

GUIDANCE AND COMPETENCES FOR THE PROVISION OF SERVICES USING PRACTITIONERS WITH SPECIAL INTERESTS (PwSIs)

OLDER PEOPLE



DH Department
of Health



English Pharmacy Board

NHS

Primary Care Contracting

FOREWORD

The White Paper *Our health, our care, our say: a new direction for community services* (http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4127453), published in 2006, set out the vision for the future of care outside hospitals. It reinforced the importance of services provided by healthcare professionals working in community settings. The public involved in the consultation process that informed the White Paper made it clear that while convenient care was important, it must be of high quality and that a transparent process should underpin that quality.

In his interim review, Lord Darzi re-emphasised this need for quality, drawing on four overarching themes for the NHS over the next 10 years, where he describes the vision of a health and care system that is fair, personalised, effective and safe. Much of the vision continued in his main report, *High Quality Care for All* and in the primary and community care strategy] is underpinned by the movement of more complex care out of hospitals and into community settings – just the sort of services that PwSIs provide. *World Class Commissioning* (“*Adding years to life and life to years*”) will be the key vehicle for delivering a world leading NHS, equipped to tackle the challenges of the 21st Century. By developing a more strategic, long-term and community focused approach to commissioning and delivering services, where commissioners and health professionals work together to deliver improved local health outcomes, world class commissioning will enable the NHS to meet the changing needs of the population and deliver a service which is clinically driven, patient centred and responsive to local needs. PCT Commissioners will therefore be looking for PwSI commissioned services to link to the world class competencies which ensure the best value of service for patients

http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_080956

Many PwSIs in Older People have been established around the country and much has been learnt from examples of best practice. All those involved in the delivery of these services recognise the need to ensure that PwSIs are suitably qualified, with demonstrable competences, training and experience. These factors underpin the delivery of safe, high quality care. As we move steadily towards a regulated service, with registration of NHS organisations and increasing use of accreditation schemes, such as that currently being piloted by RCGP, there is increasing pertinence of the processes described in this document. Through implementation of this guidance, there will be a more vivid guarantee of quality.

This document, which should be read in conjunction with *Implementing care closer to home: Convenient quality care for patients*

(http://www.dh.gov.uk/en/Healthcare/Primarycare/Practitionerswithspecialinterests/DH_074419), describes different models of care and provides information about the

competences, training, accreditation and assessment processes to support the accreditation of PwSIs in Older People . For Commissioners, this should be read in conjunction with the World Class Commissioning Assurance Framework and associated competencies

<http://www.dh.gov.uk/en/Managingyourorganisation/Commissioning/Worldclasscommissioning/Assurance/index.htm>

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DEFINITION OF KEY TERMS IN THIS DOCUMENT

INTRODUCTION

Whilst the increase in life expectancy in modern society is a triumph of health and social welfare, one consequence is an increase in the numbers of frail older people.

The National Service Framework for Older People describes three groups of “older people”:

- One group is characterised by the newly retired over 65s whose service requirements are similar to adults of younger age
- A second group is those who are generally healthy but in transition with some degree of disability, often around 75 years of age: services for these need to be tailored to be sensitive to the presence of these problems but usually this can be dealt with using inclusive approaches
- The third group is older people who are frail

Whereas the first two groups are part and parcel of routine primary care, it is increasingly recognised that specific arrangements are required for frail older people.

Frail older people in primary care settings are seen in care homes, are on community matron case loads, are known to community falls services, intermediate care services, community hospitals, and are also known to GPs, pharmacists and social workers.

It follows that skilled, integrated teams are required to manage frail older people. PwSIs contribute to these teams, through the provision of specialist medical expertise, as well as in contributing to leadership, education, quality assurance, governance, research and development.

One definition of frailty is “**living with disability through multiple long-term conditions**” although the consequences are a tendency towards exacerbations of these long term conditions. Frail older people are closer to death, and health care costs are greatest in the period closest to death.

The principles of frailty management include the need for:

- A skilled and comprehensive assessment including, but not restricted to, the relevant medical and psychiatric conditions
- A skilled and co-ordinated delivery of a package of interventions, often multiple, and usually from several members of a multi-disciplinary team

This document represents an updating of *Guidelines for the appointment of GPwSIs in the Delivery of Clinical Services: Older people* - published by the Department of Health in 2003. It provides detailed information to guide accreditors and practitioners towards the kind of evidence and competences that may be expected to be seen and tested during the nationally mandated accreditation process set out in *Implementing care closer to home: convenient quality care for patients, Part 3: The accreditation of GPs and Pharmacists with Special Interests*

(http://www.dh.gov.uk/en/Healthcare/Primarycare/Practitionerswithspecialinterests/DH_074419).

This guidance relates **only** to the specific training and accreditation needs of general practitioners and pharmacists seeking accreditation as PwSIs in Older People.

The competency framework is designed to help practitioners understand and develop the extended knowledge and skills they will require to provide services beyond the scope of their generalist roles. Such developments are expected to occur within a negotiated local framework. It is not intended that PwSIs in Older People have all the competences listed in this document. Commissioners will need to identify the specific competences (detailed in Chapter 3) required by the practitioner in order to meet the service specifications.

Commissioners should note that the training and personal development of PwSIs will need to be ongoing and will require support from specialist practitioners and / or access to relevant peer support.

This framework does not preclude commissioners from developing specialist services using other practitioners, for example, nurses or other health care professionals. Competences for NHS-employed staff providing specialist care in community settings may be assessed through the knowledge and skills framework.

Specialist practitioners are expected to operate within the local clinical governance framework and within their scope of professional practice. They must be able to demonstrate relevant expertise when moving into new areas and commissioners will need to take a more competence-based approach to reflect the current work on modernising healthcare careers.

IMPORTANT NOTE FOR COMMISSIONERS IN RESPECT OF SERVICES FOR OLDER PEOPLE

Many GPs and pharmacists who do not consider themselves to be special interest practitioners are currently providing specialist services or clinical leadership within their practice or locality.

This guidance does not intend to undermine these clinicians. It is provided for doctors and pharmacists whose objective is to extend their competences and skills within a formally accredited PwSI framework.

1. PwSI SERVICE PROVISION

1.1 DEFINITION OF A PwSI

PwSIs supplement their core generalist role by delivering an additional high quality service to meet the needs of patients. Working principally in the community, they deliver a clinical service beyond the scope of their core professional role or may undertake advanced interventions not normally undertaken by their peers. They will have demonstrated appropriate competences to deliver those services without direct supervision.

1.2 LOCAL SERVICES THAT CAN BE PROVIDED BY A PwSI

The needs of the local population will inform the services to be provided and will be likely to include health promotion as well as health and social care for older people. PwSIs will form one of a series of integrated options for the delivery of these services. The specific activities of the PwSI will depend on the service configuration, and will include raising awareness of the primary and community practitioners' role in the identification of, and response to, the healthcare needs of older people.

A potential area of work for a PwSI is within the services usually led by secondary care such as stroke services and day hospitals. The largest area of growth is likely to be within community hospitals, intermediate care services, falls assessment clinics, and care homes. Working in community mental health services is not covered by this specification.

There is also the potential for PwSIs to spearhead the development and integration of health and social services for older people within a locality, through developing pathways, information systems, and improved health promotion.

It is very important that all service providers and patients and carers are involved at every stage of service development.

The following points should be considered by commissioners when establishing a service, and by referring clinicians:

- Who will be referred to the service, including inclusion and exclusion criteria
- Type of service(s) being delivered
- Referral pathways
- Response time
- Communication pathways
- Consent
- Confidentiality and information sharing
- Multi-disciplinary working
- Caseload / frequency

Factors Influencing Service Development

Services may be developed in response to many issues including:

- That society is ageing with large numbers of people living into advanced old age
- A high proportion of older people have a number of long-term conditions which lead over time to entering a period of complexity and interaction with each other
- The need for integrated care across the health and social care community; as many can be served poorly by episodes of crisis admission to a DGH
- The vital need for adequate assessment and rehabilitation for frail older people, and the potential for this to be provided in community settings
- The need to help older people obtain maximum benefit from their medicines; four out of five people over 75 take at least one prescribed medicine, with 36% taking four or more. This increases the risk of adverse reactions to medicines, many of which can be prevented, and they are implicated in 5-17% of hospital admissions (http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4008020)
- The development of services providing more effective health care when managing chronic diseases, such as chronic lung disease, heart disease, and degenerative conditions such as dementia and Parkinson's disease
- A need for effective health promotion and effective health care for older people with a view to reducing the number of people who experience disability, vulnerability and dependence

The development of PwSIs in Older People can support the above components of community geriatrics, encourage collaborative working, eg, with community nurses, therapists and community matrons, and enable the delivery of comprehensive high quality care for older people

EXAMPLES OF PwSI SERVICES FOR OLDER PEOPLE

The table below gives examples of different types of services that a PwSI could deliver:

<p>Clinical Services</p> <ul style="list-style-type: none">• Comprehensive Geriatric Assessment• Diagnosis of acute illness and long-term conditions• Providing information in an accessible manner to patients and their carers• Treatment of all common conditions in old age care• Leadership of the rehabilitation process, and an ability to jointly set and review rehabilitation goals through multi-disciplinary working• Leadership in the discharge of patients from services• Communication with other health and social care professionals• Managing more complex drug therapy for older people• Specialist medication assessments• Specialised pharmaceutical services to maintain independence and facilitate rehabilitation, including provision a range of aids to support self administration• Leading or co-ordinating medicines management support during transfer of care (eg, a care manager)	<ul style="list-style-type: none">• Medical responsibility for assessment and rehabilitation wards in community hospitals, and in day hospitals• Medical assessment in specialist clinics for falls, movement disorders, continence, transient ischaemic attacks and stroke disease• Medical care in care homes, which may include beds commissioned by the PCT for rehabilitation, continuing care or palliative care• Medical assessment for Intermediate care services, either within a residential home or as domiciliary “Hospital-at-Home” scheme• Expert palliative care for older people dying in hospital, at home or in Care Homes• Specialist pharmaceutical care and advice on medicines management for older people, such as face to face clinical medication reviews (level 3), domiciliary visits• Take the lead in the therapeutic management for long term conditions in older people where medication plays a key role such as COPD, osteoporosis, CHF, AF, hypothyroidism
<p>Leadership</p> <ul style="list-style-type: none">• Supporting / leading local NSF implementation• Developing participation in the monitoring of NSF outcomes• Providing strategic leadership, direction, education and clinical support• Supporting the implementation of the quality and outcome framework of the new GMS contract	

Improving Practice

- Providing education and support to primary care organisations, constituent practices and other primary care providers to raise the general standard and consistency of old age care across primary care
- Facilitating and encouraging the spread of good practice from within primary care across the whole health and social care community
- Providing a link / liaison role to local practices and pharmacists to enable robust information management / understanding in areas such as the shared Single Assessment Process, and targeted screening assessments
- Working with general practitioners, pharmacists, primary care nurses, social workers, mental health nurses, specialist community nurses and other health care staff such that current best practice is implemented within effective pathways within primary care
- Lead the development of policies and guidance on the safe administration and handling of medicines in community settings by staff in care homes, social services and home care providers

1.3 PRINCIPLES OF SERVICE DELIVERY

Models of service delivery are expected to reflect the important principles outlined in the *Implementing care closer to home: convenient quality care for patients* documents (http://www.dh.gov.uk/en/Healthcare/Primarycare/Practitionerswithspecialinterests/DH_074419). This will entail partnerships of working between Primary and Secondary Care, and working with Social Services.

Local guidelines for the service should reflect and incorporate nationally agreed guidelines. Both the commissioner and PwSIs should demonstrate awareness of relevant national advice issued by organisations such as:

- Department of Health (National Service Framework for Older People 2001)
<http://www.dh.gov.uk/en/SocialCare/Deliveringadultsocialcare/Olderpeople/index.htm>
- Department of Health (National Stroke Strategy)
http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_081062
- Royal College of Psychiatrists (National guidelines)
<http://www.rcpsych.ac.uk/mentalhealthinformation/olderpeople.aspx>
- Royal College of Physicians (National guidelines)
<http://www.rcplondon.ac.uk/specialties/Stroke%20Medicine/Pages/Stroke-Medicine.aspx>
- National Institute for Health and Clinical Excellence (Guideline CG21 Falls)
<http://www.nice.org.uk/guidance/index.jsp?action=byType&type=2&status=3>
- British Geriatrics Society
<http://www.bgs.org.uk>

In addition:

There is a need to remain up to date around nationally agreed guidance, in particular:

- The Mental Capacity Act 2005
http://www.dh.gov.uk/en/Publicationsandstatistics/Bulletins/theweek/Chiefexecutivebulletin/DH_4108436
- The National Framework for Continuing NHS Care
http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_076288

The model should incorporate examples of nationally agreed good practice such as care closer to home demonstration sites:

www.dh.gov.uk/en/Policyandguidance/Organisationpolicy/Modernisation/Ourhealthourcareoursay/DH_4139717

A range of policy guidelines and other useful documents are included in Appendix 3.

1.4 THE ROLE OF ASSESSMENT IN THE CARE OF OLDER PEOPLE

Older people may have a range of health and social care needs, and proper assessment of these is a fundamentally important part of their care.

Comprehensive Geriatric Assessment

Commissioners should consider the inclusion of the Comprehensive Geriatric Assessment (CGA) tool in the service development process and its potential impact on the provision of appropriate and timely services for older people. It has a strong evidence base and is at the heart of old age care: www.bgs.org.uk/Publications/Compendium/compend_3-5.htm.

Diseases in older people do not always present clearly, but rather as common syndromes such as falling, immobility, confusion and incontinence.

Without CGA, these problems may be wrongly attributed to the ageing process, and this quickly results in age discrimination, denying the person a correct diagnosis and treatment.

The PwSI requires expertise in the process of CGA, and an understanding of his or her place within the multi-disciplinary team. Moreover the PwSI may be required to be the team leader for CGA, ensuring that case conferences assess the potential for treatment and rehabilitation, and make appropriate referrals and decisions.

The requirements for Comprehensive Geriatric Assessment to take place are:

- A suitable place for assessment
- Adequate time for the assessment
- A systematic approach delivered by a multi-disciplinary team

The **Single Assessment Process (SAP)** may identify the need for a CGA and / or for an in-depth medicines assessment. The PwSI requires an understanding of the local SAP process.

Specialist Medicines Assessment

A specialist medication assessment is a systematic, patient-centred and outcome-focused in-depth evaluation of the individual's medicines management needs / problems. The assessment confirms the presence, extent, cause and likely development of a medicines

related problem then analyses the associated risks in the context of the individual's circumstances in order to develop a co-ordinated and integrated care plan to deliver the right intervention / support to meet those needs.

Medicines management is of vital importance to older people: older people are prescribed many drugs, as most will suffer from more than one long-term condition. A thorough understanding of pharmacology and ageing (including pharmacokinetic, pharmacodynamic and homeostatic changes and the resultant effects on certain drugs), drug interactions, adverse drug reactions, compliance issues, and an ability to weigh up risks and benefits of each drug to an individual, including consideration of evidence based prescribing, contribute to providing good advice.

2. INFRASTRUCTURE REQUIRED

2.1 SERVICE LEVEL AGREEMENTS

It is important that the commissioned service meets the agreed specifications as set out by the employing authority.

This will include, for example:

- Type of service to be delivered
- Joint working arrangements (eg, with statutory or third sector agency)
- How referrals are received
- Waiting times
- Means of communication between referrer, PwSI and other specialist health care professionals
- Confidentiality / information sharing
- Number and composition of sessions to be worked by PwSI
- Location of the service, suitability, accessibility and support
- Contact with other health professionals
- Supervision, education and liaison with local consultant(s) working in elderly care
- Direct access to diagnostic provision (including reporting)
- Review / process for following-up patient
- Communication / updating medical records
- Reporting mechanism
- How the service links with the commissioner's requirements

2.2 SUPPORT AND FACILITIES

PwSIs in Older People may be working in a number of different models of care, but this should always be as part of an integrated team. They will either work within local clinical networks alongside consultants in old age care, or have clear links for support and advice on specific patients.

Facilities will vary according to the commissioned service, and it is always important to remember that it is the whole service, and not the PwSI, that is commissioned. The basic requirements for a PwSI in Older People include the following:

- Direct access to support and supervision from specialists in the care of older people
- Clinical and administrative support staff available as required for each service
- Adequate means of record keeping
- Education mentoring support and clinical network facilities
- Appropriate support to facilitate effective clinical audit and performance monitoring
- Access to educational material / clinical reference databases, events and conferences to ensure they are undertaking appropriate CPD

NB: Facilities must be kept up to date in keeping with national guidance. Such facilities are to be accredited and should take account of the Government's *Standards for Better Health*:

2.3 CLINICAL GOVERNANCE AND STANDARDS

PwSIs will operate within the local clinical governance framework and within their scope of professional practice.

Mechanisms of clinical governance need to be agreed as part of the service accreditation. This will ensure maintenance of local and nationally agreed standards in respect of patient care and patient safety. Nationally agreed standards for the provision of facilities exist, and are referred to in *Implementing care closer to home: convenient quality care for patients* (http://www.dh.gov.uk/en/Healthcare/Primarycare/Practitionerswithspecialinterests/DH_074419).

The commissioner should give consideration to the following aspects of the PwSI service:

- **Lines of responsibility:** Accountability for overall quality of clinical care.
- **Monitoring of clinical care:** Patients' and carers' experience to be included in patient surveys. Staff to be encouraged to participate in clinical governance programmes.
- **Workforce planning and development:** Continuing professional development, which may include peer review, support and mentoring, will be built into organisations' service planning. Succession and contingency plans will be in place and service users will be involved and their opinions taken into account.
- **Risk management programmes:** Included in clinical risk management and in protocols on good record keeping, patient safety, confidentiality and handling complaints.
- **Poor performance management:** All organisations should have systems in place for identifying and managing poor professional performance in line with professional organisations and national bodies, eg, NCAS
- **Linked to this is reporting of critical incidents:** Such as medication errors, which should be mandatory for all settings, not just the NHS.
- **Adherence:** To the requirements set down by the Accountable Officer in relation to controlled drugs.

3. THE COMPETENCES REQUIRED

3.1 GENERALIST COMPETENCES

The PwSI will be required to demonstrate that he / she is a competent generalist.

Competent practitioners will be able to demonstrate:

- Good communication skills with patients, carers and colleagues
- The ability to explain risk and benefits of different treatment options
- Skill in involving patients and carers in the management of their condition(s)

GENERAL PRACTITIONERS

Generalist skills can be assessed in a number of ways including:

- Meeting the competences set out in the new RCGP curriculum (www.rcgp-curriculum.org.uk) together with a holistic understanding of primary care practice
- Obtaining a pass in the examination of the Royal College of General Practitioners or equivalent and being a Member of Good Standing
- Evidence of critical appraisal skills
- Engaging in active clinical work

PHARMACISTS

A generic PhwSI competence framework was published within the national framework for PhwSIs (<http://www.primarycarecontracting.nhs.uk/246.php>). It is recommended that this is used to assess generalist (practitioner-level) skills and experience via a portfolio of evidence. CPD records are expected to form a significant part of this evidence. This framework may also be used to identify skills and experience that go beyond the core role.

3.2 SPECIFIC COMPETENCES

In developing the capacity and capability for providing specialist care for the elderly in community settings, a way forward is to build on routine procedures and core skills already in existence in general medical and pharmacy practice.

The PwSI will demonstrate a knowledge and skills level higher than those acquired by non-specialist colleagues.

It is not intended that a PwSI in Older People will necessarily have all the competences listed in this document. The commissioners need to ensure that the practitioner has the specific competences, drawn from the overall list in Appendix 1, to meet the requirements of their service specification.

This same principle applies to the differing clinical roles of GPwSIs and PhwSIs; while some competences may be relevant for both GP and pharmacist services, there may be others which relate only to a GP or pharmacist role. The competences for both roles can be drawn from the same overall list in Appendix 1.

It is important for commissioners and practitioners to note that not all of these competences will need to be demonstrated before appointment. The specific competences that can be developed after appointment depend on the roles and responsibilities expected from the practitioner.

The competences for a PwSI in Older People are summarised below:

- Comprehensive geriatric assessment
- Diagnosis and management of acute illness
- Long-term condition management
- Rehabilitation and multi-disciplinary team-working
- Management of drug therapy
- Mental health problems
- Transfer of care and discharge planning
- Intermediate care and community geriatrics
- Long-term care
- Falls clinic assessment
- Continence clinic assessment
- Stroke care
- Orthogeriatrics
- End-of-life care
- Medico-legal issues

The full guidance can be found in Appendix 1. These competences are adapted from the Joint Royal Colleges of Physicians Training Board curriculum.

PHARMACISTS

Pharmacists are expected to have the relevant competences dependent on the requirements of the service. While some competences will be similar to those listed above (eg, those that refer to attitude and multi-professional collaborative working), the prime focus of their contribution to the care of older people will relate to medication.

The specific competences that PhwSIs will need to demonstrate during accreditation for a particular role will be drawn from those listed in Appendix 1 as appropriate, including the competence on management of drug therapy for older people.

NATIONAL SERVICE FRAMEWORK

The National Service Framework for older people defines a number of standards that should be adhered to with respect to care of older people. Further standards have been added by the subsequent publication, *A New Ambition for Old Age*. It would be expected that a PwSI in Older People will have knowledge and understanding of all these core areas.

The standards relate to:

- Age discrimination
- Person-centred care, dignity in care and integrated care records
- Intermediate care
- General hospital care
- Stroke
- Falls
- Mental health in older people
- The promotion of health and active life in older age
- Medicines management in older people
- End of life care
- Integrated care for the frail and those with complex needs

4. TEACHING AND LEARNING

4.1 TRAINING FOR PwSIs

PwSIs are expected to demonstrate that they have completed recognised training which may include acknowledgement of prior learning and expertise.

Training can be acquired in several ways and would be expected to include both practical and theoretical elements.

For example:

- Self-directed learning with evidence of the completion of individual tasks
- Attendance at recognised meetings / lectures / tutorials on specific relevant topics
- As a trainee or other post under the supervision of a specialist or consultant in old age care
- As part of a GP Registrar vocational training programme
- During the Foundation Year 2 post
- As a clinical placement agreed locally
- As part of a recognised university course
- Successful completion of a Diploma in Geriatric Medicine
- Completed a postgraduate qualification, eg, Taught Masters or a Joint Programme Board postgraduate diploma in general pharmacy practice with a defined area of practice (DAP) in the pharmaceutical care of older people
- Completion of modules (eg, Therapeutics for Older People) as part of a recognised post graduate clinical pharmacy programme
- Experience of delivering a full clinical medication review service to older people eg, in an intermediate care centre, housebound, care homes
- As part of accredited training as a non-medical prescriber
- Evidence of working under direct supervision with a specialist clinician in relevant clinical areas. The number of sessions should be sufficient to ensure that the PwSI is able to meet the competences of the service requirements
- Participation in case conferences, in-depth case reviews, and other special meetings, eg, At Risk case conferences, eligibility for continuing NHS care
- Involvement in services specifically designed for certain long term conditions, eg, COPD, heart failure, working alongside other consultants / specialist nurses / therapists
- Experience (current or previous) of working in relevant departments, eg,:
 - Day hospitals
 - Care homes
 - Rapid assessment clinics
 - Falls clinics
 - TIA clinics
 - Community hospitals
 - Nursing homes
 - Other specialist clinics

Adequate training cannot be assumed from practical experience within these settings without senior supervision.

PHARMACISTS

The precise nature and duration of supervised practice will depend on the specific service requirements. Pharmacists with a special interest in old age care are expected to demonstrate a range of evidence in line with the generic competence framework and, in addition, a structured reference from an objective, relevant and independent clinician to confirm their competence to take on the new role. It is anticipated that this evidence will include formal learning, supervised practice and relevant expertise in the special interest area. Pharmacists applying for accreditation as a PwSI in Older People will need to draw on support from specialist services for older people and hospital pharmacy colleagues to develop this range of evidence, including periods of supervised practice.

For all PwSIs the most suitable teaching and learning and assessment methods will vary according to individual circumstances and it is recommended that these are agreed with an educational supervisor and / or trainer in advance.

5. ASSESSMENT

The most suitable teaching / learning and assessment methods will vary according to individual circumstances and should be agreed between trainee and trainer in advance. The PwSI can be assessed across one or more of the competences listed in Appendix 1, and it is expected that this process will be tailored towards the service that the PwSI will deliver. As a general guide five cases should be discussed through direct observation or case-based discussion for each of the domains described in Appendix 1.

The assessment of individual competences can be undertaken by a combination of any of the following:

- Observed practice using modified mini clinical examination
- Case note review and case based discussions
- Reports from colleagues in the multi-disciplinary team using 360-degree appraisal tools
- Demonstration of skills under direct observation by a specialist clinician (DOPS)
- Simulated role-play objective structured clinical examination (OSCE)
- Reflective practice
- Logbook / portfolio of achievement
- Observed communication skills, attitudes and professional conduct
- Demonstration of knowledge by personal study supported by appraisal (+/- knowledge based assessment)
- Evidence of gained knowledge via attendance at accredited courses or conferences
- Evidence of preparation for teaching sessions, case studies with therapeutic reviews and publications

Further information regarding the above assessment tools can be found in Appendix 2.

6. ACCREDITATION, MAINTENANCE OF COMPETENCE AND RE-ACCREDITATION

The mandatory processes for accreditation and re-accreditation are set out in *Implementing care closer to home: convenient quality care for patients, Part 3 The accreditation of GPs and Pharmacists with Special Interests*. During the accreditation process, the PwSI is expected to provide evidence of his or her acquisition and maintenance of appropriate competences in the care of older people.

A practitioner should only be employed to work as a PwSI once his or her competence for that service has been assessed and confirmed against the standards described in this document.

6.1 MAINTENANCE OF COMPETENCES

Practical arrangements for the maintenance of competences should be agreed by all key stakeholders as part of the service accreditation.

PwSIs are expected to maintain a personal development portfolio to identify their education requirements matched against the competences required for the service and evidence of how these have been met and maintained.

This portfolio can act as an ongoing training record and logbook and should be countersigned as appropriate by an educational supervisor. The portfolio should also include evidence of audit and continuing professional development (CPD) and, for GPs, would be expected to form part of their annual appraisal. Pharmacists will be expected to include evidence relevant to their PwSI role in CPD records and in any regular appraisals.

To develop and maintain skills it is important to see sufficient numbers of patients in a clinical setting in accordance with the scope of the commissioned service.

It is recommended that PwSIs:

- Work regularly within the specialist area in order to obtain adequate exposure to a varied case mix to support CPD
- Undertake a joint clinic or clinical supervision session on a regular basis commensurate with the number of sessions worked by the PwSI. These should be with a more specialist practitioner for the discussion of difficult cases and as an opportunity for CPD. In the absence of this there should be evidence of working and / or learning with peers.

It is also expected that practitioners will:

- Be actively involved in the local older people specialist service(s)
- Contribute to local clinical audits

Active membership of an appropriate faculty, professional group and / or a primary care organisation for the care of older people will provide further opportunities for PwSIs to develop their knowledge and skills through attendance at educational events and update meetings.

For example:

- British Geriatrics Society, and the Primary care special interest group within BGS
- The Care of the Elderly section within the UK Clinical Pharmacy Association

PwSI IN OLDER PEOPLE PORTFOLIO

The portfolio should provide a track record of providing high quality care of older people in line with national guidelines. Examples of the sections that could be included in the portfolio include:

- Assessment of practical skills relevant to the service being commissioned (in adults and children)
- Evidence of high quality clinical audit, research, training and teamwork in the care of older people
- Personal development through analytical reflection on clinical events, appraisal of three significant events, case history analysis detailing the decision-making rationale
- Evidence of educational skills via video, records or learning aims and outcomes achieved, feedback from audiences at educational sessions

An outline portfolio to support the accreditation of pharmacists with a special interest has been developed and is available at <http://www.primarycarecontracting.nhs.uk/246.php> and can be supported by CPD. This provides a guide to the range and types of evidence that will need to be included.

6.2 MONITORING

Mechanisms of clinical governance need to be agreed as part of the service accreditation. This will ensure maintenance of local and nationally agreed standards in respect of patient care and patient safety.

PwSIs are expected to be involved in the monitoring of service delivery, which incorporates the following:

- Clinical outcomes and quality of care
- Access times to the PwSI service
- Patient and carer experience questionnaires
- Prescribing / medicines management

6.3 RE-ACCREDITATION

PwSIs must maintain their specialist skills and competences on an ongoing basis as outlined in national PwSI accreditation guidance (<http://www.primarycarecontracting.nhs.uk/173.php>).

The recommendations for re-accreditation are set out in *Implementing care closer to home: convenient quality care for patients*, Part 3: *The accreditation of GPs and Pharmacists with Special Interests*.

APPENDIX 1: COMPETENCES

It is not intended that PwSIs in the Care of Older People are have all the competences listed in this document, rather that commissioners ensure that the practitioner has the specific competences, drawn from the overall list, to meet the requirements of the service specification. This same principle applies to the differing clinical roles of GPwSIs and PhwSIs; while some competences may be relevant for both GP and pharmacist roles, there may be others which relate only to GPwSIs or PhwSIs.

However the general nature of elderly care, and the non-specific mode of presentation, means that it is desirable for the PwSI to be able to demonstrate that they have attained a broad range of competences reflecting the common aspects of care for older people.

COMPREHENSIVE GERIATRIC ASSESSMENT

Objective	Knowledge Can demonstrate understanding of	Skills Is able to	Attitude
To perform a comprehensive geriatric assessment	Factors influencing health status in older people	Employ diagnostic skills	Collaborative working with other professionals and agencies (health / social care / voluntary)
	Measures employed in measuring health status and outcome	Conduct a functional status evaluation including assessment of basic ADL and IADL, social support, mental health and cognitive status, mobility including gait and balance, and nutritional evaluation	Championing the value of CGA amongst other professionals and service providers
	The concept of frailty and the evidence base for Comprehensive Geriatric Assessment	Interpret CGA results in the context of health planning, quality of life assessment, and appropriate use of available health-related and social-related resources	

DIAGNOSIS AND MANAGEMENT OF ACUTE ILLNESS

Objective	Knowledge Can demonstrate understanding of	Skills Is able to	Attitude
To diagnose acute illness in old age	Major acute geriatric syndromes and illnesses	Conduct an appropriate physical examination	To strive to recognise and diagnose acute illness early and work collaboratively with other health care professionals to achieve this
	Acute geriatric medicine and basic gerontology	Carry out appropriate cognitive assessment	To appreciate the changes in acute illness presentation in old age and the deleterious effects of diagnostic delays
	Changes in disease presentation in old age	Order investigations and interpret the results	
To successfully manage acute illness in an older person	Clinical pharmacology, therapeutics and medicines management as related to older people	Drug and non-drug interventions	A meticulous approach to the treatment of acute illness in older people and to encourage others to work in a similar way
	Ethics and their application to the care of older people	Appropriate referral to / collaboration with other specialists	To work within an acceptable ethical and legal framework to help guide patients and their relatives through consent to medical investigations and treatments
	Risks of secondary complications of acute illness in older people and strategies to prevent them	Lead a multi-disciplinary team and display strong rehabilitation skills	To work collaboratively with other professions to minimise the risks of secondary complications in older people with acute illness

LONG-TERM CONDITION MANAGEMENT

Objective	Knowledge Can demonstrate understanding of	Skills Is able to	Attitude
To diagnose and manage those with chronic disease and disability in in-patient, out-patient, day hospital and community settings	Major long term geriatric syndromes and illnesses	Perform an appropriate clinical examination, including gait assessment	A positive but realistic approach to management
	Basic gerontology and knowledge of common chronic conditions eg, cardiac failure, COPD, musculoskeletal disorders, movement disorders	Conduct appropriate cognitive and mood assessments and organising appropriate investigations	A multi-professional problem-solving approach appreciating the importance of regular review, continuity of care and fine tuning of treatments
	Clinical pharmacology, therapeutics and pharmacy medicines management for older people	Drug and non-drug interventions eg, for painful long term conditions	Appreciating the importance of active rehabilitation maintaining function
	Health promotion theory	Provide nutritional assessment and offer appropriate interventions	Actively engage patients in their own management, including health promotion and disease prevention measures
	Ethics and its application to the care of older people with long term conditions	Assist with end of life planning and support patient / carers and refer to appropriate services – health / social / voluntary	Recognition of the terminal stages of illness adjusting management plans

REHABILITATION AND MULTI-DISCIPLINARY TEAM-WORKING

Objective	Knowledge Can demonstrate understanding of	Skills Is able to	Attitude
To provide rehabilitation to an older patient in an in-patient, out-patient, day hospital and community-based settings and when to refer for further specialist advice	Basic gerontology	Manage patients with multiple medical problems and disabilities	Recognition that older people take longer to recover from acute illness and frequently require rehabilitation
	Principles of rehabilitation and comprehensive geriatric assessment	Refer appropriately to the physical therapies which improve muscle strength and function	
	Assessment scales used in rehabilitation	Provide continence care through assessment and treatments	Collaborative working to ensure that no individual should unnecessarily enter a system of domiciliary or institutionalised care
	Specialist rehabilitation services and the evidence base for its use	Select patients for rehabilitation	Promoting a rehabilitation ethos
	Goal setting in rehabilitation	Facilitate goal setting according to expected disease prognosis / outcome	
	Therapeutic techniques / training to improve balance and gait	Provide guidance on / and facilitate the use of aids and appliances which reduce disability	
	Scope and nature of intermediate care approaches	Integrate the roles and expertise of different members of interdisciplinary team	Appreciation that small changes in disability can avoid long term care

MANAGEMENT OF DRUG THERAPY

Objective	Knowledge Can demonstrate understanding of	Skills Is able to	Attitude
Manages and co-ordinates drug therapy for older people in collaboration with other health care professionals	Pharmacology, therapeutics and pharmacokinetics in relation to drug therapy for older people	Initiate, prescribe or supply, monitor response and advise on all aspects of drug treatment	Appropriate approach to benefits and risks of medical therapy in old age and frailty
		Weigh up risks and benefits of prescribing specific therapies	
		Provide specialist pharmaceutical input in multi-disciplinary teams and committees	
		Act as a referral point for patients with complex needs for ongoing support to use their medicines	
Promotes concordance and adherence to prescribed medicines	The principles of concordance and self management of prescribed medication	Able to conduct patient consultation in line with NPC Competency framework for shared decision-making with patient ¹	Listens to patients, and not imposing our views
	The range of personnel, services or pathways available locally to deliver medicines support	Able to recommend the most appropriate option	Liaises with others to ensure delivery of care
Carries out specialist medication assessments and full clinical medication	The range of factors that predispose older people to higher risks of medicines related problems	Make interventions that reduce the risk of adverse drug effects and other medicines related problems	Documents, reports and develops care plan as well as evaluate outcomes in consultation with the patient (and carer)

¹ Room for Review: A guide to medication review: NPC and Medicines Partnership
http://www.npc.co.uk/med_partnership/medication-review/room-for-review.html

reviews for older people	The single assessment process and the integration of medicines	Apply a recognised assessment tool to identify the needs of individual patients, assess the risks in the context of the individual's situation and implement a care plan to meet those needs or refer on	
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MENTAL HEALTH NEEDS

Objective	Knowledge Can demonstrate understanding of	Skills Is able to	Attitude
To recognise, diagnose and manage a state of delirium presenting both acutely or sub-acutely in patients in hospital, in the community and in other settings	Diagnostic criteria for delirium	Recognise the principal features of delirium in acute and sub-acute illness states	To take a positive approach to the management of delirium and to seek and deal with remediable causes as quickly as possible
	Relationship of delirium with dementia syndromes	Be competent in the use of the standardised measures of assessing cognitive status in delirious states	To work collaboratively with other professions to manage delirium effectively
	Appropriate standardised measures of cognitive status	Be competent in investigation and management of the delirious patient, including the underlying physical illness and the accompanying distressed mental state	To approach delirium as an acute or sub-acute medical emergency and to encourage all staff to work toward resolution of the delirious state
	Severity indices in delirium	Recognise risk factors and causes and observe main outcomes	
To know how to assess and manage older patients presenting with the common psychiatric conditions, and to know when to seek specialist advice	Major psychiatric conditions: depression, delirium, dementia, anxiety and paranoid states	Cognitive and mood assessment	To develop a positive approach to the investigation and management of psychiatric conditions in old age
	Pharmacology	Drug and non-drug interventions	To work collaboratively with other specialists, particularly old-age psychiatrists, and agencies to manage the older patient with mental ill health
	Medico-legal issues and organisation of old age psychiatry services	Refer appropriately to other specialists	To take account of a patient's family, cultural and religious background to better enable the management of the individual patient
	Psychiatric assessment methods and tools	Assess mental capacity	

TRANSFER OF CARE AND DISCHARGE PLANNING

Objective	Knowledge Can demonstrate understanding of	Skills Is able to	Attitude
To plan the successful transfer of care or discharge of frail older patients	The variety of resources available following discharge eg, intermediate care, community care, domiciliary care, voluntary sector support, respite care, institution-based long-term care, health service funded long-term care	Co-ordinate medicines management support across the interface of care Planning skills	To view discharge planning as important which is timely and appropriate (from admission)
	Roles and rights of “informal” carers	Engage patients and carers in discussion regarding a transfer of care, including their role and rights within the process	To view the discharge of a frail older person as a <i>transfer of care</i>
	The current criteria (and processes) for health service-based continuing care	To assess patients against the criteria for continuing care, including mental capacity	
	The assessment methods/processes undertaken to access services (including the unified (single) assessment process)	Lead a multi-disciplinary team in discharge planning	To ensure medical involvement in all hospital discharge planning
	The financial resources available to patients and their carers		Recognition that the patient’s wishes are important

INTERMEDIATE CARE AND COMMUNITY GERIATRICS

Objective	Knowledge Can demonstrate understanding of	Skills Is able to	Attitude
To manage elderly patients in an intermediate care/community geriatric setting in conjunction with a community based multi-disciplinary team and other agencies	Major geriatric syndromes and illnesses.	Display good clinical skills including drug therapy (eg, clinical pharmacology, therapeutics and medicines management for older people)	To develop an approach to care that crosses the traditional division between primary and secondary care
	Basic gerontology	Manage patients with multiple medical problems and disabilities	
	Models of intermediate care/community geriatrics including evolving role of day hospital	Facilitate effective liaison with GPs including joint management of cases	To recognise the importance of geriatrician involvement in intermediate care
	Understanding of the various agencies involved in community care	Lead a multi-disciplinary team in a non-hospital setting	To recognise the role of the geriatrician in education and management of community staff
	Opportunities provided by assistive technologies, eg, monitoring devices, technology assisted living	Provide appropriate rehabilitation and use the facilities effectively	

LONG-TERM CARE

Objective	Knowledge Can demonstrate understanding of	Skills Is able to	Attitude
To provide appropriate care to those in long term care in the NHS or a community setting	Major geriatric syndromes and illnesses and appropriate clinical pharmacology, therapeutics and pharmacy interventions for older people	Provide skin and wound care – assessment and treatments	To work in an acceptable ethical framework helping patients and relatives accept or reject medical investigations and treatments
		Provide continence care – assessment and treatments	
		Conduct nutritional assessments and discuss approaches to feeding eg, PEG with the patient	
		Provide drug and non drug interventions	
	Ethics and medico-legal issues	Provide CPR when appropriate	Relevant national publications including guidelines re continuing health care
End of life care	Provide or refer for appropriate palliative care	To discuss prognosis empathetically with patients and families	
Understanding of care home structures, regulation and inspection	Ability to select appropriate patients for continuing health care	To recognise the value of a structured, active approach to care in care homes	

FALLS CLINIC ASSESSMENT

Objective	Knowledge Can demonstrate understanding of	Skills Is able to	Attitude
To assess and manage older patients presenting with falls (with or without fracture) in an in- or out-patient setting	Basic gerontology	Diagnose common conditions associated with falling	Collaborative working with other professions and agencies, including orthopaedic services for fracture patients
	Causes of and risk factors for falls	Conduct gait assessment	Seeking remediable causes of falls
	Drug and neurovascular causes of falls and syncope	Administer drug and non-drug interventions to prevent falls with appropriate referral to other specialists	Positive but realistic approach to falls investigation and management
		Encourage health promotion and joint decision making with the patient	Aim to enable patients to the maximum

CONTINENCE CLINIC ASSESSMENT

Objective	Knowledge Can demonstrate understanding of	Skills Is able to	Attitude
To successfully manage the basics of urinary and faecal incontinence, and to refer appropriately for specialist advice	Risk factors, epidemiology and causes of incontinence	Conduct an appropriate physical examination	To adopt a positive and realistic approach to the management of incontinence
	Investigations available and how to use them appropriately	Interpret the results of investigations	To collaborate with other professions, medical and surgical specialities to manage incontinence optimally
	Management including the role of physiotherapy, drugs and surgery aids, appliances and equipment	Provide appropriate interventions	To learn to work with primary care to reduce the burden of incontinence
	The role of the continence nurse specialist	Involve the continence nurse specialist as appropriate	

STROKE CARE

Objective	Knowledge Can demonstrate understanding of	Skills Is able to	Attitude
To work within a TIA assessment clinic	Differential diagnosis of collapses, dizziness, and transient neurology	Diagnose and share the information clearly and sensitively with the patient and / or carer	The importance of early correct management of TIA
	Investigation pathways for TIA, and an understanding of the risks in an individual	Explain the preferred management options and engage patients in decision making	
To provide a comprehensive service for patients with acute stroke and chronic stroke-related disability in hospital and the community	Epidemiology of stroke	Assess patients with acute stroke and chronic stroke-related disability	To work collaboratively with specialists and other professions to provide a service for patients with stroke
	Evidence of primary and secondary prevention measures	Manage spasticity (including criteria for botulinum toxin administration)	To take a positive and realistic approach to the management of patients with stroke, to restore function as much as is possible and appropriate
	Acute stroke management	Manage feeding problems	
	Complications of stroke		
	Different rehabilitation models in hospital and community	Organisation of rehabilitation and leadership of a multi-disciplinary team	
	Effects on carers		
	Ethical and legal issues relating to patient with severe disability		

ORTHOGERIATRICS

Objective	Knowledge Can demonstrate understanding of	Skills Is able to	Attitude
To assess acutely ill orthopaedic patients and manage them appropriately, including rehabilitation	Basic gerontology, including responses to trauma in old age	Conduct an appropriate physical examination	An approach to the management of elderly people with fracture that seeks to maximise function
	Major geriatric syndromes and illnesses	Provide drug and non-drug interventions	Close collaboration with orthopaedic surgeons and other professionals to ensure best care
	Surgical and anaesthetic issues		
	Causes and management of osteoporosis and falls	Provide rehabilitation for older patients with fractures	
	Different models of orthogeriatric care	Plan transfers of care	

END-OF-LIFE CARE

Objective	Knowledge Can demonstrate understanding of	Skills Is able to	Attitude
To deliver appropriate palliative care to a dying patient	Symptom profiles in the terminally ill and their management	Assess prognosis (recognise when a patient is dying)	Recognise and respect the wishes of a dying patient, family and carers
	Prescribing, eg, syringe drivers	Consider the quality of life of the patient	Allowing for patient's personal, cultural and religious background
	Pathophysiology of pain and specialist interventions eg, nerve blocks, TENS, acupuncture	Provide compassionate understanding of a dying person's wishes	
	Management of emergencies in palliative care, eg, acute pain, hypercalcaemia, haemorrhage, spinal cord compression	Assess the problems and needs of palliative care patients	

	Issues around hydration and nutrition, eg, legal, ethical and technical aspects	Develop appropriate management plans that consider problems, use of medications, special equipment, formal palliative instruments, teamwork and various agencies	Working collaboratively with other professions and agencies to provide the best possible palliative care
	Modern bereavement care		

MEDICO-LEGAL ISSUES

Objective	Knowledge Can demonstrate understanding of	Skills Is able to	Attitude
To manage clinical decision-making in all situations, and understand when to seek outside legal advice	Mental Capacity Act 2005	Communicate effectively with carers	Avoiding prejudices when managing an individual
	Power-of-Attorney and Court of Protection	Assess mental competence	Allowing for patient's personal, cultural and religious background
	Guidelines relating to withdrawing and withholding of treatment	Compassionate understanding of a person's wishes	Working collaboratively with other professions and agencies to provide the best possible care
	Resuscitation Council guidelines on decision-making	Facilitate sensitive decision-making with the whole multi-disciplinary team	
	The distinction between euthanasia and good medical care		
	Elder abuse	Recognise elder abuse	
	Medico-legal relating to covert administration of medicines		

APPENDIX 2: ASSESSMENT TOOLS

It is expected that, as part of the accreditation process, the assessment of individual competences will include observation of clinical practice.

A series of assessment tools suitable for use by PhwSIs are available at:

<http://www.primarycarecontracting.nhs.uk/246.php>.

The following notes are intended to support the effective use of these assessment tools as applied to care for older people:

- It is strongly recommended that a series of clinical assessments (eg, using a modified mini-CEX or video assessment or other face-to-face assessment) takes place four times during the period of training prior to the PwSI becoming accredited.
- Each clinical assessment is expected to take the equivalent of one session and should be performed by a specialist clinician, consultant or clinical pharmacy lead, ideally an alternative to the educational supervisor.
- The assessor is expected to be present throughout the session and to make assessments, covering different clinical domains, from a number of patient interactions.
- Several assessments covering different areas are expected to be performed during each of the clinical assessment sessions.
- The subject / areas covered will depend on the type of service the PwSI is going to offer. This will be agreed at the start of the training.
- The assessment outcome will be 'satisfactory' or 'unsatisfactory'. Time will be allocated for feedback.
- It is expected that one of the assessments should include a review of case notes.
- It is expected that PwSIs will need training in the recognition and management of conditions normally seen / managed in secondary care and that this knowledge will be acquired via continuing education.
- Logbooks – there will be other competences that are not included but desirable; these can be documented in the PwSI logbook and signed off by the trainer. This will probably differ for the individual PwSI and the detail will need to be agreed with the trainer at the beginning of training.
- For PwSIs who have not completed a specialist qualification, it is envisaged that a formal test of knowledge should be included and submitted as evidence to the accreditation panel.
- Practitioners will be expected to demonstrate evidence of 360-degree review.

APPENDIX 3: LINKS TO OTHER RESOURCES

USEFUL DOCUMENTS

Action of Elder Abuse

Elder Abuse www.elderabuse.org.uk

British Geriatric Society

Falls prevention www.bgs.org.uk/Publications/Compendium/compend_4-5.htm

Orthogeriatrics www.bgs.org.uk/Publications/Compendium/compend_4-11.htm

Advance directives http://www.bgs.org.uk/Publications/Compendium/compend_2-1.htm

Capacity http://www.bgs.org.uk/Publications/Compendium/compend_2-2.htm

British Medical Association

Cardiopulmonary resuscitation

[www.bma.org.uk/ap.nsf/AttachmentsByTitle/PDFCPRDecisions07/\\$FILE/DecisionRelatingResusReport.pdf](http://www.bma.org.uk/ap.nsf/AttachmentsByTitle/PDFCPRDecisions07/$FILE/DecisionRelatingResusReport.pdf)

Mental Capacity Act 2005

www.bma.org.uk/ap.nsf/Content/mencapact05?OpenDocument&Highlight=2,mental,capacity

British Orthopaedic Association

The Care of patients with Fragility Fractures – The Blue Book www.boa.ac.uk

Department of Health

National Stroke Strategy

www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_081062

Continuing NHS health care policy

www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_076288

National Institute for Health and Clinical Excellence - NICE

(Guideline CG21 Falls) <http://www.nice.org.uk/guidance/index.jsp?action=byType&type=2&status=3>

National Prescribing Centre

Room for review (Note currently being updated)

www.npc.co.uk/med_partnership/medication-review/room-for-review.html

The 4 SAP medicines questions

http://search.cpa.org.uk/sap/documents/SAP040521100_Lambeth_4_trigger_Qs_with_prompts_revised_jan_04.doc

Service specification for enhanced medication review service

http://www.psnc.org.uk/uploaded_txt/EN7%20-%20Medication%20Review.doc

Principles for older people and their medicines

www.druginfozone.nhs.uk/Record%20Viewing/viewRecord.aspx?id=5729866

National Service Frameworks

National Service Framework for Older People, 2001

www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4003066

A new ambition for Old Age – follow up guidance in 2006 to the NSF

www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4133941

Primary Care Contracting

A national framework for PhwSIs and PhwSI generic competency framework

<http://www.primarycarecontracting.nhs.uk/119.php>

Royal College of Physicians

Joint Royal Colleges of Physicians Training Board curriculum

www.jrcptb.org.uk/Specialty/Documents/Geriatric%20Medicine%20Specialty%20Training%20Curriculum%20May%202007.pdf

Medication for Older People, Second edition

London: Royal College of Physicians (1997)

National clinical guidelines for Stroke, Second Edition

London: Royal College of Physicians (2004)

www.rcplondon.ac.uk/pubs/books/stroke/stroke_guidelines_2ed.pdf

National Sentinel Audit of Evidence-Based Prescribing for Older People

London: Royal College of Physicians (2003)

http://www.rcplondon.ac.uk/college/ceeu/ceeu_ebpop_report.pdf

Stroke Medicine

<http://www.rcplondon.ac.uk/specialty/Stroke.asp>

Royal College of Psychiatrists

Older People's Mental Health

<http://www.rcpsych.ac.uk/mentalhealthinformation/olderpeople.aspx>

APPENDIX 4: MEMBERSHIP OF PwSI OLDER PEOPLE STAKEHOLDER GROUP

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