professionals, to replace the current inefficient and fragmented records systems.

Milestones for implementation of the falls standard are longer than those for some other parts of the framework as evidence is emerging about how best to organise this key component of services. Achieving organised services for the prevention and management of falls will be a great advance in the care of older people.

An inclusive approach was used throughout the development of the national service framework. The success of the approach is one reason why the framework has been so well received; it provides a historic opportunity for transforming health and social care for older people in England.

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Proposals for intermediate care are reinventing workhouse wards

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EDITOR—Grimley Evans and Tallis draw attention to the proposed development of intermediate care and its retrogressive nature.[1] The rationale given for the implementation of intermediate care in the national service framework for older people is perplexing and inadequate.[2]

The framework states, firstly, that old people do not want to be in hospital. But if acute treatment is needed then hospital is often the best place to be. Secondly, it says that unplanned admissions might be avoided by prevention and rehabilitation. But intermediate care is not rehabilitation. Thirdly, it says that old people stay in hospital too long. This may well be true, but shunting sick people to another institution is not the solution.

The selective use of scientific evidence made by the framework to “support” intermediate care is remarkable. By its own admission “evaluative evidence of intermediate care schemes is scarce.” Evidence for the benefits of hospital at home is cited as being a Cochrane/NHS Centre for Reviews and Dissemination systematic review but is not in either archive. Evidence on hospital at home is available in the Cochrane Library,[3] but as the systematic review concludes that “there is insufficient evidence to assess the effects of hospital-at-home on patient outcomes or the cost to the health service” it was presumably deemed inadmissible.

A Cochrane review of the effects of intermediate nurse-led inpatient beds is planned (see Cochrane Library protocols) but has not yet been completed. A non-systematic review concluded, perhaps not surprisingly, that "methodological limitations render firm conclusions difficult."[4]

The secretary of state for health decided that there should be intermediate care beds, and the national service framework had to come up with a post hoc justification for them. As with any new technology, it is sensible for it to be evaluated before being widely used in the NHS—that is what NHS research and development is for. In his rapid response on bmj.com (bmj.com/cgi/eletters/322/7290/807#EL3; above letter here in printed journal) Philp shows touching faith in intermediate care, asserting that it will be done properly. But in the absence of any decent evidence, how can he know how it should be done?

A return to the ethos of the workhouse wards (diagnostic failures, inadequate treatment and rehabilitation, long stays, complications), only recently removed from our NHS, seems quite probable but will clearly cost more than before. Acting as a mouthpiece for ministers seems to mean forfeiting scientific integrity—surely too high a price to pay.

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Problems with mental health are important too

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EDITOR—It is unfortunate that Grimley Evans and Tallis concentrate only on the physical problems of old age.[1] What of the "unworried unwell"—those with dementia? Years of socially oriented policy to deal with the problems of dementia may well have greatly improved the lot of carers. They have been of less help to patients themselves.

Few older people recognise the importance of late onset memory impairment. Even if they do they are unlikely to be referred to a specialist at an early stage in their illness, unlike those with other priority illnesses such as cancer, cardiovascular disease, and stroke.