

The NSF for Older People: what next?

The National Service Framework (NSF) for Older People¹ was a ten year plan for improving health and care services for older people in England. It was published in March, 2001. I was Chair of the External Reference Group for the development of the NSF (1998-9) and National Clinical Director, responsible for its implementation during the period of 2000-8.

Professor Ian Philp Honorary Professor of Health Care for Older People, University of Warwick and Medical Director, South Warwickshire NHS Foundation Trust.

***Email** I.Philp@warwick.ac.uk

In the previous articles I described how the National Service Framework for Older People (NSF) was developed, threats to its implementation and how these were addressed. By 2008, we had made good progress towards many of the ambitions set out in the NSF. Age equality in healthcare was on its way to becoming embedded in legislation. Best practice models in end of life care had been adapted from cancer care and applied to the care of older people at the end of their lives, particularly in hospitals and care home settings. A person centred approach for the social care of older people had been promoted through the introduction of direct payments and personal budgets and the development of new models of long-term care. Dignity in Care had become a top priority in healthcare, backed up by more rigorous inspection and regulation. Stroke and dementia had become top clinical priorities alongside heart disease and cancer. There were new drivers to improve care for older people with fragility fractures. Older people had the

highest ever levels of uptake of disease prevention services and the promotion of healthy active life from middle to old age was being driven through lifestyle advice in the mass media.

David Oliver (National Clinical Director for Older People) and Alistair Burns (National Clinical Director for Dementia) are now leading national implementation of reform to older people's services. Away from the complexity of the policy environment, I am convinced that there are three new challenges: the promotion of vital ageing, early intervention for old-age related needs and responding to a frailty crisis. These are challenges for leadership from primary care, specialist practice and public health respectively.

Vital ageing

Much unnecessary dependency in old age is the result of attitudinal and environmental barriers for older people to maintain and improve their levels of physical, mental and social activity. The benefits

of removing these barriers were shown in the BBC TV series "The Young Ones," where the theories of the American psychologist, Ellen Langer, were used to provide a rejuvenating environment for six elderly celebrities.

I was involved in selecting and administering the tests used in the programme including hand grip strength, flexibility, the get-up-and-go test and walking time. The before and after effects were remarkable.

Of course as a scientific experiment more rigorous methods would be required. But the programme provided important clues to things that really make a difference to life in old age. These include validation of the person as a unique individual worthy of attention (Lionel Blair and Sylvia Sims), the importance of friendship (Dickie Bird and Derek Jameson), and the application of well established principles of geriatric medicine, like encouragement of walking (Liz Smith), and use of appropriate visual aids to prevent falls (Kenneth Kendall).

Greater attention in policy and increased public awareness



of these simple things could do much to improve health, independence and well-being in old age.

Early intervention

For more than fifty years, we have known that many of the most serious threats to the health, independence and well-being of older people are not known to their primary care physicians.¹ For the last twenty years, I have led a programme to develop an assessment system for use in primary care to identify these threats and stimulate a personal response to meeting those which are the highest priority to the older person.²

Results for cross-cultural acceptability, reliability and validity are encouraging.³ The most rigorous evaluation of this

approach has been conducted in a randomised controlled trial in the Netherlands which demonstrated strong evidence of cost-effectiveness with improved functional outcomes for older people in the intervention group, higher use of community resources and lower rates of hospital admissions.⁴ Our recent work has shifted the emphasis of the programme towards self-assessment with sign-posting to information, advice and support for the older person and their families.

I believe the time is now right for primary health care systems to properly address the challenge of our ageing populations, identify needs as they emerge, and find creative responses to meet those needs which are of greatest concern to the older person. More details can be found at www.easycare.org.uk

Responding to a frailty crisis

Frail older people occupy about 70% of acute hospital beds and use most long-term institutional care services. These are the main reasons why older people's care accounts for about 46% of total NHS and 55% of social care expenditure. Based on a systematic review of evidence from controlled trials about interventions which can reduce unnecessary use of acute hospital care in older people,^{5,6} I believe that four key changes are required to the current system:

Chose to admit

Emergency response services need to identify people with frailty presentations and if life-threatening illness is not evident, refer to rapid response step-up intermediate care services. Patients can be further assessed for their acute care needs

Abbreviated prescribing information: Lipitor®. Presentation: Lipitor is supplied as film-coated tablets containing 10mg, 20mg, 40mg or 80mg of atorvastatin.

Indications: In patients unresponsive to diet and other non-pharmacological measures, Lipitor is indicated for the reduction of elevated total cholesterol, LDL-cholesterol, apolipoprotein B, and triglycerides in adults, adolescents and children aged 10 years or older with primary hypercholesterolaemia, heterozygous familial hypercholesterolaemia or combined (mixed) hyperlipidaemia. Lipitor is also indicated for the reduction of elevated total cholesterol and LDL-cholesterol in patients with homozygous familial hypercholesterolaemia as an adjunct to other lipid-lowering treatments (e.g. LDL apheresis) or if such treatments are unavailable. Lipitor is indicated for prevention of cardiovascular events in adults estimated to have a high risk of a first cardiovascular event, as an adjunct to correction of other risk factors.

Dosage: The usual starting dose is one Lipitor 10mg tablet daily. Doses should be individualised according to baseline LDL-C levels, the goal of therapy, and patient response. Doses may be given at any time of the day with or without food. The maximum daily dose is 80mg. For patients taking drugs that increase plasma exposure to atorvastatin the starting dose should not exceed 10 mg and maximum dose of less than 80 mg may have to be considered. Safety information in doses above 20mg/day is limited in patients aged <18 years. Lipitor should be used with caution in patients with hepatic impairment.

Contraindications: Hypersensitivity to any of the ingredients, active liver disease or unexplained elevations in serum transaminases exceeding 3 times the upper limit of normal, pregnancy and breast-feeding and in women of child-bearing potential not using appropriate contraception.

Warning and precautions: Liver function tests should be performed before initiation and periodically thereafter and in patients who show signs and symptoms of liver injury (monitor raised transaminases until they resolve). Drug dosage should be reduced or therapy discontinued if persistent elevations occur above 3-times the upper limit of normal. For patients with prior haemorrhagic stroke or lacunar infarct, the balance of risks and benefits of atorvastatin 80 mg is uncertain and the potential risk of haemorrhagic stroke should be carefully considered before initiating treatment. Lipitor should be used with caution in patients with predisposing factors for rhabdomyolysis and a CK (creatinine kinase) level should be measured before treatment. If CK levels are significantly elevated (> 5 times ULN) at baseline, treatment should not be started. Patients with muscle pain, cramps or weakness especially when accompanied by malaise or fever should have their CK levels monitored. Lipitor should be discontinued if CK levels are significantly raised or rhabdomyolysis is diagnosed or suspected. If muscular symptoms are severe and cause discomfort treatment discontinuation should be considered. Risk of myopathy may increase when administered with certain medications that increase the plasma concentration of atorvastatin. The risk may also be increased at concomitant administration of atorvastatin with other medicinal products that have a potential to induce myopathy. If co-administration is required a dose reduction or if not practical a temporary suspension should be considered. The concurrent use of atorvastatin and fusidic acid is not recommended and a temporary suspension of atorvastatin therapy may be considered during fusidic acid therapy. Exceptional cases of interstitial lung disease have been reported with some statins and statin therapy should be discontinued if a patient is suspected to have developed interstitial lung disease. Patients with galactose intolerance, Lapp lactase deficiency or glucose-galactose malabsorption should not take this product. Developmental safety in the paediatric population has not been established.

Pregnancy and lactation: Lipitor is contraindicated in pregnancy and lactation.

Side effects: Side effects commonly reported in controlled clinical studies: nasopharyngitis, allergic reactions, hyperglycaemia, headache, pharyngolaryngeal pain, epistaxis, constipation, flatulence, dyspepsia, nausea, diarrhoea, arthralgia, myalgia, pain in extremity, muscle spasms, joint swelling, back pain, abnormal liver function tests, increased blood CK. Other side effects have been reported in clinical trials and post-marketing (See Summary of Product Characteristics). Adverse reactions in children are expected to be the same as in adults. Side effects commonly reported in children and adolescents are: headache, abdominal pain, alanine aminotransferase increased, and blood CK increased.

Legal category: POM. **Date of Revision:** September 2011. **Package quantities, marketing authorisation numbers and basic NHS price:** Lipitor 10mg (28 tablets), PL39933/0001 £13.00, Lipitor 20mg (28 tablets), PL39933/0002 £24.64, Lipitor 40mg (28 tablets) PL39933/0003 £24.64, Lipitor 80mg (28 tablets) PL 39933/0004 £28.21. **Marketing Authorisation Holder:** Pfizer Ireland Pharmaceuticals, Operations Support Group, Ringaskiddy, Co. Cork, Ireland. Lipitor is a registered trade mark. Further information is available on request from: Medical Information, Pfizer Limited, Walton Oaks, Dorking Road, Tadworth, Surrey KT20 7NS. Ref: LR 14_0. Date of preparation: November 2011 Item code: LIP3687n.

with an informed decision to admit to acute hospital care, or to receive care in the community.

Acute care under old age specialists

Patients requiring acute hospital care should be under the care of old age specialist teams, with movement between wards or facilities kept to a minimum.

Discharge to assess

Once acute care needs are met patients should be transferred to post-acute care services (in community settings—bed or domiciliary) with 24 hours of notification and assessed for their post-acute care in these settings.

CGA prior to long-term care provision

Comprehensive assessment should be undertaken during post-acute care, followed by discharge or transfer to on-going services such as social care re-enablement, long-term conditions management, end-of-life care, or long-term care. We are testing these re-design principles in a number of different localities in England through a “Cutting the Costs of Frailty” learning network.

Conclusion

The NSF for Older People delivered substantial and embedded changes to culture, system and practice in the health and care for older people, during a benign, and then hostile policy environment. With renewed media and political interest in the impact of ageing populations I believe there are fresh opportunities to build on the legacy of the NSF. This includes not only continuing work in key areas of the NSF, such as ensuring dignity in care, and the development of better care for people with dementia and their families, but also to break new ground in promoting vital ageing, early intervention in primary care and in cutting the costs of frailty.

Conflict of interest: Professor Philp is a Director of the EASY-Care Foundation Ltd, a not-for-profit company which supports the use of EASY-Care instruments and receives royalties from companies which undertake commercial exploitation of the instruments. EASY-Care instruments in manual and electronic formats are however available without charge to non-commercial providers of health and social care to older people.

References available on online version of article at www.gerimed.co.uk

Adverse events should be reported.
Reporting forms and information can be found at
www.yellowcard.gov.uk
Adverse events should also be reported to Pfizer Medical Information on
01304 616161.