editorial

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National Service Framework for Older People

The National Service Framework for Older People (NSF–OP) was published in March, 2001 (Department of Health, 2001*a*), 12 months behind schedule and 2 years after the publication of the National Service Framework for Mental Health (NSF–MH) (Department of health, 1999). Old age psychiatry was outside the scope of the NSF–MH, so the NSF–OP, with its own mental health standard, was keenly awaited by the speciality. Has it lived up to expectations?

What is the NSF–OP?

Because the NHS has to manage older people in most of its settings, the NSF–OP has a number of cross-cutting themes. Therefore, of the eight standards, five encompass broad issues: eliminating age discrimination, person-centred care, intermediate care, general hospital care and health promotion. The other three standards are: mental health, stroke and falls. Lastly, there is a rather overlooked medicines supplement that makes important points about medicine management and polypharmacy.

What is good about the NSF–OP?

It was certainly not foreordained that there would be an NSF for older people, and perhaps we should be grateful for a document that strongly advocates their interests. Standard 1, eliminating age discrimination, may sound like rhetoric, but is fundamental to any change. It fits firmly within the government's political agenda of fair access based on need, and is entirely consistent with the College drive to reduce stigma, since being old and mentally ill is seen as a 'double whammy'. Standard 2, person-centred care, sounds like another shibboleth but it contains important principles, such as integrated commissioning of services and standards for dignified care at the end of life, both of which old age psychiatrists welcome. It also introduces the single assessment process. Designed to stop older people having repetitive and pointless assessments there are four levels, of which one involves specialists such as old age psychiatrists.

Standard 3, intermediate care, was introduced in the *National Plan* in 1999. It aims to provide newly-commissioned, short-term alternatives to hospital care, either in the hospital or in the community. This is the only standard that is underpinned by new money. The standard for general hospital care, standard 4, concerns models of acute, ongoing and rehabilitative care, but also mentions the needs of patients with acute confusion, cognitive impairment and depression. The standard for stroke, standard 5, is the most prescriptive and delineates clear clinical pathways and service models. In the falls standard, standard 6, a broad range of preventive and rehabilitative topics are covered, many of relevance to old age psychiatry patients. Again, quite clear pathways and models are suggested. The mental health standard, standard 7, contains a thorough, if fairly basic, outline of depression and dementia and some pathways. Specialist mental health teams are to include not only psychiatrists and nurses, but also occupational therapists, clinical psychologists and social workers. The standard spells out the need to have workable protocols for depression and dementia with primary care, memory clinics, dedicated services for younger people with dementia and clear arrangements for the management of anticholinesterase inhibitors. The last standard, 8, provides an overview of healthy living for later life, with which no-one could quibble.

Difficulties

Beside stroke and falls, the only other specific disorders discussed are depression and dementia, so at first sight mental health appears well represented in this NSF. General criticisms that have been made against the NSF–OP include that other than intermediate care, there is little new money – certainly none specifically for old age psychiatry – and that the performance targets are too distant. This has not been helped by the slow, patchy development of local implementation teams, some of which have no input from old age psychiatrists.

There are missed opportunities, too. For example, Standard 3, intermediate care, contains no mention of the impact of mental health on intermediate care or the ways in which older people with mental health problems may benefit from it. Although the Department of Health is clear that intermediate care includes these individuals, soundings within the Faculty indicate marked variation so that in some localities, including my own, mental ill-health

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has become an exclusion to receiving the service. Often, this is on the grounds that no funds have been forthcoming to recruit staff with mental health expertise to intermediate care teams.

Although it is known that psychiatric morbidity is present in 40–50% of older medically-ill patients in hospital (Burn *et al*, 1993), there is no mention of the need for old age psychiatric liaison services. Requests for consultations from medical wards make up at least a quarter of the average old age psychiatrist's case load (Wattis *et al*, 1999). In Standard 4, general hospital care, 5, stroke, and 6, falls, there are a number of references to mental health assessments and the management of mental health problems, but not even a hint at what models might help to address these needs.

More specifically for old age psychiatry, conflicting pressures have resulted in almost the exact opposite to some of the intentions of the NSF–OP. For example, the aim of integrated care in standard 2, person-centred care, is undermined by collaborative arrangements, including new care trusts, in which pooling of budgets occurs only for adults of working age with mental health problems. In the first wave of care trusts for mental health, pooling of budgets for older people's services has been resisted (A. Fairbairn, personal communication) and in a recent survey, only a third of old age psychiatrists reported good integration between social and health care (Challis *et al*, 2002). Local authorities are prepared to transfer budgets from existing social service mental health teams, which dealt with working-aged adults, to care trusts, but are not prepared to hand over an unknown sum to be earmarked for the social care of older people with mental health problems. The result is a perverse sort of ageism.

The single assessment process has led to confusion. Do old age psychiatry services operate the Care Programme Approach (CPA) or the single assessment process? No one is sure. So in response to enquiries, the latest guidance suggests a bit of both (Department of Health, 2002*a*). For schizophrenia and other psychoses, the CPA is to be used with the single assessment process as the assessment tool; single assessment process and 'critical aspects of CPA' are to be deployed for severe functional or organic mental health problems. In a suffix that is unconsciously ageist, the latter criterion ends 'who were they younger would be provided for under CPA'.

A positive feature of revised CPA/single assessment process guidance is that there should be no automatic age-related patient transfers from CPA to the single assessment process. Anecdotally though, this is beginning to sour relationships in localities where general psychiatrists were accustomed to automatic transfer at age 65. This is especially relevant to 'graduate' patients with schizophrenia. Unfortunately, they are hardly mentioned in the NSF–OP. Local protocols will be needed to prevent 'graduates' being stripped of complex care packages just because they are 65, and instead being offered local authority day care. A similar issue may be brewing for younger people with dementia.

Last, in an example of disjointed thinking, the *Mental Health Information Strategy* (Department of Health, 2001*b*, 2002*b*) applies only to working-aged adults. There is to be a separate strategy to support the NSF–OP (Department of Health, 2002*b*). Information management and technology in psychiatry is already lagging behind that of acute trusts. Waiting for an NSF–OP information strategy threatens to push old age psychiatry (and other psychiatric specialities) even further back. Fortunately, most specialist mental health trusts are taking no notice of this, and are including psychiatric specialities in their information management and technology developments.

Conclusions

The NSF–OP, while ideologically sound, has paradoxically increased ageism in relation to several aspects of mental health services in later life. The speciality is missing out on new funding and service developments for severe mental illness; access to intermediate care money is haphazard, or at worst, mental ill-health is an exclusion; the new arrangements for pooling budgets with local authorities often exclude older people; old age psychiatrists are unclear whether their patients fall within the CPA and whether they will see the benefits of mental health information management and technology developments. They even have a different 'Czar' from their colleagues working along the corridor. Fortunately though, old age psychiatrists are a cohesive group and links with relevant and supportive organisations such as the Alzheimer's Society and the British Geriatric Society are robust. It would be helpful if the government put into practice its oft-repeated phrase 'joined up thinking', so that old age psychiatry does not become marginalised. The College could also add its voice to the matter.

Declaration of interest

Dr Baldwin was a member of the Mental Health Task Group of the NSF–OP. The views expressed are entirely those of the author.

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