as the ‘geriatric giants’: functions that require integration of higher order cortical processing, such as staying upright, maintaining balance and walking, are more likely to fail, resulting in falls or delirium. It therefore seems particularly worthwhile to measure mobility and balance as a means of knowing whether acutely ill older people who are frail are recovering from their illness or becoming more ill.

Finally, we must do our field justice. This comes from understanding our speciality as the intellectually challenging and personally rewarding field of human endeavour that it is.

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The main relevant standard in the National Service Framework is standard 4: General hospital care [3]. The standard states ‘older people’s care in hospital is delivered through appropriate specialist care and by hospital staff who have the right set of skills to meet their needs’. Key interventions were to occur at various stages on an older person’s hospital stay: emergency response, early assessment, ongoing care in medical and surgical wards, old age specialist care and discharge planning. It states that all ward staff should be competent in the care of older people, and planning for discharge for emergency admissions should start as soon as possible during the hospital stay.

Apart from standard 4, other standards such as standard 1 on rooting out age discrimination, standard 2 on patient-centred care, and standards 5 and 6 on stroke and falls should all have significant impact on the acute hospital care of older people.

A commentary published shortly after the publication of the NSF stated that the assertions and aspirations of the NSF for Older People were broad and ambitious opportunities to be grasped but warned about risks in implementation [4]. These included resources, especially workforce. Costing was left to local negotiation and with the exception of Intermediate Care, there was no ring-fenced funding in the same way that the NSF for cardiology and the national implementation of cancer standards had dedicated funds. For example, recruitment of extra therapist staff was left to the vagaries of local power and politics. Concern was also raised about responsibility and, in particular, the lack of hard edge targets. Instead the NSF had many ‘milestones’ without an absolute requirement for implementation.

A report on progress and future challenges of the National Service Framework for Older People was published by the Department of Health in 2003 [5]. There is no doubt that in some areas progress is being made, particularly in eradicating ageism and in improving stroke care. Direct ageism, where policies deliberately specify age limits, have mostly disappeared from the Health Service [6]. Indirect ageism, changing the culture and capturing hearts and minds, takes much longer but there is evidence that change is occurring, for example the 65% increase in coronary artery by-pass grafts in patients aged over 85 years. Stroke care was supported by a clear evidence-based statement and has been driven nationally by geriatricians’ voluntary involvement in the ‘Sentinel Audits of Stroke’ programme, run by the CEEU of the Royal College of Physicians [7]. While there is still a long way to go to ensure that all patients receive in-patient specialist stroke care, the number of specialist stroke units has increased over 4 years from 45 to 73%

In this copy of Age and Ageing, Hubbard et al. [8], report a 1 day comprehensive census of the multi-disciplinary needs of an entire inpatient population, compared with available multi-disciplinary therapy time. Although performed in a South Wales hospital, there is no reason to think this is significantly different from any large district general hospital in England. Across 54 wards for adult patients, they found 1,324 patients, of whom 67% had multi-disciplinary needs. This included 61% of all the patients on acute wards and 85% of the rehabilitation patients. On the acute ward the total therapy time available per patient with needs was just under 18 min of physiotherapy and 7.5 min of occupational therapy. In the rehabilitation setting there was 26.5 min of physiotherapy time for patients with needs and 20.5 min of occupational therapy time. Not surprisingly, the authors state that there is insufficient therapy time to provide for all those assessed as having needs as well as describing the difficulty of acting effectively as a geriatrician. They find it impossible directly to provide care for all older people admitted to their hospital, particularly with the patients and their needs spread over so many wards.

The authors describe a dilemma familiar to many geriatric services in the UK. They feel that their services are being pulled in three directions at once. Firstly, to deliver specialist geriatric services to the most frail in an effective multi-disciplinary environment where comprehensive geriatric assessment is most effective [9]. This includes the development of evidence-based specialist services for stroke and falls. Secondly, to provide a comprehensive response, including geriatric input and assessment, to the tidal wave of emergencies that are being admitted every day through A&E. Thirdly, attempting to deliver some specialist input into the community, including intermediate care. Trying to balance all these three possibilities is a very difficult task and many services feel that they can only deliver one or two of these three at any one time, which leads to feelings of frustration or even failure, when people know that they could do so much more with the right resources and infrastructure.

Providing good quality co-ordinated care remains a day-to-day struggle. Is there a way forward? There does appear to be a realization that getting it right for older people means getting it right for all. Inadequacies of care and rehabilitation services cause inefficient and expensive care. The Government is slowly waking up to comparisons with some of the managed care programmes in the USA [10]. Making progress will need action in many areas. We will need extra geriatricians but numbers will not significantly increase for at least 5 years, until the new National Training Numbers start to come through. We do need to maximize the ‘division of labour’, to including GPs with a specialist interest, consultant nurses and hopefully an increasing number of therapists in providing comprehensive services. The principles behind chronic disease management have a lot to offer the care of the most frail elderly. Wider use of nurse specialists to case management of the most complex problems within the community may help reduce the number of patients re-attending hospital [11]. We need to argue continually for a bed occupancy of 85% or less, to allow for rational organization of in-patient services [12]. However, in the same way the NSF is a 10 year plan, this is a direction of travel rather than an instant panacea.

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Who is losing the language? Persistent pain in home-dwelling elders

One of the less pleasant things about ageing is the increasing likelihood of painful degenerative diseases. About 60–71% of community-dwelling older people report feeling pain somewhere, with over 33% reporting daily persistent pain [1, 2]. The prevalence of persistent pain is even higher for residents of institutions [3]. This is substantial morbidity, interfering with activities of daily living, inducing depression and reducing quality of life. Up to the 1990s, there was very little scientific interest in persistent pain in older people [4], but our awareness of the problem has improved dramatically in the last decade. A focus for many studies has been the prevalence of pain and its management in residents of nursing homes. These studies found, almost universally, that professional staff have a low rate of awareness of pain and often fail to detect it, even in residents who are capable of reporting pain [3]. But, what about home-dwelling elderly people? We assume that these elders are less disabled than those needing supervised care, more likely to report a pain problem and to seek help for it. Yet studies from Canada, France, United States, China and Finland all tell a similar story to that found in nursing homes, that there is a high prevalence of daily pain in community-dwelling elders but a much lower rate of prescribed analgesics than expected [5]. However, few studies have looked at the prevalence and treatment of pain in home-dwelling people with dementia. Shedding more light on this aspect is a new study by Mäntyselkä and colleagues in this issue of *Age and Ageing* [6]. Although the authors found a similar rate of potentially painful conditions in both cognitively intact and demented subjects, pain complaints and analgesic use by the subjects with dementia was much less. The study adds more substance to the growing evidence that persistent pain in older people is under-reported, under-detected and under-treated, in the community as well as in institutions, and that this is particularly true for people with dementia.

If persistent pain can be expected in older people, then why is it so neglected? One way or another, significant dialogue about pain between health professionals and elders, the key to good pain management, still seems to be wanting. The literature points to three ‘P’s in this pod–professionals, patients and pathology.