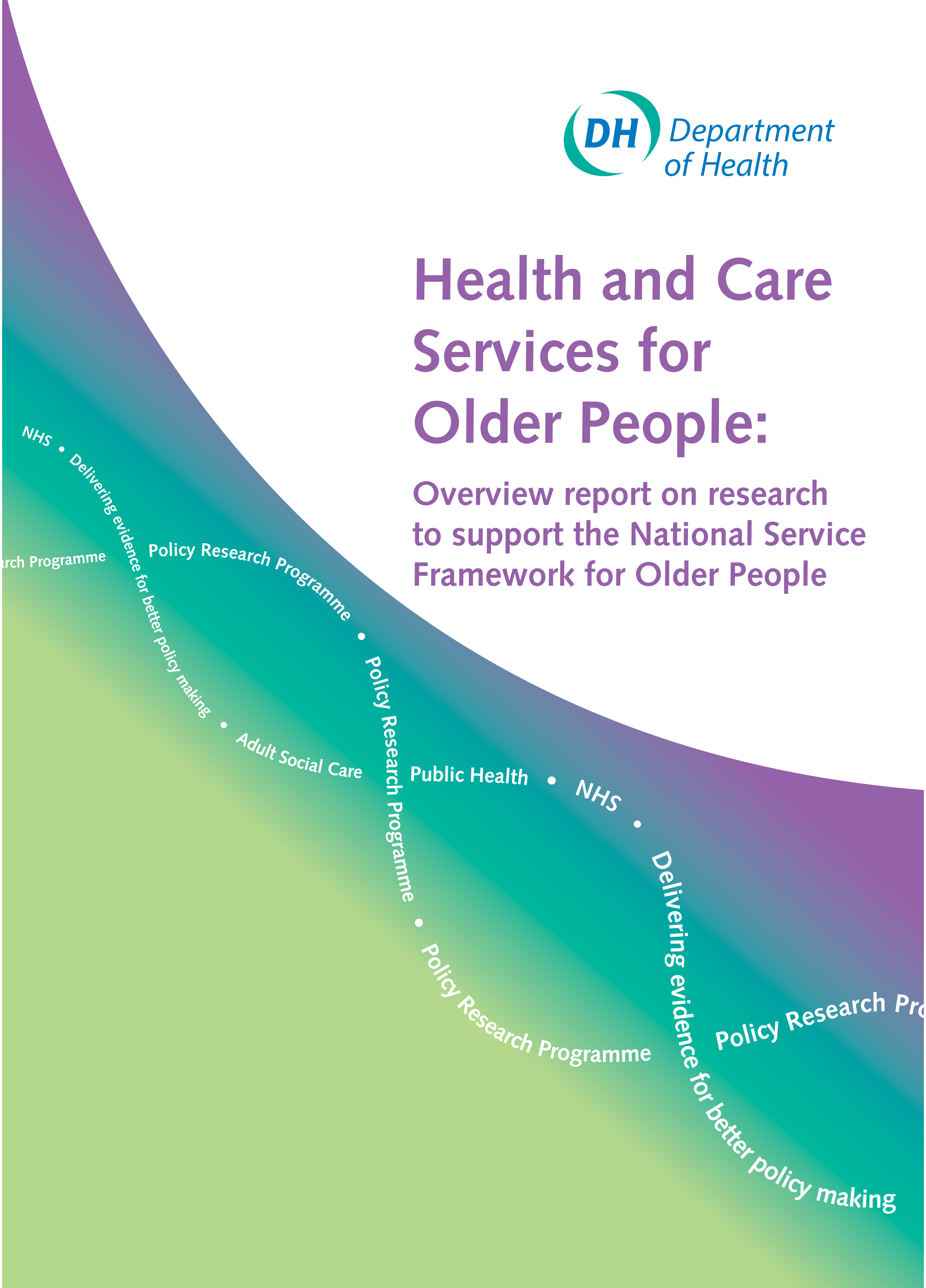
DH Department of Health

Health and Care Services for Older People:

Overview report on research to support the National Service Framework for Older People



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Foreword by the Director General of Social Care, Local Government and Care Partnerships

I welcome the publication of this impressive report. It presents the important insights and conclusions from a wide body of research commissioned by the Department of Health to support the National Service Framework for Older People (NSFOP).[1]

When the NSFOP was published in 2001, it was the first time that government had committed to a comprehensive strategy to ensure fair, high-quality, integrated health and social care services to meet the needs of the growing older population. It set out a 10-year programme of action linking services to support independence and promote good health, with specialised services for key conditions. It was based on the principles of the NHS Plan[2] and set specific standards for rooting out age discrimination and promoting person-centred care to ensure that all older people and their carers are treated with respect, dignity and fairness, and receive care based on individualised assessment.

This report draws together the findings from 16 distinct research projects under the themes of the NSFOP, with a focus on the standards that really matter to older people. The Department of Health commissioned these evaluations from a wide range of university departments, and we are grateful for the expertise and enthusiastic support.

The NSFOP was an ambitious project, which called for more effective and consistent application of evidence-based care through the development of new service models. It therefore had major implications for the way that services are organised and delivered, through a better-trained workforce. It required the strengthening of partnerships between health and social care providers and between the providers and recipients of care, their families and their carers.

These evaluations provide a wealth of research findings to show how the NSFOP – and the policies derived from its underlying principles – have contributed to improving the health and well-being of older people in England. Some aspects of

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[1] Department of Health, *National Service Framework for Older People*, 2001

[2] Department of Health, *The NHS Plan: A Plan for Investment, A Plan for Reform*, 2000

the NSFOP have been more successfully implemented than others, and certainly there are areas where more still needs to be done. What the research shows, however, is that – even with firm policy and resources – local structures and relationships, and the competing interests and demands of professional groups, are important factors.

Much of the research itself also rested upon close collaboration with both the providers of care and service users; we are grateful for their contributions, so vital if we are to better understand how useful and effective person-centred care can be delivered. The report highlights the successes but also the considerable challenges in getting this right consistently.

We are now in the seventh year of the NSFOP. The interim reports have described the very considerable progress made across its key standards and how policy is developing to further strengthen its implementation.[3] [4] The National Stroke Strategy (2007) and the forthcoming National Dementia Strategy (2008) will further strengthen and focus these components of the NSFOP. All the ongoing work will be greatly helped by this report, which sheds important new light on the task of modernising health and social care and making it fit for older people.

David Behan CBE
Director General of Social Care, Local Government and Care Partnerships

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[3] Philp, *Better Health in Old Age*, 2004

[4] Philp, *A New Ambition for Old Age: Next Steps in Implementing the National Service Framework for Older People*, 2006

Acknowledgements

Grateful acknowledgement is made to the Department of Health's Policy Research Programme for funding the Older People and their Use of Services (OPUS) research initiative to support the National Service Framework for Older People. I am especially grateful for the help and support of Susan Lonsdale and Dr Carol Lupton in the Department.

An enormous number of people have contributed to the initiative and to bringing the work to fruition. We thank all the research teams and through them the patients, service users, family members, staff and volunteers, health and social care staff, and all the advisers, research institutes and university departments whose participation has been invaluable.

I would also particularly like to thank my colleagues, numerous peer reviewers, the Picker Institute and King's College London for their support over the life of the programme.

Janet Askham
Professor of Social Gerontology
King's College London

Professor Janet Mary Askham, 1941–2008

Tragically, Janet Askham died as she was putting the final touches to this report. She had worked for the last seven years as the scientific advisor on older people to the Department's Policy Research Programme. In this role, she provided intellectual leadership across the grouped studies in the OPUS initiative and added significant value to its overall outcome.

Janet was a fine scholar, of international standing. Her own research was often ground breaking and this report is testament to her ability to synthesise, and add insight to, the work of others. Her untimely death is a very considerable loss to the age research community.

In addition to her intellectual strengths, Janet was also great fun to work with and a stimulating and supportive colleague. She will be greatly missed.

Carol Lupton
Department of Health

Executive Summary

1. This report is an overview of the Older People and their Use of Services (OPUS) research programme, funded by the Department of Health's Policy Research Programme, which was designed to assess key aspects of the National Service Framework for Older People (NSFOP). The NSFOP was published in 2001 and comprises a ten-year programme of work to improve health and social care services for older people.

2. The NHS in England has undergone major policy changes in recent years, many of them with an impact on older people. Among the major user-focused goals are: increased emphasis on health promotion; more service user involvement; encouragement of self-management of long-term conditions; maintenance of independent living; and more emphasis on tailoring services to the user, enhancing equity and fairness and improving service quality.

3. In line with this policy framework, the NSFOP comprised eight standards within four themes: *respecting the individual*, with the standards of rooting out age discrimination and fostering person-centred care; *providing a new layer of care between primary and specialist services*, with the standard of providing intermediate care; *providing evidence-based specialist care*, with the standards of delivering appropriate specialist care in hospital and improving stroke services, falls services and mental health services; and *promoting an active healthy life*, with the standard of promoting health and well-being through a co-ordinated programme of action.

4. The choice of standards for the NSFOP was influenced by several, sometimes competing pressures: on the one hand, underlying healthcare values such as the commitment to high-quality services for all on the basis of need, medical and scientific advances and rising public expectations; on the other hand, pressure on public resources, and social and demographic changes such as the rising number of people in late old age with long-term health conditions.

5. The NSFOP also contended with other underlying tensions such as that between older people as active agents in their own healthcare or as passive recipients of care; between old age as a time of decline and loss or as a period of active, healthy living; and between person-centred, individualistic approaches and the need to classify and categorise older people.

6. A research programme called OPUS was established in the light of the major service and system changes for older people which the NSFOP included, all of which would be implemented within the context of these competing influences and underlying tensions. Examination of how these changes were implemented was a key feature of the research programme. Another prime feature was the programme's emphasis on independent living and home-based care, not only through examination of policy implementation but through investigation of (a) some new initiatives to support older people at home or at key transition points between home and hospital, and (b) barriers and challenges to healthcare among older people. A final key feature of the programme was its use of studies on topics concerning equity of care, particularly in circumstances where age discrimination is often seen to be at its most intractable.

7. The 16 projects within the OPUS programme can be divided into three groups: (a) investigations of the implementation of service or system changes – NHS-funded nursing care in Care Homes, intermediate care, the single assessment process, reimbursement for delayed hospital discharge, and the nurse education programme in palliative care; (b) evaluation of local innovations – the treatment of depression in primary care, the development of a tool to help ambulance staff with decisions about people who have fallen, and structured follow-up after a disabling stroke; and (c) identification of needs and problems – the experiences of people from different cultures with dementia, the palliative care needs of people with heart failure, the timing of palliative care, specialist services and staff for older people, and the challenges of hospital discharge.

8. The projects that made up the programme varied greatly in design, ranging from complex mixed-method investigations, randomised controlled trials and national surveys to small-scale qualitative investigations in a single area or reviews of previous research.

9. While this overview report does not attempt to summarise the main findings of all the research projects, it does draw some conclusions; for example, that of the policy directives investigated, NHS-funded nursing care in nursing homes and reimbursement for delayed discharge have been most fully implemented throughout England, with other directives still en route to implementation. In fact the research project on reimbursement concluded that this was a policy that had run its course, and that in the changed health policy environment of today there is no longer a need for the kind of arrangements enforced by the reimbursement legislation.

10. For most of the policy innovations it was still too early for the research to draw conclusions about effectiveness, although there were strong indications of the supportiveness of intermediate care. The findings relating to one other small innovation – the treatment of depression in primary care – showed the effectiveness of the intervention, but with no ability to provide evidence of its wider applicability.

11. This report draws out some common themes from the research programme by examining the projects' findings in relation to five of the underlying principles of the NSFOP.

12. In relation to the principle that there should be no age, cultural or other discrimination in health and social care services, OPUS projects illustrated particularly well the tension between older age as a period of decline and the more positive view of later life, with its active approach to meeting the needs of older service users. Some service providers continue to see older people in nihilistic or stereotyped ways, which suggests a need for more professional education or national policy directives to improve the situation for older people. Equitable provision will also be aided by better evidence about what works for particular groups of older people (such as the time at which palliative care should be offered for older non-cancer patients) and greater clarity about what is needed.

13. The principle which states that, because older people have health and care needs specific to old age, they should get services from professionals who specialise or are specially trained in the treatment of older people is implemented with a good deal of confusion, only to some extent semantic. Further research is needed to determine the circumstances in which older people want, and would benefit from, specialists, generalists or a mixture of the two, and what the two terms mean in specific contexts. It is easy enough to accept the need for clinical specialists in the diseases associated with late life and the co-morbidities of old age; it is more difficult to see the feasibility of specialisms which appear to be predicated on the belief that there are social or psychological features unique to old age.

14. Under the principle that services should be person-centred (or personalised), the tensions between a person-centred approach and paternalism, the need to standardise care and the pressures to target and prioritise were particularly evident in some of the OPUS projects. The investigations demonstrated a number of problematic areas for person-centred care: that there is a shortfall in services to meet some kinds of need such as mental health; that services are often fragmented rather than holistic; that the needs of the system may

prevail over those of the service users; that older people are sometimes not enabled – or not given time – to make their own decisions; and that they are not always treated with dignity and respect. Person-centred care has the potential to be aided by the single assessment process as well as by services such as intermediate care, better prognostic tools and better education for staff. But it will be held back by inadequate provision of the kinds of services that users need, by lack of information on the part of both users and providers, and of course by the continuation of ageist attitudes and practices.

15. The principle that older people with health problems should be helped and supported to manage their own conditions, retain or regain independence and remain living at home is key to recent health policy. Clearly there is a growing drive for high-quality services to help older people remain independent, but it is slowed down by funding limitations and the need to prioritise. The OPUS projects have begun to demonstrate the value of intermediate care, of targeted support services for older people with depression and of community hospitals. They have also shown that services such as these can be jeopardised by gaps in the provision in the community of services like carer support, mental health teams, and information and advice. What is needed is not just more resources but better education and information, more research to confirm the value of particular kinds of support (such as for people with depression), and more attention to the dynamic, continuing needs of older people.

16. The principle that frail older people or those with complex needs should receive integrated and long-term care services is a complex one to put into operation. OPUS studies showed the tension between the policy focus on rehabilitation or recovery and the need for comprehensive care until the end of life; between the urge towards integration and the continued separation of services; and between the need for services that recognise processes and pathways and those that take a more static view. Findings from the research programme provide some evidence that good integrated care can be provided; for example, speedy hospital discharge works smoothly in some areas of the country, with good collaboration between the sectors. However, there is also a good deal of evidence to the contrary, and much remains unknown. People who had fallen, those with a disabling stroke or heart failure, and people who were dying were found to have health and social care needs that were not being met. The main source of these problems was the inadequacy of provision of health and/or social services in the community (e.g. district nurses or social workers). It is also clear that, in some areas, the relationships between health and social care agencies are not conducive to collaborative working. The need to strengthen primary care and to enhance

the role of GPs for the most needy older people is also apparent. Finally, the lack of comprehensive and integrated services is not helped by a lack of clarity about what integration and collaboration means, and about the distinction between health and social care needs (particularly for people with dementia).

17. The report concludes with policy and research recommendations. It suggests that there should be a more concerted policy focus on mental health in later life, including the maintenance and promotion of well-being as well as support for people with significant mental illness or cognitive impairment; more attention to the changing long-term support needs of frail older people and those with complex conditions; and more emphasis on integrated support for people towards the end of life.

18. Recommendations for future research include: (a) further evaluation of the operation of intermediate and rehabilitative care, to assess, for instance, its methods of recruiting service users, what types of organisational model or skill mix work best, and its impact on other parts of the care system; (b) more research on NHS-funded nursing care in nursing homes, such as its impact on joint working across health and social care and on standards of care and its implications for the financial stability and survival of care homes; (c) further investigation of the single assessment process, such as how it can be used to support integration of care across provider barriers and between generalist and specialist care; (d) research relating to geographical variations in service provision, for example into how best to use national indicators to promote effective implementation of policy or how good practice is most effectively promulgated (such as through networks); (e) more in-depth investigation of specialist, generalist and collaborative working; (f) more research towards the development of appropriate clinical tools; (g) investigation of professional ageism; and (h) further study of older people's own experiences and perspectives on health and social care within the broader contexts of their changing lives.

Introduction: Purpose and Scope of the Report

This report draws on 16 projects within the Older People and their Use of Services (OPUS) research programme, funded by the Department of Health's Policy Research Programme to support the National Service Framework for Older People (NSFOP). The purpose of the research programme was not to evaluate the NSFOP in its entirety, nor to enquire what overall difference it has made to the lives of older people or what they think of it, but to examine particular aspects of the NSFOP policies and recommendations which were seen to require investigation.

The research projects were carried out between 2002 and 2007. All have their own separate reports, and many have been published in whole or in part. The aim of this report is not to summarise them but to provide an overview of the programme from the vantage of some of the key themes of the NSFOP and of the research findings.

It is hoped that the report will stimulate interest in the individual projects, suggest further lines of enquiry and help policy makers and service developers to understand more about the needs of older people in England today, the relationship between principles, policy and practice, and the outcomes – both intended and unintended – of health and social policy. It is ultimately hoped that it will make a small contribution to improving the lives of all who approach, enjoy or endure old age.

The views expressed in this report are those of the author and not necessarily those of the Department of Health.

The OPUS Research Programme Projects

NB: The projects are listed here chronologically, by the title of the final project report to the Department of Health and by the authors listed on that report. Each project is also given – in parentheses – a short title for ease of reference.

The aims and methods of each project are summarised in the Appendix to this report.

1. *NHS-Funded Nursing Care in Care Homes in England: An Initial Evaluation*
   (*Funded Nursing Care*)
   Ala Szczepura, Carol Davies, Deirdre Wild, Isabelle Johnston, Deborah Biggerstaff, Pauline Ford, Yana Vinogradova

2. *Fit to Be Left: Can Ambulance Staff Use an Assessment Tool to Decide If an Older Person Who Has Fallen Can be Safely Left at Home?*
   (*Assessment of Falls by Ambulance Staff*)
   Mary Halter, Jacqueline Close, Helen Snooks, Simon Porsz, WaiYee Cheung

3. *What Went Right? A Study of What Works in Tackling Delayed Discharges in Six High-Performing Sites*
   (*Delayed Discharge: What Works*)
   Matt Baumann, Sherrill Evans, Margaret Perkins, Peter Huxley, Lesley Curtis, Ann Netten, Jose-Luis Fernandez

4. *A Controlled Trial to Investigate the Feasibility of a New Model of Intervention for the Treatment of Late-Life Depression in Primary Care*
   (*Late-Life Depression in Primary Care*)
   Carolyn Chew-Graham, Robert Baldwin, Alastair Burns, Karina Lovell, Mike Morley, Chris Roberts, Heather Burroughs

5. *NSF for Older People: Specialist Services and Staff for Older People*
   (*Specialist Services for Older People*)
   Jan Reed, Charlotte Clarke, Glenda Cook, Margaret Cook, Pamela Inglis, Bill Watson

6. *A Randomised Controlled Trial Evaluation of Structured Routine Follow-Up after a Disabling Stroke*
   (*Structured Follow-Up after Stroke*)
   Anne Forster, John Young, Jenni Murray, Chris Patterson, Peter Wanklyn, Sue Bogle, John Green, Lynn Johnston, Jane Smith, Joanna Spink, Heather Wild, Karin Lowson, Louise Carr, Stephen Chaplin, Dianne Wright

7. *Show Me the Way to Go Home: Delayed Hospital Discharges and Older People*
   (*Delayed Discharge Review*)
   Jon Glasby, Rosemary Littlechild, Kathryn Price

8. *Prediction of Appropriate Timing of Palliative Care for Older Adults with Non-Malignant Life-Threatening Disease: A Systematic Review*
   (*Palliative Care Timing Review*)
   Peter Coventry, Chris Todd, Gunn Grande, David Richards

9. *A Multi-Centre Longitudinal Study to Identify the Palliative Care Needs of Older People with Heart Failure and their Families*
   (*Palliative Care and Heart Failure*)
   Merryn Gott, Sarah Barnes, Sheila Payne, David Seamark, Chris Parker, Salah Gariballa, Neil Small

10. *A Systematic Evaluation of the Development and Impact of the Single Assessment Process in England*
    (*Development of the Single Assessment Process*)
    David Challis, Jane Hughes, Paul Clarkson, Michele Abendstern, Caroline Sutcliffe

11. *Improving the Quality of Care for People with Dementia: A Cross-Cultural Study*
    (*Cross-Cultural Dementia Study*)
    Vanessa Lawrence, Joanna Murray, Kritika Samsi, Peter Huxley, Dinesh Bhugra, Andre Tylee, Sube Banerjee

12. *Evaluation of the Education and Support Programme for District and Community Nurses in the Principles and Practice of Palliative Care: The Impact on Older People Dying from Non-Malignant Disease*
    (*Palliative Care: Nurse Education Programme*)
    Julia Addington-Hall, Cathy Shipman, Jenni Burt, Emma Ream, Teresa Beynon, Alison Richardson

13. *A Multi-Centre Study to Evaluate Community Hospital Care for Older People*
    (*Community Hospital Role in Rehabilitation*)
    John Young, Neil Small, Anne Forster, Karin Lowson, Jacqueline O'Reilly, Sue Bogle, John Green, Emma Tanner, Joanna Spink (plus clinical leads and research nurses)

14. *A National Evaluation of the Costs and Outcomes of Intermediate Care for Older People*
    (*Costs and Outcomes of Intermediate Care*)
    Pelham Barton, Stirling Bryan, Jon Glasby, Billingsley Kaambwa, Graham Hewitt, Graham Martin, Carol Jagger, Emma Reagan, Susan Nancarrow, Hilda Parker, Andrew Wilson, Stuart Parker

15. *An Evaluation of Intermediate Care for Older People*
    (*Structure, Process and Outcomes of Intermediate Care*)
    Mary Godfrey, Justin Keen, Jean Townsend, Jeanette Moore, Patricia Ware, Brian Hardy, Robert West, Helen Weatherly, Kate Henderson

16. *Reimbursement in Practice: The Last Piece of the Jigsaw? A Comparative Study of Delayed Hospital Discharge in England and Scotland*
    (*Reimbursement*)
    Mary Godfrey, Jean Townsend, Michelle Cornes, Edward Donaghy, Gill Hubbard, Jill Manthorpe

Title of project	Abbreviation
Projects on specific policy directives associated with NSFOP	
Funded Nursing Care in Care Homes	FNCICH
Intermediate care:	
i) Community Hospital Role in Rehabilitation	RR/CH
ii) Costs and Outcomes of Intermediate Care	IC/ECO
iii) Structure, Process and Outcomes of Intermediate Care	IC/EPO
Palliative Care: Nurse Education Programme	PAC/NEP
Development of the Single Assessment Process	DI/SAP
Reimbursement	RDD
Evaluation of local innovations	
Late-Life Depression in Primary Care	LLD/PC
Assessment of Falls by Ambulance Staff	AS/F
Structured Follow-Up after Stroke	SFU/S

Title of project	Abbreviation
Identification of needs and problems	
Cross-Cultural Dementia Study	PWD/CCS
Palliative Care and Heart Failure	PAC/HF
Specialist Services for Older People	SSS/OP
Hospital discharge of older patients:	
i) Delayed Discharge Review	DD/RR
ii) Delayed Discharge: What Works	DD/WW
Palliative Care Timing Review	PAC/T

Part I: Health Policy, Older People and Research

National Service Frameworks are healthcare policy statements intended to *inspire* by setting goals, *guide* by stipulating standards or authorising means, and *convince* by asserting moral principles about the rights and needs of people with particular health conditions or characteristics – such as being old. They are statements of optimism about the future of healthcare for all; as Beveridge, the author of the report that was the basis of the NHS, said, "Scratch a pessimist and you find often a defender of privilege." This report is about goals, means and principles on the healthcare of all older people, as well as about efforts to determine the best ways of providing that care.

Drivers for health and social policy for older people

There are of course many forces influencing health policy, some of which had an impact on the NSFOP. Among the key drivers are:

1. Underlying social and healthcare policy values. For example, *The NHS Improvement Plan* (Department of Health 2004) states: "At the core of this plan lies a continuing commitment to the founding principles of the NHS: the provision of quality care based on clinical need, irrespective of the patient's ability to pay, meeting the needs of people from all walks of life."Such values are central to the NSFOP.
2. Medical innovations and scientific developments. The NSFOP might not have focused on stroke, for instance, had it not been for recent developments in rehabilitation.
3. Improvements in evidence about what works and what is cost-effective. This is a complex driver because evidence is rarely definitive. As far as the NSFOP is concerned, one might perhaps cite the balance of evidence about the benefits of integrated services as a driver for the recommendations about the care and treatment of people who have fallen.
4. Rising public expectations. The NSFOP might not have focused on rooting out age discrimination had it not been that, with the rise in the number of older people in our society and changes in the way old age is perceived, it has become increasingly unacceptable to treat older people as passive recipients or second-class citizens.

5. Pressure on public resources. This is a crucial driver as far as older people's services are concerned. With the ageing of our society and increasing longevity, the growing number of older people – and particularly of very old people – is understandably fuelling fear about the rising cost to the public purse (Wanless 2006). This must have been a driver to the focus in the NSFOP on mental health services and intermediate care, as well as to the focus on health promotion.
6. Social and demographic changes, resulting in the rising tide of chronic health conditions. This too contributes to the NSFOP's emphasis on stroke, mental illness and heart disease.
7. Desire for political advantage. This of course is very hard to pin down, since the electorate wants positive benefits from the state as well as the holding down of tax levels, but we might perhaps again cite the emphasis on combating age discrimination, since older people – not only because of their numbers – are an increasingly influential sector of the electorate.
8. The desire to improve the quality of services and their outcomes. This includes how England compares with other countries; for example, the interim report of Lord Darzi (Department of Health 2007) makes frequent comparisons with other countries as a spur to further improvements in health outcomes. For the NSFOP, models of care for older people that appeared to work elsewhere – such as the chronic care model first developed by Wagner et al (1996) – clearly exerted an influence.

It is salutary to consider these drivers because they indicate the pressures and restrictions under which National Service Frameworks are drawn up, and because they show the central contradiction within which the frameworks are created. Thus rising public expectations and improvements in science and evidence all conflict with pressure on resources and the rising number of people with chronic conditions. In such a situation, the best solutions will be seen as those for which there is the best and most cost-effective evidence about outcomes. Innovations and good research are essential.

Approaches to health and social policy for older people

Research on health and social care for older people asks different kinds of research questions and raises varying kinds of hypotheses, depending on the type of conceptual framework within which it is positioned. The perspectives necessary for understanding the goals of policy, the aims of research and the interpretation of findings can be divided according to three different levels of specificity:

- *Older people and later life*. The biomedical model of ageing appears to dominate the NSFOP, with its understandable emphasis on declining ability and increasing complexity of health conditions and disability. The NSFOP made an apparent three-fold distinction between active older people, people with single or non-complex health conditions, and people with complex health conditions. However, there is also a recognition that old age is not the only factor in the onset of disability, and that people can remain well and active into late old age.
- *Agency in later life*. The days of perceiving older people as passive recipients of services have disappeared, and the NSFOP recognised older people as active agents of their own support. The old welfare-state model within which people were 'clients' of beneficent service providers has been replaced to some extent by the neoliberal model of people as service users with responsibility for holding the reins of their own package of services. This model, however, still applies less well to pronouncements about services for older people, which often appear to endorse the view that older people are passive recipients of welfare, than it does to those for younger age groups.
- *Public policy.* Despite the real increases in expenditure on the NHS in the last 10 years, the retreat of the state from welfare in advanced industrial societies is apparent in the UK. With rising incomes, individualism, consumerism and privatisation, electorates become less willing to pay high taxes and expect to cater for more of their own welfare needs. The private and voluntary sectors play a greater role in health and social care. Large corporations give generously to the voluntary sector and wield an increasing influence over welfare support. For older people, this pressure on the state is a major challenge; the incomes of the oldest (who need the most support) are often insufficient to cover their care needs, their own orientations are towards state welfare (to which they have contributed for so long), and the personal capacities of some very old people are inadequate to the challenge of orchestrating their own care. However, as far as health services in England are concerned, the model now favoured for the delivery of services is one that encourages choice among consumers, with the aim of driving up quality through competition and driving out inefficient providers (Le Grand 2007). This is unlike previous modes of service delivery (for example, where government control was more direct, or where healthcare professionals set the agendas), but the 'choice' and 'personalisation' model is still in the process of proving itself – many commentators argue that, for some older people (as well as other groups), choice may be hard to exercise or there may be less interest in providing services for older people, especially from private providers.

Recent health policy and older people

Key features of recent health policy

Leaving aside the National Service Frameworks, since 2000 there have been a number of highly influential health and social care policy papers documenting key policy changes and developments. Many of these have had an influence on services for older people or have been directed particularly at them (Department of Health 2000, 2004, 2005a, 2005b, 2006, 2007a, 2007b). Study of these policy developments suggests seven key goals, with their accompanying service or system changes; beyond the user-focused goals, there are of course the goals of efficiency, improving quality and outcomes, and holding down costs. These policy developments are summarised in the table below.

User-focused goals of recent policy	Examples of key service changes	Examples of key system changes
Health promotion	• Smoking cessation programmes • Extension of breast screening to women up to 70 years old	
Service user involvement and control	• Direct payments • User access to own care records	• Choice of provider • Reduction in waiting times
Self-management of chronic conditions	• Personalised care plans • Specialist nurses and community matrons • Expert Patients Programme	
Home-based care to enhance independent living	• Intermediate care services	• Reimbursement for delayed discharge • Intermediate care as a range of transitional services
Services tailored to the user	• Single assessment process	• Financial and legal incentives to promote the integration of health and social care • Primary care trust and practice-based commissioning • Increased variety of providers
Equity and fairness	• NHS-funded nursing care in Care Homes • Staff training to enhance end-of-life care	• No tolerance of ageism
Improved service quality	• More use of outcome measures, including patient-reported outcomes	• Greater accountability built in to the system through standards and regulation

While this is only a rough summary, with a good deal of overlap between categories, the table does show how crucial most of the recent developments are for older people's services; most of them feature in some way in the NSFOP of 2001. However, some did not come into being until after 2001 or were only beginning to impinge (for example, primary care trust and practice-based commissioning and the Expert Patients Programme), while others were not specifically focused on older people (such as the choice agenda and the encouragement of diversity in providers).

National Service Frameworks have been in existence since the late 1990s, with the aim of setting standards of care for a variety of chronic conditions as well as for particular groups of people (King's Fund 2007). The NSFOP was produced before some policy developments (such as reimbursement for delayed discharge and the emphasis on local commissioning) but after the NHS Plan (Department of Health 2000); this document, on which the NSFOP was built, laid out plans for NHS-funded nursing care in care homes, intermediate care, personal care plans, an end to ageism and the single assessment process for health and social care. Funding was made available through the NHS Plan for nursing care in care homes and for the development of intermediate care services; for instance, £900 million was to be invested in intermediate care and related services, to be followed by a further £66 million for intermediate care capital investment.

As with all the National Service Frameworks, the NSFOP is a top-down set of standards for public services. The aim of such pronouncements is to improve services for particular sets of people or specific conditions by:

- setting goals for improvement of service quality;
- outlining plans to establish or develop services;
- establishing standards in order to improve consistency of services across the country;
- showing where the priorities should lie; and
- giving a conceptual and moral steer.

It is expected that these standards will be implemented, with thematic reviews of progress by both the Healthcare Commission and the Commission for Social Care Inspection, and promotion of the standards by – in the case of the NSFOP – the then National Director for Older People's Health and newly established groups of older people's champions. User involvement was thus incorporated into the NSFOP, but older people's views did not centrally influence the setting of the standards in the first place, even though there was input from older people's and carers' reference groups. As Glendinning (2003) says in discussing top-down health and social care policies, "there is little evidence that older people are being consulted about their needs" – their expressed views look rather different from national policy priorities, placing more emphasis on preventive services and especially on "more involvement by older people in planning, organisation and monitoring of services".

The National Service Framework for Older People

The NSFOP was based on evidence as well as policy expectations (Swift 2002), and has a 10-year timetable for implementation. It was published in 2001, setting eight key standards in:

- rooting out age discrimination;
- person-centred care;
- intermediate care;
- general hospital care;
- stroke;
- falls;
- mental health; and
- health promotion.

Of course, the NSFOP acknowledged that it was not comprehensive. We might, for example, ask why relatively little emphasis was given to sensory impairments or chronic pain, and others have asked why it had little of substance to say about informal care (Brown & Evans 2001). Older people will experience conditions which are the subject of other National Service Frameworks or which have already received policy attention. The NSFOP was deliberately selective, with a focus on some conditions which have received less attention. The principles that underlie the NSFOP were stated by the then National Director for Older People's Health (Philp 2004) as person-centred care, joined-up services, timely response to needs, and the promotion of health and active life – which, as can be seen from the table on page 19, fit closely with the overall focus of current public health policy.

Analysis of the text of the NSFOP shows that these principles can be divided a little further to six underlying principles about older people and their health services (which are also goals, since the intention is to make progress towards a time when these principles are fully implemented):

1. Older people should be supported to remain active and healthy into late old age. For example, action should be taken to prevent strokes and falls, and older people should receive immunisation against influenza and fair access to screening.
2. There should be no age, cultural or geographical discrimination in health and social care services. Services should be provided on the basis of clinical need and ability to benefit rather than age, and should be culturally appropriate and consistently available across the country wherever needed.
3. Because older people have health and care needs specific to old age, they should get services from professionals who specialise, or are specially trained, in the treatment of older people. The specific policies for this principle include specialist nurses (for example, Modern Matrons for Older People) and specialist multidisciplinary teams. The discussion focuses on hospital care, but much of what it says could apply equally to older people in the community.
4. Services should be person-centred/personalised. They should be addressed to the needs and choices of older people themselves, and older people should be involved in decisions about their care and treatment. The specific policies emanating from this are the promotion of respect and dignity in care and at the end of life, the single assessment process and better integration of health and social care services.
5. Older people with health problems should be helped and supported to manage their own conditions, to retain or regain independence and to remain living in their own homes. Care should be provided as close to home as possible. The specific policies emanating from this principle are intermediate care, reimbursement for delayed discharge (though this came in after 2001) and a specialised falls service.
6. Older people with complex needs should receive integrated and long-term care services. The policies emanating from this principle include the single assessment process, an integrated continence and community equipment service, an integrated and continuing stroke service and an integrated mental health service.

These are principles which would receive almost universal support, although they do raise a number of questions. For example:

1. If there is to be an emphasis on health promotion among older people (Principle 1), does this not involve further investigation of the ways in which different older age groups should be targeted? And should health promotion not be an even more prominent part of the NSFOP and involve even more directives about helping people to remain healthy? As Wanless (2004) states, for the NHS to remain affordable over the next 30 years people must become 'fully engaged' in their health, meaning that there must be a shift towards self-care and people taking responsibility for their own health; this includes older people, for whom more support to be active agents of their own ageing should be considered.
2. Principle 3 (about older people requiring specialist services) might be in danger of conflicting with Principle 2 (about combating age discrimination), since the NSF suggests on the one hand that older people should not be treated on grounds of age, and on the other that they do have some special needs deriving from their age.
3. A conceptual distinction between older people with 'specific conditions' and those with 'complex needs' is unlikely to be an easy distinction to make in practice (Principles 5 and 6). It also sits uneasily with the concept of person-centred care (Principle 4), which suggests that people should not be placed into broad categories but seen as people with unique needs.
4. Apart from through the allocating of resources, there is no explicit prioritising among these principles and the service developments that spring from them. This is understandable since they are all high-order principles, but with scarce resources there must be prioritising – which leads to the question of how it should be done, or whether policies should be formed and services delivered in an even-handed way across each of the areas.

The NSFOP carried some conceptual maps. For example, although it stated that "chronic degenerative disease, disability and ill health are not an inevitable consequence of ageing" (p107), there was an underlying view of old age as a process of decline from entering old age, through a transitional phase, to a period of frailty before death. Perhaps for this reason, it centrally distinguished between services for active healthy older people, those for people who have some specific conditions but can remain independent, and those for people with complex needs who will need ongoing care and treatment. This denotes the influence of the chronic disease pyramid model, which suggests differing assessment needs and service responses for people with (i) early problems/single conditions and (ii) complex needs. The influence of this model may also help to explain why there was relatively little emphasis on health promotion in the NSFOP.

But such models are only one way of dividing a population according to health status. For example, the NSFOP could have used the 'bridges to health' model, which was developed in the USA (Lynn et al 2007) and divides the whole population into eight categories with accompanying priority concerns, key health services and healthcare goals; for example, there are people with chronic conditions but generally normal function or with significant but stable disability (for whom the goals are suggested to be 'living with illness or disability'), and those who have limited reserve and serious exacerbations or are undergoing a long course of decline (for whom the goals are 'coping with illness at the end of life'). This model is interesting in that all but one of the categories are appropriate to the older population, suggesting that there may be finer distinctions to be made between categories of older people which may help in the search for the most appropriate patterns of healthcare service. It should be added that both these models use traditional biomedical conceptions of illness, health and health status; it needs to be remembered that, for older people, perceptions of good health are often closely linked to social and physical functioning rather than to specific medical conditions (Bryant et al 2001).

Since 2001, an interim NSFOP report has been published (*Better Health in Old Age*, Philp 2004) and then more recently *A New Ambition for Old Age* (Philp 2006) and a review (Healthcare Commission 2006) pointing to a number of improvements that have been made for older people. These reports suggested that age discrimination was being countered (for example, through a higher proportion of cardiac surgery patients being aged 75 and over); increasing numbers of older people were taking advantage of health promotion opportunities (such as stopping smoking); there were more specialists and specialist services for older people (such as old age psychiatrists, consultants in old age medicine and continence advisers); the person-centred principle was being addressed through, for example, more carer assessments and more carers and older people in receipt of direct payments; support for independent living and care closer to home was being advanced through more intermediate care services and a continuing decline in the rates of delayed hospital discharge; and older people with complex needs were receiving more intensive home care services, with fewer having to enter care homes. Of course, some of these improvements would have happened without the NSFOP, and some are not necessarily proven examples of improvement, being related more to increases in the older population. But some undoubtedly are good signs for older people and should be applauded.

However, these reports also emphasise the need for more to be done. Philp (2006) outlines 10 new goals which build on the NSFOP and aim to improve dignity in care; dignity at the end of life; stroke care; falls and bone health; mental health care; care for people with complex needs; urgent care; care records; healthy ageing; and the promotion of independence, well-being and choice.

Researching the NSFOP

The OPUS research programme in context

A number of research questions spring out of the NSFOP – the most obvious being whether it has worked. Are the lives of older people today better than they were because of the NSF? But beyond this, as Brown & Evans (2001) say in a review of the NSFOP:

> "The standards create a research agenda not just for the successful implementation of the standards but also for their refinement and development." (p6)

More specifically, the key questions include:

1. What are the needs and experiences of older people etc which we must know about in order to frame/plan developments in services for older people, so that we can adhere to or develop the NSFOP's standards?

2. What has been the outcome of the recommended service developments set in train or fostered by the NSFOP? Have they been implemented without difficulty and have they been effective? What implications do these findings have for the development of the standards?

3. What new ideas or initiatives – in line with the standards – can be put in place and evaluated?

The OPUS research programme was established in 2002 by the Department of Health's Policy Research Programme to support the NSFOP – not to assess it as a whole (which, given its huge scope, would have been impossible) but to examine key specific issues.

Other research has examined the views and experiences of the NSFOP among older people more generally (Healthcare Commission 2006; Manthorpe et al 2007b). This latter study, funded by the Healthcare Commission, comprised a "portfolio of methods (listening events, nominal groups and interviews)" with nearly 2,000 participants aged 50 upwards in 10 areas of England. While the NSFOP "was not widely known about", older people and carers tended to:

> "perceive the changes under way in health and social care as a mixture of losses and gains, appreciating the speed and efficiency of treatments in both primary and secondary care, whilst also lamenting the loss of the kinds of personalised support and relationships with which they had been familiar". (p5)

The authors conclude that:

> "It is difficult to attribute any of the changes … to the NSFOP itself, but we can see that some change processes run contrary to some aspects of the NSFOP whilst some trends are congruent with the aspirations of the NSFOP. For example, making practice more evidence-based and more efficient at the same time may weaken person-centredness and reinforce perceptions of ageism." (p6)

Service providers are, of course, much more likely to know about the NSF, but at the front line they too may have limited familiarity with it. For instance, in a study of implementation of health policy at primary care level (Checkland et al 2007) some respondents were cited as not having read the NSFOP and saying they would be unlikely to do so.

The views of psychiatrists have also been studied (Tucker et al 2007), in a survey whose aims were to discover whether, in the opinion of consultants in old age psychiatry, mental health services for older people were being delivered according to the standards set out in the NSFOP. (These standards specify an integrated service based on the single assessment process and involving community and hospital-based services, together with a specialist service to provide outreach to residential, general hospital and primary care.) The survey was carried out three years into the NSF's 10-year programme, and showed a mixed picture – just over half the consultants thought that services had improved in the previous two years, but "patchy, inconsistent services appeared to be the norm" and there was little evidence that the introduction of the single assessment process had changed practice. The authors recommended increased investment in older people's mental health services.

The OPUS research programme

Although the aim of establishing an NSFOP research programme was not to assess the NSFOP overall, it was hoped that there would be some additional value to setting up a *programme* of research rather than a series of separate projects. This value lies in the comparisons that can be made between projects, allowing the emergence of common themes, conclusions and recommendations concerning services for older people in England in the first years of the 21st century. The themes were loosely brought together in the research programme Older People and their Use of Services (OPUS).

The scope of the OPUS programme was considerable, both in breadth and depth. As stated above, health policy in the past 10 years has had a number of major goals, reflected in the NSFOP. The OPUS projects can be shown to address several of these goals but not, of course, all of them. Matching the projects to the policy developments in the table on page 19 shows how they fit. Although this is a very crude summary, the table on page 28 shows clearly that there was no project specifically on health promotion (hardly surprising given its limited specificity in the NSFOP) or on user involvement and control or accountability; however, there were several projects on independence and home-based care and on issues primarily concerning equity and fairness in services. Also, over the whole breadth of the OPUS programme, all the policy goals were either indirectly or directly addressed, with many of the projects covering more than one goal.

This focus on the main, funded service or system changes established by the NHS Plan, the NSFOP and subsequent developments – intermediate care, the single assessment process, funded nursing care in nursing homes, specialist staff training and reimbursement for delayed hospital discharge – was a key strength of the research programme. Another strength was the emphasis on the topic of independent living and home-based care, not only through examination of policy implementation but also through investigation of some new initiatives to support older people at home or at key transition points between home and hospital; this focused on people who had experienced depression, a disabling stroke or a fall. A final key feature of the research programme was its emphasis on equity of care, particularly in circumstances where age discrimination is often seen to be at its worst: end-of-life care, care home provision and services for people with dementia. As in all programmes of research, the projects selected for funding involved the research commissioners making trade-offs between the scientifically most rigorous proposals, proposals on topics about which the Department of Health particularly wanted to get some answers at the time, and the need to cover the broad range of subjects within the NSFOP.

User-focused goals of recent policy	Examples of key service changes	Examples of key system changes	OPUS research projects directly related
Health promotion	• Smoking cessation programmes • Extension of breast screening to women up to 70 years old		
Service user involvement and control	• Direct payments • User access to own care records	• Choice of provider • Reduction in waiting times	
Self-management of chronic conditions	• Personalised care plans • Specialist nurses and community matrons • Expert Patients Programme		SSS/OP
Home-based care to enhance independent living	• Intermediate care services	• Reimbursement for delayed discharge • Intermediate care as a range of transitional services	RR/CH IC/ECO IC/EPO RDD LLD/PC AS/F SFU/S DD/RR DD/WW
Services tailored to the user	• Single assessment process	• Financial and legal incentives to promote the integration of health and social care • Primary care trust and practice-based commissioning • Increased variety of providers	DI/SAP
Equality and fairness	• NHS-funded nursing care in Care Homes • Staff training to enhance end-of-life care	• No tolerance of ageism	FNCICH PAC/NEP PAC/HF PAC/T PWD/CCS
Improved service quality	• More use of outcome measures, including patient-reported outcomes	*Greater accountability built in to the system through standards and regulation	

The abbreviations in the fourth column above are explained in the table on page 14.

As stated earlier, a National Service Framework is a complex mixture of high-level aims and specific policy objectives or directives. The projects in the OPUS programme reflect this mixture. They fall into three groups. Some of them were about how specific policy directives have worked, some were about the evaluation of innovations created locally by the research applicants to fit within the aims of the NSFOP, and another group addressed needs or problems in an area singled out by the NSFOP for attention.

The projects varied greatly in design, as shown in the table below:

Design of project	Number of projects
Mixed methods	4
Mixed methods/case study	4
Mixed methods/controlled trial	3
Qualitative interview study	1
Postal survey	1
Evaluation (not controlled trial)	1
Systematic review	2

Eleven of the projects collected data directly from older people, and 10 from carers or family members. Altogether data from the records of 8,500 older people were gathered, and 1,200 older people reported their views and experiences in interviews or surveys; 1,600 carers/family members were asked to give their views, as were 1,100 health or social care staff. It should be recorded too that many of these people, who willingly gave their time, did so while coping with frailty, illness, bereavement, stress or the challenges of very demanding work.

The research was carried out both at a national level (through surveys) and in selected areas of England, ranging from Devon in the South-West through London, Kent and Surrey up to Yorkshire and Lancashire. One project involved a comparison between England and Scotland.

Health professionals (particularly those in the medical profession) are central to the delivery of healthcare and therefore to the formation and implementation of health policy, as well as to research on the subject. Many were involved in these 16 projects, of which six had principal investigators who were qualified healthcare professionals; in the remainder, the principal investigators were social scientists.

Summary

Part I has described the background against which the OPUS research projects were played out. The main theme is the tensions that afflict implementation of service developments, from the broad national health policy setting level down to the delivery and receipt of services by individual older people. We end, therefore, by summarising these tensions before going on to show how the research projects – set within the context of ambiguities, contradictions and tensions – illuminated the principles behind the NSFOP.

Undoubtedly the main tension is between the drive for high-quality services which meet people's needs and their rising expectations, and the limitations imposed by pressure on resources resulting from on changing views about state expenditure and rising numbers of older people.

In approaches to older people and their service needs, the main tensions lie in the diversity and changing character of this population and in changes to how they are perceived. Thus there are tensions between the views of many older people – in particular that the welfare state will provide care 'from cradle to grave' – and the move towards privatised, consumerist welfare. There are also contradictions between the view that older people are and should be active agents in their care and the appreciation that some older people cannot cope with the demands that such an active stance may bring (or the older, paternalistic models which fail to appreciate that older people *can* be active agents). This fits closely with the tension between a view of old age as a period of declining ability and the opposing emphasis on active healthy ageing. It is also associated with a tension between believing that older people need specialist services while simultaneously believing that it is discriminatory to treat them differently from other age groups.

In recent health policies for older people (including the NSFOP), several key tensions can be discerned. Perhaps foremost among them is the emphasis on a person-centred, individualised approach to meeting health and social care needs, juxtaposed with (i) the need to classify older people into set categories need and (ii) the move to an evidence-based approach which sets standard guidelines. User involvement is also high on policy agendas, but there is evidence of only limited involvement of older people in the creation of these top-down policies. As far as the standards of the NSFOP are concerned, there is a tension between the undoubted importance of each of them and the need to prioritise in situations of competing demands. And at the level of specific services there is tension between the urge towards integration and the continuing separation of services, and between a focus on processes/pathways between services and an emphasis on the development of individual services.

Part II: The OPUS Research Programme – Principles in Action

Introduction: Summarising the OPUS projects

In Part II, project findings are organised around the six main principles of the NSFOP. The reason for organising this overview report around the principles should be clear: the research programme was very mixed, with no single unifying theme apart from the NSFOP itself. As such key findings would be hard to bring together. Some of the projects were also small-scale or exploratory. Nonetheless, as anticipated there are some general themes and findings that link the projects, and these are to be found particularly in relation to the underlying principles, set within the context of the tensions described at the end of Part I.

To set the scene, the three different types of OPUS project are summarised – those examining specific national policy directives (which formed the largest single group); projects examining local initiatives which fall within the scope of the NSFOP; and research with a prime focus on the needs and circumstances of older people.

Projects on specific policy directives

The seven projects in this group are clustered around the NSFOP standards of person-centred care, intermediate care and general hospital care. The projects examined a range of major policies: two had a general focus on intermediate care (IC/ECO and IC/EPO), one on the role of community hospitals in intermediate care and rehabilitation (RR/CH), one on the single assessment process (DI/SAP), one on funded nursing care in care homes (FNCICH), another on education/training for district and community nurses in palliative care (PAC/NEP), and the final – and most recent – on reimbursement for delayed hospital discharge (RDD). The three intermediate care projects were part-funded by the Medical Research Council.

The aim of all but one of the projects was to assess how well or easily the policy was implemented; and all were concerned to some extent with the success of the policy, examining both intended and unintended consequences. Such investigation is of course immensely complex, because there is no linear relationship between policy directives and implementation. Whatever its source and specificity, policy has to be interpreted, fitted into other frames of reference (both national and local), traded off against other absorbers of scarce resources, and negotiated among various competing interests and values. Not all projects could include a comparative element in order to assess the difference the policy had made, but four projects did so: the reimbursement project compared the situation in England, where the policy operates, with that in Scotland, where it does not; the community hospital study was a randomised controlled trial in which patients requiring rehabilitation following a stay in an acute hospital were randomly allocated to either the district general hospital or community hospital for their rehabilitation/intermediate care; the investigation of community palliative care nursing involved two surveys of bereaved relatives, one before the nurse education/training had been implemented and one after; and the study of the single assessment process included a comparison of assessments and of older users both before and after introduction of the process. Even such comparisons, however, were not straightforward – partly because 'other things were never equal', with many other social, demographic and policy changes taking place at the same time, and also because the time needed for policies to become embedded was often longer than the life of the project, forcing studies to conclude that it was too early to say what difference the policy had made.

The PAC/NEP and RR/CH projects did not examine the issue of completeness of implementation. Among the remainder, the policies that appeared to have been implemented most fully were those on funded nursing care in care homes and reimbursement (whose implementation was of course influenced by the legal requirements imposed). However, neither was implemented without difficulty; in particular, there was a good deal of geographical variation in the way in which reimbursement was operationalised. There were also some unanticipated consequences in both cases (see later sections). The availability of intermediate care and the single assessment process was still not universal when the studies ended – difficulties over what constituted intermediate care made it hard to assess implementation; and there were technical difficulties in implementing the single assessment process, with some professionals (particularly specialist clinicians) not as fully involved as had been proposed. Even though it was felt to be too early to draw conclusions for some of the policies, there were indications of movement in the expected direction; for example, both intermediate care studies demonstrated the expanding repertoire of intermediate care services, and IC/EPO followed the development of mechanisms to facilitate flow between services. There were also indications of unanticipated negative consequences, however: reimbursement could lead social workers to feel that they were being blamed for delayed discharges; patients could suffer if they were moved out of acute wards and onto holding wards, etc; people who might otherwise have benefited from intermediate care were not given priority because priority had to be given to those who were at risk of reimbursable delay; and the transition out of intermediate care and back to mainstream services could be very difficult.

Whether or not the policies were effective was a question that could not be answered clearly by most of the projects, because of limitations in the studies themselves or other simultaneous changes in services or demand – or because it was too soon to say. For example, there was no evidence that intermediate care had begun to relieve pressure on other services. For the single assessment process, the DI/SAP project concluded that – apart from depression – needs appear to be more accurately identified under the new process; but this analysis was carried out in only one local authority, so further research is needed. There was also evidence that reimbursement had 'brought the partners to the table' and speeded up the process of falling rates of delayed hospital discharge, but the comparison with Scotland could not be conclusive because Scotland also has a system (albeit a very different one) for getting patients out of acute hospital beds.

Only one project (RDD) concluded by suggesting that the policy – in that case reimbursement – should not continue. The researchers concluded that reimbursement had run its course and that, because the service provision climate had changed so markedly since the reimbursement legislation (through joint commissioning and local area agreements, for example) there was now no need for such legal requirements in order to ensure that hospital discharge goals were pursued in partnership.

Evaluation of local innovations

Three of the projects involved locally driven initiatives in service provision for older people. They were not evaluations of specific national policies but were designed to provide suggestions for implementing some of the NSFOP standards. One (SFU/S) addressed the NSFOP standard on stroke and its recommendation that patients should be re-assessed six months after a disabling stroke; it comprised a randomised controlled trial in two metropolitan areas in northern England to determine the effects of a structured re-assessment process on clinical and health-economic outcomes. The second (LLD/PC) addressed the NSFOP standard on mental health and consisted of a controlled trial in north-west England to assess the feasibility of a new model of intervention for the treatment of late-life depression in primary care. The third project (AS/F) was directed at the NSFOP standard on falls; involving the development and trial of an assessment tool for ambulance staff to use when called out to older people who had had a fall, it was designed to help them determine whether the older person should be taken to hospital or could be safely left at home. This intervention was carried out in the London area.

All three projects were small studies which broke new ground but whose findings could not be definitive. The only intervention that appeared to make a difference was that involving the treatment of depression, where more older people in the intervention group showed improved mental health than those in the control group. However, as the researchers concluded, further research is needed to show whether the study is generalisable.

Identification of needs and problems

The final group of six projects is hard to classify, except that they all had a prime focus on developing our understanding either of the needs of service users or of the problems and limitations of the services. They primarily addressed the NSFOP standards on mental health, hospital care and person-centred care. There were two projects on palliative care (PAC/HF and PAC/T), two on delayed hospital discharge (DD/RR and DD/WW), one on dementia in different ethnic groups (PWD/CCS) and one on specialist and generalist staff and services for older people (SSS/OP). Two were literature-based studies, two were largely qualitative and two involved mixed methods.

Though none of the projects would claim to be definitive (and the two on delayed discharge have to some extent been overtaken by recent developments in hospital discharge), among their findings about the needs of older people were the following: that older people with non-malignant diseases such as heart failure have high support needs, but these are extremely heterogeneous and their dying trajectories are hard to predict; and that people with such diseases need holistic and generalist care (needs that are often not being met) as much as, or rather than, specialist care. Little of what is known about patients' perspectives on hospital discharge is routinely built into research about the appropriateness of discharge decisions, especially the perspectives of people from black and minority ethnic groups or those with mental health problems. Understandings and acceptance of dementia vary across cultures but nonetheless there are high support needs among all groups. Among the findings about service limitations were the following: that GPs tend not to see heart failure as requiring palliative care and therefore need education in this field, particularly in symptom management; that there are, however, no existing tools which are adequate to help in decision making about referral for palliative care; and that more social care input is needed, in an integrated approach, for people with heart failure and those recently discharged from hospital.

This brief summary suggests that the studies point towards some important and neglected areas of service need and provision, but a summary cannot do justice to the rich sources of data that these projects provide. They are drawn on further in the sections that follow.

The NSFOP principles and the development of OPUS research themes

Each of the principles outlined in Part I is described in turn, with relevant findings from the OPUS projects. The exception to this is the principle about health promotion (‘older people should be supported to remain active and healthy’) because OPUS funded no projects specifically on this theme, nor did any of them have much to contribute to the debate about the most effective ways of promoting health in later life. The actions advocated in the NSFOP were mostly about illness care. For example, although the NSFOP recommended that action should be taken to prevent strokes and falls, the emphasis was mainly on after-care rather than prevention. Indeed, the progress report of 2004 (*Better Health in Old Age*, Philp 2004) recognised this gap and stressed the need to emphasise the benefits of health promotion for older people, and that there should be:

> “incentives for the NHS and councils to work together and invest in health promotion activities for people as they enter, and throughout, later life. In particular, opportunities to increase physical activity need to be encouraged and to be inclusive of marginalised groups of older people: those living alone, the socially isolated or those with specific needs based on their culture and race.” (p5)

This lack of attention is very much in line with both current and traditional policy and practice, where vastly more government expenditure goes on treatment for ill health than on preventive measures. Understandably, growing numbers of chronically ill or frail and disabled older people mean an emphasis on today’s care and treatment needs rather than on tomorrow’s prevention. But as Blank & Burau (2004) say, in a discussion of modern health policy:

> “Despite a recent shift in many countries back towards a more public health oriented strategy, there is evidence that even the most attentive countries could be well-served to put a significantly larger proportion of their health care budgets into public health efforts … Mounting evidence suggests that the most significant improvements in health have come from public health measures, not curative medicine …” (p175)

Of course, it is understandable that the OPUS research programme focused on the needs of, and services for, people with serious healthcare problems – and these people are not perhaps those for whom support to remain healthy and active is primarily designed. However, there are some points arising from the projects that are relevant.

Health promotion is essentially a forward-looking and indeed optimistic concept; there would be no point in trying to promote health in old age if there were no expectation that it could occur. There are basically two approaches to this. Taking a neoliberal stance, it may be argued that maintaining good health in late age is a matter of individual responsibility. Taking a social democratic stance, one might argue that it is either a matter of social circumstances and environment or on the other hand of advances in knowledge and science. Using the example of dementia, therefore, one would expect to find people with the condition, carers and service providers taking either an optimistic view of their future (if they saw recent developments in cognitive enhancing medication as helpful, or the disease as something that they could overcome) or more likely a pessimistic view (if they saw it as a deteriorating genetic condition for which little could be done). Our cross-cultural study of dementia (PWD/CCS) found very few positive reflections about the future. For example, of the older people with dementia:

> "Only two participants overtly hoped to overcome their memory problems. A more common approach was hoping for the best: participants hoped that faith in God, medication or strength of character might protect against future deterioration and sustain their ability to manage on a day-to-day basis."

Even among the carers there were very few who had taken steps to plan ahead. For example, one Black Caribbean carer (aged 64) typically said:

> *"How do I know if we live to see tomorrow morning? So how can you plan about tomorrow, next week or the week after, just take one day at a time. I know you have to make plans, but in reality you don't, because how many of us make plans and don't live to fulfil those plans?"*

For people with such views, health promotion campaigns will have little impact. It is important that such campaigns start from where older people themselves view their position. Only thus will they have a good chance of success.

The other five principles were the focus of at least some of the research projects.

Principle: There should be no discrimination in health and social care services

The NSFOP stated that "NHS services will be provided, regardless of age, on the basis of clinical need alone" and "should be culturally appropriate"; it remarked that older people from black and minority ethnic groups "can be particularly disadvantaged and are likely to suffer more discrimination in accessing services". In discussing mental health services the NSFOP singled out culturally biased assessments, assumptions made by staff about the capacity and willingness of families to act as primary carers, and the lack of translation of information for users, suggesting that actions of this kind can all lead black and minority ethnic groups to distrust health and welfare agencies.

Some OPUS projects confirmed the existence of age and cultural discrimination and of geographical differences, and more importantly helped to develop our understanding of the implications of differences in service use, how they come about and the contexts within which they operate.

As other research also shows (e.g. Mackenzie et al 2004, La Fontaine et al 2007), the views of older people and their families can be part of the challenge. For example, we know that ethnic minority elders with dementia “are under-represented in referrals to specialist health care and in the use of social care services”, and the OPUS cross-cultural study of people with dementia (PWD/CCS) found a tendency either to stigmatise memory problems or to define them as a part of ‘normal’ ageing. It also found evidence that:

> “some participants used old age as a means to deny/minimize memory problems and distance themselves from dementia. This prevented individuals from addressing their fears and from seeking and accepting help.”

This was particularly true of Asian older people, as dementia was not seen as undermining their important roles and relationships (which tended to centre around the family) and was therefore accepted; indeed, “offers of help from health and social care professionals were often interpreted as challenging or questioning the presence of family support”. The implications of this kind of finding are that services must find better ways of offering help so that they do not undermine family support.

Ageist attitudes among service providers were also found. There was, for example, evidence in some of the OPUS projects of ‘therapeutic nihilism’ and ‘paternalism’ among service providers, and some clear stereotypes about what older people are like. As the study of late-life depression (LLD/PC) reported:

> “The feeling that nothing could be done for this group of patients was a feature of all primary care professionals’ interviews.”

For instance, GPs remarked that older people often have good reasons to be dissatisfied with life, and that depression could be a normal response to a situation rather than a sign of pathology.

Also on the views of GPs, one of the studies of intermediate care (IC/EPO) indicated that not all older people who were eligible for intermediate care, or likely to benefit from it, were actually in receipt of it. Intermediate care staff worried that some eligible people were not being referred, particularly by GPs. This was seen to be a particular issue for people with mental health problems or whose condition was deemed 'medically unstable'.

Participants in the study of people with dementia (PWD/CCS) also frequently reported GPs as putting patients' cognitive problems down to 'old age'. The study of people with heart failure (PAC/HF) found GPs unwilling to disclose prognoses to elderly patients, and recommended more research to examine professional ageism. There is clearly scope for continuous professional development training, etc to include ways of helping professionals to examine their biases and the way they may stereotype service users.

The same kind of stereotyping was found among some of the 12 ambulance crew members interviewed in depth for the study about the use of a tool to help them decide whether someone who had fallen should be taken to hospital (AS/F); they remarked on older people's 'desire for independence' or the fact that a 'lot of elderly people have memory problems'. In addition, the new tool for ambulance crews devised by this study was not used by the majority of the crew members, even though their depot had agreed to take part in the trial; the researchers suggested that this might have been due to the low importance accorded by crew members to older people who have fallen (although it could also have been due to their irritation with the tool itself). This has a message for researchers about the importance of involving end-users in the development and implementation of new tools.

Some projects examined approaches to *countering* discrimination or differentiation in service provision; these approaches could involve the development of new instruments, the implementation of national policy to enhance equity and calls to clarify areas of uncertainty. The first such project was the systematic review of the timing of palliative care for older people with non-cancer life-threatening diseases (PAC/T), which was motivated by the knowledge that palliative care in this country is biased towards people with cancer. As the researchers said:

> "There is now considerable evidence to show that the majority of older patients who die from chronic non-malignant disease would also benefit from, and prefer, palliative and supportive approaches to pain and symptom relief toward the end of their lives. However, when compared with the experiences of cancer patients, the palliative and psychosocial needs of non-cancer patients remain largely unmet."

Of course it is recognised that the lack of such services is due not necessarily to age discrimination per se, but to the greater difficulty of predicting the approach of death for non-cancer diseases. Nonetheless, if decision making tools and predictor variables to help clinicians can be developed, they should be researched further and implemented. Hence this systematic review, which was "a first step towards improving access to palliative care services for older adults with life-threatening non-malignant disease". The study concluded that there are no such tools as yet, but made several recommendations for developing our understanding of this area. The urgent need for more research on dying trajectories is also urged by Gott et al (2007a), drawing on their research on older people with heart failure.

Some government policies are introduced at least partly to address inequity in service receipt. One such was the single assessment process (discussed in a later section), and another the introduction of NHS-funded nursing care in care homes. The initial examination of the introduction of this latter policy (FNCICH) found relatively smooth implementation but a number of problems in introducing a new scheme at a time of rapid organisational change. By and large the policy was being implemented according to plan, with "good progress reported by most primary care trusts in meeting target dates" for carrying out 'determinations' (that is, the assessments of the level of nursing care needed by individual older residents). However, there were problems over, for example, inadequate resources to carry out the determinations; administrative costs for the care homes (a problem that was said to increase the risk of care home closure in some cases); the use of less highly qualified staff to carry out determinations; and, in particular, the assessment of residents with mental health problems or cognitive impairment (see also Reed et al 2007).

For equitable treatment to be provided, there must be clarity about what this means. While the NSFOP principle on specialist services may be seen to conflict with the principle about age discrimination, it is probably fair to say that the situation is not so much 'confused' as 'complex'. Of course, older people should not be the victims of negative age discrimination, but on the other hand they should receive special services – designed for older people – if that will either combat previous negative discrimination or address needs specific to later life. As the authors of the study on specialist services (SSS/OP) said:

> "In essence a key theme of the NSFOP was to end age discrimination by addressing both negative and positive ageism: the former by tackling the issue of equal access to care and changing the practice of restricting services to older people on the basis of their age; the latter by promoting the development of specialist old age services."

Nonetheless, this study did find enormous confusion about the topic among the healthcare, social services and independent sector staff surveyed or interviewed. As the authors concluded:

> "The findings from this study suggest the emphasis on both negative and positive ageism in the NSFOP has led to confusion and different understandings of the way that services for older people should develop."

There is still some way to go to clarify this complex situation. (This point is discussed further below.)

Five studies had findings about geographical variations in care. These variations in themselves are well known, but the projects showed some of the contexts of service provision that help to illuminate these variations. One was the study of palliative care nursing (PAC/NEP), which found wide variations in health and social care service receipt between the eight cancer networks sampled in England, as reported by the bereaved relatives of older people who had died. The second was the study of the single assessment process (SAP), which found considerable variability in its implementation; for example, two-thirds of the localities surveyed in a national survey of SAP lead officers used locally developed tools rather than the nationally accredited instruments, and there were variations around the country in the way SAP was integrated with other assessment procedures such as those for intermediate care. The third study was the literature review on delayed hospital discharge (DD/RR), which by comparing a number of studies identified the considerable variations in rates of delayed discharge from one location to another – and thus emphasised the importance of local contexts in contributing both to delays and to their obverse of timely discharge. The fourth was the study of reimbursement for delayed discharge (RDD), whose findings both confirmed and extended those of DD/RR by showing that there were varying styles of implementation of reimbursement at both strategic and operational levels across the three English sites studied. Implementation ranged from "close adherence to nationally outlined reimbursement processes, to adoption of a partnership agreement with joint investment plan, which obviated the necessity for cross-charging". Patient experience also varied across sites (both in England and Scotland), "with stories of helpful relationships with staff and of lack of involvement and communication". The fifth study was one of the intermediate care projects (IC/ECO), which found in a national survey of provision considerable variation around the country, both in what was provided under the name of intermediate care and in what was understood *as* intermediate care. The findings of all five projects demonstrate the complexity of understanding local variations, which are clearly not simply a matter of, for example, variations in demand or in funding; they can involve differences in strategic and operational arrangements as well as in local providers and their cultures and working practices. The findings also remind us that policy initiatives are introduced in very heterogeneous local circumstances, and therefore are hardly likely to be implemented in a homogeneous way.

Summary

On the principle of countering discrimination, OPUS projects illustrated particularly well the tension between older age as a period of decline – about which it is thought not a lot can be done – and the more positive view of later life, with its active approach to meeting the needs of older service users. As long as some service providers continue to see older people in nihilistic or stereotyped ways, it may take more professional education or national policy directives (such as NHS-funded nursing care) to improve the situation for older people. Equitable provision will also be aided by better evidence about what works in targeting particular groups of older people (such as the time at which palliative care should be offered for older non-cancer patients) and greater clarity about what is needed (as with the provision of 'specialist' services). The situation is not helped by the perhaps inevitable tendency to 'typify' or place older people into cultural or medical categories rather than treating each person as an individual, with the consequent risk of stereotyping them and in so doing discriminating against them.

Principle: Older people with health and care needs specific to old age should have services from professionals who are specially trained in the care/treatment of older people

The NSFOP mentioned specialist service providers several times, using the term to refer to a number of different types of service provider: (i) clinicians who specialise in a particular condition, discipline or area of work such as stroke care, cardiology or podiatry; (ii) doctors who specialise in old age medicine or psychiatry; and (iii) nurses or other care service professionals who specialise in care of older people with complex problems. It also suggested that these staff may work in specialised teams, because "older people who have complex co-morbidities associated with older age are best treated by a dedicated specialised team". It is particularly where the suggestion of specialists in care of older people was made that there is likely to be some confusion, especially when the opposite of 'specialist' is seen as a 'generalist'. The NSFOP did not explore this point.

The one study of direct relevance to this principle – on specialist workers for older people (SSS/OP) – found, as stated in the previous section, uncertainty and diversity of view about specialists and the content of specialist expertise. It is quite reasonable that the term ‘specialist’ should be used in a variety of different ways; a specialist is a person who has special knowledge, skill, experience, interest, commitment or qualification. And the specialist has that knowledge, etc either in relation to a category of persons considered to have some specific needs or complexities of experience, or in relation to a specific disease or condition, or in relation to a specific kind of treatment or course of action. So far, so straightforward. The confusion appears to come about when people are termed specialists in older people or older people’s services, since older people – like younger people – may need specialists of any of the kinds described above. Thus SSS/OP reported that:

> “The specialist staff identified in the interviews ranged from strategically based staff to clinical, community or ward-based staff. The specialist staff themselves report being confused about what being a specialist means. There is no universally accepted definition of what a specialist practitioner is, but it was most often defined as knowledge, qualification or experience in a specific area above and beyond basic professional qualifications.”

Some research respondents even explicitly stated that it would be wrong to set up services specifically for older people because that would be discriminatory, but agreed that there were some specialist services that were expected to be used mainly by older people. What was agreed was that specialist services for older people had grown since the turn of the 21st century, and that this new growth was particularly identified with services which work across sectors and give co-ordinated care to older people. Intermediate care was often singled out. But people found this a confusing service as far as specialising was concerned, because intermediate care was associated not with staff specialising in one particular type of service but with those having general knowledge about several types; as it provides services across sectors and addresses a number of different kinds of need, it appeared to be both generalist and specialist (although, of course, in a multi-disciplinary context specialist input could be seen as part of a broad, though not necessarily generalist, service). Outside the OPUS programme, Manthorpe et al (2007a) found older people wanting social workers with specialist knowledge, but what they actually said suggested that they often wanted generalist as much as specialist skills and knowledge. For example, one group of participants said they wanted social workers who were “knowledgeable about the condition and its effects” and “able to make a thorough and informed assessment”, but were also “able to listen and respond appropriately, skilled in enabling a person to speak out, sympathetic and not intimidating”. These are the kinds of skills that are not specific to dealings with older people nor to specialist disciplines; they are relevant to any roles involving sensitive negotiations with other people. Perhaps, however, this is one of the meanings of 'specialist' and thus an illustration of the importance of not over-simplifying any consideration of generalist and specialist services.

When is a 'generalist' more appropriate than a 'specialist'? The study of heart failure (PAC/HF) concluded:

> "There is a role for specialist palliative care professionals in terms of educating GPs about discussing end-of-life issues. However, the high level of co-morbidities experienced by people with heart failure points to the need for a generalist rather than a specialist to take overall responsibility for patient care up until death."

Another recent study on 'generalists' in end-of-life care (Gysels et al 2007; Higginson et al 2007) explored the need for generalist care as well as pointing out the confusion about the difference between generalists and specialists:

> "Generalist end of life care is a broad and diffuse concept … there is not a common understanding of what the term stands for. It is often defined in terms of what it is not, as the type of palliative care not provided by specialist teams, which opens up a very wide field of enquiry." (Gysels et al 2007)

The depression intervention study in northern England (LLD/PC) was also interesting on this subject. Although the trial was delivered by a specialist community psychiatric nurse with a wealth of experience and knowledge, one wonders whether this was any more important than generalist skills. For example, the researchers reported that:

> "The Trial nurse described the theoretical structure and process of his work and the use of the self-help intervention in detail, but disclosed that he perceived the most valuable to patients was the personal contact with someone who was empathic and showed interest in the patient as an individual."

Conversely, one of the intermediate care studies (IC/EPO) reported a common view among intermediate care staff that older people in need of intermediate care needed specialist services. The authors stated:

> "On several sites the appointment of a community-based specialist in elderly medicine was being actively pursued … There was no single view among interviewees about which type of medical input was required. Some argued strongly for a hospital-based geriatrician who had easy access to diagnostic facilities; others thought that GPs with a special interest were able to offer a good service provided they had technical

> back-up; whilst others argued for more specialist nurses. There were a number of GPs on each site who were developing practical expertise in caring for intermediate care patients."

But this active pursuit of a specialist in elderly medicine took place against a background in which the early development of intermediate care had occurred without the engagement of medical staff and often in opposition to them, and within the growing understanding that medical input was required – particularly as 'medical stability' was a requirement for intermediate care and is a fluctuating state. This still begs the question of what kind of special expertise is needed. Is it expertise in older people, in the diseases and co-morbidities of old age, or in intermediate care or other kinds of care?

Summary

While this principle is confusing, it is to some extent – though by no means entirely – a semantic confusion. However, it is important not to oversimplify the debate. Further research is needed to determine the circumstances in which older people want and would benefit from specialists, generalists or a mixture of the two, and what the two terms mean in specific contexts. It is easy enough to accept the need for clinical specialists in the diseases associated with late life and the co-morbidities of old age; it is more difficult to see the feasibility of specialisms which appear to require the crossing of disciplinary boundaries or seem to be predicated on the belief that there are social or psychological features that are unique to old age.

Principle: Services should be person-centred

The NSFOP espoused a person-centred approach and was clear about what it meant by this: person-centred care involves listening to older people; respecting their dignity; recognising individual differences and not using a 'one size fits all' approach; enabling older people to make decisions about their own care (or involving them in decisions) by ensuring that they have the necessary information and helping them to understand their options; providing integrated services which address all relevant needs; and involving carers where appropriate.

There are several services which the NSFOP considered necessary to help fulfil this aim: the single assessment process, good end-of-life care, accurate, relevant and available information, joint commissioning, and an integrated community equipment service and integrated continence service. OPUS projects had a good deal to say about person-centred care, even though the programme did not cover all these fields.

Studying the meaning of patient-centred care is in some ways quite hard, partly because it is not a phrase which has much everyday meaning to older people. This is illustrated by an interview with one older person in the study of community hospital care (RR/CH):

> "Interviewer: Person-centred care?
>
> Interviewee: What on earth is that?
>
> Interviewer: Centred on you as a person as opposed to perhaps your medical condition. That didn't come across particularly?
>
> Interviewee: Didn't come across, no, I'm afraid.
>
> Interviewer: I suppose the next one's linked with it, a 'holistic approach'?
>
> Interviewee: What on earth is that?"

Additionally, the concept of person-centred care is perhaps so taken for granted that it is not articulated well; it is also multi-faceted and complex. For example, it is seen as a characteristic of the interaction between a service provider and an individual user, but also as a characteristic of a service or of a site of care. The researchers on the community hospital study (RR/CH) claimed that community hospitals can provide better patient-centred care than district general hospitals, commenting that their qualitative data suggested "a greater sense of engagement for the patient in the community hospital, more recognition that activities of daily living were supported, families involved and links with home prioritised, a sense that they experienced care as being provided with sensitivity and respect".

Justifications of person-centred care are hardly necessary, but some of the OPUS studies confirmed the need for a person-centred approach by the way they demonstrated the variations in values and attitudes among older people – which can affect the need for and acceptability of service support. For example, the cross-cultural study of dementia (PWD/CCS) found different types of role valued by people with dementia, such as an emphasis on independence, family life, being part of the community, an orderly and clean house, and so on. Carers too could be divided into those who had a traditional approach to caring (seeing it as natural and right) and those with a non-traditional view (who saw it as being in conflict with their other roles). Such differences appeared to affect the acceptability of support from formal services or the type of support that would or would not be acceptable.

The main question we can ask of OPUS projects is what evidence they provided that person-centred care is being delivered and received. Not surprisingly, in all the major services studied directly there was evidence of shortfalls in person-centred care (as well, of course, as some evidence of good person-centred services).

First, the survey of palliative care (PAC/NEP) found bereaved relatives reporting that one quarter of older dying people were not always treated with respect and dignity by the district and community nurses caring for them. (Furthermore, there was no change between Time I and Time II – before and after the introduction of the education programme – suggesting that the education and support programme for district and community nurses was not making a difference.)

Person-centredness is also implicated in the policy of NHS-funded nursing care in care homes. The policy would, for example, be person-centred if residents and relatives were routinely involved in the determinations carried out by nurses as to the band (level of nursing need category) to which residents should be allocated. The situation appears to be that they were involved if the determination was carried out before they entered a care home, but were much less likely to be involved if they were already resident. Some homes had a 'paternalistic attitude' – only just over half of care home staff said that existing residents were always involved, and only one in five that relatives were routinely involved in determinations for NHS-funded nursing care. One care home manager said:

> *"I usually sit down with the (nurse carrying out the determination) and we go through the notes. We usually agree … Residents aren't involved as they would not understand and it might confuse them. We do tell relatives about determinations but they do not choose to be involved."*

An absence of person-centredness is also evident in the apparent lack of services for people with mental health problems. The study of hospital discharge (DD/WW) records the lack of psychiatrists to carry out assessments for older people, who may be delayed on acute wards for that reason. It also records the dearth of community services or care home placements for them after discharge. The study of NHS-funded nursing care in care homes (FNCICH) also identified the needs of elderly residents with mental health problems as sometimes being inadequately assessed by those carrying out determinations for NHS funding, and concluded:

> "Guidance, based on further research, is urgently needed on who should be conducting determinations for residents with mental impairment in specialist [elderly mentally infirm] and non-specialist care homes ... [and a review] to determine whether [the determination tool] adequately reflects the nursing needs of people with mental health impairment."

There was also evidence of a lack of patient-centredness in the study of heart failure (PAC/HF), which found that:

> "Autonomy and playing an active role in decision making were compromised by a low level of understanding of heart failure amongst patients, including in relation to prognosis."

This study also found social services provision to lack a patient-centred focus, with services provided in a formulaic way and not meeting the needs of patients. In a separate account of the study, the researchers concluded:

> "The inflexibility of Social Services to adapt to the needs of the individual was one of the key complaints participants who had received services and their carers voiced. … Whilst providing 'person-centred' services is a key objective of future social care for adults in England, and certainly central to the single assessment process, how this will be achieved in practice is less clear. In this, as in many areas of health and social care, an intention to pursue a patient-centred approach, has to co-exist with the priorities shaping commissioning and with top-down scrutiny via guidelines and checklists." (Gott et al 2007b, p340)

We still have little information about the person-centredness of some services. The survey of patients carried out for the intermediate care evaluation of costs and outcomes (IC/ECO) was very limited; although it showed that people were satisfied with the service, it did not explore their views in any depth. In fact, the authors concluded:

> "Fragmentation and poor integration with other services remain features of current provision and continue to have an impact upon the ability of intermediate care to deliver patient-centred care and contribute towards health and social care systems as a whole."

One of the other studies of intermediate care (IC/EPO) reiterated its potential to be person-centred:

> "Our study indicated the elements of good user-centred intermediate care, which defined its quality. These were three-fold: an enabling ethos built around activities and goals of value to individual users which boosted their confidence and enhanced their motivation to take control of their own recovery; recognition of and partnership with informal support networks who could maintain and sustain that recovery; and links into ongoing practical, clinical and social support from services where necessary."

Although this study was less pessimistic about the integration of services (and considered, in fact, that good progress had been made in this direction), nonetheless it too saw person-centredness as only having been partially achieved:

> "The needs of older people, in this juncture on their pathway toward recovery, were enormously varied. Even so, it was evident that the nature and content of provision was only in part led by the needs of service users."

An absence of person-centredness was further hinted at in the study of delayed hospital discharge (DD/WW), which also examined the workings of the reimbursement scheme. While this study did not manage to interview patients, some of the staff interviewed talked of the management of patient choice through the use of guidelines issued to patients about the requirement for them to find alternative accommodation once their need for acute care was past. This of course is reasonable, but staff members commented that they were rushing older people into making decisions. This does not sound like patient empowerment, although it should be added that many of the discharge procedures set up to help older people achieve the most appropriate care after discharge are clearly very person-centred both in aims and outcomes.

The study of the implementation of reimbursement legislation (RDD) also illuminated this point. In summarising the impact of reimbursement on users, the researchers said:

> "The impact of reimbursement on patients is perceived differently by the various stakeholders, depending on their position in the system. Many hospital staff and clinicians saw benefits to patients individually, in reducing their delays in hospital, and collectively, in enabling better patient flow. Some strategic managers in the local authority, and social workers in particular, considered that reimbursement was a 'system-focused' policy and that it contributed to the general speeding up of acute care to the detriment of patients. Often, operational staff struggled to reconcile the pressures on the hospital system with their professional ideals around person-centred care. Concerns were expressed about time limits for assessment, especially where patients had complex needs, and the difficulty in finding appropriate care packages, especially long-term care placements, in time."

There is often a gap between patients being medically fit and their being able to manage at home. If the system requires them to move from an acute hospital ward and they are not ready to go home, solutions may be found which help the system but not the patients. For example, as part of the process of making acute care more efficient, patients are often moved on to holding wards or other interim solutions which have little therapeutic value and are detrimental to individuals. The authors concluded that:

> "It is important that solutions to making acute care more efficient should not just be focused at the entry and exit points of the hospital but that there should be more investment in resources for rehabilitation and community-based provision."

In considering patient-centredness, it is clearly important directly to include the experiences of the older people and their families. However, criticism was made in the review of research on delayed hospital discharge (DD/RR) that very few of the studies reviewed included a patient and carer perspective. As the authors stated:

> "In our opinion, including a patient perspective is crucial in order to understand the context within which the older person is using health and social services and develop an appropriate response."

The reimbursement project (RDD) did include interviews with patients and families. Sixty-seven – often very frail – older people who had experienced delayed discharge were interviewed, as were 40 family members. Whereas all the staff who were interviewed saw themselves as patient-focused, this did not necessarily mean that patients always achieved the outcome they most wanted. Some patients were very unhappy with the outcome, but the factors that influenced this might have had nothing to do with a lack of person-centredness. For example, the crucial factor could have been the unwillingness of family carers to continue caring, the lack of availability of rehabilitation facilities or disputes about care home fees. So it is a very complex issue: processes such as reimbursement may be put in place primarily to suit the system rather than the person (albeit perhaps to benefit the majority of patients indirectly, and directly in the sense that patients do not want to stay in an acute hospital longer than is absolutely necessary); staff may remain person-centred yet patients' experiences may seem to belie this; but patient outcomes actually result from a very complex mix of factors, including the views and actions of the patient and his/her family members. This shows the importance of recognising person-centredness as a complex, negotiated process.

Turning to policies designed to help *foster* person-centredness, one may examine the findings of the project about the development of the single assessment process (SAP). This is a key part of the NSFOP's strategy for promoting person-centred care, providing explicit guidelines for the assessment of older people on the reasonable assumption that without effective assessment appropriate services are unlikely to be routinely provided. In his 2004 progress report on the NSFOP, Philp recorded that 80% of councils had implemented SAP by October of that year (Philp 2004).

The OPUS project on SAP (DI/SAP) was a mixed-method study involving a national survey of SAP lead officers, a national survey of specialist clinicians in old age psychiatry and geriatric medicine, a small survey of older users in a number of local authorities, a comparison of the accuracy of needs identification before and after the introduction of SAP in one social services authority, and a study in three authorities to assess whether care plans were more closely allied to needs after the introduction of SAP.

Such a complex study cannot be summarised here, but the findings include some important concerns for person-centred care. For a start, it appears that local authorities are taking the lead role in implementing SAP. This may not be problematic, but – as the researchers say – “the extent to which this will affect inter-agency acceptance of the implications of this initiative is of concern in the longer term”. When one adds to this that respondents reported low involvement by GPs, geriatricians and old age psychiatrists in assessments, there must be concern over whether such assessment can be comprehensive and therefore person-centred. For example, the surveys of geriatricians and old age psychiatrists (albeit with response rates of only 49% and 60%) found that “the degree of integration with other agency assessments and patient involvement in assessment were only modest”.

A comparison of the identification of need in one local authority by Challis et al (2007) concluded that:

> “The greatest improvements in need identification were in the areas of cognitive function, mobility and activities of daily living [and] there was no improvement in identifying the presence of depression.”

Overall, the researchers concluded:

> “The study suggests that there have been increases in multidisciplinary assessment and the use of standardised approaches since the introduction of the SAP. Key professional actors appear to be social workers/care managers, occupational therapists and district nurses. However, the engagement of specialist clinicians in this process appears relatively low and there remain both technical and operational difficulties in the use of IT to facilitate assessment.”

On the effectiveness of SAP in enhancing patient-centred care, the small DI/SAP study of users found a difference between people who were given an assessment because they were accessing services for the first time and those who were either considering direct payments or on the verge of a major life change such as moving into residential or nursing home care. The latter – generally more frail – group were less satisfied both with the process of assessment itself and with the content of the assessment. Although, as reported above, the identification of needs appears to be better after the introduction of SAP, the researchers stressed that these findings should be treated cautiously, as should the findings of the last of the DI/SAP studies – that of comparison of care plans before and after SAP, which showed that there *were* differences; for instance, after SAP there were higher recorded levels of physical and cognitive impairment, significantly fewer users were receiving home care provided by the local authority and more were receiving it from the independent sector. It is certain that more research is needed, especially into the experiences of older people themselves and the extent to which they and any family carers see SAP as adequately identifying and targeting their needs so that they can be addressed.

Other researchers have examined what older people themselves think about SAP and its person-centredness. In their small qualitative study, Powell et al (2007) identified two problems with the use of a standardised assessment tool: that needs would be discovered which available resources could not meet (leading to dissatisfaction among older people), and that standardised tools could not easily assess the complex, interrelated and unique circumstances in which older people managed their own care. The authors concluded:

> "For the SAP to capture the nature of older people's lives and their experiences as 'givers' and 'receivers' of care and support, it needs to resist framing older people's needs primarily in terms of increasing dependency and burden on others." (p1055)

Other evidence about assessment of care home residents shows some disturbing lack of comprehensive assessments. A study examining the assessment documentation of 126 homes in north-west England (Worden et al 2006) found many aspects of need poorly covered – for example, oral status assessment was only included in half the homes, and pain assessment in only a quarter.

Apart from SAP, one of the other interventions studied in OPUS involved assessment to facilitate person-centred care. The structured re-assessment six months after a stroke encouraged "patient empowerment by individual patient-held outcome records describing suggested treatment approaches, service options and … therapy goals" (SFU/S), even though – because there was no evidence for the effectiveness of the intervention – we cannot say that the patient-held records were beneficial.

Other projects help to reveal the *challenges* of a person-centred approach at the front line. For example, being person-centred may lead to some loss of professional focus. As the intervention provider – a community psychiatric nurse who was clearly very person-centred – in the study on support for people with depression in primary care (LLD/PC) said:

> *"It is very, very flexible … If someone asked me what I was really doing I'd say I use a very eclectic, commonsense, non-rocket science approach that's very, very individual to whatever the patient's needs are."*

It looks as though there may be tensions here between professionalism and person-centredness.

Secondly, person-centred approaches do not work well when people are ill-informed about their condition; if they have not been informed that they have heart failure, for example, they may not expect or ask for the kind of support services that would actually be helpful in the later stage of life (PAC/HF), and will not be able to take control of their own lives.

Third, it is hard to provide the right services to people at the appropriate time if that involves making predictions about events for which there is inadequate evidence. The systematic review of predictor variables for short-term survival among older adults (PAC/T) identified several general factors associated with survival, including "increased dependency in [activities of daily living], presence of co-morbidities, poor nutritional status and weight loss", as well as others related to specific diseases; for instance, "chief among the specific predictors of short-term survival in dementia were loss of ambulatory function and impaired speech". This is encouraging evidence but, as the researchers concluded, more validation research is needed before "any prognostic model … can be recommended for routine clinical use" because what healthcare providers need are good prognostic models which "offer meaningful guidance about appropriateness of future care strategies".

Summary

The tension between a person-centred approach and paternalism, the need to standardise care and the pressures to target and prioritise are particularly evident in some of the OPUS projects. The investigations demonstrated that there is a shortfall in services to meet some kinds of need such as mental health;

that services are sometimes fragmented rather than holistic; that the needs of the system may win out over those of the service users; that older people are sometimes not enabled – or not given time – to make their own decisions; and that they are not always treated with dignity and respect.

Person-centred care has the potential to be aided by the single assessment process as well as by services such as intermediate care, better prognostic tools and better education for staff. But it will be held back by gaps in the kinds of services that users need, by lack of information on the part of both users and providers, and of course by the continuation of the kind of attitudes and practices that should have no place in healthcare services.

Principle: Older people with health problems should be helped to manage their own conditions, to retain/regain independence and to remain living in the community

The NSFOP had a strong emphasis on helping people to remain living independently at home. It endorsed support for 'care closer to home', for helping older people to manage their own long-term conditions and for regaining or retaining independence. To meet these aims it advocated intermediate care, rapid community response teams, more home care support, the Expert Patients Programme and carers' respite services (along with other welfare state services such as benefits and housing support). The NSFOP placed its specific emphasis on intermediate care for older people:

> "… to promote their independence by providing enhanced services from the NHS and councils to prevent unnecessary hospital admission and effective rehabilitation services to enable early discharge from hospital, and to prevent premature or unnecessary admission to long-term residential care".

The two follow-up reports on the NSFOP (Department of Health 2003, Philp 2006) have reported good progress here – for example, in the continuing decrease in delayed discharge and the growth in intermediate care services. However, the research picture is more complex.

If older people are to be supported to retain their independence, they must of course in the first place become known to service providers – and at a stage when intervention can be of maximum benefit. One of the problems demonstrated among all ethnic groups in the cross-cultural study of dementia (PWD/CCS) was late presentation of problems to GPs. Information and education will be needed to make people aware of the benefits of early presentation. Even after presentation and/or referral to psychiatric services, there appeared to be little use of community mental health teams, which were seen as fully occupied dealing with, for example, people with psychotic illnesses. This conforms with the findings of the study by Tucker et al (2007), reported earlier, that “patchy, inconsistent services appeared to be the norm” for older people with mental health problems. From carers’ perspectives there also appeared to be a deficit of support services, with some people describing a constant battle to get advice, information and practical assistance.

Most of the sample of people in the stroke follow-up study (SFU/S) were back at home six months after their stroke, but they still had problems, the most commonly identified being to do with communication, mobility/falls and personal hygiene. If they were in the intervention group and had a follow-up assessment, they were mainly just given advice or information and were rarely referred on to an outside agency or even within the healthcare team. This hardly sounds adequate.

The study of patients with advanced heart failure living at home (PAC/HF) also suggested a need for holistic care in that it found high levels of symptoms and little support for maintaining function. This was compounded by the well-known phenomenon of older people being unwilling to ask for help:

> *“I want to keep my independence as long as I possibly can; you see I don’t like these … well, I call them ‘do-gooders’. I mean, I manage.”*
> (Gott et al 2007b, p338)

The study of ambulance crews’ decisions about older people who have called 999 as a result of a fall (AS/F) is interesting here since its baseline data collection showed how, among people who are not conveyed to hospital but are left at home (a proportion known to vary but to be generally around 40%), “re-attendance and subsequent conveyance are alarmingly high and unexpected”. Even with the use of a tool to help ambulance crews take the decision, the risk of adverse events for people who were not taken to hospital remained high. This does not sound like adequate support within the community, and indeed the authors said that “the need for alternative care pathways and, in particular, rapid response type services was highlighted repeatedly in the clinical reviews” (which were carried out for all cases where people were left at home). Regarding the value of the tool itself, it is hard to be conclusive since so many of the staff did not use it and there did not appear to be any difference in adverse events following non-conveyance between those where the tool was used and those where it was not.

Mental health problems in later life and the need to find ways of helping older people to remain independent in the face of depression or cognitive impairment were a focus of the NSFOP. So it is encouraging that the OPUS depression intervention study (LLD/PC), exploratory though it was, found a community-based intervention which was effective – four months on, fewer people in the intervention group than in the control group were still manifesting multiple symptoms of depression (that is, 20% as opposed to 40% had five or more symptoms of depression as measured with the SCID depressive symptoms tool).

Although intermediate care (IC) is acknowledged to be a process, involving integration of services over a period of time and not just post-hospital rehabilitation, nonetheless for older patients coming to the end of a stay in an acute hospital the question of which is the best place for their rehabilitation is an important one. An answer was attempted in one of the projects, where district general hospital rehabilitation was compared to rehabilitation in a community hospital in a carefully designed multi-centre randomised controlled trial (RR/CH). Although the differences were not stark, there was a modest but significant difference between the sites – in favour of community hospitals – on people's performance on an extended 'activities of daily living' scale at six months from randomisation. There were no other clear differences, but this one allowed the authors to conclude:

> "Post-acute care for older people who are judged to be medically stable but in need of rehabilitation can be adequately addressed in community hospitals."

It should perhaps be added that this type of IC was not found to be a prevalent form of IC in the national study (IC/ECO). In fact it was fairly insignificant compared with all the other ways IC could be provided.

The IC/ECO study took a largely provider/provision perspective, though with an assessment of a sample of patients' experiences of IC and a short questionnaire to assess user satisfaction. It found that IC receipt was still fairly limited (but of course this was back in 2003/04) and identified some of the key factors encouraging or deterring the development of the services. Among the most important of these were: whether there was local pressure on acute hospital beds (the need to discharge people, especially following the implementation of the 'reimbursement' legislation); what kind of legacy of pre-existing IC-like services there was in the area; whether or not a good partnership already existed between health and social care services; funding and resources (including staff shortages or adequacies); and whether or not there were local champions for IC.

Although there was variation, overall IC/ECO found that IC made a positive difference to the people who used it. Quality of life indicators showed a statistically significant improvement, and ability to perform activities of daily living improved. As the authors said:

> "The majority of observed IC episodes were completed successfully with the patient returning to their own home in a functional state that was better than when they were admitted."

The third IC project (IC/EPO) also found that the majority of IC users returned home or remained at home at the completion of IC, and the vast majority of those whom they followed up for six months were still at home at the end of the six months. The authors of this report took a different view of IC, emphasising its nature as a set of bridges at key transition points in a person's journey from illness to recovery, and showing that 'recovery' could mean different things depending on the age, health and outlook of the person. The study certainly saw IC as generally providing those bridges successfully, and saw older people as welcoming it and seeing it as having made a difference. Thus the researchers stated:

> "Qualitative evidence from service users suggests that intermediate care made a significant difference to people's lives – supporting them at a critical juncture to make the transition from illness towards recovery. Older people's descriptions are resonant of this transitional focus: thus, 'it set me up', 'got me on my feet literally', 'gave me a boost over the worst part', 'provided a helping hand'. At the conclusion of the intermediate care episode, most people had made substantial progress along the path to recovery, defined in their own personal terms."

The authors concluded that it was too early, and that the routinely collected data were inadequate, to say whether IC was having an effect on other parts of the care system (Young and Stevenson 2006). However, the reimbursement project (RDD) was able to shed some light on this as it was conducted two to three years after the IC studies. It could not provide hard data about the national impact of IC, partly because that was not its purpose but also because it took a case study approach and only investigated three sites in England in depth (as well as two in Scotland where IC does not operate). However, the researchers found that strategic and operational staff in the three areas attributed their success in reducing delays to "such measures as increased capacity, particularly around intermediate care provision, service redesign and effective management of multidisciplinary working". In one area these measures were seen as much more significant than reimbursement, whereas in the other two areas reimbursement was seen as a powerful player in the continuing struggle with delayed discharges. However, having to get patients out of acute hospital care because of reimbursement could mean that IC was blocked up by such patients, who had to be given priority over others who might need or benefit from it more.

Summary

Clearly there is a growing drive for high-quality services to help older people to remain independent, but this is undoubtedly coming up against the tension with funding limitations and the need to prioritise. A focus on specific services also militates against older people's need for integrated, holistic services.

OPUS projects have begun to demonstrate the value of intermediate care, of targeted support services for older people with depression and of community hospitals. They have also shown that services such as these can be jeopardised by other gaps in the provision in the community of services like carer support, mental health teams, and information and advice.

What is needed is not just more resources but also better education and information, more research to confirm the value of community support for people with depression, and also more attention to the continuing needs of older service users beyond the six weeks or so of intermediate care and after the visits of the community psychiatric nurse.

Principle: Older people with complex needs should receive integrated and long-term care services

The NSFOP did not distinguish between those older people who can and cannot benefit from intermediate care or rehabilitative services. In fact, it was very clear that all older people, however frail or however complex their condition, should not be ruled out of being eligible for these services. However, it recognised that some older people are more frail, sick or disabled than others, and that towards the end of their lives they will require continuing and extensive services. For instance, it stated:

> "All those providing health and social care, who have contact with older people with chronic conditions or who are approaching the end of their lives, may need to provide supportive and palliative care."

This may include information and advice, social care, rehabilitation and support. The NSFOP also considered it important for older people for whom admission to long-term care is a possibility to receive a full assessment of their needs, stating:

> "While the care of all older people should be managed appropriately and effectively, the most vulnerable older people will often require fuller assessment and more intensive forms of care management."

Long-term care services include both home care and care home provision. Of particular interest is the interrelationship between health and social care, a strong theme throughout this programme.

One important policy development occurring at the time of the inception of the OPUS research programme was the implementation of NHS-funded nursing care in care homes, and one of the projects (FNCICH) examined this development. Of the policy the researchers wrote:

> "… from April 2003 the funding of registered nursing care for some 85,000 care home residents transferred from local authorities to the NHS. Furthermore, from April 2004 anyone entering a care home is to receive a single joint assessment *and* a determination of care carried out by a NHS registered nurse *prior* to placement …"

While this policy was welcomed by, for example, older people's organisations, it remained controversial in a number of ways; for example, many people felt that personal care should also be state funded, there was criticism of the levels of funding (which were considered to be too low) offered in each of the three funding bands, there was doubt about whether care homes would pass on the funding relief to residents, and there was concern that some kinds of resident – such as people with Alzheimer's disease – were losing out in that their care was classed as 'personal' whereas many considered it to be healthcare.

The question of whether NHS-funded nursing care in care homes has led to more co-ordinated or integrated care is an important one, but it cannot yet be answered on the basis of the one study in OPUS. As the FNCICH report said:

> "The opportunity exists to use the introduction of NHS-funded nursing care as a means of enabling the NHS, independent sector care homes and local government to work collaboratively to improve the quality of care and access to health and other services for care home residents. This has not yet been adequately capitalised on in England, possibly due to the speed of implementation and also the absence of funded time for NHS nursing and care home staff. Capitalising on NHS-funded nursing care will require acknowledgement of the time staff in both sectors spend on organising and conducting determinations, and exploration of the potential to use these regular visits to care homes to develop closer

> working relations with independent sector staff, leading to benefits for both sectors."

Turning to care in the community, a number of the OPUS projects examined the circumstances in which integrated care is needed. For example, it is accepted that people with a disabling stroke need continuing support; the NSFOP recognised this and recommended re-assessment six months after the stroke. One of the studies (SFU/S) set out to obtain evidence for this recommendation, and found "no evidence for the effectiveness of a structured, routine follow-up six months after a disabling stroke" (that is, no difference in clinical outcomes between an intervention and a control group). However, re-assessment appeared to make hospital re-admission less likely and there was therefore a small cost advantage to the follow-up assessment. Of course, re-assessment on its own is not the answer. Unless services exist and spring into action following assessment, people will continue to feel unsupported. Nearly a third of patients said that they had not been given all the necessary information about allowances or services they might need after leaving hospital; and about a third said they did not currently get all the support they needed from services such as meals on wheels, home helps, district nursing, etc. The authors wrote that stroke patients have complex problems which change over time, from a need for practical support in the early days to psychosocial support at a later stage and that "no existing community or secondary care service is designed to address these issues satisfactorily".

Older people who have fallen and then call for an ambulance are another interesting group. The study of an assessment tool for ambulance staff (AS/F) emphasised the need for readily available support services in the community. Ambulance crew members spoke of identifying problems when called to a person's home, but they saw them as problems that required a visit by the GP or other services rather than a visit to A&E. However, they also spoke of not being able to contact the patient's GP directly, GPs not taking into account their concerns over a patient, and a sense of frustration that there are no other options apart from A&E. One crew member said:

> *"Yes, it's not the perfect solution (A&E) but there's no other avenue open to us, unless we just stay there until the GP arrives."*

The primary-care-based intervention for depression was described as a collaborative and integrated care model in the study devoted to it (LLD/PC), but this description raises the question of what integrated care or services means, since the main basis of the scheme was a series of visits and calls by one community psychiatric nurse (CPN) to the older people with depressive symptoms. True, it involved an educational and self-management guide, and advice from the CPN about contacting other relevant services, but this hardly constitutes 'collaboration.' And the older people themselves appeared to value the friendly contact with the CPN above all else. Further research will be needed to assess what it was that made the difference, but it seems unlikely that collaborative care will feature strongly (although see Unutzer et al 2002).

The three projects just described were all local initiatives, pursuing NSFOP goals but not dictated by it as far as means were concerned. As such they were all exploratory and would need to prove their worth more comprehensively to attract further funding. Only the depression intervention showed sufficiently positive findings to warrant this at present. Other research confirms the effectiveness of treatment for late-life depression in primary care (Bruce et al 2004, Cuijpers et al 2006, Katona & Shankar 2004, Schulberg et al 2007, Sjösten & Kivela 2006).

Very different was the project examining the impact of the national implementation of a nurse training programme in palliative care (PAC/NEP). Both this project and that about the experiences and care of people with heart failure (PAC/HF) demonstrate a need for better GP and nurse education in the management of people who are dying.

The PAC/NEP survey of bereaved relatives about the deceased person's care in the last three months of life show considerable levels of unmet need. For a start, the education and support programme for district nurses appears to have made no difference (although caution is urged here, as the sample sizes were smaller than anticipated, or there may not have been a significantly higher proportion of older people in the second survey who had been cared for by a district nurse who had received the education). Leaving that aside, relatives reported a number of inadequacies in care services: (i) symptom control for those who received care from a district nurse was often only partial or absent for "a third of those with bedsores, two-fifths of those treated for constipation and breathlessness, half of those treated for nausea and vomiting and two-thirds of those treated for pain"; (ii) a fifth of respondents said they had been unable to contact a district nurse urgently when they had needed to in the last three months of the deceased person's life; and (iii) "only half of respondents reported that they had had as much help from health and social services as they needed when caring for the deceased".

The study of the palliative care needs of older people with advanced heart failure (PAC/HF) supports this conclusion. There was little evidence of advanced care planning (partly because the prognosis tended not to be discussed with patients); and most people had no help from social services and not enough from their GP. Forcibly the researchers concluded:

> "Despite an absence of data, UK policy is to encourage specialist palliative care involvement in heart failure management, rather than to strengthen the role of primary care in this area. However, this study provides evidence that patients receive (and prefer to receive) most of their care from their GP. The personal relationship between GP and patient/family carer was identified as essential to ensuring that psychosocial needs are met. UK health policy has undermined this relationship by changes to GP working arrangements which reduce access to, and adequate time with, a named GP (including at home). There is a need to recognise that this compromises GPs' ability to manage patients' palliative care needs at a time when there is a real need to improve such care, in light of an ageing population and a shift of chronic disease management into the community."

Joint working between health and social care, as well as a division of labour between them which is acceptable to older people and carers, is achievable, and did indeed appear to be achieved in some places. The study of hospital discharge in six areas with a good record on minimising delayed discharge (DD/WW) concluded:

> "Our findings suggest getting the numbers of delays down and sustaining good performance requires a multi-faceted, multi-agency approach addressing a range of features of the whole system. It is not a single intervention that makes the difference, but developing an effective local health and social care system."

This research also identified several key factors in the success of efforts to minimise delayed discharge: (i) the according of priority to the issue at a senior strategic level, with multi-agency forums meeting regularly and agreeing shared aims; (ii) a range of intermediate care services, both to prevent admission to hospital where possible and to provide step-down services on discharge; (iii) good communication at front-line level, for example via discharge teams and on-site social workers; and (iv) good availability of social services in the area – where these were not available, bottle-necks and disagreements could occur. Also, in two areas the reimbursement system appeared to have "driven a wedge" between social services and healthcare services, precisely because social services felt they were not getting sufficient advanced warning of patients ready for discharge. On the whole, however, the reimbursement system appeared to have helped in necessitating clear procedures and through the reimbursement grant, which was seen to have been used to advantage in most areas.

The reimbursement study (RDD) of course also covered these topics. It found evidence of some good working partnerships between health and social care, but also of tensions and difficulties. Reimbursement had certainly acted as spur to bring the different parties to the table, but the researchers saw partnership as fluid and shifting, and as a phenomenon which might work on some levels but not on others. However, joint working did not mean an integrated service for older people. In fact, pressure to get people out of acute hospital cannot possibly be the best impetus for developing an integrated package of care for someone with complex needs. The authors concluded the study by calling for more resources to develop a broader range of care services for people discharged from hospital with complex needs.

These findings support those in the DD/RR project, which reviewed previous research on the causes of delayed hospital discharge. Despite the methodological weakness of the evidence base, the researchers concluded that the causes of delays:

> "are extremely diverse, ranging from internal hospital delays to waiting for social care assessments/funding and from factors relating to patients/carers to housing needs. Indeed the diversity of the results cited above points towards the need for a whole systems approach to tackling delayed hospital discharges and raises questions about the extent to which the current reimbursement policy can tackle an issue this complex and multi-faceted."

The study also drew attention to the importance of rehabilitation services/intermediate care, as well as to the need for health and social care service providers to work together so that older people can be discharged from hospital in circumstances most appropriate to their needs. It should be noted that the DI/SAP project found in its survey of lead officers for the single assessment process (SAP) that SAP was only variably integrated with other assessment and resources allocation processes, such as that for intermediate care (see page 51).

Investigations outside the OPUS programme have revealed inadequacies in other services which are also important as part of integrated long-term care in the community. For example, a national audit of continence services (Wagg et al 2008) concluded that, although basic provision was in place, assessment and management of incontinence were inadequate; it concluded that "the requirement for integrated continence services has not yet been met".

Whether so-called specialist services or specialists in older people's care help either to foster joint or collaborative working or to enhance the ability of older people with healthcare needs to remain in the community and manage their own conditions is unknown. Further research on specialists is needed to answer such a question; the research project on specialist services (SSS/OP) was not designed to assess outcomes (although specialist staff were often identified with working across sectors).

Finally, it must be remembered that when we distinguish between continuing care and services to enhance independence, there is no clear dividing line between the kind of older people who may need one rather than the other. For example, in one of the intermediate care studies (IC/EPO) the authors were at pains to point out that most users were over 75 years and many were over 85. Such people might formerly have been dismissed as being in need of, say, residential care, but now could be seen as eligible for services which would help them remain at home, albeit at a lower level of independence than might be the case for some of those with less complex needs.

Summary

Integration of health and social care services for frail older people is a very complex issue. Although the research cited here helps to show some of the problems in integrated service provision, there are other areas which need much further research. One obvious topic is older people's own views and preferences for integrated versus separate services. For example, we know little about the circumstances in which older people themselves define problems as 'health' rather than 'social', and when such a perceived division may militate against integrated services. We also know little about the optimum skill mix between health and social care in different circumstances.

What our studies do show is the tension between the policy focus on rehabilitation or recovery and the need for comprehensive care until the end of life; between the urge towards integration and the continued separation of services; and between the need for services that recognise processes and pathways and those that take a more static view. Integration of services is not just about a package of care at one point in time; it is about how services interweave over the longer term for people making transitions between illness and supported independence or towards long-term care and the end of life.

OPUS findings provide some evidence that good integrated care can be provided; for example, speedy hospital discharge works smoothly in some areas of the country, with good collaboration between the sectors, and funded nursing care helps some of the frailest older people by ensuring that they do not have to pay for nursing as well as social care. However, there is also a good deal of evidence to the contrary, and much remains unknown. For example, people who called an ambulance because of a fall were often found not to need a visit to an A&E department but nonetheless to require an emergency community service of some sort. People with a disabling stroke or heart failure and those who were dying were found to have health and social care needs which were not being met.

The main source of these problems was simply the inadequacy of provision of health and/or social services in the community (such as district nurses or social workers). It is also clear that, in some areas, the relationships between health and social care agencies are not conducive to collaborative working. There is a need for some services which do not exist at present, at least in some areas, such as emergency call-out community services for people who have fallen or have experienced other forms of crisis. The need to strengthen primary care and to enhance the role of GPs for the most needy older people was also apparent (see Iliffe & Drennan 2004). Finally, the lack of comprehensive and integrated services is not helped by a lack of clarity about what integration and collaboration means, and by the inevitable difficulty of distinguishing between health and social care needs (perhaps particularly for people with dementia).

Part III: Conclusions

Contribution of the OPUS programme to forwarding NSFOP principles

OPUS projects have provided a wealth of research findings to show the contribution of the NSFOP – and the policies derived from its underlying principles – to improving the health and well-being of older people in England, and also some of the areas where more still needs to be done.

The OPUS programme was complicated by the fact that its research took place at a very dynamic period of policy implementation. Since the publication of the NSFOP in 2001 there has been not only the implementation of reimbursement for delayed discharge, but also the extension of direct payments to older people, choice of provider on referral to secondary care, continuing reductions in waiting times for treatment, the extension of the Expert Patients Programme, implementation of the single assessment programme, primary care trust and practice-based commissioning (including incentives for more collaboration between health and social care agencies) and greater accountability.

The NSFOP – being a 10-year programme – has itself moved on. Its follow-up reports have suggested that considerable improvements have occurred in all its goals, even though it has to be remembered that (i) these improvements are occurring while the older population – particularly the very old – is also growing, and that services need to grow just to stand still; and (ii) some of these encouraging improvements bring unanticipated and less encouraging consequences in their train (for example, hospital discharge rates may be continuing to come down, but some older people are going home sicker or staying on unhelpful holding wards). The NSFOP is now focusing on areas still in need of both research and innovation, such as dignity in care, end-of-life care and health promotion, though what it can achieve will of course be influenced by changes in the wider health policy context, such as any general reconfiguration of primary care, local secondary care and smaller specialist services.

Have NSFOP policies been successfully introduced?

In relation to the principle of anti-discrimination and promotion of equity, the NHS-funded nursing care in nursing homes policy has been introduced relatively smoothly and is a small move towards more equitable provision for older people. The OPUS research project was carried out at an early stage in the introduction of the policy, and further investigation will be needed to see more fully how it benefits older people (for example, whether it encourages greater integration between health and social care) and whether there are unanticipated consequences (such as an administrative burden on care homes leading to curtailment of services or even closure).

Within the principle of promoting person-centred care, the single assessment process has been widely introduced with improved needs identification. But the situation remains complex, with variations across the country in the way it is implemented, relatively low involvement by clinical specialists and GPs, and continuing uncertainty about whether it is helping to improve services for older people or to target those in greatest need.

The policies with a particular relevance to the principle of helping older people to remain independent or regain independence and continue to live at home are those of intermediate care (IC) and reimbursement. The OPUS programme focused much of its resources on investigating the IC policy (with support from the Medical Research Council), but because the research took place at an early stage of implementation there is clearly a need for further evaluation. IC, with targeted government resources, was introduced throughout the country, but its implementation was found (in 2003/4) to be patchy and dependent on things like pre-existing community support or rehabilitation services, the relationships between local health and social care agencies and the existence of local champions for intermediate care. Some older people who might have benefited from IC were not receiving it, sometimes because they were not becoming known to service providers. For those who did receive it, IC was found to make a significant difference to people's lives, supporting them at critical junctures between illness and recovery. Although only a minor form of IC, community hospitals were found to be at least as good as larger district general hospitals in providing rehabilitation. It was concluded that it was too early to say whether IC was having an effect on other parts of the care system, although it did appear to be of considerable benefit to speeding up hospital discharge in some places.

Reimbursement for delayed hospital discharge was introduced with legislative backing, so it too has been implemented. The OPUS case studies showed that it contributed – along with other policies such as community support services – to speeding up acute hospital discharges, and that it could enhance partnerships between health and social care services, but also that it could have unanticipated consequences such as a focus on reimbursable delays – that is, those seen as being due to a need for social care – to the detriment of other forms of delay, the placement of older people on unsatisfactory holding wards, a sense among some social workers that they were being blamed for delays, and older people being rushed into taking decisions about their future care.

Reimbursement may well be a policy whose time has now expired, especially in the light of policy developments such as joint commissioning and payment by results. As the researchers said:

> "Since reimbursement was introduced in England in 2003 the landscape of health and social care policy has changed and reimbursement in the specific sense of 'cross-charging' does not fit well into it in two important ways. In the context of Joint Commissioning Frameworks and whole system reconfiguration of care it is conceptually uncomfortable and divisive in emphasising delays relating to social care only. Its exclusive focus on delays in acute beds is at odds both with the new financial processes such as payment by results and with concepts of holistic patient-centred care around long term conditions."

Beyond IC and reimbursement, the introduction of a policy of support to older people with depression in primary care settings was found to be successful in a preliminary evaluation. Since several of the OPUS projects identified the lack of mental health services for older people, this is the kind of innovation that should be followed up, with a view to eventual national developments in services.

Finally, two other local innovations to support older people with complex or continuing needs were investigated: a tool to help ambulance staff decide whether an older person who had experienced a fall should be taken to hospital or could be safely left at home, and a tool for routine follow-up assessment of someone who had had a disabling stroke six months earlier. In neither case did research findings support continuation of the innovation in its current form. Re-assessment without real benefits in the shape of resources for people who have had a stroke is unlikely to make much difference, and a tool which staff find adds little value to their decision making (when what they need is alternative community support services to a hospital visit for people who have fallen) is unlikely to have general significance.

To conclude, policies which have legislative backing or attached resources are of course more likely to be implemented than those which do not. However, this does not guarantee full and universal implementation. Pre-existing local structures and relationships will intervene, as will competing interests and demands of some professional groups. Without the national stick or carrot, implementation is even less assured. The key difficulties of implementing such policy at the local strategic and operational level are revealed by the OPUS projects. At one level, policy implementation is dependent on the willingness and ability of individual workers in the healthcare field to carry out the task – for example, one of the reasons why the tool for ambulance staff did not work was that their ability to absorb the innovation was low and they were not facing competing pressures from elsewhere or any particular sticks and carrots. One of the reasons why the depression intervention for older people living in the community did work was that the community psychiatric nurse who proffered it was specifically employed to do so and endorsed the aims of the innovation.

What other suggestions for service developments can be made?

Several of the cross-cutting themes of the OPUS projects suggest further service developments. In particular we would single out four topics:

- More attention should be paid to the dynamic, long-term support needs of frail older people and those with continuing chronic conditions in the community (that is, those who are living with the effects of a disabling stroke, people whose intermediate care has come to an end, and those with dementia).
- There needs to be a more concerted policy focus on mental health in later life. Not only should there be more emphasis on the promotion of psychological well-being in later life and on supporting people with depression in the community, but there should also be more focus by community mental health teams on the needs of people with dementia. It is encouraging to see that priority is now, in 2008, being given to the development of a dementia strategy.
- More emphasis should be given to end-of-life care in the community, and services – whether specialist, generalist or collaborative – should be integrated and tailored to patients' needs.
- GPs have a key role to play in the care of older people who have chronic conditions or are nearing the end of their lives. GPs need to play a fuller role in the single assessment process than seems to be the case so far, and to understand more fully the support requirements of older people and what can actually be achieved for them.

Limitations of the research programme and suggestions for further research

All research programmes are limited. The OPUS programme was no exception and indicates a need for further research on three main grounds: some projects were small and/or exploratory, some of the research was carried out an early stage in the development of a service or the implementation of a policy, and some of the findings suggest other areas of enquiry which would benefit from research.

Exploratory or small-scale research

Several of the studies were – quite appropriately – small-scale or exploratory. For example, the study of timely hospital discharge (DD/WW) consisted only of 43 interviews with staff across a range of agencies in six geographical areas. The depression intervention project (LLD/PC) took place in one geographical area and included only 53 older people in the intervention group and 52 in the control. The re-assessment of stroke patients study (SFU/S) was carried out on only two sites and consisted of 132 people in the intervention group and 133 in the control. The cross-cultural study of people with dementia (PWD/CCS) was qualitative and only carried out in London.

Thus the LLD/PC project, for example, will have to be repeated if its findings are to be confirmed. The trial was short, and it involved only one community psychiatric nurse (CPN). It was effective over four months, but it needs a longer period and also an investigation which can determine what it was that made the difference (that is, was it the particular CPN or the signposting to other services, etc).

Others have expressed concern about the number of small healthcare initiatives which, because the funding is inadequate, cannot be properly evaluated, and the need for well-resourced developments with accompanying evaluation. For example, Wanless (2004) concluded that:

> "It is evident that a great deal more discipline is needed to ensure problems are clearly identified and tackled, that the multiple solutions frequently needed are sensibly co-ordinated and that lessons are learnt which feed back directly into policy." (p5)

Research at an early stage in policy implementation

Some research was carried out at an early stage in the implementation of a policy, and at a time of rapid organisational change: this is true of the DI/FNCICH, RR/CH, IC/ECO, IC/EPO, DI/SAP and RDD projects. Repeat studies are therefore needed because of the changing policy environment. For example, the project on NHS-funded nursing care in care homes (FNCICH) was conducted at the very first stage of implementation of the policy, and its full implications for care homes' survival and its impact on standards of care in care homes, the cost-effectiveness of care and joint working across sectors need further investigation.

The randomised controlled trial on rehabilitation in community hospitals (RR/CH) recommended further research to build on its findings, such as projects focusing on specific conditions at discharge and studies of specific kinds of facility such as nurse-led units or community hospitals with particular types of focus. In other words, it is too early yet to recommend putting all our rehabilitation eggs into any one basket. The IC/ECO study also recommended follow-up research in the very dynamic and rapidly evolving area of intermediate care. IC/EPO echoed this, suggesting for example the need for studies which examined the question of what kinds of intermediate care work best for different kinds of service user.

The impression many have is that older people are being sent home from hospital a lot sicker than used to be the case (as indicated by the RDD project) and that this is leading to more readmissions. Research is needed to monitor this over time. The DD/RR research review recommended more research altogether on hospital discharge, both to provide a greater focus on patients' own perspectives and to investigate specific groups of people, such as those with mental health problems and those from black and minority ethnic groups; it also called for more in-depth research and more longitudinal research.

Although some of the OPUS studies helped to reveal what makes for good integration between health and social care agencies, we still need to know more about this. For example, it would be useful to know whether NHS-funded nursing care in care homes has helped the two sectors to work more closely together. Policy innovations *can* impose integration between health and social care, but we still need to know more about what fosters it at a local level.

Other lines of enquiry suggested by the OPUS findings

It is salutary to note how many of the OPUS projects suggested the need for more research on the perspectives and experiences of older people themselves. For example, DD/WW was unsuccessful in trying to obtain the views of older people themselves, and such data are needed if we are to address the concern that older people may be being rushed into taking decisions by the reimbursement system. DD/RR also commented on how few studies take a patient perspective, and how important this is. Neither could FNCICH interview any care home residents, despite a willingness to do so. And the perspectives of older people themselves are missing with regard to community palliative care nursing.

More research on what patients think of rehabilitation in different kinds of site would also be valuable. The research on patients and carers that formed part of the RR/CH study was very modest, and some aspects (such as whether patients felt they were or were not 'closer to home' in community hospitals) need to be answered. IC/ECO noted the need for more information about users' experiences. We also need to know more about what service users think of integrated or collaborative care, so that they can be more involved in maximising its use. And more research is needed on user involvement in accountability – for example, the use of patient-reported outcomes as part of the assessment of services.

To counter the continuing tendency to see older people as a homogeneous group or to focus on the majority sub-groups, we also recommend more research on, for example, older people with life-threatening conditions, those from a range of ethnic and cultural groups, and very old people.

We recommend further research on professional ageism, and on what can counter it. This should be linked to research on dignity in care and the drivers for dignified care.

A much more focused enquiry into the work of specialists and generalists for older people is needed, to shed light on a very confused area of practice and perception.

We need fuller auditing of the geographical variations in service provision across the country, as well as the circulation of examples of good practice.

Clinical tools were not a major focus of OPUS, but the review of tools for assessing the timing of the introduction of palliative care for older people is a reminder of the importance of a continuing search for such guides and instruments.

Finally, research frequently highlights the absence of research on older people's information and advice needs. OPUS was no exception.

The future of research on older people

There are many remaining challenges for health and social care services for older people. We should not be over-optimistic; the tensions that dogged NSFOP policies will continue to dog them. There will never be enough resources, *but* new ways of working and new cost-effective programmes will be found. There will continue to be ageist attitudes which education does not eradicate, *but* in time and with higher expectations among older people these will decline. There will be better evidence about what works, and new clinical tools and scientific advances. Older people will always have to be categorised, *but* the boxes should become smaller and more numerous. More consumerist values may prevail, *but* if so, older people will become more demanding and discerning consumers.

There should be a more prominent research focus on health maintenance and promotion among older people, particularly to discover what kinds of promotion of health and independence will be most effective.

There should be a greater policy focus on long-term continuity of care – not just on the entry and exit points of hospital care, not just on the few short weeks of intermediate care, not merely on the few months after a disabling stroke, but on what happens when people return to mainstream services or are left to manage for themselves week after week after week.

There should be more emphasis on the processes of care rather than individual, separate services – especially on the transition points between home, hospital and care home. For example, there should be greater clarity about our goals for people who need extensive care towards the end of their lives, and about the conditions under which people should be admitted to a care home rather than being supported with continuing care at home.

We need to know more about how best to implement mental health services in the community, the appropriate balance between psychiatric medical and nursing staff, the circumstances in which intermediate care is effective within a community, and how to meet the palliative care needs of older people dying from non-malignant conditions.

The use of the biomedical chronic disease pyramid should be reconsidered in the light of the growing evidence about the heterogeneity of older people and their support and service needs. The process of growing old is a complex, dynamic one in which health and care needs combine and fluctuate along with the need to maintain well-being, engage in activities and relationships, and fulfil social roles. Our models of ageing should reflect more adequately the realities of later life and be influenced much more by older people's own perspectives.

Finally, ageist, paternalistic and nihilistic attitudes towards older people should have no place in healthcare; our policies should be sufficiently robust, our evidence strong and our intent so clear that all health and social care professionals – as well as older people themselves – should know that there are good reasons to feel positive and optimistic about the future well-being of older people in England.

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Appendix: Summaries of OPUS projects

PI = Principal investigator

NHS-Funded Nursing Care in Care Homes in England: An Initial Evaluation (Funded Nursing Care)

Ala Szczepura (PI), Carol Davies, Deirdre Wild, Isabelle Johnston, Deborah Biggerstaff, Pauline Ford, Yana Vinogradova

The **aim** of this project, which was carried out by a team from the University of Warwick, University of the West of England and the Royal College of Nursing London, was to evaluate the implementation of the policy of NHS-funded registered nursing care in care homes in England. It examined the use of the tool for determining the levels of nursing care required by residents, the number of such 'determinations' made, appeals against determinations, resource implications of implementing the policy, the provision of continence aids and specialist equipment, the views of staff and users, and an initial assessment of the impact of the policy on the relationship between the NHS and care homes. The **methods** used included: an interview study of key relevant staff, national postal surveys of primary care trust co-ordinators, lead nurses, nurses conducting the determinations and independent sector care home managers, and a further investigation in two primary care trusts involving in-depth interviews of a small sample of professionals and carers.

Fit to Be Left: Can Ambulance Staff Use an Assessment Tool to Decide if an Older Person who has Fallen can be Safely Left at Home? (Assessment of Falls by Ambulance Staff)

Mary Halter (PI), Jacqueline Close, Helen Snooks, Simon Porsz, WaiYee Cheung

The **aim** of this study was to design, develop, implement and evaluate a tool intended to support ambulance staff in making consistent and formalised decisions about whether or not to convey to hospital older people who had fallen. It was carried out by researchers from the London Ambulance Service, King's College Hospital and the University of Swansea. The study sites were eight ambulance stations serving three acute trusts in London. After the tool had been developed and piloted it was **evaluated** by means of the collection of baseline data (i.e. before implementation of the tool) from the records of older people who had fallen and were not conveyed to hospital, and then compared with the collection of similar data during the six month trial period when the tool was in use.

A clinical review of the non-conveyed group was also carried out and qualitative interviews were held with 12 ambulance staff.

What Went Right? A Study of What Works in Tackling Delayed Discharges in Six High-Performing Sites (Delayed Discharge: What Works)

Matt Baumann, Sherrill Evans, Margaret Perkins, Peter Huxley (PI), Lesley Curtis, Ann Netten, Jose-Luis Fernandez

Researchers from the Health Services Research Department at the Institute of Psychiatry, King's College London, and the Personal Social Services Research Unit at Kent University and at the London School of Economics took part in this project, whose **aims** were to identify factors associated with good performance (in terms of rates of delayed discharge from hospital) in six high-performing sites and also to examine the impact of the reimbursement policy on delays, staff relationships and patient care. **Methods i**nvolved semi-structured interviews with 43 staff at different levels of seniority from the acute trust, primary care trust, intermediate care service and social services, and cost analysis of innovative services supporting prompt hospital discharge.

A Controlled Trial to Investigate the Feasibility of a New Model of Intervention for the Treatment of Late-Life Depression in Primary Care (Late-Life Depression in Primary Care)

Carolyn Chew-Graham (PI), Robert Baldwin, Alastair Burns, Karina Lovell, Mike Morley, Chris Roberts, Heather Burroughs

This project was carried out in Manchester by researchers from the University and the NHS Mental Health and Social Care Trust. Its **aims** were to test the feasibility of setting up a new model of care for older people with depression in one primary care trust, to test whether it led to improved patient outcomes, to assess its acceptability to patients and primary care professionals, and to explore the views of patients and practitioners about depression among older people. The new model of care was delivered by a case manager and comprised aid for self-help, education, medication management and signposting to other services. The study was carried out in a primary care trust in North West England and involved a **controlled trial** among older people thought to have depression, who were referred by GPs and nurses and randomly allocated to the intervention or control group. Outcome measures were collected and a nested qualitative interview study was carried out with a small sample of health professionals and patients.

NSF for Older People: Specialist Services and Staff for Older People (Specialist Services for Older People)

Jan Reed (PI), Charlotte Clarke, Glenda Cook, Margaret Cook, Pamela Inglis, Bill Watson

This study **aimed** to analyse the range and scope of multidisciplinary specialist roles and teams for older people in England, processes of implementation, and the impact of specialist practice on services and service users. It used a **mixed methods** approach and was carried out in two parts. The first part was a questionnaire survey of staff at strategic, management and operational levels across the NHS, social services departments, and for-profit and not-for-profit care service sectors in England. The second part comprised six case studies, with sites being chosen to reflect a mix of primary and secondary care. A total of 132 in-depth interviews was obtained among health and social care staff, service users and carers.

A Randomised Controlled Trial Evaluation of Structured Routine Follow-Up after a Disabling Stroke (Structured Follow-Up after Stroke)

Anne Forster (PI), John Young, Jenni Murray, Chris Patterson, Peter Wanklyn, Sue Bogle, John Green, Lynn Johnston, Jane Smith, Joanna Spink, Heather Wild, Karin Lowson, Louise Carr, Stephen Chaplin, Dianne Wright

The project was carried out by a team from the Academic Unit of Elderly Care and Rehabilitation, University of Leeds, Bradford Institute for Health Research, Bradford Royal Infirmary and York Health Economics Consortium, University of York. Its **objective** was to investigate, by means of a single blind, randomised, **prospective trial**, the medium-term outcomes and cost-effectiveness of a structured assessment system for disabled stroke patients. This system, which had been developed in previous work, involved a structured routine review five to six months after the onset of the stroke. The study was carried out in two metropolitan areas in the north of England, and included 132 patients in the intervention group and 133 in the control group. Outcome measures for patients included activities of daily living, Barthel index, Euroqol EQ-5D and a measure of long-term unmet needs after stroke; carer outcome measures included general health questionnaire-28 and an index of carer strain.

Show Me the Way to Go Home: Delayed Hospital Discharges and Older People (Delayed Discharge Review)

Jon Glasby (PI), Rosemary Littlechild, Kathryn Price

This study was carried out at the University of Birmingham by a team from the Health Services Management Centre and the Institute of Applied Social Studies. Its **aims** were to examine, through a **narrative review** of previous research, the evidence about the rates and causes of delayed hospital discharge of older people in the United Kingdom. Twenty-one documents with estimates of the rate of delayed discharge were identified, although as they adopted differing definitions of delayed discharge the findings were often not directly comparable.

Prediction of Appropriate Timing of Palliative Care for Older Adults with Non-Malignant Life-Threatening Disease: A Systematic Review (Palliative Care Timing Review)

Peter Coventry, Chris Todd (PI), Gunn Grande, David Richards

Carried out by researchers from the School of Nursing, Midwifery & Social Work, University of Manchester and the Department of Health Sciences, University of York, the **aim** of this study was to help improve decision-making about when to refer for palliative care older patients with life-threatening but non-malignant disease, by examining prognostic tools and variables. This study was a **systematic review** and quality assessment. From an extensive search it identified 11 studies that evaluated prognoses in hospitalised and community-based older adults with non-malignant disease, and from these found a number of general and disease-specific factors significantly associated with survival.

A Multi-Centre Longitudinal Study to Identify the Palliative Care Needs of Older People with Heart Failure and their Families (Palliative Care and Heart Failure)

Merryn Gott (PI), Sarah Barnes, Sheila Payne, David Seamark, Chris Parker, Salah Gariballa, Neil Small

This study was carried out by researchers from Sheffield Institute for Studies on Ageing at the University of Sheffield, Institute for Health Research at Lancaster University, Institute of General Practice at Exeter University, and School of Health, Community and Primary Care at the University of Bradford. The **aim** of the project was to identify need for palliative care among older people with heart failure and their families, and develop an understanding of the nature and timing of appropriate services' responses. This was a **mixed methods** study. Heart failure patients were identified from primary care records and a sample of 542 patients and 213 family carers were recruited to the study from four geographical areas. Participants completed postal questionnaires every three months for two years. Forty in-depth interviews and 25 one year follow-up interviews were conducted with patients and 15 interviews with bereaved family carers. Nine focus groups were held with primary healthcare professionals.

A Systematic Evaluation of the Development and Impact of the Single Assessment Process in England (Development of the Single Assessment Process)

David Challis (PI), Jane Hughes, Paul Clarkson, Michele Abendstern, Caroline Sutcliffe

Carried out by the Personal Social Services Research Unit at Manchester University, this project adopted a **mixed methods** approach to evaluate the development and implementation of the single assessment process in England (SAP). Its two aims were to review the conduct of assessment across health and social care in order to highlight key issues in the initial implementation of SAP; and to evaluate its impact from the perspective of multiple stakeholders. The project had seven stages: a review of the literature on assessment; a focus group study of managers with responsibility for implementing SAP to examine implementation challenges; a survey of SAP lead officers to assess initial implementation of SAP; a survey of geriatricians and old age psychiatrists; a before- and after-SAP comparison of assessments and care plans; a study of assessments of vulnerable older people in one local authority; and a study of user experience and satisfaction with assessment in five local authorities in North West England.

Improving the Quality of Care for People with Dementia: A Cross-Cultural Study (Cross-Cultural Dementia Study)

Vanessa Lawrence, Joanna Murray, Kritika Samsi, Peter Huxley, Dinesh Bhugra, Andre Tylee, Sube Banerjee (PI)

The **aims** of this project, which was carried out by researchers from the Health Service and Population Research Department at the Institute of Psychiatry, were to identify barriers and facilitators to accessing care and management of dementia in primary and secondary healthcare and social services, paying particular attention to cross-cultural issues in presentation, recognition and treatment. This was a **qualitative interview study** carried out in South London, with 30 older people who had a diagnosis of dementia, 32 supporters and family carers of people with dementia, 28 older people without dementia, 26 primary care professionals and 12 social care staff. The sample of older people and supporters included Black Caribbean, South Asian and White British people. Analysis was based on the grounded theory approach.

Evaluation of the Education and Support Programme for District and Community Nurses in the Principles and Practice of Palliative Care: The Impact on Older People Dying from Non-Malignant Disease (Palliative Care: Nurse Education Programme)

Julia Addington-Hall (PI), Cathy Shipman, Jenni Burt, Emma Ream, Teresa Beynon, Alison Richardson

Carried out by researchers from the Department of Palliative Care & Policy and the Florence Nightingale School of Nursing & Midwifery at King's College London, the **aims** of this study were to assess the impact on care received by people aged 65 or over of the Department of Health-funded education and support programme for district and community nurses in the principles and practice of palliative care. This was a **two-phase postal survey** of random samples of bereaved relatives or friends conducted across eight randomly selected cancer networks. The two surveys were carried out one year apart (i.e. one before the education programme had been introduced and one after), each examining the older persons' experiences during the last three months of life as reported by the relatives/friends. Response rates were just over 40%. Responses were compared between phase one and phase two to detect any changes in the reported quality and adequacy of district nurse care, or in reported access to community support.

A Multi-Centre Study to Evaluate Community Hospital Care for Older People (Community Hospital Role in Rehabilitation)

John Young, Neil Small, Anne Forster, Karin Lowson, Jacqueline O'Reilly, Sue Bogle, John Green, Emma Tanner, Joanna Spink (plus clinical leads and research nurses)

The **aim** of this project was to conduct the first multi-centre evaluation to determine the health, personal experience and economic outcomes of community hospital (CH) care for older people. It was carried out by a large team including clinical leads, research nurses/therapists and researchers, the last based largely at Bradford University and York Health Economic Consortium. The project used a **mixed methods** design involving a randomised controlled trial to investigate medium-term outcomes for older patients requiring rehabilitation following a stay in a district general hospital (DGH) (with half having their rehabilitation in the DGH and half in a CH). Outcome measures were obtained by questionnaire to both patients and carers at a number of time points. A small-scale interview study of a sub-sample of the patients and carers was also carried out as well as a health economics investigation to compare costs and outcomes for the two kinds of rehabilitation site. The study was carried out in five sites in the Midlands and North of England with five DGHs and their associated seven CHs.

A National Evaluation of the Costs and Outcomes of Intermediate Care for Older People (Costs and Outcomes of Intermediate Care)

Pelham Barton, Stirling Bryan, Jon Glasby, Billingsley Kaambwa, Graham Hewitt, Graham Martin, Carol Jagger, Emma Reagan, Susan Nancarrow, Hilda Parker, Andrew Wilson, Stuart Parker

This study had five **aims**: to establish the range, spread and speed of development of intermediate care (IC) services across England; to explore the views of IC leads on the benefits and challenges of implementing IC policy; to assess the impact of IC on the service system and on individual service users; to explore the costs of IC schemes in relation to their outcomes; and to synthesise evidence from this and other research on the costs and outcomes of different models of IC. The **methods** adopted included: a national postal survey of IC co-ordinators; case studies in five sites, involving collection of both quantitative and qualitative data; and a systematic review of evidence on the effectiveness of IC. The research was carried out by a team from the Health Services Management Centre at Birmingham University, the Leicester Nuffield Research Unit and the Department of Health Sciences at the University of Leicester, and Trent RDSU and the Sheffield Institute for Studies on Ageing at the University of Sheffield.

An Evaluation of Intermediate Care for Older People (Structure, Process and Outcomes of Intermediate Care)

Mary Godfrey, Justin Keen, Jean Townsend, Jeanette Moore, Patricia Ware, Brian Hardy, Robert West, Helen Weatherly, Kate Henderson

The **aims** of this project were to identify the meanings of intermediate care, its effects and outcomes. It used a **comparative case study** design to examine intermediate care from the perspectives of different stakeholders, at different levels (system, service and individual user) and over time. The study was carried out by researchers at the University of Leeds, Institute for Health Sciences and Public Health Research, with cost analysis carried out at the University of York. The fieldwork took place in five English local authority areas, selected by geography, demography, complexity of inter-organisational relationships and with varied levels of development of intermediate care. The study involved quantitative data for 7,452 service users admitted to intermediate care over one year, data from a cohort of users admitted in a given month who were tracked over a six-month period (153), in-depth interviews with 64 service users, and 247 staff interviews (from both intermediate care and other parts of the health and social care system).

Reimbursement in Practice: The Last Piece of the Jigsaw? A Comparative Study of Delayed Hospital Discharge in England and Scotland (Reimbursement)

Mary Godfrey, Jean Townsend, Michelle Cornes, Edward Donaghy, Gill Hubbard, Jill Manthorpe

The overall **aim** of this project was to compare and contrast policy approaches and implementation strategies to tackle delayed discharge for older people in England and Scotland, highlighting the process and impact of the reimbursement policy. It involved teams from the Universities of Stirling, Leeds and King's College London, and was based in five fieldwork sites, three in England and two in Scotland. Data collection included documentary analysis and **semi-structured interviews** with strategic managers in health and social care (56), patients (67), carers (40) and operational staff involved in discharge planning (132).

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