

## Age & Health Guidance

Active ageing is the process of optimising opportunities for health, participation and security in order to enhance quality of life as people age<sup>1</sup>

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## Foreword

NHS Scotland is committed to tackling discrimination to encourage equality of opportunity to issues of age.

Evidence suggests that this continues to present challenges to the NHS. Fair for All - Age seeks to address this in relation to age and to offer guidance to the NHS in Scotland.

All our citizens deserve their health needs to be met appropriately and to be treated with dignity, respect and as individuals as they progress through their journey of care. If we get it right for our younger and our older people I believe that we will get it right for everyone as the habit of good practice will become embedded into the culture of our health services and in the practice of our professional carers. To achieve this we need to continue to work in partnership with younger and older people. We must listen to their stories and their views and learn from them.

We must make it easy for them to influence the shape of health services that promote healthy lifestyles and good quality of health care when this is required. We must encourage them to praise and criticise as they wish and to ensure that such comments are received positively without judgement, defensiveness or detriment to treatment or access but are welcomed as a means to getting things right and better for all.

I commend the guidance to you and hope that it helps the NHS in Scotland to address the whole issue of ageism positively and successfully.

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December 2007

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# 1. Introduction

This guidance has been developed by Fair for All – Age to provide information that will be helpful to national and territorial NHS Scotland health boards to:

- ❑ Understand aspects of age equality;
- ❑ Achieve outcomes and improvements in the way services and functions are delivered in relation to age;
- ❑ Understand board responsibilities as they relate to age equality and human rights.

Age is a broad equality area and has implications for all people. Research indicates that younger and older people experience particular barriers in access, attitudes and treatment. It is their experience that forms the focus of this guidance and service development for NHS Scotland.

## 1.1 Fair for all the wider challenge

Fair For All – Age is a partnership project between Fast Forward Positive Lifestyles Ltd and the Scottish Government's Health & Wellbeing Fair for All initiative. Fair For All – Age complements the existing Fair for All work supporting health boards in the development of equality practice. Fair For All - Age works alongside the additional strands of:

- ❑ Disability
- ❑ Gender
- ❑ Race
- ❑ Religion and Belief
- ❑ Sexual Orientation

**Equality** - is about creating a fairer society where everyone can participate and has the opportunity to fulfil their potential. It is mostly backed by legislation designed to address unfair discrimination and resulting inequalities based on membership of a particular group.

**Diversity** - the recognition and valuing of difference in its broadest sense. It is about creating a culture and practices that recognise, respect, value and harness difference for the benefit of patients, carers, members of the public and members of staff.





## 1.2 Equality and diversity is core business

‘Good health is more than not being ill. It is the need to improve, physical, mental and social well-being, fitness and quality of life.’<sup>2</sup>

Within NHS Scotland to achieve the vision of improved health for all people, one of the tasks, as outlined in Our National Health: A Plan for Action, a Plan for Change (SEHD: 2000) states: “We want to work with the NHS to ensure that a patient focus is embedded in the culture. To make this happen we will ensure that listening, understanding and acting on the views of local communities, patients and carers is given the same priority as clinical standards and financial performance.”

In 2007 Better Health Better Care- a discussion document sets out: ‘We are determined to put the needs of patients at the centre of our health service. We believe that we can do more to ensure openness and accountability and learn from patient experiences, good and bad, in improving the way we design and deliver services. Patient and carer involvement and community engagement in services must be a central feature of service provision.’

The challenge as outlined by Dr Kevin Woods, Director

General, Health & Wellbeing, Scottish Government and Chief Executive of NHS Scotland is: “To ensure that delivering patient services that are fair for all is more than a bureaucratic process of developing Equality Schemes: to effect real change, equity and equality must be at the heart of our service, embedded in, for example, our clinical priorities of cancer, coronary heart disease and mental health and in our health improvement agenda.”

The White Paper, Partnership for Care commits us to ‘extending the principles set out in Fair for All’. This commitment for an integrated equality and diversity approach, closely linked with Patient Focus Public Involvement, aims to ensure accessible, appropriate and non-discriminatory services. That is, services that are responsive to individual need; ensuring that our health services recognise and respond sensitively to the individual needs, background and circumstances of people’s lives.’

Commitment to this approach is set out in individual health

board equality schemes for race, gender and disability which demonstrate the actions being pursued to make a positive difference to patients. To complement the public duties, boards are also embedding an equality and diversity approach in corporate functions and board governance arrangements. This will increasingly be a focus for NHS Scotland equality work with its Diversity Task Force<sup>3</sup> assuring progress. The Scottish Health Council<sup>4</sup> also has a role to monitor equality work in its annual assessment process. Boards must ensure that age is included in this and other assessment arrangements as appropriate.

**In line with NHS Scotland policy it is incumbent upon all boards to improve service delivery and health outcomes to patients on all grounds, including age.** Getting it wrong may detrimentally affect the health of younger and older people as well as result in expensive legal challenges and lack of confidence in health services.



## 1.3 Current practice

A scoping questionnaire issued to NHS boards by Fair for All Age in 2006/7 demonstrated significant activity by boards to provide services to younger and older people in ways which meet their needs.

Equality and diversity practice is NHS Scotland's core business and is one in which health boards are increasingly proficient. This approach is underpinned by the NHS Reform (Scotland) Act 2004 which sets out health board roles to promote equality of opportunity and to involve service users in the services that affect them.

To ensure health services not only meet need appropriately, but treat people with dignity and respect<sup>5</sup>, boards must understand ageism and its impact, ageist practice and involve and listen to younger and older people in the design and delivery of services.



Currently there is no legislative regulation or 'duty' on age which requires boards to demonstrate action to promote age equality in the provision of goods, services or facilities.

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## 1.4 Who is the guidance for?

This guidance sets out how boards can extend established good practice to age. It is anticipated that for NHS Scotland this means going beyond the minimum thresholds set by legislation and policy.

NHS Scotland aims to lead the drive for more robust systems and processes and aspire for outcomes that go beyond the satisfactory for patients and staff.

This guidance provides an overview of age policy and legislation for health boards. It sets out age equality, health statistics and examples of practice to illustrate the very real difference developing age appropriate services can make to younger and older people's health. As the legislative landscape changes, including the prospect of the Single Equality Act, existing Fair for All support and guidance will change and develop in response. The development of an Equalities and Planning Directorate within NHS Health Scotland will support the development of this aspect of equality work from March 2008.

**It is relevant to all NHS staff who provide health care to older and younger people regardless of the setting, and includes Chief Executives, Policy Makers, Commissioners, HR Departments, Workforce Planners, Service Designers, Patient Focus and Public Involvement Designated Directors and all staff who deliver local services and shape patient experience.**

## 2. Age and health

The NHS Reform (Scotland) Act 2004<sup>6</sup> extends a duty to encourage equality of opportunity to all, including on the grounds of age. It acknowledges that there are specific issues relating to age that impact on prevention, diagnosis, treatment and care of patients.

Age is commonly understood to refer to older people; however NHS Scotland takes into account a spectrum of need across all ages. In particular, the specific barriers, discrimination and health needs identified in both research and conversation with, younger and older people.

Learning about and recognising age equality and discrimination enables boards to begin to understand the issues that prevent people using services or experience inappropriate services because of their age. Doing so enables boards to:

- ❑ Design and deliver effective services; and
- ❑ Allocate resources effectively; resulting in improved health and quality of life for younger and older people.

However, age equality is not just about eliminating discrimination; it means delivering equitable outcomes for people with different needs at different stages in

life. A one size fits all service aiming for 'uniformity and standardisation, so that much the same service is available to everyone'<sup>7</sup> is not sufficient. It is evident that this approach cannot adequately keep people healthy; providing the same service, in the same way to everyone ignores difference and cannot meet differing needs.

For example, older people are the main users of many health services but they may not be designed with older people's needs in mind. A traditional service designed around isolated episodes of care within well defined specialities and agencies cannot fully meet the needs of the increasing numbers of older patients<sup>8</sup>.

Health services have considerable experience in providing high quality services to younger and older people; however this does not necessarily mean that needs are being met or services delivered appropriately. Research undertaken by the Kings Fund identified that

three out of four senior health managers in England believed age discrimination existed in their local services. This they attributed to a history of 'old habits' to tackle custom and practice which had evolved rather than being planned, and a legacy of ageism in society and welfare provision<sup>9</sup>.

It can be assumed that this is also true of Scotland's health services, an assertion supported by 'The External Reference Group for Older Peoples Services 2006' (Jarvie Report), service user testimony and key age organisations advocating and working with and for younger and older people.

**By listening to younger and older people's experience we can begin to acknowledge our own attitudes or practices which may be discriminatory or understand where we make assumptions regarding the care, treatment and services required.**



## 2.1

# Demographics and statistics

Scotland's population is changing; people are living longer and the birth rate is low.

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In 1900, the average Scottish life expectancy was 40; in 2004, it was just over 74 years for men and just over 79 years for women.

In 2006 about a quarter of Scotland's population was recorded as being under 19 years old; however young people from the European accession states working in Scotland are changing this trend.

This change in life expectancy marks our success in improving general health. This trend has implications for service planning to meet the health needs of an increasing older population with a declining workforce and to continue to be responsive to their needs.

In Scotland, it is anticipated that by 2031 the number of people over 65 years will increase to over one million, and will be approximately one in five of the population. The number of people aged 50+ is projected to rise by 28% and the number of people aged 75+ is projected to increase by 75%.<sup>10</sup>

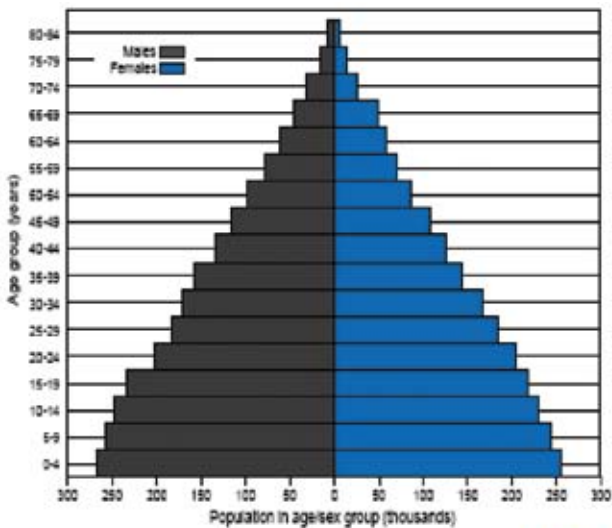
Those over 85 years will increase to approximately 150,000 and whilst getting older is not in itself an illness; on average older people are in good general health; over seventy fives in particular have higher dependency and more complex needs with a prevalence of illness and disability rising steeply over the age of 80. Though older people comprise around 16% of the total UK population over 40% of healthcare resources support their health needs<sup>11</sup>.

Life expectancy continues to increase although there are significant regional differences. People are living longer; however, many are living with a limiting long term illness<sup>12</sup> which increases significantly for those over 85 years. A boy born in 2006 could expect to live for 74.8 years and a girl for 79.7 years - increasing from 69.1 and 75.4 for those born in 1981<sup>13</sup>.

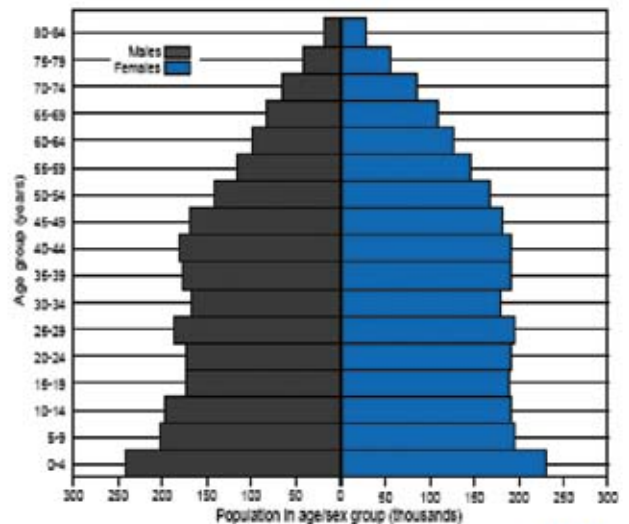


The four graphs illustrate the changing UK population profiles from 1911 to 2031. They indicate a decline in the UK's younger population and a rise in the older population; with slight gender distinctions.

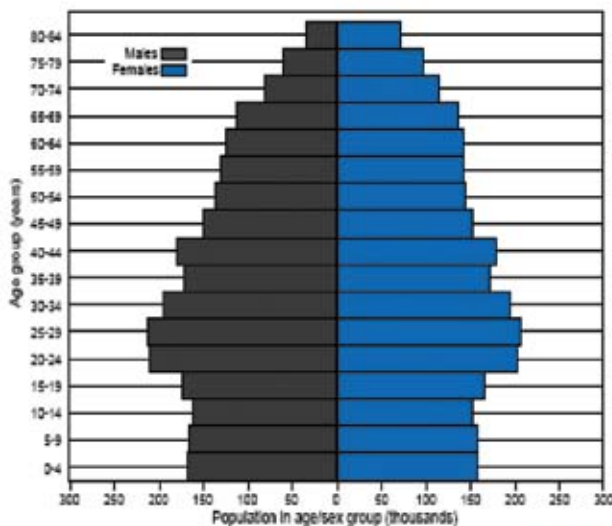
Taken from the General Registrar of Scotland demography paper 2007 developed to inform 'All Our Futures-Planning For An Ageing Population Strategy'



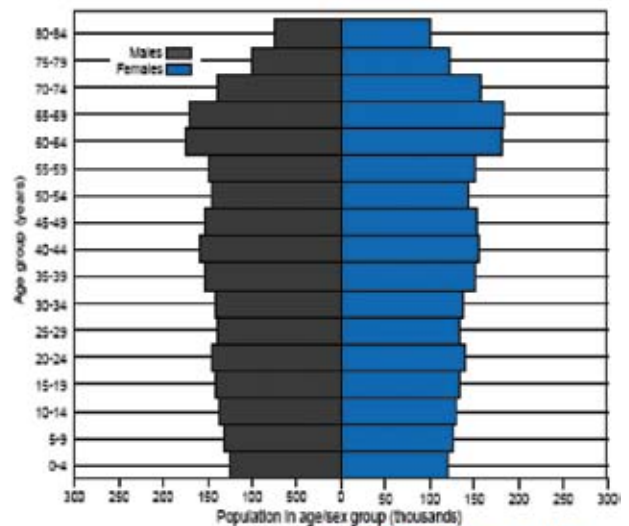
1911



1951



1991



Projection to 2031

## Teamwork makes the difference



NHS Greater Glasgow and Clyde (NHSGG&C) is ensuring that children, young people and families are at the centre of the planning for their new children's hospital.

To find out how they would like to be involved their Community Engagement team spent four months meeting families, children, young people, support groups and voluntary organisations. These meetings ascertained views and ideas for the new hospital and its services, how they could help the NHS design the building and how they would like to be kept informed.

Three groups were set up to oversee ongoing community engagement with families, children and young people. These included a youth panel to make sure the issues, needs and hopes of young people are included in the design of the new hospital.

A graphic illustrator worked with some young patients at Yorkhill to capture their ideas on the development of the new hospital in the form of a colourful poster.

Other methods included:

- ❑ Regular meetings of the three groups supported by surveys, discussion groups, on-line surveys, newsletters, a website, work in schools and youth work to extend consultation and involvement to as many people as possible.

- ❑ Discussion groups with planners and architects helped families, children and young people learn about how to plan a hospital and taught the planners and architects what it is like to be in a children's hospital.
- ❑ Art, juggling, drumming, radio lollipop and football have all been useful to encourage children and young people to get engaged and express their ideas.
- ❑ Children and young people have taken photographs of the things they like about Yorkhill and the things they don't.
- ❑ Talking walls give younger children the chance to draw pictures of the new hospital and the things that are important to them.
- ❑ The youth panel have visited Aberdeen hospital and the Royal London Children's Hospital to see how good design can help improve the experience of young people in hospital.

Over 150 groups and individuals got in touch to help shape the community engagement approach. This was presented in a report and described how NHSGG&C will engage over the next five years to deliver the best possible hospital for children and young people.



## Youth Internet Access

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The Western Isles Patient & Carers Information Project (WIPCIP) was established to provide accurate and appropriate health information to vulnerable groups and in particular those with mental health problems and their carers in the Western Isles, whilst addressing the requirements of the Patient Focus Public Involvement (PFPI) initiative.

The group comprised of representatives from NHS Western Isles and the voluntary sector; funding was obtained from Volunteer Development Scotland to match local funding. WIPCIP is establishing health information sites using a total of six computers which will be located within larger community areas. It is aimed at national and local priority groups such as children, older people and those experiencing mental health problems, and priority conditions (chest, heart, stroke and cancer),

Volunteers have been recruited and provided with specific training designed in consultation with primary care staff, other health professionals and computer services staff, they will then be located at each of the six sites. A part-time worker was also employed in 2003 to co-ordinate the project.

The project has drawn together existing information from the internet; NHS Western Isles staff materials and other Scottish Health Board material into a health information point (HI project). The 'Intouch with Health' system

aimed at enabling health organisations meet patient information requirements, has been particularly helpful.

Computers purchased through the Dialogue Youth Project co-ordinated by Community Education, are currently being set up in Western Isles youth clubs and the HI Project is increasingly available at local venues. The project helps address the difficulties of rural access, confidentiality and anonymity for young people.

Once set up and connected to the Internet the HI Project will place a direct link on each machine and deliver training on use.

Although the computers are initially for young people, other local groups and individuals, may negotiate access at appropriate times - for example during the school day.

The HI Project, is a partnership between the Western Isles Patient & Carers Information Project (WIPCIP), Intouch with Health Ltd, and Blue Chip Data Systems



The table shows the 2001 census results for each health board area which captures the local age profiles from 0-25 years and 60 years and above.

National statistical trends will impact differently across Scotland; currently rural areas generally indicate a higher older population and urban areas a higher younger one. Trends are helpful as a general indicator of service need

and boards should know their current local profiles to support effective planning and resource allocation. This may require further analysis to particular geographical or housing areas to understand specific barriers and concerns.

Area	All people	0-4	5-7	8-9	10-14	15	16-17	18-19	20-24	60-64	65-74	75-84	85-89	90 +
Scotland	5062011	5.47	3.54	2.53	6.38	1.29	2.50	2.48	6.21	5.17	8.81	5.34	1.17	0.58
Argyll & Clyde	420491	5.41	3.57	2.56	6.57	1.33	2.59	2.30	5.42	5.49	9.08	5.29	1.17	0.56
Ayrshire & Arran	368149	5.21	3.58	2.60	6.69	1.33	2.56	2.23	5.15	5.61	9.42	5.74	1.25	0.60
Borders	106764	5.16	3.59	2.60	6.30	1.24	2.32	1.71	4.19	5.82	10.01	6.57	1.55	0.74
Dumfries & Galloway	147765	5.05	3.61	2.48	6.44	1.27	2.49	1.82	4.19	6.16	10.71	6.41	1.37	0.68
Fife	349429	5.50	3.61	2.54	6.65	1.34	2.53	2.49	5.96	5.14	8.77	5.63	1.26	0.57
Forth Valley	279480	5.68	3.62	2.64	6.46	1.29	2.48	2.54	6.07	5.31	8.51	5.15	1.11	0.52
Grampian	525936	5.36	3.51	2.53	6.32	1.29	2.45	2.54	6.56	4.82	8.26	5.03	1.11	0.59
Greater Glasgow	867150	5.53	3.47	2.51	6.27	1.29	2.51	2.82	7.20	4.90	8.80	5.29	1.14	0.56
Highland	208914	5.44	3.63	2.62	6.60	1.33	2.62	1.85	4.78	5.66	9.30	5.45	1.23	0.61
Lanarkshire	552819	5.85	3.71	2.64	6.63	1.35	2.74	2.55	5.81	5.21	8.42	4.60	0.89	0.42
Lothian	778367	5.55	3.44	2.42	5.91	1.18	2.25	2.65	7.43	4.67	8.01	5.06	1.14	0.57
Orkney	19245	5.11	3.69	2.63	7.12	1.39	2.65	1.71	4.14	6.02	8.97	5.65	1.45	0.65
Shetland	21988	6.04	3.97	3.01	7.47	1.41	2.66	1.86	5.42	4.79	7.32	4.93	1.21	0.58
Tayside	389012	5.20	3.34	2.42	6.21	1.27	2.57	2.45	6.20	5.46	9.79	6.17	1.41	0.73
Western Isles	26502	4.88	3.40	2.45	6.74	1.41	2.48	1.65	4.36	6.16	10.17	6.94	1.68	1.00

## 2.2 Health information

Information and statistics on age and health are well documented, for example it is known that:

- ❑ **Cancer, heart disease and stroke, respiratory disease and injuries account for over 80% of all deaths in people aged 65 years and over.**<sup>14</sup>
- ❑ Coronary heart disease (CHD) remains the leading cause of death in the United Kingdom. One in four people die from CHD, 50 per cent of whom are over 65 years old. More than 40 per cent of older people have some degree of disability or impaired functioning as a result of CHD.<sup>15</sup>
- ❑ **Health problems caused by alcohol use disorders are often under detected and misdiagnosed among older people.**<sup>16</sup>
- ❑ Coronary heart disease is higher amongst men, older people and those living in deprived areas of Scotland, and that 80% of breast cancer occurs in women over 50 years old.<sup>17</sup>
- ❑ **Every five hours an older person dies as a result of an accidental fall in the home.**<sup>18</sup>
- ❑ Last winter more than 25,000 people over 65 died from cold-related illnesses.<sup>19</sup>
- ❑ **Mental health is an increasingly important issue and affects many people in later life; one in seven of those 65 years and over live with 'major' depression which disrupts day to day functioning**<sup>20</sup> **and over 700,000 have dementia.**<sup>21</sup> **People experiencing dementia is expected to double to 1.5 million by 2031.**<sup>22</sup>
- ❑ Older people are the largest per capita users of medication. Lack of overall knowledge of what medicines and treatments a patient is receiving is an important explanation of drug problems.<sup>23</sup> E.g. valium misdiagnosis.
- ❑ **For young men (15-34) the main cause of death is suicide. This is six times higher for gay and bi-sexual men.**<sup>24</sup> **This includes intentional self harm and undetermined death, followed by accidents and mental disorders usually associated with drug and alcohol abuse. For young women suicide and cancer is also significant.**<sup>25</sup>
- ❑ Current estimates suggest that 40-60,000 children in Scotland have a drug abusing parent and up to 100,000 are affected by parental alcohol misuse.<sup>26</sup>
- ❑ **At any one time about 10% of young people under 19 years old will have mental health problems severe enough to interfere with their daily lives.**<sup>27</sup>
- ❑ 11,000 children are looked after and accommodated by Local Authorities. Within this already disadvantaged group over 40% have emotional or mental health problems.<sup>28</sup>
- ❑ **The number of children in Scotland developing cancer each year has increased by over 20% between 1975-79 and 1995-99.**<sup>29</sup>
- ❑ The incidence of Type 1 (insulin dependent) diabetes in children has trebled in the last 30 years. Scotland now has one of the highest rates in the world for this condition.<sup>30</sup>
- ❑ **In the most recent Scottish Health Survey 5% of children reported having smoked in the previous week, increasing from 2% at age 12 to 29% at age 15.**<sup>31</sup>

## 2.3 Defining age

This section illustrates some of the key issues affecting younger and older people and their access to appropriate health services.



In planning services it is necessary to acknowledge the differences that age brings. Age responsive services support the development of young people and the independence and maintenance of good health and care of older people.

Scottish Government policy applies age definitions outlined by the World Health Organisation (WHO) and United Nations Human Rights criteria. WHO defines a younger person as one under the age of 18 years and an older person over 60 years of age. The recently published Scottish Executive, *All Our Futures-Planning for a Scotland with an Ageing Population 2007*, cites older age starting at 50 years.

'This age is chosen not because it marks the start of "old age" or because we think all people over this age are somehow similar, but because for many it is a point at which life circumstances start to change in ways that have implications for the future.'

Youth organisations and the Scottish Youth Parliament define young people as under 25 years recognising the diversity of lifestyle, needs and social context of young people as they mature.

Age is multifaceted; it can be defined by chronology; biology; psychology; functionality and socially, with overlap and blurring between the areas. The impact of gender and location are factors that influence ageing. For example a 50

year old woman living in a disadvantaged area may exhibit health symptoms associated with a much older age, the impact of lifestyle and poverty being well documented. Consequently assumptions about illness and ageing may result in symptoms being misdiagnosed and service parameters questioned.

Concepts of age and ageing vary across different cultures too and have implications for the ways in which people from different cultures view ageing and expectations for health. For example Chinese people have a different understanding of childhood; the higher mortality rate amongst Gypsy Travellers will influence their understanding of 'old age' as well as the onset of 'old age' medically; and diabetes is considered a 'normal' part of ageing for those from South Asian communities.

Younger and older people come from a variety of backgrounds including different abilities and impairments, and religious needs for example. This has implications for the design of services which need to take into account these differing needs, as well as the needs of different age groups. For example the information needs of 11-13 year olds may be different to those of a 16-18 year old and as we live longer, older age is extending; the health needs and expectations of a 50 year old may be significantly different to someone in their nineties.

Boards will need to understand these aspects to provide services appropriately.

Age equality means securing the equal participation in society of people of every age, based on respect for the dignity and value of each individual. It aspires to achieve equality in citizenship, access to opportunities and outcomes, as well as respect for differences related to age. Source: Age Concern England

Older people are not a uniform group and they have a wide range of needs. They may be broadly seen as three groups but these groupings should not be used to make assumptions of need or ability:

- **Entering old age** These are people who have completed their career in paid employment and/or child rearing. This is a socially-constructed definition of old age, which, according to different interpretations, includes people as young as 50, or from the official retirement age. These people are active and independent and many remain so into late old age.
- **Transitional phase** This group of older people are in transition between healthy, active life and frailty. This transition often occurs in the seventh or eighth decades but can occur at any stage of older age. The goals of health and social care policy are to identify emerging problems ahead of crisis, and ensure effective responses which will prevent crisis and reduce long-term dependency.
- **'Frail' Older People** are vulnerable as a result of health problems such as stroke or dementia, social care needs or a combination of both. 'Frailty' is often experienced only in late old age, so services for older people should be designed with their needs in mind.<sup>32</sup>

'Older people' constitute a very diverse group. Many older people lead active and healthy lives, while some much younger 'older people' have a poorer quality of life. People age in unique ways, depending on a large variety of factors, including their gender, ethnic and cultural backgrounds. Climate, geographical location, family size, life skills and experience are all factors that make people less and less alike as they advance in age. Individual variations in biological characteristics (e.g. blood pressure or physical strength) tend to be greater between older people than between young ones: the characteristics of two ten-year-olds would be more similar than those of two eighty year-olds. Such diversity leads to considerable difficulties in interpreting results from scientific studies on ageing, which are often conducted on particular, well defined groups of older people: the findings may not apply to a large proportion, or even the majority of older people'.<sup>33</sup>

## Braveheart project



The Braveheart project is a demonstration project as part of Ageing Well UK work; based at Falkirk & District Royal Infirmary (F&DRI), Central Scotland. (Ageing Well UK is a national health promotion programme established in 1994 to improve and maintain the health of older people through building local and national health alliances. It aims to achieve measurable health gains by encouraging healthier lifestyles and enabling earlier diagnosis and treatment).

Braveheart involved a randomised controlled study of people over 60 who attended hospital with angina or after a heart attack to encourage themselves to better health. Participants attended a series of mentor-led support groups for a year. The mentors were individuals who, after a process of assessment and training, worked in pairs to mentor the groups. This gave a unique insight into the challenges and issues of the members.

A volunteer mentor says, in the past 'We would have talks from various professionals on aspects of rehabilitation, but they were like lectures - the professionals were saying 'you shall do this and you mustn't do that'. We weren't given options on lifestyle changes, and we weren't enabled to arrive at our own decisions on how we would go forward. It didn't feel like a partnership at all,' Senior Health Mentor.

But the experience in Braveheart was very different. 'All of a sudden the professionals weren't telling me what to do - they were giving me information, encouraging and enthusing me, and letting me see the options I had. They were treating me as an equal partner in the arrangement.'

Health professionals in the project were also aware of the importance of partnership and the effect it was having on their working practices. 'It has emphasised that we can only achieve things in

partnership with patients,' he says. 'You can't change people's lifestyles by laying down the law and wagging the finger' Dr Peter Murdoch

The Braveheart project will be extended into the Forth Valley Primary Care service.

## 2.4 What is age discrimination?

Age discrimination particularly affects younger and older people but is relevant to us all.

‘Unlike race or gender, age does not define a discrete group. We have all been young, and we will all, if we are fortunate become old. Thus the basic opposition between ‘self’ and ‘other’ which marks much of the racism and sexism is not present in the same way. Yet detrimental treatment on grounds of age is widespread. Older people in particular, are subject to stigma, prejudice and social exclusion. The very old are too often also the poorest in society, and some are vulnerable to abuse<sup>34</sup>.

Discrimination is often difficult to see; poor treatment can be subtle. It can include bad attitudes or treatment that can just be considered rude, thoughtless or just a fact of life, particularly by older people. If older or younger people are treated less favourably or unequally because they have been labelled old or young, this is age discrimination.

### Discrimination arises either because:

- ❑ difference is ignored and therefore people’s needs are not met;

- ❑ difference is recognised but forms the basis of unfavourable treatment, or
- ❑ difference is recognised but fixed into a stereotypical view that does not equate with reality and therefore means that genuine difference is not taken into account.

Within health services, age discrimination may not be considered. Specific services have traditionally been directed at older people and children, delivering care and support to specific life stages and development. This approach may result in the subtle nuances of unequal or inappropriate services not being considered or an assumption that as a service is in place it is meeting need appropriately.

Addressing age equality requires that: ‘Age is not used to define or make assumptions about the role, value or potential of an individual.’<sup>35</sup>

### Direct and indirect age discrimination

**Direct discrimination** is where, on the grounds of age, a person or organisation treats someone less favourably than they would treat someone else, and cannot show the treatment to be a proportionate means of achieving a legitimate aim.

**Indirect discrimination** is where a person or organisation applies a provision, criterion or practice to everyone equally but this measure puts people of a certain age group at a particular disadvantage when compared to others; and the person or organisation cannot show the provision, criterion or practice to be a proportionate means of achieving a legitimate aim.

So with direct discrimination, people of different ages are treated differently; with indirect discrimination everyone is treated the same, but people of a certain age group are put at a disadvantage.

## 2.5 Multiple Discrimination

‘Much ageism stems from ignorance about the value of interventions in later life’<sup>36</sup>

.....

“The impression we have now is that elderly people are not worth wasting time, energy, equipment and of course budget on, as they are on their way out anyway, so why bother!”<sup>37</sup>

Understanding discrimination and equality needs an appreciation of the complexities of multiple discrimination and their impact on health outcomes and experience. The experiences and outcomes for older and younger people may be predicated on multiple aspects including, race, sexual orientation, gender and socio economic status. For example, more older women live in poverty than men and this is increased after retirement or with the death of a spouse; also there is a higher incidence of disability amongst older people especially those over 75 years.

In planning services boards should differentiate between the multiple identities of patients to meet their needs. For example, the needs of younger and older women, whilst a gender consideration, need to be considered separately from those of women generally. This will ensure that the differential impact or potential adverse impact of age is assessed.

Existing legislation for race, disability, gender, religion and belief and sexual orientation which protects from discrimination in the provision of goods, facilities and services should evidence the impact and relevancy of age too.



## 2.6 Older people

Age organisations assert that there are no illnesses or disabilities which are an inevitable part of ageing and rightly or wrongly, it is a useful starting point to consider health board practice and our assumptions of older people's health.

Assumptions can lead to inappropriate treatment or misdiagnosis and ageist attitudes can lead to a lack of respect for the dignity and privacy of older people. For example mental ill health can be misdiagnosed as dementia with the potential to lead to the wrong treatment simply because of the assumed link to ageing. Malnourishment in hospital is evidence of older people's needs being overlooked, including needs arising from dementia, other mental health problems, or from complex medical conditions<sup>38</sup> this may be considered ageist practice.

One woman reported: 'The doctor said to me: 'I could do more tests to find out what's wrong. But is it really worth the pain and hassle at your age?'<sup>39</sup>

### Help the aged report that:

- ❑ 34 % of over-65s agree that older people are treated worse than younger people in daily life;
- ❑ 27% of people over 65 say that older people are treated worse in healthcare.<sup>40</sup>

Often older people are patronised and stereotyped; viewed as dependent and helpless. "They won't tell my mother what medications she is on - her control is gone".<sup>41</sup>

Many of our commonly held views are stereotypes which negatively depict older people. These shape our expectations and assumptions regarding older people's abilities and decision making capacity; often resulting in a childlike treatment of adults. Older people are often treated like children and phrases such as 'be a good girl and eat up', are still heard in care homes and hospitals, "People talk down to us- call us 'sweetie' or 'dearie'- tell us what to do".<sup>42</sup>

### Discrimination of older people may include:

- ❑ Doctors dismissing pain as 'just getting old'; symptoms may be misdiagnosed;
- ❑ **Health programmes or certain drugs having an upper age limit;**
- ❑ Malnutrition; abuse and neglect of older people; older patients in hospitals having their food taken

away before they've finished eating or not receiving help to eat;

- ❑ **Vital health services for older people which affect quality of life and mental health, such as chiropody, not given priority;**
- ❑ Older people lose out on specialist treatments and preventative care that could improve health and prolong their lives;
- ❑ **Older people can find it difficult to access medical care – on a physical level or as a result of people's attitudes;**
- ❑ They may be placed in wards that offer poorer or non-specialist care;
- ❑ **Low expectations of older people's mental capacity, produces inappropriate and infantilising behaviours;**<sup>43</sup>
- ❑ Information is not accessible, not designed with age group in mind;
- ❑ **Stereotyping of need;**
- ❑ Not being treated with respect or dignity.

For example: Jennifer has learning disabilities, and had been living in a care home catering specifically for her needs until the age of 65. At this point she was made to leave the home, because it is only registered for the 18 to 65 age group, and had to move into another home designed for people with dementia.<sup>44</sup>

Research indicates that younger people do not value older people's quality of life as much as older people themselves, this is hugely important given professional power and access to services. For example, studies of 'do not resuscitate' decisions suggest that relatively inexperienced junior doctors do not always make appropriate decisions on behalf of their patients.<sup>45</sup>

Older people amply demonstrate examples of poor treatment which do not meet their health care needs. Exacerbating this situation are complaints that they are mistreated in the delivery of care and that their dignity and respect is not upheld.

Such treatment and decisions potentially result in poorer health for older people. 'Fairness cannot be assumed and age should not normally be used as a proxy for risk, ability or need. All age-based rules and exemptions should be open to scrutiny'.<sup>46</sup>

### Patient experience

'It has given us, her family, the distinct impression that maybe a younger person would have been taken more seriously.

The impression we have now is that elderly people are not worth wasting time, energy, equipment and of course budget on, as they are on their way out anyway, so why bother! Nothing can bring my mum back. But we want to know why the cancer was not diagnosed until it was too late. If she had been taken seriously and given the treatment she deserved and paid into all her life, then maybe she could have had radiotherapy. But she never got the choice. We could have had her home with us or admitted to a respectful and compassionate hospice. We did not get the choice. We feel that if her pain had been taken seriously from the start and if she was not treated as someone senile, which she certainly was not, she may very well still be alive today. For that we will never know.'

This woman's mother was admitted to hospital with severe pain in her leg. Less than five months later, she was dead. In the lead up to her death, she was repeatedly diagnosed as having sciatica and was prescribed drugs for sciatica and depression. An x-ray found nothing wrong with her lower leg. She lost a great deal of weight over several weeks and became too weak to feed herself. After three months, the consultant finally agreed to a scan, but she had to wait six weeks. The scan led to a biopsy but, by this time, it was too late. Two days later, this woman's mother had died from aggressive cancer of the pelvis.<sup>47</sup>

## 2.6.1 Elder Abuse

The prevalence of elder abuse and the implicit neglect of older people is becoming better understood and its awareness raised. The impact of abuse is significantly detrimental to patient health, for example malnourished patients are more likely to stay in hospital longer, develop complications and have a higher mortality rate; it is known that six out of ten older people are at risk of becoming malnourished, or of their situation getting worse, while they are in hospital.<sup>48</sup>



Older people perceive abuse under three broad areas:

- ❑ Neglect - isolation, abandonment and social exclusion;
- ❑ Violation - of human, legal and medical rights;
- ❑ Deprivation - of choices, decisions, status, finances and respect.

The Scottish Helpline for older people records abuse taking place in the following settings:

- ❑ 70% in the person's home;
- ❑ 10% in hospital;
- ❑ 10% in care based settings;
- ❑ 3% in care homes.

Stereotypes of older people as passive, child like and dependent create and exacerbate this abuse<sup>50</sup> with dementia patients being particularly vulnerable.

The Adult Support and Protection (Scotland) Act 2007 introduces measures to identify and protect adults at risk from harm. The measures contained in the Act will complement measures in existing legislation, such as the Adults with Incapacity (Scotland) Act 2000 ("the 2000 Act") and the Mental Health (Care and Treatment)(Scotland) Act 2003 ("the 2003 Act"), to provide support and protection for those who are vulnerable to being harmed or abused.

**It defines 'Harm' as all harmful conduct, in particular:**

- ❑ conduct which causes physical or psychological harm (e.g. by causing fear, alarm or distress);
- ❑ unlawful conduct which appropriates or adversely affects property, rights or



- interests (e.g. theft, fraud, embezzlement or extortion);
- ❑ conduct which causes self-harm.

This definition of harm sets out the type of behaviours that constitute harm to others. Harm can be physical (including neglect), emotional, financial, sexual or a combination of these, this is not an exhaustive list and harm includes a wide range of behaviours.<sup>51</sup>

.....

**Dorothy's story**  
 Dorothy, is 92 years old and experiences dementia. She was admitted to hospital but not given the help she needed to eat. On many occasions Dorothy's food was left untouched on her bedside table and taken away at the end of mealtimes by the catering staff. Her food also needed to be pureed but often this was not done.<sup>49</sup>

## 2.6.2 The External Reference Group for Older People's Services 2006 (Jarvie Report)

Family concerns regarding the basic care and respect of older people led Anne Jarvie, former Chief Nursing Officer of NHS Scotland to undertake a review into the care of older people across Lothian hospitals.



The report identified many shortfalls in the delivery of personal care to older people.

"At the heart of the reported dissatisfaction by patients, their relatives and friends was the lack of respect offered by services and the impact this has on their personal dignity".<sup>52</sup>

The report states: "caring for older people means more than simply treating their illness or providing rehabilitation. It means recognising that their needs are likely to be broader than the immediate reason for treatment and seeking to meet these needs in an environment that maintains their dignity and respects them as individuals." And that "delivering services that maintain the autonomy, dignity and respect of older people is something that should never be taken for granted."<sup>53</sup>

### Among its recommendations are:

- ❑ Steps to improve "personal care" on wards;
- ❑ Changes to the working culture for NHS staff;
- ❑ The appointment of an

- older person's champion;
- ❑ Safeguards to ensure patients are not "lost" in the system;
- ❑ Nutritional care should be a priority across all NHS services and systems should be transparent and open to audit;
- ❑ Mandatory staff training is required as a matter of urgency. Values that relate to the care of the elderly should be integral to all education programmes;
- ❑ A robust complaints system.

These recommendations are currently being considered for wider dissemination.

### Remember to:

- ❑ Treat older people with dignity and respect;
- ❑ Involve older people in decisions regarding their health;
- ❑ Challenge personal and institutional assumptions about older people.

## Post discharge surveillance system for surgical site infections

The Golden Jubilee National Hospital's post discharge surveillance system for surgical site infections allows patient monitoring for up to 30 days after they go home for those who have had hip, knee, or cardiac surgery.

The Cardiac and Orthopaedic patients range from 45yrs and 70yrs upwards, often experiencing other conditions eg. Disabilities. This specially designed telephony system allows patients to be monitored without repeat trips to hospital, and ensures they are seen earlier if problems arise.

The service takes into consideration individual need to ensure service access such as, the font and format of information given, communication methods and fast and effective response for complete continuity of care.

This approach frees up time and allows the monitoring of overall patient care - allowing the identification and learning from, common issues. The automated system can be accessed 24 hours a day, seven days a week, using a special pin number to help staff identify the patient. Patients are asked to call a free phone number 15 and 30 days after their surgery to answer questions about their wound by pressing numbers on their telephone keypad. The phone line is linked to a computer system, ensuring personal information goes into the system automatically. If their answers indicate that there may be a problem, a member of the Infection Control team will call them to discuss what has been happening and determine if an infection is present.

### The procedure will be as follows:

- Patient interviewed
- Information leaflet
- Questions sheet
- Date card
- Telephone on day 15 and day 30 post - operation

The post discharge surveillance system has been a great success so far. With an 85-95 percent compliance rate, a large amount of staff time has been freed up to concentrate on those patients experiencing problems when they get home from hospital. The Golden Jubilee Hospital will soon begin work to validate the system, which won the Infection Control category at the 2006 Nursing Times Awards. The judges praised the concept, results and benefits of the project as well as its relevance to local and national policies.

It has also been highly praised by patients using the service who found it easy to use, liked this way of keeping in touch and appreciated that personal concerns were considered.



## 2.7 Younger people

The health care needs of younger people are well known yet the barriers to those services are not. This section raises some of the pertinent issues affecting younger people accessing health services.

Younger people's needs may not be considered complex in terms of general medical need however their access to appropriate services, especially preventative care, is equally pertinent. Young people are identified as a key group in relation to improving health, since the predominant concerns are risk behaviours which may result in ill health later in life.

Children and young people are increasingly stereotyped by media images and stories of their anti-social behaviour. The National Children's Home (NCH) claims that negative stereotyping of young people due to associations with troublemaking results in young people being demonised despite figures indicating that only 1% of young people are involved in persistent offending<sup>54</sup>. This increasing demonisation and stereotyping has the potential to impact upon service take-up, and increase young people's fear of adults. Poor communication and judgemental attitudes by staff

also hinder the engagement of young people in health services.

Confidence and skills accessing healthcare is an issue for most young people using 'adult' services and negotiating with authority<sup>55</sup>. Many young people, particularly those in looked after care, characteristically; suffer apathy, poor self esteem with no value in themselves and therefore no value in their health.<sup>56</sup>

G.P's as gatekeepers to wider services are instrumental in shaping the experience of health care. Their attitudes, as the first contact, particularly for young people accessing services independently, can be supportive, informative and understanding or off-putting, brusque and judgemental<sup>57</sup>. Their attitudes are particularly important for vulnerable young people who will not have been supported by parents in accessing services previously.

Young people fear being judged or treated poorly<sup>58</sup>. One young person said 'Don't trust my doc - feel judged by him'<sup>59</sup>.

### **Discrimination of young people may include:**

- ❑ Young people being placed in adult wards, e.g in the provision of mental health care;
- ❑ Services only available during school hours;
- ❑ Information not accessible, not designed with age group in mind;
- ❑ Stereotyping of need;
- ❑ Judgemental attitudes;
- ❑ Confidentiality and anonymity not respected.



Assumption and stereotyping can lead to the needs of young people not being met. For example cancer is not seen as a younger person's disease, and some stigma may be attached to young people accessing screenings, services and treatment. Incidence rates of all cancers combined in adolescents and young adults have increased over time, rising from 178.3 to 237.4 per million population between the periods 1976-1980 and 1996-2000. The most striking increases in incidence are seen for germ cell tumours and melanoma.<sup>60</sup>

Consultation with young people in 2000,<sup>61</sup> identified the need to develop appropriate and accessible services. In particular, there was concern about:

- ❑ Little access to youth focused health services;
- ❑ Lack of information designed for young people;
- ❑ Lack of consultation with young people;
- ❑ General services being "inhospitable";
- ❑ Fears about patient confidentiality.

Young people want services to be confidential, welcoming, and discreet; and they want staff to be friendly, non-judgemental, and not prone to lecturing.<sup>62</sup>

They state: 'People were friendly and I felt I could trust (them)'<sup>63</sup>, '(A) friendly receptionist'<sup>64</sup>, '(The) Doctor was easy to speak to.'<sup>65</sup>

The way a service is delivered or negative perceptions of its potential delivery can create barriers for young people accessing health care.

## 2.7.1 Child Protection

Child Protection has been identified as a key issue for health and other agencies following a series of high level inquiries in Scotland and elsewhere in the UK.

Health care providers need to know how to identify when abuse is present and how to address issues of reporting and prevention as a fundamental part of child safety.<sup>66</sup>

### Remember to:

- ❑ Provide confidential services to young people maintaining anonymity;
- ❑ Provide flexible services out of school hours;
- ❑ Treat young people with respect and a non-judgemental attitudes.

## 3. Policy and legal context for action

This chapter sets out what health boards need to consider in addressing age equality and achieving services that recognise and respect difference; meet need and treat people with respect.

### 3.1 Policy and practice

The context and action for work that promotes age equality and ensures the needs of younger and older people are met are set out in the following key policies. It is outwith the scope of this guidance to identify all policy and action boards need to adhere to. Boards should take steps to be familiar with key policies whilst being mindful of the wider NHS Scotland aim to deliver patient centred services beyond the minimum statutory requirements.

- ❑ The United Nations Convention on the Rights of the Child 1991;
- ❑ The Scotland Act 1998;
- ❑ Human Rights Act 1998;
- ❑ United Nations Principles for Older People 1999;
- ❑ Our National Health 2000;
- ❑ Patient Focus and Public Involvement (PFPI) 2001;
- ❑ Fair for All - Developing Culturally Competent Services 2002
- ❑ Fair for All - The Wider Challenge 2003;
- ❑ Closing the Opportunity Gap 2003;
- ❑ NHS Scotland (Reform) Act 2004<sup>67</sup>;
- ❑ Building a Health Service Fit for the Future- a National Framework for Service Change 2005;
- ❑ Delivering for Health 2005;
- ❑ Age Employment Regulations 2006;
- ❑ The Adult Support and Protection (Scotland) Act 2007;
- ❑ An Action Plan Framework for Children and Young People's Health in Scotland 2007;
- ❑ All our Futures: Planning for a Scotland with an Ageing Population 2007;
- ❑ Better Health Better Care – a discussion document 2007.

These policies will be familiar to health boards, the most recent, All our futures- Planning for a Scotland with an Ageing Population 2007, builds upon existing expectation and policy; and sets out the continuance of robust partnership work in delivering for health for older people. Better Health Better Care reinforces the person centred approach to health care and the continued priority of addressing inequalities and the communities it affects.

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'Age is not used to define or make assumptions about the role, value or potential of an individual'.

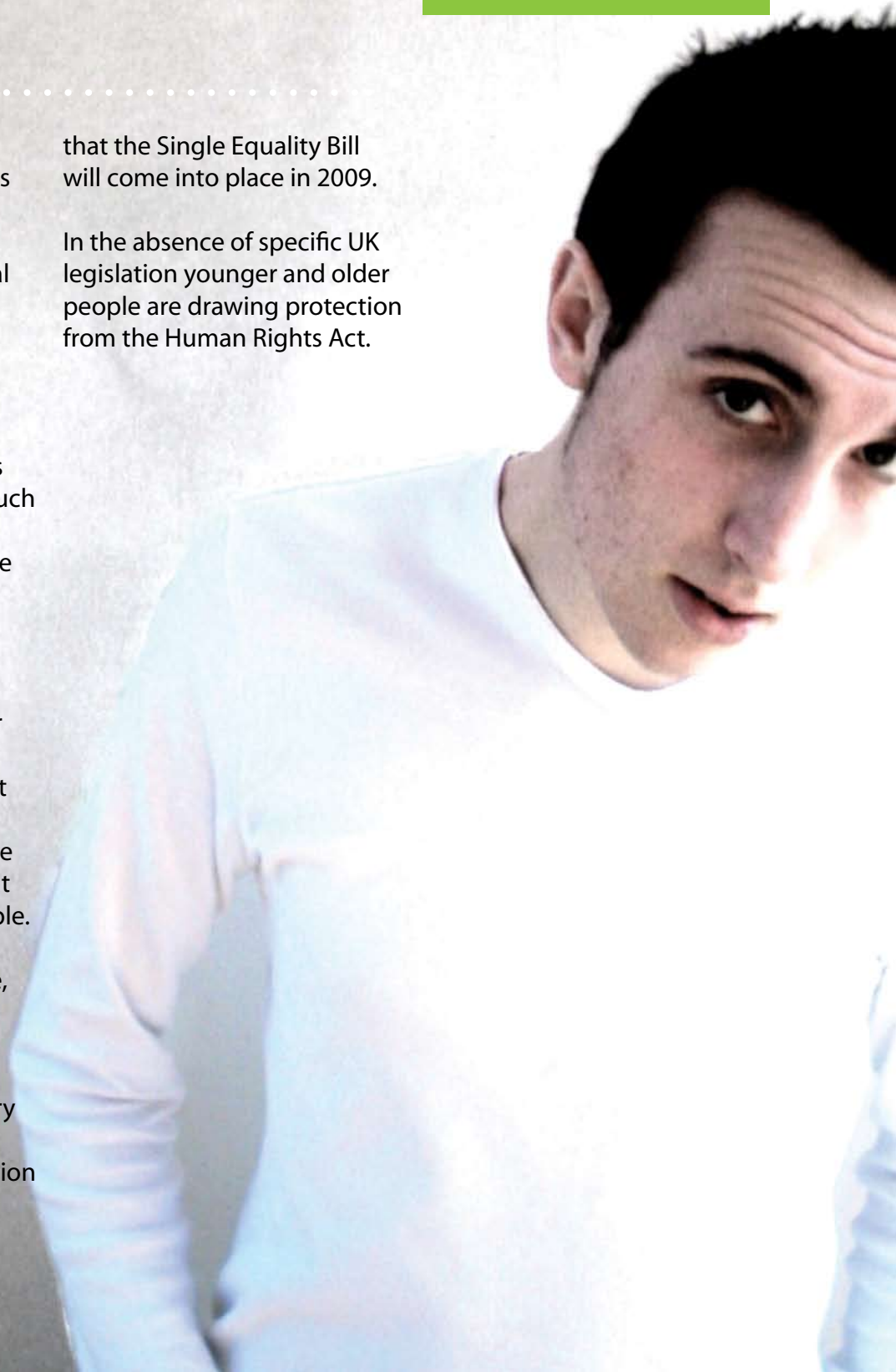
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Since October 2006 health boards must ensure services do not discriminate on the grounds of age in employment and vocational training. 2007 saw the extension of UK equality legislation on the grounds of sexual orientation and religion and belief to the provision of goods, facilities and services; currently no such legislation exists to protect on the grounds of age in the provision of goods, facilities and services.

At the time of writing the Single Equality Bill is out for consultation. In its current form the Bill recognises that some services must in their design take into account the life stages and development of children and young people. This has implications for health services, for example, paediatric services need to be responsive to specific needs which must not be challenged as discriminatory by others. Consultation will determine how positive action and specific services will be addressed. It is anticipated

that the Single Equality Bill will come into place in 2009.

In the absence of specific UK legislation younger and older people are drawing protection from the Human Rights Act.





## 3.2 Human Rights

The Human Rights Act 1998 and the further principles of the United Nations Principles for Older People and the United Nations Charter on the Rights of the Child set out fundamental rights for younger and older people.

These rights are supported by the UK and Scottish Parliament and underpin policy and legislative development. It is therefore necessary for all public bodies including health services to strive to meet these fundamental rights.

In July 2007 the Joint Committee on Human Rights appointed by the House of Lords and the House of Commons produced a report 'The Human Rights of Older People in healthcare', an investigation into the application of the Human Rights Act and the experiences of older people. It sets out detailed findings on the experiences of older people<sup>68</sup> and makes recommendations that are applicable across the UK.

The Scottish Equality and Human Rights Commission SEHRC established in October 2007 and the Scottish Commissioner for Children and Young People have a general duty to promote and encourage best practice in relation to Human Rights. The SEHRC is empowered to review any area of the law of Scotland and the policies and practices of any Scottish public authorities.

Further information on the implications of human rights and healthcare can be found at [www.bih.org](http://www.bih.org).



## Border's Youth Health Forum

The Borders Youth Health Forum (BYHF) operates in the Scottish Borders to voice the opinions of local young people to local health services. Ten young people feed in to both local and national health bodies making recommendations and suggestions for change and improvement in youth health services.



It was formed in 2006 after the 'Sex, Drugs and What You Know' health conference. This conference agreed a series of recommendations from participating young people. The BYHF are currently meeting with a range of local health services to discuss how these recommendations can be met.

To keep young people up to date with their work and to enable young people to continue to give their views the BYHF has developed the following ways to reach young people.

- ❑ The use of 'Wired', (radio show for young people on Radio Borders)
- ❑ Use of 'YOB' (Youth of the Borders) in the regional paper
- ❑ A local health page is currently being developed on the Young Scot Borders website ([www.youngscot.org/scotborders](http://www.youngscot.org/scotborders)) which will enable users to find out key information and also post questions that will be answered by a health worker. Podcasts will also be uploaded on to the website at regular intervals to keep information relevant and up to date.

Two DVDs for schools and healthcare staff are being developed. The first DVD will provide a virtual tour of a local health centre featuring services available and who is there to help. This DVD aims to inform young people of their rights and service entitlements.

The second DVD is designed to act as a training tool for health staff. It will feature the worries and concerns young people have in accessing health centres and how they as staff can help overcome these issues.

Following the success of the original conference a series of local events will also take place across the Borders visiting S1 – S3 pupils over the next academic year. The roadshow will focus on mental health and well being and will provide key information as well practical advice for young people on maintaining positive mental health. The BYHF has secured funding from the Scottish Health Council for the roadshow and to provide information packs.

The BYHF is supported by NHS Borders, BVYWF and Dialogue Youth (Scottish Borders Council)

## 3.3 Employment

From 1 October 2006 the Employment Equality (Age) Regulations made it unlawful to discriminate against workers, employees, job seekers and trainees because of their age.

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These regulations apply to all employers, private and public sector vocational training providers, trade unions, professional organisations, employer organisations and trustees and managers of occupational pension schemes. In this context an employer is anyone who has employees or who enters into a contract with a person for them to do work. The regulations cover recruitment, terms and conditions, promotions, transfers, dismissals and training. They do not cover the provision of goods, facilities and services.

### **The regulations make it unlawful on the grounds of age to:**

- ❑ discriminate directly against anyone – that is, to treat them less favourably than others because of their age – unless objectively justified;<sup>69</sup>
- ❑ discriminate indirectly against anyone – that is, to apply a criterion, provision or practice which disadvantages people of a particular age unless it can be objectively justified;
- ❑ subject someone to harassment. Harassment is unwanted conduct that violates a person's dignity or creates an intimidating, hostile, degrading, humiliating or offensive environment for them having regard to all the circumstances including the perception of the victim;
- ❑ victimise someone because they have made or intend to make a complaint or allegation or have given or intend to give evidence in relation to a complaint of discrimination on the grounds of age;
- ❑ discriminate against someone, in certain circumstances, after the working relationship has ended.



## 3.4 Remember to:

### 1. Understand the law

The Employment Equality (Age) Regulations, became law on 1st October 2006, and make it unlawful to discriminate in employment or vocational training on grounds of age.

### 2. Act now

Make sure NHS Board policies and practices comply with the regulations. Employers now risk legal claims from staff who have been treated less favourably in, for example, recruitment, promotion, training, or dismissal; are disadvantaged as a group by workplace practice and policy because of their age; or have been offended – either intentionally or unwittingly because of their age.



### 3. Communicate the changes

Explaining the new laws to staff and line managers is critical to success. Boards can be held accountable for the actions of their staff; it is therefore important to ensure all staff know what they must do to comply with the regulations.

### 4. Make the business case for diversity

Robust diversity policies contribute substantially to long-term effectiveness, attract higher skills, motivated employees and enhance service user satisfaction.

### 5. Build a culture of respect

All people should be treated fairly and with dignity and respect. It would be useful for boards to consider how they can create and sustain this ethos within their health board.

### 6. Recruit fairly

The words used in advertisements have the potential to be off-putting and potentially discriminatory; words such as 'energetic' or

'mature' link to stereotypes of age and are best avoided. Recruiters often have stereotyped notions of younger and older people's skills and abilities and these affect their decisions. Ensure that recruiters understand fair selection criteria and apply them consistently.

### 7. Tackle harassment and bullying

Put in place clear bullying and harassment policies which include age, and ensure all staff are aware of them.

## Text 4 U

Text 4 U is a text messaging service that aims to provide young people with easily accessible information on sexual health services and sexual health definitions. It was established and piloted in the greater Easterhouse area for a four month period as a partnership between Greater Glasgow NHS boards' health promotion department and H4U Teen.

Prior to the pilot consultation with young people recorded that 95% thought Text 4 U was a good idea.

**The scheme was developed to overcome the barriers to access, particularly for sexual health including:**

- Lack of knowledge of what services are available;
- Fears around confidentiality;
- Fears of judgemental staff.

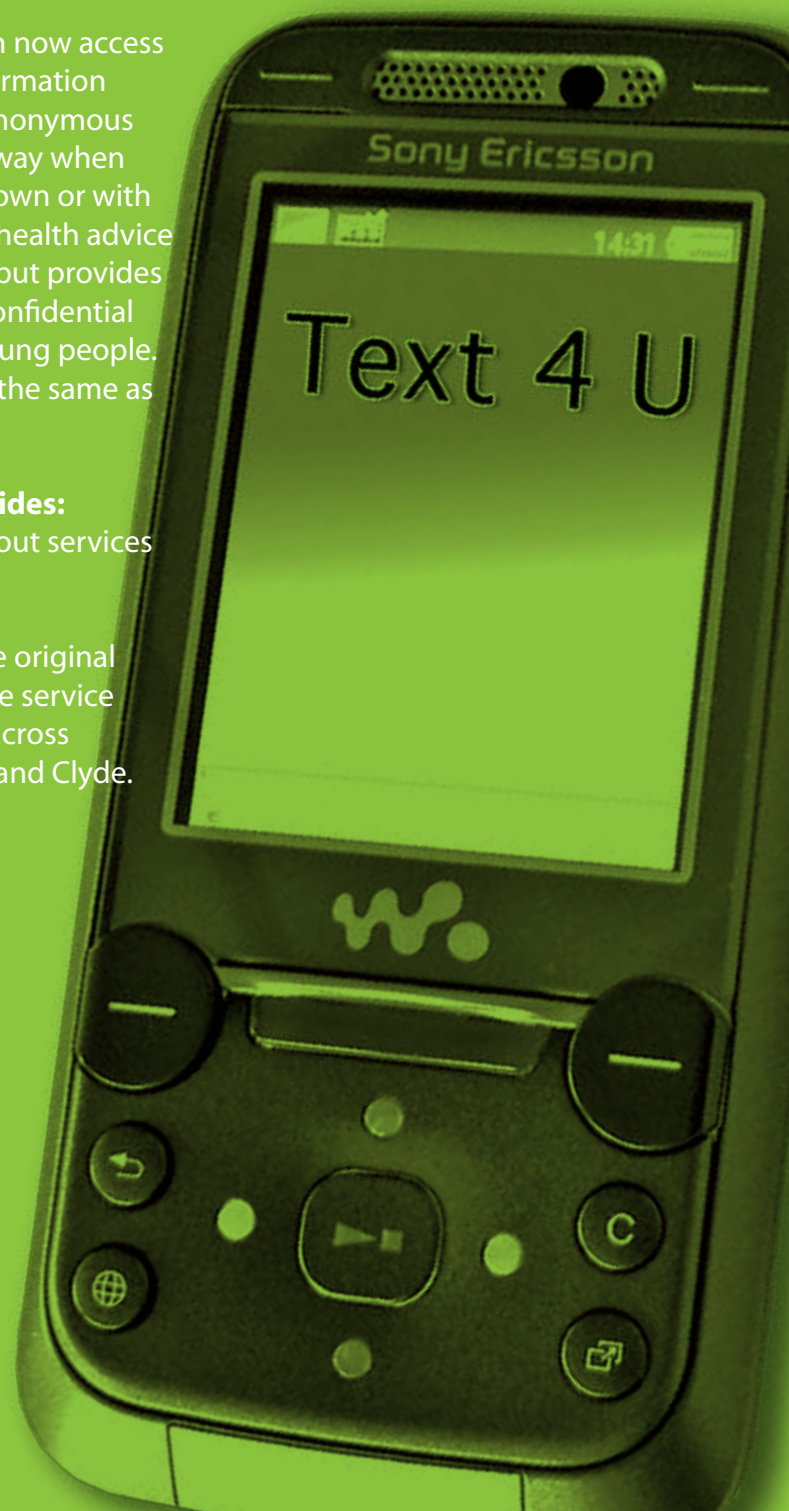
Following research and overcoming some development issues, for example word limits and signposting, the project began in 2004.

Young people can now access sexual health information in a completely anonymous and confidential way when they are on their own or with friends. It is not a health advice line or a helpline but provides immediate and confidential information to young people. The service costs the same as a normal text.

**The service provides:**

- Information about services
- Definitions

The success of the original pilot has led to the service being rolled out across Greater Glasgow and Clyde.



## 3.5 What the regulations say – in summary

Boards could be held responsible for the acts of employees who discriminate on the grounds of age. This makes it important to train staff about the regulations.

Upper age limits on unfair dismissal and redundancy have been removed. There is a national default retirement age of 65, making compulsory retirement below 65 years unlawful unless objectively justified.

Health board staff have the right to request to work beyond 65 or any other retirement age set by the company. The employer has a duty to consider such requests.

There are limited circumstances when discrimination may be lawful.

Tackling discrimination helps to attract, motivate and retain staff and enhances NHSScotland's reputation as an employer. Eliminating discrimination helps all board staff to have an equal opportunity to work and to develop their skills.

### **NHS staff who are subjected to discrimination, harassment or victimisation may:**

- ❑ be unhappy, less productive and less motivated;
- ❑ resign;
- ❑ make a complaint to an employment tribunal.



### **In addition health boards may find:**

- ❑ their reputation as a business and as an employer may be damaged;
- ❑ the cost of recruitment and training will increase because of higher employee turnover;
- ❑ they may be liable to pay compensation following a claim to an employment tribunal there is no upper limit to the amount of this compensation.

[www.dti.gov.uk/employment discrimination](http://www.dti.gov.uk/employment%20discrimination)

## 3.6 Service Design and Delivery

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### 3.6.1 Assessing the Impact

As part of the Fair For All initiative an Equality and Diversity Impact Assessment Toolkit (EQIA) has been developed to ensure the needs of all communities are considered in the policy-making process.

The EQIA toolkit provides guidance intended to support consideration of equality and diversity issues in the design, development and delivery of policies and services across NHS Scotland. EQIA is a strategic process and needs to be considered when planning a new, or redesigning an existing, policy, function or service<sup>70</sup>.

EQIA should be undertaken across all equality strands, including age.

The Scottish Commissioner for Children and Young People has developed an EQIA toolkit specifically for involving children and young people that provides specific guidance on the involvement of young people in this process which boards may find useful<sup>71</sup>.



## 3.6.2 Monitoring action

“In many organisations, what does not get monitored does not matter.”<sup>72</sup>

To achieve better health services for all as set out by the Scottish Government<sup>73</sup>; health boards are expected to research and respond to the different and specific needs of the people they serve. This includes looking at the age demographic profiles of the people that live in the board’s region; who use or may not use services; focusing on the current NHS national clinical priorities for equality in cancer, mental health and coronary heart disease (CHD).

Organisational performance management enables health boards to review practice and address areas where positive changes can be made. Monitoring is pivotal to this process and should be a central part of both workforce and service delivery functions.

As part of the commitment to create an NHS that is Fair for All it is important that monitoring is carried out for age; where this information is not currently used or collected, boards should identify where it would be

helpful to do so and how this can be achieved. It may not be adequate to monitor at only one point of service access. Boards may wish to conduct separate monitoring exercises to map the success of specific service delivery and identify patient experience.

### Why monitor

Monitoring is the process used to collect, store, and analyse data about the people using health services. It is useful for:

- ❑ highlighting possible inequalities;
- ❑ investigating underlying causes of inequality; and
- ❑ removing any unfairness or disadvantage.

Without monitoring, we do not know whether our equality policy and intentions are working for younger and older people. It can tell us which groups are using our services, and how satisfied they are with them. We can then consider ways of reaching under-represented groups and making sure that our services are relevant to their needs. For example,

monitoring services to young people, categories should be disaggregated to age bandings, 11-13 year olds, 13-15 year olds etc. There may be reasons why certain groups choose to access services or not and monitoring information can be used as the first step in identifying problems and assessing performance. Monitoring should include both qualitative and quantitative information.

The costs of discrimination claims can include legal fees, compensation payments, management time, as well as the emotional distress for those involved and the wider damage to staff morale and organisational image. It therefore makes good risk assessment sense if boards can demonstrate actions to guard against and avoid discrimination.



### Local information

Understanding local demographic information helps boards to identify where services are needed. Census material allows identification of where younger and older people may be living. For example, it is known that a quarter of older people live in rural areas, and are generally isolated; many cannot drive and are dependent upon public transport. This has implications for access and appointment times.

### Confidentiality and anonymity

All monitoring should be carried out sensitively and confidentially. Many younger people will not use services if they do not trust the confidential handling of their information; young people stress anonymity as being highly important to them. This includes both medical and personal data. Confidential and anonymous monitoring is important for service users so they know sensitive information is protected. Good practice contained in the

data protection act should be followed.

### Satisfaction

Monitoring service delivery is also about satisfaction and boards should continue to ask young and old people about the services they receive and ensure these views are used to improve delivery and planning processes.

The design of feedback forms or questionnaires can often obscure helpful information if they are not in plain English or in a simple clear format. Involving older and younger people in the design of surveys, complaints and satisfaction exercises will ensure the right questions are asked in a language and format which is accessible and attractive to their peers.

### Complaints

The majority of people making complaints or suggestions will not necessarily highlight age or recognise negative experiences because of their age.

Older people are generally well disposed towards the NHS and the services they receive and reluctant to complain. Many will be very dependent on their carers and unwilling to pursue poor treatment; also it is difficult to separate a complaint about an unsatisfactory service from the person delivering it, who may be well liked. Poor attitudes and lack of respect are attributed to busy staff, rather than ageist attitudes or poor treatment.

Lack of confidence, and information or embarrassment deters young people from complaining to adults. This has implications for boards in the way information regarding service delivery is collected.

**Remember to:**

- Collect Information and evidence by age;
- Raise awareness of age equality;
- Impact Assess policies on the grounds of age, including children, younger and older people.

Boards should continue to encourage feedback and demonstrate their commitment to improving services to younger and older people. Participants appreciate knowing how the information supplied improves services to them and boards should ensure feedback is given. Information can then be analysed to determine patterns of success and areas for improvement.

**Staff monitoring**

Workforce monitoring is essential to provide employers with information of their workforce profile and to inform workforce policy, implementation and development. Boards will continue to use age analysis of their workforce to ensure that people management practices are promoting all talent and are inclusive.

Monitoring is most effective when routinely updated and analysed across both services and employment. It should be a continual exercise to understand people's needs and develop services appropriately.



### 3.6.3 Engaging younger and older people

Children and young people should be involved in all decisions affecting their lives<sup>74</sup>. Older people have the right to participation and care.<sup>75</sup>



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This is required across NHS boards specifically in its Patient Focus and Public Involvement, Equality Impact Assessment and Community Planning requirements.

The recognised benefits of public and user involvement include: better outcomes of treatment and care; the ability of services to be responsive to needs; individuals and communities developing a sense of ownership of services; increased knowledge and self confidence for the user; and better quality in both policy and services.<sup>76</sup>

When involving people it is essential that their views are listened to; respected; taken into account; and used to inform the process and outcomes. Their input should be valued and not tokenistic. Involving younger and older people in the design of services requires consideration and an appreciation of their perspectives.

It is important to recognise that some younger and older people will be gay, disabled or come from an ethnic minority background. Boards will need to reflect this diversity in the impact assessment of functions and policies. For example sexual health information should provide information for lesbian as well as heterosexual young women.

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**Consultation** - involves asking for views to inform decision-making. The views will not necessarily be adopted but they may influence the design and decisions subsequently made.

**Engagement/Collaboration** - Collaboration involves active, on-going partnership with younger or older people in research and the development of services.

**User-control** – A user-controlled approach is when initiative and subsequent decision making is with people themselves. It does not mean that younger or older people act alone but embodies a partnership approach to service design.

## Young People's Public Partnership Forum (YPPF)



East Ayrshire Community Health Partnership (CHP) has established a Young People's Public Partnership Forum as part of East Ayrshire Public Partnership Forum to ensure the views of young people are influential in the development of services.

A range of local young people, who have links to various youth groups and organisations, have come together to form a core group for the YPPPF. This core group will act as a pathway to bring young people's ideas and issues on health services to the CHP through East Ayrshire Public Partnership Forum.

### The forum will help young people to:

- ❑ become confident in identifying what is best for them;
- ❑ have opportunities to learn about health improvement;
- ❑ will learn how to influence service design.

### The CHP has gained considerably from the YPPPF, the benefits include:

- ❑ Confident young people who will be kept up to date on the issues that affect them;
- ❑ CHP has a target audience participating in the design of services for young people;
- ❑ The CHP and staff learn from young people, having a clear idea what is important to them.

The young people have reviewed leaflets and registration forms and are currently developing a DVD about the CHP and its Public Partnership Forum.

### This engagement was built slowly over 5 months by:

- ❑ Introducing our PPF leaflets to young people through Dialogue Youth and asking the young people to gauge how youth friendly the format of our leaflets was.
- ❑ Asking for opportunities to meet with young people,

for example youth group gatherings or open events

- ❑ Asking our young people who attended those events how they would like to be engaged
- ❑ Listening to what they told us; "we like the idea of the PPF but do not want to be attending meetings" "we would like to be a group that could be involved in projects for the CHP or PPF" "If we have health issues we know that we can feed them into the PPF easily"
- ❑ Then asking the interested group of young people to come together to discuss what projects they would like to be involved with

We agreed that making a DVD to showcase East Ayrshire CHP and East Ayrshire PPF would be a good educational project. This would be fun to do whilst being a very useful tool to promote the work of the CHP along with promoting the PPF in a format that will be easy to understand for most of our population.

## 3.6.4 National Standards for Community Engagement

Boards should adhere to the Community Engagement Standards as well as other examples of effective engagement, to ensure that this aspect of work is of the highest quality.

### People expect those working with them to be:

- ❑ Non-judgemental;
- ❑ Friendly and approachable;
- ❑ Unbiased;
- ❑ Good at communication and not patronising;
- ❑ Willing to learn/gain skills;
- ❑ Open minded and prepared to be challenged;
- ❑ Maintain anonymity and confidentiality;
- ❑ Know how to identify and use participant skills;
- ❑ Give appropriate direction and information;
- ❑ Value and acknowledge contributions.

### The standards are based on following principles:

- ❑ Fairness, equality and inclusion must underpin all aspects of community engagement, and should be reflected in both community engagement policies and the way that everyone involved participates;
- ❑ Community engagement should have clear and agreed purposes, and methods that achieve these purposes;
- ❑ Improving the quality of community engagement requires commitment to learning from experience;
- ❑ Skill must be exercised in order to build communities, to ensure practice of equalities principles, to share ownership of the agenda, and to enable all viewpoints to be reflected;
- ❑ As all parties to community engagement possess knowledge based on study, experience, observation and reflection, effective

engagement processes will share and use that knowledge;

- ❑ All participants should be given the opportunity to build on their knowledge and skills;
- ❑ Accurate, timely information is crucial for effective engagement.



### Examples of engaging older people

An inter-generational conference was held which brought together school-age children and older people to talk about lifelong learning and citizenship;

- ❑ An adaptation of a community development technique called 'Planning for Real Technique' to find out what issues were most important to older people in the area. The technique involved asking older people to quickly generate 'issue cards' on which they write down an issue or concern, but do not have to discuss it. One such event was attended by 500 people, mainly older people. It was held at a venue that had some meaning for older people. Information stalls and activities such as fitness, art and crafts and music were provided to ensure that people were attracted to come to the event. The event led to the formation of a working group and an action plan.
- ❑ **A theatre production was used to help people**

### discuss health and social work services and to decide priorities in relation to these services.

- ❑ Questionnaires were adapted so that people could prioritise their needs in relation to home care using coloured stickers.
- ❑ **Participatory appraisal<sup>77</sup> was used at an event to involve older people. This approach was developed in the social development field to gain a rapid, in-depth understanding of a community, and uses visual techniques and community participation to do this;** [www.ids.ac.uk/ids/particip/research/prahtml](http://www.ids.ac.uk/ids/particip/research/prahtml)).
- ❑ Listening lunches - lunch invitations are sent to all local organisations which involve older people, plus older people who have specifically requested involvement, or made use of the comments/feedback process. The lunches are issue/needs/policy led, and representative social care staff and their senior managers

attend. Information about the available range of community care services is provided via posters and leaflets. Staff meet with older people and their representatives, taking views and comments, and give information and answer questions relating to services, and occasionally give structured presentations to elicit views on different elements of the planning.

- ❑ **An older people's group set up a writers' group which led to a drama production to get older people's views across.<sup>78</sup>**

Similar approaches can be developed to engage with younger people. (See page 12 for some examples). Effective involvement should also accommodate the different backgrounds and needs of communities and participants. For example involving older people from minority ethnic backgrounds will need to address the barriers of exclusion and multiple discrimination which hinder participation.

## 3.6.5 Promoting access

Access is a key theme across all equality areas. The way, where and how services and information are delivered can inhibit access or create barriers for younger and older people.



Young people in particular speak of confidentiality worries, lack of anonymity, staff attitudes and non-welcoming services. Older people generally express difficulties with location, transport links, appointment co-ordination and a lack of local services as barriers to health care.

### What helps?

- ❑ Choice of service location;
- ❑ Accessibility via public transport;
- ❑ Flexible hours to allow young people to access the service out-side school hours; e.g. drop-in's;
- ❑ Young people can make appointments and attend without parental consent or the involvement of a carer or parent;
- ❑ Longer appointments and taking time to listen to the patient;
- ❑ Co-ordinating appointments;
- ❑ Choice of male or female staff, access to single sex wards.

Younger and older people face some different as well as similar difficulties accessing health care services. For example young people like services to be confidential; therefore services need to be anonymous, clear about confidentiality and sensitive to location and visibility. This may be difficult in rural locations where independently accessing services via public

transport or without parental agreement may create barriers and anxiety. Accessing services within school hours requires a parental note for absence, making confidentiality impossible.

Many older people do not drive and are dependent upon public transport and services in the community are important to them. Whilst confidentiality is not a particular concern they value single sexed wards as modesty issues are important to their dignity.

Speaking to local younger and older people will help boards to indentify local barriers and solutions to promote service access and appropriate design.

### Remember to:

- ❑ Ask younger and older people about their needs;
- ❑ Learn about the barriers and concerns affecting younger and older people.

## 3.7 Overview

In 2007 there is no specific legislation or duty for health boards to set out an age equality scheme or demonstrate action to address age equality as recently expected with gender, disability and race; this is anticipated to change.

Scottish Government Health and Wellbeing expects health boards to include age as an equality component, engage with younger and older people and to develop services that meet their needs outwith the limitations of current legislation and policy.

### Health boards should continue to:

- ❑ Ensure discrimination on the grounds of age in employment and vocational training do not occur, in compliance with the Age Employment Regulations 2006;
- ❑ **Comply with the NHS Scotland (Reform) Act (2004) with the duty to promote age equality and to encourage involvement;**
- ❑ Ensure local delivery plans reflect age equality and diversity work;
- ❑ **Involve and engage younger and older people as part of Patient Focus and Public Involvement and Community Planning, in partnership with local authorities;**
- ❑ Ensure age equality is considered across corporate functions and board governance arrangements;
- ❑ **Check the age impact of all new and significantly changed policies to identify any differential impact for younger or older people to improve health outcomes;**
- ❑ Comply with NHS Quality Improvement Services clinical governance and risk management standards in which Patient Focus and Public Involvement is a core element and in which age is implicit;
- ❑ **Ensure involving and meeting the needs of younger and older people are demonstrated in the Scottish Health Council self assessment.**
- ❑ Use routine collection of age data to shape service design, development and delivery.



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### Walk the Talk

Improving services for young people does not always have to be a huge task requiring significant resources and time. A practical example of making a change without too much effort would be to provide reading materials in all waiting rooms that are suitable for young people. Another example would be to have an appropriate 'set time' in the week when young people could receive services.

[www.walk-the-talk.org](http://www.walk-the-talk.org)

## 4. Developing Practice

High quality and responsive services have, and are being developed to meet the changing needs of Scotland's people as we age. However, whilst good services are being delivered it is necessary not to become complacent and to acknowledge that poor services and attitudes also exist. Equality work is often misunderstood for trying to redress imbalance and unequal services and it is therefore important that Chief Executives and managers, understand age equality and why it matters. To assist boards to further develop age appropriate services the following are recommended.

### 4.1 Leadership

To be successful, leadership at senior level is essential. As well as commitment, there needs to be competence and an understanding of age issues in the provision of services and the health mainstreaming process.

**Age equality should be developed as part of broader equality work.**

**This could include:**

- ❑ Senior people or teams with major strategic or management responsibility, supported by key staff could contribute to age equality change across a health board;
- ❑ Regular reporting on progress to senior management teams could be put in place;
- ❑ Patient Focus and Public Involvement Designated Directors and Chief Executives have a role to contribute to an increased understanding of age equality as part of core business, policy

development and service delivery objectives;

- ❑ Understanding that age equality is not just relevant in the continuance of current services or within human resources, but also in the development, examination and evaluation of all services with service users.



## 4.2 Patient Experience

Health and social care services have made some progress in tackling age discrimination, but older people in particular still report feeling that they have received second class treatment and care simply because of their age. For example, a doctor may not refer an older person to a consultant because of their age, or inappropriate comments may be made about age whilst in hospital.<sup>79</sup>

Understanding the experiences of people who use health services, or staff working in the delivery of those services, is a useful way of examining the treatment they receive, or barriers experienced according to equality and diversity policies. "Better together" is the national patient experience programme. This will provide local and national data on older and younger peoples experience of health services which will lead to improvement programmes being undertaken.

The patient /service user model helps understanding of this experience. The journey is viewed as a process diagram where the service user moves from stage to stage. By breaking the journey down into its component parts, it is easier to identify areas for positive change.

If using the patient pathway concept it is important to understand what barriers may arise that can result in a breakdown of treatment, this will include staff attitudes and can occur at any point along the path.

(please note this list is not comprehensive and also many issues will repeat at each point of contact): For example

### Step 1: A Young person has a health problem

- Needs to decide whether to go to the GP.
- Consideration of past experience- has this been positive or negative?
- Will I see anyone I know?
- How can I get there; need money for bus fare?
- Can I go out of school: if I go in school time a note from parent is needed by the school?
- Can I go without my parent/guardian?
- Will I be treated as if I can make my own decisions?
- Will the receptionist be friendly or ask potentially embarrassing questions?
- Can I ask to see a female or male doctor?
- Are there local alternatives, a drop in, internet information?
- How do I find the answers to these concerns?
- Will they need to know about my sexual orientation?

### Step 2: Patient presents to GP

- Will they judge me?
- Can I ask questions?
- Fears of confidentiality- will they tell my parent/guardian?

### Step 3: GP / hospital investigates

- Can I take a friend with me?
- Can I get there out of school hours?
- Will it be embarrassing?
- Can I refuse treatment?

### Continuing for all points of contact it is useful to ask at each stage:

- How would I feel if staff behave in that way to me?
- What could we do or change to make this experience better?



The use of diaries to monitor experience is also a useful tool to inform service change and understand where difficulties exist for younger and older people. Using the internet interactively may also be a way of ascertaining comments on your services. The Personal Stories and Health Topic briefings developed by Fair For All can assist in increasing understanding of patient experience.<sup>80</sup>

## 4.3 Staff Development

Equality training provided to health board staff should include age equality.



Specific service provision to older or younger people within boards can obscure the need for staff development on age equality as it is assumed that age issues are being addressed and this is sufficient. Age employment cases and the increased awareness of elder abuse illustrates that understanding age equality is imperative.

As demonstrated, positive staff attitudes are cited by both younger and older people as being important to their quality of care. Being treated with dignity and respect are important to all, and negative attitudes at any point of contact create barriers that stop many from continuing to access the care they require. Communication skills will therefore be a useful complement to age equality training.

All staff should continue to develop their knowledge of patient need and understand that the way a service is delivered to younger and older people directly or indirectly can impact upon their health. This may be developed as part of the personal development plan.

The implementation of the Knowledge and Skills framework which includes equality and diversity supports staff development in this area.

### Boards should consider:

- ❑ A range of methods to raise awareness of age equality and service barriers to staff;
- ❑ Develop methods for monitoring staff development outcomes to assess the training impact on staff;
- ❑ Monitor the quality and effectiveness of training and information provided;
- ❑ Ensure all staff can access the training;
- ❑ Monitor patient satisfaction.



## 4.4 Single Equality Schemes

Some health boards may choose to produce a combined equality scheme in anticipation of a Single Equality Approach, to include age. This approach will extend good practice and develop equality work and anticipates a potential duty to promote age equality.

Boards could consider developing strategic policies; setting out their intentions; and evaluating and consolidating current practice in the form of an age action plan or scheme, as part of a single equalities approach. This format is acceptable as long as the evidence and actions of each equality strand are shown for those with existing duties and are clearly identifiable and easily accessible.

**The existing duties are both similar and distinct and a single equality scheme will need to continue to reflect the specific legal requirements.**

If boards choose to progress an age scheme or action plan the approach taken in the development of the race, disability and gender equality schemes provides a robust model. Developing action to identify issues for age equality in the services, employment and policy making of your board will challenge ageist attitudes, assumptions and stereotypes and enable older and younger people to shape the services that affect them.

### Action could include:

- ❑ Publishing an age equality scheme, with service users and employees of defined ages involved in its development;
- ❑ Setting age equality targets and actions;
- ❑ Obtaining evidence to regularly monitor progress against targets;
- ❑ Conducting and publishing age equality impact assessments of all new legislation and significant policy developments.

The effect of any plan should be to ensure that age equality is acknowledged and incorporated into all relevant policies, employment practices and service design at every level within your health board.

### It might be helpful to find out:

- ❑ What are the age issues that a health board needs help with?
- ❑ Why is age important to health services?
- ❑ What does age equality look like for health services?
- ❑ What positive difference would it make to health services?
- ❑ How can age equality in clinical priorities like cancer, CHD and mental health be implemented?

- ❑ How are aspects of multiple disadvantage addressed in terms of equality; for example older black and minority ethnic people's needs?

### National Health Boards

National Health Boards with their specific roles need to identify how age equality is relevant to their functions and continue with the Equality Impact Assessment of policies and functions to include an age perspective as well as developing good practice in line with policy and legislation as appropriate.

Whilst not directly treating patients National Boards should continue to develop tools and information to support territorial boards, setting out the needs of younger and older people and consulting with staff and stakeholders to identify issues particular to their role. For example, publicity materials and documents can be checked for ageist language or stereotyping; and ideally younger and older people are involved in the design and development of the information that they will use. Local level structures and local public partnership forums and groups would be useful here.

## 4.5 Building practice

'Checking for Change' developed by the National Resource Centre for Ethnic Minority Health to support boards in the development of race equality, can usefully be transferred across age to guide practice and service improvement.



It is anticipated that Checking For Change will be broadened to include all six equality areas. It focuses on the five key policy areas of Fair for All.

### These being:

- ❑ Energising the organisation
- ❑ Demographics
- ❑ Access and Service delivery
- ❑ Human Resources
- ❑ Community Development

To develop age responsive practice, health boards could begin to co-ordinate their actions and monitor the effectiveness of current services using the good practice developed in Checking for Change<sup>81</sup>. This will assist boards to begin to co-ordinate and demonstrate the age aspect of patient focus work and the wider equality principles of NHS Scotland.

### How to:

The following examples adapted from Checking for Change.

### Energising the organisation

Understanding younger and older people's health needs,

including legislation and communicating policies.

- ❑ Taking a lead: put in place leads or champions to indicate a commitment to age equality;
- ❑ Consider establishing a board 'network' of leads to co-ordinate age work;
- ❑ Put age on the agenda at team meetings and training events to allow plans and progress to be reported and discussed;
- ❑ Let staff know of your commitment and intentions around age equality;
- ❑ Co-ordinate an action plan and monitor effectiveness.

### Demographics

Health boards must understand the age profile of their area:

- ❑ Know your service users and population profiles by age. Use this information to plan services;
- ❑ Evaluate and identify the priority health issues of younger and older people;
- ❑ Ensure current monitoring mechanisms are robust and can be used to identify gaps, issues, and emerging trends for different age groups.



### Access and Service Delivery

Identify barriers and take action to overcome them.

- ❑ Provide information and guidance to staff, particularly those in the frontline or patient centred work on age appropriate services and treatment of service users;
- ❑ Undertake Age Impact Assessments and ensure staff are trained and supported;
- ❑ Positive images of younger and older people contained in board information will challenge perceptions and stereotypes;
- ❑ Develop and display the board's confidentiality policy widely to reassure younger people;
- ❑ Provide information with younger and older people's needs in mind.

### Human Resources

Boards will wish to ensure that people management policies and practice are reviewed in the light of the age employment legislation and this could include:

- ❑ Build staff understanding and skills about what's important to younger and older people and age equality in service delivery;
- ❑ During induction training, ensure staff are made aware of policy on discriminatory practice.

### Community Development

Involving younger and older people in promoting their own health.

- ❑ Ensure younger and older people are involved in service design recognising

difference. For example the needs of older Asian people or young people from Gypsy Traveller communities or those from rural and urban areas;

- ❑ Meet younger and older people in the local community from a range of backgrounds. This could be achieved via schools, youth groups, shopping centres and religious organisations for example;
- ❑ Provide health care advice in the community via organised events and information; evening and weekend events are particularly important to younger people;
- ❑ Consider developing ways of providing regular information to older and younger people on health services and ascertaining feedback, bearing in mind how this is written, produced and where it is distributed;
- ❑ Comply with good practice standards for community engagement.

### Remember to:

- ❑ Ensure equality and induction training include age;
- ❑ Identify methods to find out the views and health service needs of younger and older people;
- ❑ Promote and lead on age equality issues.

## Class Diamonds

NHS Ayrshire and Arran are involved as a partner to develop and deliver health care services to older people throughout Ayrshire. The project was initiated in response to identified needs of older people (60+) in relation to isolation, falls/fear of falls and loss of confidence; and to national policy and research promoting the health and social benefits of keeping active in later life. Older people were involved in the working group that developed the programme and also promoted the courses and act as mentors to new attendees

### This project aims to:

- ❑ raise awareness of home and personal safety
- ❑ promote positive changes in lifestyles
- ❑ increase the number of people aged 60 years and overtaking part in physical activity
- ❑ reduce the risk of falls and accidents in the home
- ❑ act as a referral source from and to other agencies

It did this by establishing the Class Diamonds Courses which promoted health, physical activity, falls and accident awareness raising programmes. The 12 week courses comprise exercise and activity, social opportunities, health promotion and education.

Health and safety professionals deliver information on a wide range of topics relating to keeping well and keeping safe. This work also informs older people about services, resources, aids and welfare benefits available, some delivered via peer support.



## 4.6 Getting it right

“There is a balance to be struck between the technical aspects of care and the personal and holistic care that promotes dignity and respect. This is especially true of older people where it is possible to treat their illness, without achieving a caring experience.”<sup>82</sup>

A smile, a welcoming approach, time to listen and being involved in decisions about treatment are a few things that make people feel valued using health services and despite being applicable to all are noted as significant by younger<sup>83</sup> and older people.<sup>84</sup>

### 4.6.1 Younger people

#### Getting it right for younger people means health boards need to ensure:

- ❑ A listening culture within services is an integral part of any meaningful attempt to consult children and young people about their health care;
- ❑ Communication is a key issue for children and young people, and they want all service providers (including reception staff) to be good at talking and listening to them;

- ❑ They want to be treated with courtesy and respect and for their views to be sought when decisions are being made about their health care. Children and young people would like to be offered choices in their health care and for it not to be assumed that ‘parents know better’;
- ❑ Confidentiality is a major concern using healthcare services. They are particularly wary of GP services, including reception staff, in this respect;
- ❑ Health and well-being are often seen in broad and holistic terms by children and young people, who place a strong emphasis on feelings and emotions as well as positive relationships with friends and others.
- ❑ Most young people have a good understanding about healthy lifestyles, and they are able to identify what would help them live more healthily. Patterns of behaviour in relation to sexual health,

drug and alcohol use and eating, in particular, need to be understood in the context of their feelings and emotions, and services planned accordingly;

- ❑ Children’s and young people’s accounts of healthy living place a strong emphasis on their environment, primarily their neighbourhood and school. These should be safe, friendly, enjoyable and supportive, and free from bullying and other forms of harassment.<sup>85</sup>

Services should acknowledge that disabilities and other aspects of the person have implications for the way a service needs to be delivered. For example a ‘listening culture’ will need to consider deaf and hearing impaired young people:

































