The NSF for Older People: what next?

The National Service Framework (NSF) for Older People[1] 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.

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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

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 Fraility" 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 fraility.

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