Care Development Group. As with these other key reports, the task now is to ensure that words are translated into action.

A handwritten signature in black ink, appearing to read 'E M Armstrong', written in a cursive style.

DR E M ARMSTRONG

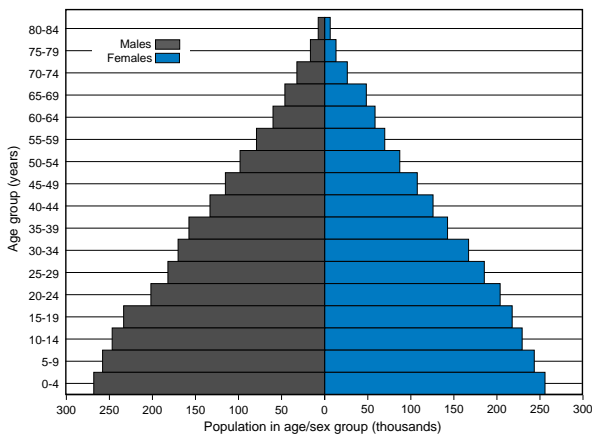
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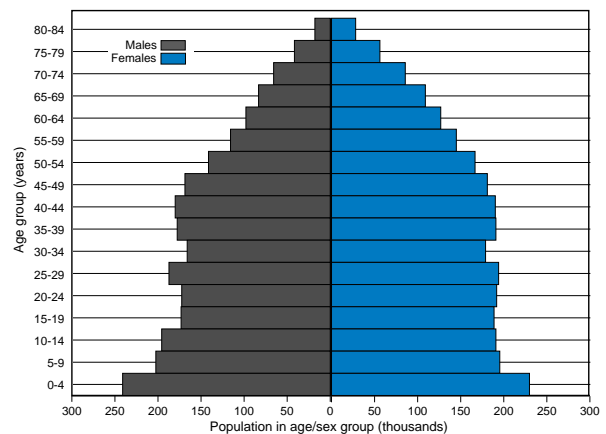
## Demography

This short chapter summarises some of the findings of the Information and Statistics Division (ISD) Report “The Health and Well-Being of Older People in Scotland”.

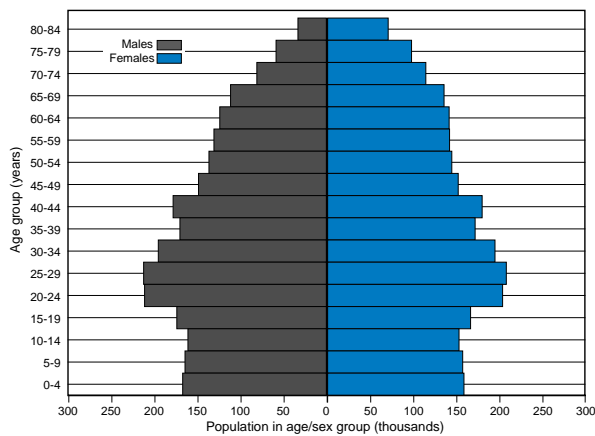
Scotland’s population is changing. This is dramatically illustrated in the four sections of fig-1, each a snapshot of the size, age and gender structure of the population, at forty-year intervals and covering the 120 years from 1911.



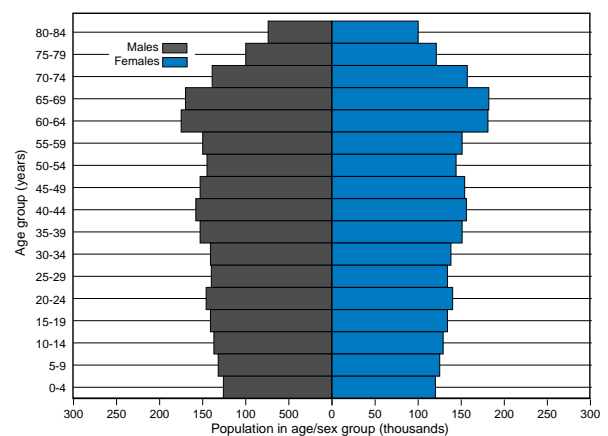
1911



1951



1991



Projection to 2031

Fig-1

In 1911, high fertility and high mortality combined to give a young population structure, tapering off rapidly in middle age, with only small numbers reaching what we now think of as old age. By 1951 the decline in mortality in younger age groups has led to a growth in the total population, and more and more people are living into their 60s and 70s.

The sustained high birth rates of the 1950s and 60s – the baby boom – are reflected in the 1991 picture, and again the numbers of people living into their 70s and 80s has increased. And the projection for 2031 shows significant mass ageing, and the consequences of lower fertility in the 1970s and beyond – Scotland's ageing population.

Between 2000 and 2031 the numbers of people over 65 is expected to increase from 787,000 to 1,200,000; and those over 85 from 84,000 to 150,000.

In general, populations are ageing more rapidly in Scotland's rural areas, with over-65s, currently accounting for less than 20%, rising to 22-24% in Borders, Dumfries and Galloway, Highland, Orkney and Western Isles by the year 2016 and Scotland's ethnic minorities, though currently mainly younger than the majority, share in this process of population ageing too. In coming decades the numbers of people from ethnic minorities will figure more prominently among Scotland's older people.

### **Older people in Scotland today: their use of health services**

Older Scots, the 787,000 over 65s, make considerable use of health services. Each year NHSScotland provides for them:

- 3,769,000 GP consultations
- 287,000 new outpatient referrals
- 206,000 day cases and elective inpatient admissions
- 185,000 emergency inpatient admissions

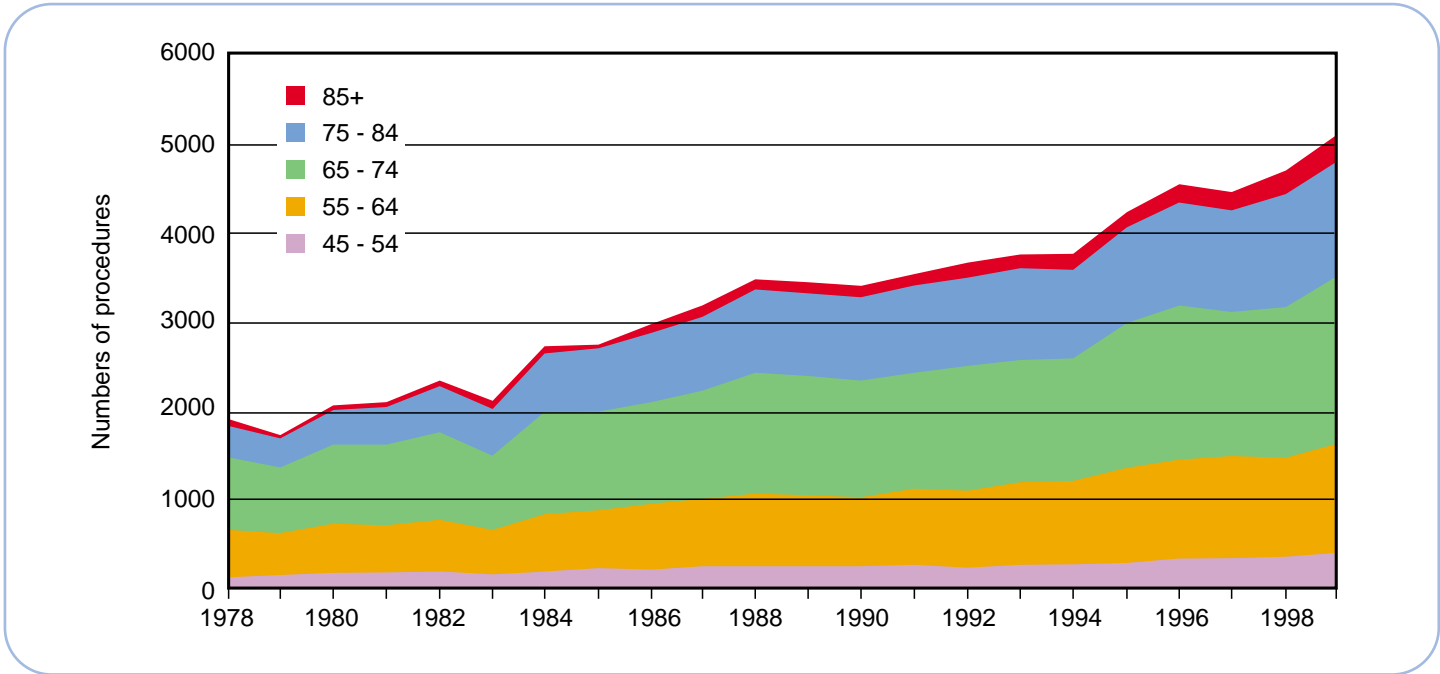
Around a third of a million Scots are over 75. In general terms, they are the group most likely to have higher dependency and more complex health needs.

The health of older people in Scotland varies according to social circumstances. The least well off and those in the most deprived areas have poorer health and shorter life expectancy.

**Trends in Elective Care**

Much of the elective – i.e. non-emergency – work carried out by surgeons in NHSScotland is for the benefit of older patients. Cataract surgery restores vision and enables older people to resume a more active lifestyle. Hip and knee replacement surgery restores lost mobility, relieves pain and also enhances quality of life.

The volume of such surgery has risen greatly in response to the needs of growing numbers of older people. This is illustrated in fig-2.



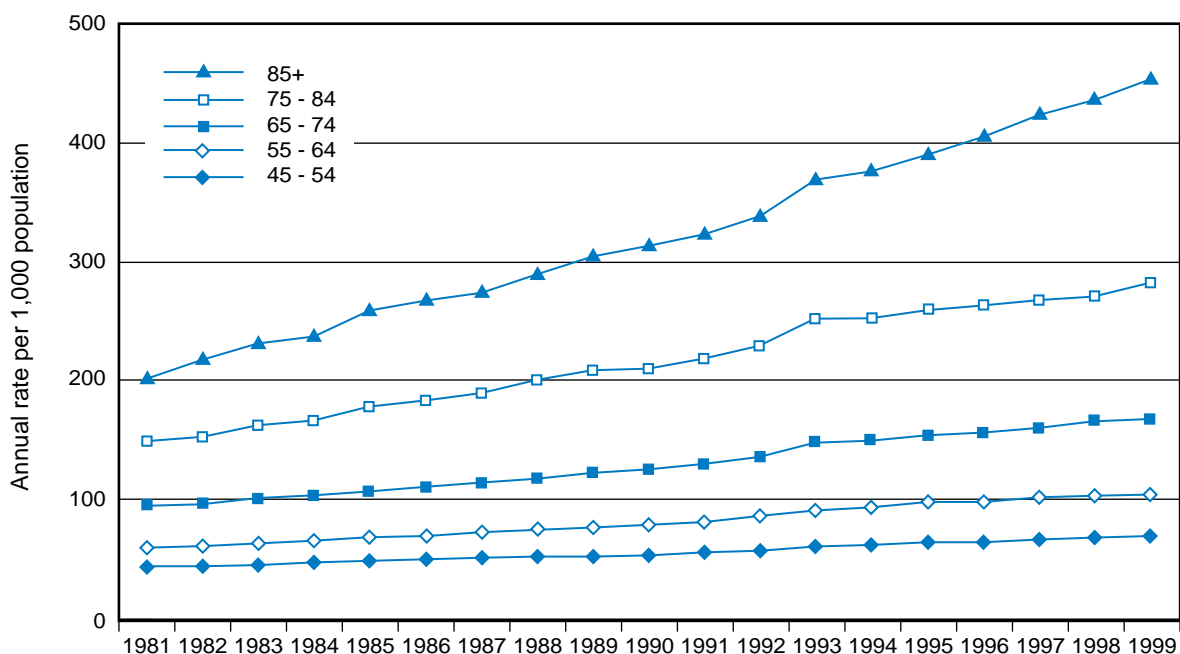
**Total Hip Replacements, Scotland 1978-1999**

**Fig-2**

Clearly the further growth in numbers of older people must be met by further increases in the provision of such surgery and the related rehabilitation, and as more older people remain healthier and more active, their expectations of such life-enhancing interventions will rise, again increasing demand.

### Trends in Acute Care

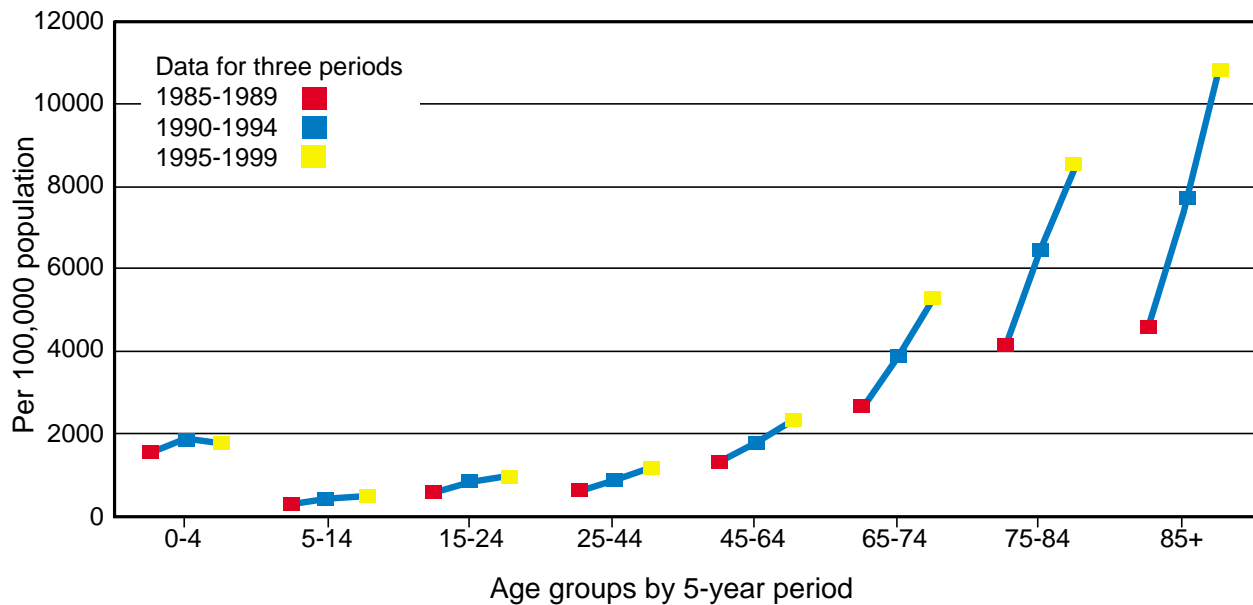
In recent years emergency admissions to acute care have increased markedly, and the increase has been most marked in the oldest age groups, as illustrated in fig-3. There are particular concerns about the care of the rapidly rising numbers of old and very old people who are unwell but for whom no clear acute diagnosis can be established.



### Trends in emergency admission rates by age group, Scotland 1981-1999

Fig-3

Another recent trend in acute admissions documented by the Information and Statistics Division (ISD) is the rising number of individual patients – many of them old or very old – who are admitted as an emergency several times over a limited period. Between 1995 and 1999, one in ten people aged 85 and over was admitted four times or more. And the number of such patients with multiple emergency admissions aged 65 and over doubled in a ten-year period, as illustrated in fig-4.



**Patients with 4 or more emergency admissions as a proportion of population. 1985-89, 1990-94, 1995-99.**

**Fig-4**

Such patients are often frail and have a number of long-standing health problems. Their admission is commonly wholly or partly determined by concerns about their dependency and support. Their diagnosis and treatment may be relatively straightforward. Successful management of such patients – whether in hospital or at home – is essential in the avoidance of unnecessary long-term care as a result of short-term illness.

These trends should be seen in the context of Scotland's ageing population, and pose a considerable challenge in the management of episodes of acute illness in older people now and in the future. The hospital sector should plan for increasing numbers of older acute admissions.

However, there is now growing recognition that better community support – encompassing nursing and domiciliary care as well as medical and rehabilitation inputs – for older people at home will allow more to remain there through an episode of acute or sub-acute illness.

#### **Recommendations:**

- **NHS Boards should plan to increase provision of elective services used mainly by older patients, including surgery and related rehabilitation.**
- **NHS Boards should plan to provide high-quality acute care for growing numbers of older people.**

- NHS Boards should, in partnership with Local Authorities, explore strategic developments encompassing health and social care. These should aim to offer more older people with acute illness the possibility of being enabled to live at home where this is clinically appropriate.



## Introduction

Ninety-five per cent of people aged over 65 stay at home. Most wish to continue to do so. When they become ill, they want easy access to the right kind of care, whether at home or in hospital.

Many episodes of ill health in older people are simple to diagnose, easy to treat and can be dealt with routinely by primary care and acute hospital services. However, particularly for the very oldest, care may be more complex. Diagnosis may be more difficult, multiple medical problems may co-exist, and care may be required from a number of agencies.

This section of the report recognises these difficulties and is therefore structured around the “Journey of Care” i.e. on the health of older people and the care actually experienced by older people at home, while attending acute hospitals, through hospital admission and on the return home or – in a small minority of cases – to other care settings.

This approach acknowledges that most people live at home and want to stay there or get back there as soon as possible, regardless of what the diagnosis is and however many problems they might have. The care of older people is the principal task for NHSScotland in the 21st century. Many health professionals and organisations are involved, but the focus should always be on the patients, not the providers.

### WHAT WE HEARD:

**“They should get the cream of the service, not second class treatment.”**

Carer

## Staying well

Most older people enjoy good health and wish to continue to do so. It is simply not true that growing old automatically means becoming unfit. There is a lot that the individual can do to remain fit and active, and, at a policy level, health promotion has a great deal to offer in reducing morbidity and promoting independence in the older population.

### Exercise and Physical Activity

Exercise in later life can be both enjoyable and beneficial. Although muscle strength declines with age, it can be maintained and regained by exercise. Even in extreme old age exercise can restore function in ways that make the difference between being safely independent at home and losing that independence.

Systematic exercise training may achieve as much as 10 or 15 years' worth of "rejuvenation", and such exercise need not be particularly strenuous. Exercise classes offer social as well as physical gains, and are both popular and successful. Even without formal exercise programmes real benefits can result from regular exercise at the level of brisk walking (at 3 to 4 miles per hour).

There are also proven benefits to healthy ageing through staying socially and mentally active in older age.

### Smoking

Older people are less likely to smoke than younger people, but around a quarter of the 65-74 age group smokes regularly. Giving up reduces risks of stroke, heart disease and lung cancer; and also reduces the risk of death as a result of respiratory infection. It is never too late to give up.

#### WHAT WE HEARD:

**"People need to plan to have a healthy old age and take some responsibility for achieving it."**

GP

**Alcohol**

Many older people enjoy alcohol responsibly and in moderation. A few – around 6% of men and 1.5% of women in the 65-74 age groups – are problem drinkers and hence at risk of falls and injury, gastrointestinal disease and confusional states. Managing these problems is very complex and consumes resources. Compared to younger problem drinkers, they are more likely to drink daily than to binge, and more likely to conceal their drinking. Supportive interventions aimed at increasing socialisation can also help reduce problem drinking in later life.

**Nutrition**

Eating well contributes to health and well-being and recovery from illness. It is essential for the maintenance of immune function and wound healing.

**WHAT WE HEARD:**

**“A doctor can only do so much. We oldies must realise we are responsible for our own health.”**

Man 70s

Surveys of older people at home and in long-term care have shown that many are under-nourished. The recent *National Nutritional Audit of Elderly in Long-term Care* (CRAG, 2000) confirmed this. Undernutrition may impair older people's health and diminish their chances of recovery. Older people in hospital are poorly fed. Average weight loss during an acute stay is 5% of body weight.

Older people at home are most at risk if they are isolated, on low income and do not have easy access to sources of healthy food. People who retain their teeth in later life eat better diets than those who don't.

**IT'S HAPPENING ALREADY:**

**In Midlothian, many older people have easy access to fresh fruit and vegetables at affordable prices. Four food co-ops help older people and can even arrange delivery to their homes.**

The frailest, including many in long-term care, may have little choice in what they eat. Their diets can be inadequate in energy terms and they may often require physical help with eating because of weakness or confusion.

ISD has in November 2001 published a feasibility study on the routine collection of data reflecting the nutritional status of older people in continuing long-term care in Scotland.

*Our National Health – a plan for action, a plan for change* commits NHSScotland to implementing the recommendations of the National Nutritional Audit, and also indicates that the Clinical Standards Board for Scotland (CSBS) will bring forward new standards on food and feeding in the NHS. This work is now underway: an expert group has been established and it is expected that the CSBS will produce standards for consultation in the first half of 2002.

New national care standards for care homes will be operated by the Scottish Commission for the Regulation of Care, and will include standards for ensuring that residents' nutritional needs are met.

Standard 13 states that care homes will guarantee older people that "Your meals are varied and nutritious. They reflect your food preferences and any special dietary needs. They are well prepared and cooked and attractively presented."

### Oral Health

Poor oral health is common in later life and less than 30% of over 75s are registered with a dentist. Many – particularly the housebound and those in long-term care – encounter real difficulties in accessing dental care.

Mouth infections and gum disease are common complications of some of the commonest diseases of later life – such as stroke, Parkinson's disease and dementia – yet professional awareness of oral health is low. Examination of the mouth is neglected and treatable conditions are missed.

#### IT'S HAPPENING ALREADY:

**In Wick, the Community Dental Service is providing training on oral care to staff looking after older people in nursing homes.**

### Footcare

Foot problems in the elderly are common. They reduce mobility and detract from the enjoyment of exercise. The incidence of diabetes and peripheral vascular disease also increases with age. The associated serious foot care problems can often be prevented by screening and regular easy access to skilled podiatric services.

### Medication

Older people commonly need drug treatment and may greatly benefit from it, but adverse drug reactions continue as a major cause of morbidity and death. Although much is known about risk factors – such as changes in drug metabolism with age, high-risk drug groups and high levels of prescribing in long-term care – such knowledge is not always translated into practice.

Problems can arise because hospital and primary care doctors prescribe independently. Poor communication and co-ordination at the time of discharge from hospital creates especial risks. Further problems can arise because the patient may add over-the-counter medication. Critical review of medication reduces risks but, although widely recommended, is not widely enough practised.

**IT'S HAPPENING ALREADY:**

**In Dumfries and Galloway community pharmacists visit at risk people over 75 living at home, offering support in relation to medication and, when necessary, referring them to other healthcare professionals.**

Older people may find child-proof bottles and blister packs difficult to handle, and small print difficult to read. Drugs for older people should be prescribed and dispensed in ways that are physically accessible, with legible labelling and advice.

*The National Care Standards for Care Homes for Older People* include a standard for the administration of medication to older people in long-term care. This includes an assurance that arrangements will allow older people to manage their own medication safely and in a way that suits them best.

**Disease prevention and disability reduction**

Effective disease prevention measures for older people include:

- Vaccination against influenza
- Aspirin for secondary prevention of stroke and heart attacks
- Warfarin in atrial fibrillation, to prevent stroke
- Calcium and Vitamin D to reduce the risk of fracture in the housebound and those in long-term care
- Hip protectors for those most at risk of hip fracture – and who can comply
- Falls prevention

A number of disability-reducing surgical interventions are established as effective, and include:

- Coronary artery by-pass surgery
- Joint replacement surgery
- Cataract surgery
- Carotid endarterectomy

Effective rehabilitation also has a major impact on reducing disability in older patients, whether after acute illness, emergency surgery or elective surgery. It improves outcomes, minimises hospital stay and is highly cost-effective. Effective multidisciplinary rehabilitation must be available throughout the older patient's journey of care, and this is a recurrent theme of the report.

**Recommendations:**

- Older people should be encouraged to be physically and mentally active.
- Older people should have access to information about healthy lifestyles, and health promotion campaigns should actively target and involve them.
- NHS Trusts, Local Authorities, voluntary and private providers with responsibility for long-term care of elderly patients are reminded of the recommendations of the *National Nutritional Audit of the Elderly in Long-term Care* and of the need to implement these recommendations.
- Older smokers should be encouraged to try to stop; and high-risk groups such as those with heart disease should be targeted for extra help in giving up smoking.
- Health professionals should be aware of the possibility of problem drinking in older people and be ready to help.
- Clinical examination should include assessment of oral health and appropriate referral when required.
- NHS Boards should ensure that older people who wish to do so have access to, and are registered with, an NHS dentist and are made aware that help may be available to assist with payment for treatment.
- Older people in hospital should be assessed to ensure that they can administer their own medications on discharge if that is clinically appropriate.
- Co-ordination of prescribing and drug provision for discharge from hospital should be improved.
- All older people who have repeat prescriptions should have a regular medication review.
- Medication for older people should be dispensed in accessible form, and with legible labelling and advice.
- Effective disease prevention measures should be advised to all older people, as appropriate.
- Disability-reducing surgery – e.g. for cataract and joint replacement – should be available on the basis of clinical need and appropriateness.
- Older patients have most to gain from good multidisciplinary rehabilitation in hospital and at home, and service organisation should reflect this.
- Multi-professional education should foster learning and innovation in service delivery.

## Health Screening of Older People

Routine health checks are available in primary care for people aged 75 or over. They usually comprise simple assessments by a nurse or doctor, aimed at picking up new or worsening problems. However, the current arrangements have a number of disadvantages. They are carried out in different ways across the country. They can fail to identify growing dependency or deteriorating mental states. The information they provide cannot be put together to be used in the planning of services, either locally or nationally, for Scotland's one third of a million over 75s.

### WHAT WE HEARD:

**“My particular medical group practice has a special clinic for the over 80s, with 20 minute consultations. If you don't turn up, they come looking for you!”**  
Man 80s

### Recommendations:

- **Screening of the over 75s should be reviewed, with a greater focus on identifying important problems such as falls, mental impairment, increasing dependency, oral disease, poor nutrition, poor foot care, tobacco and alcohol use.**
- **Standardised data from screening should be available to support planning better services for older people, enabling participation and independent living.**
- **Consideration should be given to linking screening with a check on uptake of benefit entitlements.**

### IT'S HAPPENING ALREADY:

**In West Dunbartonshire's Augmented Home Care Scheme, health checks are linked with a benefits entitlement check, with resulting increased benefit uptake by older people.**

## Supporting older people at home

Around 20% of over 65s in Scotland require regular help or care in order to stay at home, with the oldest age groups requiring most care. Such services, particularly for the most dependent, rely on good local co-operation between health and social work.

There are many examples of excellent practice across Scotland but much work is needed in order to generalise best practice.

### IT'S HAPPENING ALREADY:

**In Lanarkshire, there is good interagency co-operation, including integrated evening care, joint day care services and joint training.**

A number of Scottish Executive initiatives over the last two years will support better joint working, higher standards of care, more responsive services and the spread of best practice across Scotland. These include:

- The *Strategy for Carers in Scotland* published in 1999, which set out a strategic framework to ensure better support for all carers, as part of a Programme for Government commitment to deliver person-centred health and community care.
- The report of the Joint Future Group *Rebalancing Care of Older People*, which recommends the single shared assessment and joint resourcing and management for services for older people at home. Its implementation, including the provision of rapid response teams, short breaks, and intensive home care, will enable more and more older people to remain at home – both through acute illness which might previously have required hospital admission, and despite increasing frailty which might otherwise have necessitated long-term care.
- NHS Boards and Local Authorities having in place by April 2002 joint budgetary arrangements for older people's services, along with single shared assessment of need. There is considerable potential therefore to be tapped into for more effective joint working on major resource allocation issues e.g. delayed discharge and care planning for individuals.
- The Scottish Commission for the Regulation of Care which, from April 2002, will have responsibility for national care standards in care homes, for day care and for care at home.
- The work of the Care Development Group which, in addition to implementing free personal care, also stressed the need to improve services in order to help older and frailer people to stay at home as long as possible.
- A National Strategy Forum which has been set up to deliver integrated equipment and adaptation services across Scotland to help people maintain their independence in their own homes.
- Additional funding – rising to £48 million by 2003-4 – which will enable local authorities to improve and expand home care services for older people as recommended by the Joint Future Group. These services will include rapid response teams, intensive home care, help with shopping, domestic tasks and household maintenance for low dependency older people, and free home care for older people leaving hospital.
- Additional funding to enable local authorities to improve the numbers and range of short breaks (respite care), to help sustain carers in their vital role in the support of very frail older people.

Carers are an invaluable resource in our society. Over 600,000 people in Scotland care for someone. Many are themselves no longer young: 30% are 65 and over. Two-thirds of the people they care for are 65 and over.

**Recommendation:**

- **Carers should be seen and valued as partners with the statutory agencies in the provision of care, and should themselves receive appropriate assistance.**

**Better Access to Services: the Single Shared Assessment**

Too often in the past older people who need help in order to stay at home have not found it easy to obtain that help. They want to have convenient access to services no matter who is providing them, and they do not want to have to see, and be assessed by, representatives from every agency involved.

The Single Shared Assessment seeks to address these complexities. From April 2002, it will be used by all the relevant agencies in all settings across Scotland. It will focus on the needs of service users and their carers, and result in fewer visits, fewer questions and better assessment of need.

A single “key contact person” will co-ordinate the range of services needed more quickly. Bureaucracy will be cut, and resources will be used better. From the service user’s point of view – by far the most important one – real improvements should result.

**Improving Older People’s Access to Health Care**

Almost all of Scotland’s older people are registered with a local general practitioner, are known to their doctor, and pleased with the care they get from that doctor.

**IT’S HAPPENING ALREADY:**

**Age Concern Scotland found that 94% of older people questioned had visited their GP in the past five years. Nine out of ten thought that service was good or very good.**

**WHAT WE HEARD:**

**“Luckily, in Scotland, we have so many excellent GPs”.**

Man 70s

Most health care for older Scots living at home is provided by ‘their doctor’ and the local primary care team, with only around 10% of consultations resulting in onward referral to specialist services. And in many rural areas small local hospitals run entirely within primary care offer excellent short-term inpatient services, including rehabilitation and respite care.

Primary care doctors also provide cover for patients in care homes, many of whom would formerly have been looked after in NHS continuing care settings. Such patients may be clinically unstable and at varying degrees of risk. There was broad agreement in the Expert Group that standards of medical care varied greatly across Scotland, and that this was unacceptable. The standard contractual model for GP cover does not appear to provide a reliable basis for good, pro-active care of such patients, and alternatives need to be explored.

Standard 14 No. 3 of the *National Care Standards – Care Homes for Older People* states, “During your first week in the home, and at least every six months after that, you will receive a full assessment to find out all your healthcare needs, and staff will ensure that these needs are met. Staff will record all assessments and reviews of your healthcare needs.”

**IT'S HAPPENING ALREADY:**

**In Nairn, local arrangements – including regular GP visits and out of hours telephone support for nursing staff from the nurse who triages emergency calls for the local LHCC – have improved the quality and continuity of care for older people in long-term care.**

**Recommendation:**

- **Older people at high risk in the community, including those in care homes, should be regularly monitored by an appropriate member of the healthcare team and relevant services and specialist care provided as necessary. NHS Boards should encourage and support such developments.**

The traditional strengths of primary care in Scotland are now being supplemented by new and powerful developments designed to enhance local services, draw new skills into local multidisciplinary healthcare teams, and provide more and better care nearer the patient's home.

Local Health Care Co-operatives (LHCCs) have broadened the scope of primary care and encouraged the more active involvement of nurses, pharmacists and other members of the primary care team. Along with the new Personal Medical Services (PMS) contract, they offer new flexibility in service provision, with the potential for innovative arrangements covering such areas as home nursing support, health screening and local rehabilitation units for older people.

Older patients gain greatly from developments in primary care. As primary care continues to evolve many more initiatives can be expected. As these are observed, evaluated and adapted to local circumstances by LHCCs all across Scotland improvements will become far more widely available.

**WHAT WE HEARD:**

**“The health service is now about chronic disease management”.**

GP

The MORI poll on public attitudes to the healthcare of older people in Scotland, published in conjunction with this Report, explored whether transport was a problem for older people in terms of gaining easy access to their GPs. It is for some (1 in 7 people) especially for those without access to a car (25% of respondents) and those aged 80 or over.

The study revealed that 1 in 2 older people travel to their outpatient clinic appointment by car, including a third who drive themselves. However, a quarter rely on buses. Fewer than 1 in 10 walk or are taken by ambulance to their outpatient appointments.

### Avoidance of Unnecessary Hospital Admission

Some older people, many of them with only minor illness, are admitted to acute hospital care because the kind of care they need at home is not readily available. Simple domestic, nursing and rehabilitation support, combined with medical care from the patient’s own GP, may provide a safe and welcome alternative to acute hospital admission – which, for the very frailest, may lead to permanent long-term care.

**IT’S HAPPENING ALREADY:**

**In many areas of Scotland, Rapid Response Teams provide extra nursing, domestic and rehabilitation support for older people in their own homes, through an acute episode, often averting an admission to hospital.**

**Recommendations:**

- **NHS Boards should ensure that older people in long-term care in the community have access to the appropriate care when required.**
- **LHCCs should lead the process of health needs assessment and primary care service planning in their areas; and recognise the potential of this process in improving local services for older people.**
- **Older people and their GPs should have access to multidisciplinary, multi-agency support teams to avoid unnecessary hospital admission, to facilitate safe discharge from acute care, and to promote rehabilitation of older people in their own homes.**

## Accident and Emergency Care and Short-Stay Acute Admission

When older people attend Accident and Emergency Departments or are admitted to short-stay units, the clinical problem may often be simply dealt with. A minority of patients will require more detailed assessment because of co-existing medical problems, poor mobility, or uncertainties about how they will manage on return home.

### IT'S HAPPENING ALREADY:

In the Glasgow area, Accident and Emergency Departments now operate combined social work and emergency assessments to facilitate discharge, if appropriate, with full social and healthcare support.

### IT'S HAPPENING ALREADY:

In Glasgow, a team consisting of an occupational therapist, pharmacist and physiotherapist assess older people at home after they have attended Accident and Emergency with a fall.

Admission may rapidly increase dependence. Special steps must therefore be taken to address the rehabilitation needs of older people in the earliest stages of acute care.

The Clinical Standards Board for Scotland, as part of its work on standards for Older People in Acute Care, will review the care of older people in Accident and Emergency Departments and Assessment Areas and publish findings in a national Report in 2003.

### Recommendations:

- Older patients attending A&E Departments or admitted to short-stay acute assessment wards should be assessed to identify those with previous or recently increased dependency.
- Assessment should be multidisciplinary, covering likely risks and determining care needs (e.g. discharge, supported discharge or admission).
- A range of appropriate services should be available to facilitate safe discharge home, minimise unsafe discharge, and avoid unnecessary re-admission.

## Acute Hospital Care

Already older people are proportionately the heaviest users of acute hospital services. As the numbers of the very old increase over the next 20 years, most hospital services providing acute care will be looking after increasing numbers of older, frailer patients. Older people are more likely to be re-admitted than younger ones, and to require multiple admissions.

Many older patients – particularly the previously fit and those without multiple medical problems already – can be safely managed in acute care settings without special arrangements. Special skills are needed to ensure that older and frailer patients, particularly those who already need support at home or have multiple problems, have their needs recognised and addressed.

Such patients should be identified early. Multidisciplinary assessment and early rehabilitation in the acute ward will minimise disability and maximise the chance of successful discharge home.

The majority of older patients, including a large proportion of the frailest, can be returned home safely from acute care by a combination of multidisciplinary rehabilitation, good discharge planning and management, and a collaborative approach involving both acute and community services.

Discharge management is a vital part of overall care management. It encompasses planning and delivery of services, and checking on both patient welfare and service delivery. It improves patient outcomes, reduces length of stay and minimises the risk of readmission.

### **IT'S HAPPENING ALREADY:**

**In Edinburgh, a scheme of Early Supported Discharge for older people in the acute orthopaedic unit provides rehabilitation, pre-discharge occupational therapy home assessment, discharge planning, home support, outreach physiotherapy and follow-up by a liaison nurse. Length of stay is reduced, and patient and carer satisfaction is high.**

Successful discharge management of frailer and older patients depends heavily on successful collaboration between acute and community health services and local authority provision such as home help and community occupational therapy services. In many areas community rehabilitation teams are in place and provide rapid access to high levels of supportive and rehabilitation care. Such schemes maximise the chances of a successful return home for even the very frailest patients.

### **IT'S HAPPENING ALREADY:**

**In Glasgow, a liaison nurse ensures good communication between hospital and nursing home care, improving continuity of care and discharge arrangements.**

Particular issues arise in remote and rural areas where acute services may be far from the patient's home. In such settings community hospitals can be a major resource for the local management of acute and sub-acute illness and in the rehabilitation (near home) of patients who have undergone treatment elsewhere but are not yet fit to go home. Active multidisciplinary care, with full use of local community services, can provide excellent journeys of care, minimising separation and unnecessary travel for both patients and carers.

**IT'S HAPPENING ALREADY:**

**In the Southern Highlands the good working relationship between primary care and the orthopaedic service enables patients to have rehabilitation in community hospitals after treatment for a broken hip.**

The Clinical Standards Board for Scotland, as part of its work on standards for Older People in Acute Care, will review the care of older people in acute in-patient settings, and publish findings in a national report in 2003.

**Recommendations:**

- Older people being discharged from acute care should have appropriate access to pre-discharge assessment, multidisciplinary discharge planning, necessary community services, and follow-up to ensure their safety and well-being.
- Acute hospitals should take steps to improve the management of older people requiring multiple acute admissions, to improve continuity of disease management and to minimise repetition and duplication of investigations.
- NHS Boards should recognise that multiple admissions in older people are a problem and take strategic decisions to address this.
- NHS Boards should consider the appropriate recruitment, retention, training and development of specialist staff as part of their overall workforce planning to meet the needs of older people in acute hospital care.

## The Confused Older Patient

Confusion is common in older people admitted to acute care. Pre-existing mild dementia is a common underlying factor. Following admission many other influences – including sensory difficulties, a strange environment, infection, sleep deprivation, dehydration, necessary drug treatment, and inadequate explanation of what is going on – can make things worse.

For people with more severe dementia, acute admission can be extremely stressful, as understanding may be very limited and their distress may be expressed in ways that are seen as disruptive. Care of such patients can be a considerable challenge in the acute setting.

However, most confusional states in acute care are self-limiting, or respond to straightforward treatment of underlying causes. Poor management of confusion e.g. inappropriate or excessive sedative drug treatment or – worse still – physical restraint, can greatly add to pre-existing difficulties.

All acute and post-acute hospital services now deal with older people who are confused. Knowledgeable and sympathetic management of such patients greatly diminishes their distress and is a very rewarding part of the acute and post-acute care of older patients.

### Recommendations:

- **All NHS staff should be aware that older patients may be confused, and should be sensitive to their needs.**
- **Clinical staff should be aware of the causes and management of confusion.**

## Post-Acute In-Patient Rehabilitation

A proportion of older patients admitted to acute care will recover quickly but be unable to return home timeously even with full access to ideal discharge management and community support services. Such patients do not benefit from a prolonged stay in acute care, and need access to rehabilitation in a hospital setting. Specialists have a particular role in managing these patients.

### IT'S HAPPENING ALREADY:

**In Edinburgh there is a successful Geriatric Orthopaedic Rehabilitation Unit.**

Multidisciplinary post-acute rehabilitation will maximise any chance of returning home; provide links to a placement service for stabilised patients who cannot return to their own homes but require long-term care, and – for a minority – provide palliative care in circumstances more appropriate than those of an acute ward.

The Clinical Standards Board for Scotland, as part of its work on standards for Older People in Acute Care, will review against the relevant standard the care of older people requiring further inpatient care following acute care, and publish findings in a national Report in 2003.

### Recommendations:

- **Patients who cannot be discharged directly from acute care should have the opportunity of further assessment and rehabilitation in specialist post-acute wards with multidisciplinary staffing, or – in remote and rural areas – in appropriately staffed local hospitals.**
- **Patients who cannot return home following acute care and post-acute rehabilitation should, until appropriate placement (e.g. in a care home) is achieved, have access to regular medical review and appropriate multidisciplinary care and rehabilitation while still in hospital care.**

### Delayed Discharge

Delayed discharge occurs when a patient – most often an older patient – who has been admitted to hospital care does not have access to other necessary care when and where that other care is needed. For each patient involved, it represents a gross disruption of the journey of care.

The Expert Group felt strongly that older people delayed in inappropriate and often poor-quality wards, usually without access to rehabilitation or diversional therapy, and often far from home, were experiencing care that was frankly unacceptable. They and their families are subjected to inconvenience, separation and distress at a time of great uncertainty and anxiety. The Group heard eloquent and deeply moving accounts of such experiences. Reducing delays in discharge is therefore a matter of the highest priority for all the agencies involved.

In service terms, delayed discharges reflect a failure to resource and balance a range of acute, post-acute, community and long-term care provisions in ways that reflect the needs of an ageing population.

The consequences for patients – inappropriate care sometimes complicated by multiple transfers from ward to ward, and the sense of rejection implied in the label “bed-blocker” – are unacceptable. The consequences for services, in terms of lost capacity and disruption of elective work, are well documented and also unacceptable.

Underlying historic causes include:

- failure over several decades to develop community, acute and post-acute services to meet the needs of a changing population
- acute sector dominance, resulting in a ‘disposal mentality’ aimed at clearing beds rather than caring for patients
- adversarial attitudes between different service sectors (health services vs. social work department; acute trusts vs. primary care trusts) with poor communication, mutual mistrust and resource protection resulting in disruption and delay in the journey of care

- poor identification by Local Authorities and NHS Boards of resources available for the care of older people, both at home and in institutional settings
- continuing difficulties – in some instances amounting to market failure – in the nursing home sector.

A number of recent developments, however, give grounds for optimism.

- The Joint Future Group has provided a framework for improved collaboration among health, social work services and housing.
- Developments in rehabilitation and intensive support packages in the community may serve to minimise or, in some instances, at least delay admission to acute units and the risk of delayed discharge for long-term care.
- Standardised documentation of delayed discharge has quantified the difficulties and allowed comparisons across Scotland.

**IT'S HAPPENING ALREADY:**

**The Chief Executive of NHSScotland has already established a Delayed Discharge Task Force Group whose members come from Health Boards, Trusts, Social Services and Local Councils.**

- There is increasing recognition that, for the frailest elderly, acute admission to hospital may be avoidable, and that such patients run the highest risk of an acute admission resulting eventually in long-term care. It is therefore clear that improving services that might support older people through acute illness at home, where this is clinically appropriate, and might avert unnecessary admissions, is in their best interests.
- Following admission, a small proportion of patients will be identified as those with the most complex needs and at greatest risk of a prolonged and difficult journey of care. For them the Joint Future Group Report recommends intensive care management, with one key person having overall responsibility for managing – in partnership with the individual patient, their carers and the relevant professionals – the whole journey of care with a minimum of transition and delay.
- ISD now documents delayed discharge across Scotland in ways that facilitate comparisons and allow the monitoring of the effectiveness of means of reducing it. Over the next few years the impact of the implementation of good practice as recommended by the Joint Future Group – including that of intensive care management of those most at risk of delayed discharge – will be assessed and made public.

### Recommendations:

- **NHS Boards and Local Authorities should address delayed discharge as a top priority within joint management and joint resourcing of services, including community rehabilitation services.**
- **NHS Boards and Local Authorities should – as part of joint working – increase the transparency of resource use in the care of older people.**
- **NHS Boards, Local Authorities and the private and voluntary sectors should assess population needs and plan capacity to meet likely demands.**
- **NHS Boards, Local Authorities and the private and voluntary sectors should explore innovative means of addressing the problems associated with longer-term collaboration in service provision.**
- **ISD should continue to monitor and report standard comparative information to allow continuing scrutiny of problems and progress in the management of delayed discharge across Scotland.**

### Nearing the end of life

One result of increasing longevity and mass survival into old age is that mortality within our society is now largely compressed into the eighth and ninth decades. Good care of older people means also ensuring for them good quality of care as life approaches its end.

Many older people have only relatively brief periods of dependency and need for care before they die. A smaller proportion will – because of slowly increasing frailty – require increasing care in their last months or years.

Although most people – the vast majority of whom are old – still die in hospital or long-term care, more and more support is now available to patients who wish to remain at home as long as possible, or indeed to the end.

#### **IT'S HAPPENING ALREADY:**

**In Dumfries and Galloway, good joint working supports the Dying at Home Scheme for people who prefer not to spend the last part of their lives in hospital.**

Where the necessary care can no longer be provided at home, the aim is to ensure that continuing care, in both care home and hospital settings, provides the maximum possible quality of life.

Within NHSScotland, the number of continuing care beds has been greatly reduced in recent years and their role has changed too. Patients are admitted with higher dependency than formerly, and are more likely to have active medical problems. In keeping with this, length of stay in NHS continuing care is now much reduced, being measured in months rather than years. In effect, NHS continuing care beds are now largely devoted to care near the end of life.

The goals of independence and dignity are no less important in the very last stages of life. Recent decades have seen a remarkable change in attitudes to palliative care, along with a series of excellent developments in service provision – in hospices, hospitals and the community – and in education and research involving a whole range of health professionals.

*The National Care Standards – Care Homes for Older People* support care in dying and death. Standard 19 states that older people should be “confident that staff will be sensitive and supportive during the difficult times when someone dies.”

#### **World Health Organization definition of palliative care**

‘Palliative care’ is the active total care of patients whose disease is not responsive to curative treatment. The goal of palliative care is achievement of the best possible quality of life for patients and their families. Palliative care:

- affirms life and regards dying as a normal process;
- neither hastens nor postpones death;
- provides relief from pain and other distressing symptoms;
- integrates the psychological and spiritual aspects of patient care;
- offers a support system to help patients live as actively as possible until death;
- offers a support system to help the family cope during the patient’s illness and in their own bereavement.

The Scottish Executive has made clear its commitment that palliative care should be available to all who need it.



## Introduction

As the survey carried out for this report shows, most older people are well most of the time. Many enjoy good and even excellent health well into their 70s or later. For the less fortunate, ill health may be carried over from middle age, and for others the common disorders of later life – such as arthritis, deafness, heart disease, and diabetes – can, alone or in combination, cause increasing problems as the years and decades pass.

In later old age, increasing frailty can bring greater risk of accidents and greater vulnerability to the effects of minor infections. Yet many such people can continue to live in their own homes, enjoyably and fairly independently, if the right kind of services are there for them when they are needed.

However, when chronic disease is established, or more serious illness strikes, good services for older people are even more important. This section of the report covers six major topics: chronic disease, cancer, heart disease, stroke, mental health, and falls.

Four of these topics – cancer, heart disease, stroke and mental health – have already been the subject of important recent reports:

- *Cancer in Scotland – Action for Change*, the report of the Scottish Cancer Group was published in June 2001 and is now being implemented.
- The *Coronary Heart Disease / Stroke Task Force Report* was published in September 2001 and comments were sought during a three month consultation period. The Executive will publish its CHD/stroke strategy during 2002.
- *A Framework for Mental Health in Scotland*, in place since 1997, referred to services for older people with mental health problems, including people with early onset dementia.

Each report addresses perceived weaknesses in current services and recommends changes in service organisation and clinical practice that are designed to produce measurable improvements in care. Each will be followed up by an implementation phase to make sure that improvements happen.

Our report, *Adding Life to Years*, does not attempt to duplicate for older patients the detailed and expert work already carried out. Rather, it seeks to ensure that the improvements in care in every area are fully shared by older service users; and it does so because the Expert Group firmly believes that real progress in the care of older people is most likely if most of that care continues to take place within the mainstream services of NHSScotland.

This approach represents a positive assertion of the rights of older service users, and a refusal to countenance the evolution of two-tier services in important clinical areas where good care of all Scotland's adults, regardless of age, is the goal.

Of course care will always require to be matched to individual circumstances, and for some older people the issues of frailty, multiple pathology, limited expectations for outcome and personal choice will to varying degrees influence treatment. Such sensitivity has always been part of good healthcare.

But since age alone should not be a bar to appropriate treatment, and since the care of older patients is now the main business of NHSScotland, the Expert Group was unanimous that this "mainstreaming" of as much as possible of such care was the best way ahead. The Expert Group also took the view that recent developments in both primary and secondary care are encouraging, and give grounds for believing that this approach will succeed.

### **Better Care for Older People with Chronic Disease:**

Care for older people with chronic disease such as diabetes, arthritis and chronic bronchitis varies greatly across Scotland. Good care actively involves the patient in the management of their own disease and its problems, and relies on good information for patients, locally available primary care services and easy access to more specialist hospital services if and when the need arises.

#### **WHAT WE HEARD:**

**"The best people to manage chronic disease are the patients themselves."**

GP

Developments in primary care in Scotland – including the establishment of LHCCs and the more recent initiative of the Personal Medical Services (PMS) contract for GPs – have encouraged the spread of good practice in chronic disease management, with local multidisciplinary and nurse specialist clinics, and better links between primary care and hospital services.

**IT'S HAPPENING ALREADY:**

In Edinburgh the Acute Respiratory Assessment Service provides readily available expert care at home for people with chronic bronchitis, most of whom are in the older age groups. The service has succeeded in reducing the number of repeat admissions, and improving the quality and cost effectiveness of care.

**Recommendation:**

- **Primary care and acute services should take steps to improve the management of older people with chronic disease and at risk of multiple admissions in order to improve the continuity and quality of their care.**

**Cancer in Older People**

Cancer is commoner in later life. Around one-third of all cancers are diagnosed in people over 75, who form only around 7% of the population. Some common forms of cancer may be less aggressive in older patients but in general terms results of treatment are less good. However, older people with cancer are less likely to undergo detailed investigation, and also receive less treatment than younger cancer patients.

**Access to care**

Older people with cancer are more likely to have other illnesses as well, and some of the physiological changes associated with age – such as declining kidney and lung function, and poorer drug absorption from the stomach – may make the various forms of cancer treatment less effective and also more risky. But even when these factors are taken into account it appears that substantial numbers of older patients do not receive cancer treatment that might benefit them considerably.

**Treatment options**

There is good evidence that some older people – particularly the “biologically young” – tolerate major surgery well and gain accordingly, often with a cure. For others, more limited surgery aimed at reducing symptoms will be more appropriate. Individual assessment, sympathetic explanation and patient participation in decision-making will maximise the benefits available from surgery for older cancer patients.

The risks of radiotherapy are higher in older patients, and an extended course of treatment may be uncomfortable and physically demanding for the more frail. Again, careful patient assessment and support will maximise gains of treatment.

Chemotherapy – the treatment of cancer with drugs – continues to advance in ways that are expected to improve the care of older patients. New drugs with fewer side effects are emerging, and many can be given by mouth.

**Common cancers of later life: some key facts:**

- A number of cancers that are common in older people may be easily treatable if detected early. These include some skin cancers, oral cancers and lymphomas.
- Lung cancer is the commonest cancer in men, though its incidence is now falling because of a fall in smoking. In women it is still becoming more common. Results of treatment are generally poor.
- The outcomes of breast cancer – now the second commonest cause of female cancer deaths, after lung cancer – have been considerably improved by the use of tamoxifen, which is well tolerated by older patients. Screening has recently been extended to include women up to age 70.
- Prostate cancer is common – more than 50% of men over 75 harbour it – but highly unpredictable: only a small proportion will develop life-threatening disease. Screening for prostate cancer remains under evaluation.
- Screening for colorectal (“bowel”) cancer is being evaluated in the 50-69 age group. Many older patients tolerate surgery and some forms of chemotherapy well and therefore benefit from treatment.

Even for the oldest and frailest cancer patient, there is never “nothing we can do”. Treatment, whether palliative or aiming at cure, should always be tailored to individual circumstances, and older patients should receive scrupulous attention to explanation of the possible options and their implications. As more selective and less toxic treatments become available, the gains of active treatment will grow in relation to its disadvantages, and older cancer patients should share fully in these developments as they emerge. The new Performance Assessment Framework will be used to hold NHS Boards accountable for the quality of care they provide. Among the standards they must meet are those set by CSBS for the management and support of cancer patients and their carers. CSBS should ensure that its standards adequately assess the care provided to all age groups including older people.

**Recommendations:**

- **Older people with cancer should have full access to the service developments that follow from the implementation of *Cancer in Scotland, Action for Change*.**
- **Older patients should have access to appropriate investigation and treatment of cancer on the basis of their individual clinical needs.**
- **CSBS standards should adequately assess care provided to all age groups including older people.**
- **Older patients with cancer should have access to rehabilitation to enable them to cope with the impact of disease and treatment.**

## Coronary Heart Disease

The burden of coronary heart disease (CHD) falls most heavily on older people, with 81% of all CHD deaths occurring in people aged 65 and over, and 54% of all hospital discharges with a main diagnosis of angina in the same age group. CHD in later life is in general under-researched in relation to its impact on society, and concerns have been expressed about older people's access to the full range of effective treatments.

### Angina

There is evidence that both the more complex angina investigations and the non-drug angina interventional treatments such as coronary artery bypass grafting (CABG) and percutaneous transluminal coronary angioplasty (PTCA) are under-used in older people. Around two thirds of interventional treatments are carried out on patients aged 65 and under.

Reasons for this disparity between need and intervention are complex. Some older patients may prefer to accept medication and be less keen on surgery, but this requires further research. The nature of coronary artery disease in later life (it is likely to be more widespread and therefore harder to treat) may be a factor, but only adequate investigation by angiography can really determine this in individual cases.

Complication rates are higher for treatment in older people, but again more research is required on risks and benefits in the age group. Overall, there is an impression that many older people in Scotland could benefit from a more active approach to the investigation and treatment of their angina symptoms.

### Acute myocardial infarction (Heart attack)

Mortality from this has been falling in Scotland over the last ten years, by around 50% in the under 65s but by only around 28% in the over 75s.

Again reasons are complex. Heart attack symptoms may be less clear-cut in older patients, leading to delayed or missed diagnosis. Older people are also more likely to have other illnesses – such as stroke and diabetes – which could worsen outcomes.

Specific information from Scotland about access to Coronary Care Unit (CCU) beds for over 75s is lacking, as is information about the use of thrombolytic (clot-dissolving) drugs in older people, though there is good evidence that older people do well with such treatment.

Older people can gain positive health benefits from multi-professional cardiac rehabilitation programmes.

**IT'S HAPPENING ALREADY:**

**The Braveheart Project in Falkirk is a self-help group which provides a mentoring service to people aged 60 and over with coronary heart disease.**

**Heart failure**

Heart failure, most commonly caused by CHD, affects about 20% of older people and is one of the commonest reasons for which they contact their GPs. Drug treatment is increasingly effective, but there are concerns that too little of the relevant research relates specifically to older patients.

Older patients with heart failure are less likely to be fully investigated (with echocardiographic imaging of the heart's function), and also less likely to receive some of the most effective treatments, such as the ACE (angiotensin converting enzyme) inhibitor drugs.

Heart failure is a chronic problem, and may require recurrent hospital admissions. Some service developments, based on specialist multidisciplinary teams, have improved care by promoting closer patient involvement and better compliance with drug therapy.

**IT'S HAPPENING ALREADY:**

**In West Lothian, patients with heart failure get nurse specialist care at home. Results are good. Patients need far fewer hospital appointments, and are much less likely to need re-admission to hospital.**

**Prevention**

There is now good evidence that the "younger older" can benefit from drug treatment aimed at reducing blood pressure and blood cholesterol, with reductions in the clinical manifestations of CHD as a result. In the oldest age groups the evidence is less strong.

After a heart attack, the risk of recurrence is reduced by drug treatment with aspirin and beta-blockers. The effectiveness of beta-blockers in older patients is in fact greater than in younger age groups.

The new Performance Assessment Framework (PAF) should provide a means of assessing NHS Board's performance against the CSBS standards for secondary prevention following myocardial infarction.

The Expert Group expressed concern, however, that in this, as in other areas, the PAF does not adequately assess care provided to older people.

**Recommendations:**

- Older people with coronary heart disease should have full access to service developments that follow from the implementation of the *CHD/Stroke Task Force Report*.
- There should be increased professional awareness of heart disease in the elderly: its presentation, the range of potentially useful treatment options and the need for individual assessment on the basis of need and potential benefit.
- There should be increased awareness of the potential of preventive intervention in later life.
- Rehabilitation and support for older people with CHD should be improved by better coordination between hospital and primary care, including outreach specialist services.
- Monitoring, by means of transparent audit, of the access by older patients to appropriate investigation and treatment for CHD should be undertaken.
- Further research should be carried out to clarify best treatment, access to care, and attitudes to treatment for CHD specifically in older age groups.
- CSBS standards should adequately assess care provided to all age groups including older people.

## Stroke Care and Rehabilitation

Stroke is an illness predominantly affecting older people. Its care is complex, and involves many clinical disciplines. Good care improves survival and minimises disability. High quality services in Scotland could reduce, by several hundred a year, the number of people dying or requiring long-term care as result of stroke.

There is now good evidence about how patients with stroke should be cared for, much of it from the Scottish Intercollegiate Guidelines Network (SIGN). However, there is also evidence that the standard of stroke care across Scotland varies greatly. CSBS will commence preparation for stroke standards in 2002.

### Early care of stroke patients

Most stroke patients are admitted to hospital, and there is currently no evidence to support major service developments designed to avoid hospital admission. Early assessment should include CT scanning and swallowing assessment, with early appropriate management of patients with swallowing difficulties. Fluid balance, pressure area care and prevention of DVT (deep vein thrombosis) should all receive attention.

Early mobilisation, and the active involvement of patients and carers in treatment planning, is recommended. Care should be provided by a ward-based multidisciplinary team including medical, nursing, physiotherapy, occupational therapy, speech therapy and social work staff; and should be co-ordinated through regular multidisciplinary meetings.

### Discharge and follow-up

Discharge from hospital should be carried out according to a protocol agreed between hospital and primary care. There is recent evidence that early supported discharge schemes may allow up to 50% of stroke patients to get home sooner.

Following discharge, patients and carers should receive the services and support they need, including continuing access to rehabilitation where required, and have access to supportive organisations such as Chest, Heart and Stroke Clubs.

### Service organisation

While there is strong evidence for the effectiveness of organised, ward-based, multidisciplinary stroke care, details of service organisation will vary with caseload and geographical circumstance. In large acute hospitals, comprehensive stroke units can combine acute care with rehabilitation of up to several weeks' duration, allowing one-stop care for a majority of patients. Separate post-acute rehabilitation beds may be needed for patients requiring prolonged care, and for those living far from the main hospital.

In remote and rural areas immediate care and subsequent rehabilitation arrangements will inevitably reflect local circumstances, but should include multidisciplinary care and should follow – so far as is possible locally – the national guidelines.

### Recommendations:

- **Stroke patients admitted to hospital should be managed in a stroke unit by a coordinated multidisciplinary team.**
- **Rehabilitation should be coordinated between hospital and primary care to ensure continuity.**
- **NHS Boards should ensure that stroke care reflects current national SIGN guidelines.**

### Mental Health Problems in Older People

Mental health problems – particularly depression and dementia – are common in later life. In recent years there has been real progress in understanding the nature of these illnesses, and real progress, too, in drug treatment. Antidepressants are now more effective and have fewer side effects, and drugs are now available to treat some forms of dementia – though a cure is not yet in sight. It is important to remember that anxiety and alcohol abuse occur in older people too, and that social exclusion is most marked in those who have grown older suffering from severe and enduring psychiatric illness, notably schizophrenia.

For older people: and in society generally; the stigma of mental illness still looms large. As mental health services are uneven across Scotland, and because of lack of awareness and training on the part of some clinical staff, many older people with mental illness may be suffering unnecessarily – not receiving treatment that could help them, and missing out on support and services that could benefit both them and their carers.

Early diagnosis and effective support enable people to be cared for in their own homes for longer and with better quality of life.

Because older people with mental health problems have tended to suffer in silence, and because the kind of services that help them most involve a range of health professionals and agencies and are therefore quite challenging to organise, the Expert Group felt strongly that clear central guidance on service development should be matched by local commitments on the part NHS Boards in order to ensure generalisation of best practice in mental health care of older people across Scotland.

The Mental Health and Well Being Support Group, currently undertaking its second round of visits to Health Board areas, is concerned with the implementation of the improvements to mental health services set out in the *Framework for Mental Health Services in Scotland* and the modernisation agenda set out in *Our National Health*. The priorities include the development of a joint local strategy, agreed among the partner agencies, LHCC involvement in planning and delivery of mental health services and a co-ordinated inter-agency approach to dementia services and support.

The Expert Group recognised that better information systems are needed to support planning and delivery of mental health services for older people. They welcomed the fact that ISD and NHSScotland are running a project to improve integrated direct care through improved provision of the right mental health information at the right time and in the right place.

### Depression

Depression affects 3-5% of over 65s at any point in time, with milder forms of mood disorder being present in another 10-15%. Forty percent of people who have suffered a stroke become depressed and rates of depression are particularly high in long-term care settings.

Depression can be difficult to diagnose. Some older people simply put up with its symptoms – such as inappropriate sadness, low mood, poor appetite and poor sleep – because they do not realise that they may have a treatable illness.

About 25% of suicides occur in older people, although they form only 15% of the population. Ninety percent of such cases have serious depression, and most have visited their doctor in the three months prior to death.

Better recognition of depression – through greater awareness of the part of health professionals – could reduce much suffering and also prevent a proportion of suicides. The Geriatric Depression Scale, a simple 15-question checklist, is useful in arriving at the diagnosis. Modern drug treatment is increasingly effective, but it is not always given in adequate doses – particularly in primary care.

The effective use of antidepressants, supplemented by psychological intervention, can improve the quality of life.

### Dementia

About 5% of people above age 65 suffer from some form of dementia, a figure that rises to around 25% above age 85. The commonest form is Alzheimer's Disease, accounting for about 60% of cases. Vascular dementia – caused by a series of small strokes – is the next commonest, with a proportion of cases having both. Less common causes, for example Lewy Body Disease, which combines features of Parkinson's Disease with dementia, account for the rest.

Treatment for Alzheimer's Disease is improving; early and accurate diagnosis is now very important. Initial assessments in primary care should ideally be followed through with brain imaging and more detailed assessment at specialist memory clinics where available. In a proportion of cases treatment will reduce symptoms and slow the rate of progress of the disease, easing the burdens on patients, carers and services.

#### **IT'S HAPPENING ALREADY:**

**In Dundee there are Memory Clinics to which GPs can refer older people with memory problems.**

Sixty percent of dementia patients live at home. The best care for them can be achieved when Community Mental Health Teams for older people and primary care work together and with other agencies to deliver earlier diagnosis, followed by treatment and support tailored to individual circumstances and changing needs. Meeting the long-term care needs of older women with dementia who have previously lived alone is a particular challenge for providers of joint services.

Good joint working like this will support individuals and their carers, minimise the need for patients to go into hospital, and will provide patients and carers with practical and continuing help. But carers themselves are entitled to expect support, and carers' groups can be highly effective: providing local networks, sharing problems and feelings, and sharing skills and knowledge, too.

A small number of older people with more serious mental health problems will require hospital treatment and rehabilitation, and a few will need care in hospital. Given that such patients commonly have physical problems, too, there are advantages in some integration of in-patient care for older people with serious mental health problems with specialist care of the very frail elderly.

Older people with mental health problems who need admission for the treatment of physical illness face additional difficulties. They are more prone to acute confusional states and may become distressed and even disruptive. However, they should not be excluded from appropriate treatment simply because their mental problems make that treatment difficult. Good psycho-geriatric consultation and liaison services in acute hospitals will be of great help in their care and may even reduce delayed discharges or inappropriate placement in long-term care settings.

### **Recommendations:**

- **NHS Boards should work to raise awareness of older people's mental health issues, and to promote recognition and treatment of problems at an early stage.**
- **NHS Boards and Local Authorities should assess population needs for dementia and other mental health services and plan appropriate capacity at all levels.**
- **NHS Boards should ensure there are services to provide rapid assessment of cognitive impairment, with appropriate access to modern drug treatment and follow up.**

## Falls and Fracture Prevention

Falls and unsteadiness are very common in older people. Roughly 30% of over 65s report a fall in the past year, a figure that rises to over 40% in the over 80s, and even higher in the frailest and those with dementia.

Most falls do not result in injury but the vast majority of fractures in older women result from falls, including over 90% of hip fractures. Osteoporosis – thinning of bone structure – increases the risk of fracture. And even in the absence of falls the fear of falling limits activity and increases the risk of admission to care.

A simple test screens for instability and mobility problems.

### The Get Up and Go Test

The older person is observed:

- Standing up from a chair, without using their arms
- Walking several paces
- Turning
- Returning to the chair and sitting down

If there is no difficulty or unsteadiness, no further assessment of balance and gait is required.

Most falls are multifactorial in origin, and there is now a clear understanding of the risk factors involved. The more risk factors present, the greater the risk of falling. Successful interventions are those which address multiple risk factors and there is now substantial evidence from randomised controlled trials that these interventions are effective.

### IT'S HAPPENING ALREADY:

**In West Lothian, older people who fall are offered a balance re-training programme which has reduced the number of falls at home.**

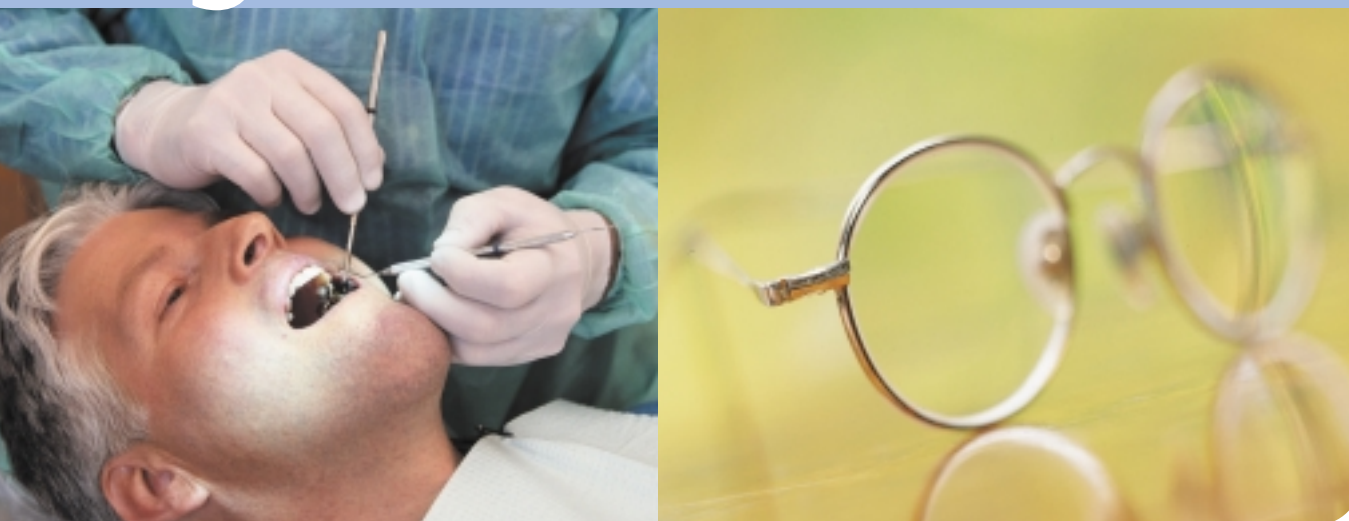
Collaboration between the American and British Geriatrics Societies and the American Orthopedic Association has resulted in evidence-based guidelines for the prevention of falls in older people. The Health Education Board for Scotland (HEBS) is developing proposals for project work to evaluate the development of local services in line with these guidelines. The Royal College of Physicians (London) has published an evidence-based guideline on the prevention and treatment of osteoporosis.

### IT'S HAPPENING ALREADY:

**In Glasgow, physiotherapists run a 12-week hospital-based osteoporosis programme, which is continued in community sports centres by trained exercise instructors.**

**Recommendations:**

- All older people should be asked annually if they have fallen in the past year.
- In those who have fallen once only, balance and gait should be assessed by the Get Up and Go Test.
- All who report recurrent falls, appear unsteady or who have difficulty with the Get Up and Go Test, and all presenting to medical attention with a fall should undergo multidisciplinary evaluation.
- NHS Boards should ensure that falls assessment services are available and that these provide interventions of proven effectiveness, tailored to community or care home settings.
- Osteoporosis management should be an important part of any falls assessment.



### What the public thinks

Ageism has been defined as “systematic and negative age discrimination”, and can exist at individual and institutional levels. But there are many other ways in which negative attitudes to older people can be demonstrated, or displayed to older people, or perceived by them. Areas of concern and recent discussion about ageism in NHSScotland include: decisions about resuscitation; access by older people to various treatments and interventions; the quality of care experienced by older people; attitudes of NHS staff; and the quality of the environment in which care is provided.

The failure of NHSScotland to adapt to the changing needs of a changing population could also be seen as “structural ageism”. In other words, a traditional service designed around isolated episodes of care within well-defined specialties and agencies cannot fully meet the needs of increasing numbers of older patients, especially those with chronic, multiple and recurrent medical problems. This analysis would explain dissatisfaction expressed by patients and carers, as well as the perceived pressures within and around the services they use. This report fully acknowledges the mismatch of provision to need, and makes many recommendations to address “structural ageism” throughout the service.

The Expert Group was determined, as an important part of its work, to find out what older users of NHSScotland’s services thought of their experiences. A consultation process in July 2001 used newspaper advertisements to invite comment, and 377 individuals and organisations responded. Analysis of these comments showed evidence of both satisfaction and dissatisfaction, with concerns about waiting lists a recurrent theme.

This consultation process was supplemented by specially commissioned research, in the form of a survey carried out by MORI, to determine older people’s views about the services NHSScotland provides; their experience of these services; and – in particular – whether they felt they were being discriminated against because of their age in terms of the services they received.

In September-October 2001, 549 interviews were carried out with a representative sample of people aged 60 and over who had had contact with health services in the previous 12 months. In broad terms, this research showed that older people are generally satisfied with NHSScotland, with many examples offered of excellent care received, and staff at all levels mentioned for praise.

But there were also areas where respondents felt improvements could be made, by such means as greater personal attention and time spent with individual patients, shorter waiting times for appointments, and more home visits. There were also comments that some staff failed to treat older people with respect and courtesy, and that at times of crisis or bereavement such incidents could leave lasting memories. One in six (17%) of older people said they felt that they, as a group, received poorer services than others.

### What did we find out? The views of older people

Does NHSScotland provide a poorer service because the person is old?

- 17% of respondents thought that older people get a poorer service. Just under a quarter of this percentage hold this view on the basis of direct personal experience.
- Particular aspects of NHS service where respondents felt older people got a worse service were: elderly patients neglected generally; low priority; put to the end of the queue.

Problems in NHS reported most frequently occurring

- Long delays before a suitable appointment date is available (46% say it occurs most of the time/some of the time/very occasionally).

Best experience of health service

- 30% said this was with a doctor.
- 10% said it was when admitted to hospital as overnight patient.

Statements explaining why it was a good experience

- 39% said it was because “I felt staff were kind and friendly”.
- 36% because “I was treated with respect”.
- 34% because “I got exactly the service/treatment that I required”.

Worst experience? (very small numbers compared with “best experience” responses)

- 9% with “Some other NHS service”.
- 6% with a doctor.
- 5% with “Outpatient clinic” and when “Admitted to hospital as overnight patient”.

Statements explaining why it was a bad experience

- 6% said “A long wait for the appointment”, others said “I did not get the service/treatment that I required”, “I felt staff were insensitive”.

What change would you like to see to improve the service for older people in Scotland?

- 16% said “Prioritise older patients/shorter waiting list times”
- 12% said “More staff”
- 8% said “Generally satisfied/happy as it is”.

Research on access to primary care services in Scotland has shown higher levels of satisfaction among older people than among younger people. A smaller-scale study has shown that older people are less likely to perceive ageism than are younger people, and it is possible that this can be explained by the higher expectations of younger people, and the “gratitude factor” which is more common among older people.

To summarise, many older people appear to be satisfied with the care they receive in NHSScotland, but around one sixth have a perception that older people receive poor service. Some of the criticisms which older people have of the NHS, for example about delays, are shared by younger users.

The full MORI poll “Public Attitudes to the Healthcare of Older People in Scotland”, from which these findings are taken, is available on the EGHOP Website and is published together with this report.

#### **WHAT WE HEARD:**

**“When I need medical attention from my GP in my local hospital I find no distinction between young and old and how they are treated. If anything, the elderly receive more consideration certainly not less.”**

Woman 80s

## **Specific Issues**

### **Access to Specialist Treatment**

The Expert Group firmly asserts the right of older people to all treatments including the most advanced and expensive whenever that treatment is likely to bring benefit. Individual circumstances vary, and many older people benefit greatly from such specialist procedures as joint replacement, cataract surgery, and interventions for coronary heart disease.

However, many older people have concerns about what they might see as futile and uncomfortable active treatment late in life, and especially as the end of life nears.

Referral for specialist treatment should always be considered in the detailed circumstances of the individual patient, with individual patients and their carers fully informed about the options, the risks and the potential benefits. Where such discussion takes place and goals of treatment are identified and agreed, difficulties and disagreements rarely arise.

### **Commencing, continuing, withholding and withdrawing treatment**

All medical care, whatever the age of the patient, should be based on a consideration of the individual circumstances of the patient: their wishes, their needs, the diagnosis and the available treatments, the presence or absence of other health problems, and – particularly in the case of older patients – the potential benefits of the proposed intervention in relation to any hazards or discomfort it may bring as overall life expectancy diminishes.

Older people have benefited greatly from advancing medical technology and drug treatments, which in many instances have brought greater benefits with fewer disadvantages. But the injudicious use of available interventions may, especially as life nears its end, bring discomfort and indignity out of all proportion to any foreseeable gain. Concerns about this are sufficiently widespread to have generated considerable interest in the use of advance directives, most of which seek to prevent interventions seen as futile.

In recent years discussion of commencing, continuing, withholding and withdrawing treatment near the end of life has become much more open. Public debate, often prompted by specific cases, has increased public awareness, and patients and carers expect – quite rightly – to be consulted when their treatment, or that of someone near to them, is being determined. Many professionals welcome this new openness, and all must now accept it, seeing patients and carers as partners in care, and making time for sympathetic and informed discussion of individual circumstances and options.

There can be no general guidance on appropriateness of treatment – whether to be commenced, continued, withheld or withdrawn – because appropriateness should always reflect individual circumstances and these will vary. But most service users and clinicians would agree that good information and good communication result in good decisions – which can be revisited if necessary as circumstances change. Conversely – as scrutiny of NHS complaints repeatedly confirms – difficulties arise where information is not shared and where communication is poor or absent.

#### **WHAT WE HEARD:**

**“Stop using age as an excuse for not giving proper treatment.”**

Carer

### **Cardiopulmonary Resuscitation of Older Patients**

Successful resuscitation of patients who collapse (and in the past would always have died) from sudden cardiac arrest or abnormal heart rhythm, is a major benefit of modern medicine. But attempted resuscitation offers no guarantee of success. Good outcomes – probably best defined as survival followed by discharge from hospital – have been repeatedly shown to be quite rare following resuscitation in the very frail elderly.

Decisions about resuscitation are therefore sensitive. This is now widely recognised by medical and other professionals within the NHS. National guidelines recommend discussion with patients for whom the risk of cardiac arrest is predicted to be high. When direct discussion with the patient is not appropriate, the views of those closest to the patient may assist the clinical team in reaching a decision about whether an attempt at CPR is appropriate.

In November 2000 a Health Department Letter (NHS HDL (2000) 22) asked NHS Trust Chief Executives to ensure that appropriate resuscitation policies which respect patients' rights are in place, are understood by all relevant staff and are accessible to those who need them.

### Proxy decision making

The Adults with Incapacity (Scotland) Act 2000 enables adults to nominate and register a healthcare proxy, the Welfare Attorney, who will be able to make their healthcare choices when they lose capacity to do so. From Spring 2002, the courts can appoint Welfare Guardians, who are authorised to take healthcare decisions on behalf of adults who have already lost capacity.

These proxies are to be consulted, where reasonable and practicable to do so, in all healthcare matters, when the adult lacks capacity for the healthcare decision in hand.

### Older People from Ethnic Minorities

If ethnic minority elders have difficulties with understanding spoken English, they will clearly need translation, interpretation and advocacy services to ensure good communication in healthcare matters. This is of particular importance when dealing with matters of consent to treatment, and where there are mental health problems.

Culturally sensitive services will be needed and the highest priority will be:

- Higher awareness of cultural issues in health and social service professionals.
- Translation service.
- Appropriate food in institutional care. Local caterers who supply vegetarian meals to local schools may be in a position to advise on quality and variety of meals, particularly for long-stay patients.
- Single sex wards. Mixed wards can cause particular distress in ethnic minority groups through use of mixed toilet and bathing facilities.
- Sensitive and appropriate support in relating to the dying and recently bereaved is necessary. Many religions have specific rules surrounding the end of life. Guidance should be sought from religious leaders of all relevant communities and this information should be made available in every care setting, including private sector nursing homes.

### Single Sex Wards

#### WHAT WE HEARD:

**“The one dread I have is going into a mixed ward.”**

Woman 80s

*Our National Health* commits the Scottish Executive to investing funds to ensure compliance with the policy to eliminate mixed sex accommodation by April 2002. The exceptions will be in intensive care, high dependency and emergency units.

**IT'S HAPPENING ALREADY:**

**NHS Trusts are taking steps to ensure the privacy, dignity and security of patients by provision of single sex wards or bays and lockable washing and toilet facilities.**

## Advocacy

**IT'S HAPPENING ALREADY:**

**In Dumfries and Galloway, the People's Advocacy and Support Service (PASS) helps older people in their dealings with health services, social services and housing agencies.**

Some older people, particularly those with sensory and communication problems, are among the most vulnerable in our society. They can benefit greatly from the kind of support and practical assistance that independent advocates can provide, both in day-to-day contact with different agencies and particularly at times of stress and when major decisions are required. Older people in the ethnic minorities have particular needs in terms of advocacy. Good interpretation services and full awareness of cultural issues are essential if advocacy is to serve them well. *Our National Health – a plan for action, a plan for change* requires Health Boards and their planning partners to set up advocacy schemes that meet the needs of their populations.

## Meeting the Needs of Frail Elderly, and Those with Sensory Impairment

As this report has already emphasised, older people are by no means a homogeneous group. Many are as fit as or fitter than younger adults. But the prevalence of difficulties with hearing and sight increases with age, and in the older age groups increasing numbers of people have difficulty getting about in comfort and without assistance.

**WHAT WE HEARD:**

**“Not all older people are deaf!”**

Woman 71

All health professionals need to be aware of these issues and sensitive in their dealing with affected individuals, and make efforts to ensure that appropriate aids to communication are available and properly used. All health service premises should be easily accessible by people dependent on walking aids and wheelchairs, and toilet facilities must also meet their needs. Design of future hospital and other healthcare premises should recognise that the majority of users will be older people, and that ready access for people with disabilities must be assured.

**WHAT WE HEARD:**

**“Old does not equal stupid.”**

(Anon)

**“Would it be possible for all trained doctors and nurses to have deaf awareness lessons?”**

Woman 70s

## Staff Attitudes

**WHAT WE HEARD:**

**“I get the feeling that doctors are bored with older people at surgeries.”**

Woman 70

**“The practice nurse has an excellent manner, and puts me at ease. She is very helpful and goes out of her way to help”.**

Woman 77

**“Doctors should be taught compassion and manners.”**

Woman 80s

**“The doctor made sure he understood me and that I understood the diagnosis and treatment”.**

Man 66

As these quotations illustrate, older people have a mixed experience of staff attitudes in NHSScotland. Some members of the ethnic minority population may feel that they have the dual jeopardy of ageism and racism. Consistently positive staff attitudes to older patients are essential since the care of older patients is the central task of health care in the 21st century, and such attitudes are more likely if staff are fully trained and supported for that task.

Most health care professionals pride themselves on positive attitudes and good communication skills; where deficiencies are identified, they should be addressed by appropriate encouragement and training.

**WHAT WE HEARD:**

**“The elderly are patronised and put to the back of the queue.”**

Woman, 70s

**Services that suit older people**

Throughout the Report “Could do better” is a recurrent theme, with the message “It’s happening already” as a constant reminder that good and indeed excellent practice in the care of older people already exists. The challenge now is to generalise best practice across NHSScotland.

**WHAT WE HEARD:**

**“In my experience, the elderly are not denied access to specific acute care services when compared with younger patients. However, there is a significant under-investment in services specifically for the elderly, when compared with acute disease-based services.”**

GP

Health services for older people must improve. That is the central theme of this report, and clearly includes recognition that there is widespread room for improvement. But to acknowledge that is not to suggest that widespread ageism exists in our health service.

Instances of poor care of older people undoubtedly occur, and investigated complaints reveal harrowing details. Such complaints should continue to be valued within NHSScotland since they throw light on lapses from expected standards and provide leverage for change.

**Ageism**

A number of health service personnel and policy analysts have commented on ageism in the NHS, and Age Concern has published accounts by older people of denial of treatment, poor service and disrespectful staff. Strictly, to prove ageism it would be necessary to show that such experiences were rooted in negative attitudes about age rather in the possible wider failings of the NHS. A survey of complaints received by the NHS appears to indicate that, proportionately, complaints about the care of older people are not over-represented compared to those concerning the care of younger adults.

It could be argued that in many ways the NHS discriminates positively in the interests of older patients although with varying degrees of success. The development of specialist services for the frail elderly and for older people with mental health problems is relatively advanced in Scotland. Services for older people are systematically reviewed by the Scottish Health Advisory Service (SHAS), and reports are made public. These show some instances of cause for concern, but also many examples of excellent practice, some of which are quoted in this report.

Although ageism is seen as an important issue, there has been relatively little formal research on it and very little of that in Scotland. A review of the published literature was commissioned expressly for this report. It covered such areas as “not for resuscitation” orders, exclusion of older people from clinical trials, exclusion from breast screening, management in Accident and Emergency Units, cancer care, and cardiology.

Briefly, research that has been done does not appear to support allegations of widespread ageism. That, however, should not be taken to mean that there is no ageism, or that allegations concerning ageism should not be taken seriously. “Absence of evidence is not evidence of absence.”

Further work on ageism should include:

- systematic original research in NHSScotland;
- acceptance that ageism might exist, with the implementation of strategies to tackle it;
- an information campaign to reassure older people that there is little systematic, negative discrimination, and that there have been considerable efforts to allocate resources in ways that actually favour older people.

The Expert Group recognised that there is little or no systematic evidence of ageism in NHSScotland; but at the same time accept that – as the polling carried out for this Report shows – there are, within Scotland, significant concerns about ageism on the part of individual older people, service users and carers, and organisations representing older people’s interests.

These concerns about ageism are real and must be recognised and addressed. If the grounds for concern lie in poor services, poor communication, and delays, then these should be tackled directly. Much of this report states quite explicitly how this should be done.

**WHAT WE HEARD:**

**“Sadly, the NHS is quite capable of providing poor services for older people without being in the slightest ageist.”**

Doctor

In the longer term, perhaps the best response to concerns about ageism in NHSScotland is simply to achieve a widespread and visible improvement in the quality of service for older people. This report, by recognising for the first time the care of older people as a central task of NHSScotland as the 21st century begins, is aimed at doing precisely that.

### Involving older people

The Executive is committed to putting the experience of service users and carers at the heart of service development and change. When healthcare professionals and people who use services come together to plan and develop services, strong partnerships are created which lead to positive change in service culture and practice. These changes can only come about because of the depth of understanding which patients and service users bring to the process.

The direct involvement of older service users in the development and monitoring of NHSScotland's services for older people is also a powerful safeguard against ageism and concerns about ageism.

#### **IT'S HAPPENING ALREADY:**

**The Clinical Standards Board for Scotland is developing standards for Older People in Acute Care (OPAC). Older people are active members of the OPAC project group, and discussions in the course of public consultations have focused on user views.**

The involvement of service users can take many forms, as members of committees and working groups, in focus groups or community forums. However, service providers must guard against "tokenism". More than one service user should be involved in any group and each must be given the information, support and training they need to play a full part in its work. They must also have their out-of-pocket expenses reimbursed in full.

The different perspective that older people and carers can bring if they are involved in planning changes in service provision contributes to ensuring that services meet the needs of their users.

#### **IT'S HAPPENING ALREADY:**

**In Lanarkshire, the Frail Older People's Strategy has been developed with input from members of the Better Government for Older People Steering Committee.**

The views of patients recently discharged from hospital can be illuminating, drawing attention to recurrent difficulties that can be addressed systematically. Older people and their carers are generally happy to provide feedback, both positive and negative, about their experience of a service. This has the advantage of demonstrating a commitment to the care of older people and addressing possible concerns about ageism in a specific service context. Health professionals can learn much from this approach, which is in general under-utilised in NHSScotland, and they will in many instances be reassured that the services they are providing are actually appreciated.

**IT'S HAPPENING ALREADY:**

In the North Glasgow NHS Trust, the Orthopaedic Supported Discharge and Throughcare Service routinely sends out questionnaires to patients following their discharge from care. Satisfaction levels are very high, and detailed comments have influenced the development of the service.

**Recommendations:**

- NHSScotland should be aware of concerns about ageism and take action to identify and remedy them.
- NHSScotland should demonstrate sensitivity, fairness and equity in its treatment of older people. This should be done continuously and transparently.
- The Scottish Executive should ensure that the PAF adequately measures the success or otherwise of NHS Boards in meeting the concerns of older people about ageism.
- NHS Boards should consult older people and their carers about their experience of services and routinely involve them in the development and monitoring of these services.
- NHS Boards should encourage feedback, both positive and negative, about the care of older patients, and address any issues raised.
- NHS Boards should involve older people in service planning and review at an organisational as well as at an individual level.
- NHS Boards should ensure compliance with existing and well-respected national ethical guidelines about decision-making around cardiopulmonary resuscitation.
- The Scottish Executive should continue to promote the opportunities offered by the Adults with Incapacity (Scotland) Act 2000 to allow people to specify, in advance of the onset of incapacity, their wishes in respect of treatment.

- All training and professional development in NHSScotland should recognise and address the needs of older people as a mainstream activity.
- NHS staff should have specific training in awareness about sensory and cognitive impairment.
- Patient areas in all NHSScotland premises should be freely accessible to people with disabilities.
- NHSScotland should develop information systems suitable for people with disabilities.



As a short life working group addressing current issues, the Expert Group on the Healthcare of Older People focused its efforts on identifying the challenges of today, and – where possible – responses to those challenges that could be delivered soon or fairly soon. In general terms, much of this work was directed at ensuring that NHSScotland is providing services that reflect a positive response to the demographic change of the last few decades.

### Meeting Future Demographic Change

However, in the course of discussion it became clear that NHSScotland must – beyond the work of the Expert Group – take a more strategic approach to planning for demographic change than had occurred in the past.

Although in international demographic terms Scotland's population is fairly mature, future projections show increasing numbers of older people, and in particular substantially increasing numbers of the very old. The population pyramid for 2031 (see fig- 1) clearly demonstrates this effect.

The Group recognises that greater longevity is a positive societal gain, and that the survival of large numbers into old age should be seen in a positive light. But it would be regrettable if the Group's proposals, which essentially seek to enable NHSScotland to “catch up with demography”, were not followed up by serious consideration of the service planning implications of significant further ageing of the population.

The recognition of care of older people as the central task of NHSScotland is a promising start, and the more detailed recommendations of the report will, to some extent, reshape services towards fitness for their tasks. But planning for continuing increases in the numbers of older people in Scotland should also take account of the following:

- **Rising expectations**

Tomorrow's older people – today's middle-aged and young – are very likely to have higher expectations of service availability and quality than are encountered in older people today, whose attitudes and expectations may still reflect to some extent the relative austerity of the 1940s and 1950s. All public services will have to cope with this and NHSScotland – as Scotland's biggest public service – should anticipate pressures for much more convenient access, such as the availability of primary care and hospital clinics in the evenings and at weekends; and higher standards of amenity extending much more widely through the service.

- **Technological change, medical advances and research to benefit older people**

Many recent and fairly recent technological advances – such as lens implants, minimal access surgery, improvements in joint replacement and interventions for coronary heart disease – have brought more benefits to older people than to any other section of the population. No doubt further advances in coming decades will bring further benefits, and these are likely to be accompanied by greater convenience and increasing cost-effectiveness. It is important that these developments and their introduction into service use are managed as part of an explicit strategy to improve the care of older people within a still ageing population.

Although much of medical care is directed at older people, medical research does not sufficiently reflect this. It is recognised that there are special difficulties in conducting research on older patients – such as the problems arising from co-morbidity (having more than one illness at once) – but it is important that new medicines are evaluated in the age groups most likely to be using them.

NHSScotland's recognition of its central task – the care of older people – should now extend to its biomedical research agenda, its approach to service development and evaluation, and indeed inform its whole Research and Development Strategy.

- **Balancing services; workforce issues**

In order to deliver sustainable improvements in both volume and quality of services for older people over the coming decades, NHSScotland must address fundamental service planning and personnel issues.

Projections of the use of both elective and emergency services show continuing substantial changes: both will deal with many more older and very old patients. There is much serious work to be done, in detail and service by service, in order to match provision to clearly demonstrated future demand.

In particular, and as a matter of urgency, the effective staffing of acute services requires to be addressed. The needs of older patients, and especially the needs of the frailest, should be matched by real expertise in their care. In nursing, specialist skills in the care of older people are recognised but must be made far more widely available in acute services. In medical staffing the nature of the acute care caseload should also be addressed by the wider involvement of care of the elderly specialists

in early management of acutely admitted older patients. And in recognition of the importance of early rehabilitation in the acute care of older people, specialist occupational therapy and physiotherapy inputs should also be strengthened.

All clinical professions and disciplines must also take account of such projections and the resulting change in service shape and practice. The care of older people is no longer a minority interest, a subspecialty, or a footnote in professional education. Different health professions will respond to this challenge in different ways, but all must respond with major shifts in emphasis in basic training, in-service training and in their research and development agenda.

- **Planning the healthcare built environment**

Again detailed studies are required to ensure that hospitals and indeed all healthcare premises reflect the needs of their main user group. Obviously this covers such matters as convenient access; but at a more strategic level there is a need to consider hospital building programmes in closer relation to the journey of care.

Ideally, the only patients in acute beds will be those whose needs can be met only in such beds. Older people whose acute care has been completed and who cannot be discharged timeously to their own homes need post-acute care in differently and appropriately staffed and equipped facilities which have not featured widely in NHSScotland's current building programme. A strategic approach to the problem of delayed discharge should certainly include balancing acute and post-acute elements of hospital services around the different elements of the journey of care of older patients.

- **Involving people in strategic change**

The success of NHSScotland's approach to strategic planning for an ageing population is more likely if the views of today's and tomorrow's older people are sought at an early stage. As noted above, expectations are rising as part of generational change, and planning for the services of the future should take account of that. Public consultation and systematic opinion polling played a powerful role in the preparation of this report, and the Group recommends that follow-up action, including strategic planning, adopts a similarly open and consultative approach.

**Recommendation:**

- **NHSScotland should plan strategically for the healthcare needs of older people, including meeting the challenges of:**
  - changing demography;**
  - emerging healthcare technology;**
  - increasing research and development of services for older people;**
  - increasing expectations amongst patients and carers;**
  - addressing workforce training, recruitment, retention and development.**



The work of the Expert Group has served to draw belated attention to the mismatch between service delivery by NHSScotland and the healthcare needs of Scotland's ageing population. In more positive terms, it has highlighted the importance of improving healthcare for older Scots as their numbers continue to grow.

In positive terms, the work of the Group has served to bring to more general notice many examples of excellent innovative practice in the care of older people. Such local initiatives, usually developed by health professionals working together and with patients and carers, and often crossing traditional service and agency boundaries, give grounds for real optimism.

Such good practice, preferably evaluated for effectiveness and cost-effectiveness, can be more widely shared, and generalisation of such practice – adapted of course to local circumstances – offers a relatively swift means of raising standards of care for older people across Scotland.

To some extent this process of generalisation of emerging good practice occurs already within professional and managerial NHSScotland networks. There is now a need to encourage a more systematic approach to the levelling up of healthcare provision for older people. To do this, and to ensure that the impact of the report of this short-life Expert Group is maximised, links with continuing developments, initiatives and agencies require to be utilised. Examples include:

- The NHSScotland Performance Assessment Framework (PAF) will provide a systematic scrutiny of services, including services for older people, from 2002. However, there are concerns that the exclusion of older age groups from many of the indicator areas specified is a weakness. Future versions should address this.
- The Scottish Health Advisory Service (SHAS) carries out a programme of visits and provides regular reports on services for older people. Updated SHAS standards will shortly be issued.

- The Clinical Standards Board for Scotland is finalising standards for older people in acute care, with an emphasis on the journey of care. A national report following visits all over Scotland is planned for April 2003
- The Information and Statistics Division of NHSScotland – whose work has greatly assisted in the preparation of this report – continues to develop more and more sophisticated data collection and analysis relating to the care of older people, covering such topics as elective surgery rates, trends in acute admissions, and delayed discharge
- The Scottish Commission for the Regulation of Care will, from April 2002, have responsibilities for ensuring standards of care in care home, day care and community settings, and will issue reports
- The Care Development Group implementation mechanisms will encourage the development of community services designed to support frail older people at home with increasing levels of care as an alternative to admission to a care home.
- Existing and emergent NHSScotland initiatives on major health problems – such as those on cancer, CHD and stroke, diabetes, and mental health – will include a focus on older service users – for most the majority group.
- The SEHD's Joint Future Unit is taking forward the implementation of the Joint Future Group's principles in conjunction with NHS Boards and Local Authorities. This work will include joint management, joint resourcing and a single shared assessment for health and community care services.

It is therefore clear that responsibility for taking forward the recommendations of this report lies with many agencies, NHS Boards, Local Authorities, clinical effectiveness and education bodies, voluntary agencies and patients groups.

To ensure co-ordination within NHSScotland and with other initiatives across the Executive in support of older people, SEHD will set up an Implementation Group, to be chaired by the CMO. This Group will monitor developments and the impact of change across Scotland, and report to Ministers and the Health Department Board.

### Demography and trends

Scotland's population has already aged significantly and will age still further. Mass survival into older age, along with the baby boom of the 50s and 60s, will lead to a rise from 787,000 to 1.2 million over-65s from 2001 to 2031, and a rise from 84,000 to 150,000 in over 85s over the same period.

The 15% of the population now over age 65 accounts for around 40% of health and social care spending. Over 75s make greatest use of services. Elective surgery – such as hip replacement – mainly benefits older people and has increased in recent decades. Further increases should be planned for.

Acute admissions are rising most rapidly in older age groups, and again further increases should be anticipated. However, improved primary care and community services should allow a proportion of potential in-patients to be cared for at home.

Many of the problems currently encountered in service provision reflect a long-term failure to match that provision to the needs of an ageing population. Information on current and projected demography, taken together with data on current and predicted service use, means that care of older people is the major task of NHSScotland as it enters the 21st century. This challenge must now be addressed positively.

### The Journey of Care:

#### At Home

Ninety-five per cent of over 65s live at home, the majority in good health. Health promotion measures such as moderate exercise, a good diet and avoidance of smoking and excessive drinking can preserve and enhance health in later life, and should be encouraged. A number of simple interventions – such as vaccination against flu, aspirin for stroke prevention and calcium and vitamin D to improve bone strength – are effective in reducing risk of illness and injury. Health screening of over 75s could be improved, to detect loss of function and provide better population data.

Around 20% of over 65s need help to stay at home. A number of recent initiatives should improve joint working between health and social work services to make care for older people at home more accessible, more effective and more responsive to individual need; and to support the efforts of carers.

Recent developments have also broadened the scope of primary care health services for older people, with many examples of innovative multidisciplinary care for older people at home and in community hospitals. These include schemes to support patients with acute or sub-acute illness at home where this is clinically appropriate; better rehabilitation services; and better management of chronic disease.

#### Hospital Care

Almost all hospital services look after older patients, and many acute services do little else. This should be fully recognised in the way they are organised, with the needs of this major client group at the centre of service provision and planning.

Care of older people attending Accident and Emergency Departments or admitted briefly to Assessment Units should include assessment of dependency and the provision of services to facilitate safe discharge home, minimise unsafe discharge, and avoid unnecessary readmission.

Older, frailer patients admitted for acute care are most at risk if their needs are not recognised. Sensitive and effective management of acute confusional states – common in older patients in the acute setting – is an essential component of good care. Early multidisciplinary assessment and rehabilitation will minimise dependency, and good collaborative discharge management, with follow-up to ensure patient safety and check on service delivery, will improve outcomes, reduce length of stay and minimise readmission.

For patients unable to return home even when such support is available, further in-patient multidisciplinary rehabilitation away from the acute ward may provide a last chance of returning home. Patients who, despite adequate rehabilitation, cannot go home and require other care in future, are at greater risk of prolonged hospital stay.

If such care is not available when and where it is needed, delayed discharge – unacceptable to patients and their carers, and an inefficient use of hospital resources – ensues. NHS Boards and Local Authorities should address delayed discharge as a top priority within joint management and joint resourcing of services; they should increase the transparency of resource use in the care of older people; and both agencies, together with private sector care providers, should address population needs and capacity planning issues.

### **Nearing the end of life**

Increasing longevity means that mortality is now compressed largely into the eighth and ninth decades. Good care for older people therefore means ensuring for them good quality of care as life approaches its end. Most die in hospital or care home settings, but improving community services will allow more who wish to do so to remain at home longer, or to the end.

For people with more prolonged dependency, lasting months or years, strengthened community services may serve to defer the move from home to a care home or NHS continuing care. Recent legislation – the Regulation of Care (Scotland) Act 2001 – seeks to ensure high standards of care at home, in day care and in care homes.

### **Overview of major health problems**

Most of the care of older people in NHSScotland is provided in mainstream services, and the improvement of their care and rehabilitation in these settings is the central theme of this report. Much work has already been done, via a number earlier reports, to improve the way NHSScotland provides care for the ‘big three’ – cancer; coronary heart disease/stroke; and mental health problems – from which many older people suffer.

This report does not attempt to duplicate such work for older patients. Rather it seeks to ensure that improvements in care are fully shared by older service users, and it positively asserts their rights to care matched to individual circumstances – with age alone as no bar to appropriate and beneficial treatment.

Better care for older people with chronic disease will mean more involvement of patients and carers and better information for them. The Group found many examples of good practice, with local services based in primary care and good access to more specialist advice when required. Such work, however, must be more widely replicated across NHSScotland.

Most patients with cancer are over 65. Early detection – especially of some skin and mouth cancers, and lymphoma – is worthwhile. Careful individual assessment, sympathetic explanation and patient involvement in decision-making are needed if older people are to gain maximum benefits from modern cancer treatments for the common serious cancers (e.g. of lung, breast, prostate and bowel). Although outcomes are generally poorer than in younger patients – because of frailty or co-existing illness – recent advances in care have much to offer. There is never ‘nothing we can do’.

Coronary heart disease also affects mainly older patients, and preventive measures can still be effective in later life. Older people gain from modern high-technology interventions, though there is evidence that they may be underused. This should be monitored. Successful developments in management of heart failure at home should be more widely available.

Good care of stroke patients, most of whom are old or very old, improves survival and minimises disability. Good care includes early multidisciplinary assessment, specialist rehabilitation and well-organised discharge and follow up.

Depression and dementia are both common in later life. Depression is under-recognised and generally treatable. Drug treatment for dementia continues to improve, and appropriate patients should have access to it. Eighty percent of dementia patients live at home, and they and their carers need access to a range of services from health and social work agencies. Again good practice exists, and improved joint working will facilitate its spread.

Falls and the fear of falling greatly limit activity; and, although most falls do not result in injury, most injuries in older people are sustained as the result of a fall. Routine checks should identify patients at risk, and multidisciplinary assessment services for patients who fall should be available for older people. Osteoporosis management should be part of falls assessment.

### Ageism

There have been concerns about ageism, defined as “systematic and negative age discrimination”, in NHSScotland. Polling carried out for this Report showed that, though older people were generally satisfied with their experience of care, around one sixth had a perception that older people received poorer service, and that long waiting times were a common cause of dissatisfaction.

The Group affirmed the right of older people to treatments – including the most advanced and expensive – that will benefit them, while also recognising anxieties about injudicious interventions. Better communication – particularly about such sensitive matters as cardiopulmonary resuscitation and treatment decisions towards the end of life – will help. Both active treatment and the withholding of active treatment should always be considered in the detailed circumstances of the individual patient, with individual patients and their carers fully informed about the options, risks and potential benefits.

The needs of older people from ethnic minorities should be recognised, with appropriate sensitivity to cultural and language issues. All services should recognise the higher prevalence of mobility and sensory difficulties in older age groups and provide suitable access, skills and communication technology.

A review of the published literature carried out on behalf of the Expert Group did not support allegations of widespread ageism. However, as the Group acknowledged, concerns about ageism clearly do exist, and it is important that these concerns are addressed. The effective involvement of older people in the development and monitoring of the services they use offers a powerful means of doing this.

In the longer term, the best response to concerns about ageism in NHSScotland would be to achieve a widespread and visible improvement in the quality of service experienced by older people. This report is aimed at doing precisely that.

### Strategic Issues

This short-life working group makes detailed recommendations to effect early improvement in the care of older people throughout NHSScotland, but recognises also that strategic issues must be addressed in anticipation of further demographic change. The volume of elective and acute care needed will increase; and the next generation of older people will also have higher expectations of accessibility, flexibility and quality in the services provided for them.

Further technological advances in medical care will continue to benefit older patients, and should be managed as part of an explicit strategy for their care. Education and training of staff, and workforce planning in NHSScotland, should also respond to the need to balance services in response to changing demography. The Research and Development agenda should also reflect demographic reality, and future NHSScotland building programmes should recognise the need for post-acute as well as acute care of an ageing population.

Strategic planning should include public consultation.

### Making it Happen

This report highlights the health and healthcare needs of older people, and emphasises that their care is the central responsibility of NHSScotland, with good mainstream care as a goal of current and future efforts in health service reform. Already good practice exists widely, and its generalisation throughout the service offers a quick route to improve care throughout Scotland.

A number of agencies and mechanisms can assist in ensuring that the desired improvements are achieved. These include the Performance Assessment Framework; NHSScotland; the Joint Future Group implementation work; the Scottish Health Advisory Service; the Information and Statistics Division; and – particularly through its Standards for Older People in Acute Care, with their emphasis on the journey of care – the Clinical Standards Board for Scotland.

The work of the Expert Group will be followed by an SEHD Implementation Group, to be chaired by the CMO, which will monitor the impact on care and report on progress.

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Mr George Howie	Health Education Board for Scotland
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### Acknowledgements

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Dr E M Armstrong

## Summary of Recommendations

### Demography and Trends

- NHS Boards should plan to increase provision of elective services used mainly by older patients, including surgery and related rehabilitation.
- NHS Boards should plan to provide high-quality acute care for growing numbers of older people.
- NHS Boards should, in partnership with Local Authorities, explore strategic developments, encompassing health and social care. These should aim to offer more older people with acute illness the possibility of being enabled to live at home where this is clinically appropriate.

### The Journey of Care

#### Staying Well

- Older people should be encouraged to be physically and mentally active.
- Older people should have access to information about healthy life-styles, and health promotion campaigns should actively target and involve them.
- NHS Trusts, Local Authorities, voluntary and private providers with responsibility for long-term care of elderly patients are reminded of the recommendations of the *National Nutritional Audit of the Elderly in Long-term Care* and of the need to implement these recommendations.
- Older smokers should be encouraged to try to stop; and high-risk groups such as those with heart disease should be targeted for extra help in giving up smoking.
- Health professionals should be aware of the possibility of problem drinking in older people and be ready to help.
- Clinical examination should include assessment of oral health and appropriate referral when required.
- NHS Boards should ensure that older people who wish to do so have access to, and are registered with, an NHS dentist and are made aware that help may be available to assist with payment for treatment.
- Older people in hospital should be assessed to ensure that they can administer their own medications on discharge if that is clinically appropriate.
- Co-ordination of prescribing and drug provision for discharge from hospital should be improved.
- All older people who have repeat prescriptions should have a regular medication review.
- Medication for older people should be dispensed in accessible form, and with legible labelling and advice.
- Effective disease prevention measures should be advised to all older people, as appropriate.

- Disability-reducing surgery – e.g. for cataract and joint replacement – should be available on the basis of clinical need and appropriateness.
- Older patients have most to gain from good multidisciplinary rehabilitation in hospital and at home, and service organisation should reflect this.
- Multi-professional education should foster learning and innovation in service delivery.

#### Health Screening of Older People

- Screening of the over 75s should be reviewed, with a greater focus on identifying important problems such as falls, mental impairment, increasing dependency, oral disease, poor nutrition, poor foot care, tobacco and alcohol use.
- Standardised data from screening should be available to support planning better services for older people, enabling participation and independent living.
- Consideration should be given to linking screening with a check on uptake of benefit entitlements.

#### Supporting Older People at Home

- Carers should be seen and valued as partners with the statutory agencies in the provision of care, and should themselves receive appropriate assistance.

#### Improving Older People's Access to Healthcare

- Older people at high risk in the community, including those in care homes, should be regularly monitored by an appropriate member of the healthcare team and relevant services and specialist care provided as necessary. NHS Boards should encourage and support such developments.

#### Avoidance of Unnecessary Hospital Admission

- NHS Boards should ensure that older people in long-term care in the community have access to the appropriate care when required.
- LHCCs should lead the process of health needs assessment and primary care service planning in their areas; and recognise the potential of this process in improving local services for older people.
- Older people and their GPs should have access to multidisciplinary, multi-agency support teams to avoid unnecessary hospital admission, to facilitate safe discharge from acute care, and to promote rehabilitation of older people in their own homes.

#### Accident and Emergency Care and Short-Stay Acute Admission

- Older patients attending A&E Departments or admitted to short-stay acute assessment wards should be assessed to identify those with previous or recently increased dependency.
- Assessment should be multidisciplinary, covering likely risks and determining care needs (e.g. discharge, supported discharge or admission).
- A range of appropriate services should be available to facilitate safe discharge home, minimise unsafe discharge, and avoid unnecessary re-admission.

### Acute Hospital Care

- Older people being discharged from acute care should have appropriate access to pre-discharge assessment, multidisciplinary discharge planning, necessary community services, and follow-up to ensure their safety and well-being.
- Acute hospitals should take steps to improve the management of older people requiring multiple acute admissions, to improve continuity of disease management and to minimise repetition and duplication of investigations.
- NHS Boards should recognise that multiple admissions in older people are a problem and take strategic decisions to address this.
- NHS Boards should consider the appropriate recruitment, retention, training and development of specialist staff as part of their overall workforce planning to meet the needs of older people in acute hospital care.

### The Confused Older Patient

- All NHS staff should be aware that older patients may be confused, and should be sensitive to their needs.
- Clinical staff should be aware of the causes and management of confusion.

### Post-Acute In-Patient Rehabilitation

- Patients who cannot be discharged directly from acute care should have the opportunity of further assessment and rehabilitation in specialist post-acute wards with multidisciplinary staffing, or – in remote and rural areas – in appropriately staffed local hospitals.
- Patients who cannot return home following acute care and post-acute rehabilitation should, until appropriate placement (e.g. in a care home) is achieved, have access to regular medical review and appropriate multidisciplinary care and rehabilitation while still in hospital care.

### Delayed Discharge

- NHS Boards and Local Authorities should address delayed discharge as a top priority within joint management and joint resourcing of services, including community rehabilitation services.
- NHS Boards and Local Authorities should – as part of joint working – increase the transparency of resource use in the care of older people.
- NHS Boards, Local Authorities and the private and voluntary sectors should assess population needs and plan capacity to meet likely demands.
- NHS Boards, Local Authorities and the private and voluntary sectors should explore innovative means of addressing the problems associated with longer-term collaboration in service provision.
- ISD should continue to monitor and report standard comparative information to allow continuing scrutiny of problems and progress in the management of delayed discharge across Scotland.

## Overview of major health problems

### Better Care for Older People with Chronic Disease

- Primary care and acute services should take steps to improve the management of older people with chronic disease and at risk of multiple admissions in order to improve the continuity and quality of their care.

### Cancer in Older People

- Older people with cancer should have full access to the service developments that follow from the implementation of *Cancer in Scotland, Action for Change*.
- Older patients should have access to appropriate investigation and treatment of cancer on the basis of their individual clinical needs.
- CSBS standards should adequately assess care provided to all age groups including older people.
- Older patients with cancer should have access to rehabilitation to enable them to cope with the impact of disease and treatment.

### Coronary Heart Disease

- Older people with coronary heart disease should have full access to service developments that follow from the implementation of the *CHD/Stroke Task Force Report*.
- There should be increased professional awareness of heart disease in the elderly: its presentation, the range of potentially useful treatment options and the need for individual assessment on the basis of need and potential benefit.
- There should be increased awareness of the potential of preventive intervention in later life.
- Rehabilitation and support for older people with CHD should be improved by better coordination between hospital and primary care, including outreach specialist services.
- Monitoring, by means of transparent audit, of the access by older patients to appropriate investigation and treatment for CHD should be undertaken.
- Further research should be carried out to clarify best treatment, access to care, and attitudes to treatment for CHD specifically in older age groups.
- CSBS standards should adequately assess care provided to all age groups including older people.

### Stroke Care and Rehabilitation

- Stroke patients admitted to hospital should be managed in a stroke unit by a coordinated multidisciplinary team.
- Rehabilitation should be coordinated between hospital and primary care to ensure continuity.
- NHS Boards should ensure that stroke care reflects current national SIGN guidelines.

### Mental Health Problems in Older People

- NHS Boards should work to raise awareness of older people's mental health issues, and to promote recognition and treatment of problems at an early stage.
- NHS Boards and Local Authorities should assess population needs for dementia and other mental health services and plan appropriate capacity at all levels.
- NHS Boards should ensure there are services to provide rapid assessment of cognitive impairment, with appropriate access to modern drug treatment and follow up.

### Falls and Fracture Prevention

- All older people should be asked annually if they have fallen in the past year.
- In those who have fallen once only, balance and gait should be assessed by the Get Up and Go Test.
- All who report recurrent falls, appear unsteady or who have difficulty with the Get Up and Go Test, and all presenting to medical attention with a fall should undergo multidisciplinary evaluation.
- NHS Boards should ensure that falls assessment services are available and that these provide interventions of proven effectiveness, tailored to community or care home settings.
- Osteoporosis management should be an important part of any falls assessment.

### Ageism in NHSScotland

#### Specific Issues

- NHSScotland should be aware of concerns about ageism and take action to identify and remedy them.
- NHSScotland should demonstrate sensitivity, fairness and equity in its treatment of older people. This should be done continuously and transparently.
- The Scottish Executive should ensure that the PAF adequately measures the success or otherwise of NHS Boards in meeting the concerns of older people about ageism.
- NHS Boards should consult older people and their carers about their experience of services and routinely involve them in the development and monitoring of these services.
- NHS Boards should encourage feedback, both positive and negative, about the care of older patients, and address any issues raised.
- NHS Boards should involve older people in service planning and review at an organisational as well as at an individual level.
- NHS Boards should ensure compliance with existing and well-respected national ethical guidelines about decision-making around cardiopulmonary resuscitation.

- The Scottish Executive should continue to promote the opportunities offered by the Adults with Incapacity (Scotland) Act 2000 to allow people to specify, in advance of the onset of incapacity, their wishes in respect of treatment.
- All training and professional development in NHSScotland should recognise and address the needs of older people as a mainstream activity.
- NHS staff should have specific training in awareness about sensory and cognitive impairment.
- Patient areas in all NHSScotland premises should be freely accessible to people with disabilities.
- NHSScotland should develop information systems suitable for people with disabilities.

### Strategic Issues

- NHSScotland should plan strategically for the healthcare needs of older people, including meeting the challenges of:
  - changing demography;
  - emerging healthcare technology;
  - increasing research and development of services for older people;
  - increasing expectations amongst patients and carers;
  - addressing workforce training, recruitment, retention and development.

## Key Documents

Adults with Incapacity (Scotland) Act 2000	2000
Cancer in Scotland Action for Change	2001
Caring for Scotland The Strategy for Nursing and Midwifery in Scotland	2001
Coronary Heart Disease/Stroke Task Force Report	2001
Fair Care for Older People Care Development Group Report	2001
A Framework for Mental Health Services in Scotland	1997
The Health and Wellbeing of Older People in Scotland: Insights from national data	2001
Health in Scotland 2000	2001
Independent Advocacy – A Guide for Commissioners	2001
National Care Standards Care Homes for Older People	2001
National Nutritional Audit of Elderly Individuals in Long-term Care	2000
Our National Health A plan for action, a plan for change	2000
Programme for Government	1999
Public attitudes to the health care of older people in Scotland	2002
Rebalancing Care of Older People: report of the Joint Future Group	2000
Resuscitation Policy HDL (2000) 22	2000
Scottish Diabetes Framework Consultation Paper	2001
SIGN guidelines	Various
Strategy for Carers in Scotland	1999

**EGHOP Website:** <http://www.scotland.gov.uk/health/cmo/eldersp1.asp>

## Glossary

A&E –	Accident & Emergency
ACE –	Angiotensin converting enzyme (ACE inhibitor is a drug used in treatment of heart failure)
CABG –	Coronary Artery Bypass Grafting
CCU –	Coronary Care Unit
CDG –	Care Development Group
CHD –	Coronary Heart Disease
CSBS –	Clinical Standards Board for Scotland
CMO –	Chief Medical Officer
CRAG –	Clinical Resource and Audit Group
CT –	Computerised Tomography (a specialised x-ray examination)
DVT –	Deep Vein Thrombosis
DXT –	Dexa Scanning (a test for Osteoporosis – thinning of the bones)
EGHOP –	Expert Group on Healthcare of Older People
GORU –	Geriatric Orthopaedic Rehabilitation Unit
GP –	General Practitioner
HEBS –	Health Education Board for Scotland
LHCC –	Local Health Care Co-operative
ISD –	Information and Statistics Division
JFG –	Joint Future Group
NHS –	National Health Service
OPAC –	Older People in Acute Care
PAF –	Performance Assessment Framework
PAMS –	Professions Allied to Medicine
PMS –	Personal Medical Services
PTCA –	Percutaneous Transluminal Coronary Angioplasty
R&D –	Research and Development
SEHD –	Scottish Executive Health Department
SHAS –	Scottish Health Advisory Service
SIGN –	Scottish Intercollegiate Guidelines Network