

The NHS English National Service Framework for Older People: opportunities and risks

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ABSTRACT – The English National Service Framework (NSF) for Older People conforms to the emerging pattern of NSFs as hybrids of policy and evidence, drafted and edited within the Department of Health, albeit with external advisory input. Physicians welcome its much-needed focus on the needs of older people, but its dynamic differs from that underlying the evolution of comprehensive services to date, raising concerns that its declared objectives may be unrealised or perversely interpreted. This applies to the first three (of eight) ‘standards’ currently being applied: rooting out ageism, the single assessment process and intermediate care. With each, there are problems of concept, operational feasibility, expertise and accountability for standards. Conversely, the standards for sub-specialty service models (stroke, falls, mental health) are more significantly underpinned by evidence and operational experience. Success overall will depend on more clearly defined resource flow and accountability, career recruitment, research direction and engagement with specialist physicians than are immediately apparent in the document.

KEY WORDS: ageing, assessment, falls, government health policy, health promotion, intermediate care, mental health, older people, service standards, stroke

Any genuine initiative from either politicians or practitioners to set or raise healthcare standards should uncover common cause in the interests of patients, but it would be naive in any sphere of medicine to anticipate absolute concordance of approach. The emerging English national service frameworks (NSFs) are proving consistent with this presupposition¹, and the NSF for Older People (the third so far, following mental health and coronary heart disease) is no exception^{2,3}.

Background

The development of specialist medical care for older people in Britain over more than 50 years originated

in unmet clinical need. Its evolution was broadly as follows:

- 1 The first advance was therapeutic achievement by means of physician-led interdisciplinary practice in the context of long-stay care, leading to the gestation and formal birth of the specialty.
- 2 Such intervention was manifestly too little too late for many patients, so activity extended ‘upstream’ to earlier rehabilitation and to a range of strategies for crisis intervention and hospital-community collaboration. (The latter might be collectively and appropriately designated *intermediate care*.)
- 3 Based on further advances (still unavailable to many patients because of preceding inappropriate delay, selection or inadequate resource), the rational integration of specialist interdisciplinary practice within acute mainstream medical care followed. Hence, the contemporary recognised models in the UK (age-related, integrated, needs-related).
- 4 Increasingly, the potential for preventive care in medical gerontology and the relevance of sub-specialisation (eg falls and syncope, stroke) have now emerged.

Successful British physician-led specialist services have two key characteristics:

- 1 The comprehensive representation of each of these four aspects of practice within a multi-disciplinary department.
- 2 Their orchestration via the department into an efficient total service appropriate in size and configuration to the local population served.

When present, clinical directorates or care groups holding defined budgets have particularly facilitated such orchestration. In successful departments, excellent partnerships with other agencies (particularly primary and social care) and with other specialties have been axiomatic.

In general, managerial support has (often reluctantly) followed, rather than preceded, good practice, with the realisation that it is staggeringly cost-effective. For example, its introduction has commonly seen the unblocking of beds in acute hospitals, the abolition of transfer waiting lists, the

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closure (with consequent savings) of outdated custodial units, and the building of community confidence in the capacity and competence of the service to respond supportively to crisis.

Background to the National Service Framework for Older People

English specialists, therefore, welcomed the announcement to develop the NSF, in the expectation that it could set the forward agenda for the field, retrieve and promote more appropriate targeting of resources, define the areas of research priority, and delineate clearer standards for the healthcare of older people for the future. This was in contrast to a previous UK policy document, *The Health of the Nation*⁴, in which population ageing as an issue was studiously sidelined and, for example, targets for stroke prevention confined to those under the age of 65.

A number of specialists (including the author and colleagues from other professions) took part in the consultative and advisory processes, and most are now involved at local, regional or national level in the implementation of the NSF for Older People.

In his foreword to the NSF, the Secretary of State characterises it as:

the first ever comprehensive strategy to ensure fair, high quality, integrated health and social care services for older people.

The introductory rationale has five main foci:

- 1 Demographic change.
- 2 Societal change (different expectations).
- 3 An acknowledgement of the phenomenon of age discrimination.
- 4 The diversity and specific subcategories of older people (eg ethnic diversity, those with disability).
- 5 The context of the NHS Plan⁵, within whose principles (restated) all the NSFs are enshrined (Table 1).

This predominantly socio-political agenda has gained a measure of popular support, but its direction of travel is self-evidently distinct from the above history, which is a story of specific forms of innovation driven by overwhelming unmet

clinical need and unnecessary (largely man-made) dependency.

The now familiar format for NSFs is followed. Advice to ministers was provided by an external reference group (ERG) supported by task groups for each standard, each chaired or co-chaired by an ERG member. Those invited to participate by the Department of Health (DH):

reflected the wide range of practitioner and management groups involved in care for older people as well as organisations representing users' and carers' interests. (page 8)

Hence the approach to advice was 'stakeholder' and representative in its ethos rather than primarily expert.

Evidence in the document was compiled by researchers and classified using a standard A-D hierarchy. The task of actual writing lay with the responsible civil servants, although there was substantial external expert input on some standards (eg stroke, falls, mental health). The document contains a range of service targets, clinical and service standards, timetabled milestones and performance monitoring measures.

What is in the National Service Framework?

The four themes and eight standards on which the framework is built are shown in Table 2. At the time of writing, the first three standards have been out to consultation and are in the first stages of implementation. The document concludes with chapters on mechanisms for local delivery, monitoring of progress and national support.

There is extensive recurring 'top-down' basic instruction about proper professional attitudes and behaviour towards older people. From a physician's perspective, its scale in this strategic document is questionable, in that much is either an unnecessary statement of the obvious – or certainly should be. Changing professional attitudes is achieved less by rhetoric and reiteration than by visible human and material investment in quality, research, knowledge, training and special skills.

The specific NSF initiatives comprise:

- 1 The introduction of a single assessment process (SAP) across health and social services.
- 2 The development of intermediate care.
- 3 The delineation of defined service models for stroke, falls and mental health.

*The single assessment process**

(*See NSF glossary⁶ for definition of all terms marked with an asterisk.)

Ageing, health problems and complexity go hand in hand. Older people with ostensibly functional or social problems present notorious diagnostic challenges intertwined with multi-dimensional need. Thus, assessment lies at the heart of modern specialist practice in the field and its effectiveness is attested in the literature⁷. Skill in assessment is a major hallmark of the successful clinician. In the NSF, the SAP is intended to perpetuate

Table 1. The principles of the NHS Plan.

- universality
- comprehensiveness
- user focus and choice
- population diversity
- performance monitoring
- workforce support
- public funds solely to NHS patients
- seamlessness
- health promotion
- confidentiality and provision of information

a multidimensional (person-centred) approach across the spectrum of social care, primary and secondary healthcare and to harmonise and facilitate the flow of information.

Most specialists (and their general practice colleagues) support the need for better information flow, particularly if an optimal minimal data set could be agreed. Departments have frequently set up autonomous systems to circumvent the chronic limitations of NHS hospital records' provision, and therefore would welcome improvement if the NSF could deliver. Investment in effective electronic systems is eagerly awaited.

The improving effect on practice and care standards of introducing a universally applied, documented assessment procedure spanning the whole of health and social care, and its practicality, are more controversial. Perceived problems have included the following:

- the lack of consensus supporting any particular instrument
- who does it?, when?, how well?, how often?, and with what degree of accountable skill?
- the potential scale of bureaucratic form filling
- the consequent risk of non-compliance or poor compliance (eg by already overstretched general practitioners)
- the potential of such new-found skill in less experienced hands to delay expert diagnosis
- concern about the lack of any pilot information supporting the workability or effectiveness of any SAP model within the NHS or similar context.

Intermediate care*

Intermediate care is explicitly fixed as government policy⁵, identified as a beneficent 'given' and singled out as a free-standing framework 'standard'. From the introduction above, it will be clear that this specific focus might present either opportunities for or threats to patient care:

- Intermediate care is not a fundamentally new concept. Indeed, in the preceding NHS guidance, and in the NSF itself, its operational description reads to specialists as a naive, simplistic, incomplete account of one long-established component of their service.
- Unless firmly embedded within the aegis and governance criteria of a comprehensive specialist service, intermediate care for older people is neither cost-effective (it will certainly not unblock hospital beds) nor clinically safe. Conversely,

Key Points

The National Service Framework (NSF) for Older People is a hybrid of policy, evidence and expertise

The NSF presents opportunities and risks, to both of which physicians should be alert

The standards on single assessment and intermediate care exemplify the above

The standards on stroke, falls and mental health have potential as service models

Inadequate clarity of funding streams, accountability and leadership may jeopardise the outcome

within such a context there is everything to be mutually gained from agreed partnerships between primary and secondary care.

- Without the same proviso, intermediate care risks being a technically substandard and cheap diversion from mainstream hospital access for older people who need it. In this respect, the potentially perverse incentives readable under Section 3.9 (page 43) have been rightly identified as ageist^{2,3}; for example:

an increase in the per capita rate of emergency admissions for people aged 75 and over of less than 2% compared with 2000/1.

This requires revision.

The extent to which this 'standard' is an opportunity or a threat to patients will depend directly on the degree and efficiency of its shared governance and strategic integration with the specialist service. The guidelines⁸ have been insufficiently explicit. In the proper context, there could be legitimate regeneration or retrieval of defined service components lost through under-resource in recent years. Conversely, in many of the diverse, autonomous, supposedly novel schemes currently attaching this label to themselves lies a route to clinical negligence and wasted resources.

Subspecialty services

The choice of a disorder of high prevalence in old age (stroke) and a true age-associated syndrome (falls) as subspecialty

Table 2. The eight national service framework standards.

Theme I	<i>Respecting the individual</i>	Standard One: rooting out age discrimination Standard Two: person-centred care
Theme II	<i>Intermediate care</i>	Standard Three: intermediate care
Theme III	<i>Providing evidence-based specialist care</i>	Standard Four: general hospital care Standard Five: stroke Standard Six: falls Standard Seven: mental health in older people
Theme IV	<i>Promoting an active, healthy life</i>	Standard Eight: the promotion of health and active life in older age

service model standards for this NSF is highly appropriate. Both are major priorities of the field, and areas in which growing evidence has driven standards and where credible specific expertise is readily available. In both cases, the NSF proposes feasible care pathways* as a positive means of resource identification. For stroke⁹ and osteoporosis^{10,11}, it was necessary only to refer to published national clinical guidelines. International guidelines have since been published for falls¹². While neither NSF standard might wholly satisfy the specialist as a technical document, both contain a great deal on which to build and have been broadly welcomed by physicians.

General hospital and mental health services and health promotion

Alongside a statement of a number of acceptable general criteria of care under the NHS, the first two of these standards comprise a simple (but perhaps important) restatement of the role of specialist medical and mental health services for older people. In the case of mental health, the focus is particularly on services for depression and dementia, with relevant care pathways for each. The standard on health promotion is more an elementary rationale than a statement of definitive action.

Conclusion: the jury is out

The stated assertions and aspirations of the NSF for Older People are broad and ambitious but, subject to some of the major caveats discussed above, physicians in the field will welcome many of them if they happen. The interests of sick older people are not entirely squeezed out by the 'stakeholder' agendas implicit, if not explicit, in the NSF. There are ostensibly opportunities to be grasped.

The greatest caveat of all, however, is the risk of the cosmetic.

Standard One correctly aspires to root out age discrimination*, but targets local practice and overtly ageist clinical policy rather than resource. Conversely, contemporary experience suggests that 'ageism' is an embedded psychology of lower expectation, therefore lower priority and therefore lower investment – nowadays affecting health economists, health policy makers and hard-pressed health service managers rather more than clinicians.

The hard realities are sought in the final three chapters of the NSF.

Resources (including workforce)

- Costings are noticeably left to local negotiation:

Local NSF implementation arrangements will be based on existing arrangements for the Older People's JIP {Joint Investment Plans} and within the framework of LSPs, {Local Strategic Partnerships} where they exist.* (page 115)

- There is no specific costing framework for each standard, either in workforce or other resources. The cited meagre expansion in consultant manpower has already been found

to be part of an existing expansion programme which allocates no real increase to the specialty either in consultant posts or numbers in training.

- It is difficult to feel confidence in the flow of central resource in any real terms. For example:

Of the stated £1.4 billion targeted investment specifically for the needs of older people the NHS Plan announced that there would be £900 million made available by 2003/04 for intermediate care and related services to promote independence. A substantial component of that relates to resources being provided to local government, mostly through the Personal Social Services Standard Spending Assessments (SSA).

(page 136)

– at a local level, most would identify this as a rescue package; there is anecdotal evidence that this has indeed already been the case.

- The relative ring fencing of budgets that previously underpinned successful clinical directorates is absent or unclear – even in the case of the proposed care trusts.

In today's NHS, even the requirement for a 3–5 year plan is welcome, but substantial change will not occur unless the funding flow becomes better targeted and delineated during implementation.

Recruitment

Commitment to careers in the care of older people increasingly brings many of the UK's ablest young physicians, nurses, therapists and social workers into a competitive field from first choice. Yet there is no credible coverage of such a standard-setting vision in the NSF, either for medicine or the allied professions. There is a hint of the concept being held at arm's length on the premise that if everyone across-the-board changes their attitudes and learns a few basic skills, all will be well. Nothing could be further from the truth. This is potentially a glaring lost opportunity of the framework.

Responsibility

Local delivery hinges on organisational advocacy (including a clinical and managerial 'champion'), partnership working between health authorities and councils*, and joint planning.

The NHS and Social Care Regional Offices will assess local performance against the Joint Investment Plan (JIP), and the NHS Service and Financial Frameworks (SaFFs)*, using the NHS and PSS Performance Assessment Frameworks (PAFs)*.* (page 122)

It remains to be seen whether this bureaucracy will have teeth and whose head will (where appropriate) roll. Conversely, a clinical director with a budget could be given a hard time.

Research

Scanning the NSF highlights the paucity of sources in categories A1/B1 (evidence supported by controlled trials) in the field. Out

of 369 citations, 61 are in either category, with stroke (21) and falls (13) accounting for 34. This lack of 'quantitative' evidence would be unthinkable in coronary heart disease or diabetes. Research initiatives itemised in the NSF include an Advisory Network, a Directed Portfolio and a Funders' Forum. Academics await the outcome with interest.

This NSF presents opportunities and risks both for patients and for the entire NHS system of care. Physicians should keep clear heads based on their own best standards and take care not to lose the plot. The DH and National Directorate need to engage energetically with career physicians in the care of older people, without whose continued commitment the initiative stands no chance of succeeding. As far as England's older people (and maybe also our Celtic neighbours) are concerned, we are all to some extent in the dock.

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