National Service Framework (NSF) for Older People – Update on Progress – August 2004.

Standard 1 **Rooting out age discrimination**	**Ref**	**Date**	
Audit of all age related policies health and social care – outcomes to be reported in annual reports	NSF	Oct 2001	Target achieved maintenance and development work to continue
JIP to include initial action to address any identified age discrimination – strategic action to be reflected in the HImP	NSF	April 2002	JIP no longer required. Any actions to be include in the OP planning group action plan.
Councils to have reviewed eligibility criteria for adult social care to ensure no discrimination	NSF	April 2002 Implement ation 2003	Target achieved maintenance and development work to continue
Analysis of patterns of service for older people to establish best practice and benchmarks	NSF	Oct 2002 (NB publication delayed figures available from early 03)	Target achieved maintenance and development work to continue
Completion of benchmarking work will allow for target setting in subsequent years to demonstrate year on year improvement	NSF	April 2003	As above

Standard 2	Ref	Date	
Person centred care Establish local arrangements for implementing the National Service Framework - Appointment of champions - CE leads - Structures for implementing the NSF locally	NSF	June 2001	Target achieved maintenance and development work to continue via the County Durham LIT meets quarterly. Older Persons Modernisation Group, which meets monthly, and replaced the LIT in January 2004. Local Planning Groups meet in each PCT area. The County Council has a Cabinet Champion – Councillor Christine Smith, and a professional one – Marion Usher, Divisional Commissioning Manager.
Introduce Single Assessment Processes (SAP) for health and social care services to include person held care plans for health and social care services (NHS Plan)	NSF NHS Plan	June 2004	Local accountability for Single Assessment implementation will be through Partnership Boards and the County Wide Steering Group Extensive background work has been undertaken to initiate the SAP Process. The Tremaduna Adult Community Care project in Sedgefield is piloting a Social Services Information Database (SSID) Single Assessment Process.
Subject to change in primary legislation the NHS should be ready in October 2001 to assume responsibility for arranging and funding care for people in nursing homes (assessment, contacting arrangements, staff and procedures)	NHS Plan	Oct 2001 (Revised to April 2003)	Target achieved maintenance and further development work to continue
Health and social care services to review all information provided to older people to ensure a range of formats Undertake a comprehensive review of information available to older people with a view to agreeing a local plan for improvements from 2002/03	NSF ISOP	April 2002 June 2002	Target achieved maintenance and development work to continue. Age Concern led this process. Social Care and Health information is reviewed every 6 months

Systems to explore user and carer experience should be in place in hospitals and all NHS/SSD organisations. This will include regular use of surveys to be developed within the national programme for NHS patients and carers	NSF	April 2003	A range of user and carer service satisfaction surveys is in place
NHS organisations should have systems in place to ensure that all complaints from older people, or carers and relatives are analysed and reported to each Board	NSF	April 2003	Target achieved maintenance and development work to continue Champions have explored ways of identifying and addressing complaint trends.
Introduce single integrated community equipment services Single integrated community equipment services in place All community equipment for older people (aids and minor adaptations) will be provided by social services within seven working days First community equipment report completed Draft action plan for meeting targets on integrated community equipment services Publish plan for integrated community equipment service	NSF *LMR OLD* 29 LDP T24	April 2004 *By December 2004* August 2004 April 2002 October 2002	The pooled countywide budget has been approved The one stop shop at the Abbey Day Centre Pity Me will be opening soon. The one stop shop in the Pioneering Care Centre at Aycliffe is now open. From April to June 2004 85.3% of community equipment was delivered within 7 working days. This was sufficient to achieve the very good (dark green) banding in the Department of Health. The Multi-agency Community Equipment Board leads and monitors this work.

HImPs and other relevant local plans should have included the development of an integrated continence service	NSF	April 2003	This target has been achieved well in advance of the deadline
Integrated continence services will be in place by April 2004	NSF	April 2004	This target has been achieved well in advance of the deadline, maintenance work remains on going.
Percentage of people receiving a statement of their needs and how they will be met (BVP 58)	PAF D39		Performance against this indicator achieved the good or light green banding for 2003/04. First quarter performance for the current year stood at 95.8%. To move back into the light green banding performance needs to improve by .2%
Clients receiving a Review	PAF D40		Performance against this indicator is improving and currently stands at 53.6% (orange banding). The highest banding that can be achieved is yellow (satisfactory) and to achieve this performance in 2004/05 would need to rise to 60%
Ethnicity of adults and older people receiving services following an assessment (this indicator is included in Race Equality in Public Services)	PAF E48		Definition for this performance indicator has changed and it will therefore not be banded for 2003/04. 2004/5 bandings have not yet been set by DoH.
The number of assessments of new clients aged 65+ per 1,000 head of population aged 65 or over	PAF E49		Current performance is in the yellow banding which is the highest that can be achieved against this indicator
Assessments of adults and older people leading to provision of service	PAF E50		From 2003/4, this indicator counts services resulting from a review as well as assessment. Care should therefore be taken when comparing 2003/4 with earlier years. This Indicator will not be banded for 2003/04. 2004/5 bandings have not yet been set by DoH.

Ratio of the percentage of older service users receiving an assessment that are from minority ethnic groups, divided by the percentage of older people in the local population that are from minority ethnic groups	BV60 E47		2003/04 data show no change in banding and was still in the orange. Small numbers of people are involved and analysis of distribution of assessments done with people drawn from minority ethnic groups
Ratio of the percentage of older service users receiving services following an assessment that are from a minority ethnic group to the percentage of older service users assessed that are from a minority ethnic group	PAF E48		Definition for this performance indicator has changed and it will therefore not be banded for 2003/04. 2004/5 bandings have not yet been set by DoH. The ratio for 2003/04 is 1,17:1
Assessments of adults and older people leading to a provision of service	PAF BV59 E50		From 2003/4, this indicator counts services resulting from a review as well as assessment. Care should therefore be taken when comparing 2003/4 with earlier years. This Indicator will not be banded for 2003/04. 2004/5 bandings have not yet been set by DoH.

Standard 3 Intermediate Care	**Ref**	**Date**	
Local health and social care systems to appoint an intermediate care co-ordinator in at least each health authority area. Devise systems to include patient/user/care involvement Complete baseline assessment	NSF NHS Plan 	July 2001 July 2001 July 2001	Intermediate Care co-ordinator post ended December 2003 when PCT's decided not to renew post. All PCTS's have their own lead now for intermediate care. A Development Officer post to work with the Modernisation Group is to be appointed to co-ordinate actions from the NSF, and to develop services.
Local health and social care systems to agree JIP for 2002/03	NSF	Jan 2002	No longer required to complete JIP.
At least 1500 additional intermediate care beds compared with the 1999/00 baseline 1500 additional intermediate care beds compared with 1999/00 baseline At least 5000 additional intermediate care beds compared to 1999/00 baseline At least 5000 additional intermediate care beds compared with 1999/00 baseline	NSF LMR OLD 17 NSF LDP Assumption	March 2002 March 2002 March 2004	Negotiation is currently on going with the Acute trust to find provision of health funded IC beds within the existing community hospital structure. The current position of the Acute trust is that all beds in Community Hospitals could be considered IC beds, however, this should not interfere with their current ability to use community hospitals to "decant to" at times of bed pressures within the acute trust. 52 intermediate care beds in CDC homes were created throughout the country in 2003/2004 to reduce delayed discharges from hospital.

At least 1700 non residential intermediate care places Increase in the number of people receiving Intermediate care 220,000 compared to 2000 baseline	NSF	March 2004	There are a number of systems and structures in place to develop IC including the development of interested teams in Durham and Chester-le-Street, Derwentside and Easington.
At least 40 000 additional people receiving intermediate care services promoting rehabilitation and supporting discharge compared with the 1999/00 baseline	LDP Assumption	2004	The 2002/03 outturn performance of people receiving intermediate care was 952 people.
At least 20 000 additional people receiving intermediate care services preventing unnecessary hospital admission compared with the 1999/00 baseline	NSF LAP PA	March 2004 (revised target)	The Access and Systems Capacity Grant provides £1million funding for domiciliary intermediate care services, which is helping to ensure that the numbers of people accessing the service is increasing.

Keep the year on year growth in emergency admissions of people over 75 to under 2%; as part of the target to provide high quality pre-admission and rehabilitation care to older people to help them to live as independently as possible by reducing preventable hospitalisation and ensuring year-on-year reductions in delays in moving people over 75 on from hospital.	LMR OLD 21 PSA Target		All health and social care organisations are exploring initiatives to impact on this milestone. This will be enhanced by the whole systems approaches evoked through the development of partnership board arrangements The presence of a therapist from the RIACT service within the Accident and Emergency department at UHND has impacted significantly on this milestone, by preventing unnecessary admissions. Social Care and Health now also provide 2 Social Workers based in A+E units (in Bishop Auckland and Durham Hospitals).
Ensure every patient has a discharge plan by 2004	LMR OLD 22		New multi-disciplinary hospital discharge policy introduced in 2004.
Year-on-year, reduce delays in moving people over 75 on from hospital, as part of the Public Service Agreement target to provide high quality pre-admission and rehabilitation care to older people to help them live as independently as possible by reducing preventable hospitalisation and ensuring year-on-year reductions in delays in moving people over 75 on from hospital.	LMR OLD 24		The reorganisation of the social service teams into Promoting Independence Teams, has allowed provision of an increased social work presence within the Acute setting, which facilitates speedier intervention. Delays in the Acute hospitals have reduced to minimal numbers.

Standard 4 General Hospital Care	Ref	Date	
All general hospitals which care for older people to have identified an old age specialist multidisciplinary team with agreed interfaces throughout the hospital for the care of older people	NSF	April 2002	Target achieved maintenance and development work to continue A successful bid was made for monies under standard 4. To employ 3 persons one at each acute site. To improve hospital services for older people. The post should be advertised shortly. The focus for each post being slightly different, Darlington – Mental Health, Bishop – General hospital care, UHND – Therapy orientation. Short listing for the posts will take place in August 2004, with posts being filled in September 2004
All hospitals will have developed a nursing structure, which clearly identifies nursing leaders with responsibility for older people. Consideration to be given to Nurse Specialists/Nurse Consultants and Clinical Leaders – Modern Matrons	NSF	April 2002	Target achieved maintenance and development work to continue
All general hospitals that care for older people will have completed a skills profile of their staff in relation to the care of older people and have in place education and training programmes to address any gaps identified.	NSF	April 2002	Target achieved maintenance and development work to continue
End widespread bed blocking	LMR OLD 23	2004	Social Care and Health have achieved excellent results in reducing bed blocking. Current performance on PAF D41 is in the Dark Green banding

Standard 5 Stroke	Ref	Date	
Every general hospital that cares for people with stroke will have plans to introduce a specialised stroke service as described in the Stroke Service Model from 2004	NSF NHS Plan	April 2002	This target was not achieved by the deadline of April 2004. As from the beginning of JUNE 2004. Beds for the assessment of stroke patients have been identified on ward 2 UHND, with follow on rehab care continuing in the community hospitals.
Every PCG/T will have ensured that: ▪ Every general practice, using protocols agreed with local specialist services, can identify and treat patients at risk of stroke because of high blood pressure, atrial fibrillation of other factors	NSF	April 2004	Work had already started in this area with the links to prevention and after care on Heart Disease (NSF activity). Community DN, HV and Staff Nurses have been trained as Heart Manual Facilitators. GP practices currently follow the British Hypertensive Society Guidelines on BP monitoring this should identify at risk patients. Plus fulfilment of GMS contract requirements.
GP practices will be using agreed protocols for rapid referral of patients with TIAs to local specialist services		By April 2004	At present, no service is available for the rapid referral and management of those with TIA within North Durham. However the PCT is undertaking a needs assessment of TIA patients, the results of which should feed into the development of a TIA clinic within UHND. CHD specialist nurses could work in partnership with UHND to support the commencement of this service.

Milestone Falls Standard 6	Ref	Date	
Local health, social care and independent sector providers should have audited their procedures and put in place risk management procedures to reduce the risk of older people falling	NSF	April 2003	Target achieved maintenance and development work continues.
HImP should reflect an all sector development relating to an integrated falls service.	NSF	April 2004	A Falls Mapping Event was held February 2004. Facilitated by Health promotion and the Falls Co-ordinators from DCLS and Sedgefield
All health and social care systems to have introduced integrated falls service	*NSF*	*April 2005*	PCT's have established falls services. The screening tool allows direct referral to this service by primary care staff.

Milestone Mental Health Standard 7	Ref	Date	
HImP and other relevant local plans should have included the development of an integrated mental health service for older people including mental health promotion	NSF	April 2004	A pilot integrated Mental Health Services for Older People team was established in Sedgefield in 2003. It has recently been agreed that similar teams will be established throughout the county, though this will require funding to enable them to be established in 2005.
PCG/Ts will have ensured that every general practice is using a protocol agreed by local specialist services, including social services, to	NSF	April 2004	Not yet established.

diagnose, treat and care for patients with depression or dementia. *GPs following agreed protocols to diagnose, treat and care for older people who are suffering from dementia*	*LMR OLD 6*	*April 2005*	
Health and social care systems should have agreed protocols for the care and management of older people with mental health problems	NSF	April 2004	To be established with the development of teams.

<table>
<tr><th>Standard 8
Promoting healthy lifestyles</th><th>Ref</th><th>Date</th><th></th></tr>
<tr><td>HImPs and other relevant local plans should have included a programme to promote healthy ageing and to prevent disease in older people. They should reflect the complimentary programmes tackling Heart Disease and Cancer; promote mental health as well as the continuation of flu immunisation.</td><td>NSF</td><td>April 2003</td><td>The PCTs have responsibility for coordinating work on this standard, leading on immunisation and blood pressure management.

Between April 2001 and December 2002: Of those who committed to quitting smoking there was a 70% success rate amongst men over 60 and 72% success rate in women over 60.</td></tr>
<tr><td>Plans should also include action specific to older people – utilising the range of local resources and opportunities including regeneration programmes and partnership working.</td><td>NSF</td><td>April 2003</td><td>Through partnership working between health, councils and the voluntary sector specific initiatives have been delivered. This work needs to be formalised and made main steam</td></tr>
<tr><td>Local health systems should be able to demonstrate year on year improvements in measures of health and well being among older people including:
▪ Flu immunisation
▪ Smoking cessation
▪ Blood pressure management
NSF and LMR
OLD 10
Local Health systems can demonstrate year on year improvement in health and wellbeing of older people; strategic and operational plans in place to promote healthy ageing</td><td>NSF and LMR
OLD 10

LMR
OLD 27</td><td>

2004</td><td>Winter 2002/2003 - the target for flu immunisation was 60% of those aged 65 years and older.

<table><tr><td colspan="2">Flu immunisations from October to December</td></tr><tr><td>2002 /2003 (target 60% of over 65)</td><td>DCLS achieved 68.5%</td></tr><tr><td>2003 / 2004</td><td>DCLS achieved 71%</td></tr></table>Source CDD share services

Overall figures for men and women over 60yrs committed to quitting smoking<table><tr><td colspan="2">Setting quit date 2002 / 2003</td><td colspan="2">Successfully quitting at 4 weeks</td></tr><tr><td>Male</td><td>Female</td><td>Male</td><td>Female</td></tr><tr><td>345</td><td>494</td><td>253</td><td>315</td></tr><tr><td colspan="2">Setting quit date 2003 / 2004</td><td colspan="2">Successfully quitting at 4 weeks</td></tr><tr><td>Male</td><td>Female</td><td>Male</td><td>Female</td></tr><tr><td>115</td><td>181</td><td>84</td><td>116</td></tr></table></td></tr>
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Milestone	Ref	Date	
All people 75+ should normally have their medicines reviewed at least annually and those taking four or more medicines should have a review 6 monthly. People 75 and over will have an annual review of medicine and those with 4 or more medicines will be reviewed 6 monthly	NSF LMR OLD 26	April 2002 April 2002	CDDAHT carries out reviews of medication on admission. An in-depth evaluation of all of the patient's medication (prescribed and non-prescribed) should be especially targeted at those older people known to be at higher risk of medicines-related problems. The PCT pharmacists are carrying out medication reviews directly for patients. Patients initially identified for medication review were: • Patients over 75 years of age • Older patients prescribed 4 or more medicines • Patients in residential care • Patients with identified medicines – related problems For 2003 / 2004 Out of a total of 22 GP Surgeries, 12 completed and returned figures for the percentage of people 75 years and over who have read codes for medication review done, the average number of people seen was 55.4% across the returns.
All hospitals should have 'one stop' dispensing/dispensing for discharge schemes and, where appropriate, self-administration schemes for medicines for older people. All hospitals will have a "one stop dispensing/dispensing for discharge" schemes	NSF LMR OLD 10	April 2002 By April 2002	North Durham Health Care Trust has undertaken a pilot of one-stop dispensing. It was hoped that this would be fully implemented by December 2002.
Every PCG/T will have schemes in place so that older people get more help from pharmacists in using their medicines *PCG/Ts will have in place schemes so that older people get more help from pharmacists in using their medicines*	NSF and *LMR OLD 13*	April 2004 *By April 2005*	This target has been met in advance of the April 2004 deadline. Practice and community pharmacists are in place carrying out medication reviews and providing advice and support to the local communities and include home visits where appropriate. It is anticipated that the next deadline will be achieved well in advance of April 2005.

Other			
Improve the quality of life and independence of older people so that they can live at home wherever possible, by increasing by March 2006 the number of those supported intensively to live at home or in residential care There are 6,900 more extra care housing places. Increase of 6,000 in the number of people in care homes supported by councils between 2003-06 Older people helped to live at home Intensive Home Care Admissions of supported residents aged 65 or over to residential and nursing home Waiting times for packages of care	LDP Target T22 PAF C32 PAF C28 PAF C26 PAF D43 now PAF D56	2006 2006	Figures indicate increasing numbers being helped to live at home. Calculations indicate that to achieve the 30% figure and extra 16 people will need to be supported. Through the restructuring of social services, the evolvement of Promoting Independence Teams and the development of integrated care pathways, work to achieve this target will be enhanced. Work is already being carried out by Social services and the independent sector to benchmark service delivery. This target will be further facilitated by the 7 extra care housing facilities recently built in the county. 7 extra care homes developed in the County mean that the target for the county will be exceeded. A further extra care home is being developed in Sedgefield. Improved performance during 2003/4 and now in the Good (light green) banding Performance against C28 and C26 is in the dark Green (very good) banding Performance is in the Good category for PAF D56
Each year there will be less than 1% growth in emergency hospital admissions and no growth in re-admissions (number of emergency hospital admissions, re-admissions, % growth in emergency hospital admissions and readmissions)	LDP Target T23 PAF A5		Banding against this indicator currently in the orange

All assessments of older people will begin within 48 hours of first contact with social services and will be completed within four weeks (70% within two weeks) Following assessment, all social services will be provided within four weeks, (70% within two weeks) For new adult and older clients, the proportion where the time from first contact to first service is more than six weeks.	LDP Target T24	December 2004	The 4-week target is already being achieved, by social services, in 80% of referrals. This target will be facilitated by the implementation of the single assessment process and integrated health and social service teams. Funding proposals have been submitted to recruit additional staff. Current performance at 79%.
A minimal of 80% of people with diabetes to be offered screening for the early detection (and treatment if needed) of diabetic retinopathy as part of a systematic programme that meets national standards, *Rising to 100% coverage of those at risk of retinopathy*	*LDP Target T25*	*2006* *2007*	Plans are under consideration for the development of the retinal screening services available in the locality. Changes in equipment and procedures are anticipated in the near future. To assist with collection of appropriate and meaningful data standardisation of read codes is being implemented across all GP practices.