



BRITISH GERIATRICS SOCIETY
SPECIALIST MEDICAL SOCIETY FOR HEALTH IN OLD AGE

31 St John's Square, London EC1M 4DN, England
Tel: +44 (0) 20 7608 1369 Fax: +44 (0) 20 7608 1041
Email: general.information@bgs.org.uk
Website: www.bgs.org.uk

Patron: H.R.H. The Prince of Wales

Submission by the British Geriatrics Society to the Department of Health on:

NATIONAL REVIEW OF AGE DISCRIMINATION IN HEALTH AND SOCIAL CARE

The British Geriatrics Society (BGS) is a membership association of doctors, nurses, therapists, scientists and others with a particular interest and expertise in the care of the frail older person and in promoting better health in old age. We are pleased to have the opportunity to contribute to this review.

Older people are important and valuable members of society who have an equal right to effective and efficient health care services. The BGS opposes discrimination against older people (either direct or indirect) and believes that decisions about health and social care should always be based around clinical appropriateness and not made on the basis of chronological age alone.

Old age itself is not an adequate explanation or cause of physical or mental illness. Although sensory impairment, vulnerability to and delayed recovery from illness may be features of advancing age, older people have a right to a correct diagnosis at the time of acute illness or loss of independence.

Older people also have a right to assessment and treatment by a team of appropriate professionals when recovering from an acute illness or change in health, even when recovery has been, or is expected to be, limited.

Evidence of and views on those services and practices that differentiate on the basis of age in a positive and fair way that should be retained:

A positive feature of the UK NHS system has been the development and establishment of mainstream specialist services for older people. There is now much research evidence to attest that these services (e.g. specialist in-patient wards for older people) deliver superior outcomes to non-specialist care.

A recent audit in one of our member's hospitals demonstrated the older patients admitted to a Care of the Elderly ward had shorter length of stay than on other medical wards. Furthermore, the readmission rates for discharges from a non Care of Elderly ward were significantly higher.

There is also a substantial body of research evidence to underpin specialist services that address common problems faced by older people (e.g. falls prevention services, continence services, rehabilitation services). All these evidence-based services share the need for specialist skills and cross-professional working.

In addition, other services by virtue of their target condition that predominantly affect older people (e.g. services for cataract extraction, joint replacement surgery, fractured hip), need to be designed and organised in such a way that they are especially sensitive to the needs of older people.

These specialist approaches, and their multi-professional teams, need to be retained if we are to continue to provide an NHS that is capable of focussing directly on the often complex needs of older people – particularly the most vulnerable group of older people, usually referred to as frail older people. Such patients, who typically have a mixture of mental and physical health problems, are among the most challenging and complex for our NHS to support.

Evidence and views on which actions need to be taken to tackle age discrimination, and by whom:

With the recent creation of the Care Quality Commission as a single Regulatory Body for health and social care services in England, and the transfer of the complaints function to the Ombudsman, there is an opportunity to ensure that the needs of older people will be addressed by the nature of future inspection and regulation.

There has been some concern that what Healthcare Commission and Commission for Social Care Inspection tended to measure was fairly superficial (policies and systems in place rather than an exploration of services as experienced by individual patients or clients). This in turn meant that services could be signed off even though subsequent serious issues became apparent. It is therefore crucial that the detail of the regulatory process is right and reflects the needs of older people. We know for instance that excessive regulation adversely affects the social care provision market. Yet there were recent reports of “reverse auctions” by councils for care provision. It is important that the regulators are not toothless in this kind of scenario. We also need to ensure that regulation is just as effective in older as in younger people (for instance, the Deprivation of Liberty Safeguards, was based on the Bournemouth ruling which concerned a home for young disabled adults. [1] We need to ensure that these and the code of practice for implementing the Mental Capacity Act are policed just as well in older people as in younger and that older people have just as much access to advocacy. [2, 3, 4, 5]

Differential access to services, and also where services provide an equitable balance between age groups:

Age should not prevent access to screening and other health checks that are effective and that are offered to young and middle aged people. Nor should age prevent access to advice about healthy living and preventative measures which can be taken to improve health at all ages, for example stopping smoking.

The notion of age based rationing of treatment has become unsustainable and unethical as robust evidence has accumulated that shows comparable outcomes for treatment of older and younger people. However, our members believe that ageism is endemic in many clinical services including cancer services, coronary care units, prevention of vascular disease, mental health services and in the management of transient ischaemic attacks and minor strokes. A key concern is that some pathways exclude an early specialist assessment of older people. This is despite evidence which shows that early assessment and intervention can lead to a reduced length of stay and improved outcomes. For further detailed information on examples of ageism in health care services please see the **Appendix** to this submission.

The BGS is also concerned that evidence of benefits for certain interventions in frail older people may be lacking due to the under-representation of this group in randomised controlled trials. In this way covert discrimination may occur through non-application of potentially beneficial interventions.

How service design can lead to ending age discrimination, and how it can be used to support age-appropriate services:

Recent policies have inadvertently resulted in actions that have discriminated against older people.

The UK has one of the lowest numbers of hospital beds per head of population in Europe and bed closures seem to be driven more by managerial dictat rather than because of improvements in diagnostics and community care. It is often very difficult to get a sick old person into an acute bed - those who are ill should have prompt assessment and timely treatment by a well-trained interdisciplinary team. Continued closures might further compromise the quality of elder care

For example, the procedure of Payment by Results (PbR), whereby trusts are paid a national tariff per patient treated, has purposefully focused on driving down lengths of hospital stay so that a trust can treat more patients per bed available and thereby generate income. This seems a sensible policy to promote efficiency but, for older people, reducing their in-patient stay has too often resulted in people returning home before they are fully recovered – the “quicker by sicker” approach. Rehabilitation care – of particular value to older people to prepare them to cope at home again – has been especially vulnerable and BGS surveys have shown that acute trust rehabilitation wards have been disproportionately closed in recent years.

Another policy that has had unintended ageism consequences has been an over-emphasis on “admission avoidance”. Here the idea has been to reduce acute admission to hospital. At face value, this is clearly desirable but, when pursued as local target, it can readily disproportionately disadvantage older people. The

issue is that acute illness in older people is more non-specific and more subtle than in younger people, social issues are often medical problems in disguise. Thus, when an admission avoidance policy is aggressively applied, it can result in an older person being labelled as a “social problem” or “not coping” and being denied appropriate assessment and timely treatment in a hospital service. The belief that many old patients are social problems is inherently ageist.

The BGS membership have numerous examples of older people with serious illness being inappropriately admitted to intermediate care services and subsequently requiring urgent transfer to hospital but with eventual poor outcomes because of this system level delay.

BGS Member: “Ageism crops up in Intermediate Care and with the desire to keep older people out of hospital. This happens through poor understanding of illness processes in older people and an over eagerness to label problems as “social”. I witnessed an example of this last week; a woman was admitted directly to a bedded Intermediate Care facility because she couldn’t cope at home, the real underlying reason for her problems being that she had active colitis and faecal incontinence requiring District General Hospital care.”

The **NHS Next Stage Review** has a welcome focus on **Quality [6]** – with the three components of quality being “**outcomes**”, “**patient safety**” and “**patient satisfaction/experience**”. Quality outcomes should be age-blind to ensure that all patients receive equal access to treatment regardless of age.

Patient safety incidents very frequently affect older people. For instance, 40% of safety incidents in hospitals are falls – with the median age of fallers being 75.

The National Confidential Enquiry into Patient Outcome and Death (NCEPOD) [33] has highlighted postoperative complications in older people. For example, opportunistic infections such as C Diff or MRSA affect older people more adversely than younger.

It is welcome that two of the four national priorities for quality are Hip Fracture and Cataract Surgery, both of which largely impact on older people.

If service user experience is now to inform services in a meaningful way, then many of the concerns expressed by older people and their relatives around communication, dignity in care, discharge planning, interagency working etc should inform services meaningfully rather than just as a tokenistic exercise.

The focus on **world class commissioning, integrated care models** and 3 or 10 year **commissioning plans** gives a potential chance to move from short term plans to investment in services based on **Joint Strategic Needs Assessments** which reflect more accurately the needs of the local population. Older people’s services and needs have not traditionally been to the fore in such plans (for instance, falls and fractures, or dementia have rarely been incorporated).

Commissioning offers a genuine opportunity to improve this situation but there is also a risk that older people’s needs will still fail to be prioritised or incorporated into commissioning. Will the framework employed by the SHAs to judge the quality of commissioning be robust enough to deal with this?

There is also a risk that as we move away from central “must do” targets, priorities will focus even more on that small number of targets – further diverting attention away from services for older patients. If it’s not in the operating framework or the Darzi quality priorities, will it be relegated? And will the role of the SHA in quality assuring world class commissioning and ironing out variations between providers and purchasers be effective?

If we are serious about “**person-centred services**” as a reality rather than a platitude, then there needs to be better **integration between primary care, secondary care and social services**, all of which tend to work in silos and to their own agendas and priorities – sometimes with conflict or suspicion rather than co-operation.

There are examples around the country of integrated care pilots [7] which are producing dividends. One of the common complaints of older service users is poor communication and information sharing between agencies, having to repeat the same information to a confusing number of different professionals. There are also issues around care at interfaces/handoffs, for example, discharge from hospital with social care involved. There are different organizational priorities (for instance social care commissioning ever closer to the client, with PCT commissioning done by larger organizations. There is also or the constant “gaming” over NHS funded continuing long term care – with both PCT and Local Authority trying to avoid the cost. So that current systems still often disadvantage older people with complex needs.

The use of **Payment by Results (both Best Practice Tariffs and “Unbundling the Tariff)** and local Care Quality Initiative (CQIN) presents an opportunity to drive up quality in key areas affecting older people. At the moment most of these priorities are centrally determined and with the exception of hip fracture and stroke management the standards are not specific to older people’s care. There may be opportunities to influence the NHS operating framework and quality initiative to incorporate further standards which might positively influence older people’s services. And CQIN priorities will be locally determined. Equally, there is a risk that we will miss a trick and fail to incorporate meaningful standards around the care of older people.

When it comes to PBR and “unbundling the tariff” (for acute versus rehabilitative care), the idea was to incentivize provision of care services closer to home for patients who no longer need an acute hospital bed. In reality, this has not happened, and there is a real risk that without the provision of more intermediate care services, the tariff will simply incentivize hospitals to discharge older patients earlier, whether or not they have access to any further rehabilitation.

The Quality and Outcomes Framework for the GP contract, has nothing about falls, fractures, osteoporosis, dementia, incontinence, comprehensive assessment of frail older people etc. Nor does it have any incentives to provide input into long-term residential or nursing care, or case management for people with long term conditions or end of life care or care planning. **The standards are therefore biased towards conditions of childhood or midlife** and towards those interventions or assessments which are easy to record and measure. This is despite campaigns (e.g. on osteoporosis falls and fractures) to change this. [8, 9, 1]

Finally, a key priority in the **Next Stage Review** and a trend for several years is a drive to reduce length of stay and **avoid hospital admission or to reduce length of stay and to provide care closer to home**. PCTs will be judged on their ability to **transfer resource from secondary to primary care**. [6] We at the BGS accept that in general, older people would rather remain in their own homes and that for many, hospitalization can be a risky, upsetting or disempowering experience. We accept that at times, people “default” inappropriately to hospital because community services have not been sufficiently supportive or responsive. We also accept that having been admitted to hospital there are often older people remaining in beds whose care needs could be met in an alternative setting if the capacity or responsiveness in the community were available.

For all this it is axiomatic that older people who are unwell or who have presented with problems such as immobility, falls, general failure to manage or thrive, cognitive impairment, carer-stress, self-neglect, incontinence etc are generally unwell. The medical model is highly relevant as these problems often have underlying and potentially treatable causes. The language used “inappropriate admission” “social admission” “acopia” “bed blocker” “delayed transfer” and the general thrust of system reform, always tends to portray older service users as a problem for the system or a “demographic time bomb.”

Older people are just as entitled to hospital assessment as younger ones. This is a question of getting the right person into the right bed or assessment, irrespective of age and not regarding troublesome older people as getting in the way of meeting other performance targets or objectives. [10, 11, 12, 13] All the talk on admission avoidance or reduced length of stay tends to focus on older people. In reality they are the principal users of the system. Such a focus also risks older people being placed prematurely in long term nursing or residential care before their care needs have been adequately assessed or before they have had a chance to rehabilitate and regain maximum potential. If people are discharged prematurely with no access to ongoing rehab there is also a danger that they will never regain their former functional status (in then end leading to excess social care costs so a false economy).

How behaviours and culture contribute to age discrimination and how they can be changed:

Tackling institutionalised age discrimination in health services will require national leadership, with open acknowledgement of the presence of ageism.

All members of multidisciplinary teams caring for older people, which include doctors, nurses, specialist nurses, therapists, social workers, dieticians and other health professionals, must be prepared to challenge behaviours and help change ageist attitudes in their own and other departments.

Older people are the main users of health and social – they are not a minority. Getting their care right is the key to the whole system. And looking after them well is often cheaper than looking after them badly. 60% of admission and 70% of bed days in hospitals are in people over 65. A core component of primary care

medicine and nursing is the care of older people with complex needs. The long term conditions agenda (with 40% of hospital bed days arising from 5 % of the local population over 65). A large proportion of the social care spend is on older people.

The balance of education and training for professionals does not reflect this reality and without the right attitudes, knowledge and skills, the care of older people is compromised. [11, 16, 17] For instance, the BGS national survey of training for undergraduates in the care of older people, showed that this was very patchy. Health professionals when surveyed frequently say that they do not wish to work with older people – even the reality for many will be that this is their day to day job as the population ages.

It is relatively **hard to attract staff to work in areas for older people, which is seen as unglamorous, low status and hard work** (when compared to more high tech areas or in children’s services). And in the social care sector (especially long term care), the financial rewards are poor and the training inconsistent (for instance for staff in residential care around nursing and dementia needs). These areas are often perceived to be “low status”

From several pieces of work around dignity in care and patient satisfaction, and from Ombudsman’s reports, on the Deprivation of Liberty Safeguards work [18, 19] we know that a **major source of concern for older people and their families concerns attitudes, communication and respect for personhood or autonomy.** [20-26] Older people are often marginalised from decision making, not given adequate information and not treated as individuals with a life history and preferences of their own. This behaviour on the part of staff can sometimes be reinforced by their relatives or carers. Older people have the right to take risks and the right to decide on their own future care but risk being infantilised because of prevalent ageist attitudes that they should somehow be treated differently from younger people.

The work on dignity in care has highlighted that older people’s concerns about dignity centre on a few core elements which must be addressed through education and training.

- **Respect and value for them as individuals with their own values**, choices and life history (even if they are becoming frail or cognitively impaired) rather than just another old patient/resident assumed to have particular values or views or needs just because of their age. Older people who have decision specific mental capacity should be afforded just as much control over their own decisions as younger people and not subtly infantilised/wrapped in cotton wool “for their own good”. And even where mental capacity is impaired, we should still do everything we can to act in their best interests and in establishing those interests have full regard for their previous choices and preferences (including where relevant advanced care planning).
- **Respect for their autonomous choices** and support in making them. This entails **adequate two way communication** with them and (if they wish) their families, with sufficient information to enable them to make choices affecting their own care, and support in doing so (for instance if they have communication or language difficulties or some cognitive impairment). But it also involves giving them unhurried and repeated opportunities to discuss their own concerns and worries and questions.
- **Attitudes** (e.g. the use of patronising “elder speak”, or impatient/critical comments, or older people being discussed over their head/round the bed/with their relatives as if they are not there). [14]
- This can run as far as **elder abuse and neglect**, or deprivation of liberty but this is much rarer than more casual breaches of dignity.
- **Specific care activities** (e.g. feeding, dressing, toileting) which can compromise privacy and dignity if done without due regard to the older person’s needs or wishes.
- **Physical environment** (e.g. cleanliness, mixed sex wards, lack of adequate screening off for care activities or to prevent overheard conversations).
- **Insufficient choice or control over end of life care**, including symptom relief, support and place of dying.

Which systems, levers and incentives can support the delivery of the changes required:

Ageism will always prosper when resources are inadequate for the target population.

All clinical policies should be regularly reviewed to ensure no age bias. All decisions made with regard to diagnosis and treatment plans should be transparent.

Much progress has already been made in the related area of diversity and equity by ensuring that any new policy developed by central and local government is routinely checked and assessed for these issues. For example NICE routinely appraises all new guidance against the potential for equity infringement as part of its sign off procedures. In addition, all new staff are formally trained in equity awareness. This example of good practice needs to be extended to ageism such that routine procedures are developed to examine for possible age discrimination. Overt ageism, where age defined cut-offs are stated can be readily identified, but covert ageism, where inadvertent disadvantages for older people are more subtle, will require specific training and awareness. Perhaps there is a role for panels of older people's advocates to have a special responsibility to assess for potential covert ageism.

The challenge is to limit older people from being denied access to a treatment or a service simply on the basis of age. Greater transparency needs to be achieved in respect of these access and treatment decisions. This requires **collection and publication of routine data**. The Department of Health made great strides with the development of a PCT-based data system that was capable of describing between-PCT and within patient group variations in service access (e.g. Coronary Artery Bypass Grafts, hip replacement surgery). This approach has much merit as the information can be made available to the local population and help identify potential areas for concern.

The education of medical, nursing, allied health and social work professionals (and perhaps managers in health and social care) needs to be seriously rebalanced to reflect the fact that much of the workforce will be delivering care to older people with complex needs. Educating and training have not caught up with the reality that 'Older People R Us' when it comes to health and social care.

The focus on **Quality and Personalization** will need to ensure that service user experiences are fed into service delivery in a meaningful way - and it is the attitude/skills of staff who come into contact with older people which most materially affects their experiences.

Regulation and Inspection will have to become better at dealing with some of these "softer" but crucial aspects of care rather than simply looking at processes/systems in place. This is a key challenge for the Care Quality Commission.

In **implementing national strategies and guidelines we must remember that these softer aspects of care are just as important** to measure and highlight as the high tech ones.

As a final recourse either individuals or lobby groups will be able to turn to **Human Rights Legislation or to the Equality Act**. They will have to recourse to **criminal law or negligence law** where appropriate

However, we recognise that shifting attitudes, cultural or organisational values can take a generation and that this process will be iterative

Professor Graham Mulley
For and on behalf of British Geriatrics Society
3rd July 2009

The British Geriatrics Society

The British Geriatrics Society (BGS) is the only professional association, in the United Kingdom, for doctors practising geriatric medicine. The 2,500 members worldwide are consultants in geriatric medicine, the psychiatry of old age, public health medicine, general practitioners, nurses, allied health professionals, and scientists engaged in the research of age-related disease. The Society offers specialist medical expertise in the whole range of health care needs of older people, from acute hospital care to high quality long-term care in the community.

Geriatric Medicine

Geriatric Medicine (Geriatrics) is that branch of general medicine concerned with the clinical, preventive, remedial and social aspects of illness of older people. Their high morbidity rates, different patterns of disease presentation, slower response to treatment and requirements for social support, call for special medical skills. The purpose is to restore an ill and disabled person to a level of maximum ability and, wherever possible, return the person to an independent life at home.

Appendix

Age discrimination (whether overt or covert) is manifested in a number of ways:

Conditions which are predominantly conditions of old age, yet which are common and cause considerable burden for older people and for services (e.g. falls, osteoporosis, urinary incontinence, dementia, and delirium) have tended to be **relatively neglected** in commissioning, targets and service priorities. And there is objective evidence to support this.

Conditions which affect people in mid life and old age alike tend to be less well managed in older people or have services which are not readily accessed (e.g. Old age psychiatry, who cares wins [27]) or in the recent case of stroke, there has been a relative overemphasis on “high tech” low volume treatments over delivering the more low tech rehabilitation more likely to benefit older people. If decisions around treatment are arbitrarily based on chronological age rather than ability to benefit then this is clearly discriminatory.

Older people who present to health and social care systems with functional problems, difficulty coping etc often have diagnosable and treatable conditions but all too often are written off as “social admissions” or “acopia”. **They need a proper assessment, diagnosis and management plan.** [11, 12] It is a key lesson of geriatric medicine that functional problems often have treatable causes and that comprehensive specialised assessment works. And that even if the problems are not reversible, much can be done to improve quality of life and reduce suffering. But this means older people having the chance to access services in the first place.

Central initiatives such as NSFs have tended to be **accompanied by investment** when for conditions of midlife (cardiac or cancer for instance) but those specifically aimed at conditions of ageing (See the National Service Framework for Older People) [28]

Although we are moving away from “targets and terror” towards a focus on better **local commissioning**, those vital signs and “must dos” that do exist and which therefore skew provider and commissioner priorities, have tended not to focus on very common conditions associated with old age, i.e. continence.

Priorities in research funding have not centred on common conditions of old age. [15] For instance, there is 100 times more money spent on cancer research than dementia research. The assessment framework for Universities also tends to prioritise basic science or pharmaceutical research over research on service delivery. So academic departments of geriatric medicine have struggled to survive and there are many vacant chairs or defunct academic departments in England in particular.

Service specific comments

- Steel N et al 2008 BMJ in a survey of 8,500 people looking at self reported quality of care indicators showed that common conditions of ageing were systematically less well recognized and managed than those of mid life and concluded that the lack of QOF targets was a major part of this problem
- In similar vein, Zermansky et al Age Ageing 2006 were able drastically to reduce prescribing costs with a secondary benefit on falls rates by systematic assessment of care home residents in West Yorkshire. They concluded that gain the lack of meaningful QOF standards on medication review and adjustment was partly to blame and also that there was little to incentivize GP input into care homes currently
- The parliamentary enquiry into the **human rights of older people in healthcare** [29] flagged up the poor access of residents of long term facilities to medical assessment or treatment.
- Both the **dementia enquiry** and the RCPsych report “**who cares wins**” [27] showed that older people with dementia and other mental health problems have poor access to specialist assessment or treatment, with more money going into **mental health services** for younger people. Indeed, mental health is one area where there are still clear age based policies. This may make sense in terms of providing specialist dementia care. However, older people with drug or alcohol problems, with acute psychosis or with self harm for instance find it harder to access services.

- We also know that acute confusion “**delirium**” is very common in hospital yet often poorly recognized and badly managed. Much can be done to prevent delirium and research has shown that teaching and training programs of staff in delirium prevention is not only effective but also cost-effective
- We know from national RCP/BGS audits of **continence care, falls and fracture management, bone health assessment and hip fracture management** that older people (despite guidelines from NICE or other national bodies) still receive very patchy care on an individual basis and that services for those very common and debilitating conditions are often poorly funded or prioritized.
- With specific regard to **fracture care**, only 30% of women with a prior osteoporotic fracture currently receive any bone health assessment or treatment as recommended by NICE even though there are over 200,000 such fractures in England and Wales per annum and they account for £2bn in health and social care costs.
- **Hip fracture** is predominantly a condition of frailer older people, with medical co-morbidities but there are still **unacceptable variations** in treatment, length of stay, access to specialist services. Older people are still frequently operated on by junior surgeons, on non-specialized lists and are frequently cancelled repeatedly to make way for younger patients on 18 week waiting lists.
- With regard to **end of life care**, the palliative care strategy has helped to improve access to specialist palliative care for older people including those with non-cancer diagnoses. However, older people are still **less likely to receive specialist support** including hospice care. And the recent **all parliamentary enquiry into end of life care** [30] showed that whilst most people would prefer to die at home and have more choice over their place of death, care needs etc (see Age Concern Work “dying to be heard”), but that this is still often not possible with largely hospital based end of life experiences often being less than satisfactory.
- **Inappropriate Admissions to a Community Hospital:** “Our PCT have set up a Primary Link service for GP’s to contact for any one they are considering admission to hospital. The details of the patient are passed on to the Primary link run by a nurse who then decides on the appropriate hospital for the patient. More often than not older patients are diverted to a community hospital (with little or no geriatric input) for treatment. I have personally been involved in rescuing older people with a number of easily treatable and reversible conditions. The most worrying example was a patient with non specific symptoms being admitted to a community hospital and who had blood tests 24 hours after admission showing severe acute renal failure with high potassium. He was transferred to the acute hospital and recovered well with a short period of dialysis. Another example is patients with severe community acquired pneumonia who can languish or die in a community hospital for lack of aggressive intravenous antibiotic treatment. I have no issue of older patients being transferred rapidly to a community hospital once they have been properly assessed and a management plan has been agreed.”
- **Ageist National & Local Clinical Guidelines:** “There is more covert than overt ageism but it is still worth looking at clinical guidelines – especially locally produced ones – for overt ageism. One Trust has a locally produced head-injury guideline that differentiates between people over and under 65 for their admitting team – under 65 with A&E and over 65 with medicine. They also have a policy for the D Dimer blood test which excludes people over the age of 70. Additionally the Trust has a Neurological Rehabilitation team which is very well staffed and for people under the age of 65 only!”

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