Buckinghamshire NHS
Health Authority

AGENDA ITEM : 6

BUCKS PARTNERSHIP FORUM
5 June 2001

BRIEFING PAPER

NATIONAL SERVICE FRAMEWORK (NSF) FOR OLDER PEOPLE

1. INTRODUCTION

The NSF for Older People was released on Tuesday 27th March 2001 and, as with previous NSFs, describes a set of standards and programme of action that aims to improve the care and services available to older people. This paper presents a summary of the standards and key early milestones in the framework and an outline of the progress made to date in response to the requirements of the framework.

2. SUMMARY OF STANDARDS

The NSF for Older People consists of 8 standards that attempt to address cultural issues related to services for older people, e.g. age discrimination, and also service delivery issues in both secondary care and in the community. Below is a summary of the standards and a brief description of each.

Standard 1: Rooting out age discrimination

NHS services will be provided, regardless of age, on the basis of clinical need alone. Social care services will not use age in their eligibility criteria or policies, to restrict access to available services.

Standard 2: Person-centred care

NHS and social care services treat older people as individuals and enable them to make choices about their own care. This is achieved through the single assessment process, integrated commissioning arrangements and integrated provision of services, including community equipment and continence services.

Standard 3: Intermediate Care

Older people will have access to a new range of intermediate care services at home or in designated care settings, to promote their independence by providing enhanced services from the NHS and councils to prevent unnecessary hospital admission and effective rehabilitation services to enable early discharge from hospital and to prevent premature or unnecessary admission to long term residential care.

Standard 4: General hospital care

Older people's care in hospital is delivered through appropriate specialist care and by hospital staff who

have the right set of skills to meet their needs.

Standard 5: Stroke

The NHS will take action to prevent strokes, working in partnership with other agencies where appropriate.

People who are thought to have had a stroke have access to diagnostic services, are treated appropriately by a specialist stroke service, and subsequently, with their carers, participate in a multi-disciplinary programme of secondary prevention and rehabilitation.

Standard 6: Falls

The NHS, working in partnership with councils, takes action to prevent falls and reduce resultant fractures or other injuries in their populations of older people.

Older people who have fallen receive effective treatment and rehabilitation and, with their carers, receive advice on prevention, through a specialised falls service.

Standard 7: Mental health in older people

Older people who have mental health problems have access to integrated mental health services, provided by the NHS and councils to ensure effective diagnosis, treatment and support, for them and for their carers.

Standard 8: The promotion of health and active life in older age

The health and well-being of older people is promoted through a co-ordinated programme of action led by the NHS with support from councils.

3. EARLY MILESTONES AND LOCAL RESPONSE

The NSF outlines targets and a work programme for the next 3 years however there is work that will need to be undertaken throughout 2001/02. A full schedule of the milestones for each standard can be found in appendix 1 for reference, however those which relate to work required for 2001/02 can be found below, in addition to key milestones for early 2002/03 that will need significant work done in advance.

A revised Joint Investment Plan (JIP) for Older People and Older People with mental health problems was submitted at the end of April 2001 and will update previous documents in describing progress against the JIP work programme. It needs to ensure that in supporting continued initiatives the work is aligned with that required for the NSF. The JIP will act as a local action plan for the year one milestones of the NSF.

In addition to detailing work that should be undertaken to contribute towards meeting the standards in year one, it also provided some initial information on investment made in 2000/01 and investment planned for 2001/02. The document will be a working document that will assist in monitoring progress against milestones and, as such, reports and further information will contribute to it's use throughout the year.

3.1 2001/02 milestones

Target date	Milestone	Progress to date
June 2001	Local arrangements for implementing the NSF are established	Existing JIP group (Bucks) and Intermediate Care Joint planning group (MK) to be used as forums to oversee implementation and provide an expert reference group for good practice and developing standards. Terms of reference being drawn up and workshop to be held to agree membership/role etc, in July. JIP, co-ordinated jointly by BHA and Social Services, provides an action plan for a work programme to meet year 1 milestones and was submitted end of April 2001. Proposed structure to include specialist sub groups to take forward specific work associated with individual standards
July 2001	Jointly appointed co-ordinators for intermediate care designated, framework for use/carer involvement agreed, baseline exercise complete	Local intermediate care steering groups have appointed IC co-ordinators to manage each local scheme. Multi-agency IC group (Mid and South Bucks) and MK Intermediate care joint planning group to take forward user/carer framework and co-ordinate stocktake
October 2001	Audits of all age-related policies complete	Monitored through reference groups
January 2002	2002/03 joint investment plan is agreed	2002/03 JIP will need to align with SaFF discussions for 2002/03 and ensure that activity levels and impact is fully understood. Similarly the budget planning for Social services will also require this to be done.
March 2002	Nationally, 1,500 additional intermediate care beds compared with 1999/2000 (locally approx. 15)	Increases in intermediate bed numbers for 2000/01 and further increases in 2001/02 to meet target increases from 1999/2000 baseline
	Nationally, 40,000 additional people receiving intermediate care services promoting rehabilitation compared with 1999/2000 (locally approx. 400)	Performance monitored throughout year through information returns and agreed monitoring mechanisms in local groups. Workshops to be held in April – June 01 on roles, fit with other services and potential development opportunities for community hospitals and day hospital/day centre.
	Nationally, 20,000 additional people receiving intermediate care preventing unnecessary hospital admission compared with 1999/2000 (locally approx. 200)	

3.2 Key 2002/03 milestones

April 2002

- Unified assessment process to be introduced
- Every General Hospital, which cares for people with stroke, will have plans to introduce a specialised stroke unit from 2004
- Councils will have reviewed their eligibility criteria for adult social care to ensure they do not discriminate against older people

4. CONSIDERATIONS FOR IMPLEMENTATION

4.1 Clinician/senior manager engagement

The philosophy of Older People NSF lies in partnership working and as such there is a need for colleagues across all statutory and non-statutory agencies to work across traditional organisational boundaries. Local success is dependent upon all partners embracing a truly whole system approach which sees the needs of the patient as the focus of the work.

To encourage such an approach it is essential to have senior manager and clinician ownership and that both are 'signed up' for this. Champions from agencies across the range of partner organisations are required to ensure work is driven by those closest to patients.

4.2 Fit with strategic / organisational changes

Much of the work required to develop services in line with Older People NSF targets link closely with developments in services across the system. For example, developing services such as intermediate care and specialised stroke units will inform and be informed by the current reconfiguration plans and redevelopment of Stoke Mandeville Hospital and also the ability of a more integrated health and social care assessment process will be greatly influenced by the relationships between developing health and social care organisations.

Work is being done to produce some initial estimates of the impact intermediate care schemes have had in managing demand into and out of acute settings. Specialised stroke units will need to be planned depending upon the future configuration of hospital based services for older people across Mid and South Buckinghamshire.

Close links will need to be developed between service leads (BHA, PCGs, Trusts, Local Authorities and District Councils) for Older People and the work programme taking forward the reconfiguration of acute services in Bucks to ensure consistent messages are shared with clinicians and service delivery plans are in line with future changes.

4.3 Prevention strategies

There is a need to ensure that the development of work that encourages and promotes independence in older people is supported and that there is a clearer understanding of the impact these schemes can have on reducing demand on other health and social care services. It is in the area of prevention that the greatest impact of joint working can be made.

4.4 Nursing/residential home capacity

Many of the goals of the NSF involve available, responsive and appropriate continuing care provision in particular to support people following hospital discharge. Problems that have been experienced within Buckinghamshire in delivering this objective have included limited nursing and residential home capacity. There is a need to ensure that local strategies for providing continuing care involve representatives of care home to ensure capacity planning can be across the whole system. We need to work with providers to shape the development of future provision to get the best fit for our needs.

4.5 Recruitment & retention

Staff shortages across the health and social care sectors have been critical for some time. In particular nursing shortages and home care staff shortages have resulted in difficulties managing elective and emergency health care demands in addition to arranging domiciliary packages for older people able to reside at home.

A number of healthcare recruitment initiatives were put into place over the winter of 2000/01 and also efforts have been made to reshape and improve working arrangements for social care staff. Many of the problems are caused by the high cost of living within Buckinghamshire without the additional weighting afforded to outer London. Clearly there is a need to continue to offer innovative and interesting working opportunities and try to ensure that employees are able respond to the needs of the potential workforce in Bucks, e.g. child care support, flexible working hours, training and careers options.

5. NEXT STEPS

A Buckinghamshire local launch workshop is planned for 4th July 2001 that will aim to set the scene and present the NSF and its context within the national agenda. It will also aim to formally agree arrangements for jointly taking forward the implementation of the NSF identifying working groups that will be responsible for taking forward each standard and agree leads to represent each work area on a local implementation team (LIT).

Other strands of work that relate to Older People (e.g. community equipment) will be brought within the remit of the NSF work to ensure a consistent approach is adopted, resources are used most effectively and relevant links are made. Additionally, the District Audit review of Mental Health Services for Older People in Buckinghamshire will align with the NSF work programme around the standard covering mental health in older people.

The JIP provides a broad programme of work that is required for work in 2001/02 and dovetails with the actions outlined in the local action plan (LAP) that accompanied the SaFF document. The aim is to correspond the JIP process more closely with the financial planning cycle of the health and social services in an attempt to mainstream the JIP within these discussions.

6. RECOMMENDATIONS

The Partnership Forum is asked to note the contents of the paper.

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