Developing a National Service Framework for older people

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National Service Frameworks are one of the “big ideas” in healthcare policy in England. They are designed to improve the quality of health care by setting standards of care including structures, processes, and intended outcomes for key conditions or client groups. These frameworks seek to level up to the good, and to eliminate unacceptable practice.

The prototype for these frameworks was the development of a National Plan for Cancer Care. National Service Frameworks were then developed for Mental Health and Coronary Heart Disease. For all three subjects there were concerns that the NHS was falling behind international standards.

The Older People's National Service Framework was next to be announced; it was different from its predecessors because it covered a population group rather than a set of conditions. It was larger and more complex, as older people consume about 50% of expenditure in health and social care; and it was the first framework to set standards for social as well as health care.

A framework for older people was needed because of widespread concerns about the loss of dignity suffered by older people, in hospital settings in particular. A campaign was mounted by a national newspaper (the *Observer*) and an older people's charity (Help the Aged), which highlighted anecdotal concerns.

The Secretary of State for Health commissioned an investigation by the Health Advisory Service, which conformed widespread problems.¹

The Secretary of State then announced that there was to be a framework for older people, which would set standards, not only for the care of older people in hospital, but also in all health settings and for the interface with social services. In addition, the Framework would set standards for some key conditions; stroke (all adult), dementia (all adult), and for depression and falls in old age.

The extraordinary breadth and complexity of the Older People's Framework convinced some that its focus should be narrowed to two subjects; the care of older people in hospital, and stroke care.

However, others involved at an early stage in the development of the Framework, including me, felt that only a broad approach could tackle the fundamental cause of problems in the care of older people—namely the lack of integration of services to meet individual needs. This view prevailed.

THE EXTERNAL REFERENCE GROUP

An external reference group was established in April 1999 to advise the Department of Health on the development of the Framework. I was asked to co-chair the group, together with the Chief Inspector of Social Services. We felt that membership of the Group should be kept small to be effective.

In addition to the co-chairs, members of the Group included an NHS chief executive, a local authority director of social services, a local authority chief executive, clinicians from old

age medicine, psychiatry, nursing, occupational therapy, speech and language therapy, neuropsychology and general practice, and senior officers from Help the Aged and the Carers National Association.

Seven Task Groups were also established, each chaired by a member of the External Reference Group, to advise on specific conditions (falls, mental health, stroke) a sector of the care system (general hospital, primary care) or processes of care (assessment and care management, transitions in care). An Older People's Reference Group and a Carers' Focus Group were also established to provide parallel advice on the development of the Framework and to comment on the External Reference Group's deliberations.

The Group developed a set of principles to underpin its work and that of the Task Forces (fig 1).

SUPPORTIVE EVIDENCE

An interactive approach was used to provide an evidence base for the Group's report.

A total of 15 databases were searched. Although they did not comply with the criteria of formal systematic reviews, the searches were conducted in a thorough manner. Outputs were saved from 200 separate search strategies of varying complexity and a detailed information management system was developed to permit ease of identification, access, and retrieval. The bulk of the references were sifted and thinned by the researchers to a total of around 2000. Task Group chairs identified items from this total that they felt were suitable for inclusion in the report; they also included references that they had previously identified from their own sources. A final list was drawn up to comprise the supportive evidence for the Framework's report consisting of about 300 key references.

The researchers weighted this evidence base using a system specifically developed for the Framework. Various systems were examined. It was felt that none adequately recognised the importance of good non-interventional research nor the experience of users and carers. In view of different conventions regarding research, methodologies, and semantic differences in terminologies, it was also considered important to

Figure 1 Organising values and principles. Underpinning value: person centred care

Table 1 Categorisation of evidence

Category	Description of category
Evidence from research and other professional literature	
A1	Systematic reviews which include at least one randomised controlled trial
A2	Other systematic and high quality reviews
B1	Individual randomised controlled trials
B2	Non-randomised, experimental studies
B3	Well designed, non-experimental studies, controlled statistically if appropriate; includes well designed qualitative studies
C1	Descriptive and other research (for example, convenience samples) not in B
C2	Case studies and examples of good practice
D	Summary articles and discussions of relevant literature (not in A)
Evidence from expert opinion	
P	Professional opinion based on clinical experience or reports of committees
U	User opinion from Older People's Reference Group or similar
C	Carer opinion from Carers' Focus Group or similar

develop a system that would integrate the Framework's medical and social services themes. The system thus finally developed and used in the report is shown in table 1. It incorporates systematic and other quality reviews, experimental research, non-interventional research and expert opinion from professionals, users, and carers. After the weighting process, the weighted evidence was interwoven into the report. A short series was published in the *British Medical Journal* focusing on four key areas; promoting the dignity and autonomy of older people,² falls services,³ mental health services,⁴ and promoting healthy active life.⁵

The government accepted the External Reference Group's report as the basis for the Framework, and then announced a comprehensive plan for modernising the NHS. This NHS Plan contained many features relevant to the care of older people including:

- The introduction of a single assessment process for health and social care of older people, leading to:
- Individual care plans for the most vulnerable
- Senior nurses (modern matrons) to enforce higher standards of care in hospitals.
- Additional support for family carers
- New monies for community equipment
- New range of services bridging primary and secondary care (intermediate care).
- Greater integration of the commissioning and provision of health and social care.
- Introduction of Care Trusts that combine health and social care provision intended to benefit older people in particular.

The National Service Framework for Older People needed to reflect this broader picture. In particular, service models for intermediate care and for the single assessment process were required. Underpinning programmes had to be developed for workforce, information strategy, performance measurement, research and development, finance, and for clear milestones for implementation of the Framework.

The NHS Plan also announced the establishment of 10 National Task Forces to take forward the modernisation programme, including one for older people's services, which would oversee implementation of the Framework.

THE FUTURE

The importance of the Framework is that it will empower stakeholders to develop better services for older people. It is not intended to ossify service development. As new evidence emerges from research and experience of implementation, the Framework should evolve. The Older People's Task Force is key to communicating the Framework to the field and overseeing implementation.

As National Director, I will spend much of my time seeking the views of service users and frontline practitioners about problems and success in implementing the older people's modernisation programme. There is some cynicism among service managers, practitioners, service users, and the public about whether the NHS can overcome its problems and deliver consistent, high quality services. Many countries, not least the three others in the UK (Scotland, Wales, and Northern Ireland) will be watching closely to see whether the English National Service Frameworks prove to be a successful mechanism for ensuring quality in care.

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REFERENCES

- 1 **Health Advisory Service.** *Not because they are old; an independent inquiry into the care of older people on acute wards in general hospitals.* London, Health Advisory Service, 2000.
- 2 **Lothian K,** Philp I. Maintaining the dignity and autonomy of older people in the healthcare setting. *BMJ* 2001;**322**:668-70.
- 3 **Swift C.** Care of older people: falls in late life and their consequences—implementing effective services. *BMJ* 2001;**322**:855-7.
- 4 **Burns A,** Denning T, Baldwin R. Care of older people: mental health problems. *BMJ* 2001;**322**:789-91.
- 5 **Andrews GR.** Care of older people: promoting health and function in an ageing population. *BMJ* 2001;**322**:728-9.