APPENDIX 1

Standard 1 – Age Discriminaton		
Date	**Milestone**	**Performance Measure**
October 2001	Audits of all age related policies to be completed with the outcomes to be reported in annual reports.	Completion monitored by RO (new measure).
April 2002	From this date SAFFs and JIPs to include initial action to address ~~any age discrimination identified~~. Strategic direction to be reflected in HImPs. Councils to have reviewed their eligibility criteria for adult social care to ensure that they do not discriminate against older people.	Completion monitored by RO (new measure). Completion monitored through the biannual reporting of councils to Social Care Regional Offices
October 2002	Analysis of the levels and patterns of services for older people, in order to facilitate comparisons across health authorities and establish best practice benchmarks based on health outcomes and needs	For some key areas, intervention rates may be used to monitor access to services. The benchmarking exercise will be critical to develop a better understanding of appropriate intervention rates for a given population. Clearly what matters most is health outcomes and we are therefore undertaking further work to develop measures for older people based on health outcomes such as overall patient and carer well-being; the proportion of older people enabled to live at home; decreasing levels of disability, life expectancy, morbidity and mortality; greater patient, service user and carer satisfaction. In the meantime, monitoring access to services may include examining the rates of the following key procedures and interventions for people aged 65+, 75+ and 85+, those which cover these interventions key to providing quality of life for older people: - Elective cataract surgery - Elective hip replacement - Elective knee replacement - Community equipment And those which reflect national clinical priorities to ensure that older people are accessing surgical interventions and medical treatments for the major illnesses on the basis of clinical need: - Revascularisation (CABG and PTCA) - Treatment for end stage renal failure (new measure).
April 2003	Once this work is complete and we have appropriate benchmarks, local health systems should, from 2003/04 be able to demonstrate year on year improvement in moving towards those benchmarks.	Completion monitored by RO (new measure).

Standard 2 – Person-centred care		
Date	**Milestone**	**Performance Measure**
June 2001	Local arrangements for implementing the NSF are established	• Numbers/rates of people aged 75+ entering long-term institutional care (total in PAF)
April 2002	The single assessment process is introduced for health and social care for older people.	• Numbers/rates of people aged 75 +in nursing and residential care (total in PAF) • Proportion of total people aged 75 +receiving long term intensive support who are receiving this at home (total in PAF)
		• Numbers/rates of people aged 75 + admitted to hospital as an emergency (SaFFR and proposed PAF indicator). We will investigate continual collections on an age-standardised basis.[i] • Numbers/rates of people aged 75+ whose discharge from hospital is delayed (overall total collected by WEST and in SaFFR and proposed PAF indicator) • Numbers/rates of people aged 75+ readmitted to hospital as an emergency within 28 days of discharge (SaFFR and proposed PAF indicator). Collection to be continued by age standardisation will be explored. • Numbers/rates of people aged 75+ who receive an assessment under the new single assessment protocol (new measure). • Numbers/rates of people aged 75+ in receipt of an individual care plan (new measure). Information to be collected at year end on an age-standardised basis. Waiting time for social services packages: • For new older clients, the proportion where the time from first contact to first services is more than six weeks (version of PSS PAF PI specifically for older people), broken down by whether referral from primary/community health, secondary health or other • As above, except the proportion where the time from first contact to provision or commission of all services in the care plan is more than six weeks (new measure). • Numbers/rates of people aged 75+ receiving overnight respite care commissioned by SSD (RAP) • Numbers/rates of people aged 75+ of key staff: • District nurses • Health visitors • Physiotherapists • Occupational therapists • Chiropodists and podiatrists • Health care assistants • Support workers • Pharmacists These cannot be broken down into the proportion of staff grades assigned to older people, but can give a general measure of access by dividing by population adjusted for age and need.

i. Age standardisation is an alternative to employing an age cut off, by taking into account the differing age structures of the local population in the calculation of indicator values. Age standardised indicators apply to all age groups, while enabling variations to be explored in more detail to see if any particular age group is contributing most to the overall indicator.

Standard 2 – Person centred care		
Date	**Milestone**	**Performance Measure**
April 2002	All health and social care services to have reviewed the information they provide on older people's services and the formats in which it is available, and to have developed an action plan to correct any shortcomings. This should be reflected in the local *Better Care, Higher Standards* charter.	Completion monitored by RO/SCR (new measure).
April 2003	Systems to explore user and carer experience should be in place in hospitals in all NHS and PSS organisations. This will include regular use of the surveys to be developed within the national programme for NHS patients and carers.	This milestone ensures that the focus is on exploring user and carer experience. Performance measures will be developed to allow benchmarking and performance management.
	NHS organisations should have systems in place to ensure all complaints from older people, or their carers and relatives, are analysed and reported to each Board.	Completion monitored by RO/SCR (new measure).
	HImPs and other relevant local plans should have included the development of an integrated continence service	Inclusion monitored by RO (new measure)
April 2004	Systems to explore user and carer experience in PCTs should be in place.	The milestone ensures that the focus is on exploring user and carer experience. Outcome performance measures are needed to back this up. These will be based on local survey questions which will feed into PAF indicators.
April 2004	Single integrated community equipment services are in place	Community equipment (which is predominantly although not entirely provided for older people): • Numbers/rates of people receiving community equipment • Time from first contact to completed assessment • Time from completed assessment to provision • Percentage of items of equipment costing less than £1000 delivered in less than 3 weeks [PSS Indicator] • Percentage of items of equipment recycled by value
	All health and social care systems to have established an integrated continence service	• Achievement monitored by RO/SCR (new measure)

Standard 3 - Intermediate care		
Date	**Milestone**	**Performance Measure**
July 2001	Local health and social care systems to have designated a jointly appointed intermediate care co-ordinator in at least each health authority area; to have agreed the framework for patient/user and carer involvement; and to have completed the baseline mapping exercise.	Achievements monitored by RO/SCR (new measure)
January 2002	Local health and social care systems to have agreed the joint investment plan for 2002/03.	

Standard 3 - Intermediate care		
Date	**Milestone**	**Performance Measure**
March 2002	At least 1,500 additional intermediate care beds compared with the 1999/2000 baseline. At least 40,000 additional people receiving intermediate care services which promote rehabilitation and supported discharge compared with the 1999/2000 baseline. At least 20,000 additional people receiving intermediate care which prevents unnecessary hospital admission compared with the 1999/2000 baseline.	Number of people referred to non-residential intermediate care teams: 6103 To prevent inappropriate hospital admission 6104 To facilitate timely hospital discharge and/or effective rehabilitation Number of people referred to/receiving intermediate care in a residential setting ('Rapid Response'/Supported Discharge): 6101 To prevent inappropriate hospital admission 6102 To facilitate timely hospital discharge and/or effective rehabilitation Intermediate Care Beds: 6157 Numbers of intermediate care beds Expenditure on Intermediate Care: 6106 Total Expenditure on intermediate care (£1,000s) 'Places' in non-residential Intermediate Care schemes: 6105 Number of "places" in non-residential intermediate care schemes Social services' support for intermediate care is indicated by: - Households receiving intensive home care per 1000 population aged 65 or over - Older people helped to live at home per 1000 population aged 65 or over These are both Best Value/PSS PAF indicators. **In addition, the performance measures for Standard 2 will indicate progress on this standard.**
March 2004	At least 5,000 additional intermediate care beds and 1700 non-residential intermediate care places compared with the 1999/2000 baseline. At least 150,000 additional people receiving intermediate care services which promote rehabilitation and supported discharge compared with the 1999/2000 baseline. At least 70,000 additional people receiving intermediate care which prevents unnecessary hospital admission compared with the 1999/2000 baseline.	

Standard 4 – General hospital care		
Date	**Milestone**	**Performance Measure**
April 2002	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.	Achievement monitored by RO (new measure).
	All general hospitals will have developed a nursing structure which clearly identifies nursing leaders with responsibility for Older People. Consideration will have been given to Nurse Specialist/ Nurse Consultant and Clinical Leaders (Modern Matrons).	
April 2003	All general hospitals which care for older people to 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.	Achievement monitored by RO (new measure).
		In addition, the performance measures for Standard 2 will indicate progress on this standard

Standard 5 – Stroke		
Date	**Milestone**	**Performance Measure**
April 2002	Every general hospital which cares for people with stroke will have plans to introduce a specialised stroke service as described in the Stroke Service Model from 2004.	Achievements monitored by RO (new measure). **Collective outcome measures** Collectively over time the milestones for stroke will reduce: • mortality from stroke (ONS) • incidence of stroke (new measure; HES data available but would need analysing) • prevalence of inadequately treated high blood pressure
April 2003	Every hospital which cares for people with stroke will have established clinical audit systems to ensure delivery of the Royal College of Physicians clinical guidelines for stroke care.	
April 2004	PCGTs will have ensured that: • every general practice, using protocols agreed with local specialist services, can identify and treat patients identified as being at risk of a stroke because of high blood pressure, atrial fibrillation or other risk factors • every general practice is using a protocol agreed with local specialist services for the rapid referral and management of those with transient ischaemic attack (TIA) • every general practice can identify people who have had a stroke and are treating them according to protocols agreed with local specialist services • every general practice has established clinical audit systems for stroke 100% of all general hospitals which care for people with stroke to have a specialised stroke service as described in the Stroke Service Model.	

Standard 6 – Falls		
Date	**Milestone**	**Performance Measure**
April 2003	Local health care providers (health, social services and the independent sector) should have audited their procedures and put in place risk management procedures to reduce the risk of older people falling.	Achievements monitored by RC (new measure). **Collective outcome measures** Collectively over time the milestones for falls will reduce: - incidence of fractured femur (new measure; HES data available but would need analysing). - deaths following fractured femur (ONS). - avoidable harm through falls or hypothermia (PSS PAF).
April 2004	The HimP, and other relevant local plans developed with local authority and independent sector partners, should include the development of an integrated falls service.	
April 2005	All local health and social care systems should have established this service.	

Standard 7 Mental Health in older people		
Date	**Milestone**	**Performance Measure**
April 2004	HImPs and other relevant local plans developed with local authority and independent sector partners, should have included the development of an integrated mental health service for older people, including mental health promotion.	Achievements monitored by RO/SCR (new measure) **In addition the performance measures for Standard 3 about reducing premature admission to long-term care will indicate progress in this area.**
	PCGITs will have ensured that every general practice is using a protocol agreed with local specialist services, health and social services, to diagnose, treat and care for patients with depression or dementia. Health and social care systems should have agreed protocols in place for the care and management of older people with mental health problems.	

Standard 8 – The promotion of health and active life in older age		
Date	**Milestone**	**Performance Measure**
April 2003	HImPs, SAFFs and other relevant local plans should have included a programme to promote healthy ageing and to prevent disease in older people. They should reflect complementary programmes to prevent cancer and CHD and to promote mental health, as well as the continuation of flu immunisation. Plans should also include action specific to older people, utilising the range of local resources, including those within regeneration programmes and reflecting wider partnership working. Local health systems should be able to demonstrate year on year improvements in measures of health and well being among older people: • flu immunisation • smoking cessation • blood pressure management	Inclusion monitored by RO (new measure). Flu immunisation rate in people aged 65+. Numbers of excess winter deaths (ONS) Smoking cessation rates in people aged 60+. Blood pressure • high blood pressure detected • high blood pressure effectively treated in people aged 65+ **Collective outcome measure** Healthy Life Expectancy index under development.